NETWORK CREATES CLINICAL SCALE WITHOUT M&A

Mayo Clinic Care Network, Rochester, MN (headquarters)

Understanding that the benefits of clinical scale do not depend on mergers or acquisitions, Mayo Clinic created a collaborative network that helps improve care delivery across communities and extend the system's reach.

APPROACH

The Mayo Clinic Care Network allows health systems to leverage Mayo clinical expertise while maintaining their independence. Established in 2011, the network is a collaboration between Mayo Clinic and like-minded provider systems.

- Members of the network can access Mayo experts via "eConsult" (telehealth), evidence-based disease management protocols, clinical care guidelines, treatment recommendations and reference materials on complex medical conditions. The clinical tools offered to members are those Mayo was already using—a true clinical scale move.

- Organizations that want to join the network must meet rigorous criteria in clinical excellence, patient care and quality. The due diligence process for new network members is based on that for an acquisition. Members pay an annual subscription fee. It takes about 9 months to fully integrate a new member into the network.

- The network allows patients to receive the benefit of Mayo Clinic expertise at their local health system, rather than having to travel to a Mayo Clinic facility. Network membership offers health systems the opportunity to collaborate with a world leader in health care.

- Beyond these benefits, each member system defines the value of the affiliation differently. Some are looking to the partnership to stem out-migration; others to fill a need for consulting services; others to increase efficiency. Common threads, however, are strong physician engagement and alignment with a sustainable, patient-centered organization.

TAKEAWAYS

Network executives see the Mayo Clinic Care Network as a clinical practice extension strategy that provides important regional relationships. A key success factor for Mayo was to involve all its physicians, not just a subset, in the network. This meant more effort initially but has helped ensure the longevity of the network.

The network is an important part of reaching an ambitious goal set by Mayo's president and CEO: to provide Mayo Clinic expertise to 200 million people around the world by 2020.

45

current members in the Mayo Clinic Care Network

The network includes health systems from California to Florida to New Hampshire, as well as international members in countries such as Saudi Arabia and Mexico.

This is an excerpt from the Sg2 report *Economies of Scale: An Untapped Opportunity in Health Care*.

M&A = mergers and acquisitions.
Sources: Sg2 Interview With Mayo Clinic Care Network, March 2014; Adamopoulos H. Keeping healthcare local: Why some providers choose non-ownership collaborations over mergers. *Becker's Hospital Review.* October 4, 2013; Mayo Clinic websites. Accessed September 2018.

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IPADS STREAMLINE DEPRESSION SCREENING

University of Rochester Medicine, Rochester, NY

When workflow disruptions complicated this medical center's ability to offer efficient depression screening and follow-up behavioral health services, it turned screen time into a smart means of integrating care.

APPROACH

Integrated care is not a new concept at the University of Rochester Medicine, where licensed clinical social workers or psychiatric nurse practitioners are embedded in 8 of its primary care practices. However, the processes of obtaining depression scores (using the standard PHQ-2/PHQ-9 or similar), capturing the data in the electronic health record and intervening in a timely manner with at-risk patients were inconsistent and inefficient.

University of Rochester Medicine began using a homegrown platform (which was originally built as an orthopedics screening tool) that enables iPads to house various questionnaires and administer the PHQ-2/PHQ-9.

- Upon patient check-in, front-desk staff scans a QR code that loads the PHQ-2/PHQ-9 onto the iPad, and the patient completes it in the waiting room.

- The finished questionnaire immediately flows into the patient's electronic health record, and the primary care provider is alerted upon login if a patient may need intervention.

- Health maintenance activities auto-activate as well; for example, when a patient indicates suicidal ideation through the PHQ-2/PHQ-9, a health maintenance activity to conduct a follow-up screening during the next primary care visit auto-populates into the electronic health record.

- Referral orders are also generated for patients who need behavioral health support. Sometimes patients have immediate access to behavioral health providers, since these providers are embedded within the practices. When immediate access is not available, however, patients leave the primary care office with a scheduled follow-up appointment with a behavioral health provider.

PHQ = Patient Health Questionnaire.
Source: Sg2 Interview With University of Rochester Medicine, September 2017.

