ACHIEVING POPULATION HEALTH: THE POWER OF TEAM BASED CARE

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GREEN BAY WI

IHI NATIONAL FORUM

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Agenda

- Why Team-Based Care
- The Story of Julie
- **Definition** of Advanced Team-Based Care
- Primary care results
- Other Team-Based Care work
  - Conditions
  - Specialties
- Lessons Learned
Preparing for Value Based Reimbursement

- Focus on quality improvement – better care, optimize reimbursement
- Ability to take on risk

Increasing Levels of Burnout for both staff and physicians

- Demands of the EHR (Electronic Health Record)
- Demands of in-between visit work
- Increasing complexity of care

Why Team Based Care?
Meet Julie
• COPD, severe dyspnea
• Tobacco Use Disorder –2 PPD
• Type 2 Diabetes
• Depression
• Congestive Heart Failure
• Morbid Obesity
• Hypertension
• Hyperlipidemia
• Sleep Apnea

Status:
October 30, 2014
• 30 medications from multiple providers in 3 systems. There wasn’t a good idea of what she was taking
• 300 pounds
• A1C 8.6
• BNP 1025
• 5 Hospitalizations and 4 ED visits in 3 different systems in the previous 5 months
• Multiple Specialists, 3 systems
• No Insurance
What to do with Julie?
A comprehensive approach to health care delivery redesign including: **office visit redesign**, **In-between visit redesign**, and use of extended care team members, system and community resources **to improve the health and wellbeing of our patients.**
Complete Redesign of the Office Visit

Enhanced role of empowered CMA/LPNs
Empowered CTC (Care Team Coordinator) role:

Medicine Reconciliation and Refill Management
Empowered CTC (Care Team Coordinator) role:

Chart Prep/Care Gap Closure

<table>
<thead>
<tr>
<th>Diabetic Measures</th>
<th>Before Team Based Care</th>
<th>After Team Based Care</th>
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</thead>
<tbody>
<tr>
<td>A1c in control</td>
<td>49%</td>
<td>77%</td>
</tr>
<tr>
<td>A1c &lt;9</td>
<td>93%</td>
<td>96%</td>
</tr>
<tr>
<td>Foot Exam</td>
<td>21%</td>
<td>91%</td>
</tr>
<tr>
<td>Blood Pressure control</td>
<td>50%</td>
<td>88%</td>
</tr>
<tr>
<td>Microalbumin screening</td>
<td>62%</td>
<td>92%</td>
</tr>
<tr>
<td>Retinal exam</td>
<td>33%</td>
<td>41%</td>
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</table>
Empowered CTC (Care Team Coordinator) role:

EHR Support during the Patient Visit
Team Approach to In-Between Visit Work

- Restructure the in basket
- Team approach to management
- The power of empowerment
- The role of the RN redefined
- The fundamental need for co-location
Key Role of Co-Location
Population Health Management

- Improved patient engagement with Core Team
- Involvement of Extended Care Team with complex patients
- Enhanced communication- regular care team meetings
- Engagement with employers, payers, and community to provide care across the spectrum
Extended Care Team

- Case Managers
- Diabetes Educators
- Clinical Pharmacists
- RN Care Coordinators
- Others as program evolves
Old Model of Care
Advanced Model of Care
Let’s get Back to Julie
Our Initial goals for Julie
November 2014

• Get her insurance coverage
• Get a handle on her meds
• Get AIC in control
• Stop smoking
• Engage!!
What's important to her?

- I want to breathe easier
- I want to get some help, I feel alone
- I don’t want to have to go to the hospital all the time
- I need people to care about me
Engagement and bonding with Core Team
Case Manager:

Obtain and backdate insurance, provide ongoing support for case management needs.
Behavioral Health:
Ongoing counseling regarding depression, life stressors, support for smoking cessation
Diabetic Educator:

Review and adjust diabetic meds, reinforce lifestyle changes
Clinical Pharmacist

Reviewed meds, cut number of meds by over half, enhanced Julie’s understanding of her meds.
RN Care Coordinator:
Home visits, intensive involvement to coordinate care and guide Julie to better health in a long term therapeutic relationship
Julie's Team
• 10 Medications plus inhalers
• 271 pounds
• 3 cigarettes a day, no significant dyspnea
• A1C 6.1
• BNP 131
• Depression well controlled
• No hospitalizations since October 30, 2014
• Understands her health issues
• Keeps in regular contact with the team
Hear from our TBC team and Julie
Primary Care Results - The 3 Wins

