Arch Health Partners

Maximizing Limited Care Management Resources to Improve Clinical Quality and Ensure Safe Transitions

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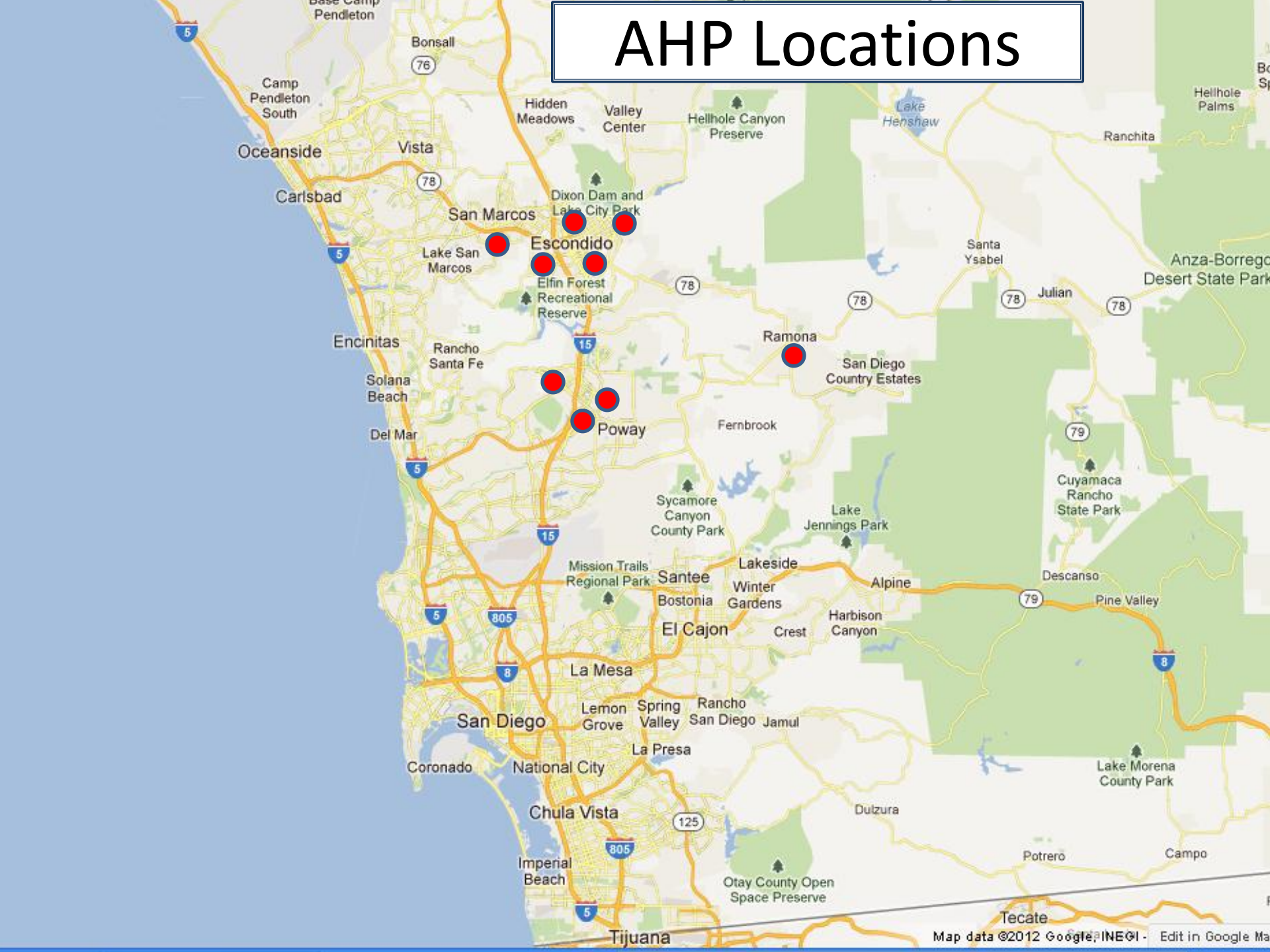
- A medical foundation formed by Palomar Health and Centre for Health Care April 1, 2010
- Currently, Arch Health Partners has over 80 providers including 31 PCPs and multiple specialties in 9 locations
- Managed Care 40% FFS 60%, 17,500 lives
- AHP has a very capable Urgent Care Center available 12 hours a day 7 days a week.