TAKEAWAYS

Success has led to program expansion: University of Rochester Medicine began the process of rolling out the Edinburgh Postnatal Depression Scale screening tool in its women's health practices to better identify and treat postpartum depression.

↓30%
Drop in ED usage by high utilizers 6 months after implementation
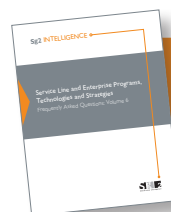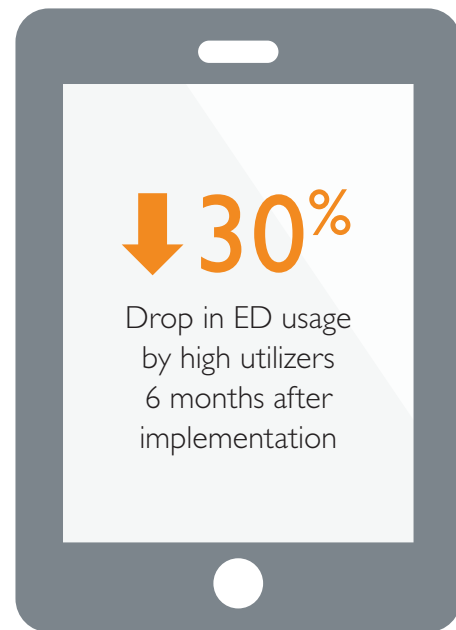
This is an excerpt from the FAQ *Integrating Behavioral Health and Primary Care*, featured in Sg2's sixth FAQ compendium.

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EARLY MOBILITY GETS METRICS MOVING

The Johns Hopkins Hospital, Baltimore, MD

For this academic medical center, now helping to build national capacity for multidisciplinary ICU early mobility programs, due diligence proved its own program offered benefits that more than offset associated costs.
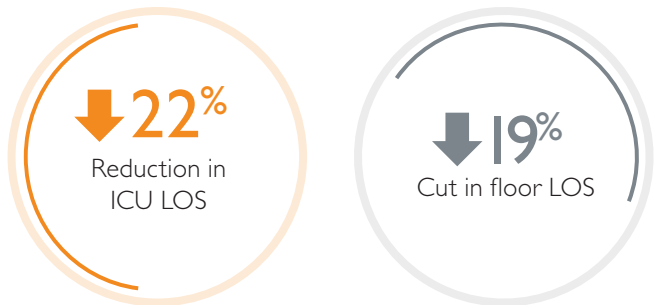
APPROACH

The Johns Hopkins Hospital evaluated the operational and financial impact of implementing an early mobility program in its 16-bed medical ICU, which sees approximately 900 admissions per year. Cost savings in smaller and larger ICUs were also estimated with financial modeling.

- The program team consists of 2.25 FTE physical therapists, 0.5 FTE occupational therapist, 1.0 FTE rehab technician, 0.5 FTE speech-language pathologist, a program coordinator and a physician leader.

    — Coverage is spread over 6 days per week.

    — Dedicated therapists were added at a cost of $358,000 per year.

- Screening for early mobility is performed by nonclinical staff using a standard algorithm.

- Most ICU patients are not deeply sedated at Hopkins; 50% of all ICU days were deemed appropriate for early mobility therapy.

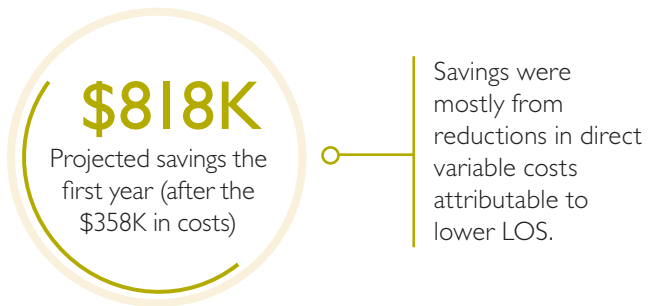- Therapy sessions range from 10 to 60 minutes once or twice daily.

