American College of Physician Executives Annual Meeting New York City April 2013
Leading US Healthcare into the new World of PPACA and Value-Based Care

The Role of the Physician Advisor in our New Healthcare System
Designing and Implementing Value-Based Care

Jeffrey Epstein, MD
Medical Director: Quality for Case Management and Resource Utilization
Stamford Hospital and Healthcare System
Stamford, CT 06970
Stamford Hospital: 300 Beds, Family Practice, Internal Medicine, Surgery, OBGYN Residencies
Cardiac Surgery and Stents, Level Two Trauma, Affiliate of Columbia Presbyterian and Weil Cornell Medical School. 17,000 Admissions per Year. 50,000 ED Visits per Year. 100 Employed Physicians in a Multi-Specialty Medical Group. MSSP ACO Approved in January 2013.
Physician Advisors and Hospital Medical Directors

What we do now in the Hospital
Our potential with ACOs and IHDS
More physicians in Administration, at the table, designing and implementing
Entry level for Physician Executive
They still see patients, still have a small practice (run small business)
What Physician Advisors Do Now
The Potential of Physician Advisors and What We Can Do As Hospital Medical Directors
Patient Satisfaction

How are we doing? Click here to let us know.

DISCHARGE PLANNING

Bill Lyons, MD

Average Length of Stay

- MWPHE
- Similar Hospitals

Number of Days
Stamford Connecticut
Potential Projects

Transitions in Care for Medicare CHF Patients
Rebalancing Care: Institutional Care to Home Care
CT Telehealth and Workforce Partnership

Stamford Hospital’s MSSP ACO and Bundled Payments
Stamford Hospitals IHDN with Commercial Payers
Stamford Hospitals Potential ROI by Helping with “Populations at Risk”

Coordinating Care, Transitions in Care
Access and Quality Care for “Populations at Risk”
High Value, Quality Care for Medicare Patients
Quality Care for Institutionalized Patients (Mental Illness/Substance Abuse)
Readmission Reduction
Transitions in Care & Coordinated Care
Accountable Care
Value-Based Care
Patient Protection and Affordable Care Act
(PPACA)
Potential “Gaps in Care” during “Transitions”

Hospital —> Transfer —> SNF/Home

Discharge
Preparation for Transfer

Intake
Establish YA in Adult System

Adult care
Communication, Trust & Relationships in our Community

Quiet Leadership

Trust's effect on Speed & Cost

Communication Skills

What's My Color

Patient Centered Care. Respect for Everyone
Care Coordination Center
Coordinate Providers, Patients and Community Resources
Coordinate the Care of Individual Patients

Provider Network and Communication
Hospitals, SNFs, Home Care Agencies, Hospice, PCP, Specialists, Nurses, PTs, CMs, SWs

Care Coordination Center
Nurse Navigators
Care Coordinators
Community Health Workers

Providers and Patient Communication
Facilitate Communication between Patients and Providers

Community Resources:
Networking and Communication
Community Health Centers, Community Groups
Medical Record Information Available
Anywhere, Anytime, For Any Patient and Any Provider

Critical Element of “Fully-Informed Care”
Show me your medical record.
Plan A: The Care Coordination Center
The People of the Telecommunication & Care Coordination Center
The Nerve Center of the ACO
The Work Space and Facilities

The latest Technology with Highly Trained Staff
Plan B: The Care Coordination Center
RECOMMENDATIONS FOR QUALITY REFORM

- Strengthen Residents’ Rights
- Assure Public Access
- End Medicaid Discrimination
- Strengthen Ombudsman Program
- Mandate Aide Training
- Support Quality of Life
- Provide Mental Health Care
- Focus Surveys on Actual Care
- Enforce Standards for Quality
QUALITY CARE FINDER

- Hospital Compare
- Nursing Home Compare
- Home Health Compare
- Dialysis Facility Compare
- Physician Compare
Home Health Compare

Use this tool to:

- Search for home health agencies and get their contact information.
- Find out what services each home health agency offers, like skilled nursing care, physical therapy, speech therapy, and home health aides.
- Compare home health agencies based on the quality of their care (for example, how well they manage pain, treat wounds, and keep patients safe).
- Get patient survey results to learn more about patients' experiences with each home health agency.
## Pressure Sores and Wound Care

### Treating Wounds and Preventing Pressure Sores (Bed Sores)

<table>
<thead>
<tr>
<th>Description</th>
<th>Allina Home Care Hospice &amp; Palliative Care</th>
<th>Minnesota Average</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often patients’ wounds improved or healed after an operation.</td>
<td>73%</td>
<td>81%</td>
<td>87%</td>
</tr>
<tr>
<td>How often the home health team checked patients for the risk of developing pressure sores (bed sores).</td>
<td>100%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>How often the home health team included treatments to prevent pressure sores (bed sores) in the plan of care.</td>
<td>97%</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td>How often the home health team took doctor-ordered action to prevent pressure sores (bed sores).</td>
<td>94%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>How often patients had more pressure sores (bed sores) when home health care ended.</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Preventing Harm

