Objectives

- Identify key levers to accelerate large-scale care redesign
- Develop strategies to address the challenges in utilizing these levers effectively
Trinity Health - By the Numbers

86* Hospitals in 21 states

128
Long-term care, assisted, independent living and affordable housing communities
- 44 home care agencies serving 160+ counties
- 14 PACE Centers
- 70 other continuing care facilities

Nearly 2.8 million home health/hospice visits

$13.6 billion in revenue

Almost $900 million in community benefit ministry

89,000 full-time employees

3,300 employed physicians

22,890 affiliated physicians

But Who Are We Really?

What We Believe

We Trinity Health serve together in the spirit of the Gospel
To be a compassionate and transforming healing presence
In the communities we serve

GO and DO likewise!
Outcomes at Scale – The Punch Line

Network Level Run Chart of Huddle Rate and PVP Rate

Measurement in waves of roll Out

- 61% → 5884

36% of DM With PVP 6264

Outcomes at Scale – The Punch Line

Network Level Run Chart of Screening Metric Rates:
HbA1c, LDL, Microalbumin

- 3% = 350 pts/month

- 5% = 549 pts/month

- 12% = 1,288 pts/month
## Outcomes at Scale – The Punch Line

<table>
<thead>
<tr>
<th></th>
<th>CG-CAHPS</th>
<th>PCMH</th>
<th>Press Ganey</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>West Division patients with diabetes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of returned surveys*</td>
<td>985</td>
<td>92.9</td>
<td>93.3 95.4</td>
</tr>
<tr>
<td>Top Box Score</td>
<td>82.4</td>
<td>52.2</td>
<td>57.4 93.0</td>
</tr>
<tr>
<td>Mean Score</td>
<td>92.8</td>
<td>92.6</td>
<td></td>
</tr>
<tr>
<td><strong>West Division patients with two or more chronic conditions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of returned surveys*</td>
<td>872</td>
<td>93.3</td>
<td>93.7 95.3</td>
</tr>
<tr>
<td>Top Box Score</td>
<td>79.3</td>
<td>49.8</td>
<td>59.8 93.2</td>
</tr>
<tr>
<td>Mean Score</td>
<td>92.6</td>
<td>93.2</td>
<td></td>
</tr>
</tbody>
</table>

*Visit dates from April 1, 2014 - June 30, 2014 with surveys received by August 10, 2014
**Chronic conditions include: Asthma, COPD, CAD, Diabetes, Heart Failure, Hypertension, or IVD

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## Framework for Going to Full Scale

IHI - Getting Results at Scale Program; Pierre Barker, Marie Schall (Feb 2015)
Key Components in Our Journey

Setting up
• Leadership
• Social networks
• Setting vision
Scalable unit
• Leadership
• Learning system
• Infrastructure for scale up
Testing scalable unit
• Leadership
• Learning system adaptation
• Infrastructure for scale up
• Human capacity for change

Key Components in Our Journey

Going full scale
• Leadership
• Learning system adaptation
• Culture of urgency and persistence
• Data systems
Sustainability
• Leadership
• Competing Priorities
Set Up – “getting ready to go”

Leadership

• Diabetes Collaborative Steering Team
• Multi-dimensional team from clinical leadership across the organization
• Monthly virtual meeting for 3 months
• Significant in between work for system office team
  • CMO
  • .5 FTE project manager
  • .1 FTE data support
  • Consulting arrangement with Accenture for support in partnership with Sanofi

Set Up – “getting ready to go”

Creating the model – shared vision
Set Up – “getting ready to go”

Creating data systems measure
- Gaps in care report
- Diabetes metrics
- PVP
- Huddles
“scrappy” first data

Set Up- “getting ready to go”

Partnership with Sanofi, Accenture
- Significant deep dive on feasible regions to choose for our scalable unit
- Opportunity to partner with pharma in the ambulatory space which was unique for our organization
- Allowed staffing capability to allow agility
Building the Scalable Unit – Mason City, IOWA

Why we picked it
• Geographically dispersed –
• Not overly supported – (like Michigan folks)
• Early in the transformation journey
• Had the band width
• Leadership Superstars!

