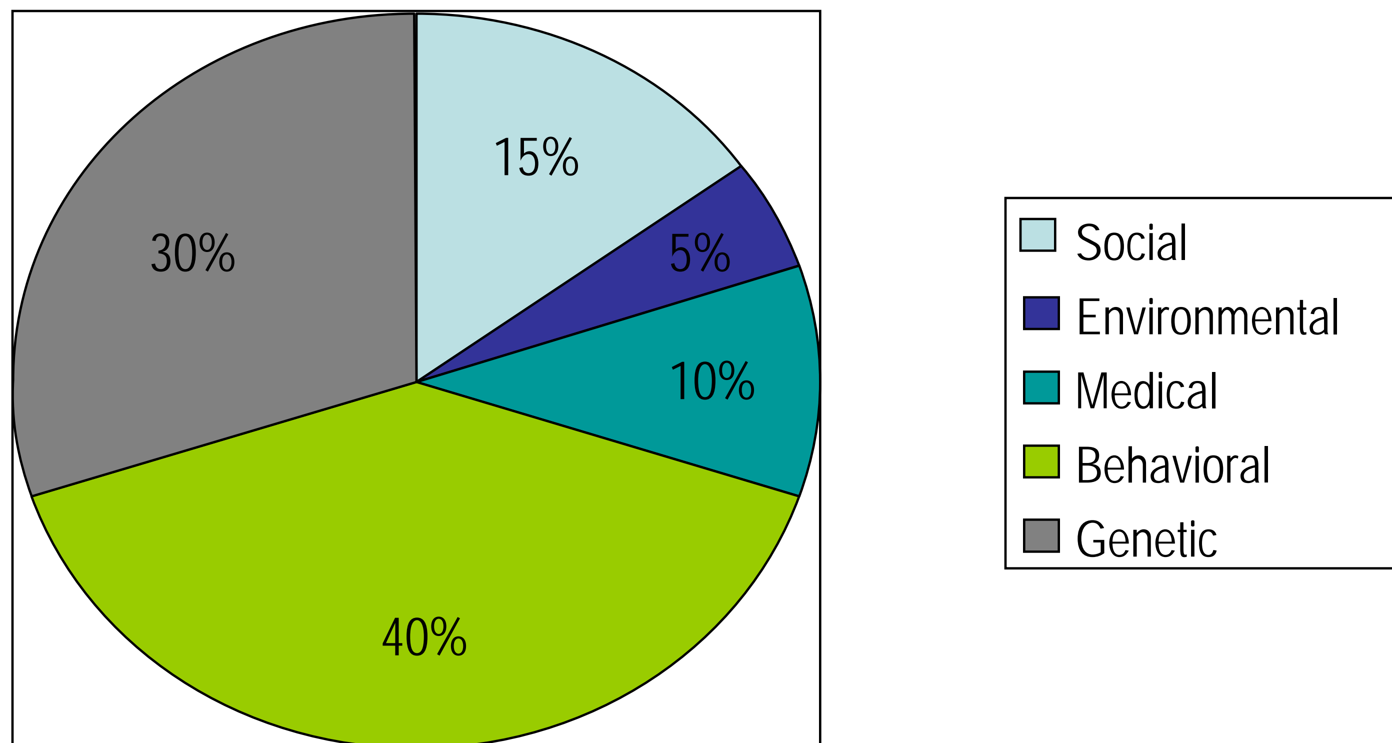
Stanford Coordinated Care

Extreme Team Care

April 20, 2015

Determinants of Health and Their Contribution to Premature Death

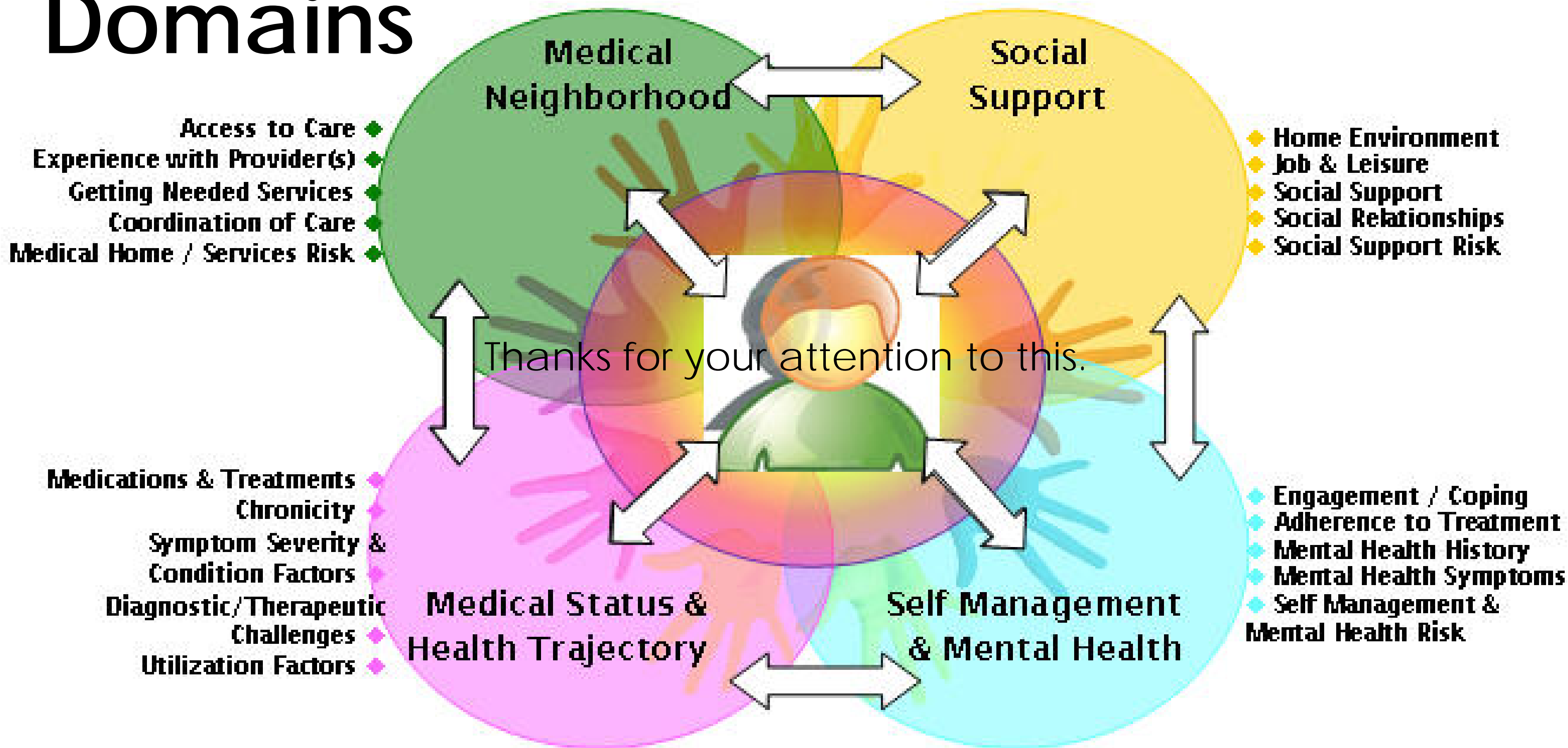


Schroeder, NEJM 357; 12

Human-Centered Design

FROM	TO
Feeling alone	Becoming an empowered patient
Forced to be at the center	Supported and confident
Feeling studied	Feeling listened to
Facts	Hands-on action
Passed between providers	Creating personal relationships
Stalling	Thriving
Resource intensive	Streamlined

Patient Variation – what the patient faces



The Team = Patient, Providers, RN Care Manager, patient's support network

What the Patient Brings: Activation Level

Level 1	Level 2	Level 3	Level 4
