TOMORROW STARTS TODAY.

Advocate Primary Care Transformation Collaborative (APCTC) Current State

September 14, 2018

Advocate Health Care
Tomorrow starts today.

-Objectives

- To define efforts to produce a better trained primary care workforce.
- Identify the value of institutional support funding for faculty development and IT support.
- Identify measureable outcomes of populations health efforts
- Design transformation with health care provider well being as a goal

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Advocate Primary Care Transformation Collaborative

- Started with involvement with Primary Care Faculty Development Initiative (PCFDI) and Professionals Accelerating Clinical and Educational Redesign (PACER) in 2013

- Brought us together for ongoing work across the disciplines of Family Medicine, Pediatrics, and Internal Medicine
  - And into intentional consideration of Interprofessional education and practice

Team Members

Internal Medicine	Family Medicine	Pediatrics
Dr. Jill Patton	Dr. Greg Kirschner	Dr. Nisha Hakhu
Dr. Rob Zimmanck	Dr. Bruce Perlow	Dr. Sanaa Qamar
Dr. Tom Holmes	Dr. Jason Howell	Dr. Joanna Lewis
Dr. Victoria Montgomery	Dr. Farah Chaus	

Executive Sponsor: Dr. Leo Kelly MD
Senior Project Manager: Greg Pytlak MS MBA
Administrative Support: Angela Luridas MBA DIR PHYSICIAN PRACTICE MGMT, and Joelle Cleary MGR PRACTICE., BUILDING OPERATIONS
Clinical Support: Jasmine Rivera, RN and Lisa Gills, RN

APCTC Goals

- Meet challenge of producing a better trained primary care workforce
- Create sustainable model for faculty development
- Support inter-professional collaborative practice and education
  - Patient-centered care
  - Shared resources
  - Quality improvement
- Reduce total cost of care
- *Our mission aligns with Advocate's goals in population health in our inter-professional culture.*

APCTC Outline

- Faculty Development
- Practice Transformation
- Patient-Centeredness
- Highly Functioning Teams
- Teaching with Quality Data
- Other

Faculty Development

-Local Events
-National Conference

Faculty Development: Local Events

Date	Presenter	Topic
November 2016	Dr. Tony Hampton	“Setting up Highly Functional Interdisciplinary Care Teams”
February 2017	Northwell Health	“Interprofessional Asthma/COPD Management”
November 2017	Megan Reyna, Micky Priester	“The Journey to PCMH”
January 2018	Family Medicine, Internal Medicine, and Pediatrics faculty and care managers	“Improving the Care of Complex Outpatients: A Collaboration Between Interprofessional Teams in Family Medicine, Internal Medicine, and Pediatrics”
May 23, 2018	Dr. Jason Howell	“Quality Improvement Statistics"
August 8, 2018	Dr. Greg Kirschner	“Introduction of technological Innovations in Residency Practice”

Faculty Development: National Conference

- Hosted “The Future of Primary Care: Hot Topics and Challenges”
- September 2017
- Hosted at the Hyatt Lodge at McDonald’s Campus
- Full day conference featuring both national and local speakers
- Guests included: physicians, residents, students, nursing, pharmacy, social work, behavioral health, care management, community health workers, and administration
- Keynote Address: Jay Fetter, MHSA
- 105 guests –survey showed 100% positive feedback
- Funding from Advocate Charitable Foundation Medical Education Funds

