

The Transformer: the UW Medicine Podcast

Episode 5: Everyday People

Opening Soundbite: When we think about when we shift from a volume-based approach to a value-based approach, so that means using everyone on the team to the best of their skills to be able to optimize the care for the patient.

[Musical break]

Josh: Greetings and welcome to The Transformer: the UW Medicine Care Transformation podcast. I'm your host Josh Kerns. A key tenet of care transformation is the way that we interact, engage and connect with our patients. We call that population health management. It's a focus on keeping people healthy, not just treating them when they're sick. It's about the move from fee-for-service to pay-for-performance and quality measures. It's also about serving whole populations as well as our individual patients in preventing disease, promoting health and reducing the burden of chronic illnesses through population health management. Ultimately, it's also about engaging in community outreach so that we're encouraging healthy behaviors and lifestyles and long-term benefits. And luckily, we've got some of the best and brightest leading the way on this front here at UW Medicine. Several of them have gathered with us today for a great conversation and let's jump right into that.

And why don't we go around the room first and just introduce yourselves, what do you do and what's your role in care transformation.

Debra: Hi, I'm Debra Gussin. I'm the executive director of the UW Neighborhood Clinics. I've been with UW Medicine for 24 years now and in my current role I partner with our physician and administrative leaders in supporting our teams in working together on care transformation, really trying to remove barriers, smoothing processes and systems to allow that to happen, and really support innovation and transformation.

Josh: And Vicky.

Vicky: I'm Vicky Fang. I've been with UW Medicine at Federal Way for 17 years now and I'm the chief at that clinic.

Van: Hello, my name is Van Chaudhari. I serve as the administrator for population health management at UW Medicine. I've been here for seven years.

Josh: And then lastly.

Leah: Hi, I'm Leah Marcotte. I'm the associate medical director for population health and work closely with Van and to help support primary care in integrating population health into practice as well as thinking about innovation around population health.

Josh: What are we actually talking about when we say population health? And then I hear a lot population health management. So, who wants to tackle sort of just the 40,000 foot. What are we actually talking about here?

Leah: Population health is a difficult thing to define because it means so many different things to so many different people. However I think when we talk about it we're really thinking about how do we shift to thinking about taking care of people when they're sick to moving towards keeping people healthy so that more proactive approach. When we talk about population health, when you think about population health outcomes. So, what are health outcomes on a population level? Traditionally, we have done primary care as a face-to-face interaction and an office visit and have thought about delivering primary care within the constraints of that office visit. That's the spirit of what we're talking about. Population health management is really the how we do that. And we do that through team-based care, through support from our centralized population management teams, and through supporting our care teams in other ways to make sure that they have time and room and space to be able to think about the people who are not just coming to the office.

Josh: Well, and that's a huge one. When I think of, for example, your clinic where you've been for 17 years in Federal Way, you might see me for an hour when I come in because I've got chest pains or a stomach ache or something like that. But if we haven't been engaged any time prior to that, it's really hard for you to have a holistic view of what a patient is actually doing throughout their whole life. And then multiply that by all of the people that come through your clinic.

Vicky: That's right. And over the years, all the operations that we've put into place are really around the visit, our taking care of you to the best of our abilities when you come in with that stomach pain. Maybe having systems in place to check up to make sure you follow through on everything we decided to do for your stomach pain. But if you don't come back in five years after that and we don't get a chance to talk about your colon cancer screening, or if you're a woman, your mammography, then we we might lose you.

Debra: And I think to Vicky's point, historically, we have had a very visit-based episodic approach to this and the transformation I think for us, UW Medicine has really been thinking about this as a care team and really looking at all the members of the team that brings something to bear, whether it's nurses, social workers, health navigators, nutritionists, behavioral health, all of the different components that may may occur outside of a visit but that are incredibly important in managing the whole patient's health.

Josh: Well, let's talk about what actually make up the components of population health. What are we actually talking about as we start to break this down here?

