
**Jefferson County Public Hospital District No.2
Board of Commissioners Special Session Agenda
October 06, 2017
Northwest Maritime Center– Port Townsend
431 Water St, Port Townsend, WA 98368**

Swedish Health Network Annual Symposium:

Present from Jefferson Healthcare were Commissioner Jill Buhler, Chair, Commissioner Marie Dressler, Secretary, Commissioner Tony De Leo, Kees Kolff, and Matt Ready, CEO Mike Glenn, Chief Medical Information Officer Corey Asbell, Chief Medical Officer, Dr. Joe Mattern, Brandie Manuel, Chief Patient Care Officer, Jennifer Wharton, Chief Ambulatory and Medical Group Officer, Lisa Holt, Chief Ancillary and Specialty Services Officer, and Caitlin Harrison, Chief Human Resources Officer.

Present from Olympic Medical Center were Commissioner, Jim Leskinovitch, President, Commissioner Jean Hordyk, Secretary, Commissioner Tom Oblak, Jim Cammack, and John Beitzel, CEO Eric Lewis, Jennifer Burkhardt JD, GPHR, Labor and Employment Council, Lorraine Wall, Chief Nursing Officer, Mark Fischer MD, Med Exec, Member at Large, Bobby Beeman, Manager, Communications, Kara Urnes, MD, OMP Physicians Council, Vice-Chair, and Gay Lynn Iseri, Executive Assistant.

Present from Swedish Health Network and Providence were Heidi Aylsworth, Chief Strategic Officer, Swedish, Tami Bloom, Sr. Business Development Specialist, Swedish, Arti Chandra, Physician, Family Medicine, SMG, Kathleen Daman, Clinical Program Manager, TeleHealth, Swedish, Kristen Federici, Director, Government and Public Affairs, Providence, Suzanne Gallant, Clinical Program Coordinator, TeleHealth, Swedish, Guy Hudson, CEO, Swedish, I-Nong Lee, Sr. Project Manager, Swedish, Jim Martin, Chief Medical Officer, SMG, Lauren Platt, Manager, Government and Public Affairs, Providence, Jesse Todhunter, Director Physician Network, TeleHealth, Swedish, Scott Marshall, Account Manager, Community Connect, Providence, Gillian Ehrlich, ARNP, Family Nurse Practitioner, SMG.

Heidi Aylsworth, Chief Strategic Officer, SHS, and Providence Western Washington and CEO Mike Glenn, Jefferson Healthcare welcomed attendees and introductions were made.

Arti Chandra, MD, SMG and Gillian Ehrlich, DNP, ARNP, SMG presented on Functional Medicine and the principles of functional medicine, and leveraging with Population Health Management.

Following a ten minute break CEO, Mike Glenn, Jefferson Healthcare, CEO Eric Lewis, Olympic Medical Center, and CEO Guy Hudson, MD, Swedish Health Systems provided organizational updates.

Following an hour lunch Kristen Federici, Director, Government and Public Affairs and Lauren Platt, Manager, Government and Public Affairs lead an advocacy discussion regarding the current environment and the effects and impacts on rural communities.

Following a ten minute break James Martin, MD Chief Medical Officer, Swedish Health Systems lead a discussion on physician engagement.

Heidi Aylsworth, Chief Strategy Officer, SHS & Providence Western Washington and CEO Mike Glenn, Jefferson Healthcare provided closing remarks.

Meeting concluded at 3:09pm.

Approved by the Commission:

Chair of Commission: Jill Buhler _____

Secretary of Commission: Marie Dressler _____

Advocacy Discussion

Presented by

Kristen Federici, Director, Government Affairs – WA & MT, PSJH Government & Public Affairs
Lauren Platt, Program Manager, State Advocacy – WA & MT, PSJH Government Affairs

How we engage in policymaking and implementation

Legislative process

The advocacy team works with executives, clinical and administrative leaders and experts to carry out advocacy strategy

Congress or state legislature passes a bill to enact a policy in statute

Regulatory process

The advocacy and regulatory team works with multiple departments and experts to determine impact and inform comments and other responses, including external advisory roles

A problem or tension motivates advocacy to change or create a policy

Federal or state agency proposes rule to implement law

Implementation and compliance process

The advocacy team works with multiple departments to inform the start of compliance

Stakeholder must comply with new regulations. Agency may publish extra guidance.

Following public comment, federal or state agency codifies final rule



SWEDISH



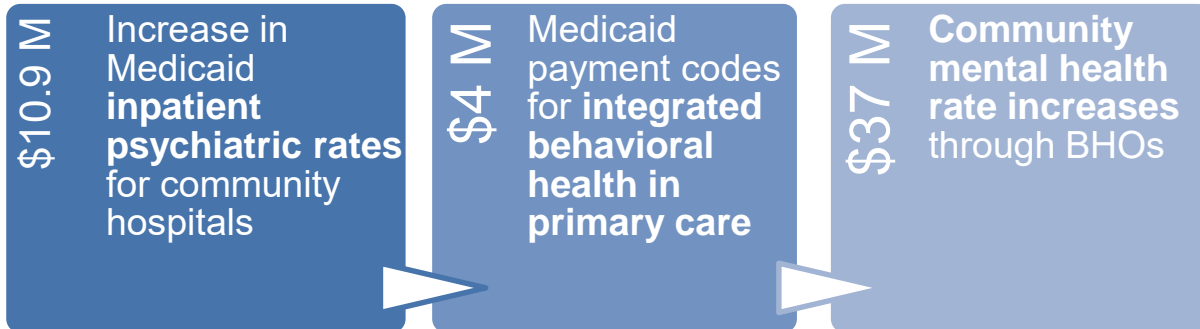
Providence
St. Joseph Health

STATE POLICY CONTEXT

State Advocacy Context & Results

Budget approved – state government shutdown avoided

- Longest legislative session in state history
- Divided control made it difficult for bills to pass without bipartisan support
- \$43.7 billion operating budget for 2017-2019 approved midnight June 30th
- Approved HCA spending of 1115 Medicaid Waiver dollars of \$1.3 billion
- Hospital Safety Net Assessment extended for two more years
- No cuts to outpatient clinic fees
- Included significant investments in Behavioral Health supports



Looking ahead – challenging policy environment

- **Potential for balance of power to shift** in the Senate
- Recent spotlight on **hospital charity care policies**
- Legislative interest in solving **balance billing issue**
- Regulation over **mergers and affiliations**
- Short 2017 interim and short session in 2018 limits timeline for advocacy

Overall – could put hospitals on the defense

Looking ahead – opportunities

- **Medicaid funding and innovation** highlighted as a major state priority
 - Pursuing innovative partnerships at community and state levels
 - Leveraging our partnerships, size, scope, data resources, and community benefit strategy to speak with, and on behalf of, the poor and vulnerable
- **Behavioral health** continues to be a priority
 - Legislative interest in community supports
 - Partial hospitalization programs to prevent inpatient stays
 - Boarding still an issue
- **Long length of stay patients:** gaining momentum, but no easy solution
- Commitment to ensure access to health care in rural communities
- Telehealth expansion and policy can continue bridging resource gaps

FEDERAL POLICY CONTEXT

The Big Issue at Hand: ACA reform

What's at stake

- A total of **20 million*** newly insured individuals gained coverage under the ACA
- **Over 750,000 Washingtonians** gained coverage through Medicaid expansion
- Latest Senate Medicaid reform proposal would have **reduced federal health care spending supporting Washingtonians by \$110 billion** between 2020 and 2036
- PSJH advocacy is focused on preservation of ACA coverage gains and stability in private insurance market and provider reimbursement

What ACA repeal could mean to our health partners

1. **Fewer people would be insured**, would affect providers ability to deliver care and dramatically increase uncompensated care levels.
2. **Insurers could cover fewer health services**, would force patients to pay more out of pocket.
3. **Patients might have to pay for more services out-of-pocket** because the ACA's limits on out-of-pocket costs might be removed in some states.
4. **Quality of care would suffer**, it would be more difficult to continue our population health model that emphasizes preventative care, overall well-being and mental health care.

ACA Repeal – beyond the legislative process

Strategies to “undo” the ACA exist outside of legislative action, and include:

1. Cutting off cost-sharing subsidy payments to health insurers
2. No longer enforcing the individual mandate
3. Giving states more freedom in defining “essential health benefits”
4. Redefining the EHBs by tweaking definitions of the 10 broad benefit categories
5. Letting states experiment through waivers
6. Letting the back-end architecture crumble (exchange websites, helpline staffing, enrollment outreach, etc.)

How we are responding

Government affairs continues the all out advocacy push in opposition to detrimental repeal efforts in partnership with Population Health and Communications teams

- **Grassroots mobilization:** PSJH grassroots campaign in WA, OR, MT, AK, and CA has netted more than 7,000 emails from caregivers to U.S. senators in those states, urging them to oppose the Graham-Cassidy bill.
- **Traditional media:** National and regional media plans have been launched and regional leaders have been provided with a media toolkit and talking points to engage proactively with local media.
- **Direct advocacy:** Direct contact with our legislators via strategic executive visits to Capitol Hill has yielded effective partnerships.
- **Social media:** Population Health and Communications are partnering on a social media strategy to compliment our traditional media strategy.

Other priority issues

- 340(b) drug pricing program
 - 14 hospitals saving \$73 million in Washington under current program
 - Would see a **\$19.5 million reduction** if proposed rule passes
 - Proposed cut would not impact critical access hospitals
- Future of value-based payments
 - bundled payment models & alternative payment models
- Mental health – regulatory issues impacting information sharing

Looking ahead: general policy environment

Debate over the size of government

Shrinking role of government in social safety net
→ **crucial role for hospitals** in the community



Regulatory flexibility

- Reporting requirements and quality metrics
- Mandatory → voluntary programs

Getting engaged



- Relationships with legislators at home
- Visits to the legislature and Congress
- Ongoing communication about impacts of policy
- Partnerships with other health providers to magnify our voice

Questions?

Contact your state government affairs team:

Kristen Federici, Director – Kristen.federici@providence.org

Lauren Platt, Manager – lauren.platt@providence.org



Functional Medicine: an Emerging Field in 21st Century Medicine

Arti Chandra MD, MPH

Gillian Ehrlich DNP, ARNP

Institute for Functional Medicine Certified Practitioners

Swedish Health Network Annual Symposium

October 6, 2017

Objectives

- Describe the basic principles and components of the Functional Medicine model in part through sharing patient stories
- Describe how Functional Medicine can address the need for new approaches to addressing complex, chronic diseases
- Describe how the Functional Medicine operating system can be applied in primary care



MIGRAINES

FATIGUE

OSTEOPOROSIS

OBESITY

DEPRESSION

ARTHRITIS

CANCER

HEART DISEASE

ACID REFLUX

ANXIETY

DIABETES

MENOPAUSE

HIGH BLOOD PRESSURE

STROKE

IMPOTENCE

CONSTIPATION

METABOLIC SYNDROME

ASTHMA

HIGH CHOLESTEROL

FATTY LIVER DISEASE

INFERTILITY

CASE STUDY - Deborah

- 55 y/o female w/ 5 year hx of progressive muscle aches and joint pains, painful swollen feet (unable to walk for more than an hour); GI sx's of bloating, pain, IBS; notable fatigue/exhaustion with even simple activities now; progressive slow weight gain
- PMH: HTN, Hypothyroidism, weight gain
- SHx, FHx: non-contributory

CASE STUDY - Deborah

- Multiple visits to multiple PCPs over the years
- Referral to rheumatologists, GI, endocrinology over the years
- Laboratory, imaging, GI testing all unremarkable
- Given various diagnoses of IBS, fatigue, joint pains/MCTD, fibromyalgia, Sjogren's, and ultimately depression.
- No longer able to engage in many of the activities that gave her joy

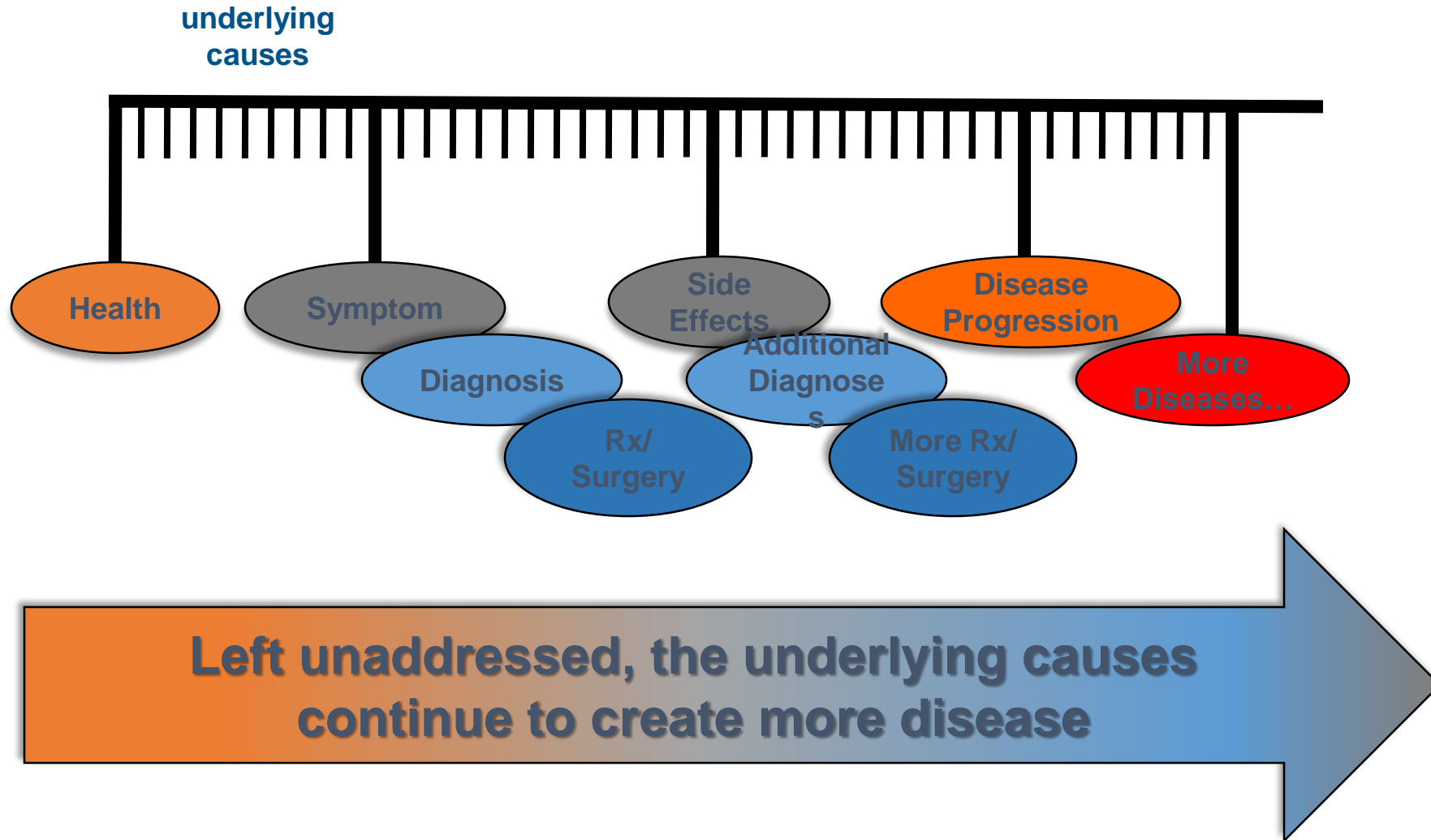
Deborah: Medications and Supplements

- Prescriptive:
 - Diclofenac (after several other NSAIDs)
 - Cyclobenzaprine nightly
 - Ambien
 - PPIs
 - Dicyclomine
 - Duloxetine
 - Hydromorphone prn
- Non-prescriptive:
 - MVI, calcium

Conventional Medicine

- Medicine of Symptoms and Diseases
- Based on ICD-10 Classifications:
 - Start with the Presenting Symptom
 - give it an ICD-10 Diagnosis Code
 - Corresponding drug Rx
 - Possible incomplete resolution, Side effects
 - over time there can be more Diagnoses
 - More Rx's
 - Specialist Referrals, Dx, Rx...