Starting to take a role Individuals do not feel confident enough to play an active role in their own health. They are predisposed to be passive recipients of care.	**Building knowledge and confidence** Individuals lack confi-dence and an under-standing of their health or recommended health regimen.	**Taking action** Individuals have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.	**Maintaining behaviors** Individuals have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

Increasing Level of Activation →

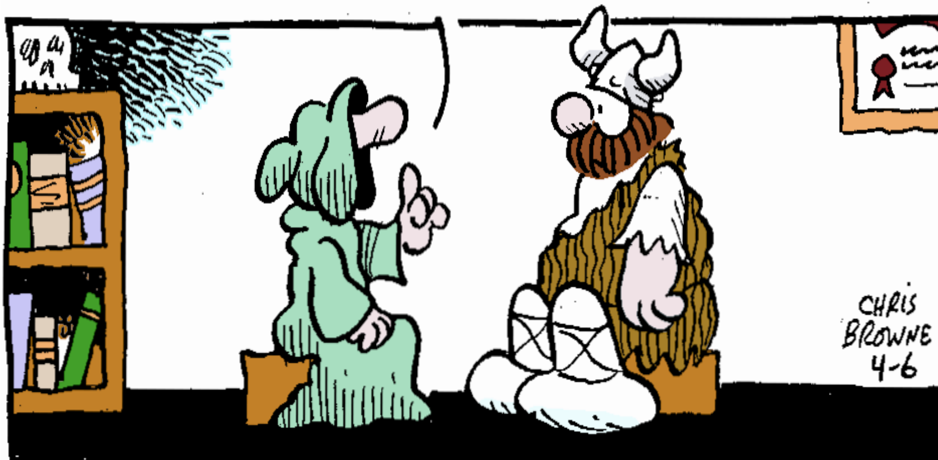
10-15% of the population*	20-25% of the population*	35-40% of the population*	25-30% of the population*

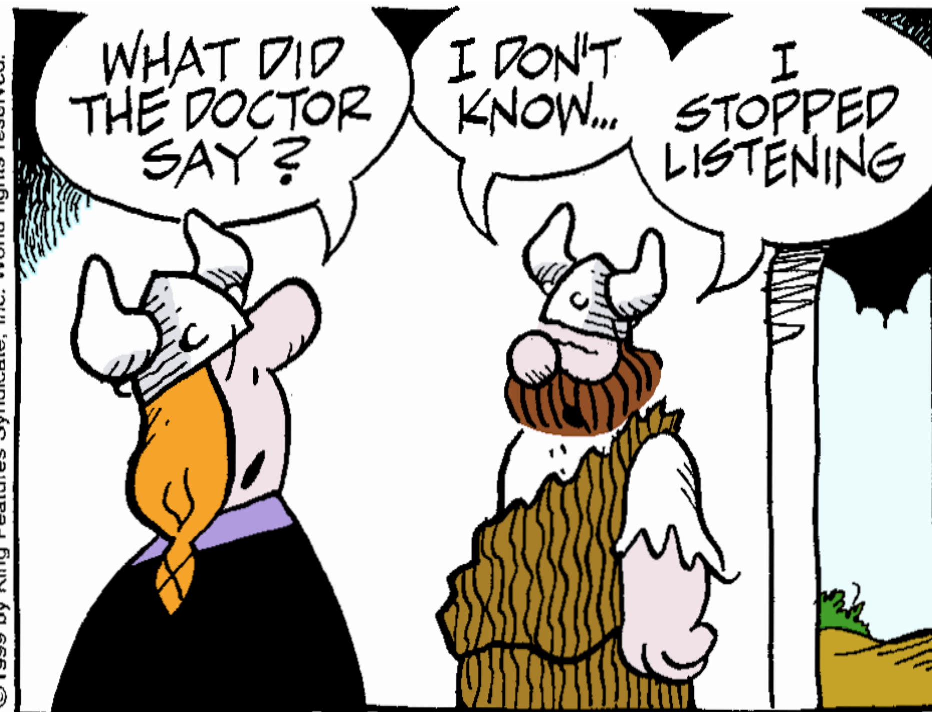
* Medicaid and Medicare populations skew lower in activation

STANFORD COORDINATED CARE
Care with the Patient at the Center

Care Model

"Why wouldn't a person with a chronic condition do everything in their power to live long and feel well?"