Van: When we when we talk about the components or the heart of population health, it has to start, of course, within primary care, with this notion of panels or empanelment. The fact that primary care teams and primary care providers now have a slice of their

sub-population of lives that they're accountable for to provide care in a way that allows their members or their patients to stay healthy and leverage the skills of their team to keep patients proactively out of the hospital and up to date on their health maintenance needs, that preventative care, health promotion needs, is something we're very excited about at UW Medicine. Building the tools within our electronic medical record, which we call Epic, to allow primary care teams to have the insights around how their panel is doing. What are the population health metrics that are looking great on panels and where having the tools in the Epic medical record that allow primary care teams to see how is the status and health of my panel. What are the population metrics that I need to improve on, or where is there some extra support needed around the different types of preventative care needs or disease control measures. So empanelment and taking a team-based approach to empanelment. We're also excited at UW Medicine within primary care to tap into the expertise of our primary care teams to develop evidence-based protocols to manage chronic diseases. We have ambulatory pathways for depression and hypertension and the management of diabetes, and we hope to foray into the area of opioid and addiction and dependence treatment in the future. We've also been able to tap into the specialist experience as an extension of primary care and monitoring outliers that sort of fall off pathways, if you will, through our PATH programs, or our Population Approach to Health programs, which look at outlier management for diabetes, folks whose A1c blood control trends are going in the wrong direction or whose blood pressure trends are going in the wrong direction or their depression trends are concerning. And then I think one to one area to highlight is we have centralized screenings for, as Deb mentioned, wanting to, and Vicky mentioned, wanting to keep folks on our panels up to date on their colorectal cancer screening or their breast cancer screening or their cervical cancer screening. So, these are all core programs we've been able to develop. We also have some new programs around care management, being able to offer every single patient who is transitioning from one sector, such as a hospital, back reconnecting them back into primary care by furnishing better care transitions and making sure everyone in our denominator gets a discharge phonecall within two days of discharging from the hospital where they're checked in and connected back to their primary care physician. And then we make sure they understand their medications when they discharged and if they need extra help, they're complex, they can get some care management. So, these are some core programs we've developed over the last two years, from empanelment all the way to pathways and PATH.

Josh: Well, and then I have to ask Dr. Vicky, given what Van just talked about, how do you actually get doctors to do that, when they tell you that we already don't have enough time. How do you manage that? How do you set up the systems in a way that a doctor and their clinic manager can actually do that

Vicky: Well, care transformation isn't just about transformation for patients. It's about transformation for physicians, for care providers, for nurses, for our staff. We all have to learn our job in a new way now. I really have to give credit to Van and her team because the rollout of the empanelment was actually a big process of transformation for our provider group. We dug down into the individual clinics, into provider by provider,

and said, here's your panel, is this your panel, and that whole process is transformation of care.

Josh: How do you get people to change the way they do their jobs.

Leah: That's the million dollar question, right? It's how do we engage physicians and other providers and care teams into this work. And I think the way to do that is to demonstrate the value-add. And so, when we think about how we shift from a volume-based approach to a value-based approach, we really want to focus on how do we leverage teams to deliver excellent care. And so that means using everyone on the team to the best of their skills to be able to optimize the care for the patient. This is my second month at UW Medicine. I trained here but have been in this role for only two months and I came from an innovative primary care practice that was centered around team-based care and this idea of delivering high-value care and focusing on population health. And the teams were the crux of delivering that care. So the idea is that physicians and other providers already feel overburdened in their work. And so if you're adding to that burden by saying, here's a list of patients who have out of control blood pressure and we want you to do something about it and you don't give resources or other team members to support it, it's not going to be done. Or maybe it will be done one time. But making that sustainable is not practical. It's just not going to work. It's not a long-term solution. But, if you say, we're gonna work on blood pressure and we're going to engage the entire team, we'll train the medical assistants to make sure they're rechecking blood pressure after they have a high value, we'll engage the pharmacists to help in some of the prescribing for blood pressure for those people who have difficult to control blood pressure. And we can also engage other pieces, other parts of the team in order to get that patient's blood pressure under control without actually adding a visit or additional documentation or really additional work for providers. And then providers, as a result, see their blood pressure numbers climb from 60 percent to 78 percent. That is a huge boon for providers. You know, as providers, we really want to take good care of our patients and to be able to see those numbers climb with the results of a team-based approach and not feeling overburdened by that approach is huge.

Josh: Well, let's talk about, you mentioned some measure of success. Deb, how do you measure success when you look at the whole system since you oversee all of the neighborhood clinics. What are you looking at, what are the barometers for you where you say, yes, we are moving the needle in the direction we want?

