



# Clinical Integration to Maximize Population Health Management

Donald J. Rebhun, MD, MSPH  
Corporate Medical Director

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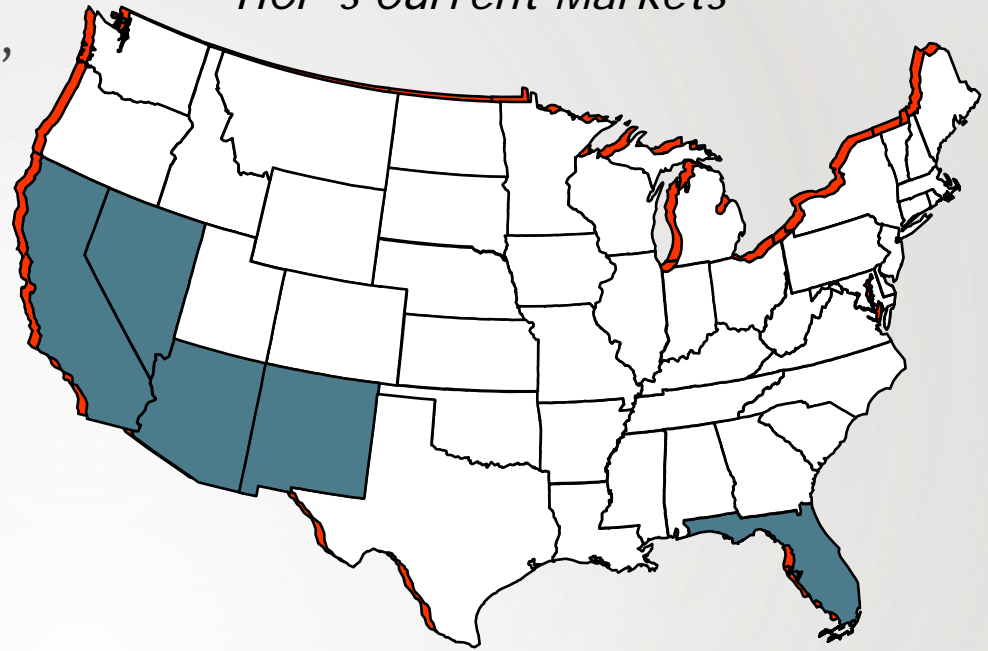


- \* Multi-State Physician Organization
- \* Delivery Model
  - \* Coordinated and Integrated Care
- \* Triple Aim:
  - \* Improve Health Care Quality
  - \* Patient Access & Satisfaction
  - \* Reduce costs
- \* Global Capitation Predominates
- \* Centrally Coordinated
- \* Regionally Driven
- \* Strong Medical Management Infrastructure
- \* Robust Business Support Units

**\*HealthCare Partners**

*Largest Private Medical Group in each of  
HCP's Current Markets*

- \* Operates in 5 states: AZ, CA, FL, NM, NV
- \* Senior HMO MAPD Patients ≈ 270k
- \* Commercial HMO Patients ≈ 400k
- \* Medicaid HMO Patients ≈ 100k
- \* Employed Physicians >1,100
- \* IPA Primary Care Physicians > 2,900
- \* IPA Network Specialists: >7,000