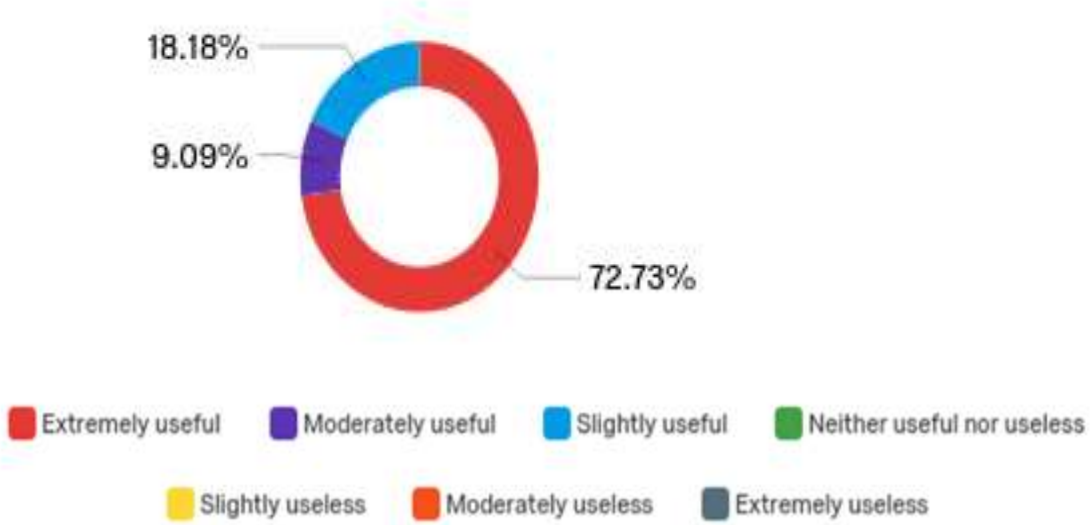
Here Is Who Attended in 2017

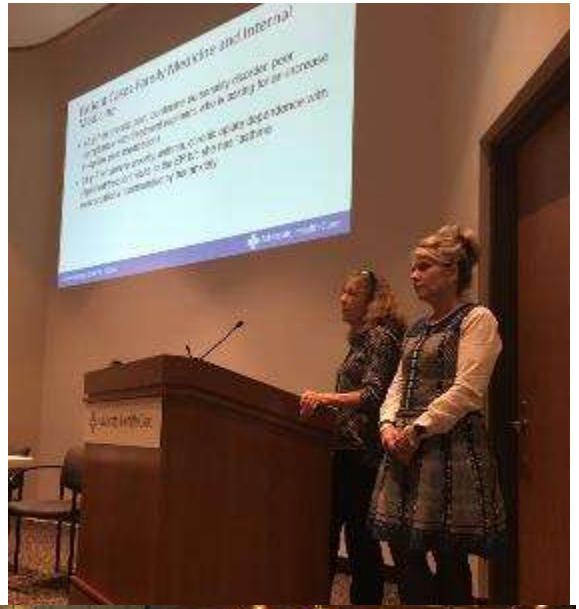
Physician Nurse Pharmacy Care Management Social Work Administration

PA or APN Medical Student Pharmacy Student Resident Community Health

Behavioral Health Other

Was the Conference Content Current and Useful ?






Clinic in a
re Office


Patient Advisory
Panels

Practice Transformation

-Interdisciplinary Care Teams
-Chronic Disease Management
-Behavioral Health Integration

Interdisciplinary Care Teams (IDTs)

- Nesset Family Medicine: Started August 2016
- Nesset Internal Medicine: Started October 2016
- Yacktman Pediatrics: Started January 2017
- The key concepts we focus on:
  - Care of complex outpatients with an intentional focus on quality and cost
  - Benefit of care planning and case management utilizing IDTs

IDT: Team Members

Team Member	Family Medicine	Internal Medicine	Pediatrics
PCP	√	√	
Care Manager	√	√	√
Faculty Physicians	√	√	√
Social Work	√	√	√
Behavioral Health	√	√	
Palliative	√	√	
Home Health	√	√	
Mission/Spiritual Care	√	√	√
Clinical Supervisor		√	√
RN		√	
Resident (until now)	√		
Practice Manager			√
Medical Director	√	√	√
Operations	√	√	√
Subspecialists			√

IDT: The Physician Perspective

- “Sometimes it’s not easy to be as patient-centered as we desire. IDTs allow us to be patient-centered”.
- Successes
  - Allow glimpse into what other people know/contributions are (social work, home health, etc.
  - Staff engagement
- Challenges
  - Resident participation, buy-in from co-attendings
  - Types of cases (ideal cases not entirely related to costs)
- Future state
  - Important to talk with care manager before, during, and after IDT
  - Mental/behavioral health is vital