Debra: Well, fortunately there are lots of very specific metrics that we can measure, both in terms of quality, in terms of process outcomes, that we can measure that tell us. But from a high level, you know, my vision would be that for our patients, if you're on a panel, if you're empaneled with us, it basically means you're part of our family. And if you're part of our family, we've got you. We will be looking out for you. We will be caring for you on every domain of health, that people can trust that we are reliably and consistently concerned and caring about every aspect of their health to make them be as healthy as they can. I'm a patient of UW Medicine and I know that I'll get prompted if I forget to do something or I'm off track Somebody is going to reach out to me and help

me get on track and make sure that I'm doing all the things that I need to do to stay as healthy as possible. And I think that's what we all want for our patients. And all of these tactics, these strategies, I think are ways that are helping us get there on behalf of our patients. But there's many things that we're measuring to make sure in a very concrete way, that we're tracking ourselves and keeping on track and we're measuring things about our chronic care management for our diabetics and our hypertensives and our depressed patients. We're measuring our preventive care measures around immunizing and screening patients for all the things that keep them from becoming sick in the first place. And tracking those on a very detailed level. We can look at them by clinic, by specific provider, by care team, to see where we have some best practices and how we can learn from that as well as where we have some opportunities to maybe revisit process and where we can make a little more progress. So it's been a huge opportunity for us and I know, Federal Way, for example, is one of the ones that's been a shining star on completing our annual wellness visits for our Medicare patients and we've learned a lot from them on what are the things you need to do to do an excellent job. And that's where I think really as a system have some opportunities.

Josh: Speaking of the system, Van, I'm fascinated by, you have a human component of change here, but then you have a systemic. You need to change software, for example, how do you input the data that everybody sees and all that. And you as the overall program administrator, that must be an interesting sort of problem to solve in how do you bring these two disparate sides, if you will, of the of the equation together to actually work.

Van: Well that's very true. You can't change what you don't measure. And so I'm glad to say that at UW Medicine, it's really been a collaborative effort bringing together not only the partners or team members on the decision support finance side that measure quality for our UW Medicine patients and all the analytics and business intelligence we need to tell us on how we're performing, like Deb cited, all the quality measures, but it's also bringing our Epic partners together to then develop the tools in the medical record where providers and our care teams actually document and live and put in documentation so that there is great alignment and we're all synched up and able to see and visualize the same targets and goals. It's been a wonderful collaborative effort. For the empanelment, for example, we started by doing a manual paper-based process which then took a number of months to build into Epic and so now I'm happy to say Epic is a source of truth and we can measure all the quality metrics Debra talked about from Epic, using business intelligence software that's actually part of the population analytics team. So it's been wonderful. They're different departments but we're all part of one team and we all work together towards the same goals in service of our primary care providers and team. So it truly takes a village. And it's worked very well for the last two years.

Josh: Vicky, you got a gold star from the boss here. You were praised there. What are you guys doing down there that's working well?

Vicky: For those of us who are the boots on the ground, I think that providers are very motivated to see these metrics but they also are motivated by individual stories. So when we were working on our AWWV lists we bring people in who haven't been in in a long time, and there are actually people that you find who you diagnose a colon cancer and get that person to care at UW Medicine. That's a personal thing. That's what our physicians really get motivated by. They love to turn the bar to green and see the metrics improve. But it's that individual relationship, having reached out to a patient. There is no thank you in the world like the one that said, wow, you found my cancer and I wasn't even going to come in until you called me in. Thank you, thank you, thank you. So I think that's a big motivator for our group. And when we have experiences like that, it really pushes the needle to want to have more of that. That's what we went into health care for.

Van: And I would add to Vicky, who is being very humble, that the Federal Way clinic in 2017 was our leader on annual wellness visits for the Medicare Advantage population. This is a key population we want to demonstrate to our different partners, our payers, that UW Medicine is passionate about keeping their patients healthy. And one way to do that is to provide health risk assessments annually, and Federal Way achieved over 80 percent on their annual wellness visit and in 2018 are again at the lead of the pack across all our primary care clinics and that is thanks to Vicky's leadership and the leadership of her teams.