*Variety of  
physician and  
hospital  
payment  
arrangements*

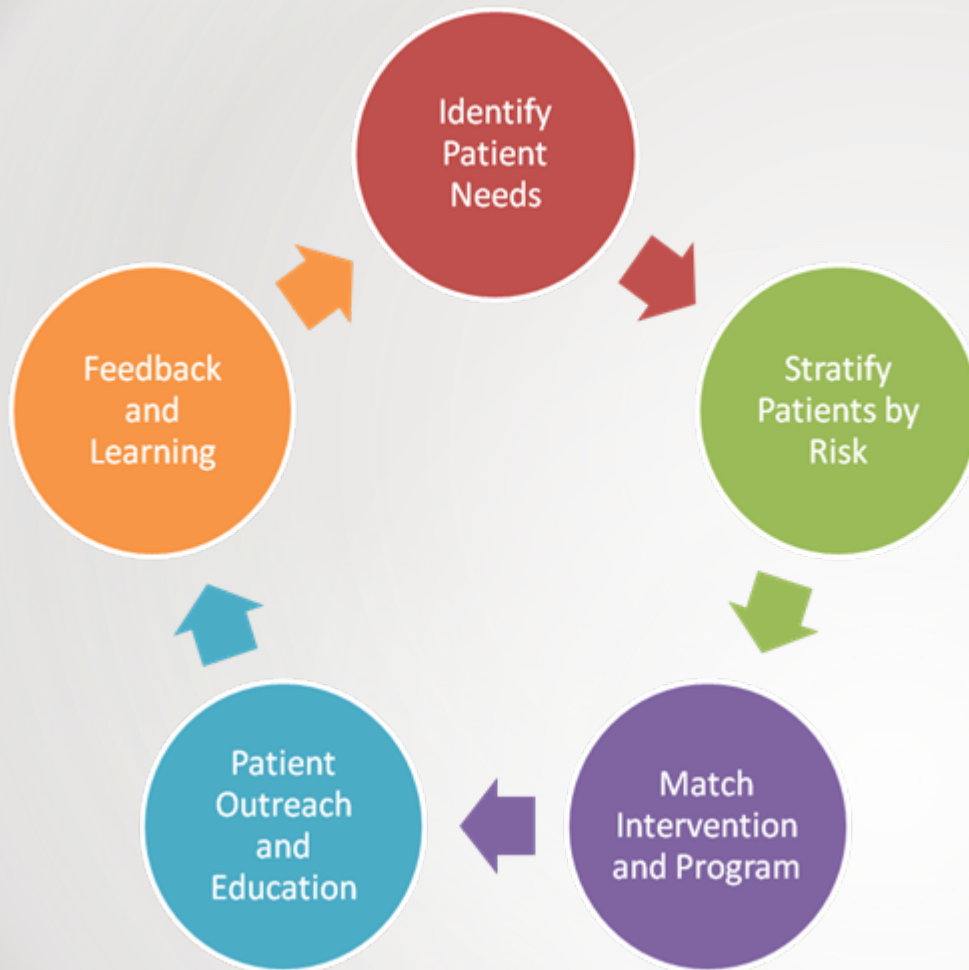
All employed physicians paid salary with incentives

Contracted Physicians (PCPs & Specialists) paid on percent of Medicare or capitation or combination plus incentives

\* **HCP Current Market Footprint**

- \*Technology Backbone
- \*Registry - Must Know the Population
- \*Stratify Patients
- \*Actionable Data for the Population
- \*Traditional and Innovative Programs to Improve Outcomes

## \*Population Health Management Requirements



The continuous “Virtuous Cycle” of improved care and outcomes is at the heart of HCPs proactive population management.

Continuous improvement to drive:

- \*Better Care
- \*Better Quality
- \*Better Efficiency
- \*Better Patient Experience

**\* Proactive Population Management**



## Allscripts/Enterprize EHR

- Fully deployed Group Model

## NextGen/PACIS for Affiliated Model

- Currently supported in physician practices
- 400 Physicians/2500 Users

## IDX Practice Management

## Data Warehouse

- Integrated warehousing system for corporate wide reporting

## Analytics geared to improved outcomes

*Electronic clinical data is necessary to improve population health and the health of individuals*

\***Technology Backbone**

**All feeds to Integrated  
Data Warehouse**

(Clinical EHR, Lab, Rx,  
Images, Encounters,  
Claims, Hospital A/D/C)

