

# Building a Population Health Program within a Medical Home



John Walker, MD  
Chief Medical Officer  
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# Cornerstone Health Care

## **Mission:**

**To be your medical home**

## **Vision:**

**To be the model for physician-led  
health care in America**

## **Values:**

**As a physician owned and directed company,  
We are committed to ensuring that patient care is  
patient centered, efficient, effective, equitable,  
safe, and timely.**



**CORNERSTONE**  
HEALTH CARE

# Cornerstone Health Care 2013

- **1,800 employees**
- **122 locations**
- **230 physicians**
- **185 shareholder physicians**
- **111 advanced practice providers**
- **34 specialties and ancillary services**
- **Total net revenue: \$205,000,000**
- **21 Practices with extended hours**
- **Total net revenue: \$205,000,000**
- **38<sup>th</sup> largest employer in the Triad**
- **7<sup>th</sup> largest employer in High Point**
- **Physicians on staff at 15 different hospitals and 6 health systems**
- **29 Primary Care practices recognized by NCQA as PCMH**



# Specialties

- Allergy and Immunology
- Bariatric Surgery
- Cardiology
- Endocrinology
- Family Practice
- Gastroenterology
- General Surgery
- Hematology
- Hospitalists
- Infectious Diseases
- Internal Medicine
- Nephrology
- Neurology
- Oncology
- Ophthalmology
- Otolaryngology
- Orthopedics
- Pediatrics
- Physiatry
- Podiatry
- Pulmonology
- Rheumatology
- Urology
- Vascular Surgery



# Ancillary Services

- **Audiometry**
- **Ambulatory Endoscopy Center**
- **Behavioral Medicine**
- **Clinical Pharmacy**
- **Imaging**
- **Infusion Services**
- **Laboratory Services**
- **Pain Management**
- **Physical Therapy**
- **Sleep Lab**



# Creation of Cornerstone's Medical Home



# Creation of Cornerstone's Medical Home

**Recognition  $\neq$  Function**

*29 Primary Care  
practices recognized  
by NCQA as level 3  
PCMH*

True medical home has:

- Care Coordination
- Health Navigation
- Advanced Practice Providers
- Clinical Pharmacy
- Behavioral Medicine
- Social Work



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# Population Health Management



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### Create, View, and Edit Graphs

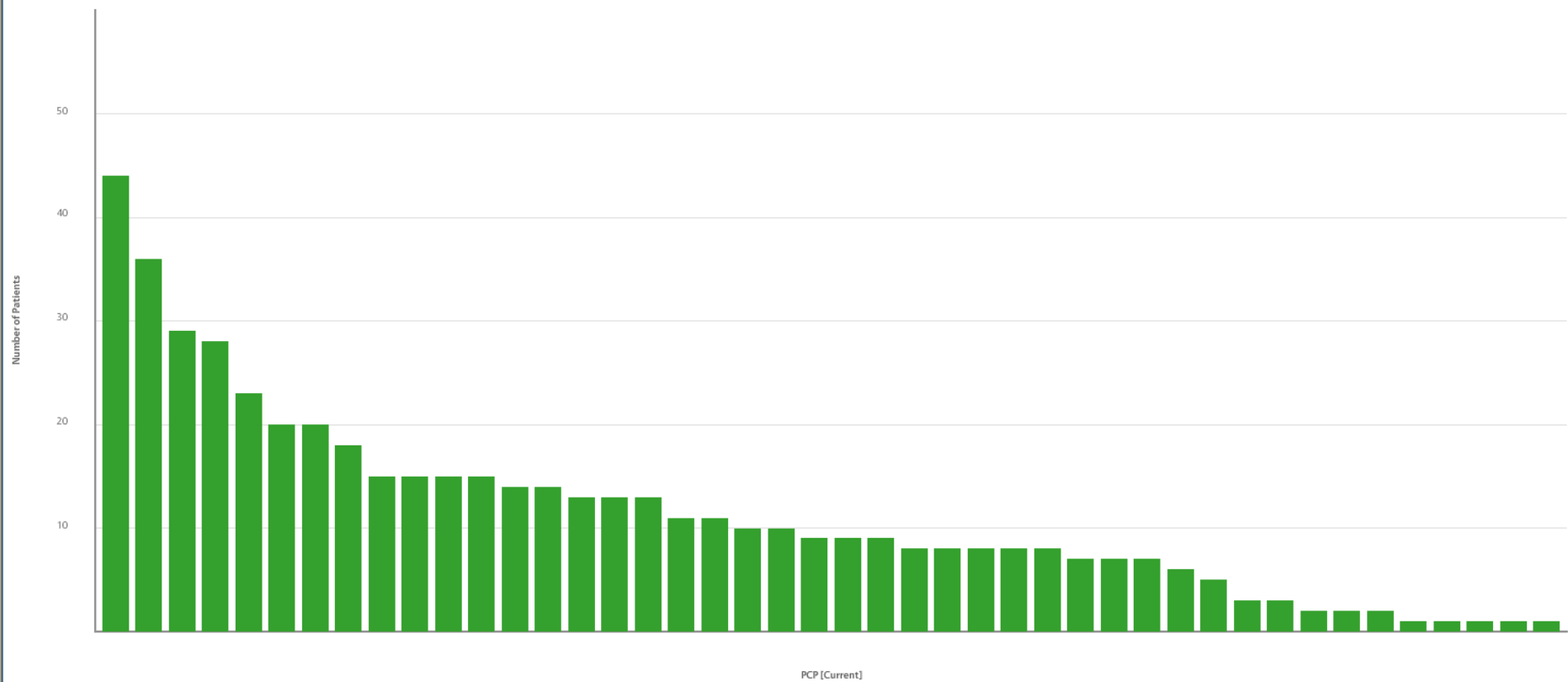
Clear Workspace Add Graph

Graph 1\* Graph 2\* **Graph 3\***

CORNERSTONE OVERALL: High Risk Pts by PCP (Pts with A1c > 9 or LDL > 130 or BP > 140)