① WIN for the Patient
② WIN for the Care Team
③ WIN for the System
Comparing Patients with a Primary Care PCP on TBC for over one year vs. those with a Primary Care PCP not on TBC for over one year

- $724 more in Bellin payments per patient
- 5.9% more in Bellin Contribution Margin
- $27.12 lower PMPM (Next Gen Patients)
- 8% average improvement in 7 Key WCHQ Metrics
- 2.2% increase in Top Box Likelihood of Recommending
WIN FOR THE PATIENT

- Improved quality of care
- Improved access and engagement with their team
- Ability of their clinician to focus on them during the office visit
- Better coordination of care throughout the system
Example: Win for the Patient - Access

Ability to get a planned care visit as soon as they thought they needed it:

• Prior to TBC – 70.72%
• 6 months post TBC – 96.65%
WIN FOR THE CARE TEAM

- The Power of Empowerment
- The Satisfaction of Team Work
- Reclaiming the Joy of providing care for our patients
Provider Satisfaction, Team-Based Care

Source: Authors’ analysis of results from the St. Norbert College Strategic Research Institute Provider Engagement Survey of Bellin Health Providers, July 2017
WIN FOR THE SYSTEM

✓ Improved Quality Measures
✓ Improved Staff Retention and Recruitment
✓ Improved ability to Thrive in Value Based Payment Systems
7 Key WCHQ Quality Metrics

- WCHQ Snapshot 9/30/2017
- Original 29 TBC PCPs vs. all other Bellin Primary Care PCPs
New Payment Models

- Fee for Service
- Insure Health
- Manage Health

High Coordination

Low Coordination

As of 2014
10,000 Patients

Fee for Service

- $-

- $-

10,000 Bellin Patients

CMS Incentive Programs

UHC Commercial
(26k)

Humana Medicare Advantage
(4k)

Bellin Insured
(5k)

Next Generation ACO
(10k)

Anthem Commercial
(4k)

UHC Medicare Advantage
(10k)

$0,000 Bellin patients
Team-Based Care work across the System
Comprehensive System/Patient View
CONDITION WORK:
CONGESTIVE HEART FAILURE
### Congestive Heart Failure

#### Knowledge of the Population

<table>
<thead>
<tr>
<th>Population</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>6647</td>
<td>Congestive Heart Failure patients all classes</td>
<td></td>
</tr>
<tr>
<td>663</td>
<td>C and D class Congestive Heart Failure patients</td>
<td>$2200.00 PMPM cost, 19.7% Readmission Rate</td>
</tr>
</tbody>
</table>

![Image](image_url)
The CHF Care Team

- Cardiologist/APC
- CHF Care Coordinators
- CMA
- Case Manager
- Clinical Pharmacist
- Nutritionist
- Palliative/Hospice Care
- Primary Care Team
CHF Results:

**Readmission Rate:** Goal <10%

- **Baseline:** 19.7%
- **Actual:** 6.6%

**PMPM:** Goal Reduce by 10% or < $1928.83

- **Baseline:** $2143
- **Actual:** $1797
CONDITION WORK:

DIABETES
Diabetes:

Knowledge of Diabetic Population

- 14,820 total patients with diabetes
- 1774 out of control (>9 A1c) diabetics
- 8,664 patients with diabetes and obesity
Design: The Glycemic Acute Care Team

• Team:
  • Endocrinologist/APC
  • Diabetic Educator
  • Case Manager
  • Pharmacist
  • Registered Dietitian

• Goals:
  • Blood sugar control 75% (70-180)
  • Transition to PCP after discharge
  3-7 days of discharge
  • Reduce readmission rate
Team-Based Care in Specialties
The Sports Medicine Care Team

Team
• Orthopedic Physician
• Sports Medicine Specialist
• Advance Practice Clinicians
• CMA
• Care Team RN
• Licensed Athletic Trainer
• Physical Therapist
• Primary Care Team

Goals
• Reduction of total cost of care
• Improved physical functionality post surgery
Lessons Learned

- Team-Based Care is an effective way to improve the quality of patient care
- Advanced Team-Based Care, including Electronic Health Record support for the clinician, can help alleviate burnout
- Transformation to Team-Based Care takes time, effort, and commitment from all stakeholders
- Team-Based Care transformation is not just for primary care but rather for the entire system
Lessons Learned

• Think innovatively in specialties to organize effective teams
• Set expectations up front, don’t assume!
• Be prepared for staffing issues and turnover, especially for lower paid roles. Develop comprehensive training protocols and recruitment strategies to maintain staffing levels
• Think innovatively, try new approaches, but discard or modify them if not working
• Team-Based Care is an effective way to prepare for a value based world
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