Lean Care Management and Automation

How Lean process improvement and health IT can reduce waste, lower costs, and improve quality

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Primary care practices must be reengineered to achieve the Triple Aim of improving the experience of care, improving population health, and reducing the cost of care. As new value-based payment and delivery models continue to expand, care practices have strong incentives to take on the necessary reengineering. In addition, shortages of generalist physicians in many areas of the country, coupled with increasing patient demand, offer additional pressure to redesign the current fee-for-service primary care model.

One promising alternative to the traditional model involves the use of care teams that include a variety of clinical and nonclinical staff members. By sharing responsibility for care among team members, high-performing practices have been able to increase their capacity and productivity. There’s also a growing body of evidence that this model can improve quality and care coordination.

Launching the team care model can be culturally and financially challenging as healthcare organizations traverse the path from volume-based payment (e.g., fee-for-service) to value-based payment (e.g., population-based quality performance and cost savings). Effective care coordination can require additional staff and technology that few small practices can afford.

Strategic leaders recognize that investing in team-based care today is imperative for success tomorrow as value-based payment becomes more dominant.

Practices managing population health typically need additional RNs to serve as care managers for patients with complex chronic diseases. In addition, family medicine societies and the National Committee for Quality Assurance (NCQA) recently recommended that behavioral health specialists be integrated into the patient-centered medical home (PCMH), an increasingly prevalent model that emphasizes team-based care. And it’s not unusual for high-performing practices to include pharmacists, nutritionists, diabetes educators, health coaches, and social workers.

Not all of these kinds of professionals are included on all care teams. Nevertheless, based on the literature and interviews with practice administrators, researchers have calculated that a PCMH care team has an average staffing ratio of 4.25 staff per full-time primary care physician. By comparison, the staffing ratio in the typical primary care practice is 2.68:1.

Some health plans pay care coordination fees and/or incentivize practices that have been recognized as a PCMH. Value-based reimbursement may also be available in the form of shared savings and risk contracts with a quality component. To the extent that primary care practices can deliver that kind of value, while also increasing their own efficiency, they should do well in the emerging world of value-based reimbursement. In many cases, that should justify the extra overhead that fully capable care teams add to practices.

PCMH Care Team

A Calculated Average of 4.25 (Staff) : 1 (Physician)
Today most practices are using manual methods of care management that don’t achieve the labor saving potential of health IT. And, unless they have a systematic approach to process improvement, they’re often not as efficient as they could be in engaging everyone in their patient panels.

To maximize efficiency and achieve the Triple Aim, primary care providers should consider two emerging trends: **IT-driven automation and continuous quality improvement** based on Lean and Six Sigma principles. These approaches, while common in other industries, have only recently begun to gain traction in healthcare.

And they are already showing promise as healthcare organizations transition from the model of the physician who has sole responsibility for providing care to the care team model in which many healthcare tasks are delegated to non-physicians.

Lean thinking goes back decades to the Toyota production model. Later associated with Six Sigma, which focuses on reducing defects and variations in processes, Lean is a continuous quality improvement method that relies on motivating frontline workers to reduce cycle time through waste elimination. A growing number of healthcare organizations have fully adopted Lean principles to improve quality and reduce waste by reengineering workflows, and many other providers are getting started.

Automation is not required to apply Lean in healthcare. But automation tools and other types of health IT can be powerful adjuncts to the transformation of healthcare based on the Lean approach. Health IT solutions can be used to automate many routine tasks of care management, increasing the productivity of care teams.

For example, it’s inefficient for a healthcare organization to have care managers call every patient with gaps in recommended care. Automated phone, texting, or e-mail messaging could reach the vast majority of these patients, significantly reducing the amount of staff time that must be devoted to this task. As a result, the organization could employ fewer care managers or could deploy its existing ones more effectively to help high-risk patients.