AHP Locations



Forces Influencing our Approach

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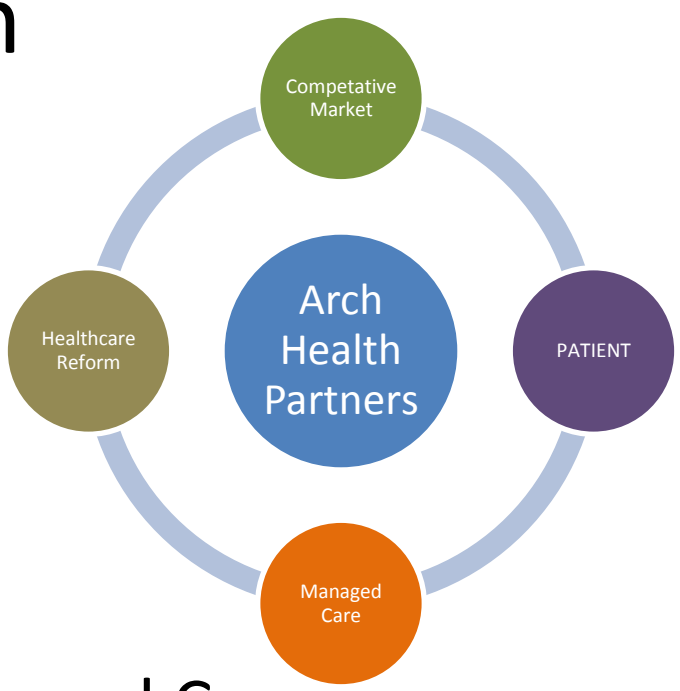
- Competitive Market
  - Sharp
  - Scripps
  - Kaiser
  - UCSD
- Heavy Penetration of Managed Care
- Health Care Reform
- Right thing to do for the patient



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High Value Organization

$$V = \frac{Q}{C}$$

Quality Initiatives

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Our goal is to be a Top Performing medical group. We strive to constantly improve our clinical quality, patient experience and appropriate resource use.

Quality Awards

- IHA
  - Top Performer 2010, 2011, 2012
  - Bangasser Award for Improvement 2009, 2012
- CAPG Standards of Excellence
  - Exemplary status 2010, 2011, Elite 2012
- California Department of Managed Health Care Right Care Initiative
  - Gold Performance Award 2011, Silver 2012

Quality Program

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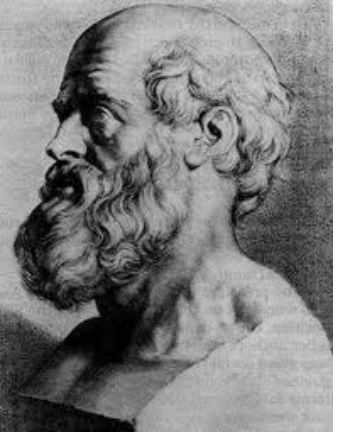
- Set Goals
- Clinical data registries for population management
- Balanced Scorecard Reporting and Incentives
- Patient Engagement and Outreach
- Care Management Programs to support medical management

In the Beginning, there was …

- California Pay for Performance Program (2003)
- Our initial scores did not represent the type of care we felt we were delivering, nor what our patients deserved.



Primum non nocere (First, Validate the Data)

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- Initial results based on health plan data
- We developed our own Clinical Registries for the P4P metrics to validate health plan data
- In 2006 began using Intelligent Health Care to develop registry
- 2009 supplemented by EMR
- Discovered better to self report in California as health plans in California may not receive all the clinical data with claims (improving).

Next, Own the Data

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- After scrubbing the data, still not as good as we thought we were.
- Engaged providers with validated data, but did not wait for “perfect” data
- Gaps identified
- Primary Care team established action plans by clinical measure for improvement

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Reporting and Incentives

- Targets established, set the bar high - top quartile
- Initially limited internal public reporting – create competition
- $s

Balanced Scorecard for Providers

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Clinical Quality	**Patient Experience**
Appropriate Resource Use	**Professional Development**

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Balanced Scorecard Implementation

- 24+ clinical metrics reported quarterly by MD
- PCP put own $s at risk
  - maximum increased over the years from $500 to $10,000
- Medical Assistant incentive developed for achieving positive outcomes in chronic disease and preventive care metrics

Snapshot of MD's Diabetes Scorecard (Qtr.)

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Member Name	DOB	AGE	Health Plan	SCORE	PCP	A1c Date	A1c Value	LDL-c_DATE	LDL-c Value	Retinal Eye Exam
		62	Aetna HMO			01/11/2012	6.8	01/11/2012	67	01/11/2012
		71	PacifiCare - Senior			03/02/2012	6.1	03/02/2012	71	07/20/2012
		49	Cigna Healthcare			03/13/2012	6.7	03/13/2012	104	01/10/2012
		61	Blue Cross HMO			03/12/2012	6	03/12/2012	54	05/21/2012
		51	Blue Cross HMO			07/06/2012	7.5	07/06/2012	105	03/06/2012
		46	Health Net HMO			09/24/2012	7.5	09/24/2012	60	07/18/2011
		69	BlueCross Senior			04/13/2012	7	04/13/2012	56	07/13/2012
		55	Pacific Care HMO			04/09/2012	6.3	04/09/2012	96	04/22/2011
		54	Aetna HMO			03/02/2012	7.4	03/02/2012	39	10/06/2011
# of Diabetics		40	Results YTD		Target Score for Incentive					
		#	%							
2012 HbA1C Screening		40	100.00%		Score >=92.61					
2012 Lipid Screening		38	95.00%		Score >=89.35					
2012 Nephropathy Monitoring or ACEI/ARB		30	75.00%		Score >=91.43					
2012 A1C Good Control <7%		21	52.50%		Score >=46.04					
2012 A1C Good Control <8% (this is the Right Care metric)		36	90.00%		Score >=66.59					
2012 A1C Bad Control >9%		0	0.00%		Score <=21.86					
2012 Lipid Control < 100 mg		31	77.50%		Score >=57.29					
2012 Blood Pressure Control < 140/90		26	65.00%		Score >=69					
2012 Retinal exams for diabetics		23	57.50%		Arch-wide score >4 Star Cutpoint of 64%					