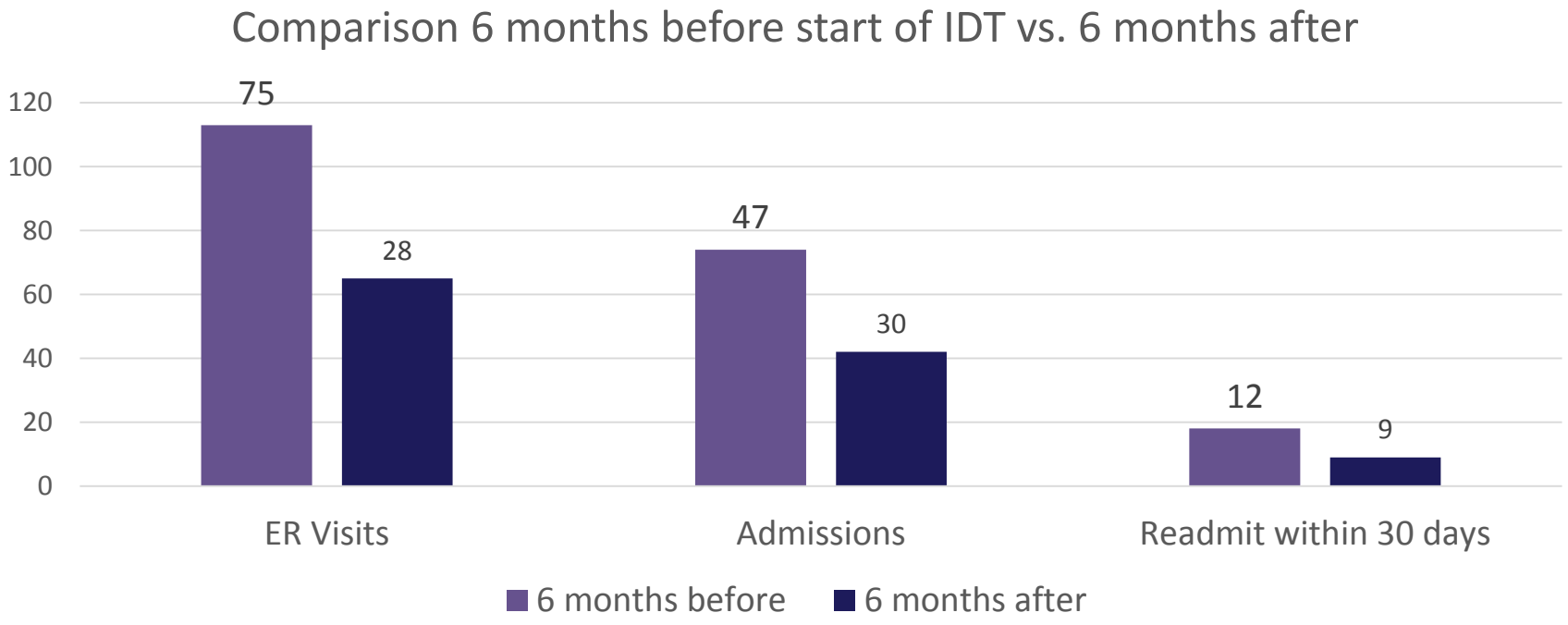
IDT: Case Examples

- 45 y F in chronic pain, borderline personality disorder, poor compliance with treatment regimens who is asking for an increase in opiate pain medications
- 74 y F w/ severe anxiety, asthma, chronic opiate dependence with repeated/frequent visits to the ER b/c she has “asthma exacerbations” confounded by her anxiety
- 14yo M HIE with CLD, TPN dependent recurrent bacteremia and sepsis like infections terminally ill, full code, refusing palliative care/hospice

IDT: Data

- An important part of this journey has been catching the attention of system leaders
- Our leaders are encouraging us to do more after reviewing our outcomes!
- Limitations
  - Small amounts of data
  - No control group

