

UPDATES & INNOVATIONS

REPORTS AND BEST PRACTICES FROM ST. JOHN HEALTH SYSTEM

MAY 2009



Welcome



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WE ARE DELIGHTED to introduce to you the first issue of *Updates and Innovations: Reports and Best Practices From St. John Health System*. As the title implies, our intention is to keep you abreast of developments throughout our health care organization that are pertinent to you and your practice.

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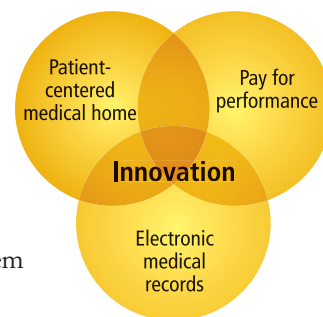
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The St. John Health System primary care physician network

A winning strategy to provide excellent health care



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AT THE CORE of any thriving health care system is a strong primary care network, which St. John Health System is committed to

growing and preserving. In the cooperative relationships the network builds, everyone benefits—physicians, patients, and the hospital.

Part of our primary care development effort is to also reach out to large private group practices in order to create strategic alliances for growth and expansion of our quality initiatives. In October 2008, we were proud to announce a new affiliation with **Millennium Medical Group, PC**, a 65-physician multispecialty group practice, comprised primarily of internal medicine physicians with offices located in Southfield and Farmington Hills. According to Michael Wiemann, MD, President of Providence Hospital, “The relationship with Millennium is intended to broaden and strengthen our primary care network in the western region, supporting Providence Hospitals in Southfield and Novi.”

“We have been a successful private group practice model over the past 15 years,” says Geoffrey Trivax, MD, President of Millennium Medical Group. “Our affiliation with St. John Health System will allow us to continue that success by providing us with opportunities to expand our group and meet the growing demands of consumers expecting greater coordination of care with specialists and hospitals. We sought a partner like St. John Health System and Providence Hospital that recognizes the value of the primary care physician and our role in the patient care continuum.”

For **primary care physicians**, aligning with St. John Health System can ease the strains associated with qualifying for reimbursement, provide a cushion against increasing regulatory restrictions, and facilitate access to individual insurance. Affiliation also has very real advantages in the context of today’s changing medical environment. In this issue of *Updates and Innovations: Reports and Best Practices From*

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Welcome (continued from page 1)

In this issue, we focus on St. John Health System initiatives in primary care medicine. Given today's economic and political realities for physicians, health care systems, and consumers of health care, our challenge is to achieve greater efficiencies while continuing to improve the quality of care. To this end, St. John Health System has implemented several coordinated strategies across its primary care system, and on page 1, Vincent DiBattista, president of St. John Physicians Network/Medical Resources Group, introduces the topics for this issue and explains how they are interrelated.

In the next issue of *Updates and Innovations*, watch for articles on oncology services—ranging from best practices in diagnosis and treatment to new initiatives throughout St. John Health System.

We want to hear from you. Each of the authors in this issue has provided contact information so that you may follow up with questions or comments about what is happening at St. John Health System. [↗](#)

The St. John Health System primary care physician network (continued from page 1)

St. John Health System, we focus on distinct yet interdependent initiatives at St. John Health System to help physicians adapt to this new reality.

Physicians can partner with us in creating a **patient-centered medical home** (PCMH), the practice structure of the future. Scott Eathorne, MD, describes our ground-breaking project, PartnerHealth, which, with funding from Blue Cross Blue Shield of Michigan, is designed to demonstrate the value of collaborative, coordinated care on behalf of patients.

Measurable quality and process improvement is another requirement in health care today and it is integral to the PCMH concept.

Pay for performance, as explained by Bruce Carl, MD, is restructuring reimbursement to help drive quality and process improvement.

Finally, the outcomes we hope for in the above areas would not be possible without computerized tools. Michael Balon, MD, and Kenneth

Bollin, MD, detail their experiences with **electronic medical records** and the profound difference they have made in practice. In affiliating with St. John Health System, physicians also have access to capital for growing their practices as well as assistance with investing in clinical technology.

Each of these areas of focus is tied to the others in building an integrated whole that will improve patient care.