MA's marching orders

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Member Name	DOB	AGE	Plan Name	PCP Name	HBA1C_DATE	HBA1C_VALU	LDL-c Date	LDL-c Value	MICROA_DATE
		48	Unknown		08/06/2012	7			
		72	PacifiCare - Senior		11/07/2011	5.6	03/01/2012	67	07/12/2012
		67	Aetna - Senior		07/18/2012	7.2			05/23/2012
		66	Health Net HMO		04/13/2011	6.6	06/21/2011	109	05/01/2012
		51	Health Net HMO		03/22/2012	9.5	03/22/2012	91	04/25/2012
		73	PacifiCare - Senior		09/27/2012	9.8	09/27/2012	58	09/27/2012
		56	Cigna Healthcare						
		46	Blue Cross HMO		09/13/2011	6.6	09/15/2012	116	09/15/2012
		64	Blue Cross HMO		08/07/2012	8.7	10/24/2011	71	09/10/2012
		56	BlueCross Senior		08/02/2012	5.8	11/16/2011	108	08/04/2012
		51	Aetna HMO		03/30/2012	9.4	03/30/2012	168	07/20/2012
		57	Blue Shield HMO		08/24/2012	9.3	08/24/2012	161	08/24/2012
		46	Aetna HMO		08/21/2012	10.5	03/20/2012	152	06/27/2012
		75	Aetna - Senior		07/05/2012	7	11/16/2011	75	11/16/2011
		59	Health Net HMO		09/15/2012	6.5	11/22/2011	101	01/27/2012
		57	Pacific Care HMO		12/06/2011	5.4			12/09/2011
		53	Health Net HMO		09/05/2012	6.8	12/16/2011	78	12/16/2011
		67	Blue Shield HMO		08/14/2012	5.6	08/14/2012	92	09/21/2011
		71	Health Net HMO		09/26/2012	6			
		68	Blue Shield HMO		06/15/2012	9.5	03/05/2012	76	03/05/2012
		70	BlueCross Senior		03/07/2012	9.2	03/27/2012	70	08/02/2012
		57	Aetna HMO		09/25/2012	11	09/25/2012	153	09/25/2012

Patient Engagement and Outreach

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- Based on identified gaps
- Personalized phone outreach by primary care office for evidence based screenings
- Care management team outreach for disease management - coordinated with primary care team
- Centralized targeted mailings and Televox

Care Management Program

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- Support medical management
- Initially focused on Quality metrics, evolved to include Appropriate Resource Use (ARU)
- Care Management Team
  - RN Case Manager
  - RN Disease Manager
  - SNF NP
  - Pharmacist (0.5)
  - Dietician (0.5)

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Where healing begins

Arch Health Partners Care Management Services

A proactive approach that promotes health and healing.

Health Promotion

- Support healthier lifestyles with Wellness promotion classes, chronic disease education and patient support groups
- MD-specific Preventive Care registries and lists
- Preventive care reminders
- Website health library

Disease Management

- Anti-Coagulation Clinic, including Lovenox self-injection teaching
- Diabetes, CHF, COPD/Asthma, Chronic Disease and co-morbid depression programs
- Direct Telephone access to RN or CDE for questions/concerns
- Medication titration Co-management
- Chronic disease registries to identify gaps in care
- Personalized self-management consultations using motivational interviews to develop action plans for self-management skills

Safe Transitions

- Post Hospital outbound calls to assess status, ensure follow-up care, reconcile medications, and answer questions
- Coordination of services post transition
- Patient-specific discharge plans

Complex Case Management

- At-risk patients are assigned to a Care Manager.
- A comprehensive assessment and care plan is developed and patients are monitored to assess progress and ensure continuity of care

Health Promotion and Disease Management

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- Importance of Education by PCP within Office Visit regarding Diabetes self-management stressed
- Monthly Diabetes Support Groups to supplement Ongoing Educational Series
- Certification as “Chronic Care Professional” within Care Team RNs initiated to strengthen patient activation skills

Complex Case Management

Patient Management Report

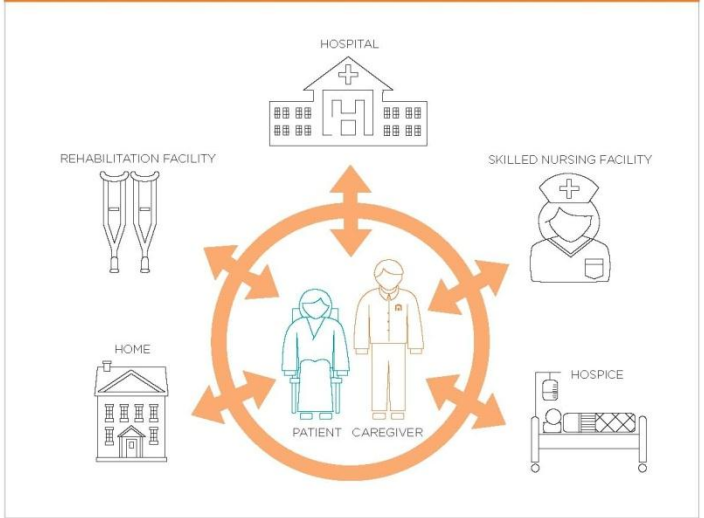
Provider Group Name: ARCH HEALTH PARTNERS (G_126516)

