STANFORD HOSPITAL & CLINICS
Stanford University Medical Center

STANFORD SCHOOL OF MEDICINE
Stanford University Medical Center

Stanford Coordinated Care

"Support the patients, manage their care"

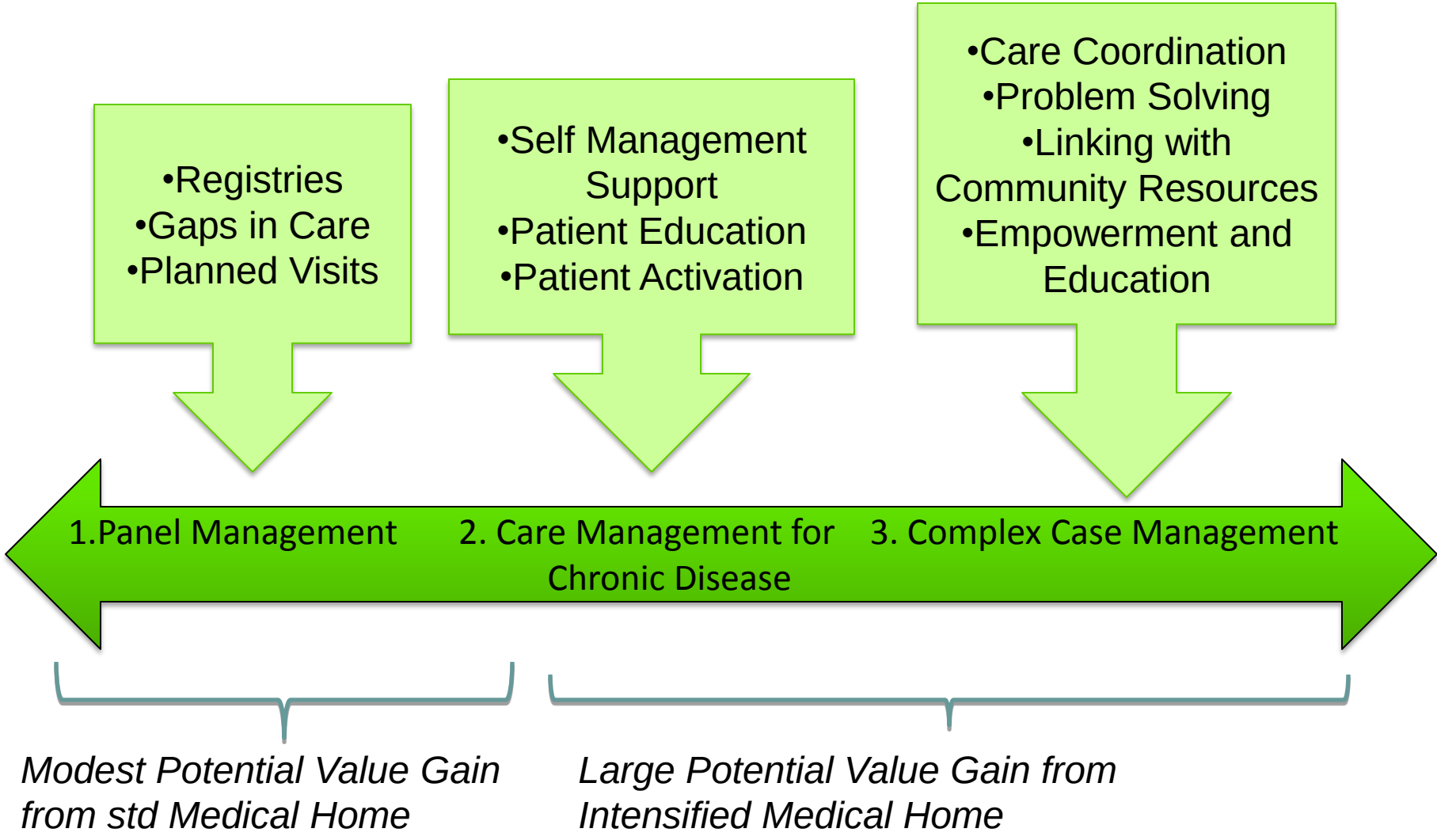
Alan Glaseroff MD

Best Practices Forum

San Francisco

November 6, 2013

Where's the Leverage on Trend?



“Hot Spotting” in Employed Populations

- **Boeing & Atlantic City Resorts (A. Milstein)**
  - AICU in 2 self-funded industries

    Capitation fee plus FFS for specialized MD-led teams within 3 MD groups and free-standing (Atlantic City)
  - 18%- 20% net reduction in per capita spending vs. propensity matched controls

- **Humboldt (A. Glaseroff)**
  - Partnered with PERS and PBGH (Anthem as ASO);
  - Disseminated rural county model within a distinguished IPA inserting RN care managers into 25 private practices
  - 20% savings estimated in first year

- **Stanford University (A. Glaseroff, A. Lindsay)**
  - Pilot for University & Hospital Employees + Dependents enrolled in self-insured plan.
  - Stanford Coordinated Care (SCC) is a team of medical professionals and health coaches who help people with chronic illnesses lead a healthy life and smoothly navigate their healthcare.

Better, Faster and Leaner: Boeing A-ICU Results After Year One

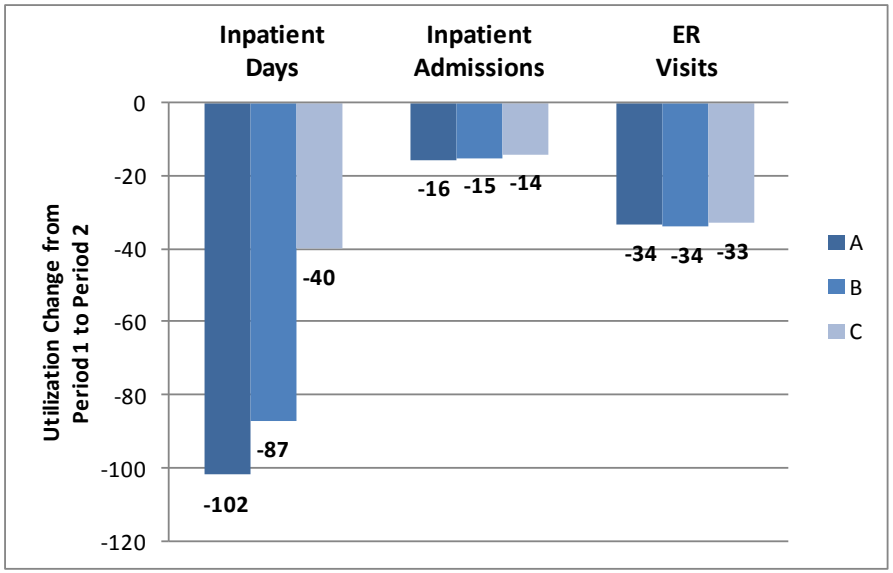
Change in Combined Total Per Capita Health Care Spending, Functional Health Status, Patient Experience, and Absenteeism	
	% Difference
% change from baseline in unit price-standardized total annual per capita spending by patients and Boeing, compared to a propensity-matched control group, net of supplemental fees to medical groups	–20%*
% change in SF12 physical functioning score for IOCP patients compared to baseline	+14.8%
% change in SF12 mental functioning score for IOCP patients compared to baseline	+16.1%
% change in patient-rated care "received as soon as needed" compared to baseline**	+17.6%
% change in average of patient-reported work days missed in last 6 months compared to baseline	–56.5%

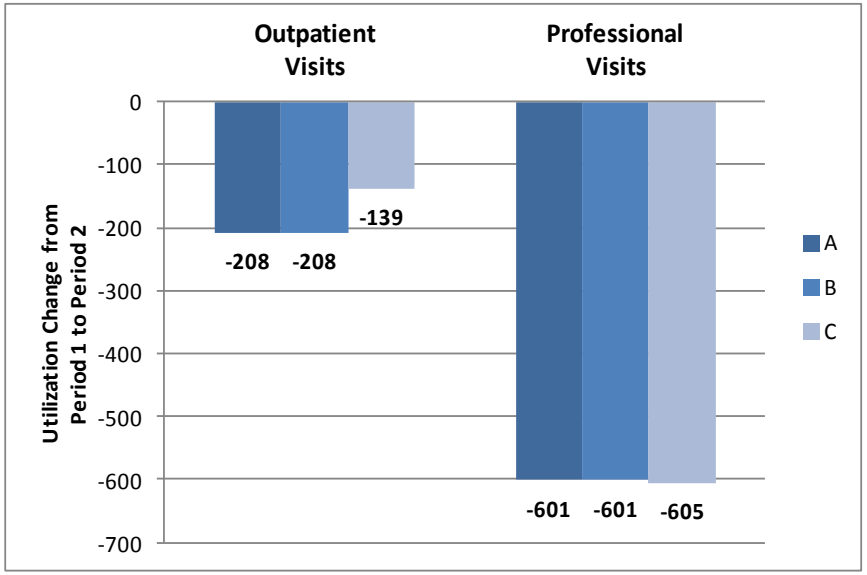
* p = 0.11 after first 12 months for 276 chronically ill enrollees vs. 276 matched controls.
** From the Ambulatory Care Experience Survey – patients responding "always" or "almost always" to the question: "When you needed care for illness or injury, how often did the IOCP provide care as soon as you needed it?"

4 4

Findings: Total Utilization Metrics

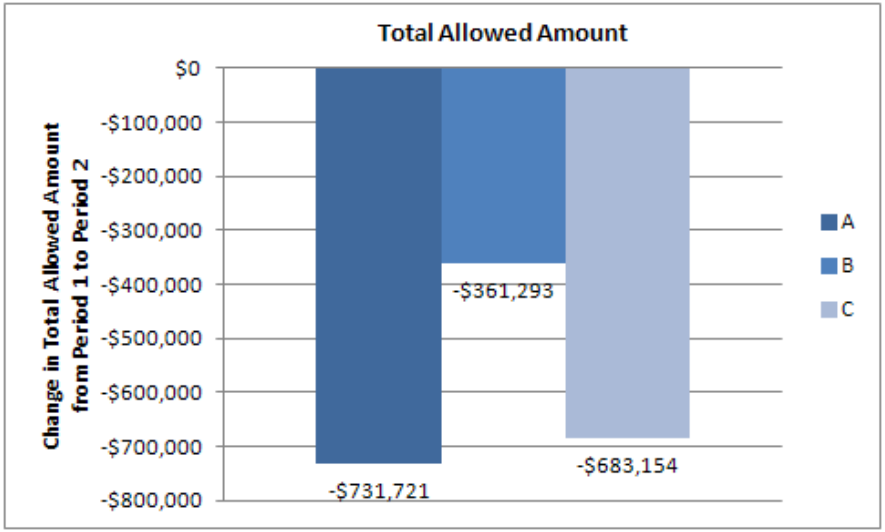
Exclusion Method	Number of Members Excluded (n=259)	Inpatient Days	Inpatient Admissions	Outpatient Visits	Professional Visits	ER Visits
		% Change from Period 1 to Period 2				
A = All Members and Claim Lines Included	0	-63%	-51%	-17%	-11%	-25%
B = All Members Included; Claim Lines over $250,000 Excluded	0	-59%	-50%	-17%	-11%	-25%
C = Members with Total Allowed Amount over $250,000 Excluded	4	-52%	-54%	-15%	-11%	-26%

