Prevea Health

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PREVEA health

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Agenda

- About Prevea
- Identifying Gaps in Care
- Impact of Office Visit Frequency
- Automated Patient Outreach
- Results

About Prevea Health

- Founded in 1996
- Multi-Specialty Medical Group
- Over 200 physicians
- 1000+ employees servicing Northeast Wisconsin
- 18 health centers, including nine in the Green Bay metro area and regional locations
- 50 specialties

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Our Values

Mission

- To take care of people with passion, pride and respect.

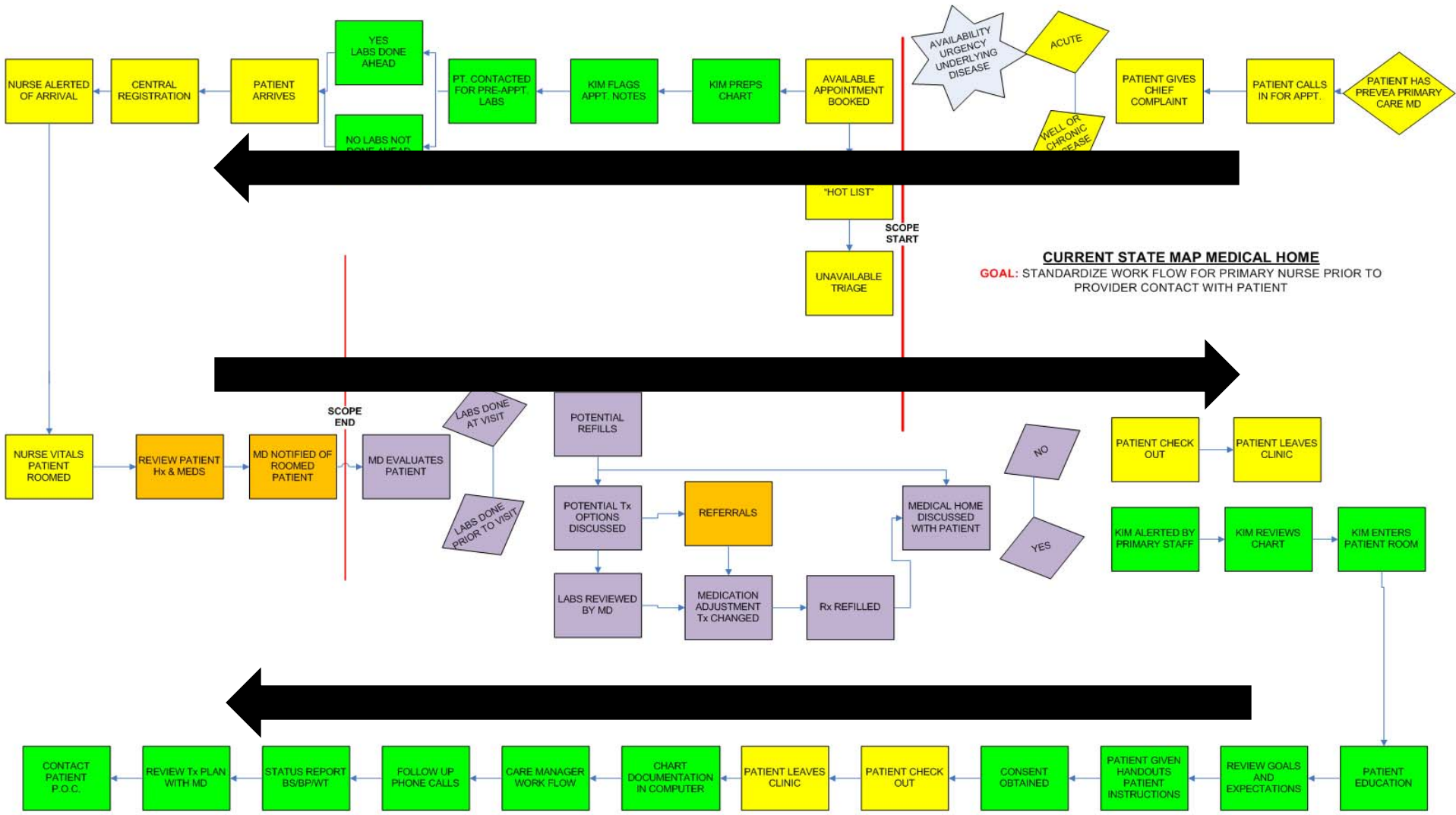
Vision

- The best place to get care
  The best place to give care

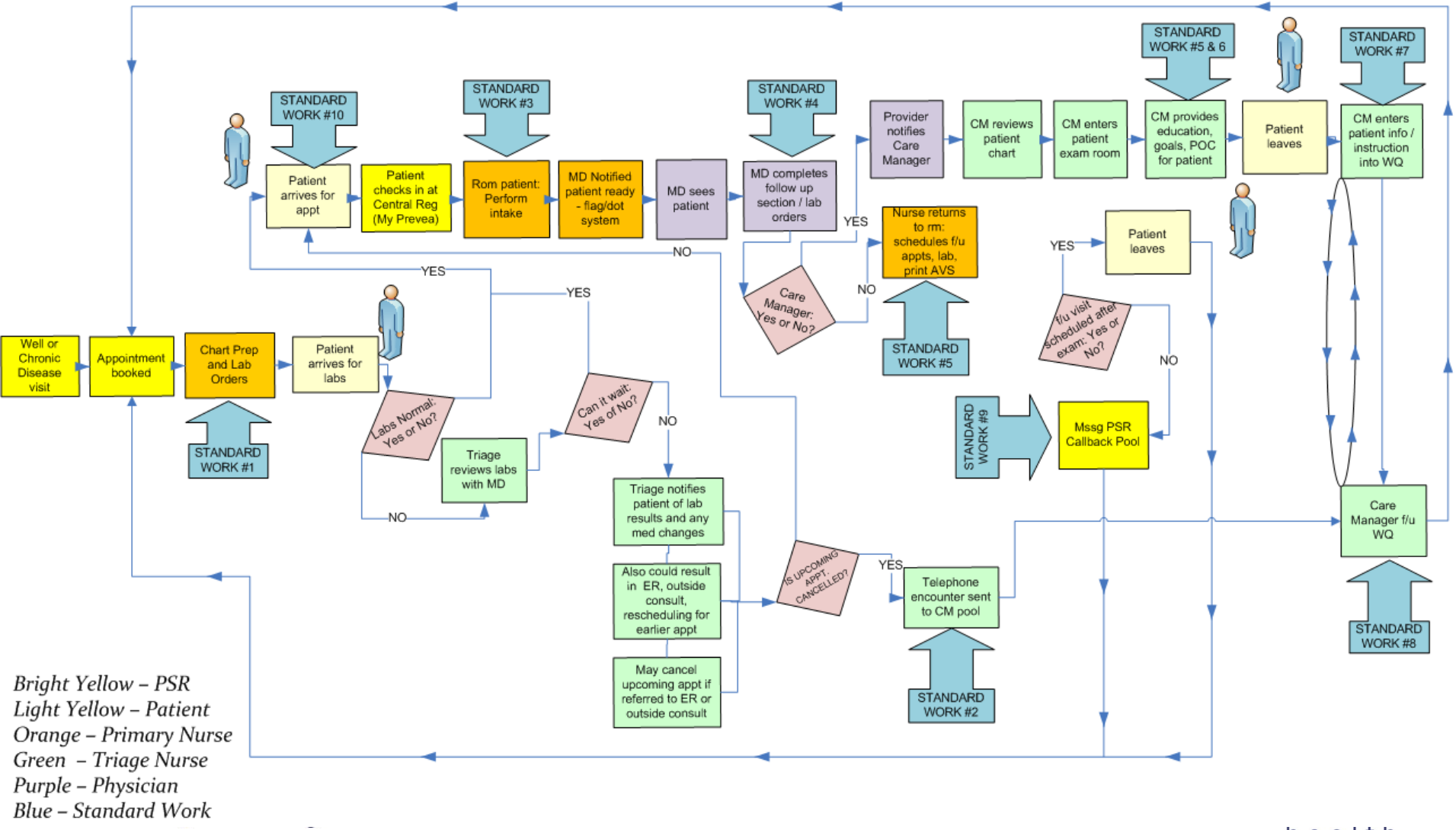
Our Medical Home Pilot

- Re-design of the care process
- Reaching out to the patients who need us the most

