Quality and Productivity Commission

29th Annual Productivity and Quality Awards Program

Champions of Change: Together We Make a Difference

2015 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: EXPANSION OF PULMONARY SERVICES

DATE OF IMPLEMENTATION/ADOPTION: JANUARY 01, 2014
(Must have been implemented at least one year - on or before July 1, 2014)

PROJECT STATUS: X Ongoing _____ One-time only

HAS YOUR DEPARTMENT PREVIOUSLY SUBMITTED THIS PROJECT? _____ Yes X No

EXECUTIVE SUMMARY: Describe the project in 15 lines or less using Arial 12 point font. State clearly and concisely what difference the project has made.

Previously, many of our patients obtained services through uncoordinated efforts resulting in at times fractured care due to an inconsistent relationship and failure to see the Division of Pulmonary/Critical Care (PCC) as an extension of the patient's medical home. In collaboration with Ambulatory Care Network's Research and Innovation Department (ACN R&I), we have applied its asthma disease management (A-DMP) team-based care and coordination to expand services to this division by establishing disease-specific clinics such as the Pulmonary Hypertension (PH) and Interstitial Lung Disease (ILD) clinics. As a result, wait times for the general pulmonary clinic decreased from 5-6months to 6-9 weeks for non-emergent follow-up and from 2-3 months to 1-2 weeks for emergent and post-discharge follow-up. Clinic show rates also improved, analysis of data 6 months prior to implementation of these changes saw a show rate from an average of 62% of patients of non- A-DMP clinics to a consistent average show rate of 75% for A-DMP clinics, an increase of approximately 13%. Furthermore, preliminary data shows decreased inpatient hospital and ER visits by an average of 2 days for those enrolled in the Pulmonary Hypertension Program.

(1) ACTUAL/ESTIMATED ANNUAL COST AVOIDANCE	(2) ACTUAL/ESTIMATED ANNUAL COST SAVINGS	(3) ACTUAL/ESTIMATED ANNUAL REVENUE	(1) + (2) + (3) = TOTAL ANNUAL ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
$	$	$	$	X

ANNUAL = 12 MONTHS ONLY

SUBMITTING DEPARTMENT NAME AND COMPLETE ADDRESS	TELEPHONE NUMBER
Division of Pulmonary/Critical Care Medicine Olive View-UCLA Medical Center 14445 Olive View Drive, 6C-111, Sylmar, CA 91342	818-364-4427
PROGRAM MANAGER'S NAME Catherine Reyes, NP	**TELEPHONE NUMBER** 818-364-3704 catreyes@dhs.lacounty.gov
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE (PLEASE CALL (213) 893-0322 IF YOU DO NOT KNOW YOUR PRODUCTIVITY MANAGER'S NAME) Gerardo Pinedo **DATE** 7/9/2015	**TELEPHONE NUMBER** 213-240-8104
DEPARTMENT HEAD'S NAME AND SIGNATURE MITCHELL KATZ, M.D. **DATE** 7/9/2015	**TELEPHONE NUMBER** 213-240-8101 MKATZ@dhs.lacounty.gov

We Support Plain Language

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1st FACT SHEET – LIMITED TO 3 PAGES ONLY: Describe the **Challenge, Solution, and Benefits** of the project. State clearly and concisely what difference the project has made. Use Arial 12 point font

The Challenge: To transform pulmonary services at OV-UCLA Medical Center by investing and integrating care in the outpatient setting without added cost to the institution. This is to be achieved by providing a full scale service center that specializes in disease-specific illnesses, treating high acuity pulmonary illnesses and complete certain procedures to negate the necessity of having inpatient stays, ER or urgent care visits and to improve the overall patient experience. Previously, many of our patients obtained services through uncoordinated efforts resulting in at times fractured care due to an inconsistent relationship and failure to see the Division of Pulmonary/Critical Care (PCC) as an extension of the patient's medical home. Cultivating patient relationships and committing to a patient-centered approach while broadening and enhancing our services thus became a priority. The goal was to improve clinical and operational outcomes in an efficient manner without adding additional resources but rather streamlining the process by collaborating and engaging in a cooperative arrangement between the Department of Medicine's PCC Division and ACN R&I's Asthma Disease Management Program (A-DMP).