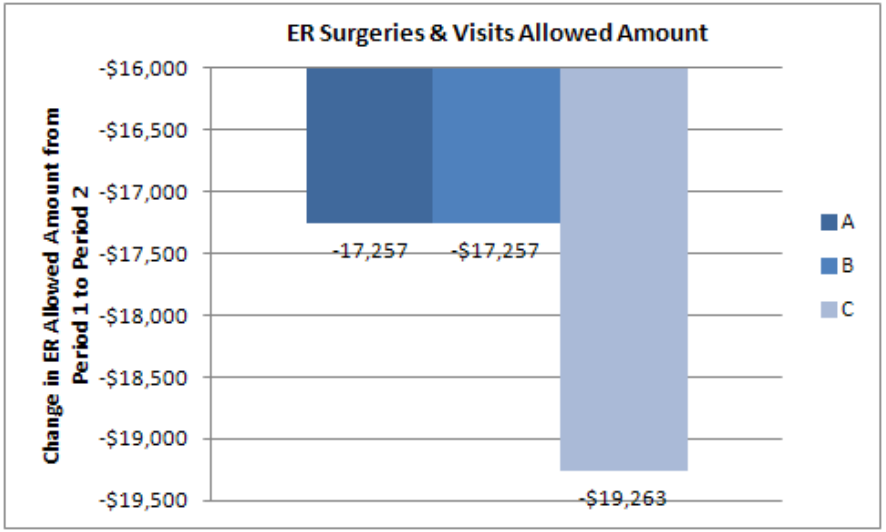




Findings: Total Cost Metrics

Exclusion Method	Number of Members Excluded (n=259)	Total Allowed Amount	ER Surgeries & Visits Allowed Amount
		% Change from Period 1 to Period 2	
A = All Members and Claim Lines Included	0	-23%	-16%
B = All Members Included; Claim Lines over $250,000 Excluded	0	-13%	-16%
C = Members with Total Allowed Amount over $250,000 Excluded	4	-29%	-19%





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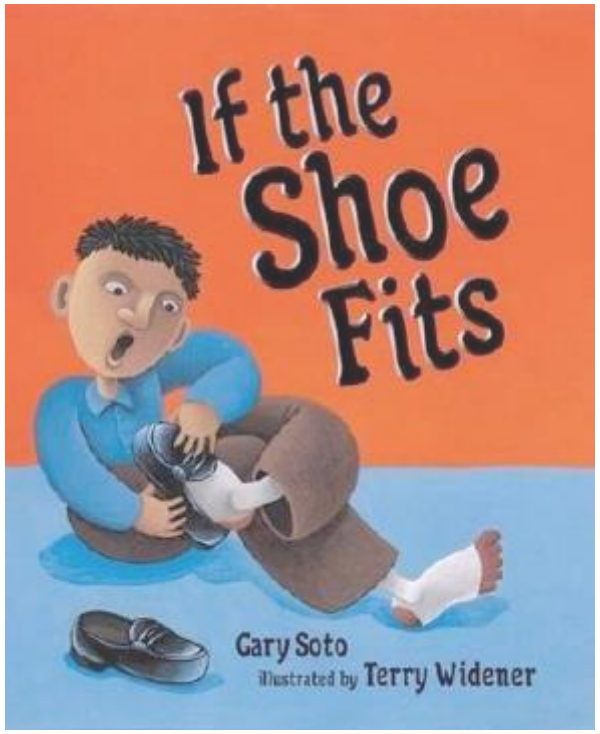
Designing the Program: *"One size fits none"*

- *Defining the problem before designing the s*olution



Human-Centered Design

- Interview people from targeted lists – 10+ if possible
- Explore strengths, barriers, past experiences with healthcare (positive and negative)
- Categorize responses to develop common themes (the 20% of what was frequently heard that accounts for 80% of what patients face in regards to their health).
- Brainstorm about possible solutions to that limited set of barriers – don't edit while brainstorming
- "Vote" as a group
- Design program/hire accordingly/test ideas

ELEMENT 1

THE TEAM CARE APPROACH

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CURRENT PATIENTS

With a team of trusted providers by their side, SCC patients experience the benefits of becoming an empowered patient in their care.

"At SCC my healthcare providers share the information about me among themselves; they trust me, they trust each other, and they work hand-in-hand."

"CORINE" (38)
Patient at SCC

"At SCC it's not about a doctor telling me what to do. It's about what we're going to do together. They give me confidence and take the drama out of health care."

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ELIGIBLE PATIENTS

Eligible patients often feel left alone and wish there was a care team by their side, yet can't envision how this might work.

"Someone should be watching over me. I don't understand what it takes to get a group of people to watch over me, and make sure that my condition doesn't get worse."

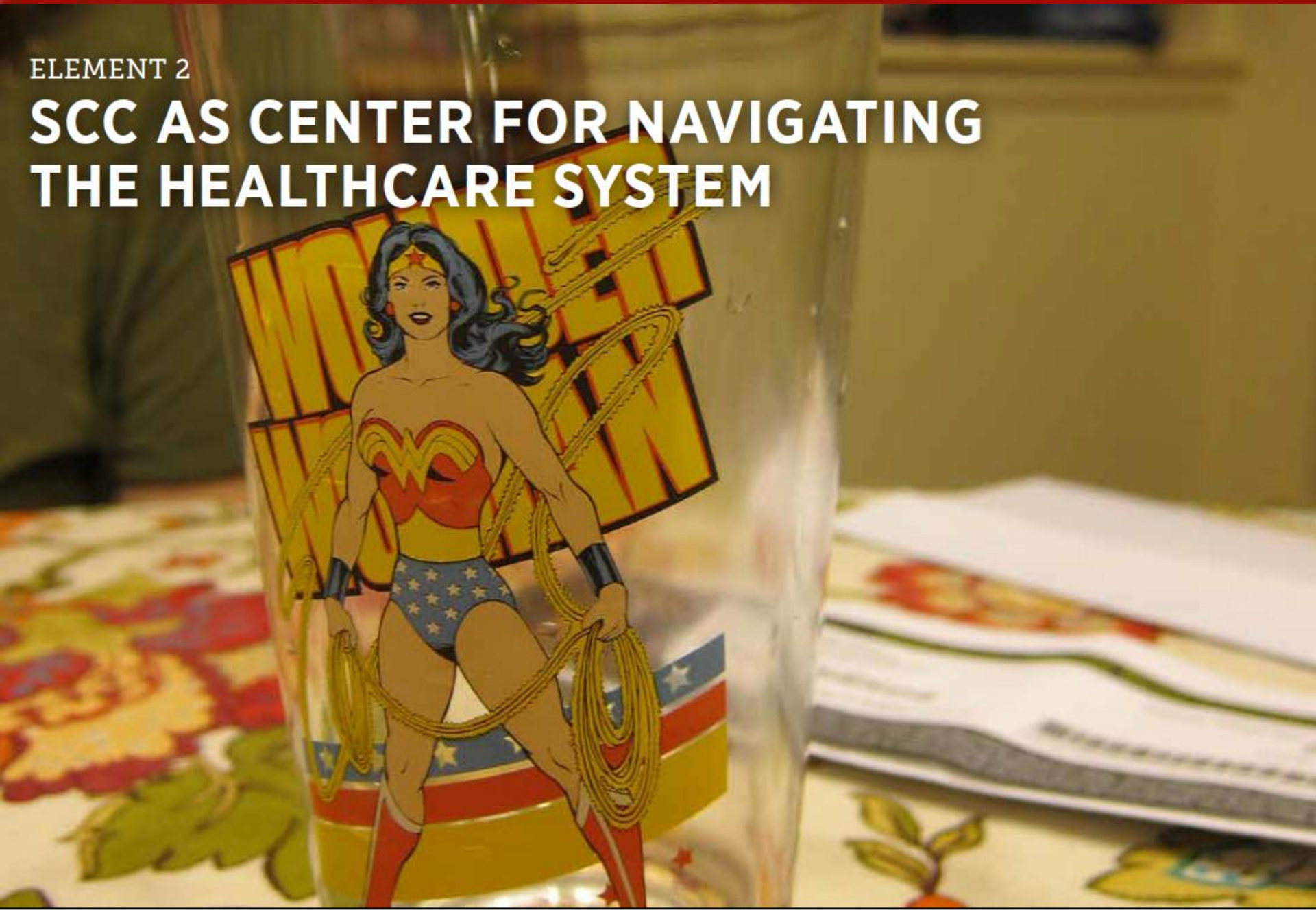
"CARA" (62)
Eligible patient
Currently with Family Medicine

"To my friend, coordinated care means everyone knows everything about you. That's not true of course but it's hard for me to explain to her."

"DAWN"
Patient at SCC

ELEMENT 2

SCC AS CENTER FOR NAVIGATING THE HEALTHCARE SYSTEM



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Patients at SCC feel supported and confident they get the best care available.

"When I have a question, I start with my Care Coordinator. At SCC I can rely on one doctors' office when I am sick, and when I am healthy. Everything gets resolved here, not outside, in a different reality or by a third party."

"DAWN"
Patient at SCC

"As a patient you don't always know how to communicate with your specialists and tell them what's important to you. SCC helped me figure out how to ask my specialist the right questions and feel more confident talking with her."