**Patient Keeper  
Hospitalist System**

**Predictive Modeling  
(Patient Risk  
Stratification)**

**PIP**

**(Physician  
Information Portal)**

**POP**

**(Patient Online  
Portal/PHR)**

**HealthCarePartners.com  
Corporate Webpage**

**\*Technology Backbone**

*Continued*

# HR Diabetics w CHF and CKD and GFR less 30 NO ACEARB

HCP Reporting Services Development  
Home > DZReg > ReportModel

Home | My Subscriptions | Help  
Search for:  Go

Contents Properties

New Folder New Data Source Upload File Report Builder Show Details

- ChfDetailReportModel
- Commercial\_Group\_Diabetics\_LDL\_150\_NO\_LIPID\_RX
- DiabetesDetailReportModel
- dzreg
  - dzreg
  - HR Diabetics w CHF and CKD and GFR less 30 NO ACEARB
  - JH HR Group Diabetics All Regions
  - JH HR IPA Diabetics All Regions
  - R1 Diabetic Eye Exam Call List Commercial Group Patients
  - R1 Diabetic Eye Exam Call List Senior Group Patients
  - R2 and R4 Senior Group Diabetics LDL GR130 No LipidRx
  - R2 Group Seniors BMI Greater 30 and SHTN
  - R2 Group Seniors LDL Greater 100
  - R3 Senior Group Diabetics LDL GR130 No LipidRx
  - R4 Bixby Group Diabetic Commercial w LDL Greater 100
  - R4 Bixby Group Diabetic Seniors w LDL Greater 100
  - R4 Bixby Group Diabetic Seniors WO LDL 2yr
  - R4 Bixby IPA Diabetic Seniors w LDL Greater 100
  - R4 Bixby IPA Diabetic Seniors WO LDL 2yr
  - R4 CHF SCAN Patients
  - R4 Group Diabetic Patients Senior N Commercial No LDL
  - R4 Group Seniors GFR Less 60
  - R5 Senior Group Diabetics With Systolic Hypertension LDL G100
  - R5 Diabetics A1C Greater8 and SHTN
  - R5 Group Diabetic Patients Senior N Commercial LDL Greater Than 100 On Lipid Rx
  - R5 Group Seniors BMI Greater 30
  - R5 Group Seniors GFR Less Than 30 No CKD Dx
  - R5 Group Seniors GFR Less Than 45 No CKD Dx
  - R5 Group Seniors GFR Less Than 60 No CKD Dx
  - R5 IPA Seniors GFR Less Than 30 No CKD Dx
  - R5 IPA Seniors GFR Less Than 45 No CKD Dx
  - R5 IPA Seniors GFR Less Than 60 No CKD Dx
  - R5 Senior Group Diabetics With Systolic Hypertension LDL Uncontrolled
  - Region 4 Diabetics LDLGreater 100 Lipid Rx
  - Region 4 Diabetics LDLGreater 100 Lipid Rx Bixby
  - Region 4 Diabetics LDLGreater 100 Lipid Rx Katella Docs
  - Region 4 Diabetics LDLGreater 100 No Lipid Rx
  - Region 4 Diabetics LDLGreater 100 No Lipid Rx Katella Docs
  - Region 4 Diabetics No LDL All Patients Group IPA
  - Region 4 Diabetics No LDL Bixby

\* Custom Registries Based on Specific Interventions



- By Demographics
- HCC By Category
- HCC Physician Pursuit List
- High Risk Pursuit List
- No HCC History
- HCC Non Recaptured Codes
- P4P By Category
- [P4P Pursuit List](#)

Performance Measures

Code Clearing

Medicare Advantage PD

Clinical Viewer

Tools

Help

PATIENT NAME	DOB	LAST CDC SERVICE	P4P MEASURE STATUS	OTHER INTERVENTIONS	HEALTH PLAN	NEXT PCP VISIT	PIR
		04/12/2013	<ul style="list-style-type: none"> <li>• LDL Control and Retest</li> <li>• Perform Nephropathy Screening</li> </ul>				
		04/05/2013	<ul style="list-style-type: none"> <li>• HbA1c Control &lt; 7% and Retest</li> </ul>				
		06/05/2013	<ul style="list-style-type: none"> <li>• HbA1c Control &lt; 8% and Retest</li> <li>• LDL Control and Retest *</li> </ul>	<ul style="list-style-type: none"> <li>• STAR - Needs eye exam for glaucoma</li> <li>• STAR - Needs retinal or dilated eye exam</li> </ul>			
		05/31/2013	<ul style="list-style-type: none"> <li>• LDL Control and Retest *</li> </ul>	<ul style="list-style-type: none"> <li>• STAR - Control and recheck BP</li> <li>• STAR - Needs eye exam for glaucoma</li> <li>• STAR - Needs retinal or dilated eye exam</li> </ul>			
		03/25/2013	<ul style="list-style-type: none"> <li>• HbA1c Control &lt; 7% and Retest</li> <li>• LDL Control and Retest</li> </ul>	<ul style="list-style-type: none"> <li>• P4P - Needs PAP</li> </ul>			
		09/07/2012	<ul style="list-style-type: none"> <li>• Perform HbA1c Test</li> <li>• Perform LDL Test</li> <li>• Perform Nephropathy Screening</li> </ul>			06/20/2013 9:00 AM	
		04/22/2013	<ul style="list-style-type: none"> <li>• LDL Control and Retest</li> </ul>				
		03/23/2013	<ul style="list-style-type: none"> <li>• Control and recheck BP</li> <li>• LDL Control and Retest</li> </ul>			06/28/2013 8:00 AM	
		04/29/2013	<ul style="list-style-type: none"> <li>• Perform HbA1c Test</li> <li>• Perform LDL Test</li> </ul>	<ul style="list-style-type: none"> <li>• P4P - Need CRC screening</li> <li>• P4P - Perform K+ AND SCr or BUN Test</li> </ul>			
		04/25/2012	<ul style="list-style-type: none"> <li>• Control and recheck BP</li> <li>• Perform HbA1c Test</li> <li>• Perform HbA1c Test *</li> <li>• Perform LDL Test *</li> <li>• Perform Nephropathy Screening *</li> </ul>	<ul style="list-style-type: none"> <li>• 250.00 - Needs Coding</li> <li>• HCC - Diabetes</li> <li>• 357.2 - Needs Coding</li> <li>• HCC - Diabetes</li> <li>• STAR - Needs</li> </ul>			