Cohort (5) Time Period Filters (3) Graph Settings Show Data Actions

CORNERSTONE OVERALL: High Risk Pts by PCP (Pts with A1c > 9 or LDL > 130 or BP > 140/90) with No Follow Up Amb Visit



# of patients: 503



### Create, View, and Edit Graphs

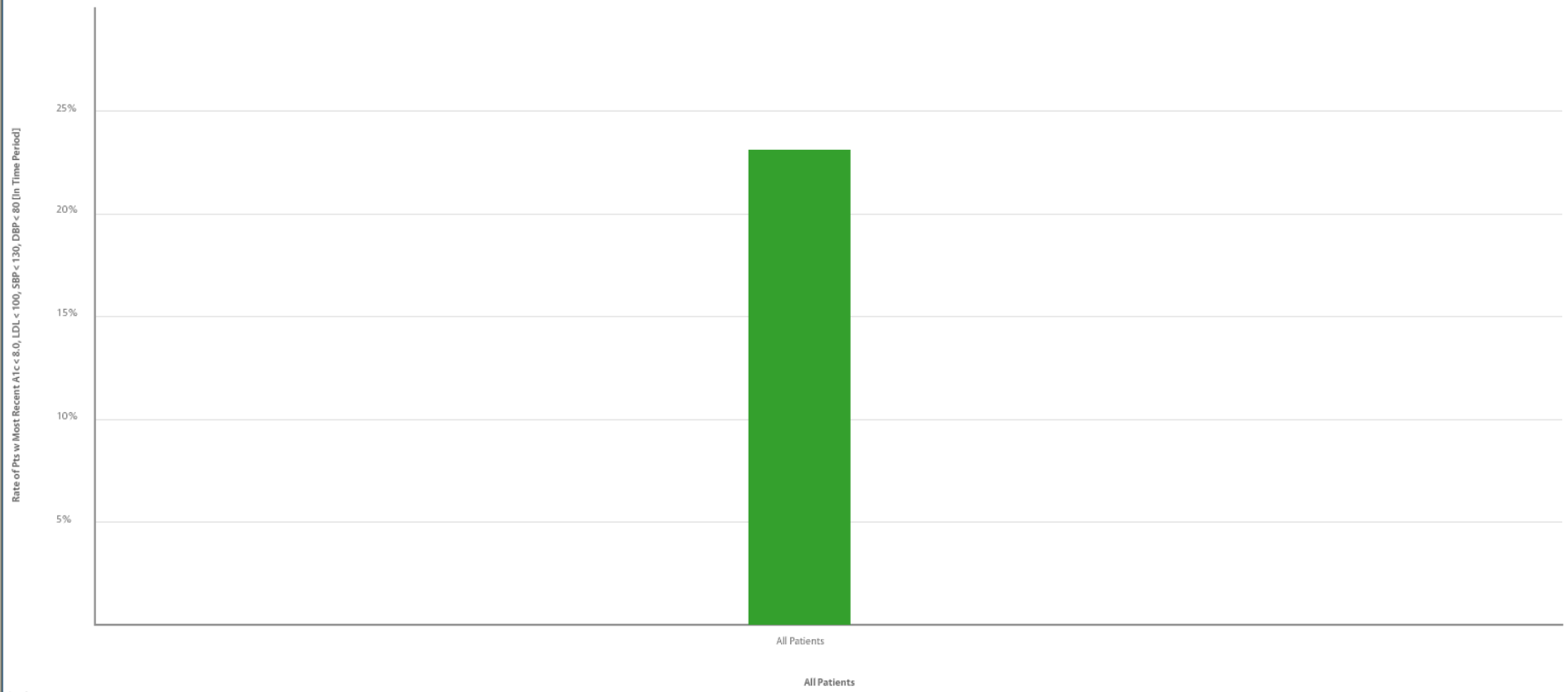
Clear Workspace  Add Graph

Graph 1\* Graph 2\* Graph 3\* **Graph 4\***

CHC total diabetic triple goal

Cohort Time Period Filters (5) Graph Settings | Show Data Actions ▾

CHC diabetic triple goal rate



# of patients: 1834

Create, View, and Edit Graphs

Clear Workspace Add Graph

Graph 1\* Graph 2\* Graph 3\* **Graph 5\***

Diabetics rate of A1c<8 Cohort Time Period Filters (5) Graph Settings Show Data Actions

Rate of Pts w Last A1c < 8.0



# of patients: 7179

# Patient Care Advocate (PCA) Program





YOU ARE ABOUT TO ENTER A SMILE ZONE!