Member ID	Member Last Name	Member First Name	Member DOB	Member Phone	Date of Last Visit	Plan	Risk Level	HCC RAF	Total RAF	CHF	COPD	DM	CAD	Dementia	Cancer	Rheum Arthritis	Asthma	Renal	CVD	PVD	Depression	PCP Name
					10/24/2011	SecureHo	4	4.394	4.866	Y		Y			Y							JOSWIG,BILL
					10/03/2011	SecureHo	4	3.277	3.858	Y		Y			Y	Y		Y			Y	PUTNAM,RIC
					10/26/2011	SecureHo	4	3.82	4.524	Y					Y			Y		Y		ZGLINIEC,RO
					10/26/2011	SecureHo	4	4.99	5.407	Y	Y	Y	Y	Y	Y			Y			Y	CARTY JR,DA
					09/13/2011	SecureHo	4	3.346	3.818	Y		Y	Y		Y			Y		Y		PRESANT,LA
					07/24/2011	SecureHo	4	5.212	5.548												Y	DURE-SMITH
					10/04/2011	SecureHo	4	5.248	5.829	Y	Y	Y	Y		Y			Y		Y	Y	PUTNAM,RIC
					10/04/2011	SecureHo	4	5.345	5.763	Y	Y	Y			Y			Y		Y		MALETZ,LOU
					11/10/2011	SecureHo	4	5.4	5.872	Y			Y		Y			Y	Y	Y	Y	LIND,CHRIST
					11/03/2011	SecureHo	4	3.624	4.048			Y						Y		Y	Y	ZGLINIEC,RO
					08/26/2011	SecureHo	4	3.651	4.196	Y	Y	Y			Y			Y		Y	Y	LUAN,GORD
					10/21/2011	SecureHo	4	3.369	3.865		Y				Y							DURE-SMITH
					09/20/2011	SecureHo	4	3.471	3.761	Y	Y	Y			Y					Y	Y	LIND,CHRIST

Risk Stratify and Identify Highest Risk Candidates

- Identify high risk patients
- Assessment and close coordination of care
- Tracked and reported monthly

Safe Transitions



- Hospitalist program – we do it the old fashioned way (plus one)
  Plus one also Palliative Care

- Inpatient Case Management – liaison with inpatient, ambulatory, and disease management teams
  – supplements hospital case management program.

- SNF NP – manage SNF to ED, SNF to home

- Post-discharge continuity of care program to ensure follow up post ER, SNF and inpatient stay.

QI Review for Readmissions – Common Themes

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- End of Life
- SNF after hours to ER
- Social Services
- Post op complications
- Medication
  - proper med
  - med compliance

Safe and Proper Transitions

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- Appropriate time
- Appropriate care - SNF vs. LTCF vs. home vs. Palliative Care
- Appropriate meds, DME
- Appropriate Follow-up - outpatient appointment arranged prior to D/C

Care Management Team

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- Prior to Outpatient Appointment
  - Call post inpatient or ED discharge
  - Review D/C summary
  - Med Reconciliation
  - Assess Health Literacy
  - Advise of available transportation resources
  - Patient Activation
  - Daily Huddle

Med Reconciliation

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- PSRs – ask patient to bring in meds
- MA - check EHR active med list
- Docs – final review, access to inpatient EHR

SNF NP

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- Liaison with hospitalists to facilitate transition of patient from Hospital to SNF
- Care Provider in SNFs – enters D/C summary in outpatient EHR
- Coordinate care from SNF to outpatient
- Facilitates conversation re End of Life care

Enabling Care Across the Continuum

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- Urgent Care available 9-9
- ED Docs and Pharm Tech read only access to outpatient EHR
- Pharmacy Technician Med Reconciliation in ED

