Overview of Care Model Package 2
“Care of the Complicated Patient”
March 5, 2014

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Susan Marks, Director of Population Health
Lori Hauschild, Clinic Operations
Objectives

1. Review accomplishments of redesign efforts
2. Report on status of **Standardized Primary Care Model** implementation
3. Address questions and concerns
Our Growth

2013–2014
• Spread of optimized Care Model clinical office encounter workflows
• Call center / centralized outreach
• Complex Case Management / Complicated Care Management

JUNE 2013
• Delta Site Retreat: Care Model workflow refinement before spreading to all UW Health primary care clinics

MAY 2013
• Optimized Care Model clinical office encounter workflows implemented in 4 sites across the 3 specialties

JUNE 2012
• Rapid Design Session: Detailed Care Model workflow development

JULY / SEPTEMBER 2011
• Care Model design session

MAY–DECEMBER 2010
• Anticoagulation Protocol rolled out to all sites

JANUARY 2010
• Patient Engagement: UW partnership with Center for Patient Partnerships

SEPTEMBER 2009
• Microsystems program launched

JULY 2009
• Centralized outreach for breast cancer screening (BCS) launched
• Health Maintenance launched

JULY 2008
• Primary care redesign planning began
Retention of primary care patients despite major loss of physicians

Enhanced recruitment and retention of Primary Care physicians

Insertion of NPPA on DFM and GIM care teams

Definition of panels and panel weighting for population management

Cutting-edge new patient portal
  - (Welcome Center and Welcome Center Clinic) – contribution to Unity market expansion

Innovative PC comp plan based on population management/health outcomes
• Implementation of HL tools to support population management (HM, BPA, My Chart, E-visits, Registries)
• Integrated clinical leadership (Vice Chairs – PCLC) – dyad model of site leadership across all primary care
• Engagement of patients in design and improvement of care model
• Enhanced teams trained in process improvement principles (microsystems)
• Respect from entire organization for efforts to date
• Recognition of critical requirement/benefits of standardization***
Why Standardize?

- Reduce unnecessary variation in **processes** and re-work / waste
- Emphasize / facilitate team-based care and communication
- Ensure staff is able to work to highest level of licensure/certification through role optimization
- Engage patients in the effort; our processes should fit patient needs— **patient centered care**
- Make it easier to do the right thing
- Provide a sound foundation for future improvement initiatives
Ambulatory Warfarin Management

Time in Therapeutic INR Range

INR goals: 2.0-2.5; 2-3; 2.5-3.5
Critical INR Values

- Critical INR defined at UW Health as INR ≥ 5

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Critical INR</th>
<th>Total INR</th>
<th>Incidence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>331</td>
<td>22,379</td>
<td>1.5%</td>
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<tr>
<td>2010*</td>
<td>218</td>
<td>21,778</td>
<td>1.0%</td>
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<tr>
<td>2011*</td>
<td>93</td>
<td>22,417</td>
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<tr>
<td>2012</td>
<td>94</td>
<td>22,454</td>
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</table>

* P<0.0001

- After implementing the warfarin management program critical INR values significantly decreased
- Critical INR values continue to remain low
### Time Savings from Building Robust Teams
(from Bodenheimer, Health Affairs 11/2013)

#### Exhibit 1

<table>
<thead>
<tr>
<th>Type of care</th>
<th>Percent of physician’s time in traditional practice</th>
<th>Estimated percent of physician’s work that can be reallocated to nonclinicians</th>
<th>Estimated percent of physician’s time saved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive</td>
<td>17</td>
<td>60</td>
<td>10</td>
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<tr>
<td>Chronic</td>
<td>37</td>
<td>25</td>
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<td>Acute</td>
<td>46</td>
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<tr>
<td>Total</td>
<td>100</td>
<td>—a</td>
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</table>

**Sources**
- KS Yarnall et al., Note 14 in text; J Altschuler et al., Note 16 in text.  
  aNot applicable.
The Care Model

A standard set of workflows that provides a consistent clinical experience for patients and consistent processes for the delivery system leading to improved outcomes.
STANDARDIZED CARE MODEL

- Designed and tested by PC physicians, staff, and patients
- Standardization of processes/work flows
- Maintain customized clinician – patient interaction
- Measurement/quantification of work linked to roles
- Assessment and optimization of Health Link for staff and clinicians
- Defined team function – trained/standardized roles
- MA + Team RN for daily office work
- RN care coordinator in office for between visit care/management for complicated patients with multiple chronic conditions
- Centralized RN-Social worker case management for complex patients
- Implementation incorporates MU, ACO, JCAHO, PCMH requirements
Population Management

Advanced illness: Requiring ongoing management by Centralized Complex Case Managers

At-risk, multiple chronic conditions: Requiring ongoing management by RN Care Coordinators based in primary care clinics
PCR Package 2
Test began Dec. 16, 2013

Healthiest: Utilizing preventive and wellness services, some acute care, MA work
PCR Package 1
Centralized Outreach
Testing Nov 2013-March 2014