# \* Sample Pursuit List: PiP-Diabetes Management

# HEALTHCARE PARTNERS

# PATIENT INTERVENTION REPORT

REPORT DATE: 3/1/2012

Page 1 of 7

Region(s): Region V

Site(s): HCP IPA - San Fernando Valley

PCP(s): [Redacted]

Name	[Redacted]	Telephone	[Redacted]	Address	[Redacted]
MRN	[Redacted]	Enrolled	[Redacted]	City/Zip	[Redacted]
DOB	[Redacted]	Gender	M	Next PCP Appt	[Redacted]

Last ER/UCC visit

## Last UCC/ER Visit Summary

DATE OF SERVICE	FACILITY NAME	FIRST DX
08/16/2011	WEST HILLS EMERGENCY MEDICAL ASSOCIATES	789.03 - ABDOMINAL PAIN RT LWR QUAD

## PIR Summary 2012:

Intervention Type	Description	Suggested Actions
P4P	Comprehensive Diabetes Care	Perform HbA1c Test Submit both Blood Pressure CPTII Codes
P4P/STAR	Comprehensive Diabetes Care	Perform HbA1c Test Perform LDL Test Perform Nephropathy Screening
STAR	Diabetes Care- Eye Exam Glaucoma Screening in Older Adults	Needs retinal or dilated eye exam Needs eye exam for glaucoma
HCC	15 Diabetes With Renal Or Peripheral Circulatory Manifestation 250.40 Diabetes W/renal Manif, Type II Or Unspec, Controlled	Needs Coding
	19 Diabetes Without Complication 250.00 Diabetes W/o Complication Type II / Unspec, Control	Needs Coding
	131 Renal Failure 585.3 Chronic Kidney Disease, Stage III (moderate)	Needs Coding
Chart Review	105 - VASCULAR DISEASE 440.0 - AORTIC ATHEROSCLEROSIS	Hospital Summary or Discharge Note - 02/07/2008 - West Hills Radiology. CT Angio with atherosclerotic vascular disease of the aorta. This would be consistent with aortic atherosclerosis. Also note on 10/15/2007 CXR.

Comprehensive POC reminders for the PCP - based on established best practices (e.g. P4P)

# \* Stratifying Patients into the Appropriate Program

## Hospice/Palliative Care

### Home Care Management

Provides in-home medical and palliative care management by specialized Physicians, Nurse Care Managers and Social Workers for chronically frail seniors

*Level 4  
Home Care Management*

### High Risk Clinics and Care Management

Intensive 1:1 physician, social worker, & case management for the high risk, and/or post-discharge population. Patient is transferred to Level 2 when stable. Physicians and Care Managers are highly trained and closely integrated into community resources and Physician offices or clinics.

*Level 3  
High Risk Clinics*

### Complex Care and Disease Management

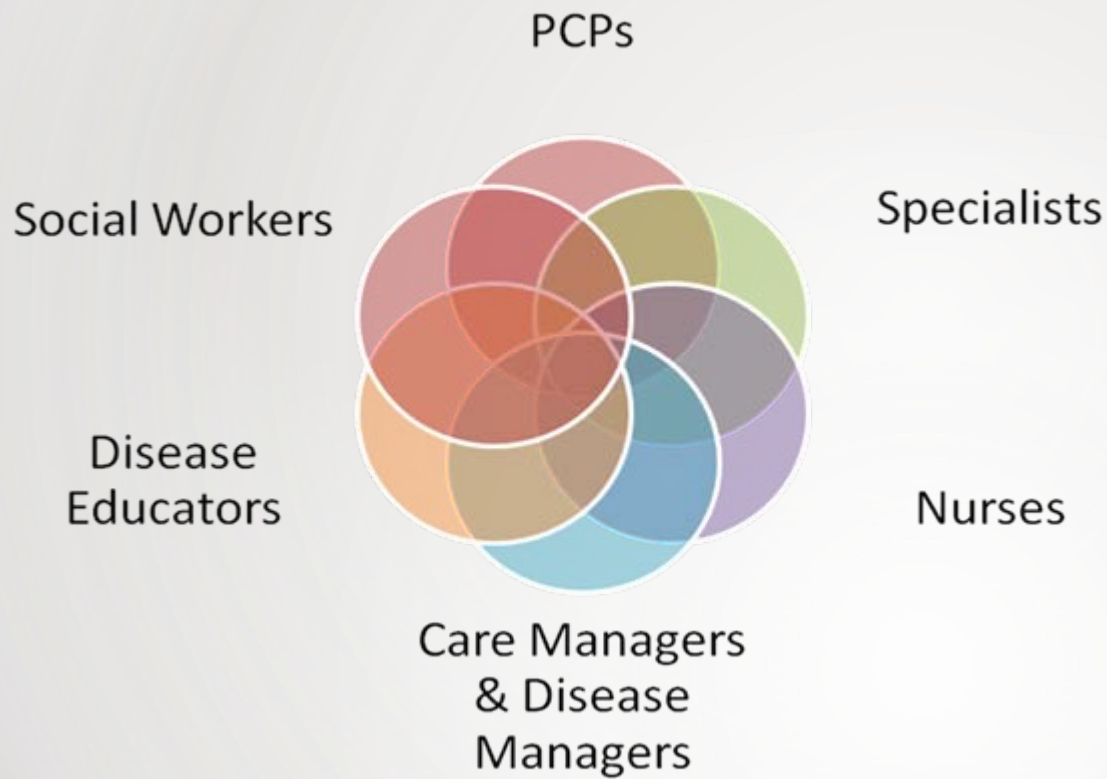
Provides whole person care enhancement for the population using a multidisciplinary team approach. Diabetes, COPD, CHF, CKD, Depression, Dementia, CAD, organ transplant