The Conventional Path



Condensed Conventional Medicine Approach

- Often very limited history-taking (limited time, clinic pressures, etc)
- Common Labs: CMP, Arthritis Panel, CBC, TSH – often normal
- Possible XRs/Imaging – often normal
- Initiation of Drug Rx:
NSAIDs, PPI, Dicyclomine, Sleep Meds.....SSRIs,
- If above not helpful, referral(s) to GI, Rheum, Endo.....Psychiatry
- More testing, additional Rx's such as Immunomodulators

Condensed CM Approach

- Often, with each specialty, if there is no significant response to Tx and no clear findings with w/u → refer back to PCP w/o dx or helpful plan
- Patient is often left with continued chronic Sx and no understanding of why these Sx exist and how to address the causes
- Pt may end up on a “vicious cycle” of meds and tests hopping from silo to silo

The background of the slide is a photograph of several large, cylindrical industrial silos or storage tanks. They are made of metal and have various pipes, ladders, and platforms attached to them. The sky is clear and blue. Overlaid on this image are five dark blue rectangular boxes, each containing a medical specialty in white capital letters. The specialties are arranged in a staggered, overlapping fashion: 'RHEUMATOLOGY' is at the top center, 'PSYCHIATRY' is to its right, 'CARDIOLOGY' is to its left, 'GI' is below 'RHEUMATOLOGY', and 'NEUROLOGY' is at the bottom center.

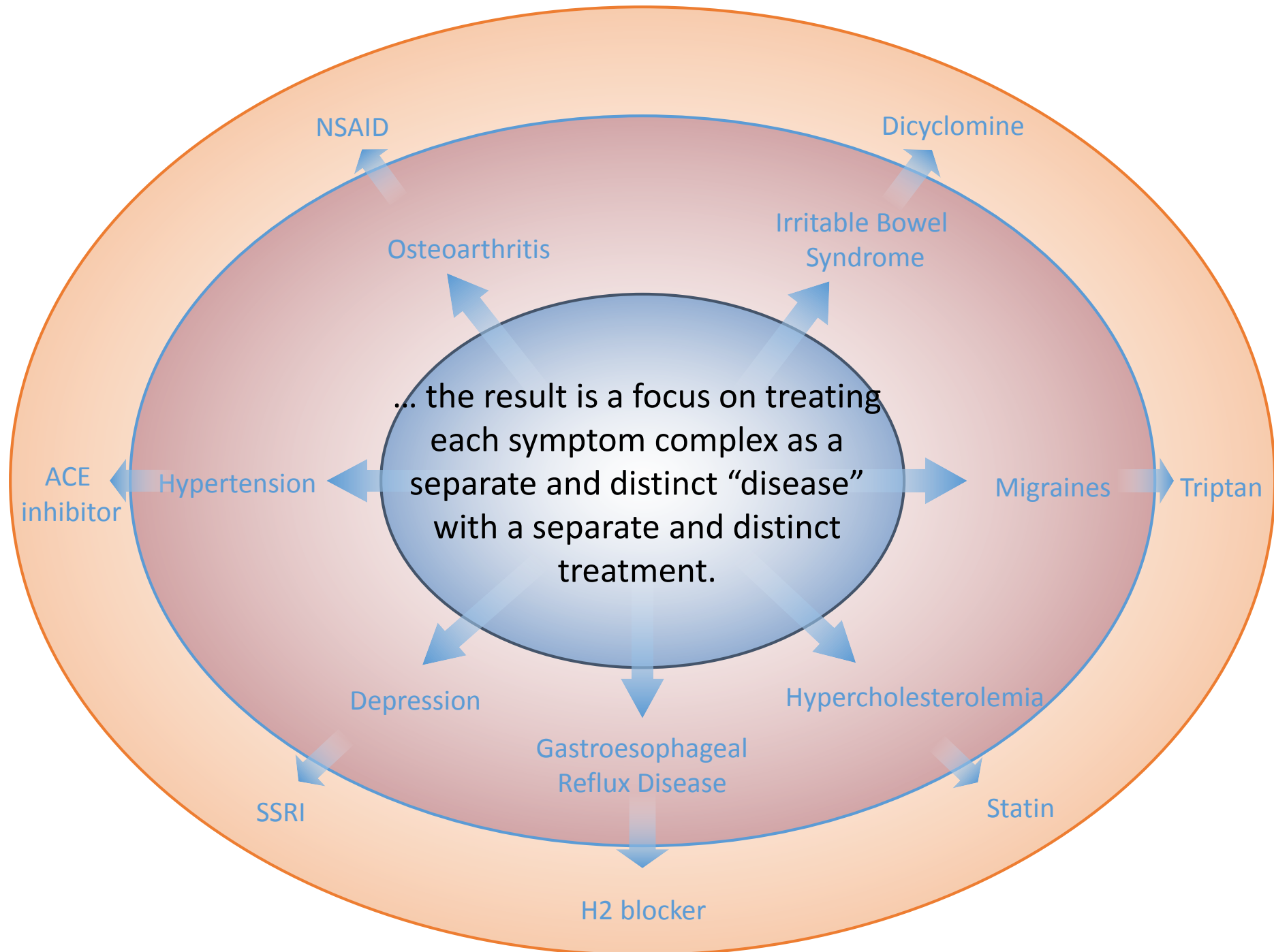
CARDIOLOGY

RHEUMATOLOGY

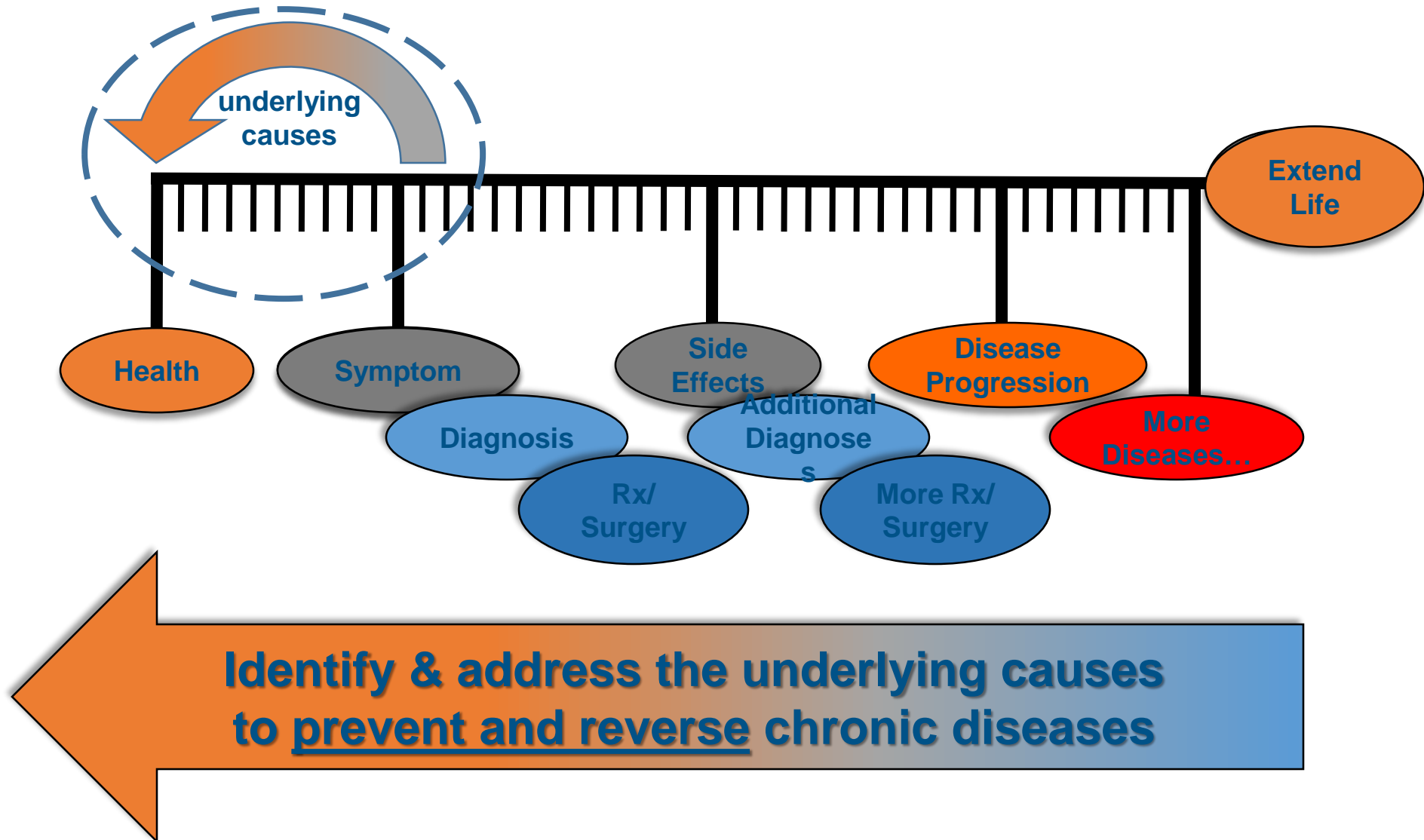
PSYCHIATRY

GI

NEUROLOGY



The Functional Path



Functional Medicine

Key Points

Rooted in Science

Medicine of **causes** (systems biology, systems medicine)

- A move away from the "name it, blame it and tame it" approach to symptoms and disease
- what are the things that disturb system function?
- what are the things that normalize system function?

Restore balance to the system

Biochemical Individuality – genomic and environmental

Patient-centered treatment

How do I partner with this patient to help them reach their individual goals?

Deborah: The FM Deeper Dive

- Born NSVD, not breastfed, colicky baby
- Tonsillectomy as a child
→ multiple abx courses
- Hx of UTI's – teens and adulthood → abx
- Lots of vaginal yeast infections over the years
- Acid Reflux symptoms → PPIs
- IBS/diarrhea, frequent bloating/gas – worse after PPIs
- Intermittent Asthma/SOB symptoms/weakness
- Chronic intermittent headaches
- Disturbed sleep most nights – even with Rx
- Daily fatigue/energy crashes – worse after PPIs

Deborah: Family History

- Mother: Hypothyroid, Arthritis, Migraines
- Father: HTN, CABG age 64, Colon Polyps
- Brother: HTN, Obesity, Type 2 DM
- Family/Social environment: nurturing, poor diet, lots of financial stress, no notable emotional/physical trauma

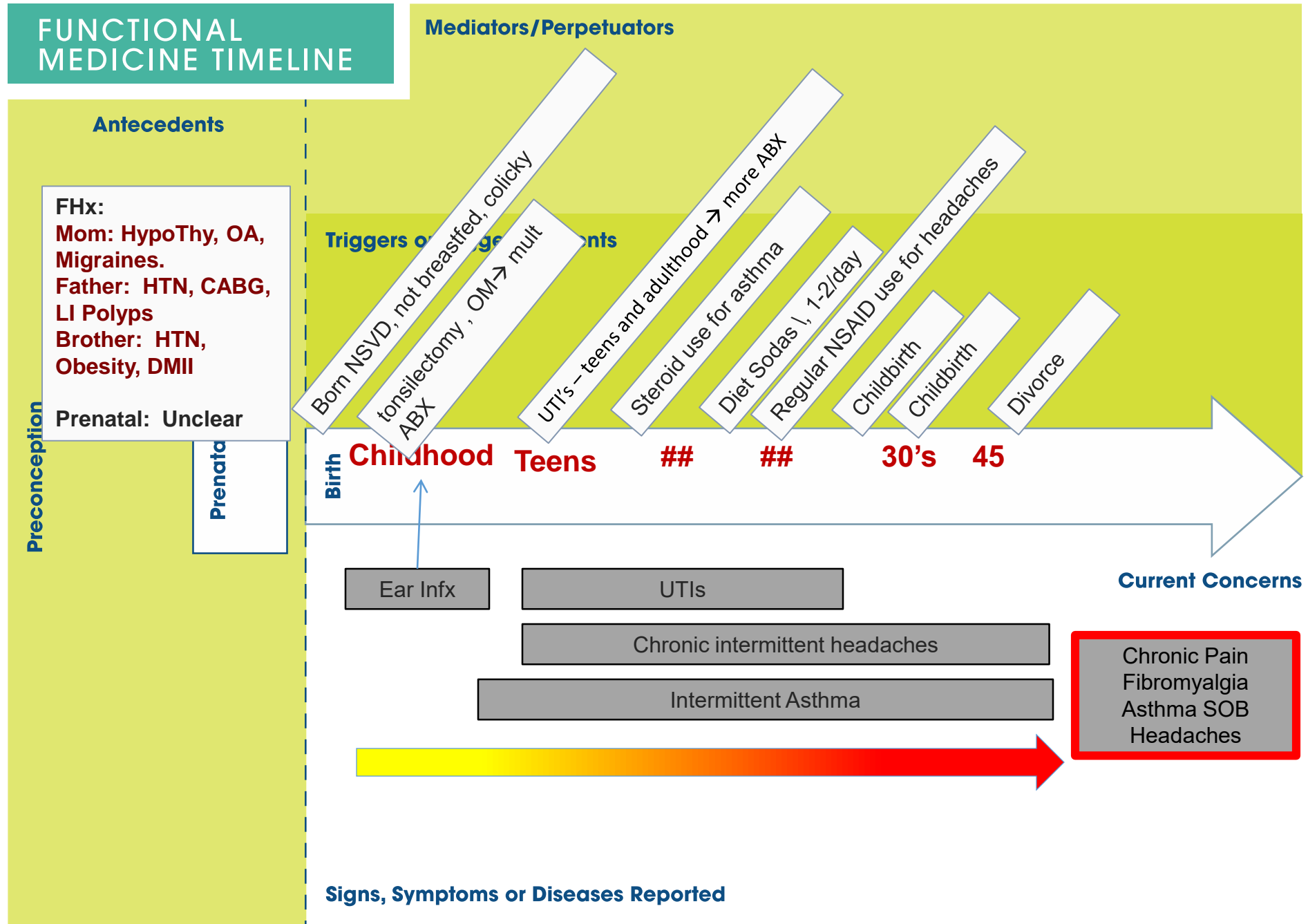
Deborah: Social History

- Divorced: grown kids she is close to
- No Tobacco/ETOH/Drugs
- Work History: Office manager; sedentary work much of her career; misses work a lot now or leaves early
- Exercise History: not able to exercise because of pain and fatigue; feels like she's aging quickly
- Hobbies: Enjoys crafting; went regularly to craft fairs but has not been able to join friends for this for the last 2-3 years due to her sx's/loss of social life
- Denies depression/anxiety: asserts that her symptoms and conditions without clear understanding, explanation or hope about them is what is leading to her become depressed