5%
6-20%
21-100%
UW Health Performance at a Glance:  
WCHQ Ranking by Provider Groups -- CY 2012, FY 2013  
(Nota: Chronic kidney disease measures other than "screening" are not included)

### Chronic Care

<table>
<thead>
<tr>
<th>Wisconsin Provider Group</th>
<th>1 - Top Performer</th>
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<tbody>
<tr>
<td>Diabetes - A1c Testing*</td>
<td>82.3%</td>
<td></td>
<td>76.9%</td>
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<tr>
<td>Diabetes - A1c Control*</td>
<td>77.5%</td>
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<tr>
<td>Diabetes - LDL Testing*</td>
<td>95.3%</td>
<td>91.9%</td>
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<tr>
<td>Diabetes - LDL Control*</td>
<td>69.4%</td>
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<td>62.2%</td>
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<tr>
<td>Diabets Kidney Function</td>
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<td>65.8%</td>
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<td>Diabetes - Blood Pressure</td>
<td>89.7%</td>
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<td>77.3%</td>
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<td>Diabetes: All or None Measure (Optimal Testing)*</td>
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<tr>
<td>Diabetes: All or None Measure (Optimal Control)*</td>
<td>49.8%</td>
<td>42.9%</td>
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<tr>
<td>Controlling Uncomplicated Essential HTN*</td>
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<td>Ischemic Vascular Disease - LDL Testing**</td>
<td>97.2%</td>
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<tr>
<td>Ischemic Vascular Disease - LDL Control**</td>
<td>76.8%</td>
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<tr>
<td>Ischemic Vascular Disease - BP Control**</td>
<td>86.7%</td>
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<tr>
<td>Ischemic Vascular Disease - Daily Aspirin or Other Antiplatelet Therapy**</td>
<td>95.7%</td>
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<tr>
<td><strong>Chronic Care</strong></td>
<td><strong>Top WCHQ Performance Rate</strong></td>
<td><strong>UW Health Performance Rate</strong></td>
<td><strong>Lowest WCHQ Performance Rate</strong></td>
<td><strong>Dean Health Performance Rate</strong></td>
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WCHQ Measure

Chronic Care

- UW Health performs well on process measures, but falls behind on outcomes.

### Preventive Care

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<tr>
<th>Wisconsin Provider Group</th>
<th>1 - Top Performer</th>
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<tbody>
<tr>
<td>Breast Cancer Screening**</td>
<td>82.7%</td>
<td>81.8%</td>
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<tr>
<td>Cervical Cancer Screening**</td>
<td>87.3%</td>
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<td>86.6%</td>
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<tr>
<td>Colorectal Cancer Screening**</td>
<td>80.1%</td>
<td>80.0%</td>
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<td>Osteoporosis Screening**</td>
<td>89.8%</td>
<td>84.4%</td>
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<tr>
<td>Chronic Kidney Disease Screening*</td>
<td>93.8%</td>
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<td>87.8%</td>
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<td>87.3%</td>
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<tr>
<td>Adults with Pneumococcal Vaccinations**</td>
<td>89.7%</td>
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<td>78.8%</td>
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<td>Adult Screening for Tobacco Use*</td>
<td>99.95%</td>
<td>99.7%</td>
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<tr>
<td>Tobacco User: Receiving Tobacco Cessation Advice*</td>
<td>98.75%</td>
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<td>98.8%</td>
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</table>

Preventive Care

- Implementation of standardized guidelines and care management should help move us toward improvement, similar to what we have seen with the INR initiative.
# of Care Gaps for FM Diabetes and (uncomplicated) Hypertension Patients

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Provider NM</th>
<th>DIAB: Total Patients</th>
<th>DIAB: Total # of Eligible Measures - 3 Care Gap Measures, 3 Provider Gap Measures, 1 All or None Outcome, 1 All or None Process per patient</th>
<th>DIAB: Total # of Gaps</th>
<th>DIAB: Care Team Gaps - Up to 3 measures per patient</th>
<th>DIAB: Provider Gaps - Up to 3 measures per patient</th>
<th>DIAB: All or None Outcome Gap</th>
<th>DIAB: All or None Process Gap</th>
<th>UNCMP HTN: Total Patients</th>
<th>UNCMP HTN: Total # of Eligible Measures - 1 per patient</th>
<th>UNCMP HTN: Provider Gaps - 1 measure per patient</th>
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<tbody>
<tr>
<td>BELLEVILLE FAMILY MEDICINE</td>
<td>Total</td>
<td>212</td>
<td>1,696</td>
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<td>COTTAGE GROVE FAMILY MEDICINE</td>
<td>Total</td>
<td>124</td>
<td>992</td>
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<td>CROSS PLAINS FAMILY MEDICINE</td>
<td>Total</td>
<td>204</td>
<td>1,632</td>
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<td>124</td>
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<td>DIFOREST WINDSOR FAMILY MEDICINE</td>
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<td>506</td>
<td>4,048</td>
<td>1,339</td>
<td>292</td>
<td>526</td>
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<td>FITCHBURG FAMILY MEDICINE</td>
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<td>NORTHEAST FAMILY MEDICINE</td>
<td>Total</td>
<td>517</td>
<td>4,136</td>
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<td>ODANA ATRIUM FAMILY MEDICINE</td>
<td>Total</td>
<td>750</td>
<td>6,000</td>
<td>1,685</td>
<td>266</td>
<td>760</td>
<td>467</td>
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<td>STOUGHTON NYGAARD FAMILY MEDICINE</td>
<td>Total</td>
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<td>872</td>
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<td>SUN PRAIRE FAMILY MEDICINE</td>
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<td>3,568</td>
<td>1,431</td>
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<td>VERONA FAMILY MEDICINE</td>
<td>Total</td>
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<td>3,280</td>
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<td>445</td>
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<td>613</td>
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<td>182</td>
</tr>
<tr>
<td>YAHARA FAMILY MEDICINE</td>
<td>Total</td>
<td>502</td>
<td>4,016</td>
<td>1,160</td>
<td>182</td>
<td>527</td>
<td>322</td>
<td>129</td>
<td>973</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>4,430</strong></td>
<td><strong>35,440</strong></td>
<td><strong>11,143</strong></td>
<td><strong>2,057</strong></td>
<td><strong>4,765</strong></td>
<td><strong>2,906</strong></td>
<td><strong>1,415</strong></td>
<td><strong>6,967</strong></td>
<td><strong>6,967</strong></td>
<td><strong>2,094</strong></td>
<td><strong>2,094</strong></td>
</tr>
</tbody>
</table>
# Care Model Workflow Packages