SMILE UPON ENTERING 😊

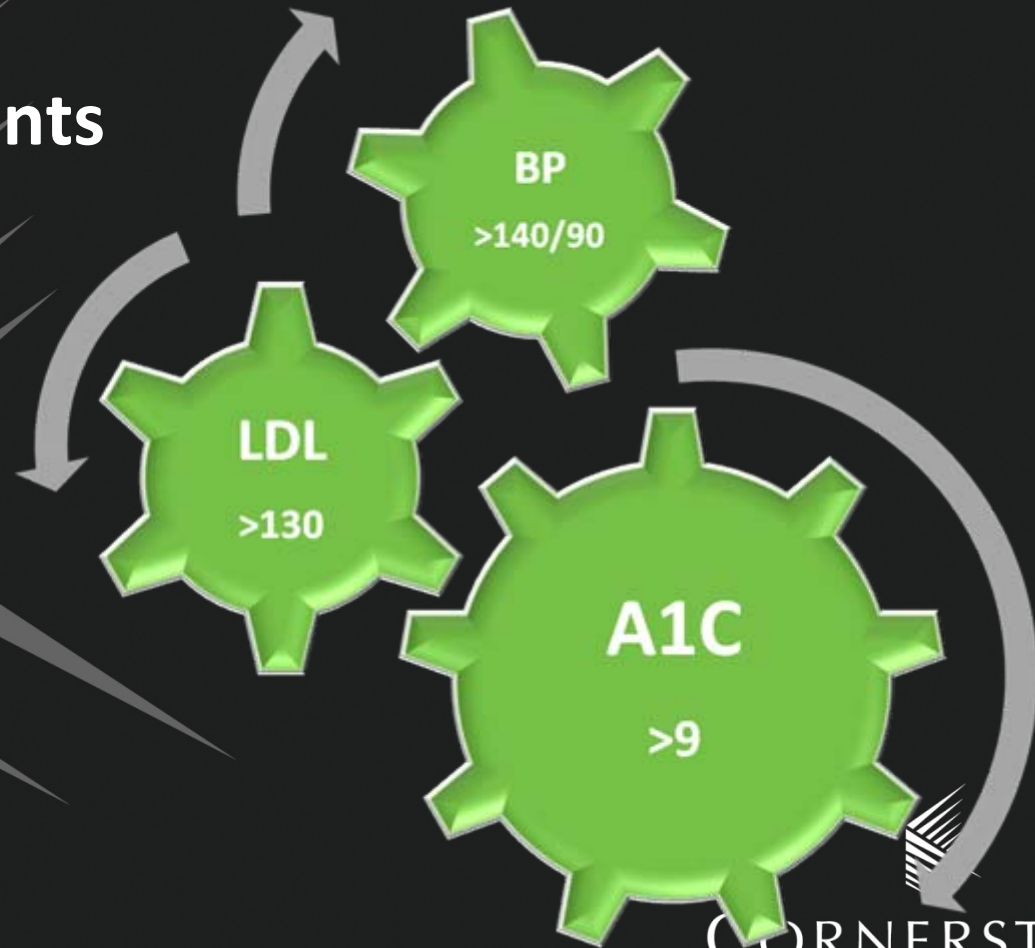
Thank you,  
Patient Care Advocates



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# Target Population: High Risk Patients

**Diabetic Patients  
with:**



CORNERSTONE HEALTH CARE, P.A.  
PATIENT CARE ADVOCATES  
PHONE SCRIPT

**PREPARE/ATTRACT/EDUCATE/SATISFY/PRESERVE**

*SMILE! (We offer QUALITY healthcare!)*

*EXCELLENT deliverance on the phone is preparing for the call:*

*\*\*Some key points\*\**

- ✓ Review → Patients Health Information/Diagnosis/Age/Family History
- ✓ Provider(s)
- ✓ Last seen
- ✓ Focus on condition/exam(s) needed
- ✓ Take notes while preparing/future task reminders, etc.
- ✓ Scheduling template/requirements
- ✓ **WOW** the patient excellent service

*Remember: We are here to Outreach/Serve/Recover... the extended hands for our Providers.*

**INTRODUCTION**

Hello, may I speak with \_\_\_\_\_?

This is \_\_\_\_\_. I am a Patient Care Advocate with Cornerstone Healthcare calling on behalf of Dr. \_\_\_\_\_ office.

**TIMING/RESPECT**

Ask the patient, is now a good time?

**MEDICAL HOME/ATTRACT**





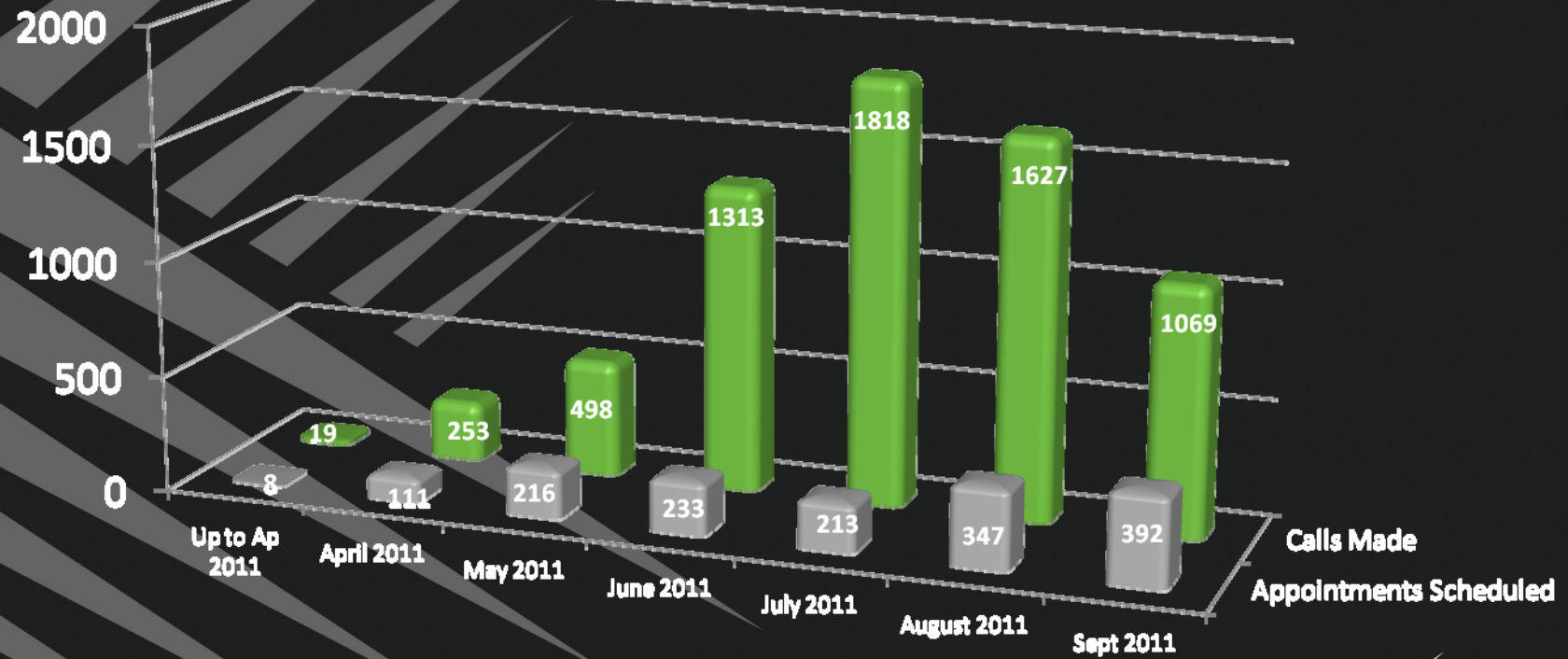
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Early Results  
2011