*Level 2  
Complex Care & Disease  
Management*

### Self Management, PCP

Provides self-management for people with chronic disease.

*Level 1  
Self-Management & Health Education  
Programs*



\* Interactive and collaborative teams support clinical programs.

\* High Risk Programs:

- \* Home Care/ House Calls
- \* ESRD
- \* Comprehensive Care Center
- \* Post-Acute Comprehensive Care
- \* Collaborative Care for Chronically Mentally Ill

\* Disease Management Programs:

- \* Diabetes
- \* CAD
- \* CHF
- \* COPD
- \* Dementia
- \* Depression

# \*The HCP Care Team Approach

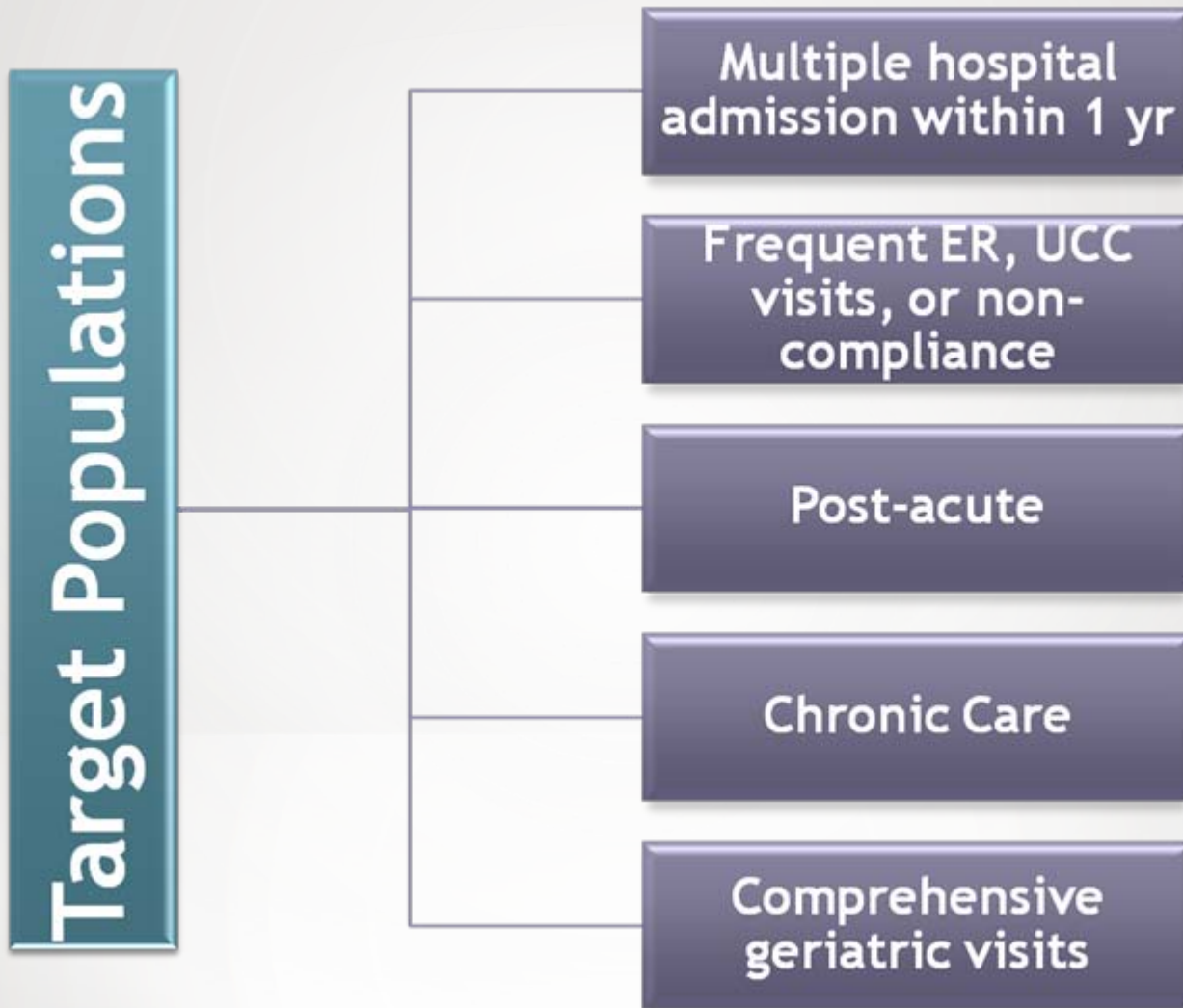


# \*Focus on Population



- \* 62% of older people - 2 or more chronic illnesses
- \* 75% of all hospital admissions attributable to chronic conditions (accounts for over \$75 billion of overall healthcare costs)
- \* High Risk Program
  - \* Multiple admissions
  - \* Patients discharged from the hospital with multiple medical conditions
  - \* For the chronically ill and frail patient

# \* High Risk Clinics Comprehensive Care Clinic



# \*High Risk Programs

## Comprehensive Care Clinic (CCC)

- \* Post-hospitalization clinics/appropriate transitions of care
- \* Medication reconciliation
- \* Access to additional community resources
- \* Psycho-social health assessment
- \* Disease and care plan education
- \* Advanced care planning
- \* Communication with PCP, specialists, and patient/family





- \* Top 2-3% most at-risk patients
- \* Comprehensive assessment:
  - \* Living conditions
  - \* Social and financial needs
  - \* Medication regimen
  - \* Medical and behavioral health
- \* Advanced care planning
- \* Palliative care




**\* High Risk Programs:  
Home Care**



High Risk Programs have shown a decrease in hospital days & ER utilization

*Example of CCC Outcomes*

- 
- 25% decrease in Days per Thousand
  - 26% decrease in Admits per Thousand
  - 27% decrease in ER visits