For patients in the communities we serve, the physician network means ready access to deep resources and to coordinated care through St. John Health System's active commitment to the medical home concept.

As an example of clinical resources available to your patients, we also feature in this issue the important work Malaz Almsaddi, MD, and Kathleen LaRaia, MS, are doing at the **St. John Chronic Headache and Migraine Institute**. [↗](#)

Building the patient-centered medical home

A bold initiative at St. John Health System



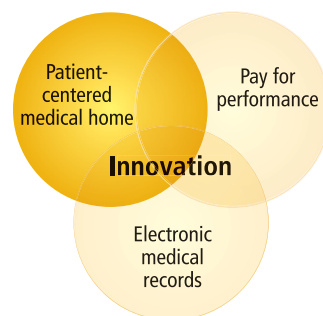
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TODAY'S HEALTH CARE delivery system rests uneasily in a "perfect storm" created by a convergence of rising medical costs, a nation in severe economic recession, and an aging

population demanding high-quality, efficient, and accessible care at reduced costs. In the midst of these conditions, we at St. John Health System are building a safe haven for patients—the patient-centered medical home (PCMH).

Health care in need of reform

Adding to the challenges of the "perfect storm," we see medical costs



rising; at the same time, the burden of paying for these costs is shifting to patients in the form of higher deductibles and co-pays on their health insurance.

These stresses also lead to competition among care providers, which is escalating on many fronts:

(continued on page 3)

The patient-centered medical home

(continued from page 2)

within specialties, across specialties, between physicians and hospitals, and between physicians and newer care entities such as medi-clinics. Often, increasing fragmentation and potential for duplication of services occur as byproducts.

Overall, we need to keep in mind that, while our national health system remains strong, it pales in comparison to systems in other countries that boast better health outcomes, such as treating preventable causes of death, immunization rates, and screening rates for various diseases. Each of these countries shares a common denominator: an effective primary care system. In the United States, however, primary care is caught in the turmoil of this “perfect storm.”

Can the medical home succeed in this environment?

The PCMH may very well represent a solution. In this framework, each person establishes a continuous relationship with a personal physician to coordinate both sick and well care.

The federal government's pending demonstration project

A demonstration project sponsored by the Centers for Medicare & Medicaid Services (www.cms.hhs.gov) will be conducted in eight states yet to be identified. The project's incentive for physicians to follow the medical home model will be a blended payment scheme, significant for practices that care for many Medicare patients. Physicians will be rewarded for evaluation and management services, for coordination-of-care services, and for achieving improvement in quality and efficiency indicators.

This relationship, based on trust, respect, and shared decision making, helps create an environment of care focused on the whole person. Such a relationship helps ensure that care is provided in the right place, at the right time, and by the right provider. Overall, care is provided in a more collaborative, integrated fashion and better coordinated across the health care continuum, helping improve quality, satisfaction, and patient safety.

For this new model to work, though, a radical change in the reimbursement system is required. If payment reform does not occur in a way that supports this new model, then the medical home concept may become just another good idea that never materialized.

A promising start through a local “stimulus package”

One local insurer, Blue Cross Blue Shield of Michigan (BCBSM), has taken an active role in stimulating medical home development. In 2004, BCBSM created the Physician Group Incentive Program (PGIP). Part of this program's mandate is to provide resources for primary care practices to make the necessary infrastructure changes to support the development of the medical home model. Funding is administered through physician organizations, which coordinate resources such as e-prescribing tools, electronic medical record systems, and disease/patient registries to support their successful implementation in physician practices. BCBSM's HMO product—Blue Care Network—has sponsored a physician-recognition program for years that has focused efforts on creating incentives to improve quality, efficiency, and patient satisfaction outcomes through rewards to primary care providers.

The St. John Health System medical home project for diabetes patients

For the past three years, St. John Health Partners, a physician-hospital organization consisting of St. John Health System and affiliated physician organizations across its various hospitals, has implemented a demonstration project involving 80 primary care physicians in 20 local practices. Using PGIP funding and other support, PartnerHealth is obtaining the tools and resources its member physicians need—e-prescribing, patient registries, process improvement—and enabling practitioners to work toward PCMH certification.