# Calls and Appointments Made with High Risk Patients

High Risk: Patients with A1C>9, LDL>130, or BP>140/90

■ Appointments Scheduled  
■ Calls Made



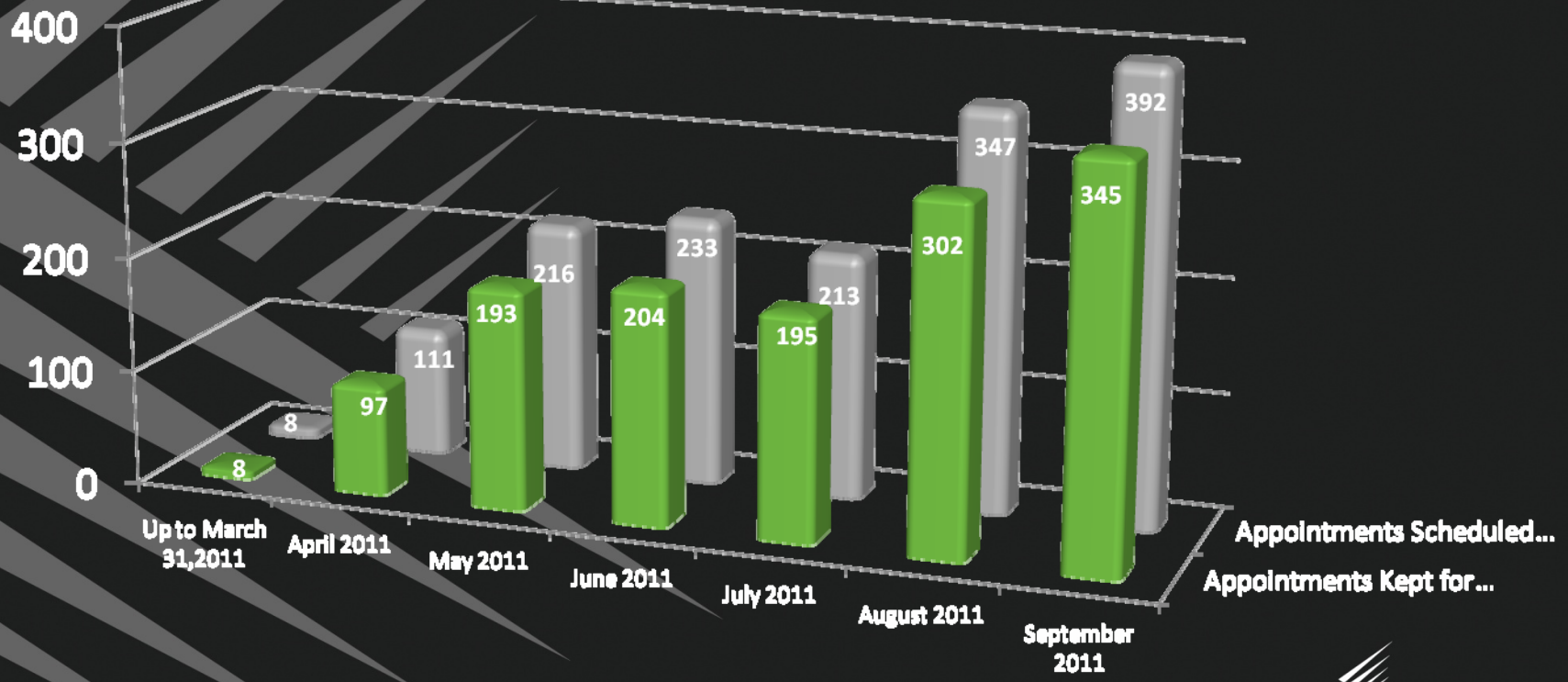
32.9% of calls made resulted in appointments