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ELIGIBLE PATIENTS

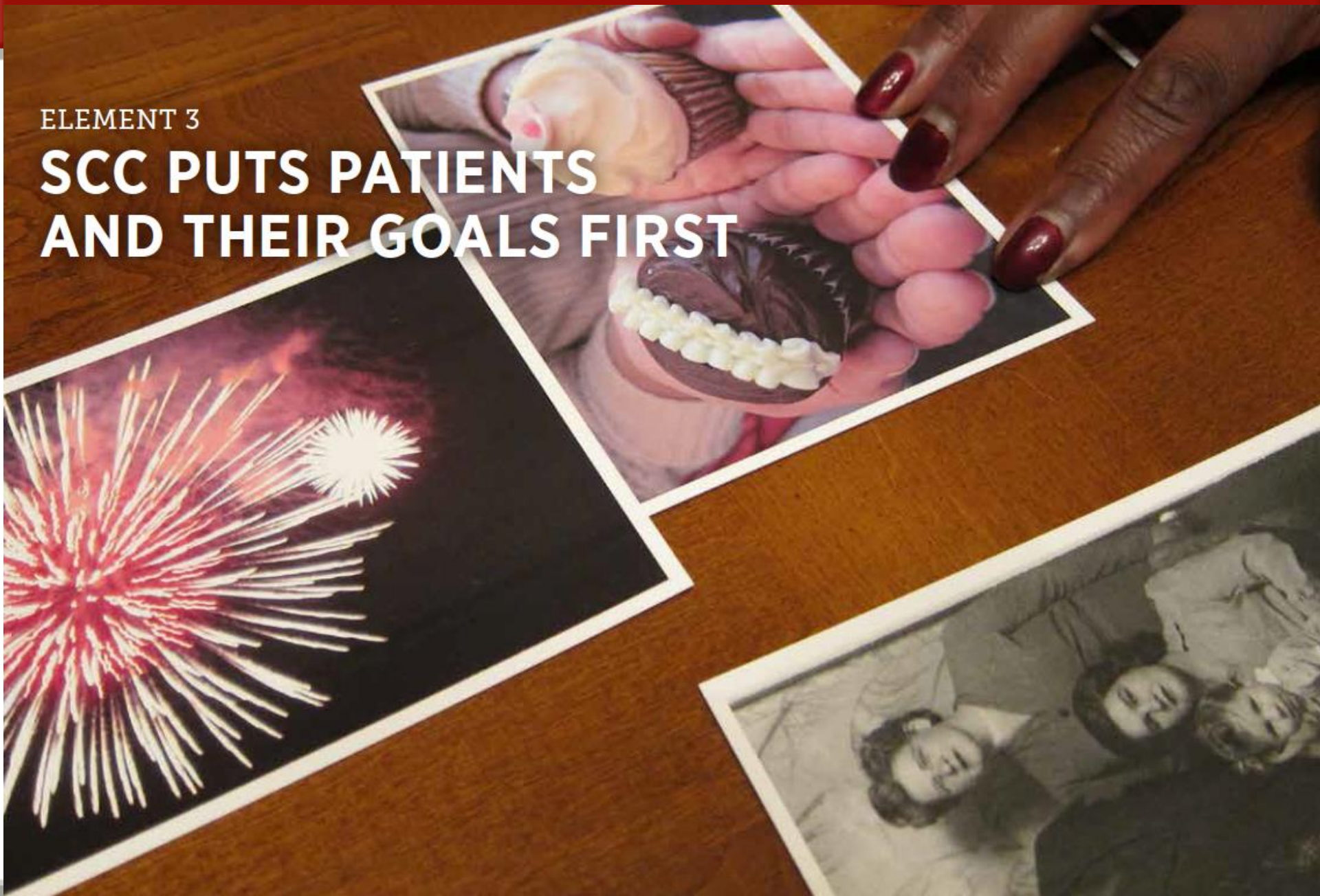
Being forced to be at the center of their care, eligible patients struggle to understand how SCC works with their specialists.

"Before joining SCC, I didn't understand how SCC could have a relationship with my specialists. I thought SCC may not be able to handle me since they can't replace all of my specialists."

"CORINE" (38)
Patient at SCC

"This is my care team. They have never met and don't know each other. My pharmacist sometimes reaches out to my doctors, but only if she has to. The first two times I went to the ER and ended up in hospital, my primary care physician didn't even know."

"CARA" (62)
Eligible patient
Currently with Family Medicine



ELEMENT 3

SCC PUTS PATIENTS AND THEIR GOALS FIRST

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Patients know that their healthcare team at SCC listens to them and puts an action plan in place that aligns with the patient's goals.

"At my first visit my doctor pulled up a chair next to me, listened to my story, and said, 'You have a valid point.' I just wanted to hug her!"

"DAWN"
Patient at SCC

"At SCC my doctor gave me a little tool so I could measure my blood sugar, and I measured every day. I was in control. I learned it's important to know how your body is working, and that made me feel motivated."

"JUAN"
Patient at SCC

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ELIGIBLE PATIENTS

Patients with multiple chronic conditions often feel studied rather than listened to.

"I needed somebody to listen to me, to go into my records and acknowledge that I needed something else. Why am I not being treated as a whole person. I'm not just a bunch of symptoms."

"CARA" (62)
Eligible patient
Currently with Family Medicine

"Before joining SCC I felt like they treated me like a lab project, like an intellectual curiosity."

"DAWN"
Patient at SCC

ELEMENT 4

SCC PROVIDES HANDS-ON SOLUTIONS

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CURRENT PATIENTS

Patients have experienced first hand how their SCC team helps them solve issues in unconventional, hands-on ways

One patient felt lost calculating the amount of insulin she needed to inject. So SCC asked her to send a picture of her food to her care coordinator, who would reply with the amount of insulin needed. After a month, the care coordinator put together a binder with her most common meals.

Leaving the ER with injuries from a car accident, a senior couple wasn't able to take care of themselves. SCC sent their nurse to evaluate the situation. Knowing them and their life situation, SCC quickly had their meals organized through their local church.

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ELIGIBLE PATIENTS

Patients too often are simply given facts without a helping hand to translate these facts into action.

"One time, when I asked my doctor whether I should do Jenny Craig or Weight Watchers, she disappeared to consult with a colleague. When she came back, she just told me that I should eat whole foods. And that was it."

"CORRINE" (38)
Patient at SCC

"My blood sugar had been out of control for a while. I didn't understand that I had to do something. My doctor would just say impossible things that didn't make me want to do anything."

"JUAN"
Patient at SCC

ELEMENT 5

SCC CARES FOR THEIR PATIENTS LIKE IN THE GOOD OLD DAYS

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CURRENT PATIENTS

Patients at SCC benefit from personal relationships and small town feel.

"When I call, they already know it's me. I don't have to verify my identity. They can tell by my voice that it's me. Knowing the people at the clinic and having them know me keeps me from getting sicker."

"DAWN"
Patient at SCC

"My nurse and my doctor came to my bedside at the hospital after surgery, and then my nurse came to my home. I guess the only downside is that I stressed out that my house wasn't clean enough for a home visit!"

ANONYMOUS
Patient at SCC

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Patient at SCC

ELIGIBLE PATIENTS

Patients have come to accept healthcare as a series of impersonal experiences.

"Every time I went to my primary care clinic, I ended up seeing someone else. They just passed me around. In 12 months you could see 12 different doctors, easily."

"CARA" (62)
Eligible patient
Currently with Family Medicine

"At my clinic in Hayward when they transferred me to the PA, I never saw the real doctor again. I felt like I was in 2nd place."

"JUAN"
Patient at SCC

ELEMENT 6

SCC HELPS PATIENTS TO GET ON WITH LIVING

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CURRENT PATIENTS

SCC helps their patients thrive with their chronic conditions.

"After joining SCC I began to feel like life was about growing again. I was opening up. I was moving forward. They encouraged me to go on a vacation despite my health issues. Now I am looking into getting my masters."

"DAWN"
Patient at SCC

"At SCC they helped me understand the night shifts were really wearing me down. My doctor at SCC is helping me change my schedule…he wrote a letter to my manager. I'm going to be able now to take my kids to school, to go to the gym. I'm going to feel better."

"JUAN"
Patient at SCC

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SCC HELPS PATIENTS TO GET ON WITH LIVING

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"DAWN"
Patient at SCC

"My doctor at SCC helped me understand that the night shifts were wearing me down. He wrote a letter to my manager, and now I'm in the process of transitioning to a day shift. I feel lucky that I get so much support."

"JUAN"
Patient at SCC

ELIGIBLE PATIENTS

Patients tend to focus on finding out what's wrong with them, while stalling in life and not feeling better.

"I wanted it fixed, not just a band aid of medications."

"CARA" (62)
Eligible patient
Currently with Family Medicine

"I went from specialist to specialist to find out what's wrong with me. The more specialists I saw, the more they labeled me. In the end I spent a lot of my time and energy for nothing."

"DAWN"
Patient at SCC

ELEMENT 7

SCC SIMPLIFIES THE LOGISTICS OF HEALTH CARE

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CURRENT PATIENTS

Patients realize that their health care is more streamlined at SCC.

"At SCC I'm in and out in half an hour. That's not just great for me, but also for my manager because it's less time out of my seat. Also, there are far fewer bills but who knows, they might still be coming."

"DAWN"
Patient at SCC

A patient with scheduled surgery still had not received authorization from their insurance the day before. The day of her surgery, her care coordinator came in early and spent hours on the phone with the insurance - with success. She got authorization just in time so the patient could walk into surgery reassured that her insurance was covering the procedure.

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"DAWN"
Patient at SCC

"My care coordinator saw that one day before my scheduled surgery, my insurance still hadn't authorized the procedure, so she came in early to call them. She must have spent hours and was successful. She helped me get authorization just in time so my scheduled surgery could take place."

ANONYMOUS
Patient at SCC

ELIGIBLE PATIENTS

Patients accept that health care uses a lot of their resources, often inefficiently.

"Before joining SCC, I budgeted one and a half hours for my doctor appointments. After getting to the clinic, there's waiting in the waiting room, then waiting with a backless gown on, all this waiting just to see the doctor for 15 minutes."

"DAWN"
Patient at SCC

"Of course there are many bills. That's just what it is."

"CARA" (62)
Eligible patient
Currently with Family Medicine

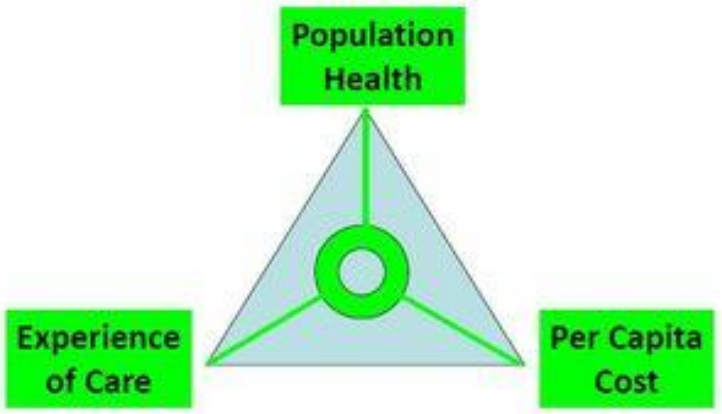
What they said they needed to thrive…

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

GOALS OF STANFORD COORDINATED CARE

Primary SCC Goals:

- Build the relationship to primary care *team*
- Enhance patients' self-management
- Transform the primary care/specialty care relationship to better serve the patient's goals: Access by tele-presence, email, phone
- Achieve "Triple Aim" results
  - Better health
  - Better care
  - Lower cost



Model 1 & 2 – SCC Program Overview

Primary Care Plus+ Description:

Target Population: Top 10% risk category

Primary Care Plus is a service provided by Stanford Coordinated Care, to those who wish to access the primary care services to the caring hands of an SCC physician. Those enrolled in Primary Care Plus are welcomed by a care team which includes a physician, nurse, care coordinator, physical therapist, pharmacist, and clinical social worker.

Chronic Care Support Description:

Target Population: Top 10-20% risk category

Chronic Care Support is a secondary service provided by Stanford Coordinated Care to those established within a medical home and would like to have the help and coordination from an SCC nurse who works closely with the PCP to offer enhanced support. A care coordinator is also designated to each individual to provide support of health care complexities regarding chronic conditions and visits to specialists.