Deborah: Dietary History

- “Standard American Diet” (SAD)
- High in refined carbs and sugars; occasional whole grains, high in dairy, no red meat
- Minimal vegetable/fruits, minimal health fats
- 1-2 diet sodas daily; no coffee, 3-6 beers on weekends
- Admits emotional eating related to her chronic pain and being single – mostly simple carbs/sweets

FUNCTIONAL MEDICINE TIMELINE

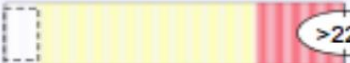



Digestion/Absorption

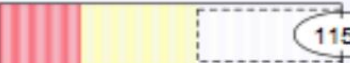


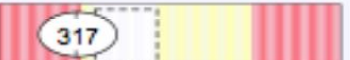
Analyte	Result	Reference Range
1. Pancreatic Elastase 1 *		≥ 201 mcg/g
2. Putrefactive SCFAs (Total*)		1.3-8.6 micromol/g

*Total values equal the sum of all measurable parts.


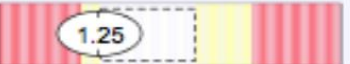
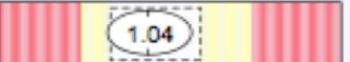
Gut Immunology

Analyte	Result	Reference Range
3. Eosinophil Protein X		≤ 7.0 mcg/g
4. Calprotectin		≤ 50 mcg/g

Metabolic

Analyte	Result	Reference Range
5. Beneficial SCFAs (Total*)		≥ 13.6 micromol/g
6. n-Butyrate		≥ 2.5 micromol/g
7. pH *		6.1-7.9
8. Beta-glucuronidase		337-4,433 U/g

Bile Acids

9. Lithocholic acid (LCA)		0.65-5.21 mg/g
10. Deoxycholic acid (DCA)		0.67-6.76 mg/g
11. LCA / DCA Ratio		0.39-2.07




*Total values equal the sum of all measurable parts.

Microbiology

Bacteriology


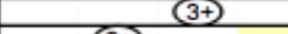




12. Beneficial Bacteria

Lactobacillus species
Escherichia coli
Bifidobacterium

13. Additional Bacteria

alpha haemolytic Streptococcus
gamma haemolytic Streptococcus
Bacillus species
Haemolytic Escherichia coli
Klebsiella pneumoniae
Staphylococcus aureus

NP	
NP	
NP	
NP	
NP	
NP	

14. Mycology


Candida albicans 

Human microflora is influenced by environmental factors and the competitive ecosystem of the organisms in the GI tract. Pathological significance should be based upon clinical symptoms and reproducibility of bacterial recovery.

*NG	NP	PP	P
			
No Growth	Non-Pathogen	Potential Pathogen	Pathogen

Interpretation At A Glance


DIGESTIVE DEFICIENCY

Analyte #: 

DYSBIOSIS

Analyte #: 

INFLAMMATION/IBD

Analyte #: 

NEOPLASTIC RISK

Analyte #: 

FUNCTIONAL MEDICINE MATRIX

Retelling the Patient's Story

Antecedents

Mom: Hypothyroid, OA, Migraines
 Father: HTN, CABG, Colon Polyps
 Brother: HTN, Obesity, Type 2 DM

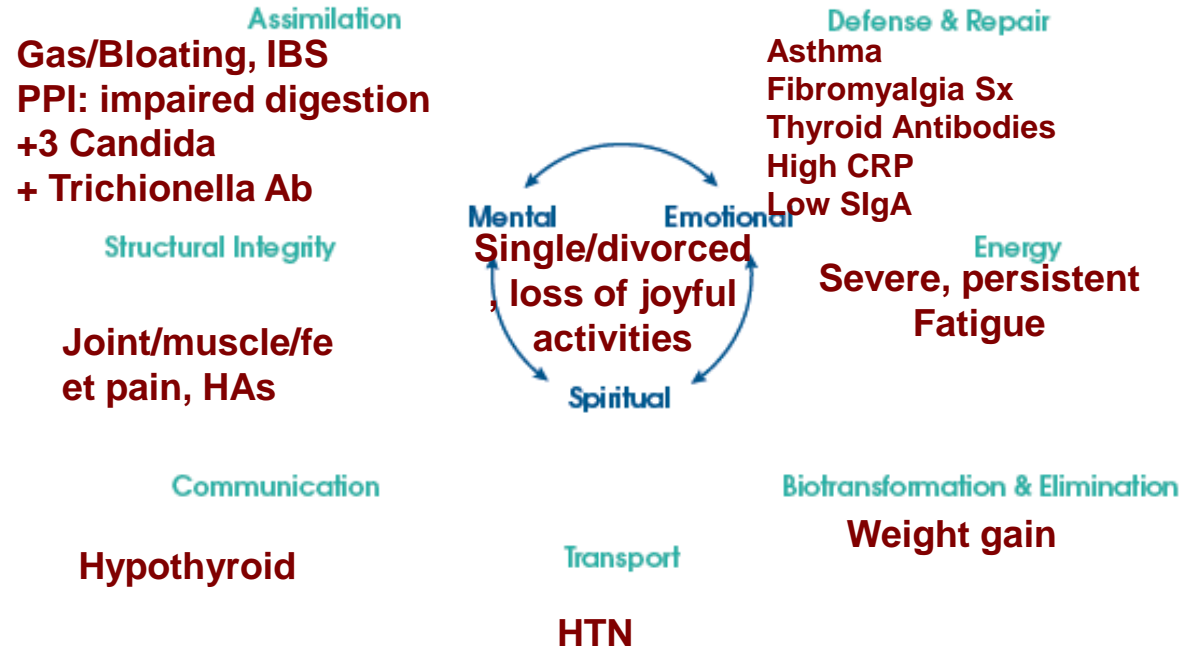
Triggering Events

Not Breastfed
 Frequent ABX

Mediators/Perpetuators

Diclofenac
 Cyclobenzaprine
 PPIs prn
 Cymbalta

Physiology and Function: Organizing the Patient's Clinical Imbalances



Modifiable Personal Lifestyle Factors

Sleep & Relaxation

Poor sleep quality

Exercise & Movement

Currently not exercising dt pain and fatigue. Sedentary office job.

Nutrition

SAD: high carbs, sugars dairy
 no red meat
 1-2 diet sodas/d

Stress

Admits emotional eating

Relationships

Previous Divorce
 Isolated from crafting friends due to fatigue/pain

Deobrah: FM Laboratory Evaluations

- hsCRP: 7.9 (high); ESR: 15 (WNL); Celiac Panel: All negative
- Vitamin D: 30 (Optimal 60-80)
- WNL: TSH, T4,
- Low T3, elevated thyroid antibodies (Hashimoto's –can be associated with gluten intolerance)
- Food Allergy IgG panel: 1-3+ reactions to white potato, bakers yeast, wheat, cheese, corn
- Comprehensive Digestive Analysis through outside FM lab:
 - +3 Candida; Bacterial Overgrowth; Low Intestinal sIgA; Elevated Alpha Anti-Chymotrypsin; + sIgA Ab to Casein, Soy, Egg, Gluten; + Ab to Trichinella Spiralis (negative serum IgG)
- Salivary 4 point Cortisol Testing – low daytime levels, elevated at night

Deborah: 5-R Program

- **REMOVE**
 - Offending foods: dairy, soy, egg, gluten, sugars, soda
 - Tx Parasite and Candida: Oral Antifungal Rx and Botanical Tx
 - Stressors: advised breathing/meditation/gentle exercise
- **REPLACE** - Digestive Enzymes; add anti-inflammatory/modified paleo diet
- **REPAIR** (presumed leaky gut)- L-Glutamine, Omega-3 fatty acids, Active B-complex, oral mast cell stabilizer, Vit D
- **REINOCULATE** – Probiotics + fermented foods
- **REBALANCE** – mind/body approaches, stress reduction

Deborah: 8 Week Follow-Up Visit

- Painful, swollen feet nearly resolved
- Improved blood pressure
- 10 lb weight loss
- Diffuse joint/muscle pains resolved (still with OA sx's of knees)
- Discontinued taking Diclofenac (occasionally takes Vicodin for OA)
- Notably improved energy (60-70%)
- Regular BMs; No Gas/Bloating
- Still with allergic rhinitis sx's/PND

Deborah: 1 Year Later.....

- Normal energy level
- No IBS Sx's
- No diffuse joint pains
- No feet swelling/pain
- Still mild HTN, weight concerns
- No illnesses in last year
- Allergy sx's improved

Why Focus on the Gut??

- 70% of the Immune System is housed in the gut
- 80% of Serotonin receptors are in the gut
- 2-3 lbs of body weight are in good, healthy flora
- It's where every single nutrient is absorbed into the body, and every single thing the body does is dependent on nutrients

All Disease Begins in
the Gut

-- Hippocrates

Why Bother???

Why Change the Way We Practice Medicine??



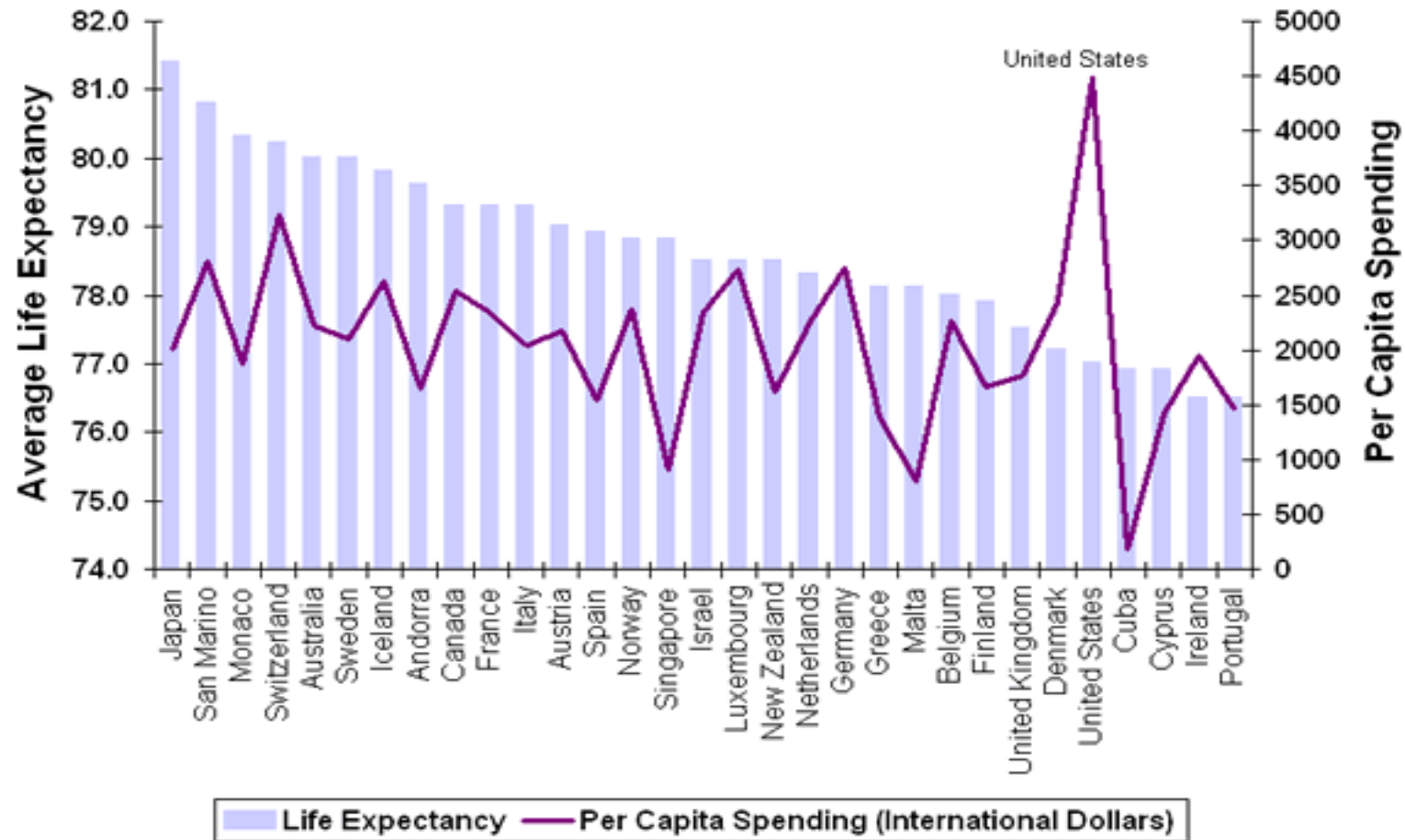
The Individual and Community Costs of our Current Approach

- Loss of productivity, less or loss of financial independence
- Increased absenteeism
- Lesser ability to move forward in one's life
- Consequences on family and community
- Less contribution to the community – financial, creative, collective well-being
- Less vitality and joy

Population Health-Driven Need

- ***Dramatic increase in the prevalence of chronic disease (CD)*** over acute diseases in this past 50+ years in the U.S.
 - ***The number of people who suffer from complex, chronic diseases, such as diabetes, heart disease, cancer, mental illness, and autoimmune disorders has skyrocketed.***
- The ***\$1.3 trillion*** estimated to be the cost of chronic disease in the U.S. today is ***projected to grow to \$4.2 trillion*** within 15 years, making the cost of care using the current model ***economically unsustainable.***
 - ***These costs are about twice as much per capita as in other industrialized countries, but still the U.S. ranks shockingly low on most parameters of health.***
- The 2009 World Economic Forum posited that chronic disease is a ***severe threat to global economic development.***
- Chronic Disease now accounts for 70% of all deaths in the U.S.

