Improving Health Outcomes

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Catholic Medical Partners

Independent Practice Association
• WNY: Erie/Niagara counties
• 900 physicians
• Four (4) Acute Care Hospitals
• Certified Home Care/Continuing Care
• Governing Board
  - 23 members
  - 16 physicians
  - 7 hospital leaders
Clinical Integration Progression

Office Based Programs:
- Prompt reporting of consults
- Rx Utilization
- Non-FFS population based payments
- Electronic Medical Records
- Non-FFS population based payments
- PCP/SCP at risk for Hospital based measures

Registered Programs:
- Diabetes
- CAD
- CHF
- Asthma

Hospital Based Programs:
- LOS
- Core Measure
- Prompt Discharge Reporting

Physician Educational Seminars

Care Coordination Programs:
- Adult PCPs
- CAD, CHF and Diabetic patients
- Disease Management
- Advanced training and support for selected Care coordination practices

PCMH Programs:
- Technical assistance towards NCQA Recognition
- Pediatric nutrition referral program

Meaningful Use and Interoperability Programs:
- CCD Exchange
- Host EHR for practices
- Support and training for MU

Patient Experience Surveys

High Performing Health Care System Programs:
- Payment Reform
- Enhancement of population based payment programs
- Bundled payments proposed to Health Plans

NCQA Accreditation for Disease Management Programs:
- Emmi, PAM, Nutrition

The Role of Catholic Medical Partners is to provide all the necessary resources for successful Clinical Integration
Program Goals

To expand upon the fundamentals of office based care management by intensifying efforts on the identified population with disease management strategies.

To transform the practice through care coordination, team development, PCMH implementation, Disease Management and then contracted delegated Disease Management as part of Catholic Medical Partners Patient Oriented NCQA Accredited Disease Management Program

Focus is on Diabetes, CHF, CAD
Care Coordination and Disease Management Principles

1. Promotes evidence based medicine
2. Population based management/measurement with stratification of patients based on “NEED”
3. Supports physician-patient relationship
4. Promotes quality interaction between disease management program and physicians/patients
5. Stresses continuous quality improvement process
6. Create organized linkage from physician office to CHS service lines

Program Objectives

- Understand the burden of illness for patient and provider
- Assess patient care vs. best practice guidelines
- Registry review – sorting through low, medium and high risk
- Review of tool kit (EMMI, Health buddy, Care Connections, Health Connections, Health plans, Community resources, PAM tool)
- Understand disease management and Patient Centered Medical Home
- Managing the population – data at your fingertips
- Refining coaching skills and promotion of self management
Care Coordination

Engagement and trust are the cornerstones of care coordination

The Care Management Cycle

- Patients in Need
- Interventions
- Registry Review
- Follow-up
- Patients in Need
Care Coordination and Disease Management System

a. Patients with disease
   b. Patients at risk

1. High
2. Medium
3. Low

a. Office interventions
b. Referrals to service Line
   Diagnostic Services
   Consultations
   Treatment
   1. Acute
   2. Rehab
   3. PACE
   4. HHC
   5. Sub-acute
   6. LTC

Patient Registry:
  a. Chronic Illness
  b. Patients at-risk
  c. Preventive Health

Interventions:
  a. Clinical Office interventions
  b. Referrals to service line leaders
  c. Community referrals

Population Management:
  a. Clinical office
  b. Reporting and benchmarking
  c. Care Coordination
**Care Coordination Numbers**

**Total Care Coordinators Trained**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Care Coordinators Trained</th>
<th>Total Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>2011*</td>
<td>82</td>
<td>287</td>
</tr>
</tbody>
</table>

*Does not reflect year end total.

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**Care Coordination Numbers**

**Total Practices Trained**

<table>
<thead>
<tr>
<th>Year</th>
<th>By Year</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>29</td>
<td>60</td>
</tr>
<tr>
<td>2011*</td>
<td>26</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40</td>
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</tbody>
</table>

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*Does not reflect year end total.*
CI Resources Facilitate Meaningful Improvements

Control of Three Diabetes Indicators Among CMP Patients

Uptick in “Perfect” Diabetes Care Follows Investment

<table>
<thead>
<tr>
<th>Measured Indicators and Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c: Less than 7%</td>
</tr>
<tr>
<td>LDL cholesterol: Less than or equal to 100 mg/dl</td>
</tr>
<tr>
<td>Blood pressure: Less than 130/80 mm Hg</td>
</tr>
</tbody>
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Control of Three Diabetes Indicators Among CMP Patients

HbA1c: Less than 7%

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- LDL cholesterol: Less than or equal to 100 mg/dl
- Blood pressure: Less than 130/80 mm Hg

Diabetes Results Comparison: Chart review process to EMR extracts *

<table>
<thead>
<tr>
<th>Measure</th>
<th>Chart Review Practices (sample)</th>
<th>EMR Practices (all patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Measured</td>
<td>73.66%</td>
<td>89.94%</td>
</tr>
<tr>
<td>HbA1c &lt; 7</td>
<td>41.69%</td>
<td>59.62%</td>
</tr>
<tr>
<td>B.P. Measured</td>
<td>71.61%</td>
<td>92.77%</td>
</tr>
<tr>
<td>B.P. &lt; 130/80</td>
<td>32.77%</td>
<td>36.20%</td>
</tr>
</tbody>
</table>

Quality Outcomes
Diabetes

<table>
<thead>
<tr>
<th>% A1c &lt; 7</th>
<th>% BP &lt; 130/80</th>
</tr>
</thead>
<tbody>
<tr>
<td>41.85</td>
<td>59.62</td>
</tr>
<tr>
<td>16.28</td>
<td>36.2</td>
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</table>

2009 - Baseline  2010 - Outcome

Quality Outcomes
Congestive Heart Failure (CHF)

<table>
<thead>
<tr>
<th>% BP &lt; 130/80</th>
<th>% with Beta Blocker</th>
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<tbody>
<tr>
<td>29.2</td>
<td>46.1</td>
</tr>
<tr>
<td>35.4</td>
<td>66.38</td>
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2009 - Baseline  2010 - Outcome
Quality Outcomes
Coronary Artery Disease (CAD)

Questions ???