Early Results  
2011

# Appointments Made and Kept with High Risk Patients

High Risk: Patients with A1C>9, LDL>130, or BP>140/90

■ Appointments Kept for Month

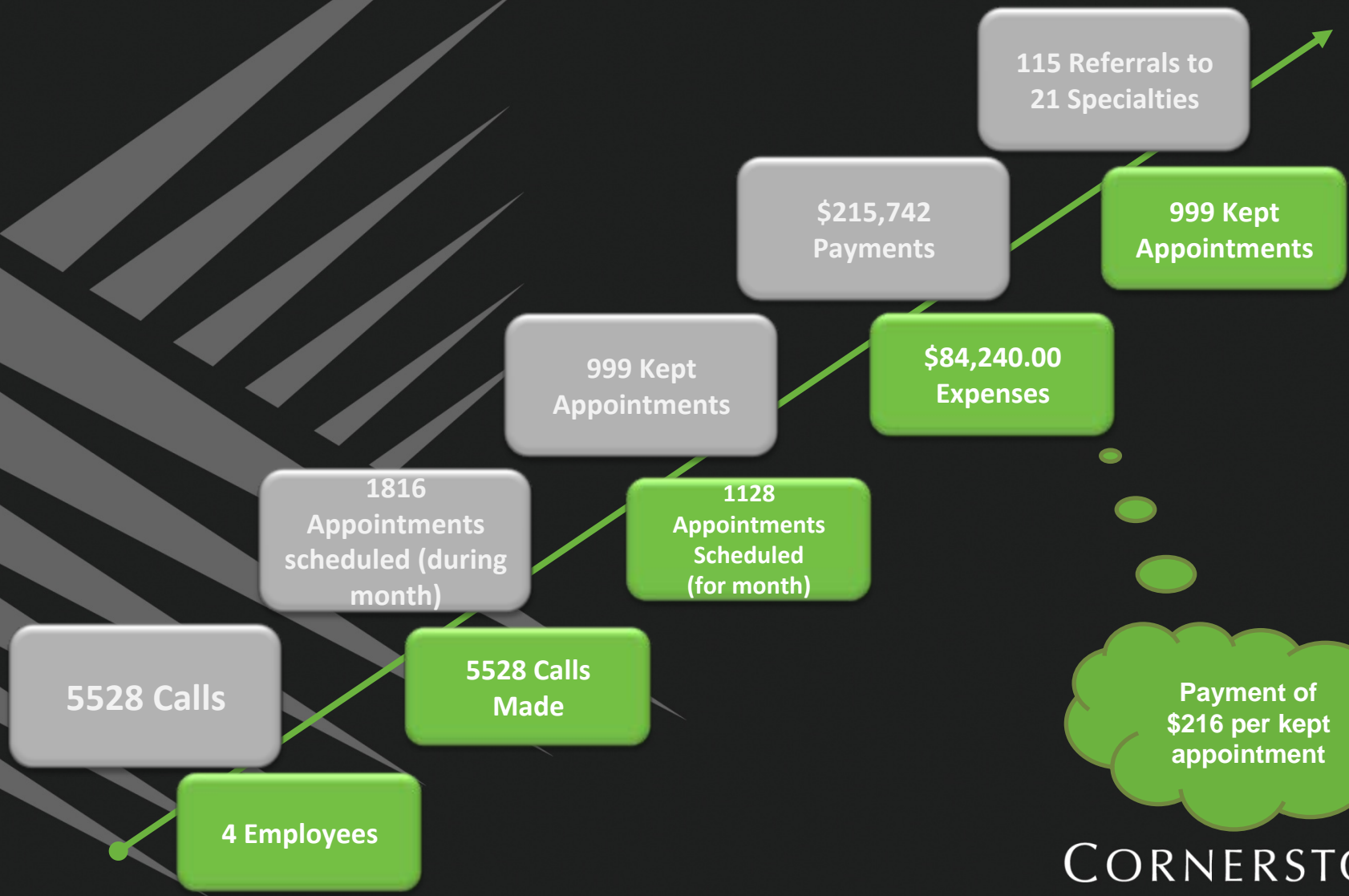


89.6 % of scheduled appointments were kept



Early Results  
2011

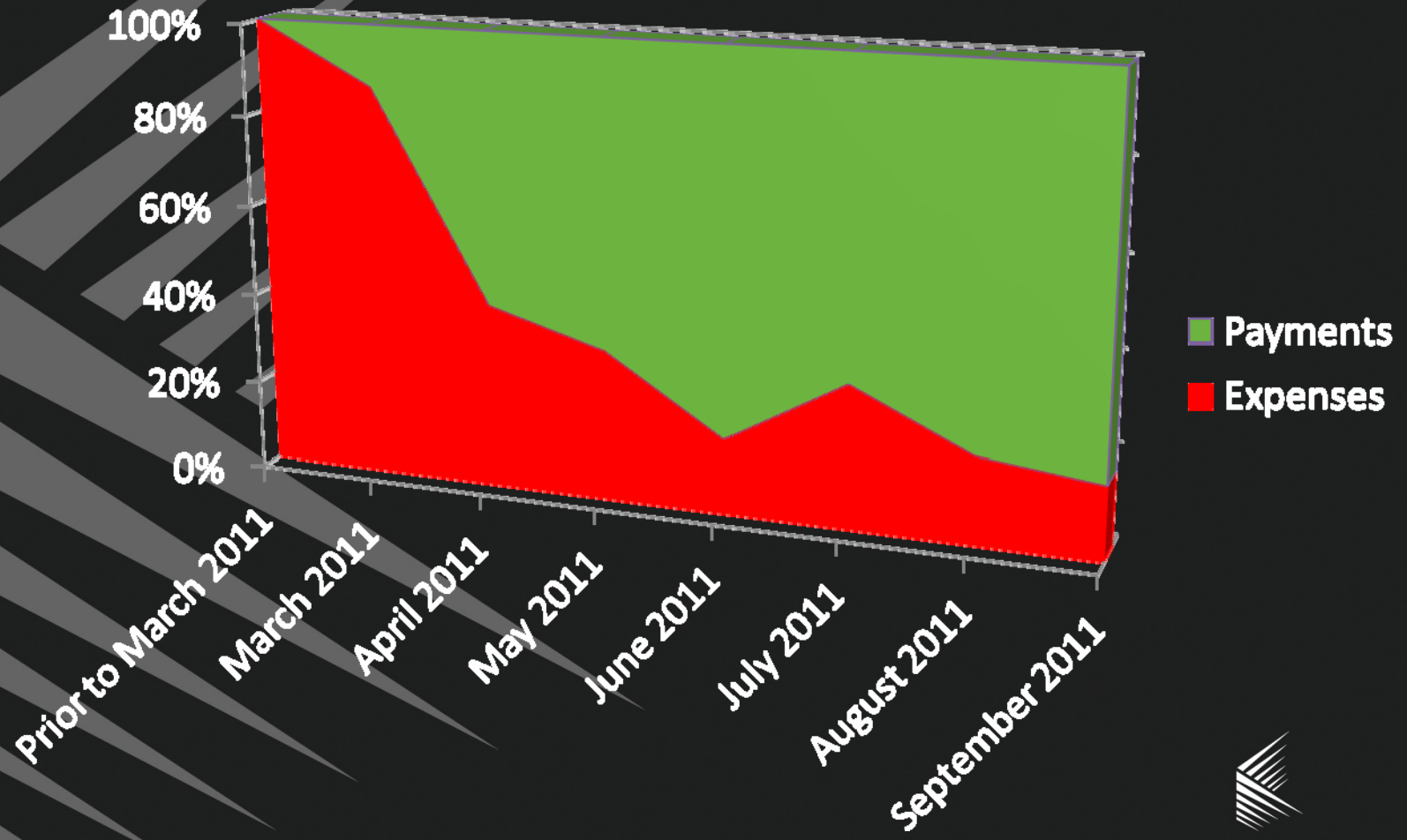
# Successes



Payment of \$216 per kept appointment

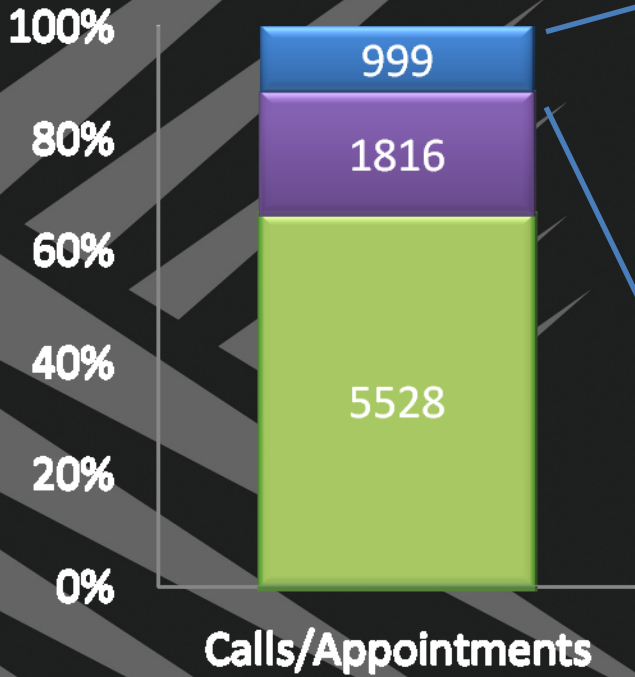
Early Results  
2011

# Financial Analysis



Early Results  
2011

# Downstream Effect through September 2011



■ Calls Made  
■ Appointments Scheduled  