SCC Approach: "The Activation Model"

- From:

  "What bothers you the most?

- To:

  "Where do you want to be in a year?"

Depression

- "Depression significantly increases the overall burden of illness in patients with chronic medical conditions…***depression is associated with a 50-100% increase in health services use and cost.***"

Simon, Gregory E. "Treating Depression in Patients With Chronic Disease". Western Journal of Medicine 2001:175:292-293

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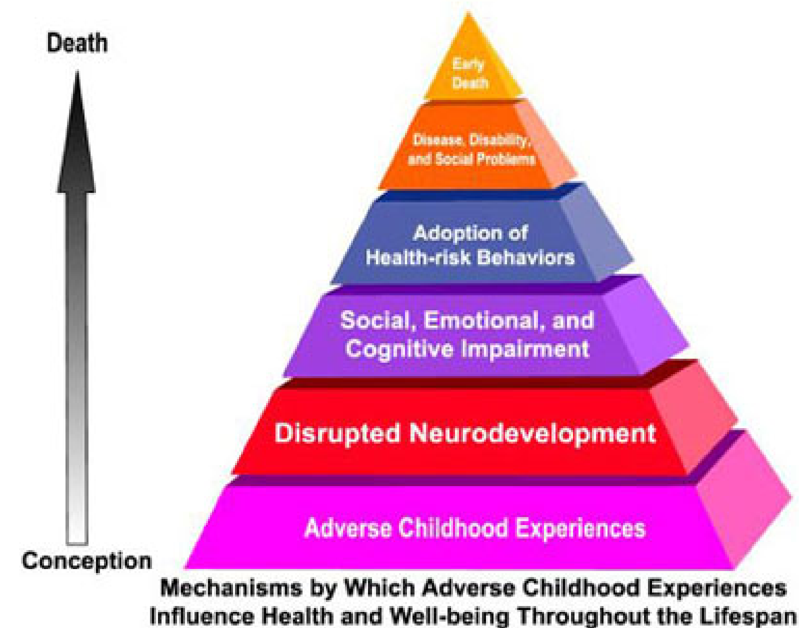
The Often *Hidden* Driver: Adverse Childhood Events

ACE Score = 1 point each for positive responses to 10 questions inquiring about exposure to:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Physical neglect
- Emotional neglect
- Divorce/separation
- Domestic violence in the home
- Parent that used drugs or alcohol
- Parent that was incarcerated
- Parent that was mentally ill



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

From: www.acestudy.org

How does ACE play out later in life?

- Increased smoking:
  - The higher the ACE score, the greater the likelihood of current smoking
- COPD:
  - A person with an ACE score of 4 is 2.6 x more likely to have COPD than a person with an ACE score of 0
- Depression:
  - A person with an ACE score of 4 was 4.6 x more likely to be suffering from depression than a person with an ACE score of 0
- Suicide:
  - There was a 12.2 x increase in attempted suicide between ACE 4 vs. 0; at higher ACE scores, the prevalence of attempted suicide increases 30-51 fold!
  - Between 66-80% of all attempted suicides could be attributed to ACE.

SCC PAM 6 Month Results

Change in PAM level between 1st and 2nd measurements at 6 months

- 58% of patients improved at least 3 points (0-100 scale) – minimal significant change (associated with change in cost and health)

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From "Cup Runneth Over"…

Provider

Medical Assistant/Care Coordinator

Nurse

Behavioral Health

Clinical Pharmacist

Physical Therapist

To “Share the Care”

Provider

Medical Assistant/Care Coordinator

Nurse

LCSW/Behavioral Health

Physical Therapist

Clinical Pharmacist

From MA to Care Coordinator

- "Artisanal" vs. assembly line
  - Coach, advocate, MA, scribe, outreach worker, pop health manager combined in single person: ***relationships are key***
- Empanelment
- Training: onboarding and ongoing
- Case presentations at team meetings
- Staying with the patient – *few handoffs*
  - Scribing the visit: ***learning as the patient learns***

CREATE NEW JOB CATEGORY AND PAYSCALE to reflect greater skills and responsibility

EPIC Charting

Superman,Clark

Superman,Clark | MRN: 17353806 | Sex: Male | DOB: 12/01/1967 | Age: 46 yrs | Allergies: Sulfa (Sulfonamide Antibiotics) | PCP: Lindsay, Ann D | Ins: None | Alert: Health Maintenance | MyHealth: Code Exp | Infection: None | FYI | Pref Language: None

SnapShot
Chart Review
Results Review
Synopsis
Review Flowshe...
Problem List
History
Letters
Demographics
Education
FYI
Send Patient Me...
Patient Messag...

Problem List

Patient Care Coordination Note A summarized plan of care for the patient and all providers

Clark Superman is 46 Y with a PAM level of 4

Patient Goals	1) Become weightless
	2) Avoid krypton
	3) Get married to Lois when I am healthy
Action Plans	1) Fly three times a week for stress reduction
	2) Try a lighter weight cape to help with shoulder pain

Follow up 1) Stool test for colon cancer screen
2) See Deborah for shoulder pain

Delete | Past Versions | Accept | Cancel

Add a new problem | Add | Show: Past Problems | Options

Diagnosis		Sort Priority	Updated
Diabetes mellitus type II, uncontrolled	Edit Overview	Unprioritized	05/14/2014 Lindsay, Ann
Overview: Diagnosed 2004. Retinal exam 6.2013 On metformin 875 BID but hasn't been taking med regularly. 5/2/2014 A1C 8.4. LDL135 Urine A/C ratio due		Last Eye exam -	Last foot exam -
Hypertension	Edit Overview	Unprioritized	05/14/2014 Lindsay, Ann
Overview: On meds since 2006 Stable on lisinopril and metop			
Morbid obesity	Edit Overview	Unprioritized	05/14/2014 Lindsay, Ann
Overview: 5/2/2014 BMI 35.2. Referred to Healthy cooking class and dietitian. Will not eat after 8 pm.			
Hyperlipidemia	Create Overview	Unprioritized	06/16/2014 Valcourt, Sa...