The Cost of a Long Life



Population Health-Driven Need

From 2000-2009 in the U.S:

Heart Disease: *25% increase*

Diabetes: *32 % increase*

Stroke: *27% increase*

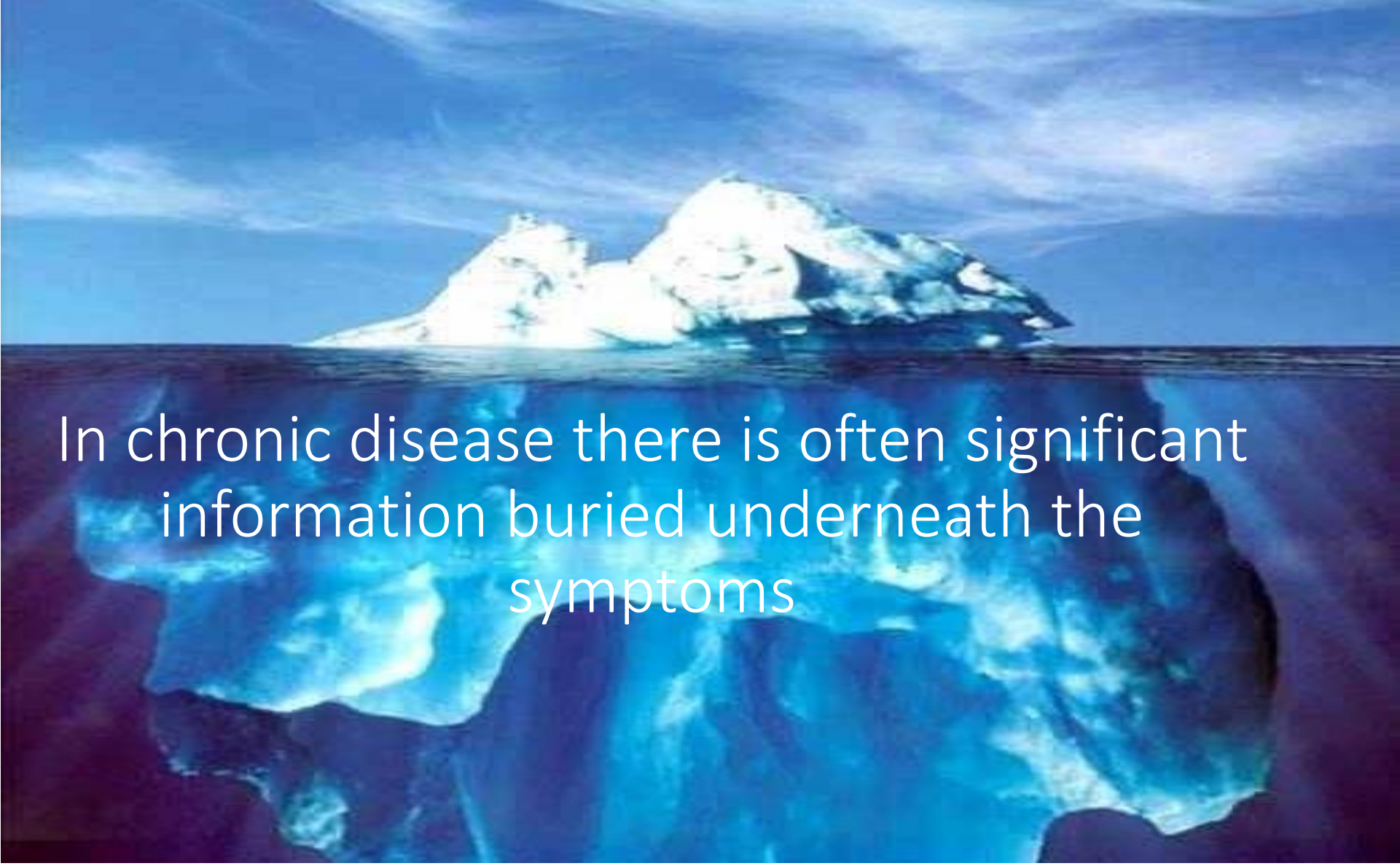
Data Trends & Maps Web site. U.S. Department of Health and Human Services
Centers for Disease Control and Prevention (CDC),
National Center for Chronic Disease Prevention and Health Promotion,
Atlanta,GA, 2010. Available at <http://www.cdc.gov/dhdsp/>



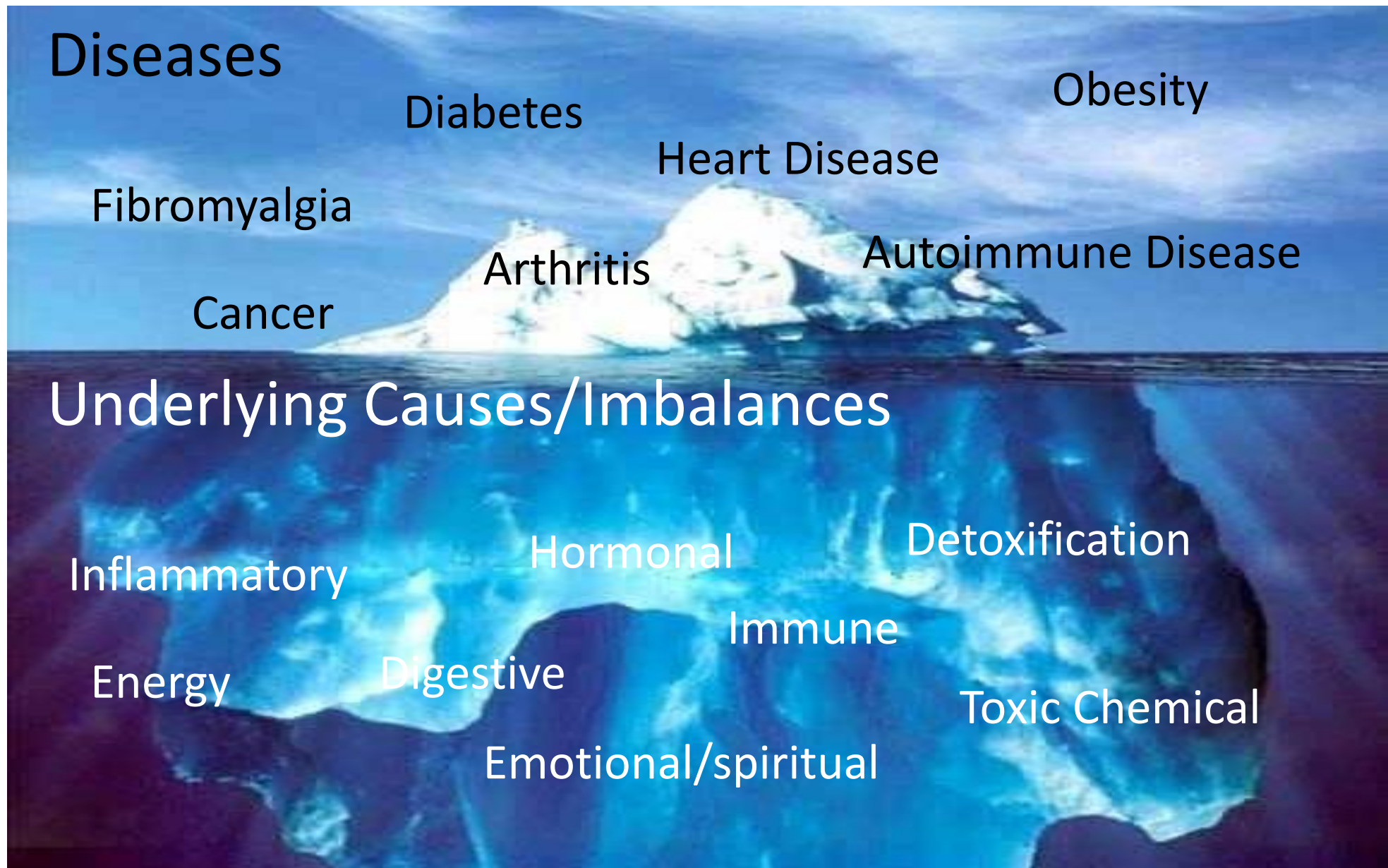
Population Health-Driven Need

Doing more of the same,
Even if we do it better
will NOT fix this problem.



A photograph of an iceberg floating in the ocean. The visible tip of the iceberg is small and jagged, while the vast, submerged portion is much larger and more complex in shape. The water is a deep blue, and the sky is a lighter blue with some wispy clouds. The text is overlaid on the submerged part of the iceberg.

In chronic disease there is often significant
information buried underneath the
symptoms



The 7 Core Physiologic Systems and Clinical Imbalances

1. Immune and inflammatory imbalances
2. Energy production problems
3. Detoxification imbalances
4. Hormonal and neurotransmitter imbalances
5. Digestive, absorptive, and microbial imbalances
6. Structural imbalances
7. Mind-body/body-mind imbalances

The 5 Fundamental Causes of Illness

1. Toxins (biologic, elemental, synthetic)
2. Allergens (food, mold, animal products, pollens, chemicals)
3. Microbes (bacterial, yeast, parasites, worms, etc)
4. Stress (physical or psychological/emotional)
5. Poor Diet (Standard American Diet “SAD”)

Effects of the Core Imbalances

Obesity

Heart disease

Cancer

Type II diabetes and
metabolic syndrome

Sleep Disorders

IBS/IBD/heartburn/GERD

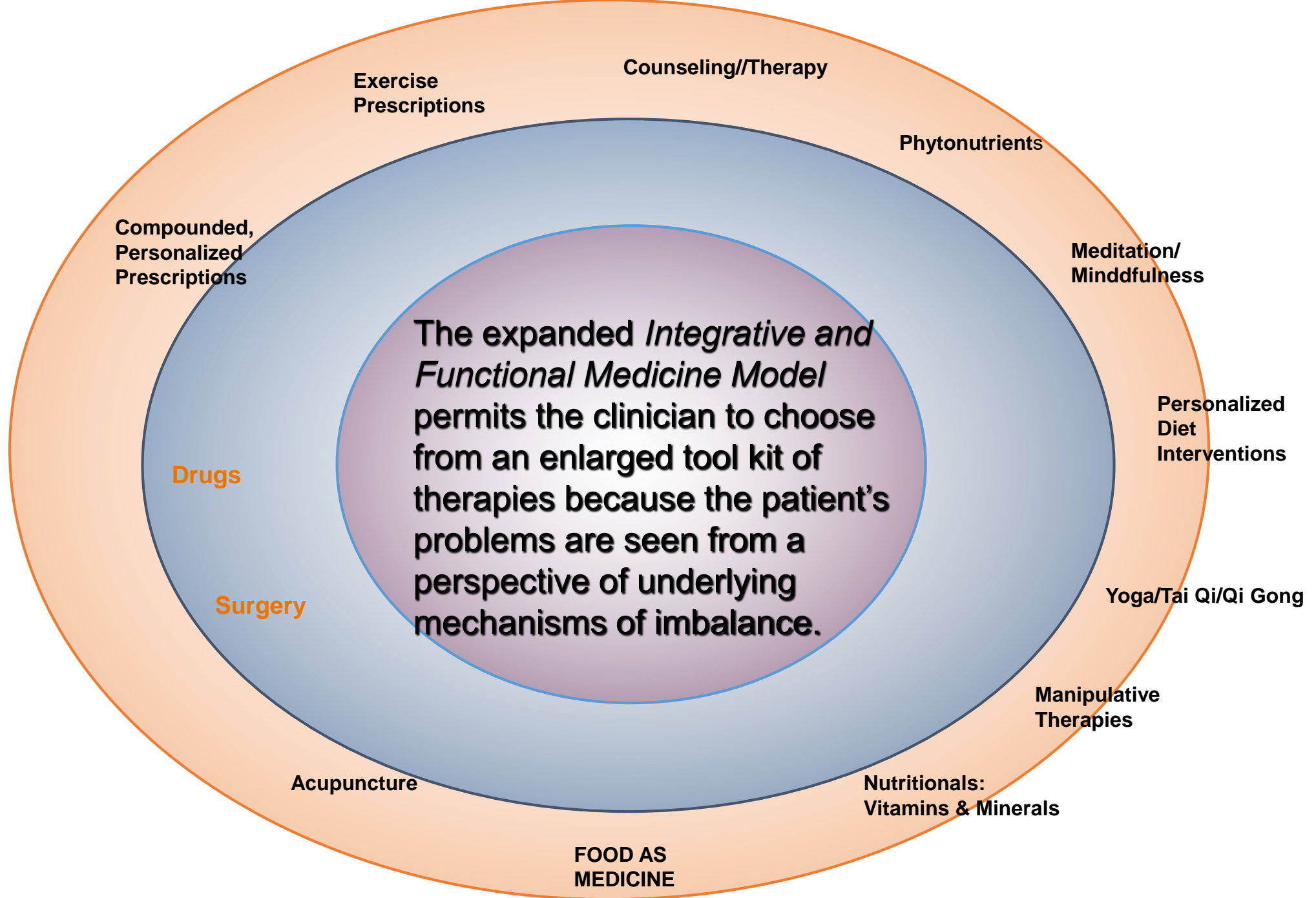
Neurological conditions

Rheumatologic and

Autoimmune conditions

Dermatologic conditions

Mental health problems



Functional Medicine

- A comprehensive, integrative, science-based, systems biology approach that offers a framework to apply integrative and conventional approaches to care
- “Upstream” medicine
- Truly patient-centered care
- Integrates and “bridges” the best medical practices from a variety of disciplines



So what does
Functional Medicine
look like in
clinical practice?