Nesset Internal Medicine and Family Medicine



IDT start date June 2016-November 2017
Source: AMG Finance, APP claims

80 Patients

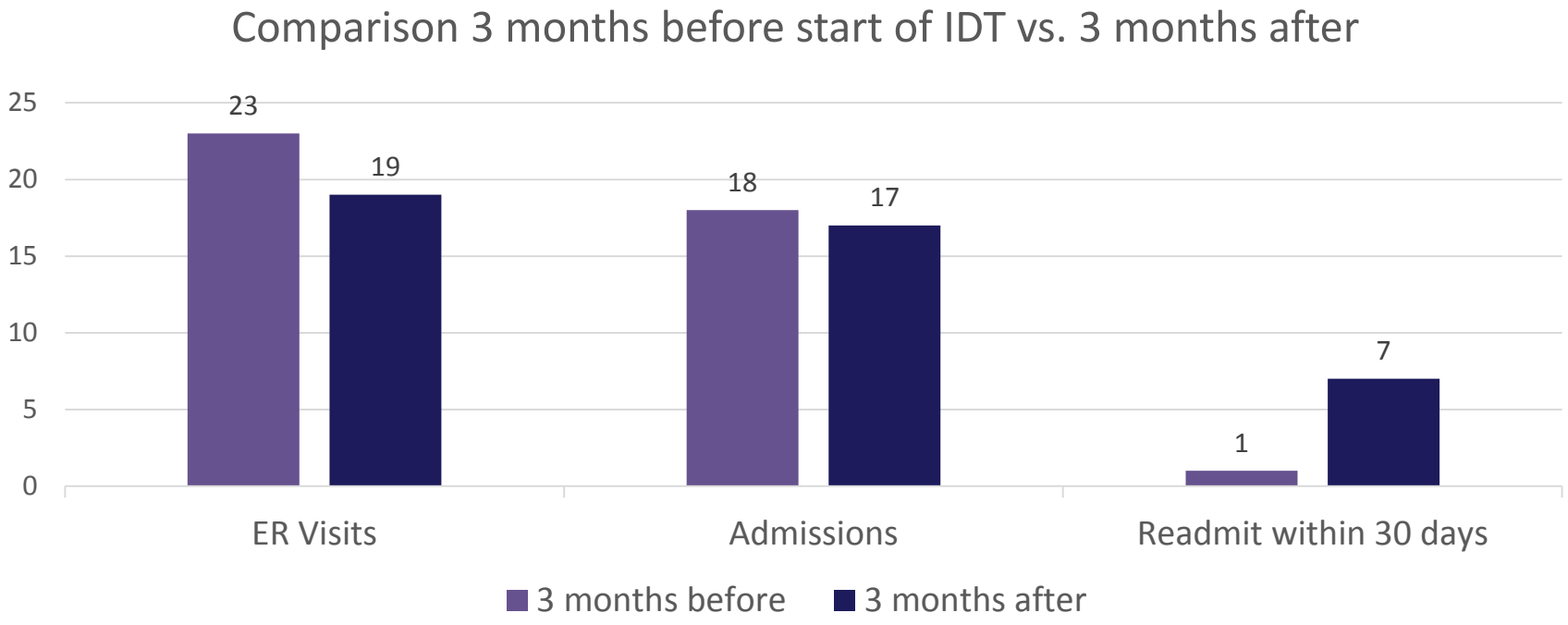
Nesset Internal Medicine and Family Medicine

Measure	6 months before	6 months after	Savings	% Change
ER Visits	75	28	47	63%
ER Visits/1000	1,596	596	1,000	63%
Admissions	47	30	17	36%
Admissions/1000	2,765	1,765	1,000	36%
Readmits within 30 days	12	8	4	33%
Readmit rate	15%	10%	5%	33%
Total inpatient cost	$566,755.00	$291, 229.00	$275, 526.00	49%
Total inpatient cost per patient	$7,084.44	$3,640.36	$3,444.08	49%