PartnerHealth is providing care-management services to participating physicians and their patients through the efforts of two registered nurses. The initial focus is to improve the care of select patients with diabetes, as measured by commonly recognized performance metrics. The program also helps coordinate care outside the primary care office, engaging specialists and the hospital to assist patients in navigating the health care system. In 2009, these care-management services will expand to include patients with other chronic disorders, such as congestive heart failure, coronary artery disease, and asthma.

A reason to be optimistic

The medical home's emphasis on patient-centered care, building healthy relationships, and effectively navigating the health care continuum—for managing both health and chronic disease—provides a strategic advantage for a physician-hospital organization. The leadership of St. John Health System has been committed to the medical home concept from the start. Considering its geographic location, St. John Health System can be a strategic partner for physicians who share this vision for the future of health care. ↗

St. John Chronic Headache and Migraine Institute

Help free your patients of headache pain



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TOO MANY PATIENTS who live with headaches assume that their condition is normal. Headaches are not normal, but fortunately they're treatable. Causes of headaches vary, and so must therapy. Migraine in particular is underdiagnosed. At the St. John Chronic Headache and Migraine Institute, we offer comprehensive, individualized care for each headache patient.

Overview of our capabilities

A team of specialists in the St. John Health System network work with the Institute to provide quality care using a variety of state-of-the-art medical and complementary techniques:

- A pain psychologist, who concentrates on lifestyle modifications and biofeedback instruction to control heart rate, blood pressure, and muscle tension
- A physical therapist, who is trained in craniosacral therapies
- A pharmacist, who advises on

The St. John Chronic Headache and Migraine Institute has been serving southeastern Michigan for four years, and it is the only headache and migraine program of its size between Detroit and Ann Arbor that accepts all major health insurance plans. Our location is 27483 Dequindre Road (just north of 11 Mile Road), Madison Heights, in the Oakland Professional Building. Phone: (248) 967-7988

matching medications to specific diagnoses

- An addiction medicine specialist, who helps patients wean themselves from unhelpful analgesic medications
- An interventional anesthesiologist, who can administer pain pumps
- A psychiatrist, who can assist in caring for patients for whom pain is part of a complex clinical picture

Our process

About 30 new patients visit the Institute each month. The usual wait for the first appointment is seven to ten days. In close collaboration with a patient's personal physician, we create a treatment plan. If needed, we initially hospitalize the patient for detoxification from analgesic medications. Based on the presumptive diagnosis, we prescribe appropriate therapies, which may include medications or nerve block, and follow a protocol to assess the patient's response to therapy. Following assessment, we make adjustments as needed and coordinate follow-up care with the personal physician and patient.

Established patients may visit the center without notice if they experience intense pain. For patients already in our care, we seek to avoid emergency department visits because they may be reintroduced to painkillers from which they have previously been weaned. Should a patient visit one of our affiliated St. John Health System hospitals, our standing operations

protocol agreement with EDs prevents this mistake.

Innovative therapies available

Patients whose migraine headaches have not responded to conservative measures or to pharmacologic therapy may be candidates for botulinum toxin type A (Botox) injections. This treatment for migraine—used for more than 10 years—is not yet approved by the FDA. In this procedure, we use electromyography to identify the optimal injection site from among 11 possible locations on the forehead, side, or back of the head. Posttreatment, about 60% of patients experience relief immediately or within a few weeks. Many of those who obtain relief are able to discard medications and enjoy a long-lasting reprieve from their headaches. Others will have relief for about three months, after which the beneficial effect may wear off and repeat injections may be needed.

Not all insurance companies cover this treatment. But, if we think a patient needs a botulinum toxin injection, we will submit an application with supportive letters.

Think of us when . . .

1. Headaches occur frequently, ie, two or more per month.
2. Headaches are unresponsive to first-line treatment or the patient develops complications with continuing therapy.
3. Headaches are associated with visual or sensory changes (numbness, tingling); these require in-depth assessment.