Initially the program's physician leader met daily with the team as well as with physicians and nurses to promote culture change. As the program took hold, the physician leader met weekly with the coordinator and rehab staff, and periodically with the program coordinator and physical medicine and rehabilitation leadership.
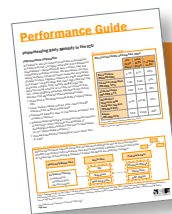
TAKEAWAYS

Results after 1 year revealed:

↓22% Reduction in ICU LOS

↓19% Cut in floor LOS

Additionally, financial modeling indicated:

$818K Projected savings the first year (after the $358K in costs)

Savings were mostly from reductions in direct variable costs attributable to lower LOS.

Financial modeling also demonstrated cost savings in ICUs with 200 to 2,000 annual admissions.

This is an excerpt from the Sg2 Performance Guide *Implementing Early Mobility in the ICU*.

FTE = full-time equivalent.
Source: Sg2 Interview With Johns Hopkins University, July 2013.

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CANCER PATIENTS GET CUSTOMIZED URGENT CARE
Siteman Cancer Center, St Louis, MO

Looking to increase access to care and respond directly to patient complaints about long wait times in the ED, this institution created an urgent care clinic tailored to the unique needs of the cancer community.

APPROACH

In an effort to lower ED volumes and provide a care option for patients with nonurgent conditions, the Barnes-Jewish Hospital and Washington University School of Medicine opened the Cancer Care Clinic at Siteman Cancer Center.

- The 24/7 urgent care clinic is located on Barnes-Jewish Hospital's main campus and is close to Siteman's other cancer facilities. The 15-room facility includes 5 beds, 11 infusion chairs and 4 rooms—1 isolation room and 3 semiprivate rooms.

- Program staff includes 1 nurse practitioner, 1 medical assistant and 1 medical technician available 24/7. Four to 5 oncology-trained nurses are available during the day; 1 to 2 registered nurses are available at night.

- The clinic, whose mission is dedicated to the acute care of cancer patients, treats pain, dehydration, nausea, vomiting, neutropenia, fevers and other complications related to treatment.

- Though the clinic takes appointments in advance, there are slots reserved for walk-in, urgent or last-minute appointments. The clinic does not treat trauma cases.

- The facility operates much like a traditional cancer infusion center with patients receiving services such as chemotherapy, blood transfusions, and fluid replacement and antibiotic therapies. Some patients and referring physicians favor its quiet treatment environment. Though this is uncommon, some patients are treated at night to accommodate their work schedules.

- A 24/7 nurse triage line staffed by medical fellows allows patients to report and discuss symptoms and whether or not an in-person visit is necessary.

TAKEAWAYS

To tailor care, patients are categorized and treated by acuity level (1–4), but only 10% of the clinic's patients are eventually admitted for inpatient care. The clinic sees an average of 25 patients per day, outpacing original expectations.

The clinic sees approximately 630 patients monthly.

Roughly 60% of the patients are there for infusion services.

The remainder are there for evaluation.

This is an excerpt from the FAQ *Outpatient Urgent Cancer Care* featured in Sg2's fourth FAQ compendium.

Source: Sg2 Interview With Siteman Cancer Center, 2016.

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CONSUMERS FLOCK TO MULTIPLE "FRONT DOORS"

Cleveland Clinic, Ohio

For this multispecialty academic medical center, a multichannel primary care access strategy that harnesses diverse data is helping to meet unmet demand, enhance loyalty and attract patients to the system.

APPROACH

Patient-centric access strategy is integral to Cleveland Clinic's "Patients First" philosophy, adopted in 2008 to ensure better understanding of and responsiveness to patients' preferences. The range of preferences is reflected in a diverse set of primary care access options, including:

- **Same-day appointments:** Primary care offices are expected to meet 95% of requests for same-day appointments. Varied strategies enabled individual practices to rapidly achieve 100% compliance, including open-book scheduling for a subset of physicians and expanded appointment slots in the daily schedules.

- **Walk-in clinics:** Up to 16,000 patients access primary care services monthly without an appointment through the clinic's family health centers. Centers have extended hours—early-morning, late-evening and weekends.

- **Virtual/online appointments:** Nonurgent care and postprocedure/surgery follow-up visits are available without an in-person encounter.