IDT start date June 2016-November 2017
Source: AMG Finance, APP claims

80 patients

APCTC Members



IDT start date: January 2018-June 2018
Source: AMG Finance, APP claims

35 Patients

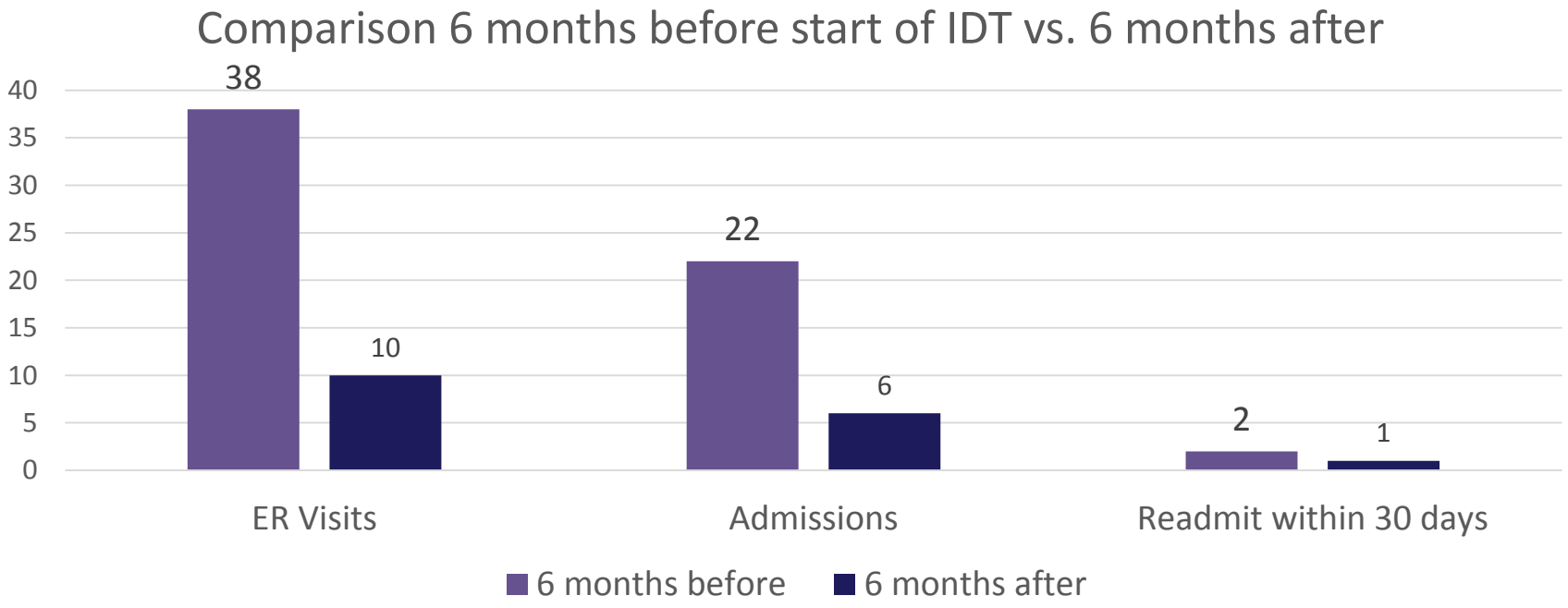
APCTC Members

Measure	3 months before	3 months after	Savings	% Change
ER Visits	23	19	4	17.39%
Admissions	18	17	1	5.56%
Readmits within 30 days	1	7		%
Total inpatient cost (Net revenue)	$200,854	$162,149	$38,705	19.27%

IDT start date: January 2018-June 2018
Source: AMG Finance, APP claims

35 patients

Yacktman Pediatrics



IDT start date January 2016-August 2017
Source: AMG Finance, APP claims

40 patients

Yacktman Pediatrics

Measure	6 months before	6 months after	Savings	% Change
ER Visits	38	10	28	74%
ER Visits/1000	950	250	700	74%
Admissions	22	6	16	73%
Admissions/1000	550	150	400	73%
Readmits within 30 days	2	1	1	50%
Readmit rate	9%	17%	(8%)	89%
Total inpatient cost	$685,612.00	$48,627.00	$636,985.00	93%
Total inpatient cost per patient	$17,140.30	$1,215.68	$15,924.62	93%

IDT start date January 2016-August 2017
Source: AMG Finance, APP claims

40 patients

IDT: Care Plan Form we created

Patient Name:
MRN:
DOB:
Does ER Need the Plan (Yes/No):

PCP:
Consultants:
Date of IDT:
Next Clinic Appointment:

Patient Goals	
Active Medical Diagnoses	
Psychiatric Diagnoses	
Medication Review (key issues)	
Adherence (meds, plan, diet, visits, etc.)	
Access Barriers (finance, transport, etc.)	
Social Barriers (language, substance abuse, culture, etc.)	
Social Support (individual/ organization names)	
Advance Directives	
Plan of Care	
Recent ER Visits	
If pt arrives in the ER	

IDT: Lessons Learned

- Significant variation by practice
  - Team members
  - Resident involvement
  - Attending engagement
  - Care Manager engagement
  - Role of the care plan
  - Practice culture
- Finance
  - We are in a transition period in health care finances that allows for this IDT care planning experiment “Fee for Volume” vs. “Fee for Service”
  - Demonstrating cost reduction leads to support from administration

IDT: Wins/Opportunities

- Wins
  - Starting January 2018 licensed clinical psychologists joined the IDTs by telephone to provide Behavioral Health support
  - Summer 2017 Family Medicine created and implemented the “Plan of Care” form that are developed during the IDT and are then shared with the Emergency Department at ALGH.
- Opportunity for Improvement
  - Attendance by residents, attendings, specialists
  - Practice culture surrounding the value of IDTs in Internal Medicine and Pediatrics
  - Support for data collection and reporting in a timely manner from system