<table>
<thead>
<tr>
<th>Description</th>
<th>Allina Home Care Hospice &amp; Palliative Care</th>
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</tr>
</thead>
<tbody>
<tr>
<td>How often the home health team began their patients’ care in a timely manner.</td>
<td>91%</td>
<td>87%</td>
<td>88%</td>
</tr>
<tr>
<td>How often the home health team taught patients (or their family)</td>
<td></td>
<td>97%</td>
<td>96%</td>
</tr>
</tbody>
</table>
$72 Million in Federal Funding
$24 Million from Connecticut
$13 Million from the State

Expansion of Home Care Services for Seniors and Adults with Disabilities
Nursing Home Transition Grants
Money Follow The Person Grants for Home Modifications
Creation of Adult Family Homes
Residential Care Homes transition to Adult Family Homes
Medicare Readmission Reduction CHF
Connecticut TeleHealth and Workforce Partnership (CTWP)

Train MAs to become Care Coordinators
Work Based Clinical Training along with an Academic Pathway at Norwalk Community College
Career Advancement for Medical Assistants & New Jobs for Community Health Workers (CHW)
Better Quality of Care in the Community because of the Coordinated Care
Better Access to Care in the Community because of the CCs and CHWs
Better Financial Health in the Community Because of Job Training and Job Opportunities
Connecticut Telehealth and Workforce Partnership

Create Jobs
Create Job Opportunity Advancement
Improve Access to High Quality Coordinated Healthcare
Use Telehealth to Teach and Coach Patients to Self-Management and Exercise
Connecticut Telehealth and Workforce Partnership
CTWP

Robust and Well-Developed Community Resources
Education on New Type of Providers for Care Management Teams
Job Creation and Career Pathways Lower Wage Workers
Higher Quality Healthcare
Improved Access to Healthcare Services
Serving Populations at Risk
VITA

Community Health Center
Healthy Lifestyle
Exercise, Food, Farm
Community
Shopping Area
Jobs, Community
Housing: Mix of Income Levels
Partner with Hospital, City and Community Resources
The Care Coordination Center and Community Resources
ACO Infrastructure

**Information Technology Infrastructure**
Data Collection, Organization, Warehousing and Analytics: Business Intelligence
Performance Improvement: Dashboards and Real-Time Drill Down Capabilities for Providers

**Communication Infrastructure**
Communication Support

**Medical Record Information Access**

**Care Coordination Infrastructure**

**Physician and Patient Engagement Infrastructure**
Education, Training, Design Involvement, Satisfaction Scores
Community Center
Neighbors Link Stamford

Adult English Classes
Baby Sitting while Taking Classes
Referrals: Local Health, Education & Social Services
Social Activities
Job Hiring Site
Computer Skills
Other Skills to Enhance Employability
“Facilitating Fully-Informed Care through Enhanced Communication”
Healthcare Providers and Workers in the Care Coordination Center

Social Workers

Mental Health Social Workers

Nurse Navigators

Care Coordinators

Community Healthcare Workers
Community Resources

Community Healthcare Centers

Community Centers
English as Second Language
Job Training & Job Postings

Soup Kitchens
Shelters
Goodwill
HIV Clinics & Immunization Services

Public Health Service

Safe and Affordable Housing
The Care Team

Primary Care Nurse

Physicians / Clinicians

Primary Care Team

Psychologists

Case Manager / Social Worker

Case Finders

Peer Buddies
The Care Team

- MD
- Oriental Medicine
- Your Provider
- Aesthetics & Skin Care
- Naturopath
- Acupuncture
- Health Coach
- Massage
- Psychologist
- Nutritionist
- Physical Therapy
- Who Would You Add?
Back to the Hospital
Care Team Coordination and Communication within the Hospital

Rapid Rounds
Whiteboards
MediTech
Face to Face
Phone
The Care Coordination Center

includes
Telecommunication Center
Performance Improvement Center
LEAN Performance Management, Data Collection and Analytics

This functions like a consultant for the PCP.
Consultation Services:

**Nurse Navigator** (Case Manager): Help Manage Complex Patients with multiple comorbid conditions

**Care Coordinator** (Medical Assistant): Help Nurse Navigator manage Complex Patients via Telemonitoring, Home Visits and Health Coaching

2 **Social Workers** (Regular and Mental Health Specialist): Provide Mental Health assistance as part of the plan of care in patients who are appropriately triaged to this service. This service is critical to any treatment plan if the patient has mental illness, substance abuse of extreme poverty

**Community Health Worker** (Entry Level Position): Patient from the community who understands the culture and the language and the people. Part of the community but a health teacher, coach and mentor. Accompany patients to doctor visits to take notes and help patient coordinate and track their care. Works with the Care Coordinator and Nurse Navigator to coordinate care of each individual patient
Patient Satisfaction at the Time of Discharge Taskforce at Stamford
Optimize LOS & Reduce Readmissions
Care Team Communication
Better Discharge Experience & Higher Quality Discharge
Higher Patient Satisfaction
Higher Quality Care, Higher Value Care
Putting the Anticipated Discharge Date (ADD) to Work

2+ Days Prior
ADD Visible in Patient Room by RN, MD
ADD Visible at Nursing Station
ADD Discussed with Patient/Family by MD, RN, Case Mgmt.
Inquiries from RN, CM, PT re: expected (but not yet entered) consults
Checklist: Ambulating, Eating, Foley Catheter?