Mark as Reviewed | Last Reviewed by Lindsay, Ann D, MD on 5/14/2014 at 12:24 PM

STANFORD COORDINATED CARE
Care with the Patient at the Center

HEDIS: Care Gaps Tool

Care Coordinator : COLEMAN, DELILA

	Patient Name	PCP	Next Appt. Date	Diabetes (Screening) HbA1c	Diabetes (Screening) LDL	Diabetes (Screening) Nephropathy	Cardio (Screening) LDL	Preventative (Screening/Immunization) Flu	Pneumococcal	Chlamydia	Cervical Cancer	Breast Cancer	Colorectal Cancer	Med. Mgmt. ACE/ARB/Diuretic/Digoxin	SCC PAM	# Overdue
1		VOLLRATH, K	01/09/2015	N/A	N/A	N/A	N/A	Overdue	N/A	N/A	04/17/2015	02/28/2015	03/07/2021	N/A	Overdue	2
2		VOLLRATH, K		N/A	N/A	N/A	N/A	09/01/2014	N/A	N/A	N/A	12/08/2016	09/30/2019	09/26/2015	03/26/2015	0
3		VOLLRATH, K	01/05/2015	N/A	N/A	N/A	N/A	09/01/2014	N/A	N/A	N/A	N/A	N/A	N/A	01/07/2015	0
4		GLASEROFF, A	03/11/2015	N/A	N/A	N/A	N/A	09/01/2014	N/A	N/A	N/A	N/A	08/20/2015	N/A	05/24/2015	0
5		GLASEROFF, A		N/A	N/A	N/A	N/A	Overdue	N/A	N/A	Overdue	N/A	N/A	N/A	Overdue	3
6		VOLLRATH, K	01/20/2015	N/A	N/A	N/A	N/A	09/01/2014	N/A	N/A	N/A	N/A	N/A	N/A	06/11/2015	0
7		GLASEROFF, A	01/15/2015	N/A	N/A	N/A	N/A	Overdue	Adherent	N/A	N/A	N/A	10/14/2015	N/A	02/20/2015	1
8		LINDSAY, A		N/A	N/A	N/A	N/A	Overdue	N/A	N/A	N/A	08/09/2016	03/20/2015	Overdue	02/21/2015	2
9		LINDSAY, A	01/08/2015	11/14/2015	11/15/2015	01/04/2016	N/A	09/01/2014	N/A	N/A	N/A	N/A	N/A	11/15/2015	02/27/2015	0
10		LINDSAY, A		N/A	N/A	N/A	N/A	Overdue	N/A	N/A	03/19/2016	N/A	N/A	N/A	05/19/2015	1
11		GLASEROFF, A		N/A	N/A	N/A	N/A	09/01/2014	N/A	N/A	N/A	N/A	N/A	N/A	05/26/2015	0
12		GLASEROFF, A		N/A	N/A	N/A	N/A	09/01/2014	N/A	N/A	N/A	N/A	N/A	N/A	05/25/2015	0
13		VOLLRATH, K	01/07/2015	N/A	N/A	N/A	N/A	Overdue	N/A	N/A	N/A	N/A	N/A	N/A	Overdue	2
14		GLASEROFF, A		N/A	N/A	N/A	N/A	09/01/2014	N/A	N/A	N/A	N/A	Overdue	06/03/2015	05/25/2015	1
15		GLASEROFF, A	01/07/2015	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	04/01/2015	0

HEDIS: SCC results

http://analytics.stanfordmed.org/QvAJAXZfc/opendoc.htm?document=
PH Stanford Primary Care.qvw

Clear | Select Bookmark | Select Report | More | Close

Welcome | Performance View | Population View | Patient View | Panel Mgmt | Panel Stats

STANFORD HOSPITAL & CLINICS
Stanford University Medical Center

Primary Care

Filters

Year Thru Date	Today
Service Area	SH&C
Location	HOOVER
Department	STANFORD COO
Provider	

Reset Filters | Select My Department

Current Selections

RuleTypeNM	Today
PCPDepartmentNM	STANFORD COO
PCPLocationNM	HOOVER
PCPServiceAreaNM	SH&C

Overall Composite	Diabetes Composite	Cardio Composite	Preventative Composite	Meds Mgmt Composite
84%	84%	67%	84%	97%
Patients: 292	Patients: 63	Patients: 15	Patients: 291	Patients: 97

Legend

0-24th pctl | 25-49th pctl | 50-74th pctl | 75-89th | 90-100th

Percentile Ranking (estimated) | Goal

Distance from Goal | Internal Comparisons

Measure	Percentage to Goal	Current Rate	Goal	Patients	Patients to Goal	Percentile Ranking (Estimated)
Composite						
• Overall	33.8%	84.3%	50.5%	292	n/a	
• Diabetes	9.1%	83.9%	74.8%	63	n/a	
• Cardio	13.0%	66.7%	53.7%	15	n/a	
• Preventative	42.6%	83.5%	40.9%	291	n/a	
• Meds Mgmt	3.2%	96.9%	93.7%	97	n/a	
Diabetes						
• HbA1c Screening	5.4%	98.4%	93.0%	63	0	
• HbA1c Control	9.5%	90.5%	81.0%	63	0	
• LDL Screening	-0.1%	88.9%	89.0%	63	1	
• LDL Control	-1.6%	54.0%	55.6%	63	2	
• Nephropathy Monitoring	7.2%	95.2%	88.0%	63	0	
• BP Control	-5.4%	76.2%	81.6%	63	4	
Cardio						
• LDL Screening	-5.3%	86.7%	92.0%	15	1	
• LDL Control	9.5%	46.7%	37.2%	15	0	
Preventative						
• Flu Immunization	11.9%	72.9%	61.0%	291	0	
• Pneumococcal Immunization	11.9%	96.6%	84.7%	59	0	
• Chlamydia Screening	-8.0%	50.0%	58.0%	4	1	
• Cervical Cancer Screening (EB)	9.9%	91.9%	82.0%	124	0	
• Breast Cancer Screening	9.7%	89.7%	80.0%	107	0	
• Colorectal Cancer Screening	17.7%	87.7%	70.0%	187	0	
Medications Management						
• ACE/ARB/Diuretic/Digoxin	2.9%	96.9%	94.0%	97	0	

