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Value-Based Healthcare Through Care Coordination and Clinical Integration

Angelo Sinopoli
Greenville Health System

Jennifer Snow
Greenville Health System

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Value-Based Healthcare
Through
Care Coordination and
Clinical Integration

Angelo Sinopoli, MD
VP, Clinical Integration
Chief Medical Officer
Strategic Positioning

Multi-Year Goals

- **Total Health Organization**
  - Right Care, Right Time, Right Place
  - Clinical competencies to perform under Health Reform

- **Health Care Value Leader**
  - Business systems and structures to perform under Health Reform
  - Partnerships with payers and industry
  - Cost efficient, quality focused

- **Clinical Integration**
  - Systems, structures, and processes to improve operating performance
  - Network development for FFS business and for population coverage
  - Building and linking the healthcare continuum

- **Innovation in Academics**
  - Leverage academics to improve clinical and financial performance
  - Create a clinical workforce to lead in a reformed healthcare environment

- **Sustainable Financial Model**
  - Efficiently create and allocate resources to achieve mission
  - Strong performance in today’s environment while positioning for Health Reform
“Population Based Care”

The new mantra of healthcare.
Beyond the Medical Home

Healthy Communities
(Nutrition, Prevention, Physical fitness, Healthy living)

Community Resources
(Supportive housing, Social Services, Eligibility programs, etc.)

Medical Neighborhoods
(Specialists, ER, EMS, Fire Department Medical personnel, Employer work sites, MD 360, Pharmacists, Home Health, School nurses)

Providers
(Physicians, Health Systems, Care Managers, Office staff, Family Members)
Strategic Positioning
Accountable Care Organization
The Care Continuum

Information Systems
Care Coordination Competencies
Duke Innovation Grant

Overview:
• $2.7 million grant for delivery innovation

Eligibility:
• Initial pilot focused on Medicaid clinic population and subsequently the unfunded population
• Developed a stratification process based on ER and hospital utilization
# Duke Innovation Grant

<table>
<thead>
<tr>
<th>Areas of Focus</th>
<th>Process and Infrastructure Changes</th>
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</thead>
<tbody>
<tr>
<td>Access</td>
<td>Added a NP to improve access</td>
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<tr>
<td>Care Management and Coordination</td>
<td>Added nursing case management and social work to provide care management and coordination</td>
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<td></td>
<td>Connected to ED case management program</td>
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<tr>
<td>Self-Management</td>
<td>Developed diabetes and pulmonary self-management programs</td>
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<td>Clinical Decision Support System</td>
<td>Developed and implemented quality outcome monitoring methods using PQRS within the electronic medical record</td>
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<td>Education</td>
<td>Educated physicians, staff and patients as to the processes and intent of the program</td>
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<tr>
<td>Data Reporting</td>
<td>Developed monthly outcome reporting tools for feedback to physicians and leadership</td>
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Results to-Date:

- In year one, there was a **26% decrease** in Emergency Department visits and a **55% decrease** in inpatient days.
- For Diabetes, the number of patients with HgA1c High values (>9%) decreased **14%**.
- LDL-C Abnormal values decreased **15%**.
- For Hypertension, Non-Diabetic, the number of patients with readings within 140/80 parameters improved approximately **13%**.
- For Asthmatics, the number of patients appropriately receiving corticosteroid/acceptable alternative therapy improved approximately **11%**.
ER Care Management

- 130 Patients Enrolled
- Active Case Management
- Connecting to a Medical Home
- Addressing Social Issues
Awarded a $300,000 grant to reduce unnecessary ER and EMS utilization by:

- Creating an innovative nurse triage call center that is currently being used in only two other locations in the US
- Providing care coordination to ER and EMS high utilizers so they receive the right care at the right time and place
- Developing patient-centered medical neighborhoods within the community
Collaboration between GHS, GCEMS, and Greenville City Fire Department to create patient-centered medical neighborhoods within the Greenville Community.
Medical Neighborhoods

- Health System and Safety-net Collaboration
- Providing Access to Care within Communities
- Community Paramedic and Health Worker Models
- Home Health
- Mobile Health Clinic
- Care Management
- Care Coordination
Patient-Centered Medical Neighborhoods Initiative

- BCBSSC Grant Year Three
- Proviso 33.34
- ED/EMS High Utilizers
- Pilot Neighborhoods:
  - Parker
  - Berea
  - Gantt
  - Belmont
  - Dunean Mills
Accountable Communities

- Community-led Innovation
  - Community Volunteer Programs
  - Community Paramedics
  - Community Resources (Faith-Based Organizations, Schools, EMS, Police and Fire Districts)
- Patient Education and Social Determinants
- Population Health Management
- Social Service Providers
Patient-Centered Medical Neighborhoods (PCMN) Providers Accountable Communities
Clinical Integration Building Blocks

- Improved Quality and Access
- Reduce Costs and Waste

Finance/Managed Care

Delivery Network

Care Model/Information Technology

Organizational Structure

- Value-based Payment Models
- Funds Flow Distribution
- Expand Primary Care Base
- Strengthen Partnerships Along Continuum
- Define Membership Criteria
- Care Management
- Population Health Management
- Clinical Data Repository
- Data Analytics
- Physician Leadership
- Entity Formation
- Change Management
- Establish Governance
Evolution of Knowledge Management

Information Management—Leveraging Explicit Knowledge
Enhancing individual learning for increased employee capability
- Capturing documents
- Best practice repositories
- Lessons learned databases

Experience Management—Leveraging Tacit Knowledge
Supporting horizontal knowledge sharing for productivity improvement
- Communities of practice
- Expertise locators
- Team/project learning – before, during, after
  - Conversational-based processes

Idea Management—Leveraging Analytic Knowledge
Opening vertical knowledge exchange for organizational learning
- Using collective knowledge to: address complex issues, create new knowledge, grow innovation
- Enablers: Cognitive diversity, transparency and convening
- Processes: Joint sense making and crowd scouring

 Sophistication

Collection  Connection  Conversation
Learning Cycle