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Results

Arch Health Partners: Final 2011 Clinical P4P Results

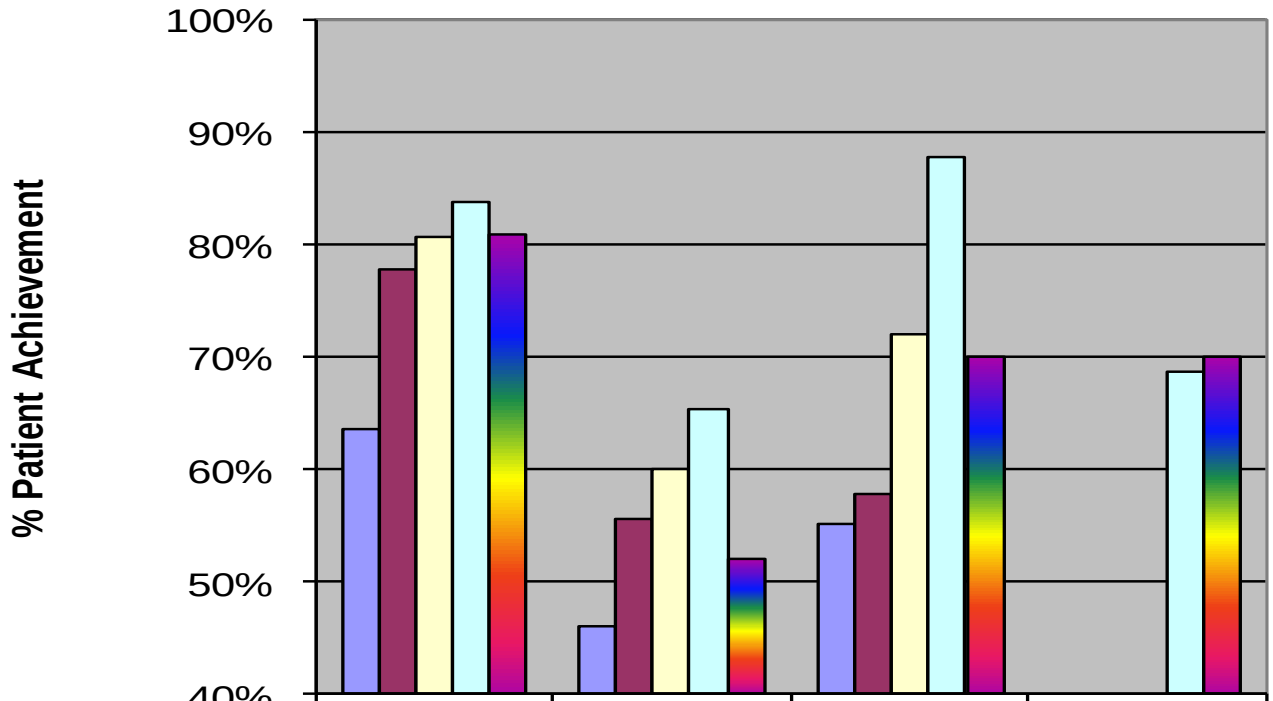
Target: Exceed 75th %ile Statewide

ers

18 out of 24 exceeded 75th %ile (vs 15/24 in 2010)
14 out of 24 exceeded 90th %ile (vs 10/24 in 2010)
16/24 or 67% showed improvement (vs. 13/18 or 72% in 2010)

Measure	AHP 2010 Score: % Compliant	2011 Score: % Compliant	50th %ile Cutpoint	75th %ile Cutpoint	90th %ile Cutpoint
CARDIOVASCULAR CARE					
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	92.68	97.44	89.47	94.45	95.76
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control <100 mg/dL	87.8	82.1	65.69	73.71	76.69
Annual Monitoring for Patients on Persistent Medications: Overall	78.09	79.85	80.52	83.55	87.87
DIABETES CLINICAL MEASURES:					
Diabetes Care: HbA1c Screening	95.06	94.82	87.24	91.3	93.23
Diabetes Care: HbA1c Poor Control > 9.0%	16.36	18.13	29.59	21.42	18.43
Diabetes Care: HbA1c Control < 8.0%	74.03	72.5	61.31	67.34	71.06
Diabetes Care: HbA1c Control < 7.0%	51.02	54.4	40.17	45.73	51.91
Diabetes Care: LDL-C Screening	94.03	92.49	84.19	88.9	92.22
Diabetes Care: LDL-C Control <100 mg/dL	65.19	65.54	46.33	55.79	64.27
Diabetes Care: Nephropathy Monitoring	94.29	95.34	81.9	88.77	93.02
Diabetes Care: Blood Pressure Control <140/90 mm Hg	68.57	67.1	23.95	64.9	79.01
Optimal Diabetes Care Combination Rate 1: A1c < 8%, LDL-c <100mg/dL and Nephropathy monitoring	50.65	50.77	28.13	41.64	46.92
Optimal Diabetes Care Combination Rate 2: All Combo 1 and BP Control <140/90 mm/Hg	38.7	39.12	7.69	27.87	39.41
RESPIRATORY AND MUSCULOSKELETAL CARE					
Asthma Medication Ratio	74.07	83.78	68.42	73.53	77.44
Appropriate Testing for Children with Pharyngitis	97.14	85.19	65.9	86.59	93.54
Appropriate Treatment for Children with Upper Respiratory Infection	97.78	100	93.75	97.61	98.47
Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	65.63	54.1	37.48	50.9	61.87
Use of Imaging Studies for Low Back Pain	80.65	82.55	79.86	84.85	88.24
PREVENTIVE CARE:					
Childhood Immunization Status: All Antigens (by Age 2)	79.37	88.88	71.19	82.16	88.02
Immunizations for Adolescents: All Antigens (by Age 13)	53.07	72.37	41.35	54.51	62.7
Chlamydia Screening: Age 16-24	42.51	51.6	53.29	62.86	69.27
Evidence-Based Cervical Cancer Screening - Appropriately Screened	28.63	32.72	35.05	43.58	72.91
Breast Cancer Screening: Ages 52-69	73.82	79.56	73.36	80.44	83.71
Colorectal Cancer Screening: Ages 51-75	62.77	69.99	55.87	69.42	72.94