Cleveland Clinic

Center for Functional Medicine

Cleveland Clinic Gets "Functional"

Saturday, 30 August 2014 21:58

By Erik Goldman | Editor in Chief

The Cleveland Clinic has teamed up with functional MD, to establish the multi-million dollar Cleveland Center for Functional Medicine, slated to open on September 23, 2014.

Long recognized as one of the world's finest health care institutions, the Cleveland Clinic is now what's best about American medicine, the Cleveland Clinic is now wholeheartedly embracing the function of the Institute of Functional Medicine.



The project began when Dr. David Hyman met Dr. David Cleveland at a conference in Europe.

"For two years, I've come to see the value of participants at the Cleveland Clinic in New York City."

Initially skeptical

January 22, 2017 1:30 am UPDATED 1/27/2017

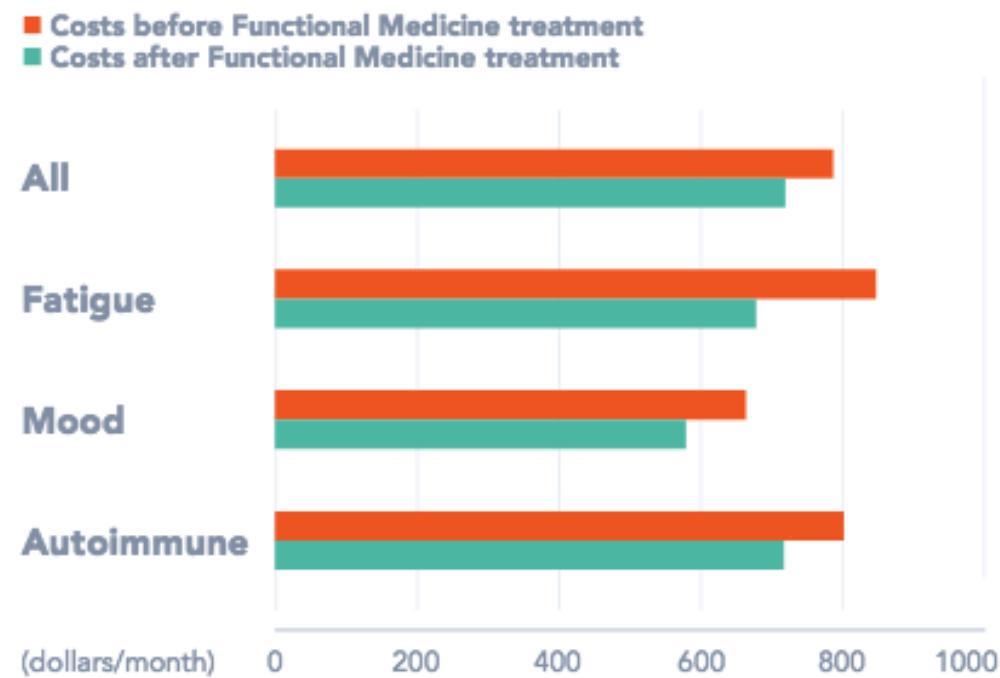
Cleveland Clinic's holistic center is on rapid ascent

By LYDIA COUTRÉ



CFM Outcomes:

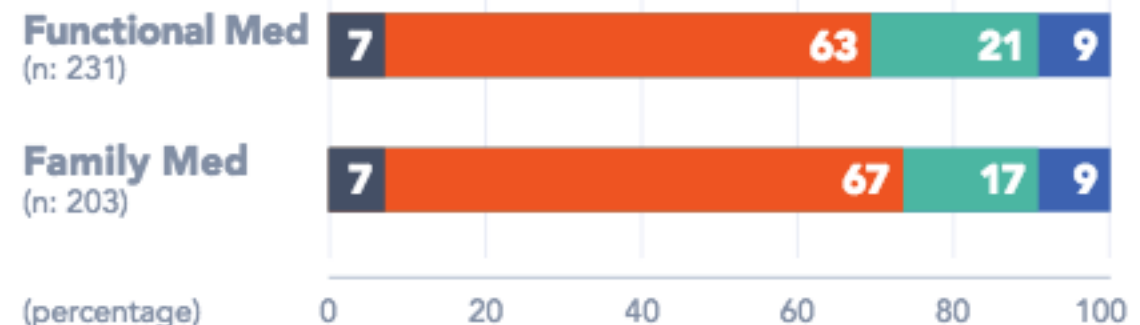
Functional Medicine Treatment Reduces Patient Payments



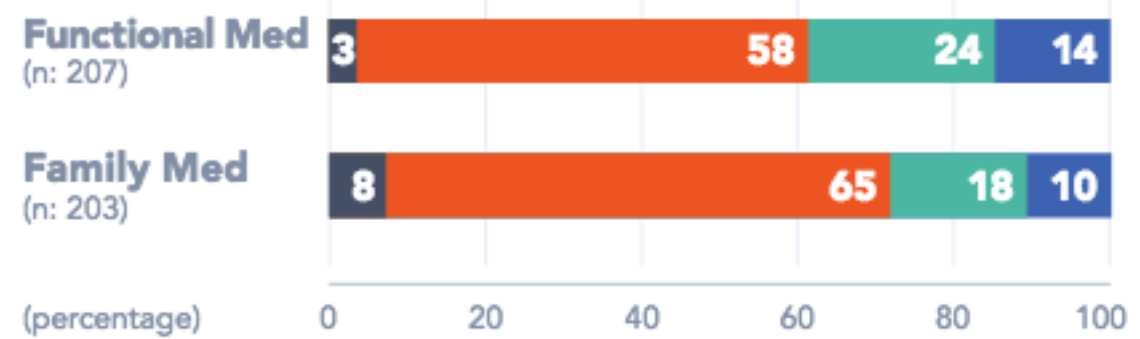
Functional Medicine Treatment Outperforms Family Medicine Care

■ Worse ■ No Significant Change ■ Improved ■ Much Improved

Mental Health

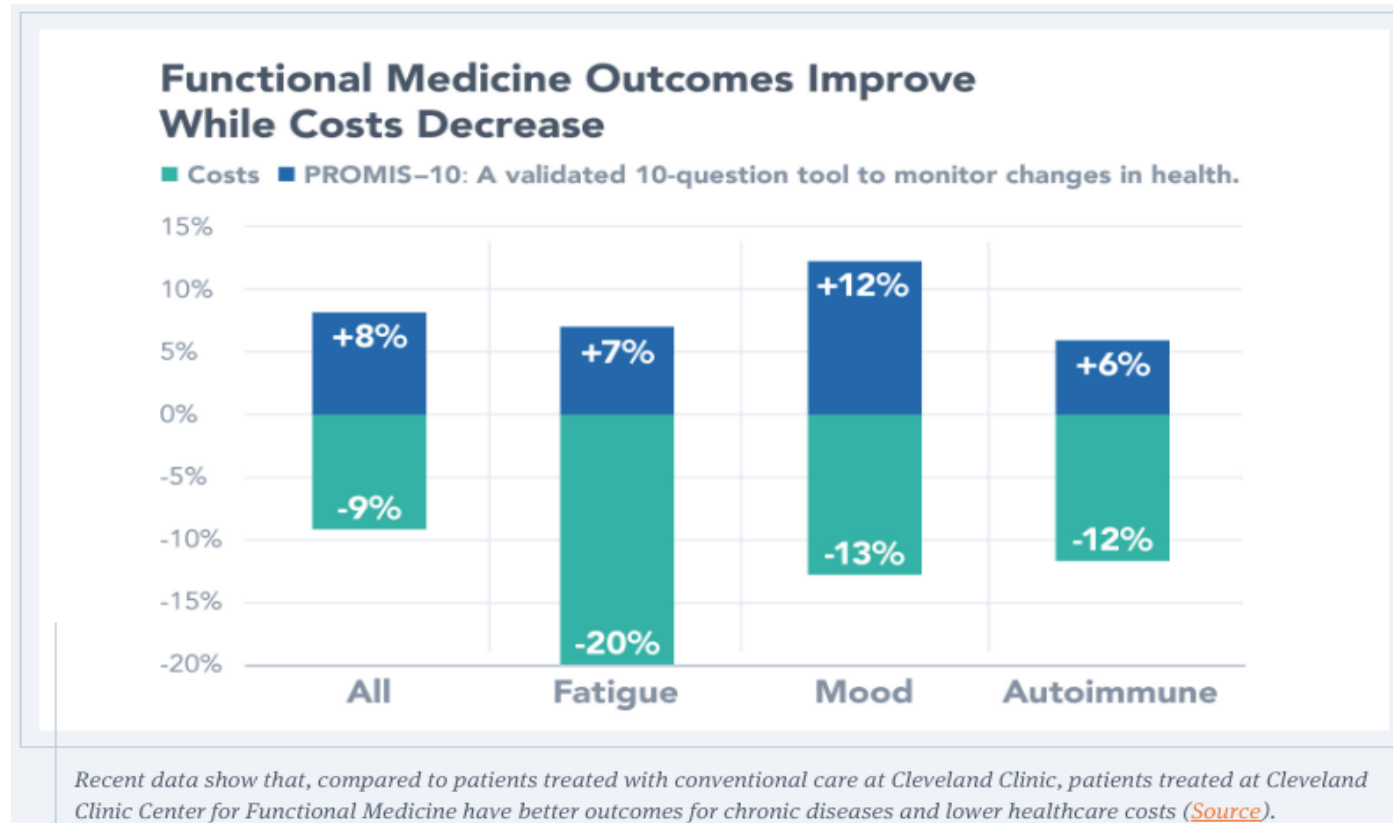


Physical Health



Source: https://p.widencdn.net/rtp7hp/IFM_PLMI_OneSheetl_v7

CFM Outcomes:



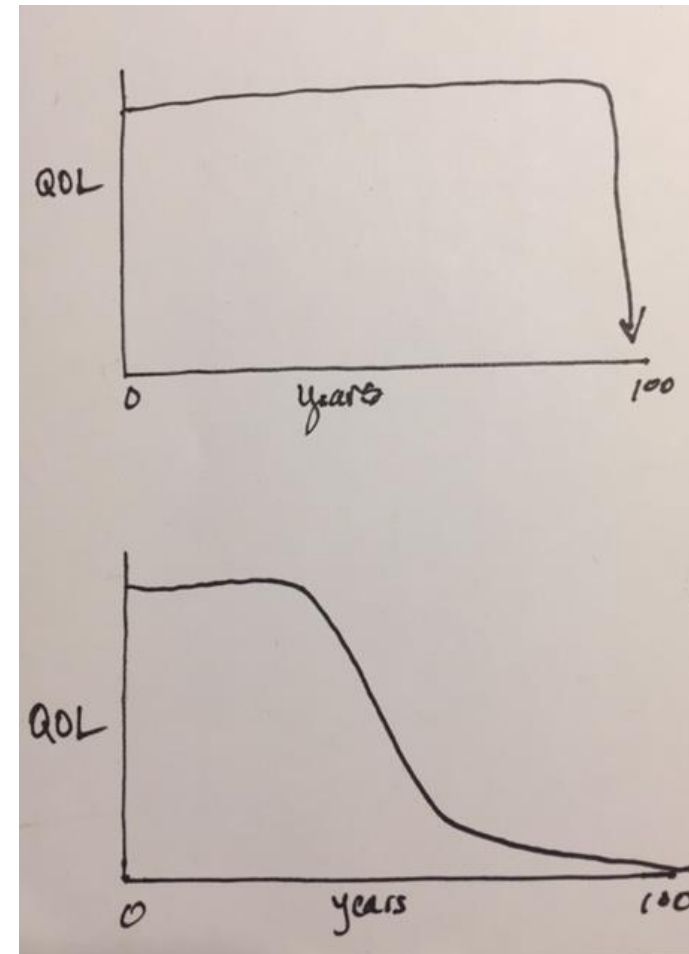
Source: https://p.widencdn.net/rtp7hp/IFM_PLMI_OneSheetI_v7



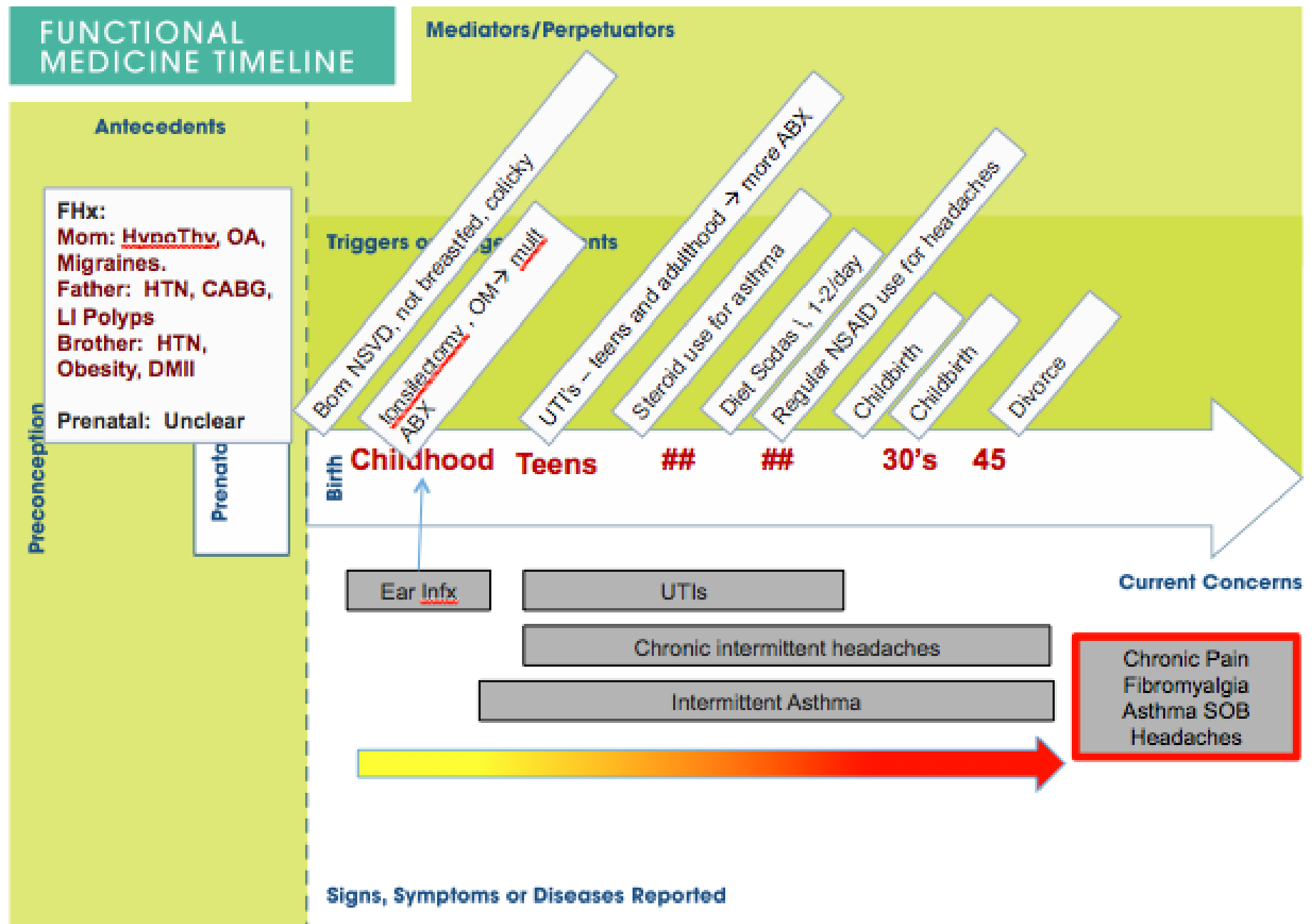
Changing The Way We Do Medicine,
And The Medicine We Do