The combination of Lean with automation can boost care teams’ productivity and can eliminate much of the waste in healthcare. This paper explains the basic tenets of this approach.
A Lean Foundation in Healthcare

The Toyota Production System, which began in the 1950s, was originally called “just-in-time production” and was later rebranded as Lean. After Toyota used this manufacturing approach to catch up to and later surpass the U.S. automakers, many other companies began to emulate its methods. The key concepts of Lean thinking include:

+ **Value:** Define value from the customer’s perspective. Products should be designed for and with customers, should suit the purpose, and be set at the right price.

+ **Value stream:** Each step in production must produce “value” for the customer, eliminating all sources of waste.

+ **Flow:** The system must flow continuously and without interruption. Flow depends on materials being delivered, as and when they are needed, to the quality required.

+ **Pull:** The process must be flexible, producing what customers need when they need it.

+ **Perfection:** The aim is perfection. Lean thinking creates an environment of continuous improvement, emphasizing suggestions from workers and learning from previous mistakes.

Several Lean principles are applicable to healthcare. First, workflow is analyzed and broken down into a series of steps so that any failure in the process can be easily identified. Second, problems are addressed immediately through rapid experimentation with proposed solutions. Third, the ideas that succeed are spread throughout the organization. Fourth and most important, people at all levels of the organization are expected to contribute suggestions for improvement and to participate in testing these “countermeasures” to solve problems.

Gaining the cooperation of frontline staff is not easy or natural in many organizations, especially in healthcare. Healthcare is organized along hierarchical lines that can be difficult to break down. In both physician practices and hospitals, physicians stand at the top of the clinical pyramid, with all other clinical staff deferring to them. Nonclinical staff report to administrators and practice managers and also defer to physicians in doctor-owned practices.

Lean thinking requires that these hierarchies be flattened for the purposes of quality improvement. Management must give employees the freedom to critique existing processes and to suggest ways to improve them. Physicians, too, must be willing to delegate tasks to care teams and to let them find ways to improve the workflow and add value to the process.

Even without the addition of Lean, physicians may find it hard to accept the idea of delegating some of their duties to care teams in patient-centered medical homes. In a paper evaluating a national medical home demonstration project of the American Academy of Family Physicians (AAFP), the authors noted:

“We found that changing roles was perhaps most difficult for physicians, who believed deeply that primary care doctoring was based on a strong, trusting relationship between a patient and a physician. Sharing that relationship with other practice staff members was, for many, a significant challenge to their identity as physicians.”

There are other cultural changes that practices must make as they transition from a physician-directed to a care team model. In an appendix to the study cited above, the researchers noted that the leaders of one practice in the demonstration project ran into challenges when they tried to use their registry
in population health management, “largely due to difficulty in reassigning roles and responsibilities to the existing mix of staff.” 12

Engaging frontline employees to be involved in process improvement poses another cultural challenge, but when leadership is persistent, the effort pays off: The Illinois-based Christie Clinic, for example, worked on incorporating Lean concepts for several years before its efforts bore fruit. The organization has divided its 800 employees, including 160 providers, into 71 site-based teams that work on process improvement. In a two-year period, these teams made 2,000 improvement suggestions, and most of those have been implemented. 13

In a research paper from the Institute for Health Technology Transformation, Christie Clinic CEO Alan Gleghorn said that the key to applying Lean in his organization was to create an environment where it was safe for frontline employees to propose process improvements. They also had to be told that this was expected of them as part of their jobs, he added.

**LEAN GAINS TRACTION IN HEALTHCARE**

The first big application of Lean principles to ambulatory care occurred around 2000. That was when the Boston-based Institute for Healthcare Improvement (IHI) launched a three-year initiative to redesign primary care at 40 practice sites across the country. The program aimed to remove barriers to patient access, reduce waste and inefficiency, and improve patient-doctor communication, among other goals. Open access scheduling, team care, non-visit care via phone and email, and practice “huddles” to plan daily work were all part of the game plan. 14

Clinical staff received new roles and enhanced responsibilities, and the care team approach necessitated the addition of staff in many practices. But doctors had more time to spend with patients, the patients were happier, and the practices ran more smoothly.