Learning system
• Learning Collaborative methodology - in person every other month
• Practice coaches remained in place between sessions

Use of process excellence in the ambulatory space
• Virtual fishbone
• Swim lane redesign
Fishbone Pre visit Planning

Charter Development

1. PROBLEM STATEMENT
Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 M Americans have diabetes, and half these cases are undiagnosed. Diabetes accounts for nearly 20% of all deaths in people > 25 years. As of 2012 baseline data, Trinity Health Physician Networks have variable performance on NQF endorsed metrics due to gaps in care or data capture in the registry/electronic health record. In addition, there is varied process and practices for care delivery for patients with diabetes across the UEM.

2. CASE FOR CHANGE
The bleak health care statistics secondary to a fractured health care delivery system, coupled with disengaged patients has brought us to a critical juncture in our role in the health care system. This failure is quantified by communities, struggling with chronic diseases, poor behavioral choices, obesity and premature morbidity. This challenge is quantified yearly in the RWJ Foundation County Health rankings, with most of the Trinity communities struggling in at least one area of the assessment.

Many complications for patients for diabetes, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. In 2007, diabetes was estimated to cost the U.S. economy $174 billion. Complications from the disease cost the country nearly $100 billion annually.
Charter Development

3. PROJECT GOALS

Improvement NQF endorsed process & outcomes measures for A, B, C, Ds for diabetic care. (HgA1c <8; Blood Pressure 140/90, LDL <100, Urine Protein Dip Screening) for patient with diabetes by ____% by completion of fiscal year July 2014.

4. DELIVERABLES

1. Define and implement UEM scorecard to evaluate clinical processes and outcomes for adult patients with diabetes seen at the PNO primary care practices by July 2013.
2. Establish a conceptual framework for care delivery transformation for adult patients with diabetes in the ambulatory space and complete assessment of practice by August 2013.

5. SCOPE DEFINITION

Evaluate processes, structures, outcomes for all adult patients with diabetes seen at the physician network primary care practices.

Please note: Impact to Clinical Integration Network (Independent Physicians & Free clinics is still being evaluated. These groups may be added in the future as the Collaborative progresses.)

6. PROJECT MILESTONES

- Steering Kickoff – May 15, 2013
- Collaborative Kickoff – June 21, 2013
- Scorecard Implementation – July 2013
- Assessment of Clinics – August 2013
- Design Phase First Intervention – September 2013
- Pilot Phase – November 2013
- Implementation – February 2013
- Sustain -
Charter Development

7. CUSTOMERS
Physician Network practices (ACE – physician network practices)

8. RISK

<table>
<thead>
<tr>
<th>Risk Name</th>
<th>Description</th>
<th>Impact on Project (In Cost, PD, Schedule, etc)</th>
<th>Severity (H,M,L)</th>
<th>Probability (H,M,L)</th>
<th>Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data</td>
<td>No single source to obtain data from the physician network</td>
<td>Hinder improvement efforts</td>
<td>H</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>Competing Priorities</td>
<td>Competing priorities in the Physician Network Space</td>
<td>Team ability to focus on work</td>
<td>H</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>Readiness for Change</td>
<td>First UCO collaborative in the ambulatory space</td>
<td>Ability for clinics to implement quality improvement project</td>
<td>H</td>
<td>M</td>
<td>H</td>
</tr>
<tr>
<td>Magnitude of Impact</td>
<td>Numerous PNO practice to spread change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Building the Scalable Unit – Mason City, IOWA
- Creation of standard work flow
- Creation of tool kit for:
  - PVP
  - Huddle intervention
Use of Mason City Data for Testing Scale Up

Improved patient quality

<table>
<thead>
<tr>
<th></th>
<th>March</th>
<th>November</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP&lt; 140/90</td>
<td>52.17%</td>
<td>76.33%</td>
</tr>
<tr>
<td>Urine micro</td>
<td>65.22%</td>
<td>81.66%</td>
</tr>
<tr>
<td>LDL &lt; 100</td>
<td>16.77%</td>
<td>27.22%</td>
</tr>
<tr>
<td>HbA1C &lt; 8.0</td>
<td>37.27%</td>
<td>46.15%</td>
</tr>
</tbody>
</table>