PCMH Current State Map



PCMH Future State Map

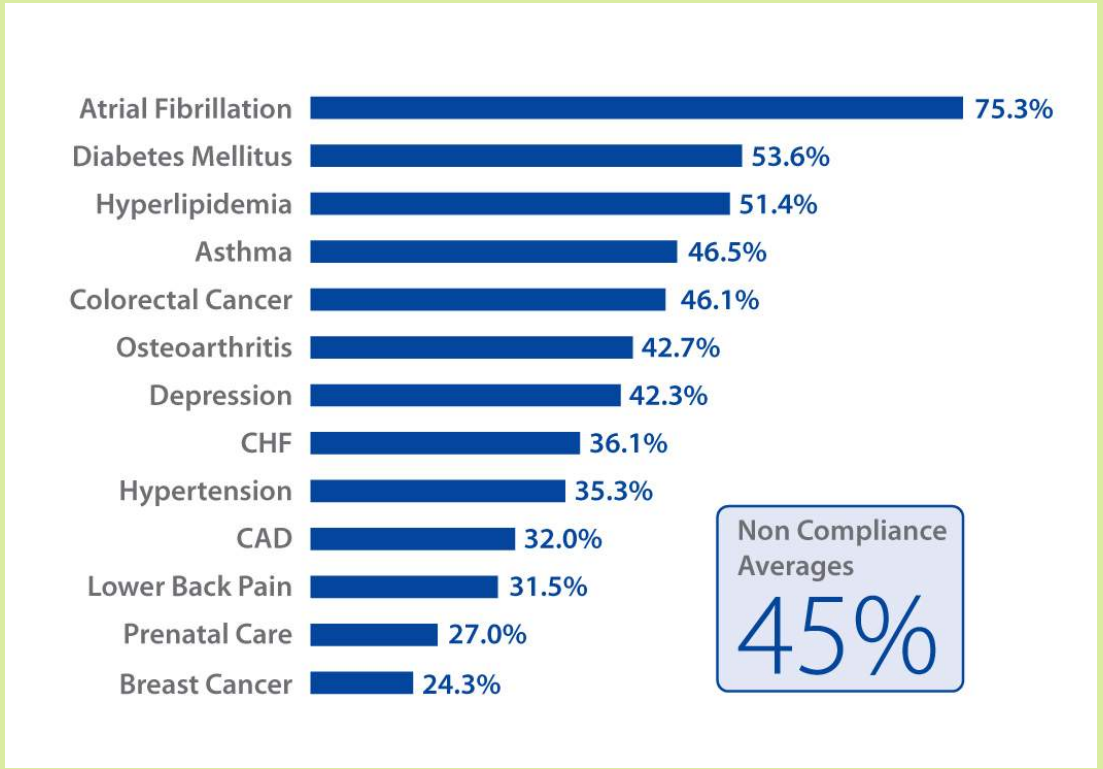


Bright Yellow – PSR
Light Yellow – Patient
Orange – Primary Nurse
Green – Triage Nurse
Purple – Physician
Blue – Standard Work

Patients Are Not Receiving Recommended Care

The NEW ENGLAND JOURNAL of MEDICINE

The Quality of Health Care Delivered to Adults in the United States



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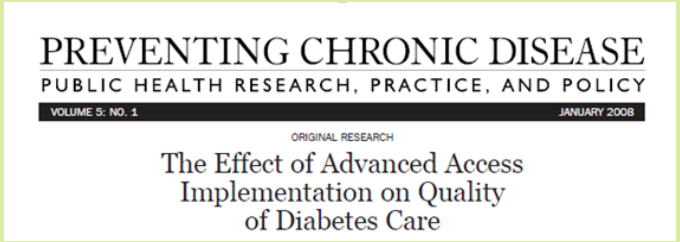
McGlynn et al
"The Quality of Health Care Delivered to Adults in the United States" NEJM June 26, 2003

Effects of Visit Frequency and the Quality of Diabetes Care

Patients with low frequency office visits receive substandard preventive care for diabetes

Concluded that those patients who frequently miss appointments for diabetes care had substantially poorer glycemic control



Diabetes care improved through continuity of care - coming into the office for the visits and being seen by their physician

Fenton et al "Quality of Preventive Care for Diabetes: Effects of visit Frequency and Competing Demands" Annals of Family Medicine, Jan/Feb 2006
From the Division of Research, Kaiser Permanente, Oakland, California.2004 Andrew J. Karter, PhD, The Division of Research, Kaiser Permanente, The Effect of Advanced Access Implementation on Quality of Diabetes Care; Dr. JoAnn Sperl-Hillen, MD, et all; January 2008

Overview

- Automated Outreach is designed to connect patients with treatment needs to their physician.
- Prevea has been using Outreach since 7/15/2008.
- Prevea has 97 providers live on Outreach.
- Prevea is utilizing both chronic condition and preventive care protocols.