Many aspects of the IHI program were later incorporated into the PCMH approach, which got off the ground in 2006, when the AAFP started its demonstration project. Meanwhile, a number of healthcare organizations were already experimenting with Lean thinking. The better-known healthcare systems that have tried Lean to date include ThedaCare, Virginia Mason Medical Center, Group Health Cooperative, and Cleveland Clinic. 15

ThedaCare, a Wisconsin organization that also participated in the IHI project, has founded the ThedaCare Center for Healthcare Value (TCHV), which disseminates its knowledge of Lean and brings together members of TCHV’s Healthcare Value Network to exchange insights. In the past two years, the Healthcare Value Network has grown from 14 to 60 member organizations. 16
High-Performing Practices

Several recent studies of high-performing primary care practices have examined the characteristics that enable them to deliver high-quality care efficiently. While none of these studies looks at these practices through the lens of Lean principles, many of them have absorbed Lean thinking into their approach. Other practices—notably, those that have studied the Virginia Mason and ThedaCare models—are consciously imbedding Lean into process improvement.

The high-performing practices discussed in these studies all use care teams. Those teams not only improve care delivery but also provide the environment required for the implementation of Lean processes. So before we examine how the Lean approach can be applied to care management, we’ll take a look at how care teams transform primary care.

PERFORMING AT TOP OF LICENSE

The care team approach requires that practices think about how best to use each team member to provide better care with less waste. A cardinal principle is to enable care team members to work at the top level of their training, experience, and ability. For example, physicians should not be doing clerical work that does not require their level of knowledge. Nurses should be empowered to do as much as possible within the limits of their licensure. And lower-level employees can also be trained to perform important functions for the care team.

A study funded by the Robert Wood Johnson Foundation, for example, found that many high-performing groups train medical assistants (MAs) to do pre-visit chart reviews, identify patients with gaps in care, and contact them via calls or letters. Some MAs who received extra training also act as health coaches for patients with chronic conditions. And MAs in some groups lead daily “huddles” of care teams to plan the day’s activities. Using MAs for these kinds of tasks has been shown to improve rates of preventive services and outcomes of care.

RNs in these practices provide intensive support for high-risk patients with chronic diseases, follow up on patients discharged from the hospital, and coordinate complex specialty care. They also work with patients who have multiple conditions and medications.

In this model, physicians, physician assistants, and nurse practitioners can perform their indispensable diagnostic and treatment functions while other team members prepare patients for their visits and help them with their care plans afterwards.17

Another study finds that the common characteristics of high-performing practices are proactive planned care, shared clerical tasks, improved communication, and improved team functioning.

The 23 study sites built their capacity to serve patients by giving nurses and other non-physician clinicians partial responsibility for delivering care. For example, at North Shore Physicians Group (NSPG) in the Boston area, MAs perform an expanded range of functions during the rooming process. These include medication review, agenda setting, form completion, and closing care gaps. MAs review health monitoring reminders, give immunizations, and book appointments for mammograms and DXA scans for osteoporosis.
Clinica Family Health Services, based in Lafayette, Colo., has created standing orders so RNs can diagnose and treat simple problems such as strep infections, ear infections, and urinary tract infections on their own. Nonprofessional health coaches provide patient education and counseling to help patients with chronic conditions, set goals and formulate action plans. When care managers sense a patient is depressed, they administer a standardized depression screening tool and, depending on the result, may refer the patient to a behavioral specialist.\textsuperscript{18}

**CARE COORDINATOR MODEL**

Another study analyzes three different approaches to team-based care in primary care practices. The first is the “top-of-license model” described earlier. The second is an “enhanced traditional model” in which nurses, MAs, and front-office staff are organized to support the physician in nontraditional ways. The third is a “care coordinator model” that is designed for population health management.

In the latter approach, the care team includes a care coordinator, usually a nurse, who works for multiple providers. The care coordinator’s main tasks are to coordinate patient transitions in care and to manage high-risk patients. The coordinator also coaches patients who manage their own conditions poorly.

The nurses on the care team perform a number of high-level functions, including identifying care gaps, administering EKGs and immunizations, doing cognitive and mobility assessments, and supporting patients between visits.