Right Care Initiative Trends - Arch Health Partners



	Diabetic A1c < 9%	Diabetic LDL-c < 100	Cardiac LDL-c < 100	Diabetic BP < 140/90*
2007	63%	46%	55%	
2008	78%	55%	58%	
2009	81%	60%	72%	
2010	84%	65%	88%	69%
RCI Goal	81%	52%	70%	70%

RCI metric

2012 Inpatient Readmission Rates %

	Jan	Feb	Mar	Apr	May	Jun	YTD
Commercial	6	0	17	4	8	6	**7**
Senior	5	11	4	11	11	4	**7**

SNF Readmission Rates %

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	Jan	Feb	Mar	Apr	May	Jun	YTD
Commercial	0	0	0	20	0	0	**4**
Senior	25	0	18	17	0	0	**9**

Was it Because we had long Lengths of Stay?

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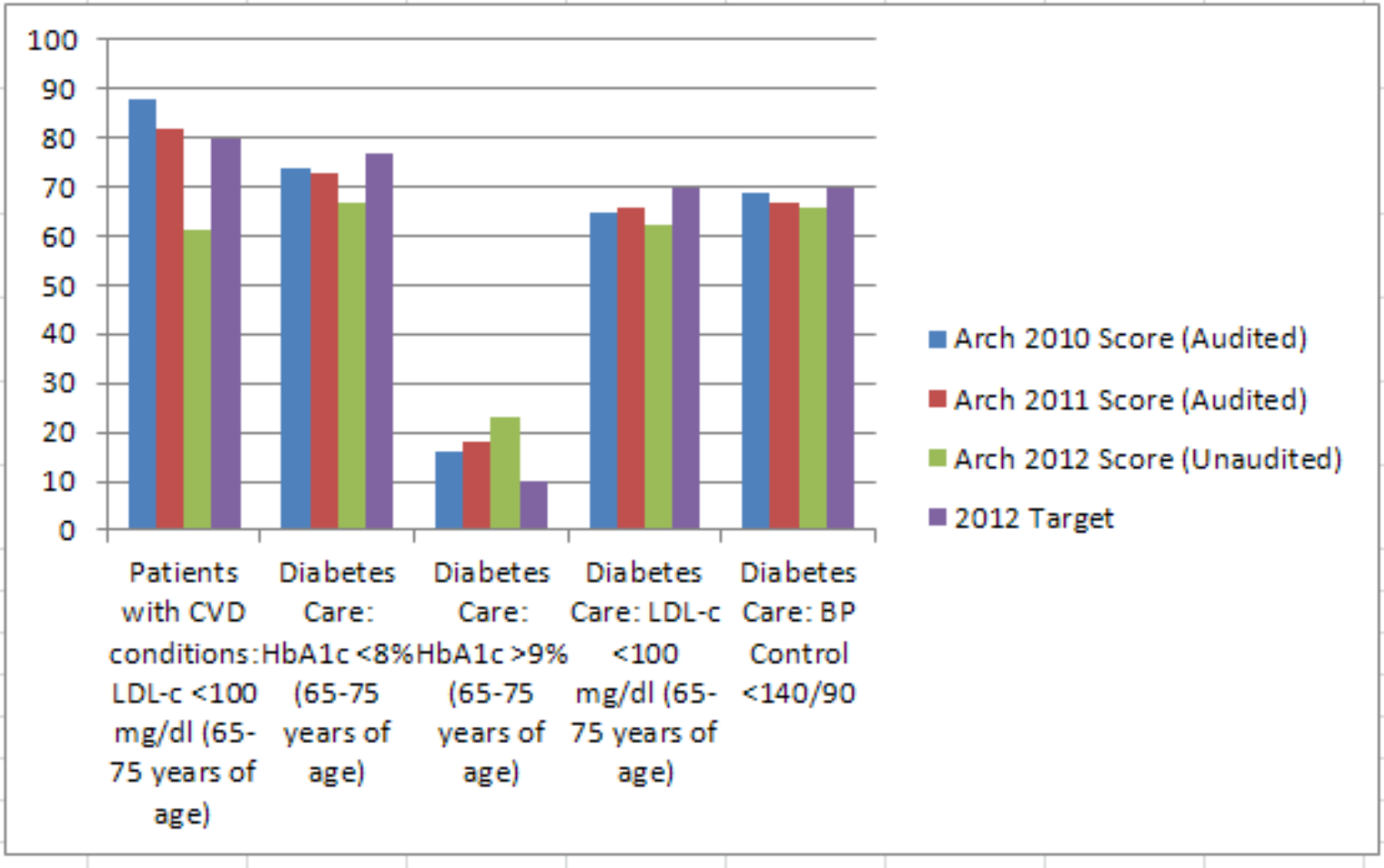
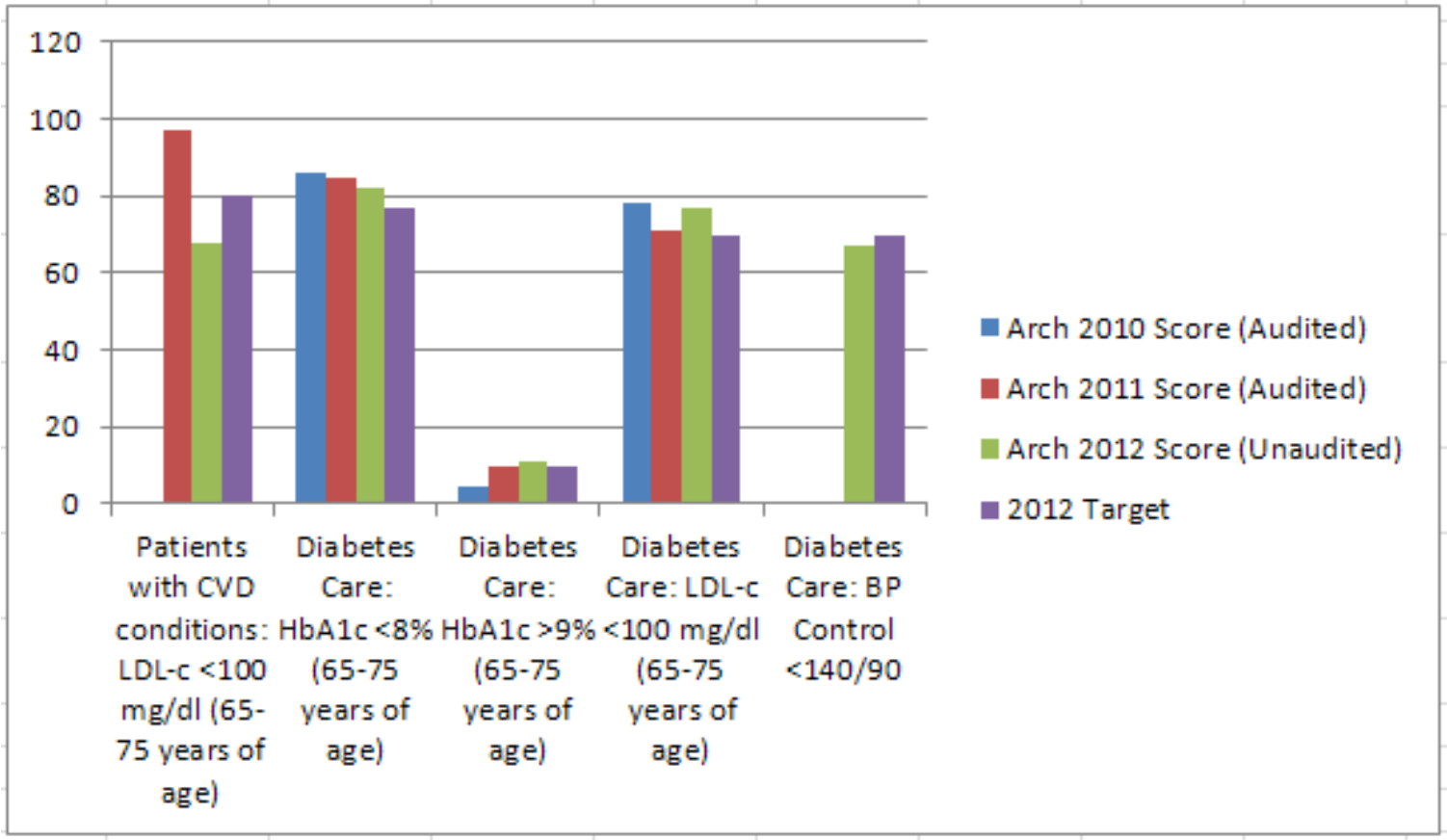
Senior Length of Stay	2011	2012	Milliman Well Managed
Inpatient Comm	3.3	3.3	3.6
Inpatient Sr	4.2	4	4.1
SNF Sr	14.4	17	12
Bed Days/1000			
Inpatient Comm	144	143	150
Inpatient Sr	859	759	935
SNF Sr	1061	872	1010