Business Case
- For Current DM absent from care - $2 million
- HIX population $6 million

Staff experience –
- Process valued by the team – they didn’t want to float out of the pilot office
- Providers were volunteering to be the next wave of roll out

Testing Scale Up –
Care Redesign Initiative
Moved from Mason City to over 200+ practices in West Division
Testing scalable unit key components
- Infrastructure for scale up
- Human capacity for change
- Leadership
- Learning system adaptation
Testing scale up – Care Redesign Initiative: Infrastructure

Need to assess the current state of all the practices

- Move to virtual tool for assessment
- Assessment completed in over 80% of practices
- Hybrid of Practice PCMH-A MacColl with questions related to our “bulls eye” model – ie depression screening
- Phone debrief with each RHM on their survey results

Allowed development of relationship with system office, and understanding of the scope of the work

Further development of the system office team to include a clinical transformation director, with a .5 FTE project manager

Testing scale up – Care Redesign Initiative: Human Capacity for Change

Engaging change management expertise from system office
Testing scale up –
Care Redesign Initiative: Human Capacity for Change

Reframing of resistance as good ---
• They care enough to push back
Allowed conversation about the elephants in the room
Help each RHM formulate the “elevator speech” for engagement specific to their regional issues

Testing scale up –
Care Redesign Initiative: Leadership

Standardized roles/responsibility
• Accountable clinical exec (ACE) employed network (PNO)
  • Network level physician lead
• Health network coordinator
  • Clinical lead at the practice level – not MD
• Accountable executive hospital
  • Often was a physician but could be CEO/COO
Testing scale up –
Care Redesign Initiative: Learning System

Launch virtual learning network –
- Move to all virtual framework
- Loss of the practice coaches
- System level leadership / Director of Clinical Transformation “hit the road” site visits

Adaptation of tools for various RHM technologies
- Moved from one EHR or paper, to multiple EHRs

Adaptation to “virtual” process excellence tools

Testing Scale Up:
Learning System - Roll Out Plan

<table>
<thead>
<tr>
<th>January</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop implementation plan</td>
<td>Wave 1 1 Clinic Per Network (Evaluate Measures/Tools/Change Plan)</td>
<td>Wave 2 20% of clinics or providers</td>
<td>Wave 3 50% of clinics or providers</td>
<td>Wave 4 75% of clinics or providers</td>
<td>Wave 5 85% of clinics or providers</td>
</tr>
</tbody>
</table>
Current Status Description Data

Registry Data
- Lakeshore Health Network
- Mercy Health Physicians
- Loyola
- Mason City*
- Sioux City
- Port Huron

NextGen Data
- Mercy Health Physicians
- Mason City*
- Sioux City
- Boise
- Grand Rapids
- Columbus

Tentative: nonstandard NextGen or other
- IHA
- Ann Arbor
- Columbus

Unavailable Registry Data:
- Boise
- Mercy Chicago
- Fresno
- Dubuque
- Clinton
- Grand Rapids
- Livonia

Paper
- Oakland
- South Bend
- Cadillac
- Grayling
- Chelsea

* Consider validity of Mason City data

Testing Scale Up – Measurement – needed to adapt

Clinical Process Measures
- Eye Exam
- Foot Exam
- Microalbumin Screening

This ended up much harder to capture without a consistent data system

Patient Outcome Measures
- Hemoglobin A1c Control (<8%)
- Hemoglobin A1c Poor Control (>9%)
- Low Density Lipoprotein (<100)
- Blood Pressure <140/90

Could not pull these out for just our employed providers
- Hospital Readmissions
- ER Visits

Patient Satisfaction (coming in January 2014)
- COCAHG: 1) During your most recent visit, did this provider explain things in a way that was easy to understand?
- 2) During your most recent visit, did this provider show respect for what you had to say?
- 3) During your most recent visit, did this provider listen carefully to you?
- 4) In the last 12 months, did anyone in this provider’s office talk with you about specific goals for your health?
- 5) In the last 12 months, did anyone in this provider’s office ask you if there are things that make it hard for you to take care of your health?
- 6) In the last 12 months, did anyone in this provider’s office ask you if there was a period of time when you felt sad, empty, or depressed?