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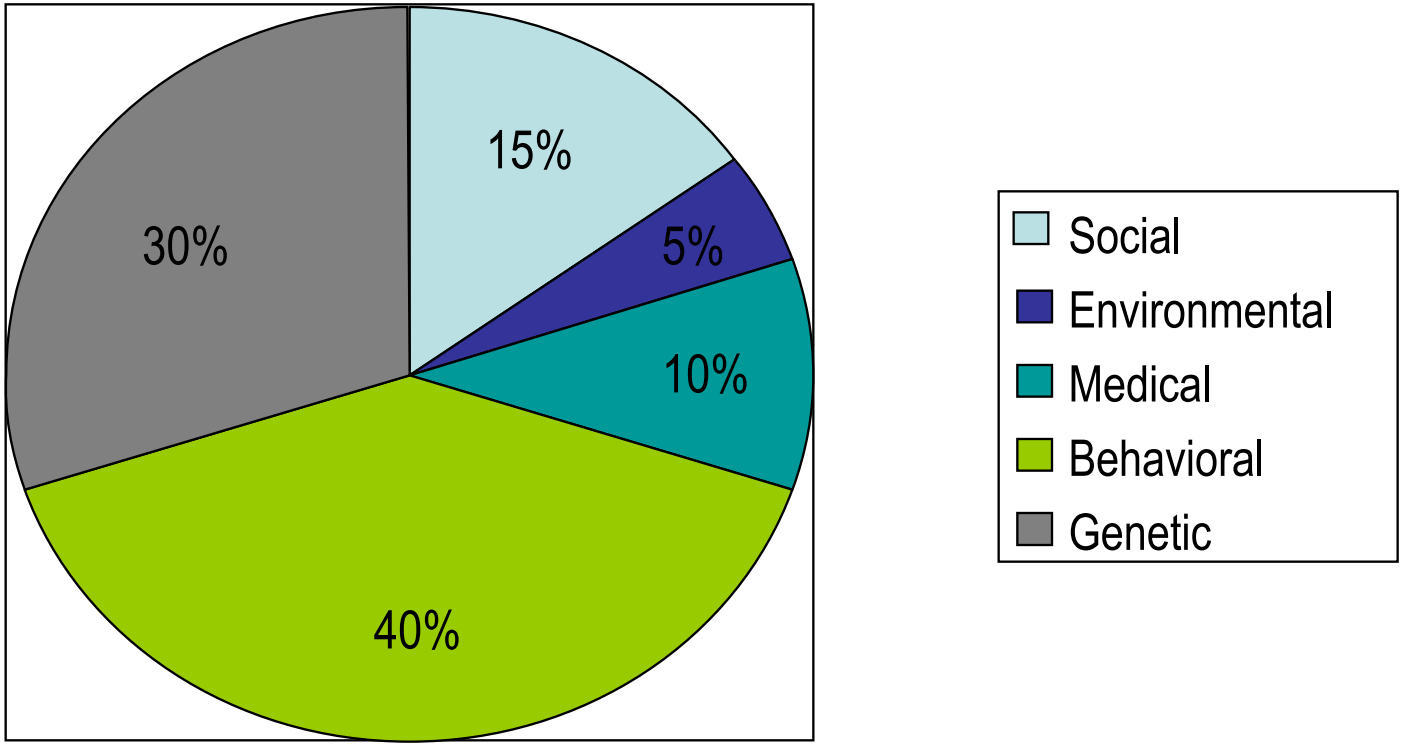
Care Model

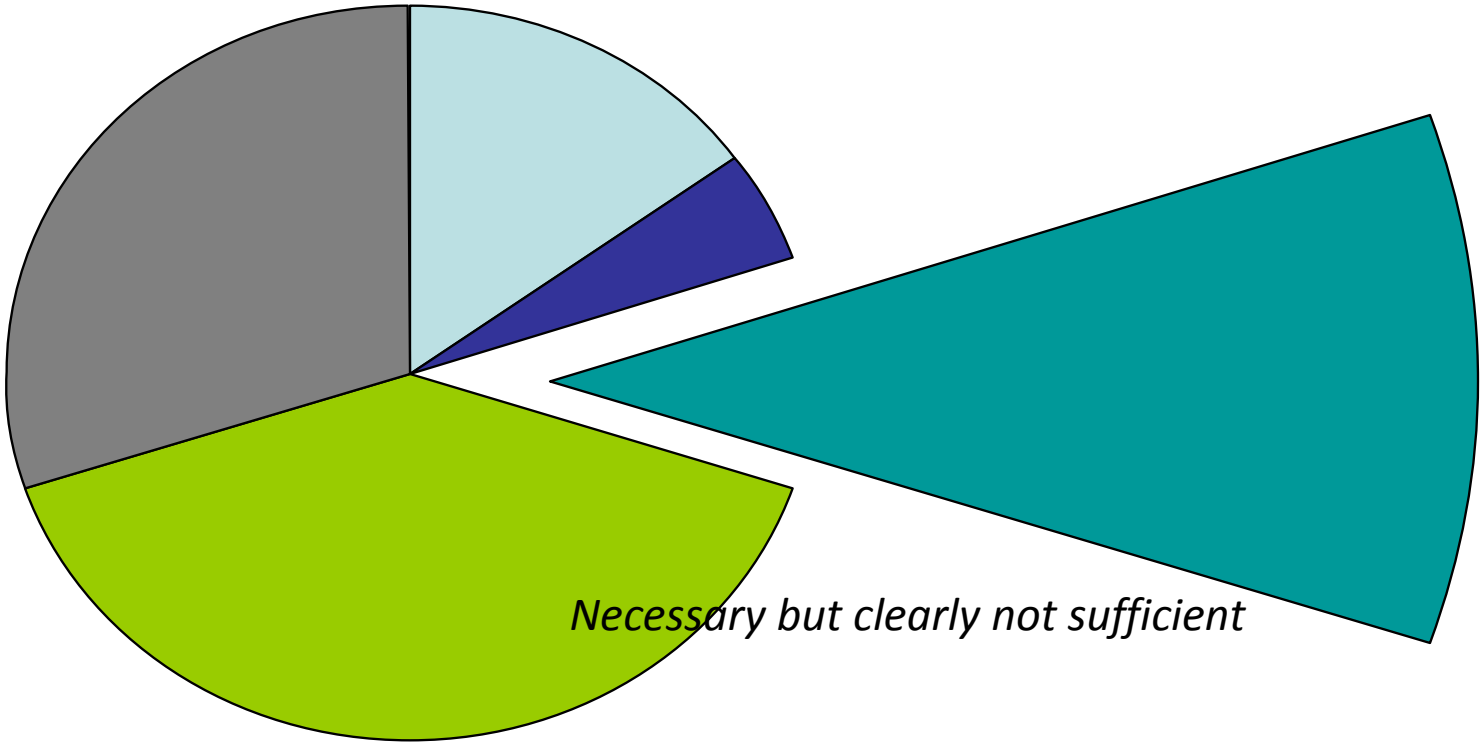
"Why wouldn't a person with a chronic condition do everything in their power to live long and feel well?"

Causes of Premature Mortality



Schroeder, NEJM 357; 12

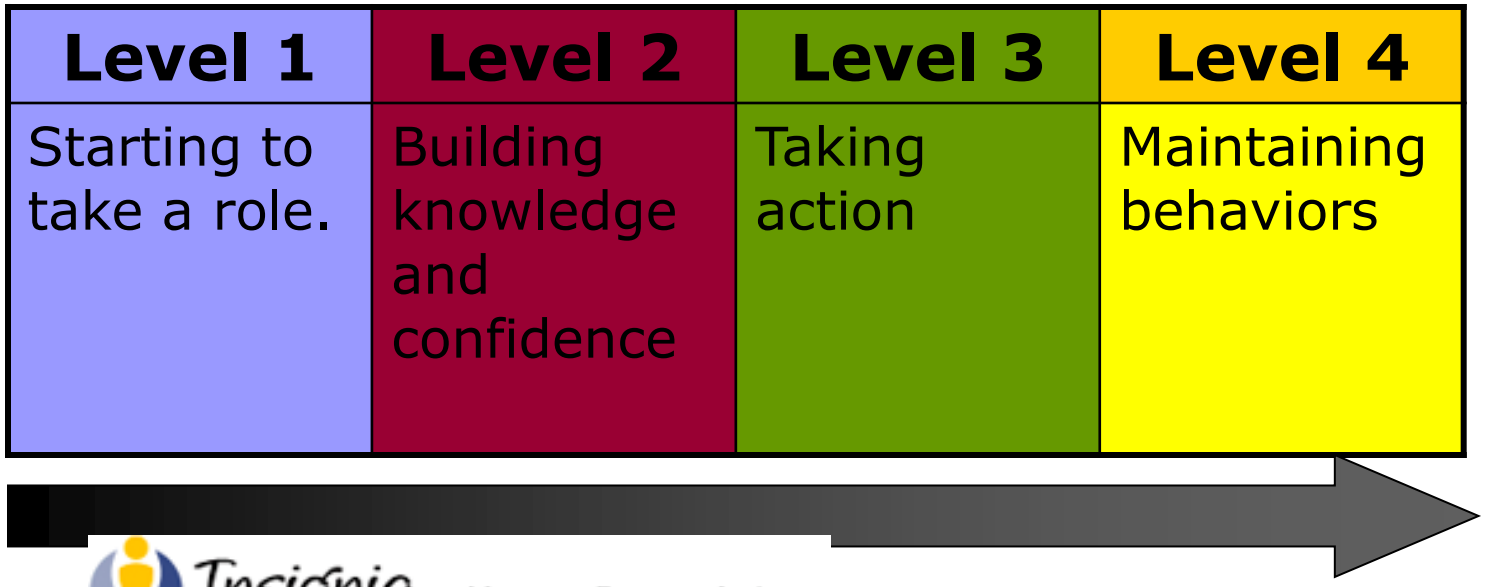
Reducing Clinical Variation – “The 10% solution”?



The most important variation is within the patients!