Pvnt - Colorectal Cancer Screening

100%
80%
60%
40%
20%
0%
90th Pctl
7/2013, 8/2013, 9/2013, 10/2013, 11/2013, 12/2013, 1/2014, 2/2014, 3/2014, 4/2014, 5/2014, 6/2014, 7/2014, 8/2014, 9/2014, 10/2014, 11/2014, 12/2014, Today
Patients

Measure

- Cmp - Overall
- Cmp - Diabetes
- Cmp - Cardio
- Cmp - Preventative
- Cmp - Meds Mgmt
- DM - HbA1c Screening
- DM - HbA1c Control
- DM - LDL Screening
- DM - LDL Control
- DM - Nephro Screening
- DM - BP Control
- Cardio - LDL Screening
- Cardio - LDL Control
- Pvnt - Flu Immunization
- Pvnt - Pneumococcal Imm
- Pvnt - Chlamydia Screenin
- Pvnt - Cervical Cancer Scr
- Pvnt - Breast Cancer Scre
- Pvnt - Colorectal Cancer S
- Meds - ACE/ARB/Diuretic/

STANFORD COORDINATED CARE
Care with the Patient at the Center

Monthly "Speed Dating"

PCP Name	Care Co-ordinator	Measure	Measure Value	Measure Dat
GLASEROFF, ALAN MARTIN	CURIEL, MONICA	PAM Score	1	5/30/13
		PHQ9 Score	24	5/30/13
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	LDL	169.00	5/27/14
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	LDL	158.00	10/2/13
		PHQ9 Score	19	3/17/14
LINDSAY, ANN D	POSO, NASTASIA	BMI	40.60	9/17/14
VOLLRATH, KATHAN HICKEY	CURIEL, MONICA	LDL	130.00	6/10/14
VOLLRATH, KATHAN HICKEY	COLEMAN, DELILA	BMI	41.18	12/17/14
LINDSAY, ANN D	CURIEL, MONICA	A/C Ratio	238.00	4/26/13
VOLLRATH, KATHAN HICKEY	CURIEL, MONICA	LDL	133.00	6/30/14
		PHQ9 Score	15	9/24/14
GLASEROFF, ALAN MARTIN	CURIEL, MONICA	BP (Systolic)	166	1/2/14
		Pain Score	8	8/1/14
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	A1c	14.00	11/10/14
		A/C Ratio	70.00	1/22/14
		LDL	131.00	11/12/14
LINDSAY, ANN D	POSO, NASTASIA	LDL	137.00	10/6/14
VOLLRATH, KATHAN HICKEY	CURIEL, MONICA	BMI	36.01	11/21/14
VOLLRATH, KATHAN HICKEY	CURIEL, MONICA	PAM Score	1	9/26/14
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	LDL	182.00	2/3/14
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	Pain Score	8	12/16/14
		Smoker	YES	12/16/14
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	BMI	40.73	12/1/14
		LDL	138.00	9/12/13
		Smoker	YES	4/2/14
LINDSAY, ANN D	POSO, NASTASIA	BMI	46.43	12/2/14
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	Pain Score	8	12/19/14
LINDSAY, ANN D	COLEMAN, DELILA	BMI	41.33	4/10/14
		LDL	157.00	12/11/13
LINDSAY, ANN D	CURIEL, MONICA	LDL	138.00	9/10/14
VOLLRATH, KATHAN HICKEY	CURIEL, MONICA	BMI	44.40	11/25/14
		PAM Score	1	11/25/14
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	LDL	191.00	6/21/12
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	PAM Score	1	11/25/14
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	LDL	154.00	6/3/14
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	A1c	9.90	10/1/14
NO PCP	Unassigned	LDL	278.00	4/23/14
LINDSAY, ANN D	COLEMAN, DELILA	BP (Systolic)	154	11/14/14
		PHQ9 Score	15	10/30/14
LINDSAY, ANN D	CURIEL, MONICA	BMI	35.12	11/19/14
GLASEROFF, ALAN MARTIN	CURIEL, MONICA	LDL	143.00	9/23/14
LINDSAY, ANN D	POSO, NASTASIA	BMI	40.41	9/17/14
		LDL	143.00	6/11/14
LINDSAY, ANN D	POSO, NASTASIA	BP (Systolic)	164	11/12/14
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	BMI	41.08	9/18/14
GLASEROFF, ALAN MARTIN	CURIEL, MONICA	LDL	164.00	12/2/14

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Each care coordinator conferences with relevant clinician on CC panel they share

- Each CC works with each clinician – allows for cross-coverage
- Focus on "red" areas – immediate risk for poor outcome
- CC panel ~100
- No one "falls through the cracks"
- Care gaps also addressed

STANFORD COORDINATED CARE
Care with the Patient at the Center

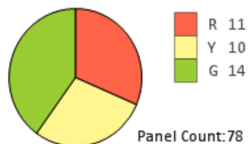
Analytics Risk Dashboard

Risk Measures | Health Portrait | FAQ

<< Clear All >>

Population Health Dashboard

Panel Health Indicator



Time

2000	2002
2001	2006
2008	2007
2009	2011
2010	2012
-1	2013

Q1	Q2	Q3	Q4
1-Jan		7-Jul	
2-Feb		8-Aug	
3-Mar		9-Sep	
4-Apr		10-Oct	
5-May		11-Nov	
6-Jun		12-Dec	