This care coordination approach helped increase one practice’s mammography screening rates from 37% to 70% and the blood pressure control of its diabetic patients from 39% to 72% over a three-year period. But the practice had to reduce the number and role of care coordinators because of financial difficulty in supporting the model with no extra reimbursement from payers.\textsuperscript{19}
While it’s still rare for clinics to combine automation with Lean principles of continuous quality improvement, early evidence indicates that this would be an even more effective method to increase efficiency and cut waste than automation alone.

With that qualification, here are a few examples of how organizations have used automation tools to improve their ability to manage population health.

North Mississippi Medical Clinics (NMMCI), a branch of North Mississippi Medical Center in Tupelo, Miss., operates a regional network of 38 primary and specialty care clinics. To improve its care management, NMMCI purchased a patient registry and automation applications that it interfaced with its EHR.

Care managers used the registry to identify patients who had poorly controlled diabetes. An automation tool generated work lists showing all preventive services and lab tests required for patients in that category who were scheduled to visit in the next two days. The care managers communicated via email and messaged the patients and encouraged them to get any necessary lab work done before their visit. Workflows were automated and standardized so that no patients slipped between the cracks.

As a result of this campaign, 31 of the 76 patients who originally had HbA1c levels >9 are now below that level. Most of the other at-risk patients have received specific education on how to manage their diabetes more effectively.

Prevea Health, a 180-doctor multispecialty group in Green Bay, Wisc., needed a way to reach out to chronic disease patients who had care gaps but did not make appointments to see their providers. Care management processes were largely manual, making it very difficult to engage all these patients on a regular basis.
Prevea acquired a population health management solution that included a registry and related technology. Through an interface, the group’s EHR populated the registry automatically with demographic and clinical information. Using embedded clinical protocols, a program linked to the registry triggered automated messaging to patients who had care gaps in the areas of diabetes and hypertension. Those patients who were contacted made office appointments at two to three times the rate of non-contacted patients.

The key lesson of Prevea’s experience is that the ability to identify patients with care gaps must be coupled with automated outreach capabilities to improve compliance.

Bon Secours Virginia Medical Group (BSVMG), a hospital-owned multispecialty group with more than 100 locations in and around Richmond, Va., has used a care team approach and the patient-centered medical home model to prepare for value-based reimbursement.

BSVMG uses an outside registry connected to its EHR for risk stratification and other applications for identifying patient care gaps. In addition, its population health management solution suggests various appropriate interventions for subpopulations of patients. Because these interventions can be automated, care teams are able to communicate with many patients at once while simultaneously implementing multiple quality improvement programs. An analytic application is also being deployed to measure the performance of providers, sites, and the entire practice.

Partly as a result of the process improvements enabled by automation, BSVMG has been able to succeed in its performance-based contracts with commercial payers. Under a contract with just one health plan, the group expects to generate annual savings of $4 million that it will share in. Meanwhile, the increased visits by patients with care gaps have generated more than $7 million in incremental revenue.

Overall, the experience of these and other groups has shown that automation tools can increase the effectiveness and efficiency of care management. In addition, the automation of workflows guarantees that organizations will be able to reach most of the targeted patients who need preventive, chronic care, or other services.
Lean Care Management

There is no one-size-fits-all method to create an optimal care team or design the workflows that enable the team to deliver the best care with maximal efficiency. Practices vary by specialty, size, resources, payer mix, and the composition of their patient population. The use of information technology and automation can vary dramatically from one practice to another. And the medical neighborhoods in which practices operate—including whether or not they’re part of a healthcare system—also influence the way that care teams function.20

All this only begins to explain the nuances that must be considered when one sets out to improve the care management processes in a particular practice. For example, many high-performing practices use pre-visit planning and pre-testing to avoid inefficient visits that don’t meet the needs of the patient. A care coordinator might contact an out-of-control diabetic patient who has not visited his provider for some time and ask that person to make an appointment. In addition, the care coordinator might arrange for the patient to have an HbA1c test prior to the visit so that the physician can discuss the results with the patient.