Patient variation – what the patient brings

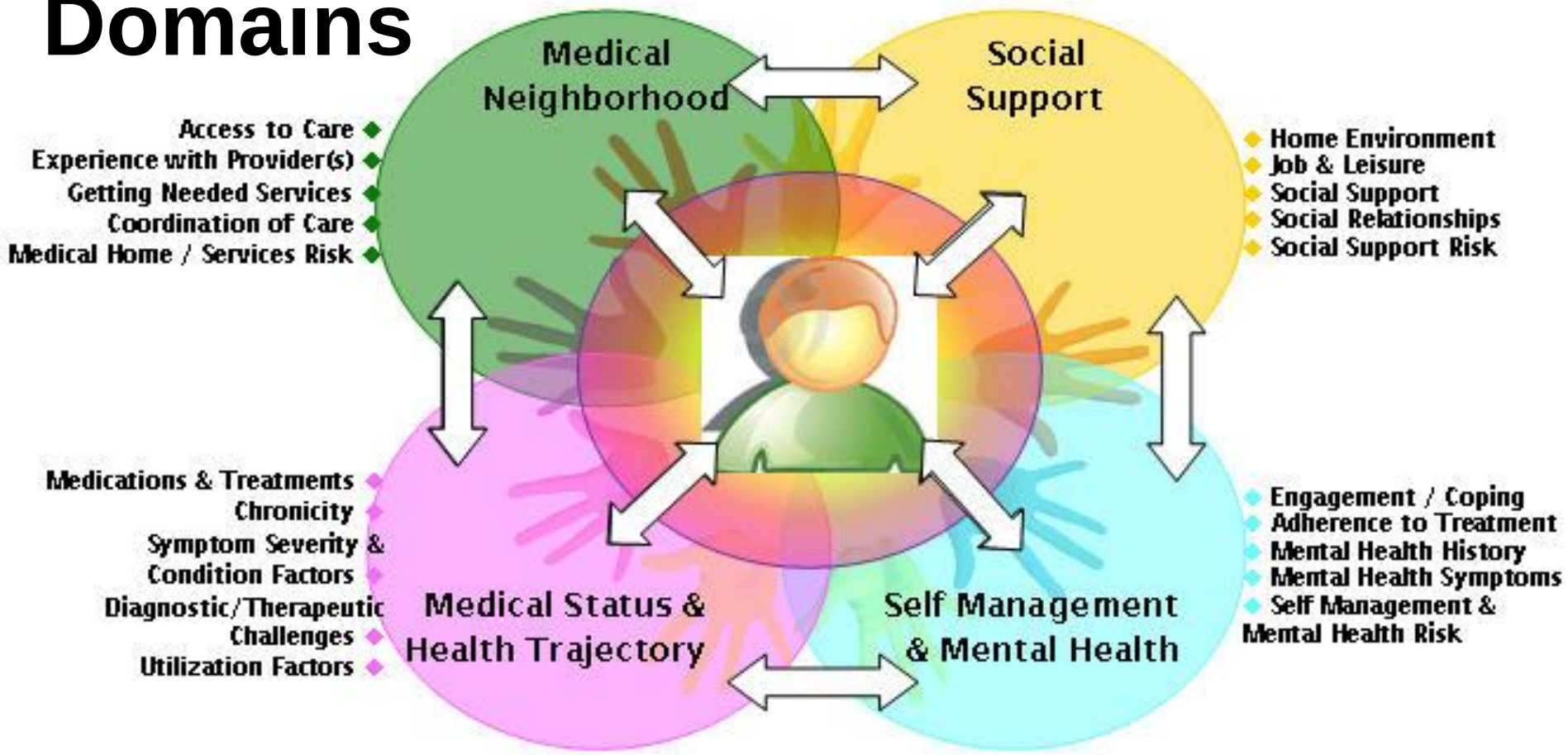
The **Patient Activation Measure® (PAM®)** assessment gauges the knowledge, skills and confidence essential to managing one's own health and healthcare.



Insignia Health Measure. Engage. Activate.

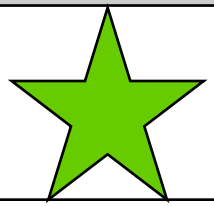
Patient Variation – what the patient faces

Domains



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

Domains: *"What to do?*
Patient Activation Measure: *"How to do it?"*

PAM / Domains	1	2	3	4
Social				
Access				
Behavioral				
Medical Trajectory				

Workflows based on patient variation

SCC Approach

- From:

  “What bothers you the most?

- To:

  “Where do you want to be in a year?”

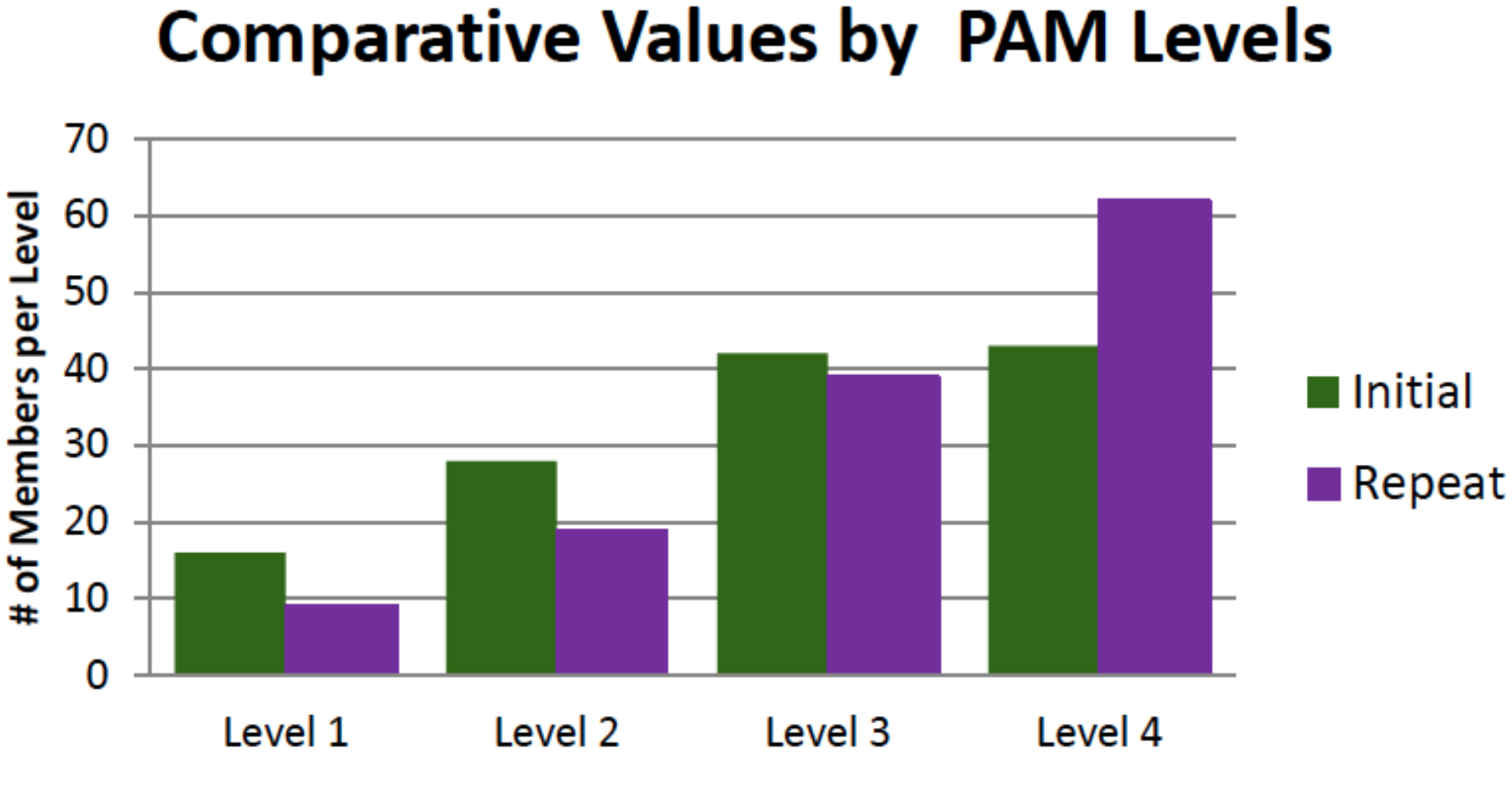
The Overarching Approach

The patient must…

- BELIEVE SELF-MANAGEMENT IS WORTHWHILE: The patient must feel there is hope and benefit in doing a good job (GOALS)

- KNOW WHAT TO DO: The patient must have a clear and achievable plan for self-management (ACTION PLANS)

Humboldt Priority Care PAM Results



How was this achieved?

3 Step Method

- Engage the patient
  - Their goals, not ours
- Determine importance
  - Why isn't it lower?
  - What would it take to make it higher?
- Action planning
  - What are you going to do tomorrow?
  - How confident are you that you can succeed with your plan?
  - What would increase your confidence?

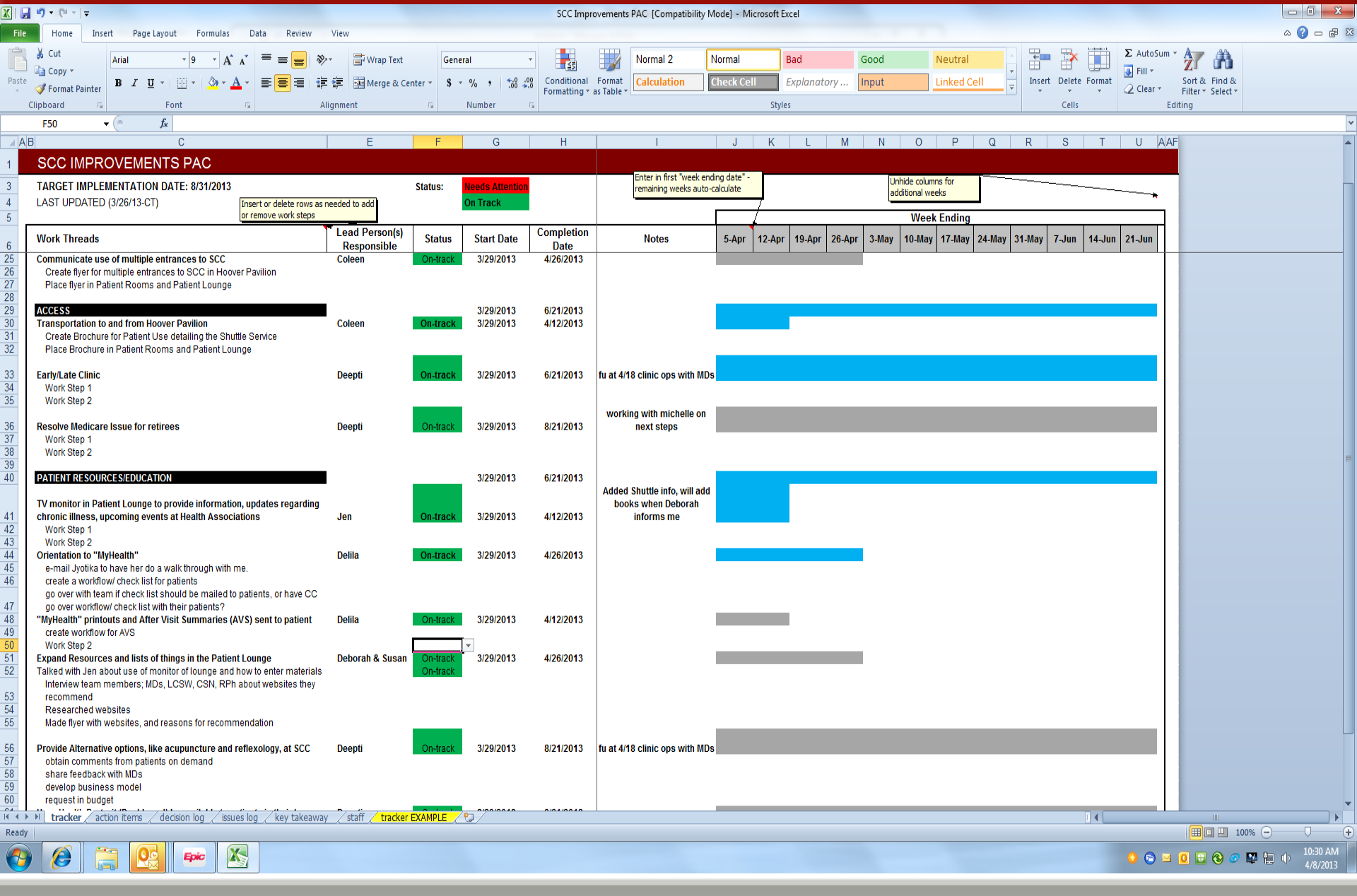
SCC Team

Team: 1.5 FTE MD, 1 RN, 1 LCSW, 0.6 FTE PT, 1 clinic manager, 1 data manager, 1 receptionist, 1 administrative assistant, 1 strategic planner, 3 care coordinators/medical assistants

GENERAL RULES FOR TEAM CARE

- Panel management:
  - SCC Care Coordinators have their own panel, handle med refills, referrals, scribe office visits and follow up with patient between visits
- Staff work to limits of their credential:
  - SCC Care Coordinators are responsible for getting routine care done.