Changes in the *way we do medicine*:

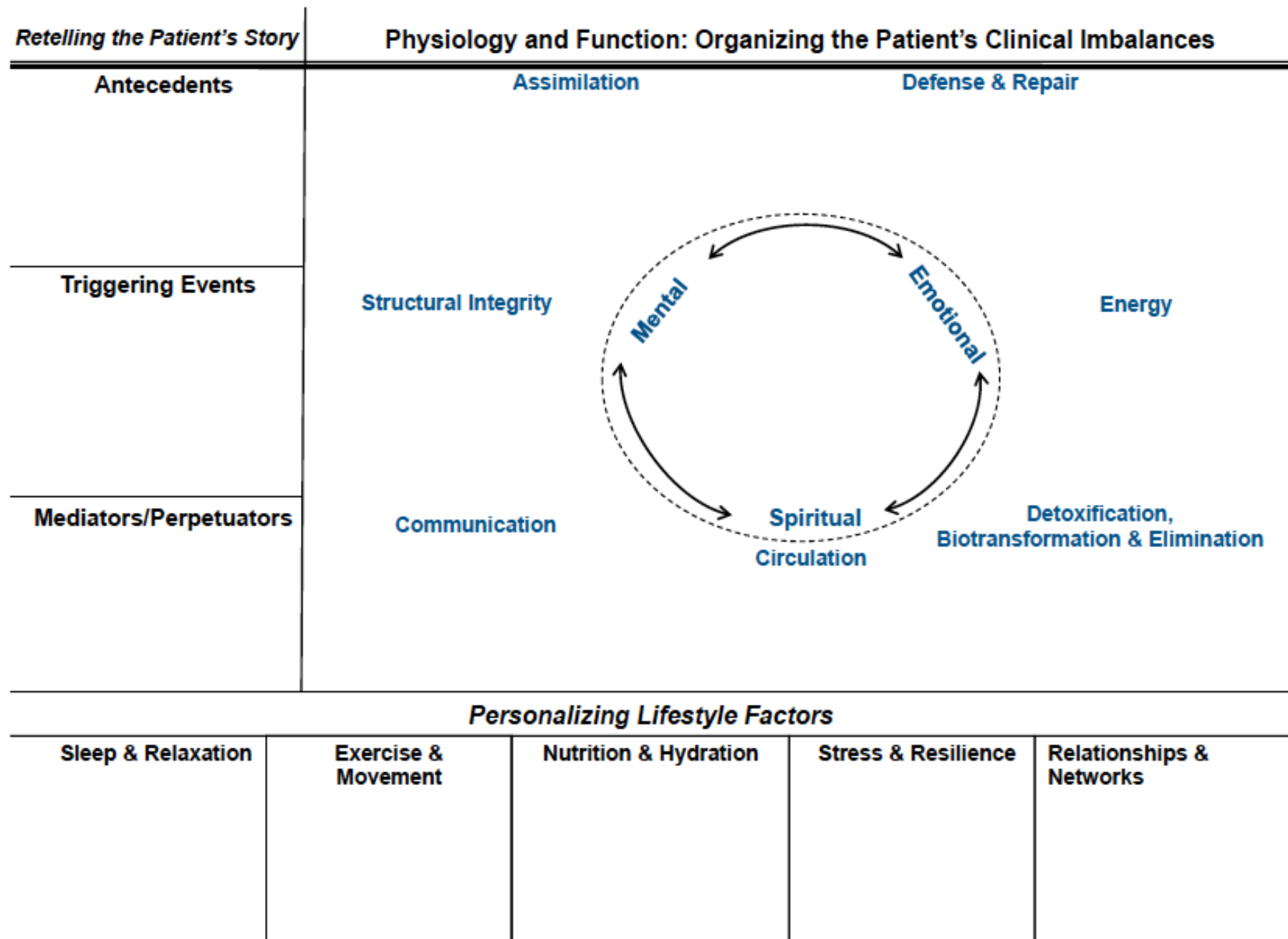
1. Openly discussing the goal of ideal health- what does the patient want?
2. The FM Time Line
3. The FM Matrix
4. Asking unique questions: WHY is this happening?
5. Prioritize relationship and slow steady progress



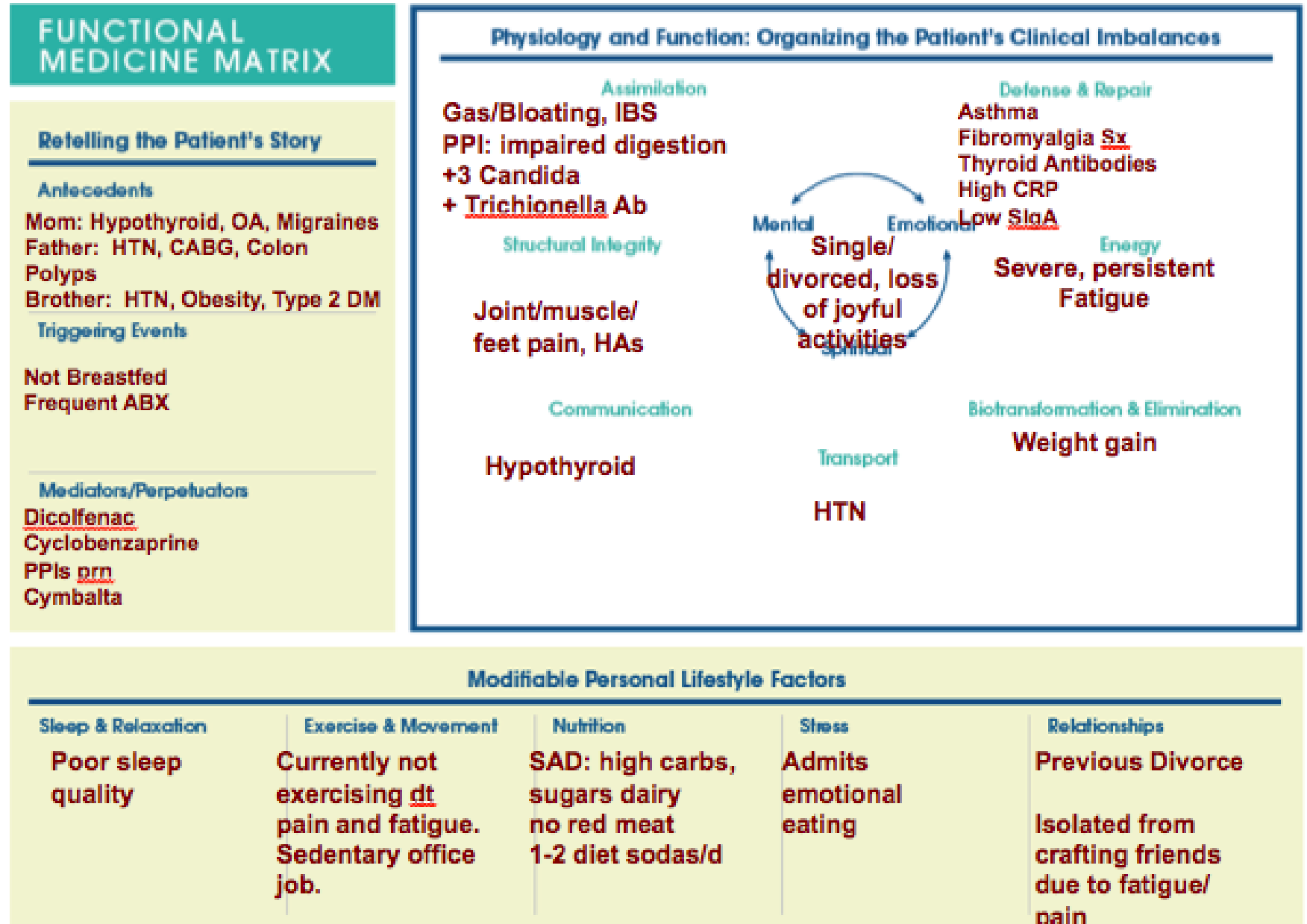
2. FM Time Line



3. FM Matrix: Our tool for mapping out the areas of imbalance and need



Deborah's matrix



What does the matrix give us?

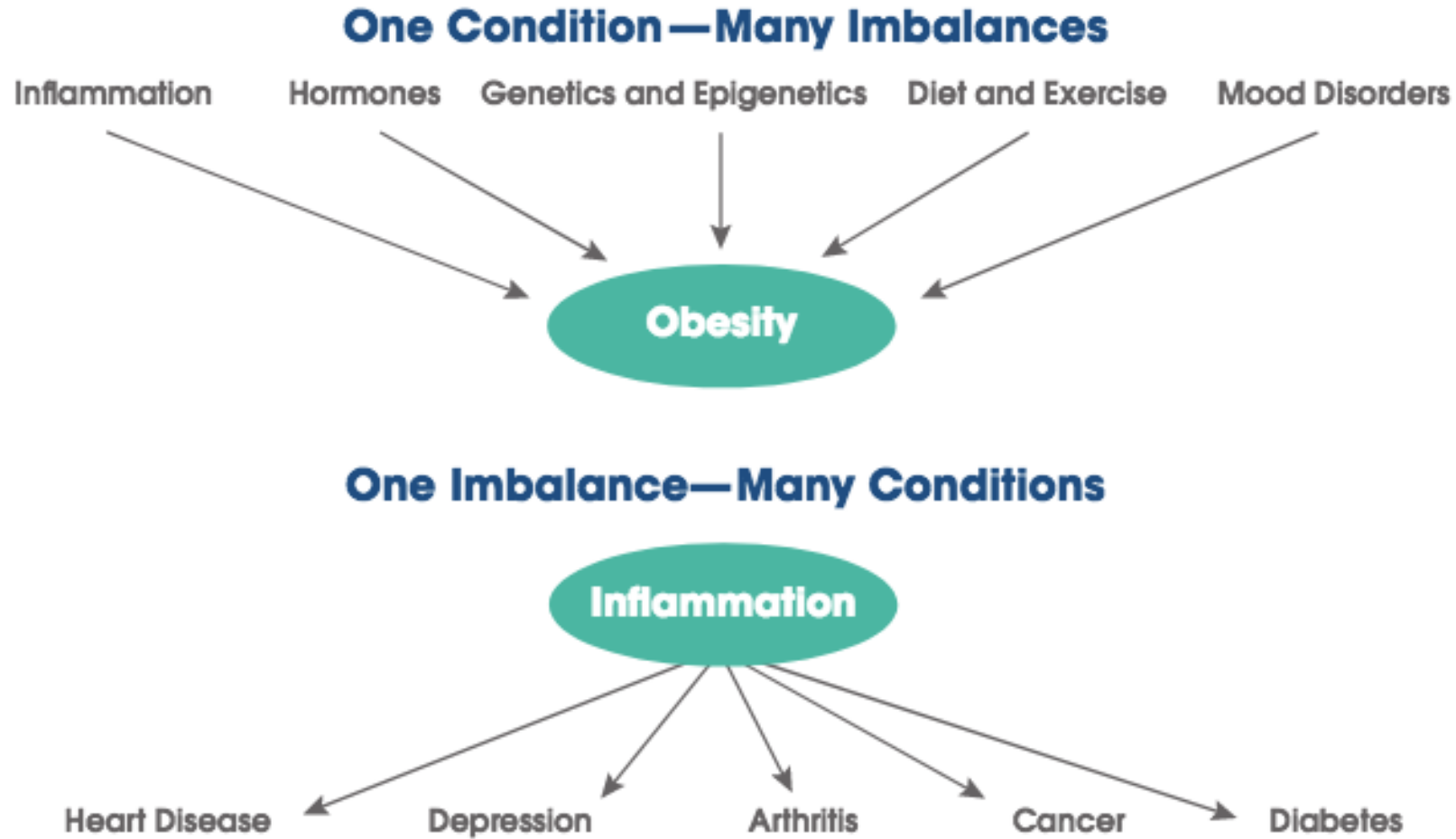


Figure 2. The relationship between Core Clinical Imbalances and Disease

4. Two Important Questions

Does this person need to be rid of something, such as toxins, allergy, poor diet, stress?

Is there an unmet individual need that must be filled for optimal functions, such as food (protein, fats, carbohydrates, fiber, vitamins, minerals, other essential nutrients), hormones, light, water, air, sleep, relaxation, movement, community, connection, meaning, purpose?

Relationship-Centered Care

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PMCID: PMC2720820

NIHMSID: NIHMS113039

Practitioner Empathy and the Duration of the Common Cold

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Abstract

Go to: 

Objective

To assess the relationship of empathy in medical consultations to subsequent cold outcomes.

