A Vision for Connected Care
March 3, 2016, Session 1112

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DISCLAIMER: The views and opinions expressed in this presentation are those of the author and do not necessarily represent official policy or position of HIMSS.
Conflict of Interest

Faron Thompson, MBA
Tiffany Nelson, MD

Have no real or apparent conflicts of interest to report.
Agenda

• Scottsdale Health Partners (SHP) Overview and History
• SHP Keys to Success
• Physician Engagement
• Information Technology
• Care Management Programs
• Enabling Ambulatory Care Management with Technology
• Questions
Learning Objectives

• Describe how health information exchange and population health technologies can be leveraged to enhance and support ambulatory care management processes that are critical to Clinical Integration Networks and Accountable Care Organizations.

• Analyze a successful care coordination model from a pluralistic Clinical Integration Network.

• Recognize how a Clinical Integration Network is transforming healthcare delivery through innovative integrations of HIE and communications technology.
SHP’s Vision for Connected Care as it relates to the Value of Health IT is as follows:

**Satisfaction:**
- Physician Satisfaction
- Personalized patient care

**Treatment/Clinical:**
- Reduced readmissions
- Improved clinical scores

**Electronic Secure Data:**
- Secure text messaging and notifications

**Patient Engagement/Population Management:**
- Transitional Care Management
- Comprehensive Care Coordination

**Savings:**
- Decrease in total healthcare costs across all payer populations
SHP Overview and History
SHP Overview and History

What is Scottsdale Health Partners (SHP)?

SHP is a Clinical Integration Network and Accountable Care Organization

- CI - Legal mechanism that allows practices to remain independent but work together to provide coordinated quality care
- ACO – Participant in Medicare Shared Savings Program (MSSP) Very similar to CI, but contracted with CMS

*Scottsdale Healthcare is now HonorHealth*
Who is SHP?

• SHP was established in June, 2012

• Located in Phoenix and Scottsdale, Arizona

• HonorHealth (formerly Scottsdale Healthcare) is comprised of 5 Hospitals

• Scottsdale Physician Organization has 700+ physicians in 59 Specialties
# SHP Membership

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<th>Specialty</th>
<th>Members</th>
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<td>Family Medicine</td>
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<td>Dermatology</td>
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<td>Ear, Nose &amp; Throat</td>
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<td><strong>Specialist Total</strong></td>
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<td><strong>Grand Total</strong></td>
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## Patient Volume Growth Since Inception

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<th>Quarter</th>
<th>Patient Volume</th>
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<td>Q3</td>
<td>1,986</td>
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<tr>
<td></td>
<td>Q4</td>
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<td></td>
<td>Q1</td>
<td>3,543</td>
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<tr>
<td></td>
<td>Q2</td>
<td>4,190</td>
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<td></td>
<td>Q3</td>
<td>7,836</td>
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<tr>
<td></td>
<td>Q4</td>
<td>8,024</td>
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<tr>
<td>2013</td>
<td>Q1</td>
<td>21,902</td>
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<td></td>
<td>Q2</td>
<td>23,578</td>
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<td>32,057</td>
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<tr>
<td></td>
<td>Q3</td>
<td>34,667</td>
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</table>

- ACO (Medicare FFS) 17,000+
- Medicare Advantage 5,000+
- Commercial 7,000+
- Self-insured 5,000+
**SHP Strategic Framework**

**Mission:** Scottsdale Health Partners is a collaboration of medical professionals and a healthcare system which provides high quality, coordinated and innovative care for the patients and families we serve.

**Vision:** Scottsdale Health Partners will transform healthcare through coordinated, patient centered care of the highest quality and value.

**Values:**
- High quality evidence based healthcare.
- Focused on patient experience.
- Physician driven.
- Transparent and fair.
- Fiscally sustainable.
- Accountable to our patients and members.