Patient Partners



Care Coordinators

- Expanded MA role
- Who to hire?
- “Training up”
- Panel size - ~150
- Visit model:
  - Scribing the visit – ***no handoffs***
  - Arranging follow-up
- Responsible for:
  - Monthly “meaningful contact”
  - Action plan support
  - Care gaps
  - Refills

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Pain: Integrative Physical Therapy

- PT embedded in practice
- 40% of patients access service
- “Salutogenesis” vs. “Pathogenesis”
  - Asset-based approach
- Body scan – “Mindfulness”
- Feldenkreis approach
- Small steps towards goal
- Working with campus Wellness program

Patient Self-Management Barriers

- Social devastation (poverty, homelessness, lack of access to health care services, etc)
- Lack of information
- Cultural disconnect
- Low functional health literacy
- Relative lack of life skills
- ***Anxiety/disease-specific distress/depression***

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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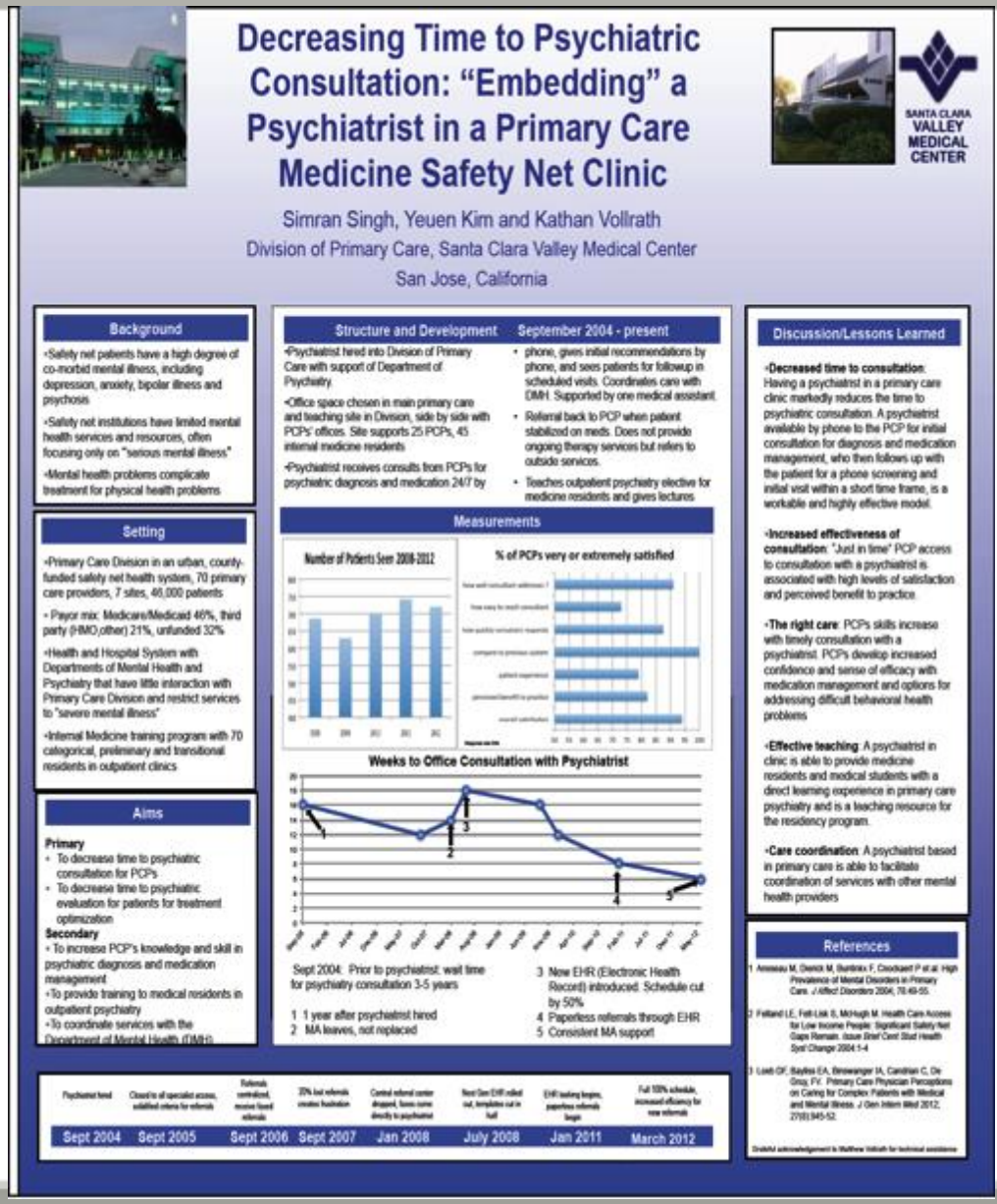
Integrating Behavioral Health

- Full-time LCSW on team
  - Sees 30% of patients
- Exploring embedded Psychiatrist within SCC
  - telephonic, email, and brief consultation model

(aspirational)



Decreasing Time to Psychiatric Consultation: "Embedding" a Psychiatrist in a Primary Care Medicine Safety Net Clinic

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Background

•Safety net patients have a high degree of co-morbid mental illness, including depression, anxiety, bipolar illness and psychosis

•Safety net institutions have limited mental health services and resources, often focusing only on "serious mental illness"

•Mental health problems complicate treatment for physical health problems

Setting

•Primary Care Division in an urban, county-funded safety net health system, 70 primary care providers, 7 sites, 46,000 patients

• Payor mix: Medicare/Medicaid 46%, third party (HMO,other) 21%, unfunded 32%

•Health and Hospital System with Departments of Mental Health and Psychiatry that have little interaction with Primary Care Division and restrict services to "severe mental illness"

•Internal Medicine training program with 70 categorical, preliminary and transitional residents in outpatient clinics

Aims

Primary
- To decrease time to psychiatric consultation for PCPs
- To decrease time to psychiatric evaluation for patients for treatment optimization

Secondary
- To increase PCP's knowledge and skill in psychiatric diagnosis and medication management
- To provide training to medical residents in outpatient psychiatry
- To coordinate services with the Department of Mental Health (DMH)

Structure and Development September 2004 - present

•Psychiatrist hired into Division of Primary Care with support of Department of Psychiatry.

•Office space chosen in main primary care and teaching site in Division, side by side with PCPs' offices. Site supports 25 PCPs, 45 internal medicine residents

•Psychiatrist receives consults from PCPs for psychiatric diagnosis and medication 24/7 by phone, gives initial recommendations by phone, and sees patients for followup in scheduled visits. Coordinates care with DMH. Supported by one medical assistant

- Referral back to PCP when patient stabilized on meds. Does not provide ongoing therapy services but refers to outside services.
- Teaches outpatient psychiatry elective for medicine residents and gives lectures

Measurements

Sept 2004: Prior to psychiatrist: wait time for psychiatry consultation 3-5 years

1 1 year after psychiatrist hired
2 MA leaves, not replaced
3 New EHR (Electronic Health Record) introduced: Schedule cut by 50%
4 Paperless referrals through EHR
5 Consistent MA support

Discussion/Lessons Learned

•**Decreased time to consultation**: Having a psychiatrist in a primary care clinic markedly reduces the time to psychiatric consultation. A psychiatrist available by phone to the PCP for initial consultation for diagnosis and medication management, who then follows up with the patient for a phone screening and initial visit within a short time frame, is a workable and highly effective model.

•**Increased effectiveness of consultation**: "Just in time" PCP access to consultation with a psychiatrist is associated with high levels of satisfaction and perceived benefit to practice.

•**The right care**: PCPs skills increase with timely consultation with a psychiatrist. PCPs develop increased confidence and sense of efficacy with medication management and options for addressing difficult behavioral health problems

•**Effective teaching**: A psychiatrist in clinic is able to provide medicine residents and medical students with a direct learning experience in primary care psychiatry and is a teaching resource for the residency program.

•**Care coordination**: A psychiatrist based in primary care is able to facilitate coordination of services with other mental health providers

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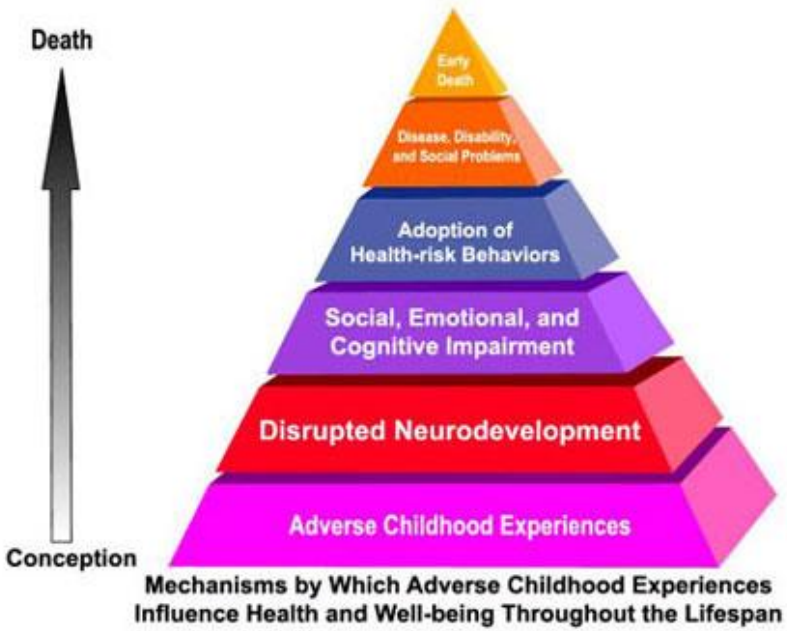
Grateful acknowledgement to Matthew Vollrath for technical assistance

The Often *Hidden* Driver:
Adverse Childhood Events & Trauma

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

Behaviors and Symptoms Associated with Trauma

- Layers of clothes
- Hypervigilence & hyper-reactivity
- Fear of shelters
- Not bathing
- Not willing to seek medical or dental attention
- Distrustful, especially of people in authority
- Aggressiveness
- Not taking medications
- Use of drugs and alcohol (self-soothing)
- Participation in the sex trade
- Self-destructive behavior
- Unable to focus on or plan for the future
- Suicidality

Our Conclusion

- As a population defined by poverty, Medicaid members are much more likely to represent a racial minority and have lived with social inequity most, if not all, of their lives

- The highest cost/highest acuity Medicaid recipients have multiple medical, social, and behavioral co-morbidities **BUT more importantly, the vast majority have experienced a lifetime of trauma with resulting health effects – estimate > 70%**

Trauma

"Adverse Childhood Experiences (ACE) are common, destructive, and have an effect that often lasts for a lifetime. *They are the most important determinant of the health and well-being of our nation."*

--Vincent Felitti, MD, co-chair of study

But are we really expected to eliminate poverty and homelessness, erase the effects of trauma, and address addictions and mental health instability?