Changing the *medicine we do*:

1. Validated Questionnaires & Extensive History Taking
2. Evidence-Based Evaluations
3. Research-informed treatments

Extensive History Taking

Validated questionnaires:

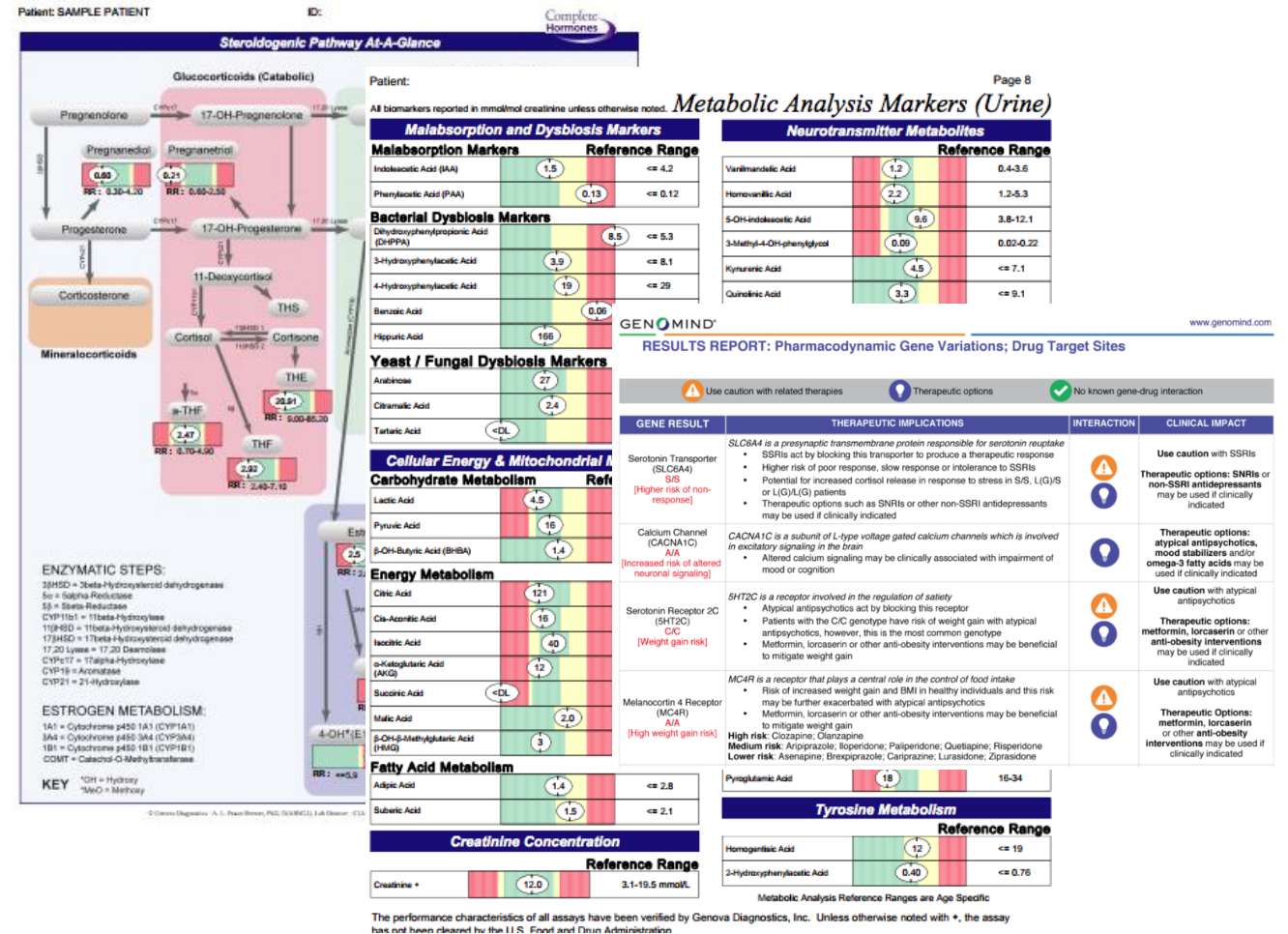
- MSQ: Medical Symptoms Questionnaire
- TEQ-20: Toxic Exposure Questionnaire
- Others

Hearing the patient's whole story:

- When were you last well?
- Why do you think this is happening?
- Infection Exposure History
- Stress/Trauma/A.C.E. History
- Diet log: week's worth of food, beverages and substances

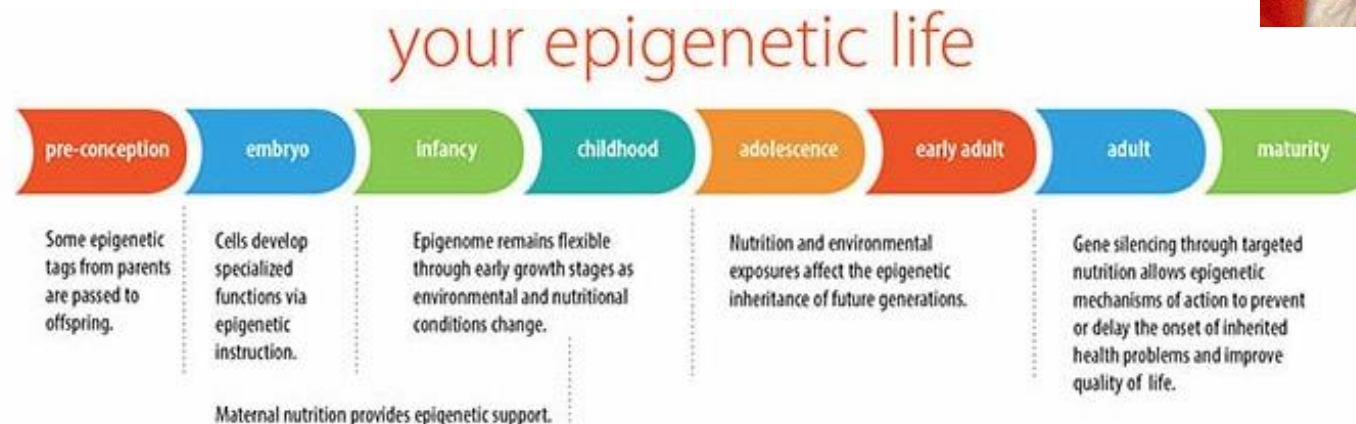
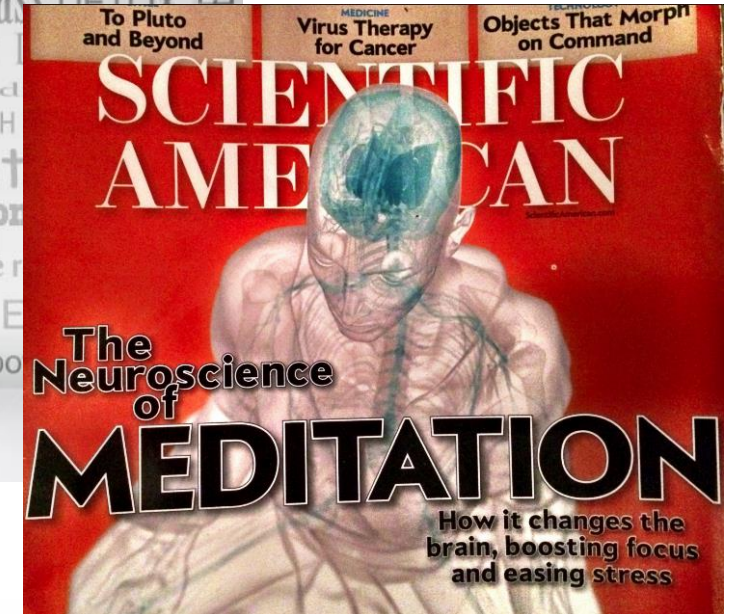
Research based evaluations

- Common CM testing
- Comprehensive Digestive Analysis
- Metabolic testing (organic & amino acids)
- Salivary hormone testing
- Genomics



Research Based Treatments

- Food as medicine
- Mind/Body treatments
- Epigenetic interventions
- Behavioral health
- Nutraceuticals
- Scientifically verified medical devices: neurofeedback, BIA



Condensed FM Approach

- Multiple Symptoms Questionnaire (MSQ)
- Toxin Exposures Questionnaire (TEQ-20)
- Providing the space and time for patients to share their full story and experience of symptoms
- Thorough diet and lifestyle history
- Re-Telling the story back to the patient
- Discussion with pt: HOW diet, stressors, meds and lifestyle may have contributed to Sx,
- Description of gut health. (*L. docere* = teacher)
- Engaging patient in a hopeful plan of action and in active participation on their path to improvement

How do we do this at Swedish?

- Time based visits: 99204/99214 & 99205/99215
- 1 hour new patient visits; 30-45 minute follow-up visits
- Support from functional med RN
- Lots of handouts & dot phrases
- Lots of community relationships for referrals: behavioral health, nutrition, yoga/PT/movement, massage and others
- Results:
 - We saw 1700 unique pts in combined 1.25 FTE in last 12 months
 - On par with revenue of PC colleagues
 - Top Press Ganey scores
 - 280+ person waiting list. Intermittent closing to new patients to reduce follow up wait time of ~2+ months.

IFM

Patients, Practitioners, Employers, Health Systems

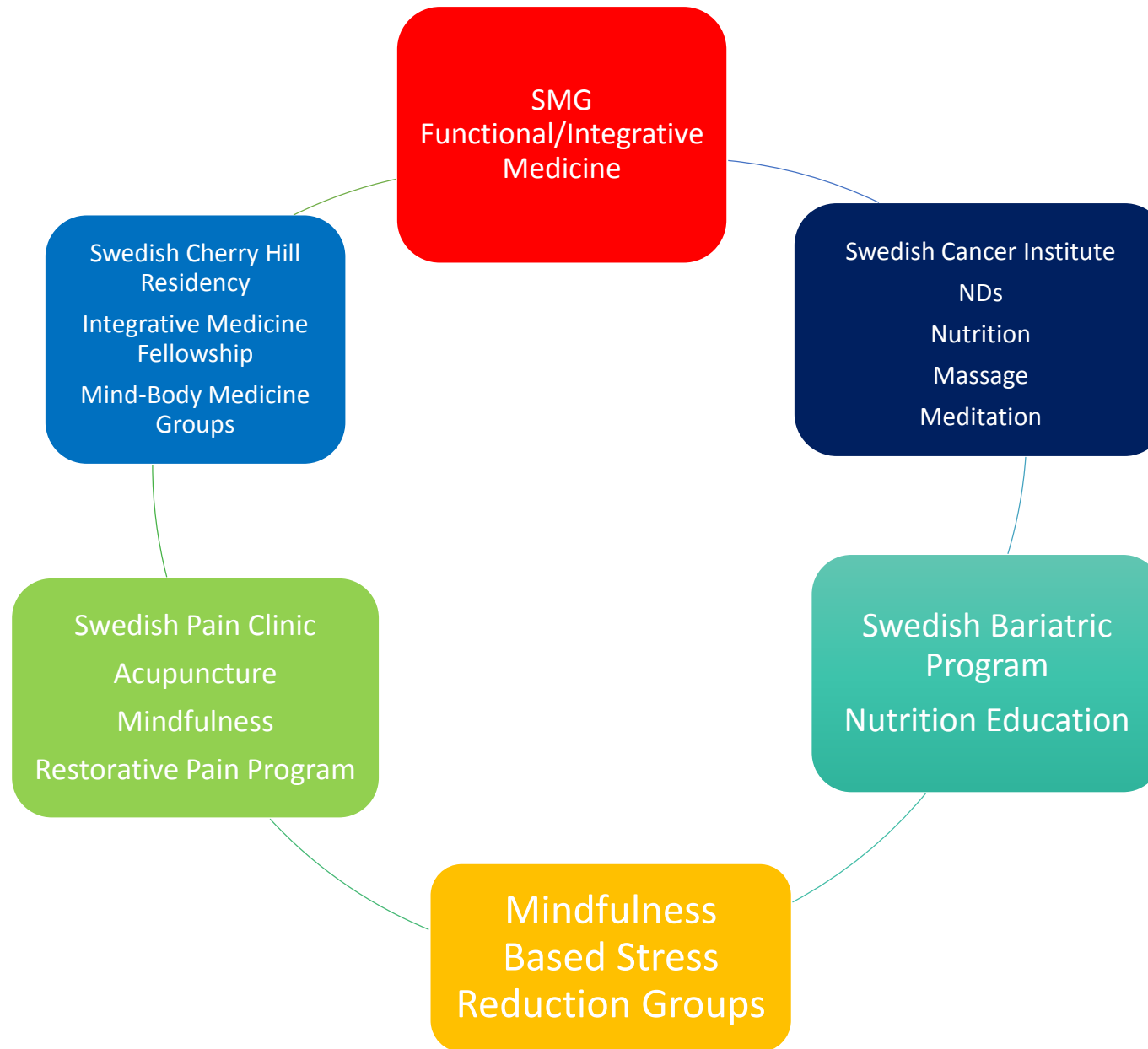
- More than 420,000 unique visitors to IFM website monthly
- Over 90,000 unique Find-A-FM Practitioner searches monthly
- Employers hiring FM practitioners
 - 180% growth in postings by employers, practices, health systems, industry looking to hire FM practitioners
 - 500% growth in unique users of website

IFM

International and Academic Demand also Exploding

- AFMCP 2017: 4 US programs plus UK, Peru, China
- Other international programs: Taiwan, Ireland, Colombia
- Advanced Practice Modules: record attendance in 2017
- IFM Certified Practitioners: on-track to reach 5000 goal by end of 2020
- Certification programs for collaborative care team members established for nurses (INCA), nutritionists (IFNA), coaches (FMCA) – all using IFM curricular assets and training tools
- Academic programs: electives, grand rounds, residency rotations, Master's degrees and a Fellowship in FM – all in collaboration with IFM

Complimentary Care Offerings at Swedish



Patient referral sources for FM at Swedish

- Self-referred (increasingly finding Functional Medicine on the internet: health websites, chats, blogs)
 - Local patients
 - Regional: other parts of WA state, AS, ID, MT
 - A few international referrals
- Referred by another patient
- Primary Care doc referrals
- Swedish Specialty Referrals: GI, Sleep, Pain, Endo, Neuro, Rheum
- Referrals from docs, other providers in the community/at other institutions