■ Appointments Kept

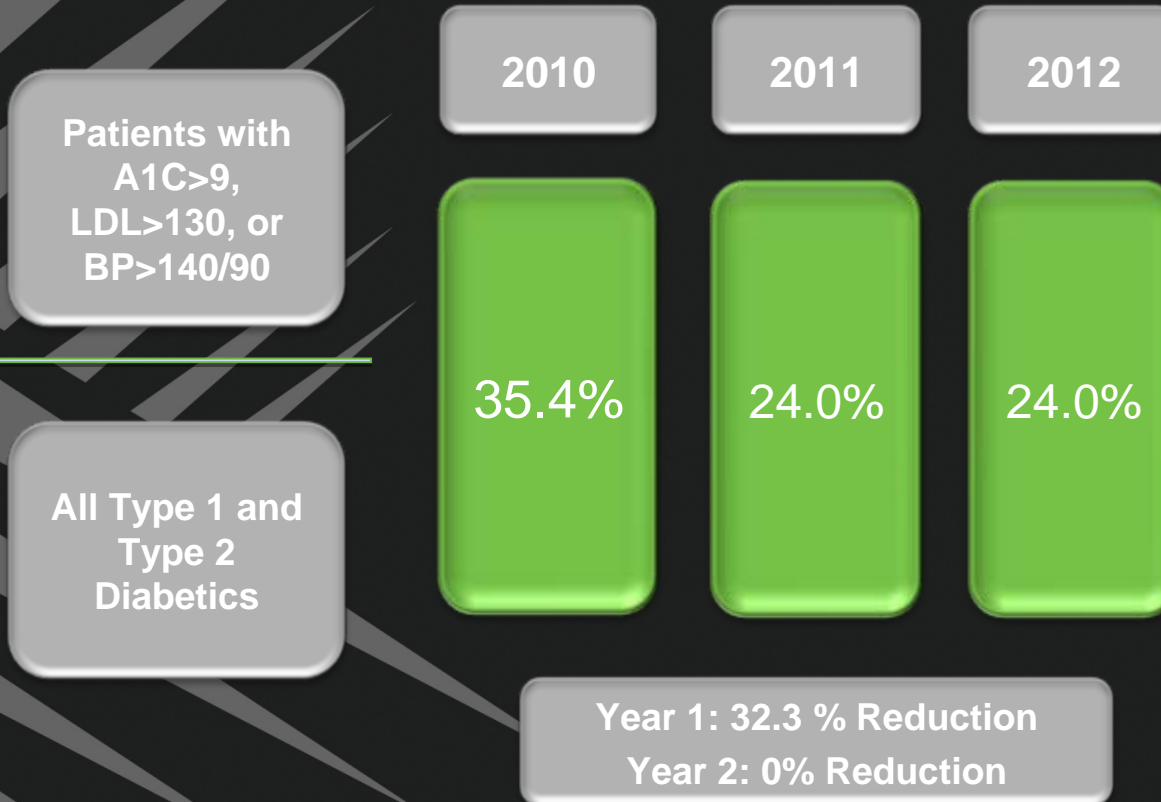
## Resulted in Consult Appointments

- Allergy
- Audiology
- Cardiology
- Endocrinology
- ENT
- GI
- Hematology
- Neurology
- Nutrition
- OB/GYN
- Ophthalmology
- Orthopedics
- Physical Therapy
- Podiatry
- Surgery
- Urology
- Psychiatry
- Coumadin Clinic
- Rheumatology
- Wound Care

= 115 Consults

TODAY

# Improvement in Cohort



TODAY

# Improvement by Risk Factor

	2010	2011	2012
Patients with A1C>9		16.8%	18.2%
LDL>130	Begin Tracking High Risk Patients	30.1%	30.6%
or BP>140/90		32.8%	32.7%