**SHP Pillars for Risk Success**
SHP Outcomes

The destination is worth the journey…
SHP Results to Date

- **Medicare Advantage Plan**
  - 10% cost reduction in 2013 and another 4.5% in 2014

- **HonorHealth Employee Health Plan**
  - 10% decrease in costs in 2013 vs 2012
  - **Total savings of $1.78 million** resulting in shared savings payment to SHP of $891,570.96

- **Commercial Plan**
  - 2% decrease in costs compared to market in first year
  - 5% decrease in costs compared to market in year 2

- **MSSP**
  - Only Arizona MSSP to ever achieve Shared Savings payment
  - **Total savings of $3.74 million**
  - SHP shared savings of $1.83 million
SHP Yr1 Performance Nationally

Total Expenditures per Assigned Beneficiary

*SHP PY1 2014 Final Performance Data And Data from the MSSP ACO Public Use File for MSSPs with same or more beneficiaries as SHP and achieved shared savings

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SHP MSSP Yr1 Performance in Arizona

Total Expenditures per Assigned Beneficiary

*SHP PY1 2014 Final Performance Data
What is SHP’s Recipe for Success?

• Most ACOs have similar objectives…
• How each ACO achieves their objectives are very different
• What works for one ACO might not work for another
• SHP’s Keys to Success
  – Physician Engagement
  – Technology Enablement
  – Care Management
Physician Engagement
Pluralistic Governance Model

Scottsdale Physicians Organization (SPO) 50%

Ownership 50%

HonorHealth

Scottsdale Health Partners (SHP)

6 PCPs, 6 Specialists
SHP is Physician-Driven

- Clinical Committee
- Quality & Performance Committee
- Operations, Finance & Contracting Committee
- Information Technology Committee

Over 90% of Committee Members are Physicians
High Level of Physician Engagement

• Meaningful Governance and Leadership – Physicians leading Physicians

• Useful Technologies (See IT section)

• Communication Transparency
  – All Member Meetings (3 times per year)
    • Consistently have over 100 physicians in attendance
  – PCP Meetings (3-4 times per year)
    • All PCPs meet together to discuss clinical issues
  – PCP Practice meetings (Quarterly)
    • CMO or CSO meet with physicians and practice to discuss results and initiatives

• Newsletter (Monthly)
  – Open rate is 44% compared with Constant Contact average of 16%
The IT Challenge:

How do you get 700+ physicians from 244 practices on 30+ different EHRs to communicate and collaborate in order to take care of patients?
Step 1
Enable Communication
Secure Text Messaging

Time to Implement: 1 month

Go-Live: March, 2013

Purpose: Secure provider to provider, asynchronous text messaging

Users: 1,200 users
Secure Text Messaging Adoption and Use

Over 25,000 messages per month!
Step 2

Aggregate and share data
SHP Technologies

Provider Portal

Risk Management

eReferrals

Secure Text

Health Information Exchange

Integration Engine

EMPI

CDR

SHP Technologies

HonorHealth

EHRs

Labs

Radiology

Cardiology

Home Health

ED

Owned Practices

Community

Care Managers –

Images/Reports

Reference Labs

Payers

Community

Practice

EMRs

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## Data in SHP CareConnect

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<thead>
<tr>
<th></th>
<th>Hosp</th>
<th>HHMG</th>
<th>SMIL</th>
<th>Sonora Quest</th>
<th>Lab Corp</th>
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<td>12/14</td>
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<td>Radiology Reports</td>
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<td>CCD</td>
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<td>10/15</td>
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<tr>
<td>Transcribed Reports</td>
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</table>

### Legend
- Date indicates when patients record for each data source starts
SHP CareConnect Patient Searches

Over 10,000 patient searches per month!
SHP CareConnect Physician Satisfaction

“‘I don’t need to call the hospital as much. I can find what I want in SHP CareConnect”
Fountain Hills Pediatrics and Internal Medicine

“‘Our specialist was called in by the SHC hospital for one of their ED patients and we could pull the ED reports from SHP CareConnect before the doctor visited the patient in the hospital’
NKL Neurology

“I will direct as many of my patients as possible to SHC hospitals, SMIL and Sonora Quest because it was so great to see all the information in one place”
Kara Tiffany, MD

“‘We had a missing post-operative report for a patient, as a "fill-in doctor" that did delivery for Dr Laughead. Now we can see this report from the hospital right away and we can bill for this patient.”
Sonoran Consultants in OB/GYN

“‘I found labs here that I have been trying to get for days! This will save me a lot of time’
Kristin Lau, MD