Our goal is to return patients to your practice headache-free and once again able to enjoy life. 🏡

Caring for patients: Becoming more purposeful

The intention behind pay for performance



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A RECURRING THEME in this issue of *Updates and Innovations: Reports and Best Practices From St. John Health System* is medicine's move away from episodic, piecemeal care to a coordinated system of ongoing care for patients, particularly those with chronic disorders. This change in emphasis necessarily calls for a change in practice behavior—namely, we no longer wait for patients to come to us; instead, we take on the responsibility for the health of the population. We reach out to patients with plans for care and educational tools that foster good health.

How revised reimbursement will influence patient care

The incentive plan of the recent past was built on shared risk—ie, in practicing moderation and efficiency in specific aspects of care, we either split surplus funds or took a loss at the end of the fiscal year. The model of the new incentive focuses on compliance with clinical measures that define best patient care in key disease areas. These measures have been developed and approved by national expert organizations, such as the Joint Commission, the Physician Consortium for Performance Improvement (PCPI), and the National Quality Forum (NQF).

We can choose the measures on which we will report. Because of its public health and cost implications, diabetes is an important initial target.

For every physician's panel of patients assigned under an HMO plan or the Blue Care Network, critical measures of care in the management of diabetes are clearly identified (eg, cholesterol and HbA1c levels, regular retinal and foot exams).

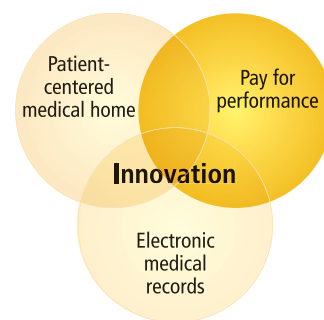
The plan tracks how physicians monitor these measures and whether follow-up care is appropriate. Coronary artery disease, congestive heart failure, and asthma are examples of other clinical conditions with reportable measures. Coding documentation for all measures is communicated to our physicians by Health Partners.

The Blue Care Network, for example, has a rich reward program, funded at \$3.50 per patient per month. The goal for each physician is to achieve a 75% composite rate in his or her panel of patients. In 2008, physicians who did not attain that rate forfeited between \$10,000 and \$20,000.

Happily, in the last two years, the percentage of physicians who meet these targets has increased from one-half to three-quarters. In all, this program means that significant amounts of funds can be retained or surrendered by physicians throughout the St. John Health System network—all based on performance.

Transition to an electronic medium is key to our process


At St. John Health System, staff members are dedicated to assisting physicians with action plans to aid in this process. Specific strategies depend on the practice environment. Although some still use paper records, we require that all offices use e-mail for communication to avoid assessment of a penalty on payment. We regard



electronic communication as essential for effective communication in today's environment.

Many physicians are concerned, of course, about the major investment necessitated in adopting an electronic medical record system—particularly when any given system may not interface with systems used by the hospital or laboratory. However, such an investment may be worthwhile, especially since St. John Health System heavily subsidizes these purchases (see articles by Michael R. Balon, MD, and Kenneth W. Bollin, MD, on pages 6 and 7 of this issue).

Other readily available electronic resources pay for themselves quickly, among them e-prescribing tools and registries. Also, the Michigan State Medical Society sponsors "patient portals" wherein patients can communicate with their physician by e-mail and receive lab results electronically. This arrangement may be a more cost-effective transition from a paper office than going directly to EMR. Again, St. John Health System funds much of the investment for these products.

In short, we are willing to work with our physicians to achieve excellence in patient care in today's changing medical environment. 



Electronic

Two early adopters share their experiences

EMRs pay off financially while enabling better medicine



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Implemented the NextGen electronic medical record system for a large group practice

IN OUR EVOLVING medical environment, acquiring electronic medical record (EMR) technology will be needed to sustain productivity and to improve practice quality. Users will ultimately be pleased, as long as they take the time to understand associated costs and prepare for the necessary adjustments to practice work habits. Understand that productivity will lessen for a few months. But when productivity returns, reimbursement will rise, primarily because of improved coding. Physicians generally bill for less than they deserve. With an EMR, you'll document what you've actually done, and the act of documentation will train you to code appropriately. Nationally, reimbursement has improved by 10% to 12%. Our company's income rose by 15% within a year, which is dramatic. The growth in income has more than

compensated for our investment in EMR technology.

Match performance to expectations

The EMR system gives us the ability to prove we're doing the things we're supposed to do—Pap smears, breast exams, diabetes retinal exams, and blood sugar measurements—and when we're supposed to do them. Managed care plans track our performance and reimburse us accordingly.