- Where should we start?
- What is realistic given the tools we have?
- What new tools can we realistically add?

"Ambulatory Care Sensitive Conditions"

- **Defined by AHRQ (2001) as: "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early prevention can prevent complications or more severe disease."**
  - Based on analysis of Healthcare Cost and Utilization Project (HCUP) data
    - Federal-State-Industry large data system partnership
    - Identifies 16 **"Prevention Quality Indicators" (PQI)**
  - Markers / Indicators of Quality of Primary Care
    - Need to be "important"
    - Reliably measureable
    - Show non random variation

Ambulatory Care Sensitive Conditions

AHRQ "Prevention Quality Indicators"

- Diabetes, short-term complications
- Diabetes, long-term complications
- Uncontrolled diabetes
- Lower extremity amputations among patients with diabetes
- Chronic obstructive pulmonary disease
- Adult asthma
- Pediatric asthma
- Hypertension
- Angina without procedure
- Congestive heart failure
- Bacterial pneumonia
- Urinary infections
- Low birth weight
- Pediatric gastroenteritis
- Dehydration
- Perforated appendicitis

Why Are ACSC Hospitalizations Important?

- "In 2006, **nearly 4.4 million hospital admissions, totaling $30.8 billion in hospital costs, could have been potentially preventable** with timely and effective ambulatory care or adequate patient self- management of the condition."
  - About one of every 10 dollars of total hospital expenditures
  - $8.4 B for CHF; $7.2 B for Bacterial Pneumonia

- This is probably an under estimate…

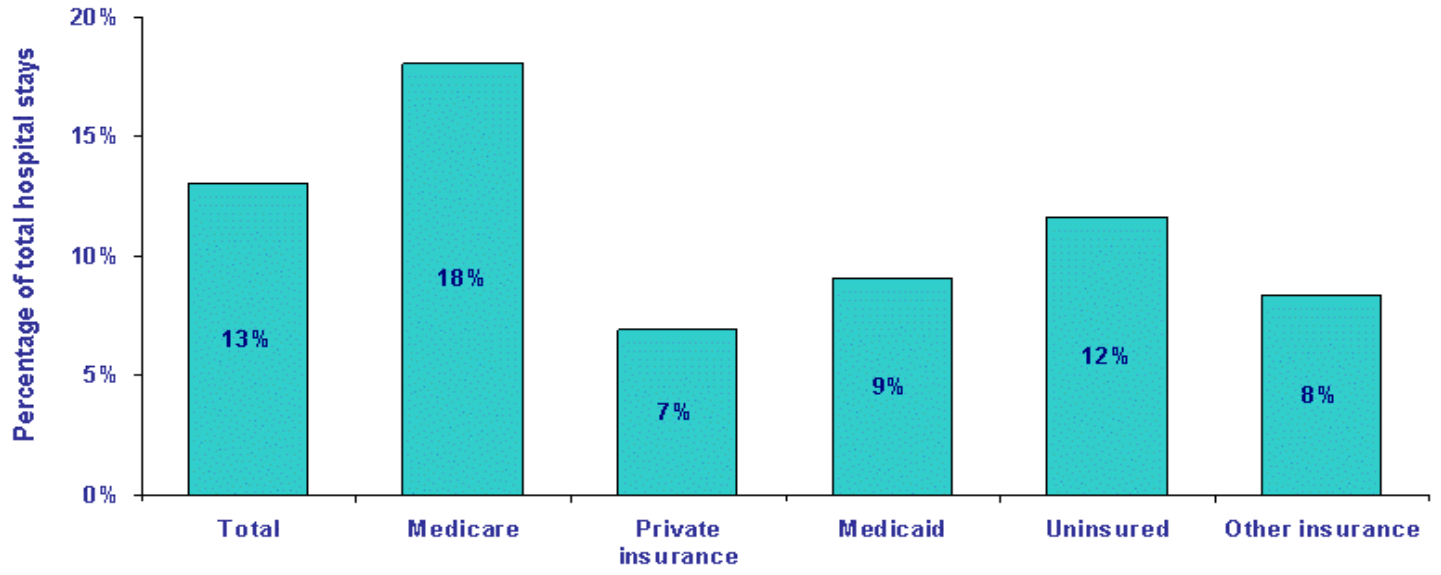
AHRQ Statistical Brief #72

- Poor experience of care – Sub Optimal Health – High Cost

- Shouldn't eliminating "preventable hospitalizations" be a core competence/ accountability of primary care ?

How Many Admissions Are "(AHRQ) Ambulatory Sensitive?"

Figure 2. Potentially preventable hospitalizations accounted for one in five Medicare stays (18 percent), as compared to only 7 percent of privately insured stays, 2006*



*Includes adult non-obstetric hospitalizations only
Source: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2006 and AHRQ Quality Indicators, version 3.1

How Many Admissions Are "(AHRQ) Ambulatory Sensitive?"

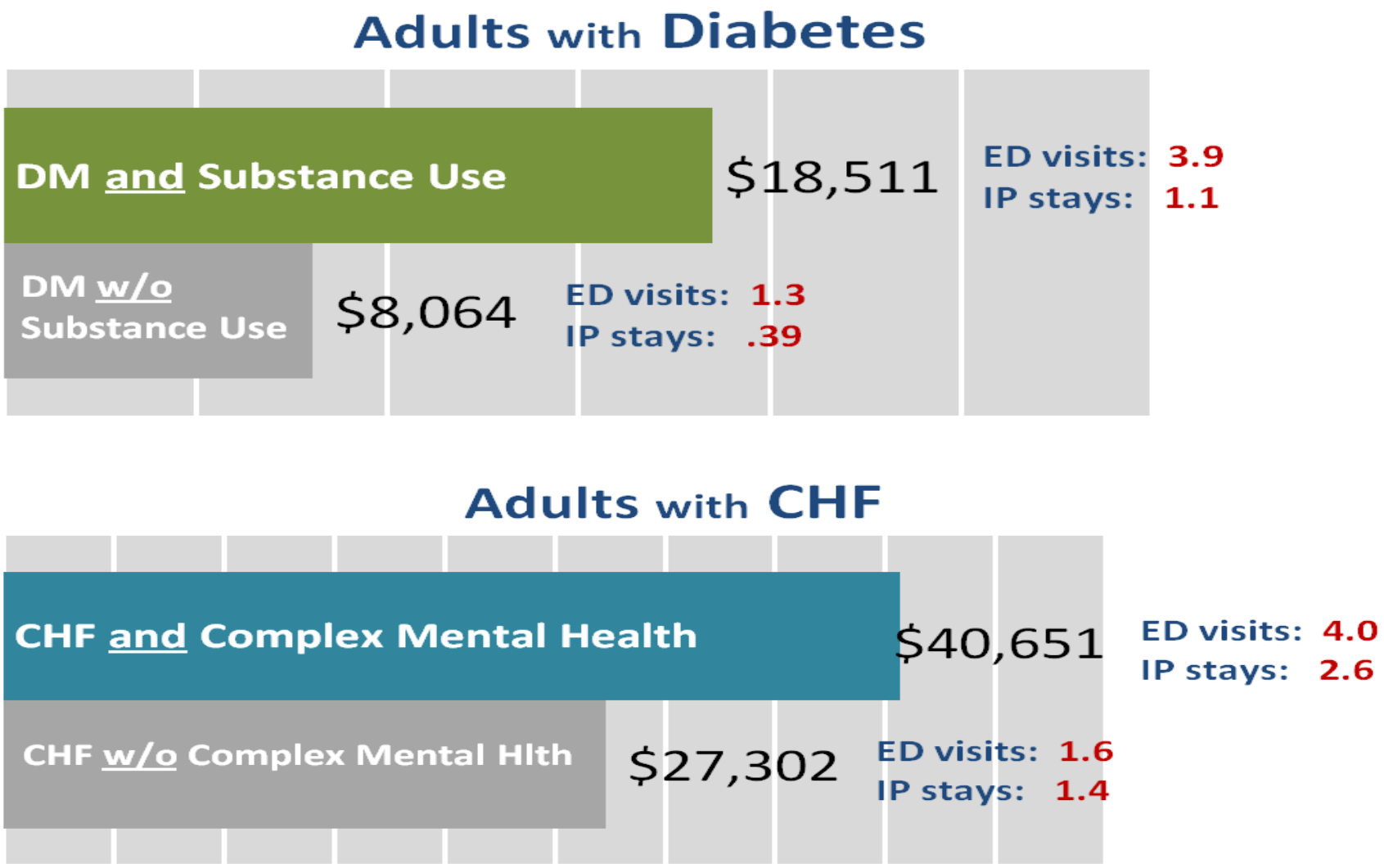
FIGURE 3: INCIDENCE OF ACSAS BY CONDITION

	ACSA PER 1,000	% OF CLASS
DIABETES SHORT-TERM COMPLICATION	0.3	0.5%
DIABETES UNCONTROLLED	0.3	0.5%
LOWER EXTREMITY AMPUTATION	0.7	1.3%
ANGINA	0.7	1.3%
HYPERTENSION	1.1	2.0%
ADULT ASTHMA	1.8	3.3%
DIABETES LONG-TERM COMPLICATION	2.4	4.3%
DEHYDRATION	4.0	7.1%
URINARY INFECTION	6.2	11.2%
COPD	6.6	11.9%
BACTERIAL PNEUMONIA	14.1	25.5%
CHF	17.6	31.8%
TOTAL ACSA	55.4	100.0%