“‘Whoever thought of this is a genius!” …“It’s fast, it’s easy. You really should be using it.”
Don Opila, MD

“We had a missing post-operative report for a patient, as a "fill-in doctor" that did delivery for Dr Laughead. Now we can see this report from the hospital right away and we can bill for this patient.”
Sonoran Consultants in OB/GYN

“‘The wife of a patient called indicating the patient was admitted to hospital. Patient’s wife was elderly and confused and could not give much detail. But we were able to lookup the patient in SHP CareConnect and ascertain his current status.”
Arizona Prostrate Cancer Center

“It was worth the price of admission.”
Lawrence Cook, MD

“I will direct as many of my patients as possible to SHC hospitals, SMIL and Sonora Quest because it was so great to see all the information in one place”
Kara Tiffany, MD

“Whoever thought of this is a genius!” …“It’s fast, it’s easy. You really should be using it.”
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Don Opila, MD

“I found labs here that I have been trying to get for days! This will save me a lot of time”
Kristin Lau, MD
Step 3

Build a care management program to aid physicians in taking care of complex patients
SHP Care Management Program

Central Care Management Department
Care Coordination Support Hub

Payer Services & Programs

HonorHealth– TPK Hospital

HonorHealth– Shea Hospital

HonorHealth– Osborn Hospital

Transitional Care Manager

Complex Care Coordination Program: Care Coordination
MD

Complex Care Coordination Program: Care Coordination
MD

Complex Care Coordination Program: Care Coordination
MD

Post-Acute Care Services

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Care Management Programs

**Transitional Care Management** (Hospital/Post-Acute Setting)
- Available for SHP physicians/patients
- Assist with the transitional needs of SHP patients in the hospital
- PCP Notification of admission, discharge, and emergency room visits
- Focus on maintaining clear communication to primary care physician about treatment plan

**Comprehensive Care Coordination** (PCP Office Setting)
- Intensive outpatient care program using well trained care manager embedded in a high – performing primary care team
- Creates close relationships with medically complex patients and delivers highly individualized and accessible primary care
- Develops a patient-specific, goal orientated treatment plan
- Geared to use mostly MA level staff to economically reach more people with the same budget
Transition Communications

- SNF Coordinator
- Specialist Physician
- Primary Care Physician
- Emergency Physician
- Acute Rehab Coordinator
- PCP Care Coordinator
- Home Health Coordinator
- Chief Medical Officer
Comprehensive Care Coordination

• **Primary care based** for predicted **moderate to high risk** patients
• **Specially trained** care coordinators
  – Behavioral modification interviewing
  – “Super-Visit” process
  – Medication Management
  – Assessment tools:
    ✓ **SF-12 (VR-12)** – measure health related quality of life and estimated disease burden
    ✓ **PAM** - tool that measure patients engagement in their health care (Levels 1-4)
    ✓ **PHQ–2 & PHQ-9** – tool used to screen, diagnose, monitor, & measure severity of depression
• Mutually agreed upon “**Shared Action Plan**”
• High level **(face to face) contact** with patients and providers.
Step 4
Enable Care Management with Technology
The Clinical Challenges

• For the Transitional Care Managers
  – “Who are the hospitalized SHP patients that I should follow?”
  – “How can I communicate with the busy PCPs about their hospitalized patient?”

• For the Comprehensive Care Coordinators
  – “How do I know when one of the patients I am following is in the hospital or ER?”
  – “I need to communicate with the Transitional Care Manager to discuss my hospitalized patient.”

• For the physicians
  – “How do I know when my patients are in the hospital or ER?”
  – “When was my patient discharged and what happened to my patient in the hospital?”
The IT Challenges

• How to enable Care Coordinators with technology to efficiently perform their jobs?
  – Multiple systems; with many barriers to ease-of-use
  – No good place to document
  – Inaccurate/incomplete data
  – Workflow inefficient

• Most existing care management technologies were designed for inpatient case management
  – Many heavy, over-engineered, inflexible, expensive solutions
Solution: Build it Ourselves

Leverage the flexible technologies we already utilize:

• Build a real-time patient census customized to each Transition Care Manager
• Enable PCP-based Care Coordinators to better follow their patients by enabling them to establish relationships in the HIE
• Integrate HIE notifications with Secure Messaging to deliver real-time, content-rich notifications to Care Managers and physicians
Real-Time Patient Census

Challenges:

• Needed to create algorithm to formulate census that included matching on PCP and insurance plan
• Ever changing insurance codes as well as multiples (PO boxes, spelling)
• Internal processes within sending systems that transmit old transactions
Care Coordinator Relationship Management

**Challenge:**

- Care Coordination not a typical relationship captured within systems nor transmitted out of systems
A patient for whom you are recorded as Ordering MD and Primary Care Provider has had recent activity sent to SHP CareConnect.

Bob SMITH (unique identifier 00011111111) was admitted as an inpatient with the MED specialty a facility SHC (ward SHC) on May 30, 2015.

Hospital: Shea
Room: 2412
Bed: 1
SHP Care Management Outcomes
Transitional Care Management

Readmission rates 40% better than Arizona average
Comprehensive Care Coordination Outcomes

% of Patients by Depression Level Baseline and Follow-Up

- Baseline: 67.0%, 33.0%
- Follow-Up: 87.6%, 12.4%

% of Members by PAM Level for Baseline and Follow-up

- Level IV: 27.6%, 29.1%
- Level III: 29.1%, 39.6%
- Level II: 23.1%, 19.8%
- Level I: 10.1%, 14.6%

Demonstrated improvement in patient depression, function and activation.

Average Scores for Patients who completed the VR12 Survey - Baseline and Follow-Up

- Baseline: Mental Mean Score 47.2, Physical Mean Score 30.9
- Follow-Up: Mental Mean Score 51.9, Physical Mean Score 32.7

Average Scores for Patients who completed the VR12 Survey - Baseline and Follow-Up National Medicare Avg. (2014)

- Baseline: Mental Mean Score 53.8, Physical Mean Score 39.5
- Follow-Up: Mental Mean Score 51.9, Physical Mean Score 32.7

Demonstrated improvement in patient depression, function and activation.
Patient Case Study

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<tr>
<th>Expense and Utilization</th>
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<th>2014</th>
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<tbody>
<tr>
<td>Overall</td>
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<td>Acute Admits</td>
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<td>Total Days (Acute Admits)</td>
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<td>ER Visits</td>
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What’s Next?
Future of Ambulatory Care Management Technology

Work with a strategic technology partner to design and develop a “game changing” technology solution

- Partner with Leading HIE vendor
- Leverage existing flexible products to design new capabilities
- Make it configurable by the customer
The Next Generation of CM Technology

Technology Vision

- Leverage all the data available in the HIE
- Patient and Care Coordinator centric
- Circle of Care
- Documentation
- Custom form creation tool
- Custom workflow design
- Integration in EMRs
The Anatomy of Care Coordination

Patient Analytics

Quality Compliance Monitoring

Workload Management

Progress Documentation

Shared Patient Record

Platform for Care Team Collaboration

Patient Engagement

Collaborative Care Plan

Secure Communication

Best Practice Pathways

Proactive Notifications
Leverage All the Data in the HIE
Patient and Care Coordinator Centric
Circle of Care
Documentation
Patient-Specific Task Management
Repeating Tasks Creation Tool

Repeating Tasks for Documents
Custom Workflow Design

- A graphical interface, used to easily create and configure pathways with repeating workflow
- Workflow decisions can easily be configured based on data input
SHP’s Vision for Connected Care has driven value after only 3 years:

**Satisfaction:**
- High physician satisfaction with easy to use technologies
- High physician satisfaction with secure patient event notifications
- High physician satisfaction with Care Management support

**Treatment/Clinical:**
- Improved patient scores:
  - Patient Activation
  - Depression
  - Physical and Mental Function

**Electronic Secure Data:**
- Secure physician messaging
- Secure, real-time patient event notifications

**Patient Engagement/Population Management:**
- Specially trained care coordinators
- Personalized plan of care

**Savings:**
- Only Arizona MSSP to ever receive a Shared Savings payment
- Cost reductions in all payer populations
Thank You

Questions?

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Email: ftthompson@scottsdalehealthpartners.com