This kind of pre-visit planning has been shown to reduce the total amount of work, save time, and improve care.21 But some providers may feel the approach is not patient-centric, because it requires the patient to come into the office twice or go to a reference lab before his visit. Other doctors expect they might have to order other tests during the encounter, so rather than asking the patient to travel to the lab twice, they’ll order the tests at the end of the visit.

What this scenario underlines is the need for continuous quality improvement by care teams trained in Lean principles. Some groups are taking this approach and are finding that it helps them optimize workflows in their own unique environments.

LEAN CARE TEAMS

In the aforementioned study of 23 high-performing groups, the researchers observed that the practice from ThedaCare Clinic in Oshkosh, Wis., had raised its clinical and operational performance from last to first place among ThedaCare’s 22 primary care clinics.

The group attributed this turnaround to systematic workflow planning using Lean techniques. These methods included identification and elimination of waste through value stream mapping and process standardization. Clinic Site Director Kathy Markofski reported, “The team maps out the work flow of a patient visit. We identify wait times, do a root cause analysis, develop countermeasures and then quickly reassess with data.”22

At Cleveland Clinic, “the physician and clinical staff meet weekly to review data and refine their workflows,” the study notes. They look at what went well and what didn’t and the changes they need to make to improve the workflows.

Practices that follow Lean principles can benefit from a quality management committee or a similar entity to supervise the quality improvement process and make sure that the group is meeting the quality metrics specified in its payer contracts. But this committee should not do the actual work of process improvement.
“They can educate people about what the measures are, and they can be the ones to pull together the quarterly or monthly meetings and share the data so everyone has a common ‘line of sight,’ which is also a Lean principle,” says Karen Handmaker, MPP, vice president of population health strategies for Phytel. “But the work is done on the front line, and the care teams build it up from the bottom.”

“LEANING OUT” THE 8 TYPES OF WASTE IN PRIMARY CARE

<table>
<thead>
<tr>
<th>TYPE OF WASTE</th>
<th>LEAN DEFINITION</th>
<th>EXAMPLE SOLUTIONS</th>
</tr>
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<tbody>
<tr>
<td>DEFECTS</td>
<td>Errors resulting from omissions, inaccurate information, or mistakes. Errors often require rework and can cause harm.</td>
<td>Use algorithms to evaluate patient “care gaps” against evidence-based guidelines and take action to close them with automated patient communications &amp; provider alerts.</td>
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<tr>
<td>OVERPRODUCTION</td>
<td>Providing more services than needed, including redundant services.</td>
<td>Query integrated patient registry before ordering tests and services for patients.</td>
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<tr>
<td>WAITING</td>
<td>Idle time for the customer or staff member while waiting for needed information, action, or resource.</td>
<td>Build in “same day” appointment slots to improve access; redesign visit preparation process with daily huddles and new roles for care team members while rooming patients.</td>
</tr>
<tr>
<td>TYPE OF WASTE</td>
<td>LEAN DEFINITION</td>
<td>EXAMPLE SOLUTIONS</td>
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<tr>
<td>NOT FULLY UTILIZED</td>
<td>Unused talent, creativity, and skills.</td>
<td>Train medical assistants to do health coaching; delegate or automate non-clinical tasks to maximize use of clinical team members’ specialized skills.</td>
</tr>
<tr>
<td>TRANSPORTATION</td>
<td>Moving people, equipment, and supplies takes valuable time and resources.</td>
<td>Do lab testing in the office instead of sending patients to another location.</td>
</tr>
<tr>
<td>INVENTORY</td>
<td>The supply of resources waiting to be consumed by customer demand.</td>
<td>Survey patients to determine best days, times, and locations to hold group education sessions so “supply” matches demand.</td>
</tr>
<tr>
<td>MOTION</td>
<td>Movement of people or resources while performing tasks.</td>
<td>Co-locate physicians and medical assistants in “pods” to eliminate extra steps to communicate (messaging, walking); utilize automated reporting and alerts to minimize “clicks” and research time.</td>
</tr>
<tr>
<td>EXPRESS PROCESSING</td>
<td>Redundant or otherwise “non-value-added” activities.</td>
<td>Ask patients to update existing information instead of completing new profiles at every visit.</td>
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Automation in Lean Processes

As mentioned earlier, Lean does not require health information technology. One of the earliest and most effective parts of Lean manufacturing, for instance, was the kanban cards used to control and replenish inventory. But by applying health IT and automation tools within a Lean context, organizations can become much more efficient in managing population health.