IDT: Final Thoughts

- This is the right thing for our patients
- We should be teaching this
- This has been energizing
- This has been messy
- This has raised a lot of questions
- Changes in healthcare financing will make this even more important

Chronic Disease Management: Yacktman Pediatrics

- Asthma Clinic
  - Start date January 2018
  - Dr. Sanaa Qamar will block out an afternoon for “Asthma Clinic”
  - Will book patients directly to see her
  - Dedicated Medical Assistants are asthma educators
  - Resident involvement
    - Outreach to families
    - Developing survey
    - Developing asthma toolkit

Chronic Disease Management: Nesset Internal Medicine and Family Medicine

- Asthma/COPD Management Program
  - Attempted to implement in April 2017
  - Direct patient outreach to high utilizers
  - Appointments with embedded pharmacists
  - Attempted revamp in October 2017 –redefine expectations, improve data tracking, ensure appropriate staffing
  - On hold due to limitations: pharmacist left, staffing issues, push back from leadership

Patient Centeredness

How do we keep our care centered on you ?

Patient-Centeredness: Nesset Family Medicine Patient Advisory Council

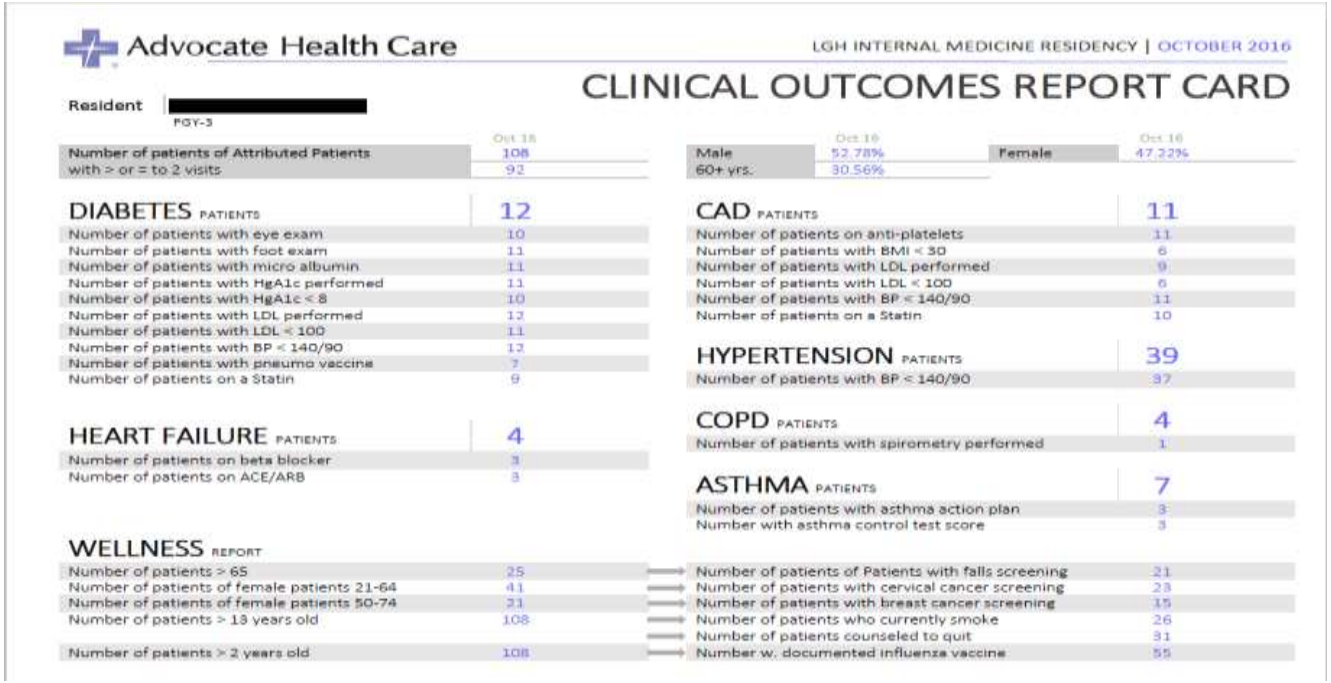
- Nesset Family Medicine Patient Advisory Council
  - 4 meetings per year
  - Topics discussed include: continuity of care, communication with physicians, resident practice, patient portal, team-based care, etc.
- Opportunity
  - October 23, 2018 Patient Advisory Council in Internal Medicine