Last Updated: 10/07/2013

<table>
<thead>
<tr>
<th>#</th>
<th>Workflow</th>
<th>Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Pre-visit Planning (PVP)</td>
<td>Face-to-Face Encounter (Package 1)</td>
</tr>
<tr>
<td>2a</td>
<td>Daily Huddle</td>
<td>In Progress</td>
</tr>
<tr>
<td>3</td>
<td>Registration / check-in</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Rooming and visit preparation</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Clinician visit (non-acute / routine)</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Check-out and distribution of AVS</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Assessing readiness for change and supporting behavior change</td>
<td>Advanced Care for Complicated Patients (Package 2)</td>
</tr>
<tr>
<td>11</td>
<td>Supporting patient progress with self management using care plan</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Care management for high risk patients (includes med titration)</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Care coordination between providers and sites of care using care plan (Hospital to PCP)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Scheduling a future appointment (non-acute / routine)</td>
<td>Between Visit (Package 3)</td>
</tr>
<tr>
<td>7</td>
<td>Results Reporting and Follow Up</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Outreach for care gaps using bundles</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Providing resources and direction in response to patient questions regarding health</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Clinical advice and triage (may include after hours care)</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>New Patient On-boarding / Welcome Center Workflows</td>
<td></td>
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</tbody>
</table>

**OTHER**
Tests and Pilots: expectations

- We utilize front line care teams to design work flows/roles – seek patient input
- We recruit test sites with input from PCLC and local dyads
- We ask test sites to USE the workflows designed, collect data and provide feedback.
- We utilize data and ongoing feedback to make adjustments

Examples of adjustments made in Package 1:
- Stopped Learning Assessment
- Adjusted vital signs
- Moved permission to leave messages from rooming to check-out staff
- Med Reconciliation list handout became optional
- Modified pain assessment script
Two Distinct Roles Identified

- Defined by a group of front-line primary care RNs:
  - U-Station
  - Deforest
  - 20 S. Park
  - Odana Atrium
  - Yahara

Team Nurse

- “Today’s Work Today”

RN Care Coordinator

- NEW
- “Tomorrow’s Work Today”
- Proactive care for patients with chronic disease
RN Roles

Team Nurse – Today’s Work
- Triage nurse calls
  - Provide care management activities for patients not assigned to a care coordinator
- Starting IV’s
- Responding to emergencies
- Maintaining an RN schedule

RN Care Coordinator – Tomorrow’s Work
- Telephonic Care
- Patient visits
- Disease management
- Medication titration for diabetes and HTN utilizing delegation protocols
- Will formalize work of many ambulatory care nurses
RN Care Coordinator Activities

- Facilitate work with Chronic Disease Registries and common mental health issues
- Medication Titration
- Anticoagulation titration
- Review lab tests and goals with patient
- Monitor & support Medication Adherence
- Home Monitoring of chronic disease(s)
- Review signs/symptoms
- Support patient self-management
- Support positive behavior change
CHALLENGES

- Disruption of existing team relationships
- Facility barriers
- Part time staff and clinicians
- Significant differences in existing work flows—comfort with them even when not working well
- Staff attrition / vacancies---career decisions
- Need for extreme clarity of communication
- Patience with the process —ability to hold the course —loyalty to the test process
Testing now at 20 S. Park and West Women’s
  – “Hope to start” in the summer-FM clinics tentatively later in fall/winter
1. Current State (HL) assessment
2. Optimization for Package 2 skills
3. Train MA’s to do new work (previously done by RN’s)
4. Train RN Care Coordinators
5. Coaching of staff
6. Monitoring/auditing
Care Model Implementation and PCMH Certification Process
Questions?