Chronic Condition

Asthma
CAD
CHF
COPD
Diabetes
HyperTension

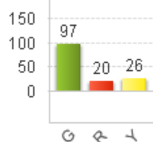
Pat Name | MRN | Ethnicity | Language

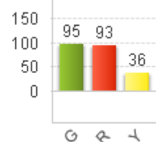
AEMJT,DJGBVLVZA H
AEMLQQR,KAQUVD B
BFZUNBVN,QKNIA
BIDOKY,ZHKIJB XSZGG
BLZGLBDRLZRX,MJDCKJL
BPDRLUSJ,GKFUQL
CTOMBP,BZFSYIOL E
CYQGVMW,JZYXFXHRP
CYRDQ,R LHJFIUS
DMUGMUSAB,HAFAO

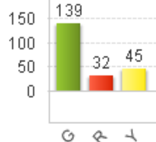
Clinician

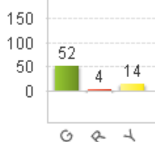
AGPZ, X KKEAPFYT	1
BZCI, KBBVMNZ G	1
IURNDBJ QQLGPYQFC, FFDW	1
IWXMQLT, PWOYCPBPK I	1
JYFTXVFMEHKCI, BUD I.	1
LONG, GKRMAMSV	1

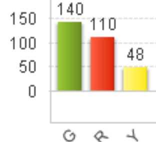
Current Selections

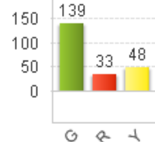












View Patient Record

Panel Summary | Visit Detail | Progress | Clinic Performance By Measure

Patient Name	PCP	MRN	Care Coordinator	RED	YELLOW	GREEN	Domain Score	PAM Score	PHQ9 Score	SF12 Score	Pain Score	Smoker	On AntiPlatelet?	A/C Ratio	A1C	LDL	BP (Systolic)	BMI	Ejection Fraction	Alcohol (Gl/Wk)	ICU Asthma Admit	RAPID HAQ	NY HAC	mMRC	FEV 1	Exacerbation	Glucocorticoids	Beta 2 Agonist	Fracture	FRAX Tool	Pharmacotheraphy
MQRRSVIODE,APTQHFZ L	FZWVYIQ, HHJ U.	33296654		2	3	9	8	2			0	QUIT	N		6.5	140	119	27.8													
XYJABAC,ZXQC	INOPXMLOK, HBZE...	34830525		5	1	7		2	7			NEVER	N			163	151	24.2													
NERTRVGFQH,LWCQ	FZWVYIQ, HHJ U.	4389232		3	0	9	11	4			4	NEVER	N		13.00		150	20.1													
PYQV,SODRUQP	INOPXMLOK, HBZE...	3279585		5	1	6	17	3	17		0	YES	N				117	47.3													
SHZVFEN,OBQYBDU	INOPXMLOK, HBZE...	6885185		4	2	5		4	3		5	NEVER	N				156	63.6													
ORJLWLOEMK,JMHJYIM E	FZWVYIQ, HHJ U.	18629249		3	3	6	7	2			6	NEVER	N				157	34.5													
NHXMQRIT,XBDLGCEC C	INOPXMLOK, HBZE...	33768172		3	3	4		2			7	NEVER	N				140	39.5													
QDNHMFPGLJ,ODWUU	INOPXMLOK, HBZE...	5900922		3	2	7	17	1	11		0	QUIT	N				126	28.7													
IQMFKQBY,ERML	FZWVYIQ, HHJ U.	21606283		3	2	6	19	2			0	YES	N				104	28.0													
ZFIRPMF,PKDAJ	FZWVYIQ, HHJ U.	13476823		3	1	7	17	1	13		3	NEVER	N				161	27.3													
YVICAHDN,ZXFSLJ	FZWVYIQ, HHJ U.	32174226		3	1	7	10	4			0	QUIT	N				106	36.8													
XPTUHA,GXOJ	PZZYEDQEVI, LXSL...	28999027		3	1	3		1	18				N																		
UTLUPXIJ,ZRPHNXZ	GGQFNSU, GCO	4309316		3	1	3							N				170	41.1													
PCOLQC,YQIZAFZ M	TPC, KDYAOFJ	5791610		3	1	6					0		N				120	37.9													
OAHOGJ,KGVLD	FZWVYIQ, HHJ U.	12372245		3	1	7	13	3	4		0	NEVER	N				169	40.1													
LOTOH,LNDZI	FZWVYIQ, HHJ U.	5942203		3	0	8		4			3	NEVER	N				106	41.3													

STANFORD COORDINATED CARE
Care with the Patient at the Center

Patient Health Portrait

Risk Measures | Health Portrait | FAQ

HEALTH PORTRAIT - MQRRSVIODE,APTQHFZ L

Search | << | >>

Current Selections | Clear All

FullNM MQRRSVIODE,APTQHFZ L

Patient:	MRN:	Provider:
MQRRSVIODE,APTQHFZ L	33296654	FZWVYIQ, HHJ U.

BirthDT	Address Line 1	Adress Line 2	Gender	Language	Ethnic Group	Religion	Benefit Plan	Coverage Type	Payor
3/19/1967	-	-	M	English	Non-Hispanic/Non-...	No Religi...	BLUE SHIELD...	Indemnity	BLUE SHIELD

Time

2000	2002
2001	2006
2008	2007
2009	2011
2010	2012
1	2013

Q1	Q2	Q3	Q4

1-Jan	7-Jul
2-Feb	8-Aug
3-Mar	9-Sep
4-Apr	10-Oct
5-May	11-Nov
6-Jun	12-Dec

Print Page | Print FAQ

Chronic Conditions

A1C	-
A/C Ratio	-
BMI	27.83
BP (Systolic)	119
LDL	-
On AntiPlatelet	N
Smoker ?	QUIT