SD RCI Metrics
Commercial HMO (2010-2012)



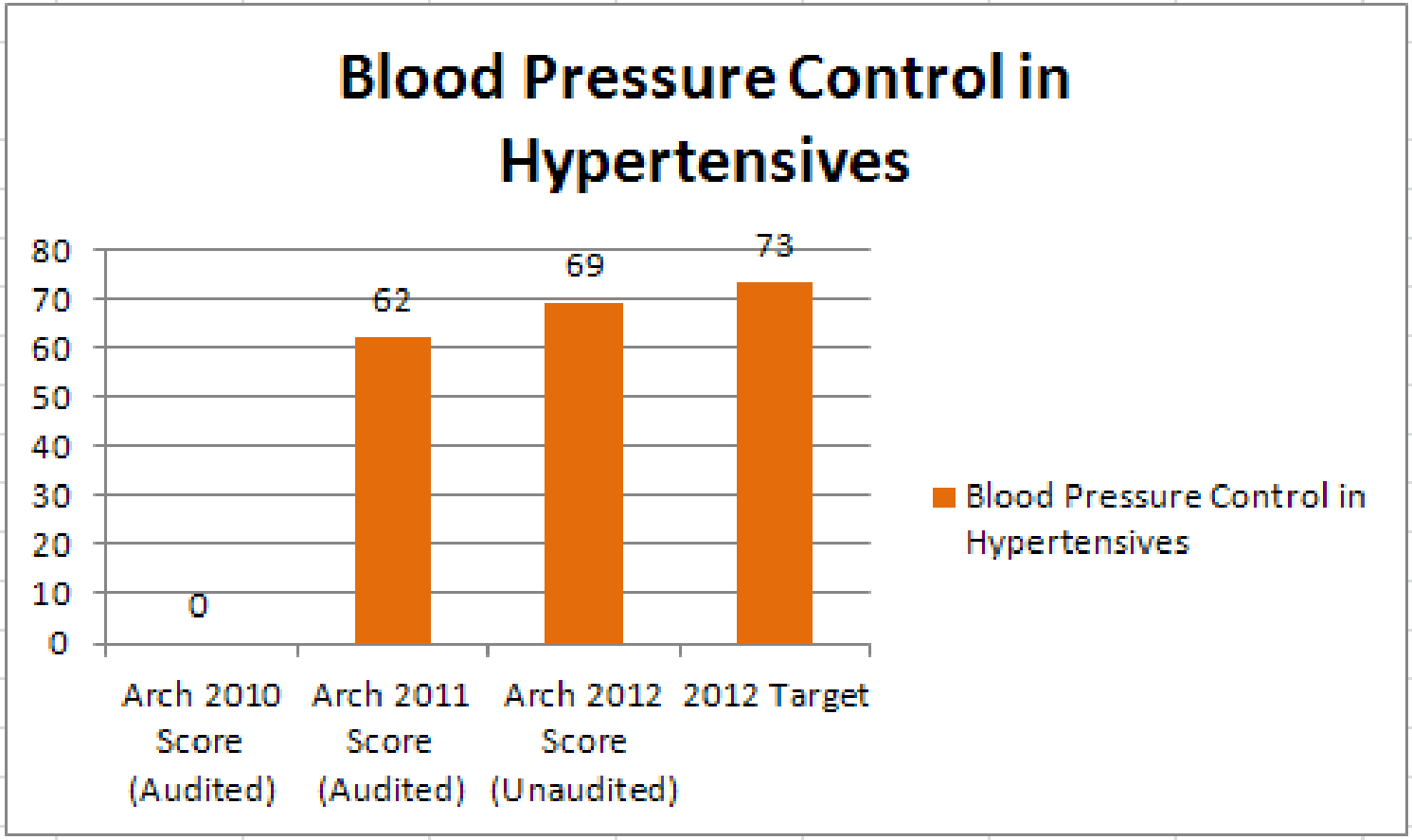
2012 Score based on Q3 data

SD RCI Metrics
Medicare HMO (2010-2012)



2012 Score based on Q3 data

BP Control in Hypertensive 18-75 Year Olds (2010-2012)



To view the top medical groups for your region move your mouse pointer over the map of California or view full list of top medical groups.

San Diego

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Sharp Rees-Stealy Medical Centers
Southern California Permanente Medical Group - San Diego
UCSD Medical Group

http://www.opa.ca.gov/report_card/topmedicalgroup.aspx

Why did we do so well?

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- Had a clear vision of where we wanted to go and people with the skills to take us there
- Entire team cared about the outcomes – everyone bought in
- Patients that cared
- Initially two locations – could concentrate resources
- Sustained the effort

Challenges

- Limited staff in Care Management
- Manual nature of data processing
- Motivating office staff in an already busy practice
- Ongoing nature of staff education, e.g. blood pressure measurement and documentation

Where do we go from here…

- Continue journey toward PCMH to further strengthen population management skills within our practice
- Implementation of an integrated population health management system
- Participating in Measure-up, Pressure-down

But Wait, there's More…

- Pharmacist role expansion
  - Medication Reconciliation
  - Generic Prescribing
- Participating in social media pilot for HTN patients
- Home Monitoring Pilot
- Right Care Initiative

Participants

San Diego Vision

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San Diego will be a heart attack and stroke free Community

- Heart attack and stroke prevention focused on heart disease and diabetes patients through lipid and blood pressure management
- Right Care will support medical directors of San Diego via its “University of Best Practices” luncheon series

Statewide Goals

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- **Achieve National HEDIS 90th Percentile Targets:**
- **74%** of hypertensive patients with **blood pressure** controlled: <140/90 mm Hg
- **72%** of patients with cardiovascular conditions with **lipids** controlled: LDL-C < 100 mg/dL
- **70%** of diabetic patients with **blood sugar** controlled: HbA1c <8
- **57%** of diabetic patients with **lipids** controlled: LDL-C < 100 mg/dL

- **Reduce Hospital Acquired infections:**
  - Median of zero **central line infections**

Summary - Best Practices

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- Data - Disease Management Registries
- Team
  - Primary Care Team – Doc and MA
  - Disease Management Nurse
  - Case Management
  - Complex Case Management
  - SNF NP
  - Pharmacist
- Patient, Staff, and Provider Activation
  - Staff activation incentives
  - Provider activation – incentives and reporting
  - Patient Activation
    - Primary Care team
    - Direct Patient Activation

Questions?

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