- **House calls:** A group of physicians follows nearly 1,000 high-risk patients, making home visits to manage their multiple medical problems. Most of these patients have challenges going to outpatient facilities. By providing care in the home, Cleveland Clinic saw a 29% reduction in ED visits and 39% reduction in hospital admissions.

- **Group appointments:** Patients interested in self-learning who are comfortable sharing with others take advantage of this option.

TAKEAWAYS

To ease access and reduce patient frustration, Cleveland Clinic is also focused on:

- The patient portal
- 1-click online scheduling
- Consumer-focused process redesign for its call center

The clinic is working toward tracking patient preferences and feedback in its centralized customer relationship management (CRM) system and linking that data to the electronic medical record to ensure they're available to clinicians at all touchpoints.

1.3M+

Same-day visits delivered yearly as of December 2016
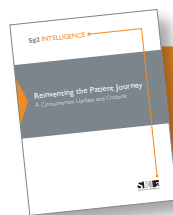
This is an excerpt from the Sg2 report *Reinventing the Patient Journey: A Consumerism Update and Outlook*.

Sources: Sg2 Interview With Cleveland Clinic, September 2016; Sg2 Webinar: Consumerism Outlook and Update: Building a Consumer-Informed Access Strategy. February 1, 2017.

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AMC PARTNERS TO PURSUE GROWTH
UCLA Health, Los Angeles, CA

UCLA Health is executing its strategic growth plan, reaching into new geographies, and developing a foundation for value-based care and population health management. How? By aggressively courting partners.

APPROACH

Like many academic institutions, UCLA Health must straddle 2 worlds—the fee-for-service world of tertiary and quaternary care in the flagship hospital and the value-based world of accountable care, which is rapidly taking hold in California. The organization has turned to strategic partnerships to nimbly seize opportunities and fill gaps.

- The system, which already has a staff of over 2,000 physicians serving more than 150 community offices and outpatient clinics, has recently begun joining forces with businesses specializing in urgent care and ambulatory surgery.

- Another partnership is aimed at building a new 140-bed acute rehab hospital. In the future, UCLA Health may expand the post-acute portion of its System of CARE via this alliance.

- UCLA is also participating in a new health plan, Anthem Blue Cross Vivity, that bills itself as "a first in the nation partnership between an insurer and 7 competing hospital systems." This HMO is a novel concept designed to ensure the hospital systems participating in Vivity will share in any profits and losses with Anthem.

Decisions about these collaborations are guided by the strategic growth plan. Along with the typical operational and financial due diligence, other considerations include:

- Does it make sense economically?

- Can we execute on it?

- Does it drive other partnerships?

AMC = academic medical center.
Sources: Sg2 Interview With UCLA, March 2015; Terhune C. New Anthem Blue Cross plan takes on Kaiser. *LA Times.* September 16, 2014; Anthem Blue Cross Vivity websites. Accessed March 2015.

TAKEAWAYS

UCLA Health's affiliations are often "opportunistic"— collaborations made possible by strong relationships and shared goals. But even so, UCLA Health executives are methodical about execution.

To create a sense of momentum, they aim to announce a new partnership every month.

The organization even has a webpage titled "Why Partner With UCLA Health?" that describes the types of partners UCLA Health is seeking and lays out the benefits of working with the system.

> "*With partnerships, you don't call the shots. This is new for UCLA, and it hasn't been easy. But sharing authority and decision making is something we are going to learn because we need to.*"
>
> —Santiago Muñoz, Chief Strategy Officer, UCLA Health System

This is an excerpt from the Sg2 report *Effective Organizational Structures*.

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TIERING STRATEGY REINFORCES SAFETY NET
Virginia Commonwealth University Health System, Richmond, VA

When an internal analysis showed significant care gaps for—and high costs associated with—the uninsured medically indigent, this system pursued a tiering strategy to strengthen primary care capacity and meet patient need.

