

Geisinger Written Testimony

HIT Policy Committee Meaningful Use Workgroup

The role of the physician in optimizing chronic disease should be to focus on two essential activities: complex medical decision making and patient relationships. All other activities can and should be performed by other team members including advanced practitioners, care managers, office nurses, non-clinical staff, the electronic health record, and patients all engaged and working at the top of their license. Because of its ability to support all of the team's members in the care of every patient, every time, HIT is uniquely suited to the physician directed, team delivered care that we are employing at Geisinger.

Team Member	Role
Physician	Complex Medical Decision Making, Patient Relationships
Advanced Practitioner	Focused management of select subpopulations, supportive management of total population
Case Management Nurse	Directed, proactive communication and patient support, coordination of care of multi-morbid patient, population analysis
Clinic Nurse	Completion of process measures, chronic disease management support
Non-Clinical Staff	Scheduling and communication of routine tasks
Patient	Contribute beliefs and update status, Patient entered data, multi-directional communication
EMR	Active Prompts, Population and individual data, communication tool, Preventive Care Management

We have a coordinated system of care for multiple chronic diseases including diabetes, coronary artery disease, osteoporosis, chronic kidney disease, and we are in the process of adding several more, most notably hypertension. These people and electronic systems are designed to integrate all elements necessary for chronic disease and are organized around the principles of performing as much as is possible outside of the office, if it must be done in the office can it be performed by someone other than the physician, and if it must be performed by the physician how can we make it as easy as possible to achieve the optimal outcome. The program starts with the identification of key performance measures from the literature by a multi-disciplinary, multi-specialty panel. This team identifies the core elements of care for that disease. We then build the system to support delivery of that optimized, patient centered care. Beginning with the patient, for those active on our patient portal, in the case of diabetes, we display and explain each of the nine measures, why they are important to the patient's health and the patient's performance on each measure. These are updated on a daily basis. The medical team also receives monthly reports of population performance with individual detail. All or none patient centered scoring is used to enhance the cognitive dissonance and drive performance. All performance is transparently available to all physicians across the enterprise and excellent team

performance is rewarded. All staff participate in the reward system. Additionally, HIT enhances performance by alerting team members as appropriate to gaps in care. Non-clinical members of the team receive alerts for patient scheduling, sequencing, and follow up of tests. Nursing staff receive process alerts - this patient needs to have a pneumonia immunization, this patient needs to have blood drawn. Physicians receive alerts that involve medical decision making. We do not dictate how the physician practices, but rather prompt them to make an active decision, i.e. this patient's LDL was 142 mg/dL on July 28 2010, the goal is <100 mg/dL. Additionally, a single summary screen containing all the information, medications, test results, diagnoses, vital signs, etc is provided. Very quickly physicians have complete information and can concentrate on developing a shared plan with patient and family. For those patients without electronic connectivity, or as a supplement for those that do, a patient report card is printed and given to the patient after the conclusion of the nursing portion of the visit and prior to the physician portion of the visit. This improves patient understanding of their disease, its goals, builds a more robust conversation, and helps overcome clinical inertia. Additionally, coordinated order sets, allowing for all routine orders for an entire year to be placed or for patients with multiple order needs to be satisfied with a single stroke, support optimal care by removing unjustified variation. This process has improved the percentage of patients receiving all nine elements of care, understanding that because this includes intermediate outcome measures such as hgba1c<7.0 and BP <130/80 and that it may not clinically be appropriate for all patients to achieve all of these goals, we have improved it by 500% since its inception in 2006.

BestPractice Alerts	
Action(s)	
▼ Dx of DM. LDL every 12 months, Standard <100.	<input checked="" type="checkbox"/> Open SmartSet: BPA GHS DIABETES LDL
▼ Dx of DM. Pneumovax - at least one lifetime vaccine. One time revaccination >64 years old (if vaccine given more than 5 years ago).	<input checked="" type="checkbox"/> Open SmartSet: BPA_GHS_PNEUMOVAX
▼ Dx of DM. Flu vaccine - once per flu season is standard.	<input checked="" type="checkbox"/> Open SmartSet: BPA-GHS_DIABETES_FLU
▼ Dx of DM. Hgba1c every 3 months, Standard < 7% Last HGBA1C: Not on file	<input checked="" type="checkbox"/> Open SmartSet: BPA - GHS DIABETES - HGBA1C Greater than 7.0
▼ Dx of DM. Microalbumin every 12 month, Standard < 30.	<input checked="" type="checkbox"/> Open SmartSet: BPA GHS DIABETES MICROALBUMIN