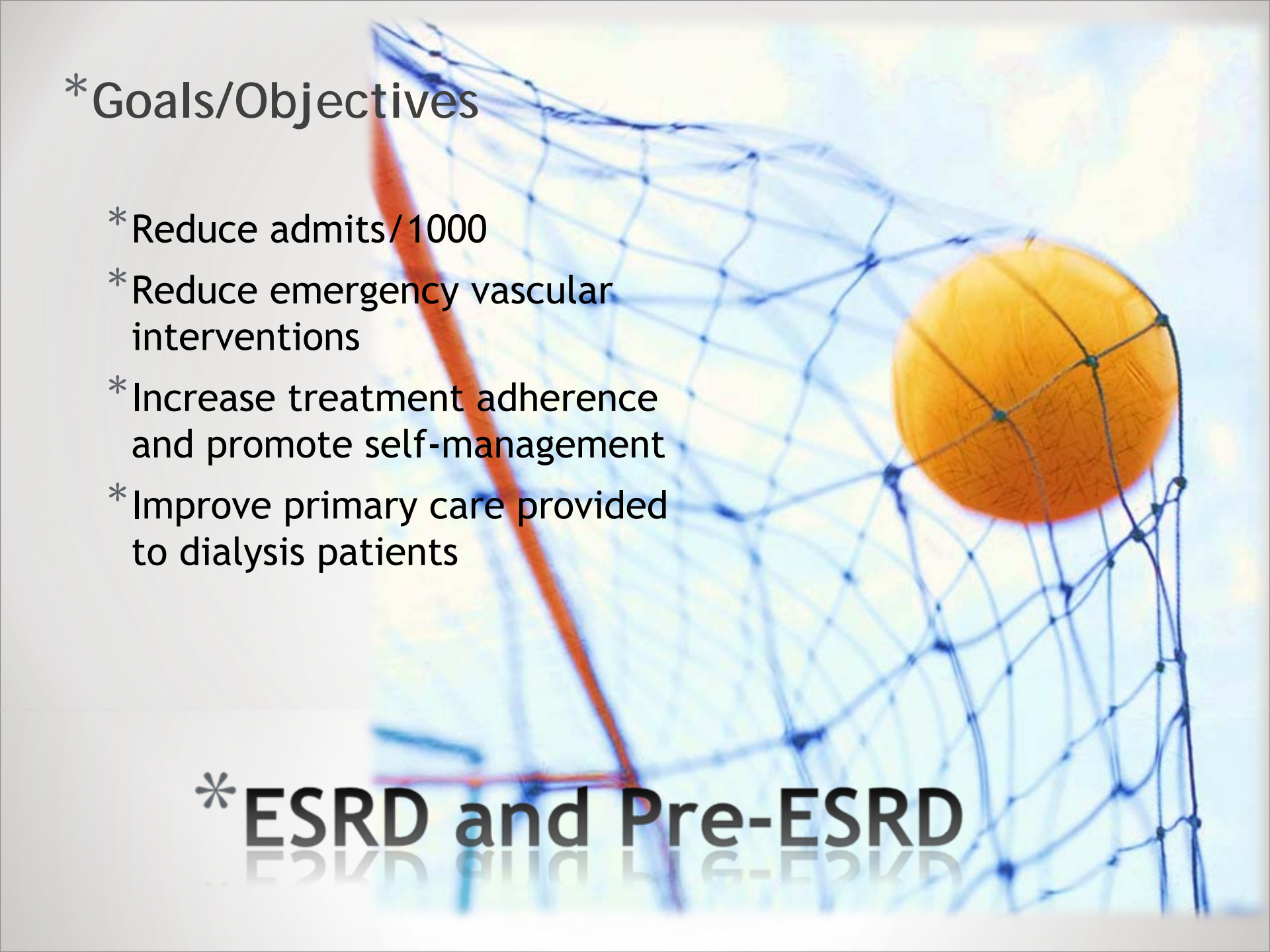
\* **High Risk Program  
Outcomes**

- \*Target CKD Stage IV and V - provide complex care management
- \*Improve primary care provided to dialysis patients
- \*Emotional and physical preparation for patients and caregivers prior to dialysis
- \*Establish early access placement
- \*Reduce emergency vascular interventions
- \*Increase treatment adherence and promote self-management
- \*Advanced care planning

**\*High Risk Programs: ESRD**

- \* ESRD population is our highest risk and highest cost population
- \* ½ of all ESRD patients accounted for all utilization costs (pre-program). The challenge is to identify those patients prior to an event.
- \* Need to engage community nephrologists
- \* Need to engage our PCP community to address the pre-ESRD patients
- \* Education on “access” to prevent crash dialysis
- \* Education on dialysis options; peritoneal dialysis