The majority of primary care practices now have EHRs, which generate data that can be used to improve the quality of care. However, EHRs were not designed as the basis for Lean process improvement.

For example, ThedaCare found that its EHR could not produce a single plan of care for the multiple physicians, nurses, and other professionals who care for patients across the continuum of care, including primary care, specialty care, and the hospital. As a result, multidisciplinary care teams could not use the EHR to coordinate care. Eventually, ThedaCare and its vendor reprogrammed the software to accommodate the single care plan.24

Aside from some control chart and kanban applications, there aren’t many off-the-shelf programs designed specifically for the Lean approach in healthcare, experts say.25 Some population health management solutions, though, could be adapted to the Lean approach.

Automation tools, for instance, can play an important role in Lean process improvement. These tools cannot fix a broken process, but after a practice has analyzed and reengineered its workflows, it can consider where automation fits in and how it can improve care management processes further. By delegating routine tasks to automation tools, care teams can provide appropriate forms of care management to most of the patient population, while improving their ability to help patients who need human assistance.

**Basic Automation Tools**

The first step in this process is to use an analytic application that stratifies the patient population by health risk. For example, a population might be broken down into low-, medium- and high-risk individuals. This becomes the basis for deciding which automation tools to use with specific patients. The risk stratification analytics should be applied to a combination of clinical and claims data to get a wide-angled view of patients’ health status. Health risk assessment surveys can also be helpful in evaluating patients’ health behavior.

Automation tools can be used to link workflows together. For example, a patient-centric registry provides a full picture of each patient, including the person’s health conditions, what services have been provided to each one, and when the patient is due for particular preventive or chronic care services. Using embedded protocols for recommended care, reports can be run on registry data to reveal patient care gaps.

The program can then send alerts to providers that patients need certain kinds of care, such as a mammogram or diabetic eye exam, when they come in for their next visit. Another kind of automation tool uses the same registry data and protocols to generate automated messages to patients who need preventive or chronic care. These messages ask them to make appointments with their providers.

A different type of population health application produces work lists that enable care coordinators to prioritize their management of high-risk patients. Instead of having to wade through electronic charts...
and look at each patient’s lab results, recent ER visits, and other relevant data, the care managers can instantly see which patients are at the greatest risk of complications and/or hospitalization. This type of automation can save a great deal of time and can help the care managers attend to the sickest patients proactively.

A basic assumption of population health management is that many of the patients who have serious health risks are “under the waterline”: in other words, they haven’t yet developed the condition or the exacerbation that will generate high health costs. So to manage population health properly, care organizations must target not only high-risk patients but also those with low and medium risks. They must also initiate patient engagement campaigns to improve the health of those with various chronic conditions and keep healthy patients healthy.

This is an area where automation excels: Technology and mobile healthcare applications can launch hundreds of educational campaigns and other interventions aimed at people in different subcategories simultaneously. Of course, some patients need human interventions as well, so automation is only part of the mix. If used correctly, automation becomes a member of the care team to which certain tasks are delegated.
‘TOP OF LICENSE’ APPROACH

Earlier, we discussed a care team model that assigns to every care team member the work that matches his or her training and expertise. Automation can be part of this “top of license” approach. The goal is to assign the right patients to the right staff members or to automation only. With the help of risk stratification, the care team can decide which approach will work best for each individual. A healthy patient might just need automated reminders to maintain wellness and get recommended preventive services. Patients who are at risk of developing a chronic condition might receive various automated interventions as well as health coaching from MAs. Nurses and MAs work with patients who have chronic conditions to prevent disease progression and avoid unnecessary complications. And nurse case managers have responsibility for managing high-risk patients with multiple conditions.