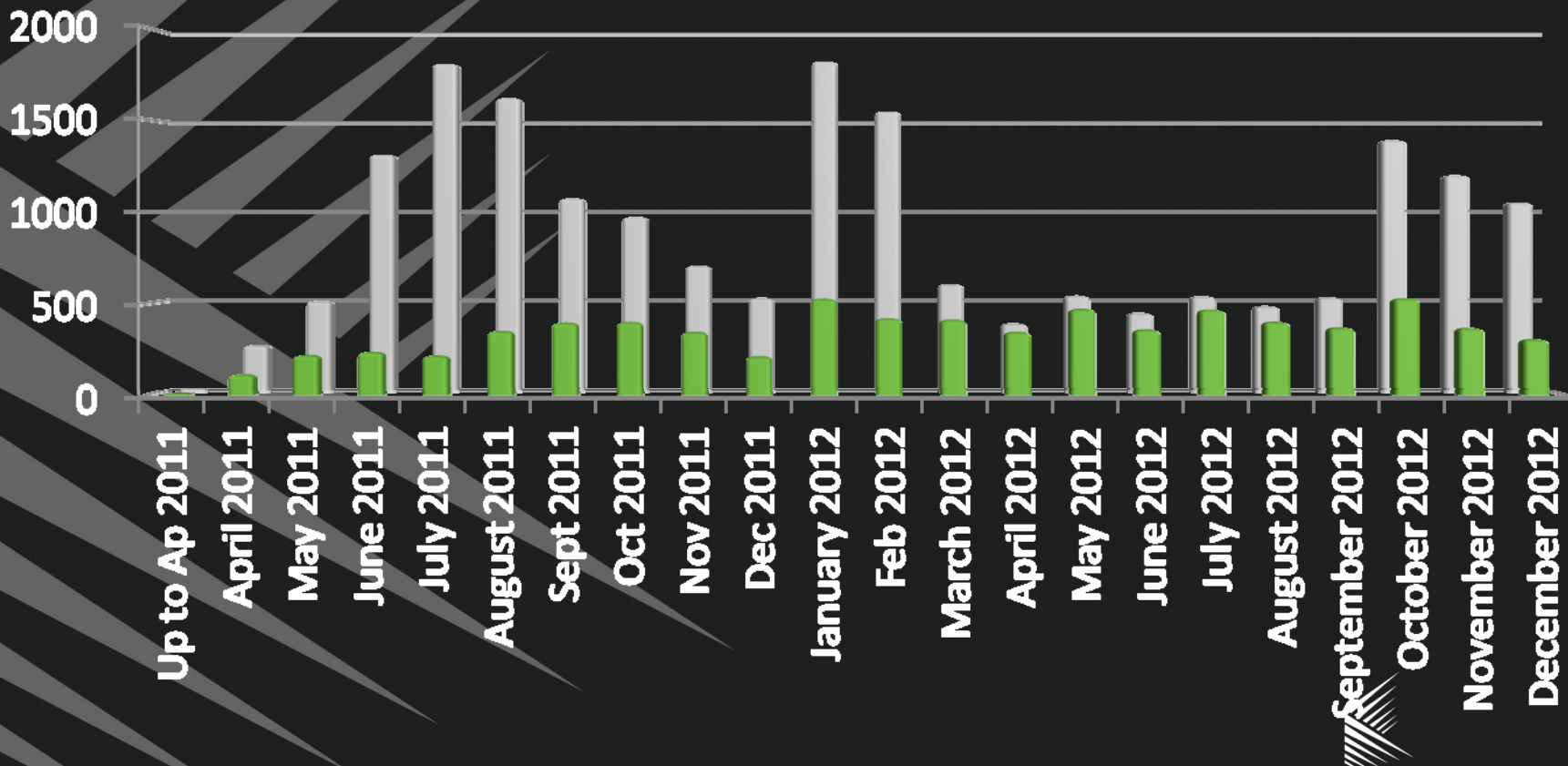




TODAY

# Calls and Appointments Made with High Risk Patients

High Risk: Patients with A1C>9, LDL>130, or BP>140/90

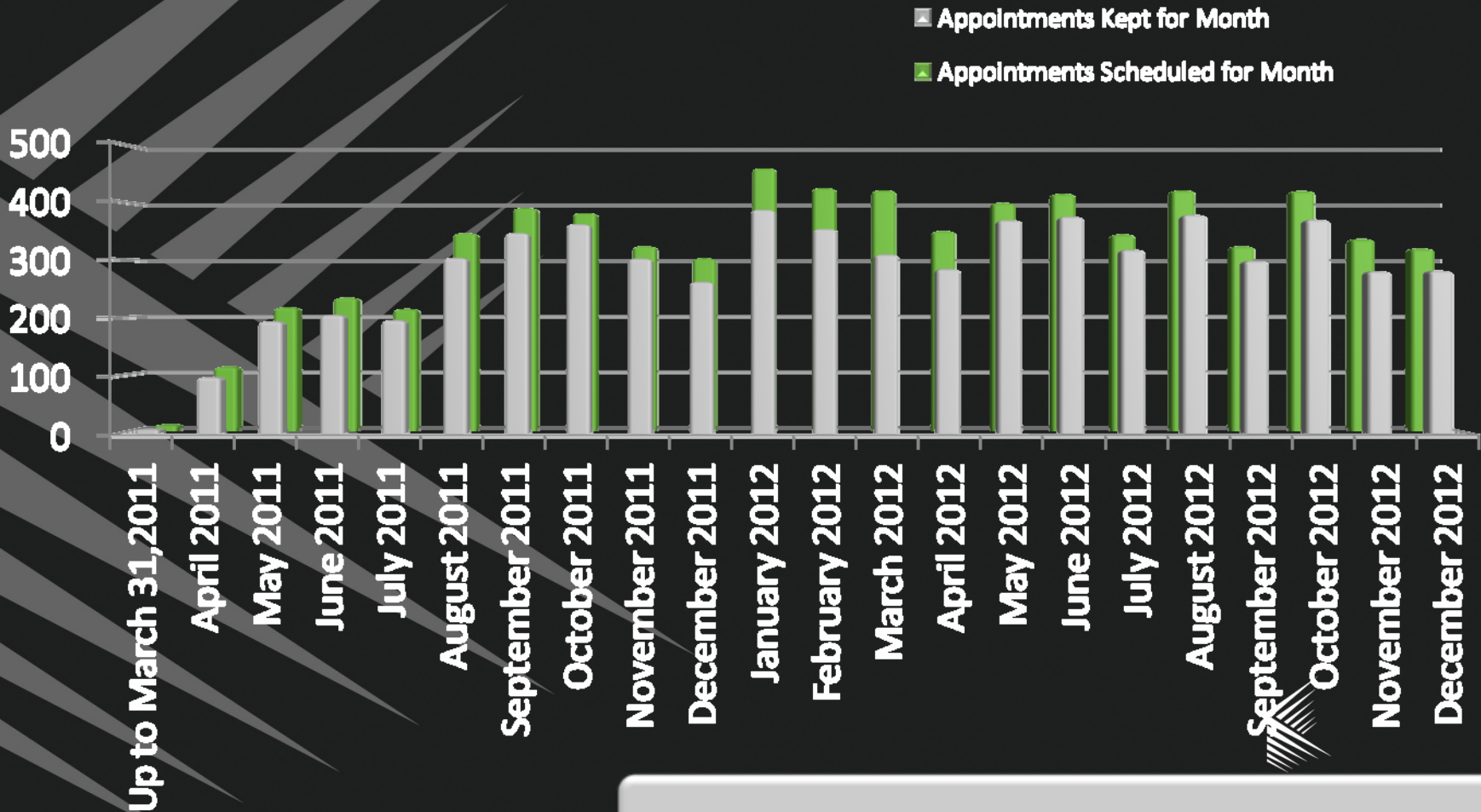


■ Appointments Scheduled

38.4 % of calls resulted in appointment made

TODAY

# Appointments Made and Kept with High Risk Patients



87% of scheduled appointments were kept

TODAY

# Long term Benefits PCA Program // Medical Home

## PCA program enhances Medical Home

Service recovery  
Information on practices  
and providers  
Easily Scheduling New  
Patients

Improved Patient  
Satisfaction  
Transition patients to new  
practice  
“Cornerstone Cares”

TODAY

# Long term Benefits PCA Program // Medical Home

PCA program fosters Population Health Management

Internal referrals

Closing gaps in P4P contracts

Manage cost in fee-for-value world

Keep people within network

Optimizes shared savings

# Conclusions

- Population Health Management is a critical part of a true Medical Home
- Utilizing population management data can improve patient outcomes
- Re-engaging patients in their care can also increase practice revenue





“Learning and innovation go hand in hand. The arrogance of success is to think that what you did yesterday will be sufficient for tomorrow.”

*William Pollard.*



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Thank you!

Any questions?



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