We have employed an even more robust fashion in managing the prevention needs of all 210,000 adult patients enrolled at our primary care sites. The physician's role is to determine whether the patient should be enrolled in the program. Everything else, from order creation, to patient scheduling, and performance of the needed testing, occurs in an automated fashion. The patient receives a letter and then a series of automated phone calls during the month of their birth. Once the patient answers, they are connected to a live agent who knows who they are, why we called them, what they need to have done, basic information about the tests or procedures themselves, complicated questions are passed to a nurse, and what the proper sequence of tests should be, culminating in a physician visit to review the findings. The percentage of patients that have received all necessary screenings based on age and sex improved 250% since inception of the bundle in 2007 and is expected to improve even faster with the full automation deployed in February of this year. Physician engagement with ProvenHealth Navigator (our advanced medical home model) innovations moves through characteristic phases and full evolution typically takes 9-18 months of support, modeling, feedback, and development. Appropriate leadership and management training for the local and regional physician and administrative managers is also required.

Phase	Timeline	Characteristic activities
Passively Passive	3-6 months	Attends meetings, active learning phase, develops new mental models of care
Actively Passive	6-12 months	Responds to Case Manager requests, activates patient specific protocols for identified high risk diseases, tests mental models against care delivered by others
Active	9-18 months	Drives care management, integrates population data into daily work flows, actively develops and implements new care models and shares with partners, manages population care

Care transitions are also enhanced by HIT through automatic notification of admissions, transmission of medication lists, test results pending, and needed procedures and follow up appointments from the outpatient to inpatient settings and then from inpatient to outpatient. We work in 14 outside community hospitals and have developed connectivity with each facility to enhance the interaction. Geisinger Health Plan receives admission notification and this is passed seamlessly to office based staff that can then monitor the inpatient or nursing home stay. Daily reviews of inpatient census lists allow us to determine patients who are in need of care transition support. Expansion of our connectivity through regional HIE (Beacon Communities Grant) will allow us to automate this function. Once aware of the admission, case management staff then monitor these patients during their inpatient stay and connect with 24-48 hours of discharge to ensure a seamless transition and that emerging medical needs are rapidly managed. This has resulted in reduced readmissions (on average by 40% through out the 31 PHN sites where the program has been implemented.) Additionally, alerts to scheduling staff remind them to make all hospital or nursing home discharge follow up appointments no more than 7 days from the day of discharge. They are also simultaneously alerted to other care gaps that the patient may have for preventive and chronic disease management.

Case managers and other clinical staff use the notification alert as a prompt to obtain any missing data. While all Geisinger information is available on a shared information platform, only three of the local facilities EMRs are linked in our current information exchange. Missing information is gathered and scanned into the record to allow all primary care team members and involved specialists to readily access it. We have shared this ability with the five (moving to 14) non-Geisinger employed physician sites that are part of the ProvenHealth Navigator program. Their embeded case managers and the practices have access to our EMR to monitor the progress of the patient at all inpatient and outpatient sites. Additionally, Geisinger Health Plan has created population management tools for all health plan members of the non-employed physician sites, duplicating our tools and similarly enhancing the capabilities of those practices

Transition management for non-employed physicians that are not part of the ProvenHealth navigator sites has been more problematic. The principle reasons for this are that these sites have dedicated less time to practice redesign, have focused less on a patient centered model, and see the attempts to optimize the coordination of care, whether electronically or otherwise, as an intrusion on clinical autonomy. Essentially, they see the inpatient based care coordinators who are attempting to optimize the handoff, both in clinical content and in timing, as a foreign source impacting their business.

We have also developed a Skilled Nursing Facility Strategy involving embeded full time advanced practitioners in these facilities. We identified key partners with administrative interest and ability, activated local leaders that are capable of supporting change, and some ability to enhance their infrastructure. We then worked with them to enhance our relationship and data flows. Once complete, an advanced practitioner is placed in the facility 4-8 hours per day. They are able to access all of our office based tools for care management, and to connect with the outpatient office and care management staff to coordinate transitions from hospital to SNF, SNF to hospital, and SNF to home. The goal is to see all new admissions within 24 hours and to connect with the inpatient and outpatient physicians. Additionally, they aggressively manage known medical issues, support and train facility personnel, and proactively identify and treat emerging exacerbations. Substantial reductions in re-admissions with this program have already been realized.

Nursing Home	Baseline Readmissions 2008	PY 1 Readmissions 2009	Reduction
A	34%	18.5%	- 45.5%
B	18.5%	14.5%	- 21.6%
C	27%	9%	- 66.6%
D	44%	33%	- 25%
E	42.5%	31%	- 27%
F	27.5%	24	- 12.7%