Refilling prescriptions has always raised issues of efficiency and safety. Electronic prescribing with EMRs addresses these issues and also enhances remuneration.

Increase patient satisfaction

Many aspects of a patient's encounter with the medical system can affect satisfaction. How long must I stay on the phone to schedule an appointment? How soon can I be seen? How much time must I spend in the waiting room? With the implementation of our EMR system, we are able to better manage scheduling functions, which has dramatically improved patient satisfaction. We also offer Web-based appointment scheduling, which many patients prefer.

We can now share lab results with patients faster because we receive electronic reports from the laboratory. Our EMR system generates reports automatically, which we can embellish before patients receive them. Perhaps one of the more telling indications of perceived satisfaction is the influx of new patients who have been attracted by word of our technology capabilities.

Increase staff satisfaction

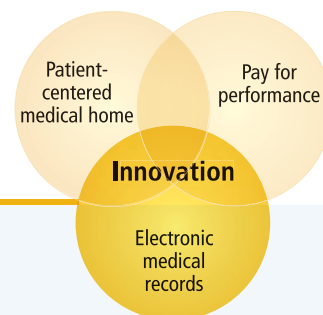
It takes about a year for the system to become fully operational, when, for example, every patient's prescriptions are in the system and ordering a refill requires just a simple keystroke. But physician and staff satisfaction will become apparent before then, as the system's advantages become increasingly realized.

Don't try to do everything at once

Plan a migration pathway that makes sense for your office. In moving from a paper system, we began by billing for office visits electronically and then gradually assigned other tasks to the EMR system. Ramping up in a stepwise fashion will keep the process from feeling too burdensome and will encourage "ownership" by colleagues and staff. 🏠

medical records

As these two reports explain, the benefits of EMR technology are real. Although investing in an EMR system requires substantial capital, reimbursement under newer pay-for-performance plans makes the investment worthwhile.



The benefits of systemwide electronic connectivity



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Implemented the Cerner electronic medical record system for the hospital's residency program

IN MANY PRACTICES that still rely on paper systems, office processes are broken—inadequate communication exists between doctors and staff or doctors and patients, important details are trusted to yellow sticky notes, impossibly bulky folders make it difficult for physicians to track what has and has not been done for patients. With paper records, there is no way to look at an entire practice or a group of patients. An electronic medical record (EMR) system is the solution to improving office communications and correcting other deficiencies.

Same information at everyone's fingertips

St. John Health System has a patient-centric system. For each patient, a single chart is shared across the entire organization. All clinical activity is

recorded in one record. We don't have to shuffle papers trying to figure out what happened to patients at their last visit or hospital stay. We can also gain access to records remotely from home or while traveling. And if a patient switches practices, the new physician has immediate access to all data.

More than one way to capture patient information

One complaint sometimes heard about EMRs is the time needed to prepare notes following patient visits using embedded templates. But EMRs are flexible and can accept data in several ways. Instead of using the embedded templates, you can continue to dictate or write notes on paper and have them scanned into the system. A definite advantage in using embedded templates, however, is that it can save tens of thousands of dollars in transcription fees annually.

Closing the cracks that things can fall through

Other e-tools allow us to prescribe medications or write orders for lab work or radiology studies. These can be submitted electronically and given to patients on hard copy. We can track


testing to find out if it has been done.

The health maintenance module, or disease registry, tells us what preventive services are needed for patients of a given age and sex, and displays these details prominently. Similar clinical recommendations are made for disease categories such as diabetes or coronary artery disease.

Keeping patients in the loop

Our EMR system also dovetails with an Internet patient portal, IQ Health. Patients sign up for a personal Web-based electronic record. When they log on, data from my EMR (eg, medications, immunizations, problem lists) load into their personal online record. I can also upload new reports and alert patients to their presence by e-mail. Patients can request appointments or medication refills through this portal without having to phone us.

Help in getting started

The time needed to make the transition from paper to EMR is indeed a big commitment. But the efficiencies gained in making the transition will make it all worthwhile. Moreover, you need not do it alone. 



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A PASSION *for* HEALING

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