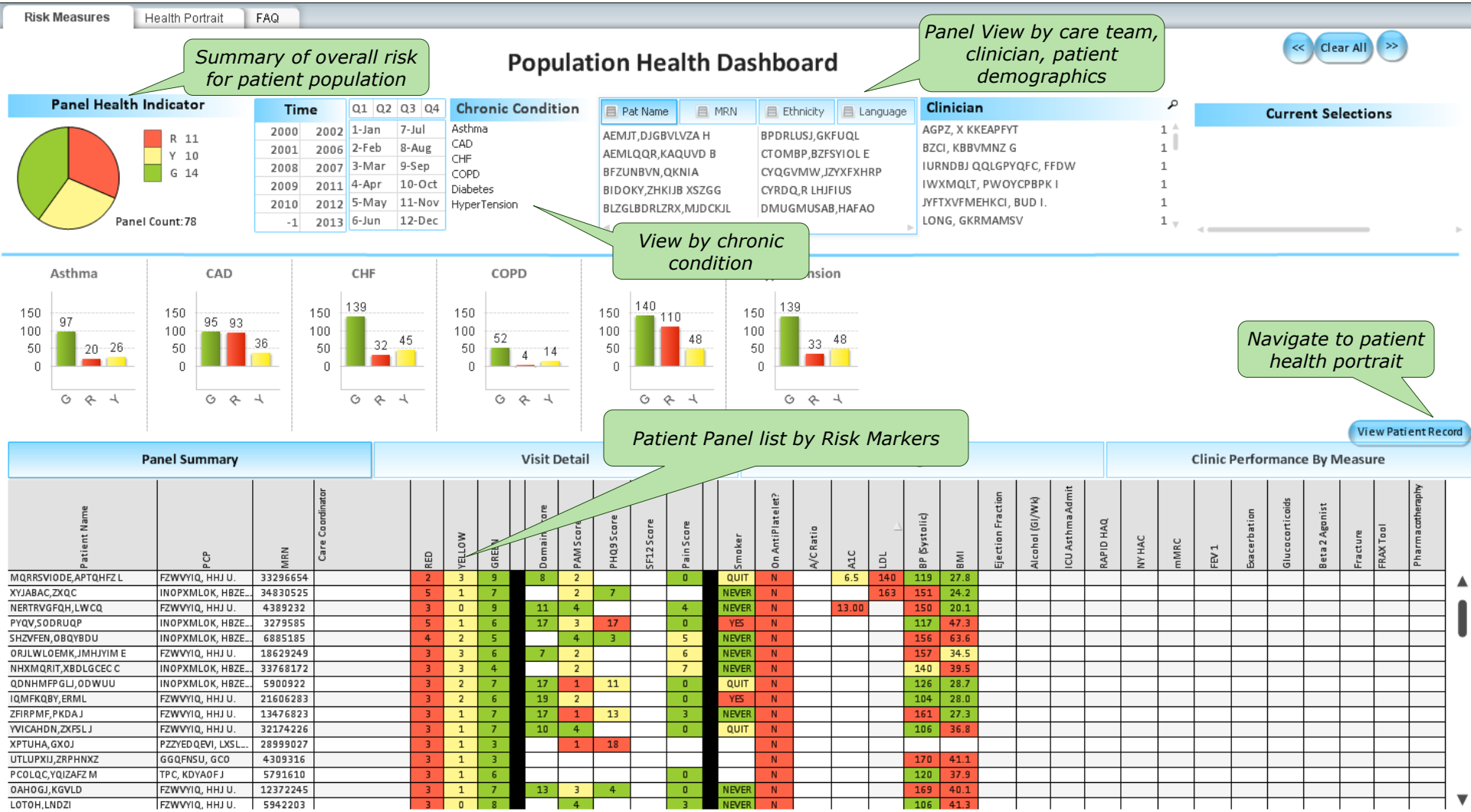
Data sources: Milliman analysis of Medicare 5% sample data, 2006; AHRQ Prevention Quality Indicators, version 3.2.

Effect of Substance Use and Mental Illness on Cost/Utilization

Average 12 months TOTAL cost, ED and Hosp utilization by group



Population Health – Risk Measures



Patient Name	PCP	MRN	Care Coordinator	RED	YELLOW	GREEN	Domain Score	PAM Score	PHQ9 Score	SF12 Score	Pain Score	Smoker	On Anti Platelet?	A/C Ratio	A1C	LDL	BP (systolic)	BMI	Ejection Fraction	Alcohol (G/Wk)	ICU Asthma Admit	RAPID HAQ	NY HAC	mMRC	FEV 1	Exacerbation	Glucocorticoids	Beta 2 Agonist	Fracture	FRAX Tool	Pharmacotherapy
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, KDYAOF J	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													

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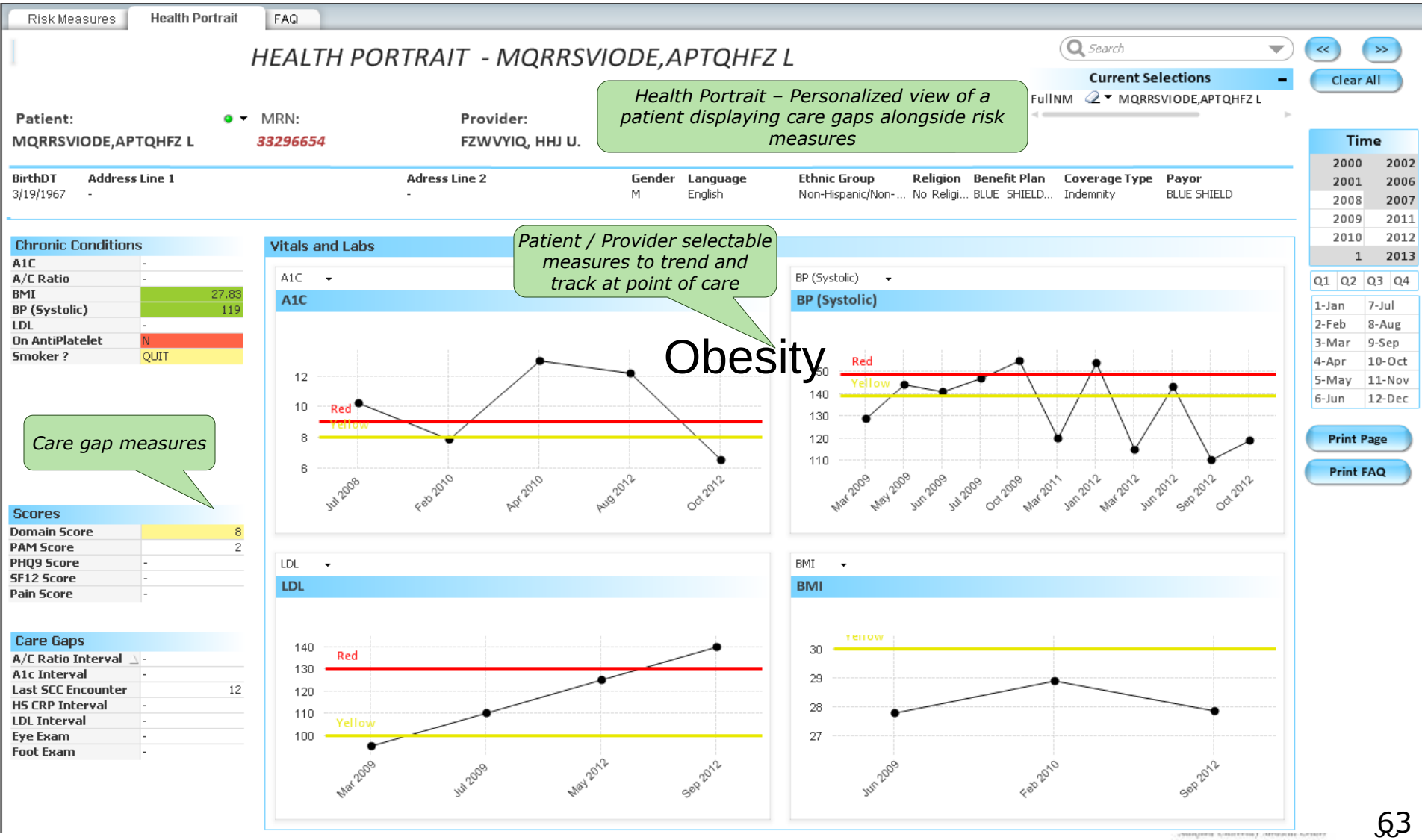
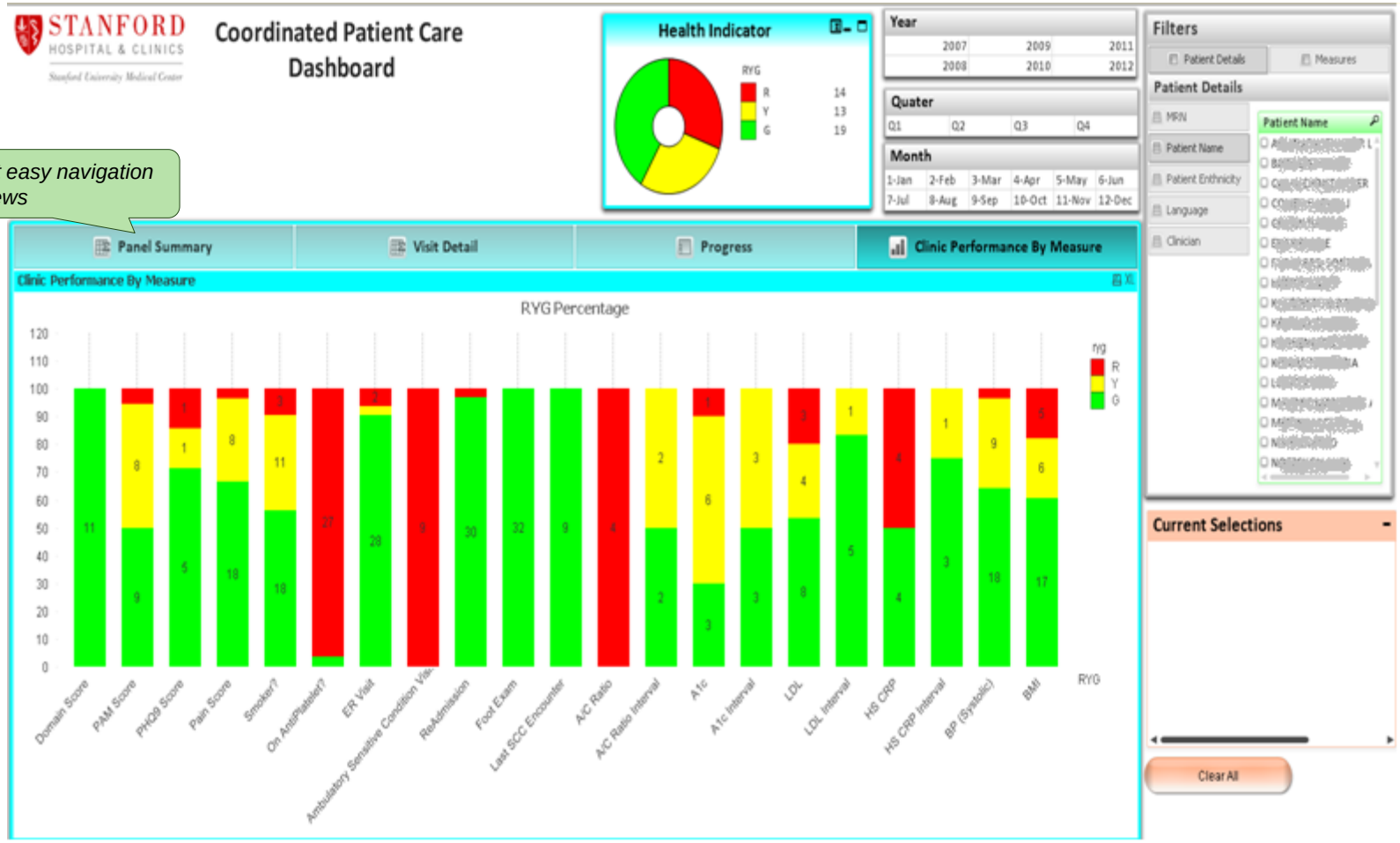
Population Health – Health Portrait



SCC – Reducing Clinical Variation

Assessment panel of SCC patient population by health measure and risk level



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Thank You!

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