Josh: Do you guys share those stories. Is there a little friendly competition, if you will. Do you guys now tell these stories so the other clinics hopefully will say, well gee, I'm going find two colon cancer instances or something like that?

Vicky: You know one of the things that happened in Federal Way was we were very certain that we would fail because we looked at our numbers of Medicare patients and realized that we had a very, very large denominator. So, facing this failure, we said we were going to go down fighting and we were going to need the whole team to do that. So, I think one of the learnings for us was that we had to engage not just the chief and the manager, we had to engage not just the providers, we had to engage the staff. And so we reached down and asked individual provider and medical assistant dyads to start owning this project together. And by the end of it, we had medical assistants, front desk people, everyone making outbound calls. We had physicians very conscious of, I think that patient's on my list, they're coming in for a cold, let's let's make sure we get them scheduled for the AWWV or, hey, we have enough time, let's do it today. So I think it's a real team effort. If you put this all on providers, it just doesn't get done. One of the big learnings of care transformation is that our staff are really knowledgeable and able and hungry to help with these efforts.

Leah: I just wanted to share one of my favorite stories from the neighborhood clinics is the celebration of saving a life through population health management. And going on what Vicky said, and Vicky and Debra can speak more to this in detail, but that when colon cancer is found early and that patient is cured, it's not just the provider who gets the satisfaction of that. The team also celebrates the person who made that phone call

to ask the patient to come in or who sent the colon cancer screening to the patient or scheduled that colonoscopy. And I think that's a really important part of this work because when we are celebrating teams and you know you don't just give all the credit to the providers, this is a really team effort, it also makes that person who was either at the front desk or a medical assistant or navigator in the neighborhood clinic, it gives them a sense of purpose and mission and they're able to take part in that credit, of really making a difference in people's lives. And so I think I really appreciate that the neighborhood clinics specifically celebrate those wins with the whole team.

Josh: You guys are all involved at the clinic level and then I think back to the mothership, if you will, and UWMC, are we going to continue to move away from that sort of centralized hub, if you will, or does that still complement what you're doing, and you as satellites, if you will, then can still feed into the main system when the need arises, so you still have the support of the main hub or the hospital or some of those larger facilities that are in the system there, whether it's in Northwest or in Renton--Valley.

Debra: Well, I think we'll always have a continuum of care and that's how we see ourselves as a whole system. We have our four hospitals that are incredibly important in doing amazing work in the unique ways that each of them deliver services. But, really important that we have a strong primary care network as well. And increasingly, we're seeing payers, patients, employers, really expect us to be doing more in the outpatient arena. And we want to try to respond to that and provide great care in the communities to the greatest degree. But it's a tremendous advantage for our patients that we have the ability to very quickly get them to one of our hospitals for advanced care for procedures, for hospitalizations, if need be. I think it's a tremendous advantage and one reason that patients really seek out UW Medicine. I think people see the advantage of being part of that larger system.

Josh: Speaking of that, there are such regional differences. The people in Kent, I hate to generalize, but there are some differences between say the Sammamish plateau and Kent and Renton, just in general, and Federal Way, broader based in populations. When we talk about population health management, are we talking more condition-based vs. socioeconomic? I tend to think socio-economically, more in general. What do we look at when we're determining who is part of a certain group, if you will?

Debra: So, I'm a social worker first, by background, Josh, and so I think about that as well quite a bit. But I'll tell you, my bias is all patients deserve to have excellent health care and definitely some people bring more complex things to the table but that's our job to help them figure out how to optimize their health even if they have additional complications. And I see our care teams doing an amazing job with that every single day, really helping them think through what are all of the factors that are involved in their health, hereditary factors, you know things that they can control, as well as things like where they live, their employment status, whether they're homeless. They have other things that are influencing their health but all of those are just part of the picture that we need to help them with. [00:27:21][25.1]

Josh: Vicky, we've talked a lot already about how successful this has been done at your clinic. How are the providers and care teams actually embracing the work as you began to make some of these changes? And conversely what are the challenges?