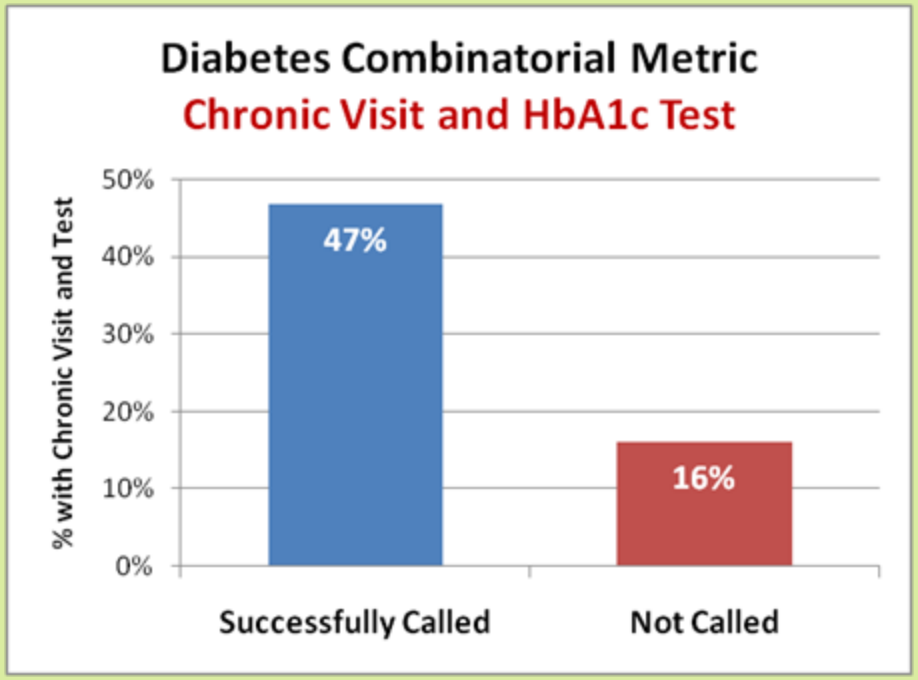
Analysis Overview

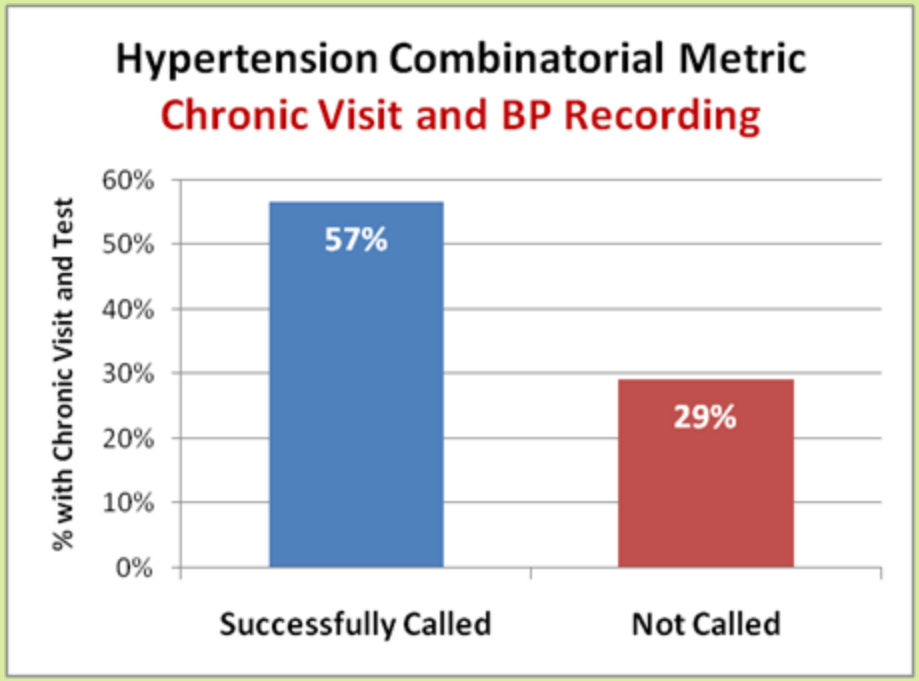
- **Purpose**: to evaluate the impact of the Outreach program on patient care seeking behavior in relation to two variables:
  1. Treatment related to chronic conditions and
  2. HbA1c testing and electronic documentation of blood pressure values
- **Chronic Conditions Analyzed**: Diabetes and Hypertension, which are the chronic protocols utilized by Prevea.
- **Patients Included**: All patients who were identified as non-adherent for Diabetes and Hypertension protocols between the period of 7/1/2008 and 2/1/2009, whether those patients were associated with a provider utilizing automated outreach services or not.
  - All patients were required to have at least 2 service dates in the last 2 years billed with an ICD-9 code related to the Chronic Conditions and no chronic service dates in the last 6 months.
  - Patients were removed if they had no history of a visit with a Prevea Primary Care physician (END, FP, IM or NPP for Diabetes; and FP, IM or NPP for Hypertension).