DOWNSTREAM VALUE

The team-based, population health management approach discussed in this paper confers financial advantages in a value-based reimbursement system. Whether an organization has pay for performance, shared savings, or risk contracts, the ability to improve outcomes and lower costs will result in a better bottom line. And health IT is a key component of that capability.

According to the Health Information Management and Systems Society (HIMSS), health IT can create five kinds of value:

- Satisfaction of patients, providers, staff, and others
- Treatment/clinical—patient safety, quality of care, and efficiency
- Electronic information/data—use of evidence-based guidelines, data sharing, population health, and quality reporting
- Prevention/patient education—improved disease surveillance and patient compliance with therapies
- Savings from improvements such as reduced days in accounts receivable, patient wait times, and emergency department admissions.

By eliminating waste and improving care processes, the health IT-enabled Lean approach can provide even more downstream value to payers and/or accountable care organizations (ACOs). Better ambulatory care management leads to lower rates of ED visits, hospital admissions, and readmissions. Care delivery transformation enables primary care physicians to provide more comprehensive care and limit referrals to specialists. And as previously mentioned, the efficient use of care teams also increases practice capacity so providers can see more patients.

Automation tools enable care managers to do more and manage patients better. Practices can use these tools to reach their entire populations, not just those who visit their care providers, which is what population health management is all about.
CHECKLIST FOR LEAN CARE MANAGEMENT

+ Make care team transformation a strategic objective with assigned leadership and visible executive support.

+ Create an environment that supports continuous quality improvement.

+ Form multidisciplinary care teams to share the work of care management.

+ Map clinical and administrative processes and engage staff in suggesting how they could be improved.

+ Identify and eliminate waste through value stream mapping and process standardization.

+ Reengineer processes to allow each care team member to perform at the top of their licenses.

+ Make pre- and post-visit care planning part of the clinical process.

+ Introduce a quality management committee to supervise the quality improvement process and track progress and results.

+ Use automation tools and other technology solutions to reduce waste and improve efficiency— but only after analyzing and reengineering workflows.
Conclusion

The transformation of healthcare delivery requires high-performance care teams. But care teams that include care coordinators and other ancillary professionals are likely to be too expensive for many primary care practices because many important services of care team members are not reimbursed under most contracts, although this is starting to change.

Value-based reimbursement can justify the higher overhead expense if practices can produce real savings. But to move the needle on cost and quality, practices need to undertake a kind of population health management that’s impossible to do with manual methods. Automation tools can enable practices to meet this challenge while making them more efficient.

Automation alone, however, cannot fix broken processes. One proven way to do that is to use the Lean approach to continuous quality improvement. Lean thinking, coupled with automation tools, can make care teams more efficient and productive, while helping practices deliver value to patients and payers.

Leading healthcare organizations are moving in this direction. They will be among the organizations best suited to succeed in the world of value-based reimbursement.

Notes


8. Institute for Health Technology Transformation, “Lean Health IT: The Next Step for Clinical and Business Intelligence,” accessed at: http://ihealthtran.com/iHT2LeanHealthIT.pdf?submissionGuid=082415b0-a22c-41fa-a683-c3fa0c0ee170


12. Ibid.

13. “Lean Health IT: The Next Step for Clinical and Business Intelligence”


15. “Lean Health IT: The Next Step for Clinical and Business Intelligence”

16. Ibid.


19. “Team-Based Care: A Critical Element of Primary Care Practice Transformation”


22. Ibid.

23. “Lean Health IT: The Next Step for Clinical and Business Intelligence”

24. Ibid.

25. Ibid.

Empowering Provider-Led Population Health Improvement

Phytel is the premier company empowering provider-led population health improvement. Phytel provides physicians with proven technology to deliver timely, coordinated care to their patients. Phytel’s state-of-the-art registry uses evidence-based chronic and preventive care protocols to identify and notify patients due for service, while tracking compliance and measuring quality and financial results.

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