Vicky: I think with any care transformation, there are always champions. So, in my clinic, and I'm sure this is true at every clinic, there are providers and staff who drag their feet on the change and then others who embrace it wholeheartedly and lead the charge. And I think one of the the challenges in transformation is to find those champions and bring them to the front and celebrate them. And people will follow their natural leadership and it can be a growing experience. Providers are staff as well who step forward as leaders. In our clinic, one of our strongest leaders right now is a medical assistant who has really owned a lot of this panel management and is really excited about it and passionate about it. So I think you have to find those natural leaders in the clinic. They don't necessarily, they aren't necessarily the people with the highest title or the highest pay, but they are the people who other people follow naturally.

Josh: Van, how do you identify the leaders when you first go out to the different clinics? What are the things you're looking for and say, ok, I'm going to partner with Vicky. That's a person I want, I need to be sort of my Trojan horse, if you will.

Van: Well, as someone who doesn't live in the clinics, I'll have my own take into this answer, of course, as Vicky and Deborah can attest better. There's insights within the different primary care clinics of who the leadership and who the change agents are, but from somebody who sits at a central level and is responsible to drive change around population health management and achieve targets and metrics by working with and collaborating in partnership with our primary care teams, all of them. I can definitely tell who is, you know, a great partner in terms of the results. You know the results are very clear in terms of wanting to ask questions, wanting to partner, wanting to share best practices and being first at the table to say, you know, we want to do this, we may not have the answers around how to do this. We know how to care for our patients, but what is some process insights or how could we do this in a more efficient way in collaboration to achieve our stated aims on improving the health of our populations. You know Debra Gussin, as our leader, has made very clear to us over the last many months, something that I'm very excited about, that let's become more efficient in how we deliver population health by truly allowing the primary care teams at the frontline to be efficient and able and have the time to be able to leverage the skill set so that when they're with patients they can see as many patients as they need to and the work they're doing is really about the patient in the clinic and that all the preparatory forecasting, prospective, proactive planning work and follow-up to some extent can be done centrally. And that's a principle my team and many teams have embraced and I'm excited about supporting those sorts of processes and workflows to allow our primary care teams and our providers to be efficient and to have their back so that we can really own pieces as a team, support, own pieces of planning and whether it's calling patients and scheduling them and moving them out of the clinics to following virtually and providing care management or even triage, but really helping them when they have

patients in clinics see patients and that's all they can do and that's what is front and center for them and then helping and having their back on the outside.

Vicky: It's a conversation between local and central. And we need that energy, knowledge, expertise, that comes from a central group. But then when we were implementing it locally, you know, we do find little things we can add and if we can push that back up centrally and actually make some changes in what we are given back again, it's a dialogue back and forth. And that's where it really works well when you can, for example, send us, you know, gap analysis and we can look at those AWV lists and say, wait a minute, we're missing a little bit of data here. How did you get this and send it back to you and have it refined. So, I think it's keeping that dialogue going that's important.

Josh: Debra, how important is it to you to empower everybody all the way down the line to the primary care provider, to the desk person at the Federal Way clinic, for example, so it's not just you issuing edicts from on high.

Debra: It's essential. And I think you know what you hear in the conversation so far is this is truly a journey that takes every member of the team. And I'm so proud of what our teams have done so far to innovate and come up with new ways of doing things but we're not done. And I think all of us know we still have things we need to do and there will be over the next several years, things will look very different and we'll get to a place where we're doing this in an even easier way, a better way. But it really takes every single person on the team to do this well.

Josh: Dr. Leah, who still has the badge that says attending physician is off to rounds after this I'm sure, you've come from the outside, from another system, an innovative system. How has it been to bring your outside perspectives? How do you integrate your learnings and all of that with what was being done here prior? And what is that process looking like.

Leah: I came from a system where when we think about this work, we were very spoiled. And by that I mean we were paid for taking care of populations of patients. We were not paid at all in the fee-for-service model. So, we weren't paid for how many visits, we were only paid for how good of a job we did. And in that setting, that's a lot easier to very have kind of narrow focus on population health and strategies of population health and design care teams to deliver the best care that we can for patients, whether they're calling us up or not, and whether we're seeing them for acute or sick care visits or not. And so, I think it's been really helpful for me to have had that experience, to say if we were paid in that way, if we were paid strictly on value and for taking care of populations, what are the best practices that we could learn from to deliver that care at UW Medicine. And I have been really impressed with how much of those learnings the various primary care practices within UW Medicine have taken already and implemented despite still primarily being paid for in a fee-for-service system. For example, the health navigator role at the neighborhood clinics. So, the health navigator role in the neighborhood clinics is not a traditional role that you see in