Analysis Methodology

- **Time Period**: Outcomes were analyzed over the 13 month period from 7/1/2008 to 7/31/2009
- **Study Groups**: We separated the non-compliant Diabetes and Hypertension patients into two groups: one that received successful outreach communications and one that did not receive any outreach communications.
- **Chronic Visits**: Utilizing billing data, we identified for both groups how many patients had a visit related to a chronic condition within 6 months after their minimum non-adherent registry date, thus making them adherent. (Minimum non-adherence dates were determined on a monthly basis).
- **Test and Vital Stats**: Utilizing electronic medical record (EMR) data, we identified for both groups how many patients had a relevant test or vital statistic (HbA1c for Diabetes and Systolic Blood Pressure for Hypertension) recorded within 6 months after their minimum non-adherent date.

Results Summary





For both conditions, successfully called patients are significantly more like to have both a chronic visit and the relevant test result recorded in the EMR.

Diabetes Results Detail

- Over 3,000 patients were included in the hypertension study.
- The Odds Ratio of 4.61 indicates the difference in the response rates is significant.
- Automated messaging brings more patients into the office for condition specific treatment.

	Successfully Called			Not Called		
	Patients	Male %	Average Age	Patients	Male %	Average Age
Total Sample	1,765	51.2%	62.2	1,315	48.8%	66.7
With Chronic Visit						
With Relevant Test	827	51.8%	62.9	211	46.4%	63.1
No Relevant Test	245	55.5%	64.2	227	53.7%	63.3
Total	1,072	52.6%	63.2	438	50.2%	63.2
Without Chronic Visit						
With Relevant Test	19	52.6%	62.2	2	50.0%	43.0
No Relevant Test	674	49.0%	60.7	875	48.1%	68.4
Total	693	49.1%	60.7	877	48.1%	68.4
Chronic Visit 6 Mos Yield	**61%**			**33%**		
Relevant Test 6 Mos Yield	**48%**			**16%**		
Combined Visit-Test 6 Mos Yield	**47%**			**16%**		
Combined Visit-Test Odds Ratio	**4.61, 95% CI 3.87-5.49**					

Hypertension Results Detail

- Over 9,000 patients were included in the hypertension study.
- The Odds Ratio of 3.18 indicates the difference in the response rates is significant.
- Automated messaging brings more patients into the office for condition specific treatment.

	Successfully Called			Not Called		
	Patients	Male %	Average Age	Patients	Male %	Average Age
Total Sample	**5,701**	45.0%	63.8	**3,404**	42.6%	68.3
With Chronic Visit						
With Relevant Test	**3,227**	44.1%	64.8	**990**	39.6%	65.4
No Relevant Test	410	42.2%	66.8	574	42.5%	66.5
Total	3,637	43.9%	65.0	1,564	40.7%	65.8
Without Chronic Visit						
With Relevant Test	451	41.0%	60.4	88	36.4%	62.9
No Relevant Test	1,613	48.7%	62.2	1,752	44.6%	70.8
Total	2,064	47.0%	61.8	1,840	44.2%	70.4
Chronic Visit 6 Mos Yield	**64%**			**46%**		
Relevant Test 6 Mos Yield	**65%**			**32%**		
Combined Visit-Test 6 Mos Yield	**57%**			**29%**		
Combined Visit-Test Odds Ratio	**3.18, 95% CI 2.90-3.38**					

Results Discussion

- The results were strong, suggesting that Automated Outreach had a significant impact at Prevea.
- The results indicate that a well-designed automated outreach message increases the probability that patients with chronic conditions will receive treatment specific to their chronic (rather that acute only) needs.
- As with any control group study, possible differences in the two groups of patients – including physician and patient characteristics – may have contributed to the results.
- Key outcome the analysis did not consider is the change in HbA1c and Systolic Blood Pressure values for the two groups of patients. Follow-on analysis will be conducted so as to better understand this outcome.

QUESTIONS