Structural measures
- Huddles
- Pre-visit Planning
# Test of Scale – A3 Measurement

<table>
<thead>
<tr>
<th>Collaborative Network Name</th>
<th>Ambulatory Diabetes</th>
<th>Status</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Alphonsus Physician Services</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Mercy Medical Services</td>
<td></td>
<td>13% of sites reporting huddles</td>
<td>Y</td>
</tr>
<tr>
<td>St. Joseph Physician Network</td>
<td></td>
<td>Slow progress at adding sites (33% for both PVP and Huddles)</td>
<td>N</td>
</tr>
<tr>
<td>Mercy General Health Partners &amp; Lakeshore Campus</td>
<td></td>
<td>35% sites rpt huddles</td>
<td>Y</td>
</tr>
</tbody>
</table>

# Taking to Full Scale

[Map of the United States with various markers indicating healthcare facilities and locations.]

- Hospital
- Other Continuing Care Facility
- Home Care Agency
- Employed Physicians
- Affiliated Physicians
- HCIE Center
Taking to Full Scale

Learning methodology
- Virtual collaborative
- Utilization of tool kits created previously
- Pull methodology for east division

Addition of embedding care management capability in the primary care team
- Transition of care
- Annual wellness visit
- Chronic care code documentation / billing

Taking to Full Scale
- Leadership CEO Dr. Rick Gilfillan
- Culture of urgency and consistency

- Addition of embedding care management capability in the primary care team
  - Transition of care
  - Annual wellness visit
  - Chronic care code documentation / billing
# Test of Scale – A3 Measurement Evolving

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>St. Alphonsus Physician Services</td>
<td></td>
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<td></td>
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<tr>
<td>Mercy Family Care Network</td>
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<tr>
<td>Mercy Medical Services</td>
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<td>IHA</td>
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<tr>
<td>Chelsea</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holy Cross Hospital</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Peter’s Health Partners</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

* Tasks are green - updated plan submitted.  
* Metrics are green - exceeding March targets.  
* Continue to work the plan to meet April PVP and Huddle targets.

* Tasks are amber - updated plan not submitted.  
* Metrics are red - not meeting March targets for Huddles or PVP.

# Taking Full Scale

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td></td>
<td></td>
<td>Tasks are green - updated plan submitted.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Indiana</td>
<td></td>
<td></td>
<td>Metrics are green - exceeding March targets.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mercy Family Care</td>
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<td></td>
<td>Tasks are green - updated plan submitted.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Holy Cross Hospital</td>
<td></td>
<td></td>
<td>Plan submitted six months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Peter’s Health Partners</td>
<td></td>
<td></td>
<td>Some of the sites are doing Huddles and PVP. Work on implementing Trinity standards will start once they upgrade to NG standard.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

* Tasks are green - updated plan submitted.  
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### Full scale – Modified A3

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Iowa</td>
<td>Mason City</td>
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<td>Tasks are green - updated plan submitted.</td>
<td></td>
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<td><em>Tasks are green - updated plan submitted.</em></td>
<td></td>
</tr>
<tr>
<td>Illinois-Indiana</td>
<td>Loyola</td>
<td></td>
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<td>Tasks are green - updated plan submitted.</td>
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<td></td>
<td></td>
<td><em>Tasks are green - updated plan submitted.</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chicago</td>
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<td>Tasks are green - updated plan submitted.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><em>Tasks are green - updated plan submitted.</em></td>
<td></td>
</tr>
</tbody>
</table>

### Sustaining Change

- Meaningful Use
- Care Management for High Risk
- ICD 10
- Funding Redesign Initiatives: MSSP, Bundled Payments
- Patient Safety
- Evolving Population Health Data Analytic Tools
- Transitioning and Piloting two different EHR solutions
Sustaining change

Cadence
Convergence –
Order from Chaos

Thank You – Questions?

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