Teaching with Quality Data

-Resident Clinical Outcomes Report Card
-Resident Quality Improvement Projects

Teaching with Quality Data: Clinical Outcomes Report Card

- Clinical Outcomes Report Card monthly for each resident



Advocate Health Care

LGH INTERNAL MEDICINE RESIDENCY | OCTOBER 2016

CLINICAL OUTCOMES REPORT CARD

Resident [redacted]
PGY-3

	Oct 16
Number of patients of Attributed Patients	108
with > or = to 2 visits	92

	Oct 16		Oct 16
Male	52.78%	Female	47.22%
60+ yrs.	30.56%		

DIABETES PATIENTS 12

Number of patients with eye exam	10
Number of patients with foot exam	11
Number of patients with micro albumin	11
Number of patients with HgA1c performed	11
Number of patients with HgA1c < 8	10
Number of patients with LDL performed	12
Number of patients with LDL < 100	11
Number of patients with BP < 140/90	12
Number of patients with pneumo vaccine	7
Number of patients on a Statin	9

HEART FAILURE PATIENTS 4

Number of patients on beta blocker	3
Number of patients on ACE/ARB	3

CAD PATIENTS 11

Number of patients on anti-platelets	11
Number of patients with BMI < 30	6
Number of patients with LDL performed	9
Number of patients with LDL < 100	6
Number of patients with BP < 140/90	11
Number of patients on a Statin	10

HYPERTENSION PATIENTS 39

Number of patients with BP < 140/90	37

COPD PATIENTS 4

Number of patients with spirometry performed	1

ASTHMA PATIENTS 7

Number of patients with asthma action plan	3
Number with asthma control test score	3

WELLNESS REPORT

Number of patients > 65	25	Number of patients of Patients with falls screening	21
Number of patients of female patients 21-64	41	Number of patients with cervical cancer screening	23
Number of patients of female patients 50-74	21	Number of patients with breast cancer screening	15
Number of patients > 18 years old	108	Number of patients who currently smoke	26
		Number of patients counseled to quit	31
Number of patients > 2 years old	108	Number w. documented influenza vaccine	55

Teaching with Quality Data: Resident Quality Improvement Projects

- APCTC is active participant and/or partner in resident Quality Improvement projects
  - Family Medicine QI project involving patients with COPD. Goal is to improve both clinician and patient understanding of the disease and their treatment. Will use what is learned to develop better patient education resources for the clinic. Using PDSA format.
  - Family Medicine and APCTC plan to collaborate by providing a platform for patients in the Asthma/COPD chronic disease management program to participate pre and post surveys related to the content provided in sessions with our pharmacist

Other

-PCMH Congress, STFM Conference
-Value Transformation
    -Overview, What, Where, When, How
-AdvocateCare© Center at Nesset
-ALGHPE Grant
-AdvocateCare Index

Other: STFM Conference on Practice Improvement and PCMH Congress

"Improving the Care of Complex Outpatients: A Collaboration Between Interprofessional Teams in Family Medicine, Internal Medicine, and Pediatrics"

December 2017 Louisville, KY

"An Interdisciplinary Collaborative: Pediatricians, Internists, and Family Medicine Improving Patient-Centered Care"

October 2016 Chicago, IL

Advocate Lutheran General Health Partners Endowment Grant

- Team: Dr. Greg Kirschner and Lauren Wemple
- Applied June 2017, received September 2017
- Received $20,000 grant from ALGHPE

- Accelerate training of Family Medicine, Internal Medicine, and Pediatric residents in practice transformation through:
  - Increased collaboration on ambulatory quality improvement, care coordination, and learning activities by providing access to teleconference equipment to collaborate with offsite team members
  - Improve capacity and effectiveness of interdisciplinary care teams through faculty development and multi-site participation
  - Expand home-based care provided by primary care residencies

Thank You

Today we hope to have fostered relationship with the shared goal of patient centered care with the well being of the health care providers in mind. It is our hope that we will continue to collaborate and share our learnings to provide a better trained primary care workforce and high quality patient centered care.

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