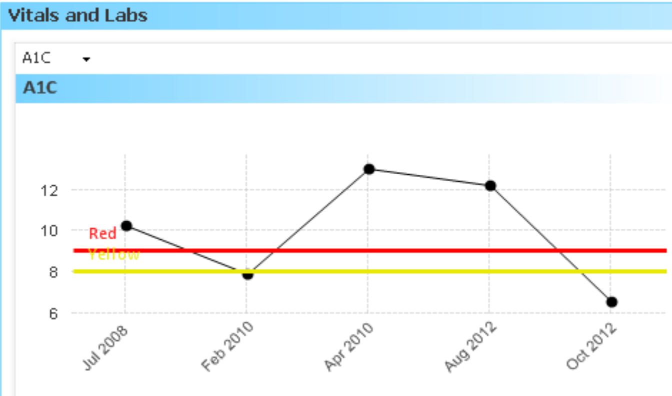
Scores

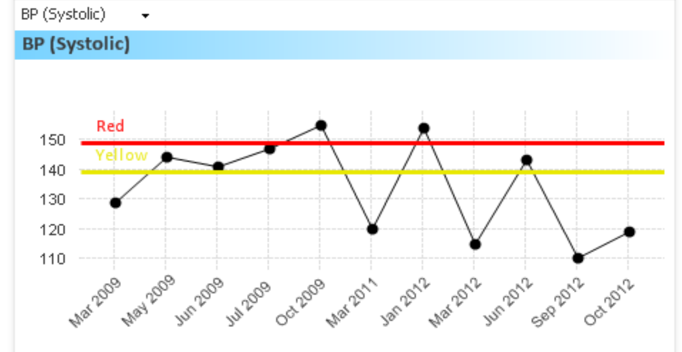
Domain Score	8
PAM Score	2
PHQ9 Score	-
SF12 Score	-
Pain Score	-

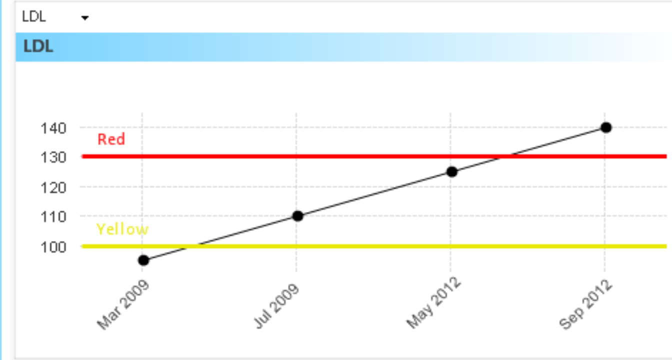
Care Gaps

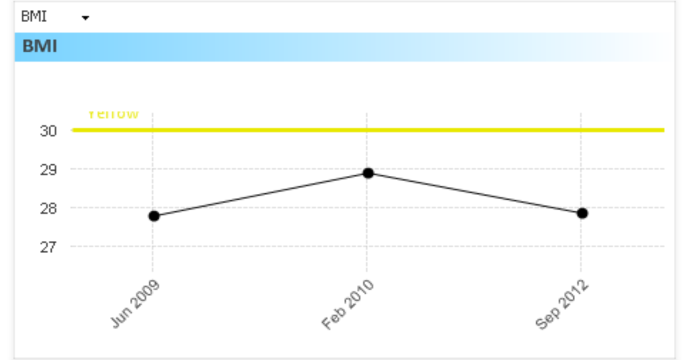
A/C Ratio Interval	-
A1c Interval	-
Last SCC Encounter	12
HS CRP Interval	-
LDL Interval	-
Eye Exam	-
Foot Exam	-

Vitals and Labs









STANFORD COORDINATED CARE
Care with the Patient at the Center

Medication Refill Protocol

	A	B	C	D	E	F
1	Medication Refill Protocol					
2	Medication (generic name)	Medication (Brand name)	Condition	Refill	Appt	Labs
3	acarbose	Precose	Diabetes	6 months	< 6 months	A1c < 6 mo; Lipid panel & CMP < 12 mo; Urine Microalb < 12 mo.
4	acyclovir ointment or oral	Zovirax		12 months	< 12 months	
5	albuterol	Proventil	Asthma	12 months	< 12 months	
6	albuterol	Ventolin	Asthma	12 months	< 12 months	
7	alendronate	Fosamax	Bone Density	12 months	< 12 months	
8	allopurinol	Aloprim	Gout	12 months	< 12 months	BMP, Uric Acid
9	alprazolam	Xanax	Anxiety			forward to provider
10	amioderone	Cordarone	Atrial Fibrillation	6 months	< 9 months	AST, AST, TSH <12 mo
11	amlodipine	Norvasc	Hypertension	12 months	< 12 months	BMP <12 mo
12	amlodipine and benazepril	Lotrel	Hypertension	12 months	< 12 months	BMP <12 mo
13	atenolol	Tenormin	Hypertension	14 months	< 12 months	BMP <12 mo
14	atorvastatin	Lipitor	Cholesterol	12 months	< 12 months	Fasting Lipid Profile, AST, ALT <12 mo
15	benazepril	Lotensin	Hypertension	12 months	< 12 months	BMP <12 mo
16	benazepril with hydrochlorothiazide	Lotensin HCT	Hypertension	12 months	< 12 months	BMP <12 mo
17	budesonide	Pulmicort	Respiratory Agent	12 months	< 12 months	
18	budesonide	Rhinocort Aqua	Allergies	12 months	< 12 months	
19	bupropion	Wellbutrin SR	Depression	12 months	< 12 months	
20	bupropion	Zyban	Depression	6 months	< 6 months	
21	candesartan	Atacand	Hypertension	12 months	< 12 months	BMP <12 mo
22	candesartan and hydrochlorothiazide	Atacand HCT	Hypertension	13 months	< 12 months	BMP <12 mo
23	captopril	Capoten	Hypertension	12 months	< 12 months	BMP <12 mo
24	carvedilol	Coreg; Coreg CR	Hypertension	12 months	< 12 months	BMP <12 mo
25	chlorpromazine	Clonazapam	Anxiety			forward to provider

Triple Aim Results

Inpatient Admissions	ER Visits	Patient Experience	HEDIS
271 patients with at least 6 months enrollment			
-25%	**-39%**	**99th percentile**	**>90th percentile** (10/15 measures)