primary care. And right now, the health navigators are supporting the care teams and a lot of this population health management or panel management work. So instead of, as I said before, giving lists to patient to providers of their patients who are out of control in blood pressure, the lists go to the health navigators and the health navigators will look through that list and have a good idea and be able to tell stories about each patient and bring it to the team and be able to strategize how through a team-based approach will outreach to these patients. And so the provider becomes the manager of that work and leads and inspires the work but there's not a whole lot of time that's additionally put on the provider to do that work which is really key.

Josh: So, as we wind down here, where do we go from here? And then any last thoughts each of you might have. Van, let's start with you. Where do we go from here and anything else we haven't touched on.

Van: I think one of the key paths we get to walk down from here are, of course, to continue our journey of better population health for all members, whether they come in or don't come in, and finding various modalities to engage and bring our patients back to or continue to maintain excellent health and keep them healthy. That's something we're passionate about and we'll continue down that path. One of the benchmarks for success for us, in addition to monitoring quality metrics for prevention and promotion and disease control and immunization status, is also how we look to stakeholders outside of our four walls as a health system and one of the stakeholders we routinely engage with are direct employer contracts as we move to more value-based models as well as insurers or payers. And I'm happy to say that over the last two years, we've really changed the way we're viewed with payers. For example, in the Medicare Advantage space, we contract with about seven different payers and two years ago UW Medicine appeared a little bit differently as a partner to payers. We seem to live in the middle of the pack range around quality measures which they call HEDIS stars and our risk scoring was in the middle of the pack. Through our focused efforts from our primary care clinicians, our leadership and collaborative teams, we're now best in class on our risk scoring. We are known as a great partner that is focused on prevention, on our annual wellness visits. And our HEDIS scores are rapidly improving. So it's truly a pretty amazing space to be in and there's more to go and do, so I do want to recognize how we appear as a partner.

Vicky: Another important measure of success for us is being the employer of choice. This work is the kind of work that attracts the best young physicians, the best staff to work for UW Medicine. So we very much need to have it at the heart of what we do.

Leah: I think one of the big things that we're working on and moving toward is addressing this tension of fee-for-service and value-based care. And right now there's still very much attention of making sure we have a volume of visits to the clinic and trying to figure out how to deliver that out of clinic care that nobody's getting paid for the vast majority of our patients and be able to shift toward payment models that make better sense for taking care of populations of patients. So growing those opportunities to engage in value-based care.

Debra: I think we're not even in the middle of, we're at the very beginning of an incredibly disruptive change in healthcare and it's a little scary, but very exciting. I think five or ten years from now, we're not going to even recognize what we're doing now. I think things feel difficult right now because we are at the beginning of making some of these hard changes and so we're not as things are a little clunky as we're working things out. And I'm excited to get to a point where this not only makes a ton of sense for our patients but also is a wonderful place for our providers and our staff to work and practice. We need to make sure that this ultimately becomes a way of life that works well for everybody but it's an incredibly exciting time.

Josh: Debra Gussin is the executive director for UW Neighborhood Clinics and is now also associate vice president of primary care services and population health. Leah Marcotte is the associate medical director of population health management. Van Chaudhari, the UW Medicine population health management administrator. And Vicky Fang is the associate medical director for the southeast region of the UW Neighborhood Clinics. And ladies, thank you all so much for such a fantastic conversation and I really look forward to seeing where this all goes from here.

[Musical break]

Josh: So, as you heard in that conversation, we're making some big changes when it comes to the way we serve our patients and populations and making some big improvements. But the reality is still a lot of people are getting left out and getting left behind. In our next episode of The Transformer, we'll talk in-depth about healthcare equity and glaring inequities and what we're doing to close that gap. Diversity, equity and inclusion in our system is one of our core values and we're committed to serving everyone in our communities with high-quality care that leads to the best possible health outcomes. Until then, I'm your host, Josh Kerns. Thanks so much for listening. We'll talk to you again soon on the next episode of The Transformer.

[Musical outro]