1 Day Prior
ADD Visible in Patient Room by RN, MD
ADD Visible at Nursing Station
ADD Discussed with Patient/Family by MD, RN
Flag for Discharge order Prompted, Written

Day of Discharge

[Image of a folder with Bayhealth logo]

[Image of a red telephone]

[Image of a form from St. Jude Children's Research Hospital]
Fully Informed Care
Communication
The ACO Care Coordination & Communication Center

“Facilitating Fully-Informed Care through Facilitating Enhanced Communication”
General Comments

Communication
Data Collection and Analytics
Physician Engagement
Provider Engagement
Patient/Family Engagement
Analytics
Dashboards
Provider Satisfaction
Quality, Value, Satisfaction

Quality

Patient Satisfaction
The Integrated Healthcare Delivery System of the Future

- Care Coordination
- Communication Center
- Medical Record Availability
- Providers Communicate in Real Time
- Data to Manage System and Manage Providers (Physicians)
- Physician Income Same or More
- Increase Footprint, Reduce Overhead, Convert to Outpatient Revenue
- Care for 5% Sickest Patients: Complex Case Management
- Care for Patients with Chronic Disease: Disease Management
- Care for Healthy: Health Maintenance and Wellness
- End of Life Care
- Fully Capitation and Full Risk
Value Based Care which Depends on:

- HI Quality Care
- Readmission Reduction
- Adverse Event Reduction
- High Patient Satisfaction
- Length of Stay Optimization
- High Provider Satisfaction
- High Patient and Provider Engagement

Robust Care Coordination and Communication across the Full Spectrum of Care

Quality of Care, Value of Care, Patient Satisfaction
Provider Satisfaction is the Engine of work and innovation ...
Important Tasks for IHDSs

Data Collection and Analytics and Performance Improvement
LEAN Toyota Performance Improvement Method

Data Collection
Data Analytics
Data Display and Presentations (Scorecards, Dashboards and Interactive Portals

Cost
Quality
Patient Satisfaction
Provider Satisfaction
Outcomes: Cost and Quality

Electronic Medical Records
The Physicians Advisors Role in the Evolution and Development of our New Healthcare System
Transitional Care Reference Library

Hot Spotters
The Cheesecake Factory: Efficient Healthcare
Redesign of Primary Care - General Internal Medicine Society
Primary Care Model in Washington State: Commonwealth Fund Article
Community Health Workers, Patient Navigators, Peer Educators, Health Advocates
Accountable Care News, Readmission News, Medical Home News
JAMA January 23/30, 2013
Evidence-Based Medicine to Evidence-Based Health
CHF Readmissions: More Complex than You Think
Project RED, BOOST, Transitions in Care
Connecticut Telehealth and Workforce Partnership (CTWP)
Qualidigm and Communities of Care
Physician Engagement: The Sharp Experience and Advocate in Chicago
End of Life Care: Aetna’s Educational Program, How Doctors Die, Anna’s Story
ACO PowerPoint Presentation
Coordinated Care PowerPoint Presentation
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The End
New York Yankee baseball player Reggie Jackson’s comments in Sport magazine from May 1977 angered other Yankees, such as catcher Thurman Munson. Jackson was quoted as saying: “it all flows from me. I’m the straw that stirs the drink. Munson thinks he can be the straw that stirs the drink, but he can only stir it bad.” It has been claimed that Sport writer Robert Ward fed the line to Jackson while they were at a Fort Lauderdale bar during 1977 Florida spring training, but New York (NY) Times sportwriter Murray Chass (see October 20, 1977 citation below) wrote that the quote is accurate.

‘The straw that stirs the drink” is now a cliché that has been used to describe situations where one person (other than Reggie Jackson) is the center of all attention.
Emerging Leader Series

Making the Transition to Leadership
True Colors: Personality Temperament
The Leader’s Role in Communication
Building High Performing Teams
Promoting Engagement & Motivating Your Staff
Time & Meeting Management
HR Forum-Managing The Disciplinary Process

True Colors for Whole Staff

Gain awareness of your personality temperament style, strengths and blind spots.

The Speed of Trust: 100 Spots Open
An Integrated Healthcare Systems includes Acute Hospital Care, Primary Care, Multispecialty Medical Care and the capacity to contract for other needed services.

Integrated Health Care Delivery System - a managed care system in the United States that includes a hospital organization that provides acute patient care, a multispecialty medical care delivery system, the capability of contracting for any other needed services, and a payer.