APPROACH

Virginia Commonwealth University Health System (VCUHS) partnered with community primary care physicians to establish the Virginia Coordinated Care (VCC) Program, a primary care network that categorizes patients (about 27,000 annually) with incomes up to 100% of the federal poverty level into 3 tiers:

- Level 1 (~70%): Patients who need episodic care. Not formally enrolled in VCC; receive services through other channels serving the indigent unless health needs escalate
- Level 2 (~20%): 1 or 2 chronic conditions
- Level 3 (~10%): 5 or 6 chronic conditions, most commonly including congestive heart failure, chronic obstructive pulmonary disease, diabetes, vascular and liver disease

All patients at Level 2 and about 70% at Level 3 are assigned to a network of 50+ community primary care physicians who accept VCC patients as part of their panels.

- From its bottom line, VCUHS pays VCC primary care physicians 110% of Medicaid rates plus $5 per member per month, and also provides EMR access.
- VCC community primary care physicians refer patients to VCUHS for surgery, specialty services, ancillary and diagnostic services, and inpatient care.

The most complex Level 3 patients are assigned to a multidisciplinary Complex Care Clinic on the VCUHS campus staffed by an employed physician, nurse practitioner, RN care manager, pharmacist, clinical psychologist and social worker. Team members may see patients as often as weekly.

Source: Sg2 Interview With VCUHS, 2012.

TAKEAWAYS

In the Complex Care Clinic, costs fell from $4M in the 6 months prior to enrollment to $2M in the 6 months after. Inpatient utilization also dropped 50% and ED use fell 40%. Level 2 nonurgent ED use also declined.

50%
decrease in cost and inpatient utilization

Keys to success included:

- Organizational backing (VCUHS absorbs all primary care costs for patients in Levels 2 and 3)
- Processes and primary care physician incentives that support timely postdischarge follow-up
- Comprehensive team roles

This is an excerpt from the Sg2 report *Reengineering Primary Care: Workforce, Workflow, Workplace*.

UMBRELLA APPROACH SAFEGUARDS PAC STRATEGY
Partners HealthCare, Eastern Massachusetts

To unify its post-acute strategy and optimize overall care, Partners brought together its diffuse post-acute care facilities under a single business unit aimed at enhancing enterprise-wide initiatives.

APPROACH

Partners HealthCare created the Partners Continuing Care (PCC) post-acute care division to reduce cost and increase value across the organization, prepare for risk-based payment, and position the system to play a leading role in the emerging era of population health management.

Under its Spaulding Rehabilitation Network, PCC encompasses:

- 2 inpatient rehab facilities
- 2 long-term acute care hospitals
- 3 skilled nursing facilities (SNFs)

Within its Partners HealthCare at Home (PHH) division, PCC also includes:

- Home health
- Private care agencies
- A technology and product line offering a personal emergency response system, telemonitoring and preloaded medication dispensers

A single board and management team oversee PCC. The chair of the PCC Board of Trustees also sits on the Partners Board, and the president of PCC participates in weekly meetings with the Partners HealthCare leadership team. In many ways, Partners behaves as if it has a "virtual" common bottom line even though each entity within the system maintains its own profit-and-loss statement and balance sheet.

TAKEAWAYS

PCC supports overall system goals by focusing on 5 key strategies:

1. Devise processes to reduce readmissions.
2. Embed clinicians in post-acute care sites.
3. Leverage PHH to support population health management.
4. Create a collaborative SNF network.
5. Integrate care across all post-acute care settings.

PCC also aims to extend early successes. For example, in its first year as a Pioneer accountable care organization, Partners slowed cost growth by 3%, translating into:

$14.4M in shared savings that Medicare returned to Partners

This is an excerpt from the Sg2 report *Restructuring Post-Acute Care*.

PAC = post-acute care.
Sources: Sg2 Interviews With Partners HealthCare, 2013–2014.

TECH ENABLES HIGH-TOUCH CARE AT LOW COST
MUSC Health, Charleston, SC

For MUSC Health, the clinical enterprise of the Medical University of South Carolina (MUSC), an array of virtual specialty care programs has enabled participants to receive high-quality care while saving time and travel.

APPROACH

The MUSC Health Center for Telehealth offers a range of virtual programs, including telestroke, behavioral health and others, across South Carolina. Many, including the system's Virtual Tele Consult Clinic (VTCC), are targeted to the large rural areas of the state. The VTCC offers tertiary services to primary care practices and clinics.