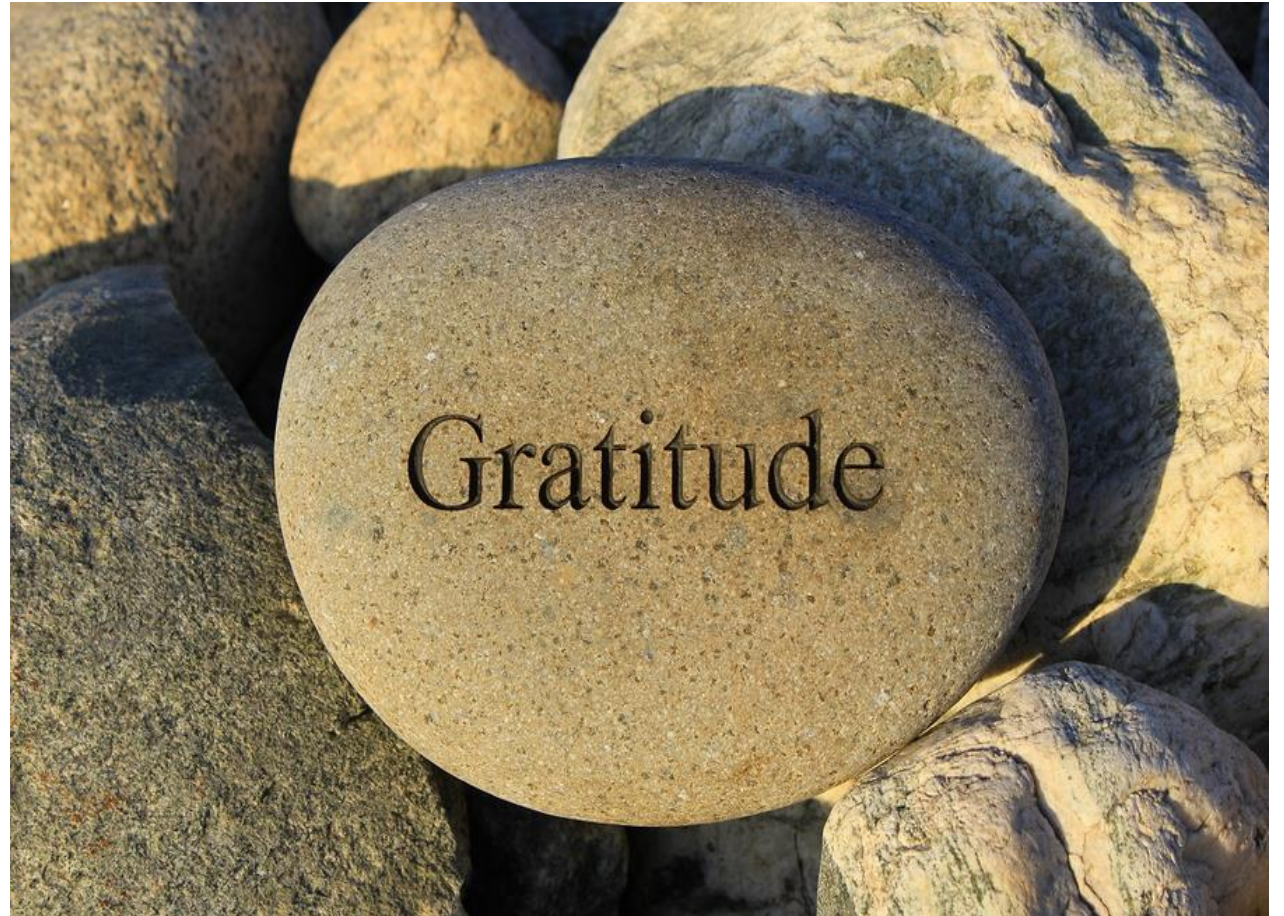
Functional Medicine Training

The Institute for Functional Medicine: functionalmedicine.org

- Onsight and live-streamed courses
 - Applying Functional Medicine in Clinical Practice: foundational 5 day course
 - Advanced Practice Modules – 3 Day:
 - GI
 - Hormone
 - Immune
 - Cardiovascular
 - Detox
 - Energy
- Annual International Conference 3-4 days (May/June)
- Certification in Functional Medicine

Our Thanks To:

- Warren Fein MD
- Jim Cunningham MBA
- Ralph Pascualy MD
- Guy Hudson MD
- Heidi Aylsworth



Thank You!



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Jim.Cunningham@swedish.org (SMG Admin)

Provider Engagement at Swedish Health Services

2017 Swedish Health Network
Annual Symposium

James Martin, MD
Chief Medical Officer, Swedish Medical Group

Disclaimer

- No financial arrangements to disclose (although Swedish does pay my salary)
- I am not an expert by any means.

Objectives

- To share what we have learned about provider engagement
- To share the recent Swedish Health System experience with respect to provider engagement – and what we are doing about it
- To learn from other groups and systems – tell us what you know!

Some simple definitions

- **Engagement:**
 - How well a provider likes his/her immediate surroundings and work – colleagues, coworkers, work place. How do you like the work?
- **Alignment:**
 - How do you like who you work for? How do you like administration? Are you “aligned” with them?

An Academic Definition

The effective coordination of efforts between health care organizations and physicians to provide care to patients and populations.

Why Does Engagement Matter?

- When people are engaged, they use discretionary effort – they go the extra mile.
- Engaged providers lead to better service, better care, and better individual and organizational performance.
- Engagement is the key to activating a high potential work force

What happens when people aren't engaged?

- Increased turnover
- Lost productivity
- Financial impact
- Low morale
- Recruitment challenges

What does the literature * say is important for engagement?

1. Respect for my competency and skills
2. Feeling that my opinions and ideas are valued
3. Good relationships with my physician colleagues
4. Good work-life balance
5. A voice in how my time is structured and used

* 2013 Survey conducted by Cejka Search and Physician Wellness Services.

What is less important than engagement?

1. Participation in setting broader organizational goals and strategy
2. Working for a leader in innovation
3. Alignment with the organizations mission and goals

KEY POINT: **LESS** IMPORTANT DOES NOT
MEAN **UNIMPORTANT**

What are we up against?

- Declining reimbursement, shifting payor mix
- Increasing regulatory demands
 - MACRA, etc
- Competition for patients and providers
 - Kaiser Permanente
- Consumerism
- Turnover – loss of providers and staff → **BURNOUT**

Annual Provider Engagement Survey

- Third party vendor now owned by Press Ganey.
- Around 50 questions covering several domains
- Ambulatory and inpatient versions
- In depth data analysis performed by Press Ganey

Overall Physician Engagement

	2016 Swedish - PC/S	2016 Swedish - HOSP
Engagement Score	3.97 34 th	4.06 47 th
Difference from Natl Phys Avg	-.08	+.01
Difference from 2015 Swedish	-.15	-.08
Difference from Providence System Overall	-.17	-.05
n-size	436	163

Primary Care/Specialty Note: In this presentation **GREEN/ RED** notes a statistically significant difference for the National Physician Average +/- .12 and Providence System Overall Survey +/- .12, History +/- .19

Hospital Note: In this presentation **GREEN/ RED** notes a statistically significant difference for the National Physician Average +/- .19 and Providence System Overall Survey +/- .20, History +/- .22

Overall Physician Alignment

	2016 Swedish - PC/S	2016 Swedish - HOSP
Alignment Score	3.33 21 st	3.31 20 th
Difference from Natl Phys Avg	-.26	-.28
Difference from 2015 Swedish	-.22	-.19
Difference from Providence System Overall	-.38	-.18
n-size	436	163

Primary Care/Specialty Note: In this presentation **GREEN/ RED** notes a statistically significant difference for the National Physician Average +/- .12, Providence System Overall Survey +/- .12, History +/- .19

Hospital Note: In this presentation **GREEN/ RED** notes a statistically significant difference for the National Physician Average +/- .19 and Providence System Overall Survey +/- .20, History +/- .22

Improved/Declined Items: Primary Care/Specialty View

				Diff from:	
ITEMS Compared to your last survey	Domain	2016 Swedish- PC/S	% Unfav	2015 Swedish - PC/S	Natl Phys Avg
33. I am satisfied with the appearance and cleanliness of the patient care areas.	ORG	4.17	6%	+.15	+.24
10. I am satisfied with the amount of time I can spend with my patients.	STF	3.68	19%	+.11	-.03
5. I am satisfied with the competency of clinical staff.	STF	4.04	8%	+.02	-.08
31. I have the opportunity to review patient satisfaction data.	ORG	3.89	13%	-.51	+.13
38. My clinic/department takes effective steps to remain competitive.	ORG	3.67	15%	-.42	-.19
19. Methods used by my clinic / department to communicate with providers and medical staff are effective.	ORG	3.48	21%	-.37	-.15

3 of 57 survey items improved from 2015 survey; none are statistically significant
53 of 57 survey items declined from 2015 survey; 28 statistically significant

Highest/Lowest Performing Items: Primary Care/Specialty View

				Diff from:	
ITEMS Compared to the <u>National Physician Average</u>	Domain	2016 Swedish - PC/S	% Unfav	Natl Phys Avg	2015 Swedish - PC/S
34. I am satisfied with the ease and efficiency of the Electronic Medical Records system.	ORG	3.55	22%	+.49	-.33
33. I am satisfied with the appearance and cleanliness of the patient care areas.	ORG	4.17	6%	+.24	+.15
40. My clinic/department conducts business in an ethical manner.	ORG	4.42	3%	+.22	-.03
18. Administration's actions support my clinic/department's mission and values.	ORG	3.29	29%	-.54	-.25
50. I have confidence in administration's leadership.	LDR	3.13	30%	-.52	-.24
46. I am satisfied with the overall performance of administration.	LDR	3.08	32%	-.51	-.28

17 of 57 survey items are above the Natl Phys Avg; 7 statistically significant
36 of 57 survey items are below the Natl Phys Avg; 25 statistically significant

Overall Key Drivers of Engagement: PC/S Clinics

				Difference from:		
KEY DRIVERS of Physician Engagement	Domain	2016 Swedish	% Unfav	Natl Phys Avg	2015 Swedish	PSJH Overall
51. My clinic/department treats providers with respect.	LDR	3.92	11%	+.17	-.23	-.23
45. I am satisfied with the recognition I receive.	LDR	3.52	17%	-.12	-.25	-.23
15. I have confidence that my clinic/department will be successful in the coming years.	ORG	3.85	12%	-.20	-.20	-.27
30. My work gives me a feeling of accomplishment.	STF	4.12	8%	-.28	N/A	-.11
50. I have confidence in administration's leadership.	LDR	3.13	30%	-.52	-.24	-.48

* Denotes key driver on your previous survey

Burnout: Mini Survey Results

Swedish Medical Group: March 23-April 21, 2017

148 responses from physicians/APCs

1. Type of practice
2. Rate your satisfaction with your career
3. Top 3 stressors in your work day
4. Describe culture at clinic, SMG, SHS
5. Describe your ideal culture

(Q3) Top 3 Stressors: Themes

- Lack of staff (clinical & support); staff turnover
- Lack of adequately trained clinical staff
- Drowning in documentation/Epic
- Too much time spent on non-medical, clerical tasks
- Productivity pressure; not enough time with patients
- Loss of physician input, voice, leadership
- Feeling undervalued

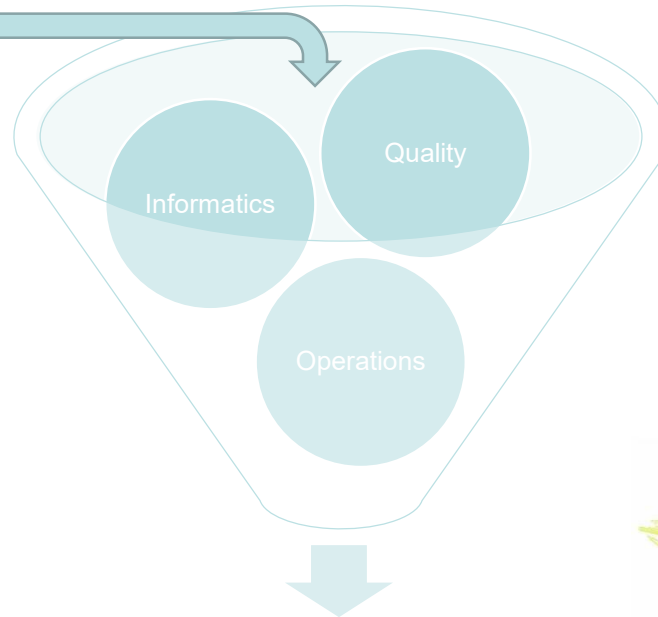
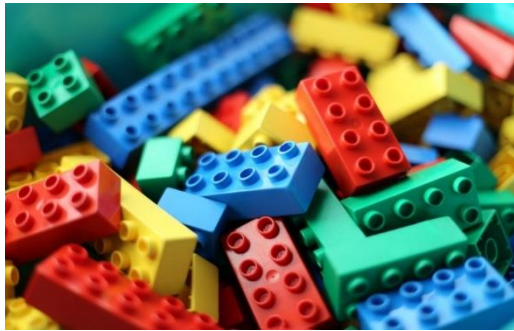
Ongoing and Future Actions

- Regional Town Hall style listening forums at each campus – including food and drink!
- **Communicate**
- Leadership Visibility: fast and furious clinic visits – primary care first, specialty to follow – informal, casual, food for the clinic. ENGAGE!
- **Communicate**
- Education of frontline administrative leadership on physician and APC engagement – a lot of engagement is local. (guardrails v. railroad)
- **Communicate**
- Action Plan based on Mini Survey responses
 - i.e. clinic staffing, “Home for Dinner”
- **Communicate**
- Compensation Plan Redesign (!!)
- **Communicate**

Show them we mean it:

- Elevate the voice of the physician and APC
- Respect and acknowledge the body of work performed
- Provide them a way to influence the way their time is spent, their day is structured, and how their work environment flows.

Best Practice Team



“Make it easy to do the right things”



Best Practice Team

- Highly integrated with IS, Process Improvement Teams (PCMH), and Operations.
- Strong physician leader : program manager dyad relationship
- Clinical Epic Optimization trainers
 - “Home for Dinner”
- Work flow specialists
 - Current state analysis; develop and design best practice work flows and training; future state recommendations.

Recommended Reading

- **Stop Physician Burnout: What to Do When Working Harder Isn't Working**
 - Dike Drummond, M.D.
- **Remedy for Burnout: 7 Prescriptions Doctors Use to Find Meaning in Medicine**
 - Starla Fitch, M.D.
- **Finding Balance in a Medical Life**
 - Lee Lipsenthal, M.D.

Thank You!