**\* High Risk Programs: ESRD**

A blue fishing net is stretched across the frame, with an orange buoy attached to it. The background is a light blue sky with some clouds. The net is made of a fine mesh of blue lines, and the buoy is a solid orange sphere.

## \*Goals/Objectives

- \* Reduce admits/1000
- \* Reduce emergency vascular interventions
- \* Increase treatment adherence and promote self-management
- \* Improve primary care provided to dialysis patients

\* **ESRD and Pre-ESRD**

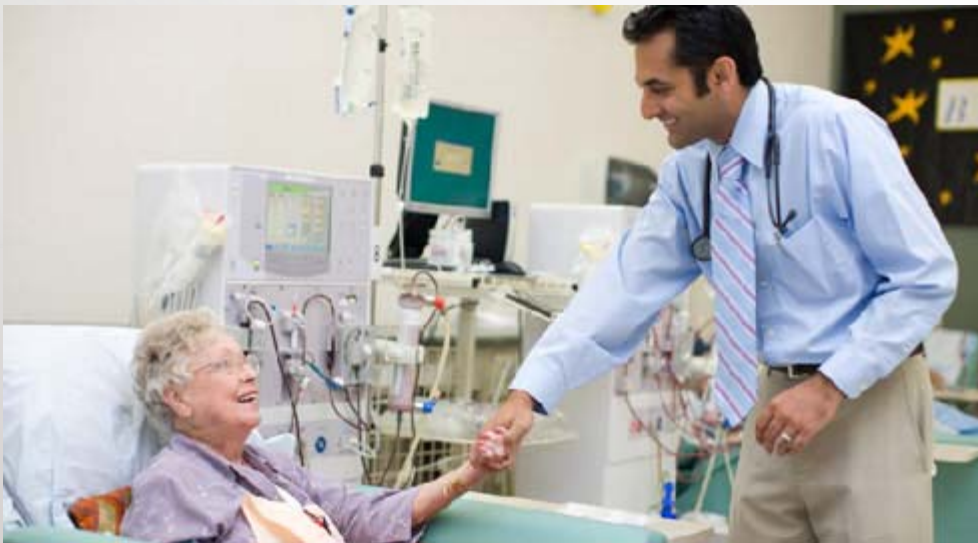


# \* Overview of Pre-ESRD Program

## \* Pre-ESRD (CKD)

- \* Monitoring patients approaching dialysis; and those ready for dialysis (GFR & Dialysis Reports; monthly); targeting patients with  $GFR < 30$
- \* Identifying patients without a referral for nephrology and those without a referral for vascular surgery; facilitating referrals for those patients
- \* Promote education to the patient