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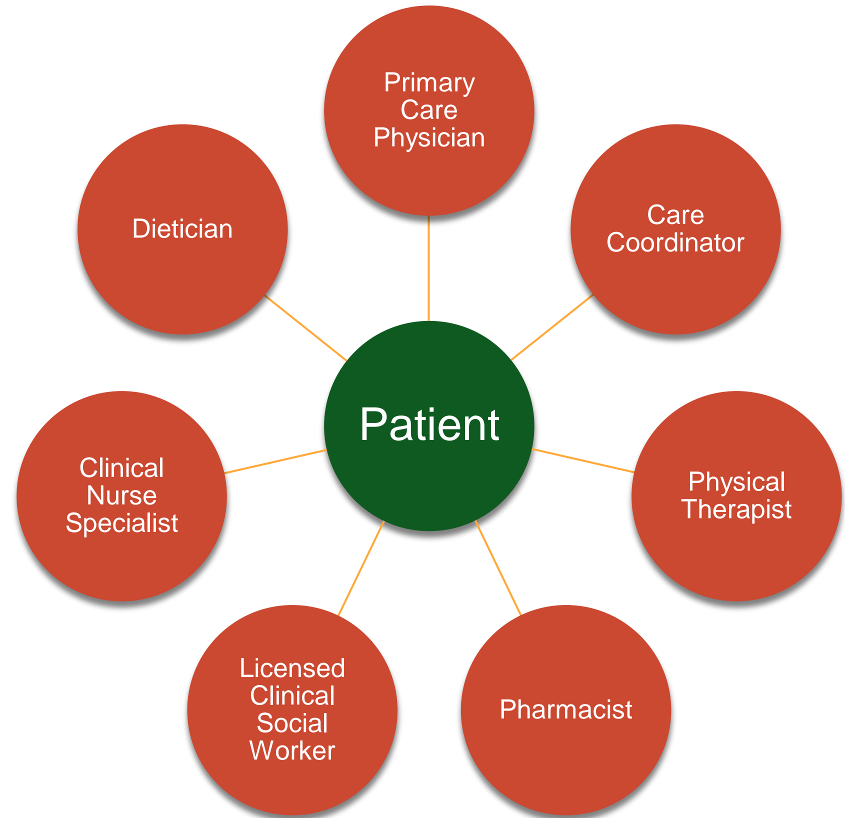
STANFORD COORDINATED CARE
Care with the Patient at the Center

Primary Care Plus

Services:

- No co-pays for patients to see any of our providers
- 24/7 access to Primary Care Physician
- Coordination with your other physicians and specialists so everyone is on the same page
- Care transition planning at hospitalization with home visit if needed
- Contact with SCC staff once a week on average



Program Value:

- All of these services cost Stanford health plans $3432/year, less than 10% the average annual total cost of care for SCC patients

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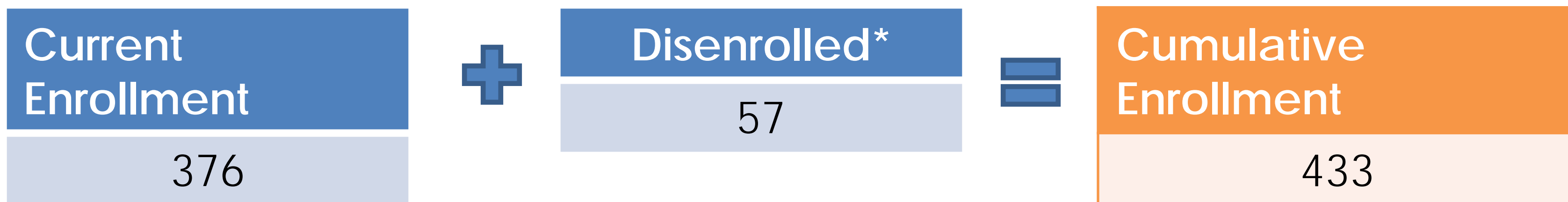
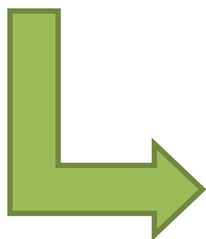
SCC is growing! 3/24/15





Program	Enrolled
Primary Care Plus	336
Care Support	40

Other Programs

Program	Enrolled
BCBH Online	16
BCBH In-Person	9
Seminar Series	60
D-School	12

Better Choices Project

Mode	Enrolled
Online	32
In-Person	20
Mail Kit	38

* = Disenrolled from SCC, but were enrolled in the program for longer than 6 months

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Stanford University Medical Center

STANFORD COORDINATED CARE
Care with the Patient at the Center

SCC Case Study

<table>
<tr>
<td rowspan="2">A quote from a patient:

"Stanford Coordinated Care focused on the little things that were leading to my needing to be hospitalized."</td>
<td><u>Before</u> enrolling in SCC
01/24/2012 – 06/24/2012

4 Urgent inpatient admission
(syncope, sepsis, peritonitis, osteomyelitis)
1 PCP and 5 Specialists

$627,076 billed charges
$104,513/month</td>
<td><u>After</u> enrolling in SCC
06/25/2012 – 12/25/12

No (0) inpatient stays or surgeries
1 PCP and 2 Specialists

$7837 billed charges
$1306/month</td>
</tr>
<tr>
<td colspan="2">Care Management Interventions</td>
</tr>
<tr>
<td>Conditions:
Corns and Callosities
Osteomyelitis
Systemic Lupus Erythematosis
Lupus anti-coagulant disorder
Vitritis of right eye
Chronic Kidney Disease (stage IV - severe) on hemodialysis
Immunosuppressed status
Hx Peritonitis
Pericarditis in SLE
Gout
Anemia</td>
<td>PCP pared foot callouses (source of osteomyelitis)
Conference call with providers to adjust immune suppression drugs to reduce sepsis risk
Family conference with PCP about importance of not cancelling specialist visits or risk falling off transplant list
Development of an Action Plan with patient
Regular patient contact from the Care Coordinator</td>
<td>A quote from the PCP:

"By getting the specialists together on a conference call we were able to reduce the patient's risk of sepsis."</td>
</tr>
</table>