The Solution: The A-DMP is composed of a multidisciplinary group of committed individuals whose aim is to provide better care while reducing the costs of the episodic nature of this disease. The program targets patients with the most severe symptomatology since by its nature, it necessitates attention to and requires coordination of care to better manage the patient's condition and lower the cost of impact on the institution by using evidence-based practice. The team consists of a physician (MD) and nurse practitioner (NP) as lead team member with the registered nurse (RN), nursing assistant (NA), social worker (SW) and community worker (CW) as the supporting care team. The care team essentially fills in any gaps for the lead providers such as the need for remote patient monitoring or referral to community resources to help manage their disease. Routine feedback between the patients and the A-DMP is necessary to assure that the patients are managing their conditions and receiving the care that they need. This approach was replicated and translated into practice for the expansion of pulmonary services at OV-UCLA Medical Center. Both PH and ILD clinics were established separate of the general pulmonary clinic already in existence. Involvement in bimonthly multidisciplinary case conferences attended by pulmonologists, thoracic radiologists, thoracic surgeons, and pulmonary pathologists was included as part of care coordination to obtain an individualized approach to the patient's treatment plan. In addition, integration of services involving other departments and divisions such as Cardiology and Interventional Radiology was achieved via a feedback loop either through direct communication, eConsult (system used to refer patients to specialists) or through case conferences with the providers. No additional resources were acquired. With the NP as the lead program facilitator

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And directing the supporting care team proper tasks and workload, a seamless process was developed in coordinating care for these patients. Frequent communication between the providers, care team and involved departments were relayed to the patient either during their clinic visits or via phone calls. By using the team based approach, frequent feedback and easy access to the care team, patients began to identify the PCC as an extension of their medical home. Patients became invested in their treatment plans as they saw themselves to be informed partners in their health decision-making. This in turn improved patient care by streamlining continuity of care between the outpatient and inpatient setting.

The Benefits: This expansion of services has resulted in improved access to specialty care, improved clinic show rates, reduced clinic wait times, and reduced hospitalization and emergency room visits for patients enrolled in the Pulmonary Hypertension Program. In addition, as part of our commitment to excellence in patient care and education, we routinely bring together local, regional and national experts, thereby providing our medical professionals with a unique opportunity to learn about the most recent advancements in the diagnosis and treatment of such disorders. This new multidisciplinary team-based approach allowed providers to easily share information with each other, including patient health status, clinical information and case management notes to keep the lines of communication open and ultimately benefit the patient. Establishment of both the ILD and PH clinics also resulted in decreased scheduling wait times for the general pulmonary clinic from 5-6months to 6-9 weeks for non-emergent follow-up and from 2-3 months to 1-2 weeks for emergent and post-discharge follow-up if needed. Clinic show rates also improved which is attributable to the patient identifying with a dedicated care team for their health needs. Analysis of data 6 months prior to implementation of these changes saw a show rate from an average of 62% of non-A-DMP clinic patients to a consistent average show rate of 75% for A-DMP clinics, an increase of approximately 13%. Though not enough to show the full scale benefits of ER and hospitalization visits due to its premature establishment, preliminary data show decreased inpatient hospital and ER visits by an average of 2 days for those enrolled in the Pulmonary Hypertension Program. Providing a team-based patient-centered disease management approach to the expansion of pulmonary services at OVMC strengthened the patient-provider relationship allowing for a more efficient and robust infrastructure in the outpatient setting.

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LINKAGE TO THE COUNTY STRATEGIC PLAN (DETAIL IS REQUIRED FOR COUNTY DEPARTMENTS): Use Arial 12 point font

The project is linked to the following strategic goals:

1) Operational Effectiveness/Fiscal Sustainability: Maximize the effectiveness of processes, structure, operations, and strong fiscal management to support timely delivery of customer-oriented and efficient public services.

2) Integrated Services Delivery: Maximize opportunities to measurably improve client and community outcomes and leverage resources through the continuous integration of health, community, and public safety services.

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COST AVOIDANCE, COST SAVINGS, AND REVENUE GENERATED (ESTIMATED BENEFIT): If you are claiming cost benefits, include a calculation on this page. You must include an explanation of the County cost savings, cost avoidance or new revenue that matches the numbers in the box. Remember to keep your supporting documentation. Use Arial 12 point font

Cost Avoidance: Costs that are eliminated or not incurred as a result of program outcomes.

Cost Savings: A reduction or lessening of expenditures as a result of program outcomes.

Revenue: Increases in existing revenue streams or new revenue sources to the County as a result of program outcomes.

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$	$	$	$	X

ANNUAL= 12 MONTHS ONLY

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