- For the VTCC, ensuring the continuing involvement of referring providers is essential. At first, some primary care physicians were concerned about losing patients to MUSC. Therefore it was important to reassure these providers that MUSC specialists would be working with them to care for patients and not interacting with the patients directly.

- Virtual consults initially focused on general surgery consultation; diabetic nutrition counseling; and pediatric subspecialties including urology, nephrology, neurology, genetics and surgery. Additional adult and pediatric specialties were later involved in the program.

- Off-the-shelf technology keeps costs low. VTCC provides all the needed technology (low-cost HD camera, videoconferencing software, a computer if necessary) and training for spoke sites. Costs to set up an individual site average $3,500, but the equipment needed varies depending on the type of consultations to be done at the site.

- The process mimics an in-person visit. Because the VTCC program coordinator worked with MUSC IT staff to set up "telehealth clinic" as a location in the EMR, appointment scheduling and documentation of a virtual consult are the same as for an in-person consult. The spoke site can submit test results and imaging studies in advance of the virtual visit and may bill a facility fee for the visit.

TAKEAWAYS

In-person visits by VTCC personnel to spoke sites for training and relationship building have been key to program success. The VTCC found that it's particularly important to get buy-in from the spoke practice manager, even if it means taking care of administrative details for him or her.

Virtual visits have also saved time, fuel and costs. Over a 2-year period, the VTCC arranged 360 visits, which saved 53,000 miles of travel. Savings per patient include:

$22
in fuel cost
($8,000 overall)

142
miles

2.8
hours
per visit

This is an excerpt from the Sg2 report *Virtual Health: Taking the Next Step*.

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OFF-SITE SUPPORT BOLSTERS CRITICAL CARE
Emory Critical Care Center, Atlanta, GA

When the Emory Critical Care Center realized that 24/7 intensivist staffing was needed but too cost prohibitive, it integrated tele-ICU into its workforce model to help improve care in a cost-effective way.

APPROACH

After several years of investing money into critical care and seeing no improvements in value or access, the Emory Critical Care Center opened in 2009 as a reimagined way of delivering critical care. While it wasn't feasible or practical to have intensivists in-house 24/7, the system had to ensure the same level of care would be provided regardless of day or time.

To help tackle its workforce challenges, Emory incorporated tele-ICU into its center design. Tele-ICU provides monitoring coverage when an intensivist is not on-site (nights, weekends, holidays). It provides additional monitoring for highly critical patients and alerts on-site staff to anomalies or deteriorating conditions. The tele-ICU staffing model is set up as follows:

- Average census: approximately 85 beds from 5 hospitals (4 Emory hospitals, 1 rural non-Emory hospital)

- Weekdays: 3 critical care nurses (RNs with a minimum of 5 years of critical care experience); 1 administrative assistant

- Nights (7:00 pm–7:00 am)/weekends/holidays: 1 intensivist; 3 critical care nurses (RNs with a minimum of 20 years of experience)

The hospitals monitored by Emory's tele-ICU facility staff their ICUs with critical care–trained advanced practitioners (APs) at half the cost of physicians. Hospital leads are able to recruit and retain intensivists who work day shifts and do not take after-hours calls or pages. Newer APs are able to gain critical care experience with a safety net.

TAKEAWAYS

Emory was able to close the workforce gap created by increased demand for services and the shortage of intensivists available and willing to staff the ICU 24/7. At the 5 ICU facilities remotely monitored by Emory:

- Length of stay
- Mortality rates
- Cost of care

have all decreased

In addition, the ICUs have become revenue centers as opposed to cost centers due to their ability to admit and treat higher-acuity patients at any time of day instead of transferring them to another facility.

> *Critical care is different from other areas because of the workforce factor. In critical care, it has been, first and foremost, the critical care nurse serving as guardian of the patients' well-being. But he/she needs a partner, and that partner must be a physician.*

—Timothy G Buchman, PhD, MD, Director, Emory Center for Critical Care
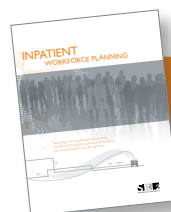
This is an excerpt from the Sg2 report *Inpatient Workforce Planning*.

Source: Sg2 Interview With Emory Critical Care Center, 2015.

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