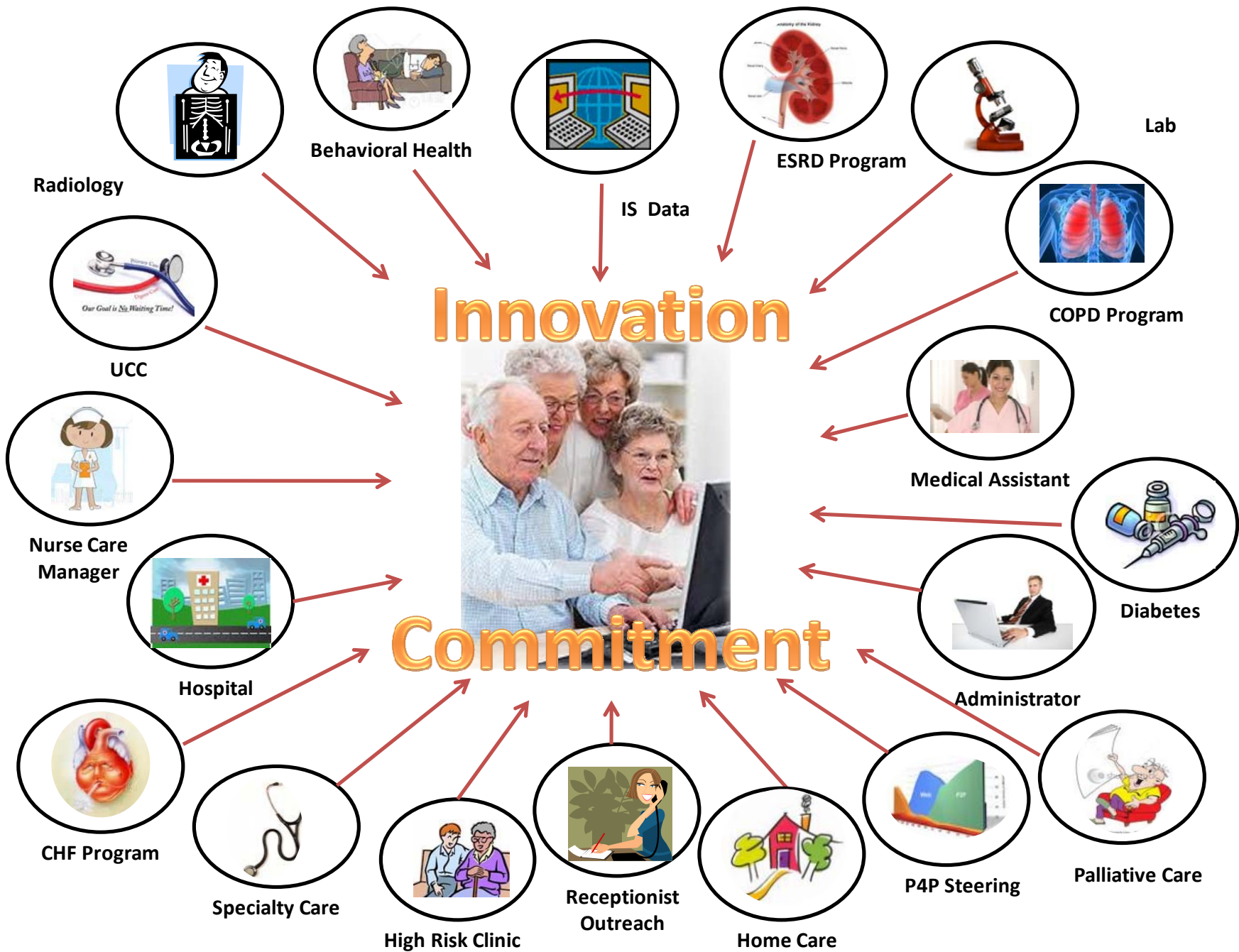
- \* Work with patients at dialysis centers
- \* Focus on those patients admitted within the past 12 months
- \* Focus on dialysis new-starts
- \* Focus on problematic patients
- \* Address vascular access issues timely
- \* Managing comorbid conditions, preventative care
- \* Coordinators assist with specialist visits, transportation needs
- \* Supported by Nurse Practitioners



# \* Overview of ESRD Program

Patients	Pre Program	In Program	% change	
Distinct Patients		488		
Member Months	5,653	5,804		
<i>Acute</i>				
Inpatient Admits/1000	1295	970	25%	↓
Days/1000	5702	3,581	37%	
<i>Sub Acute</i>				
Sub Acute Days/1000	4,203	3,118	26%	↓
<i>Total Days/1000 (acute, sub acute)</i>	7,304	4,855	34%	
<i>ER/1000</i>	469	616	31%	↑

# \* 2012 ESRD Program Outcomes





**\*Thank You!**