



Using IT to Systematically Identify Patients in Need of Additional Care: Risk Stratification to Improve Care Management Efficacy

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Mission

HealthCare Partners is dedicated to the well-being and the respectful, compassionate healing of our patients and our communities. HealthCare Partners believes in promoting wellness and is committed to provide a complete continuum of care to the patients that we serve

HCP Business Overview

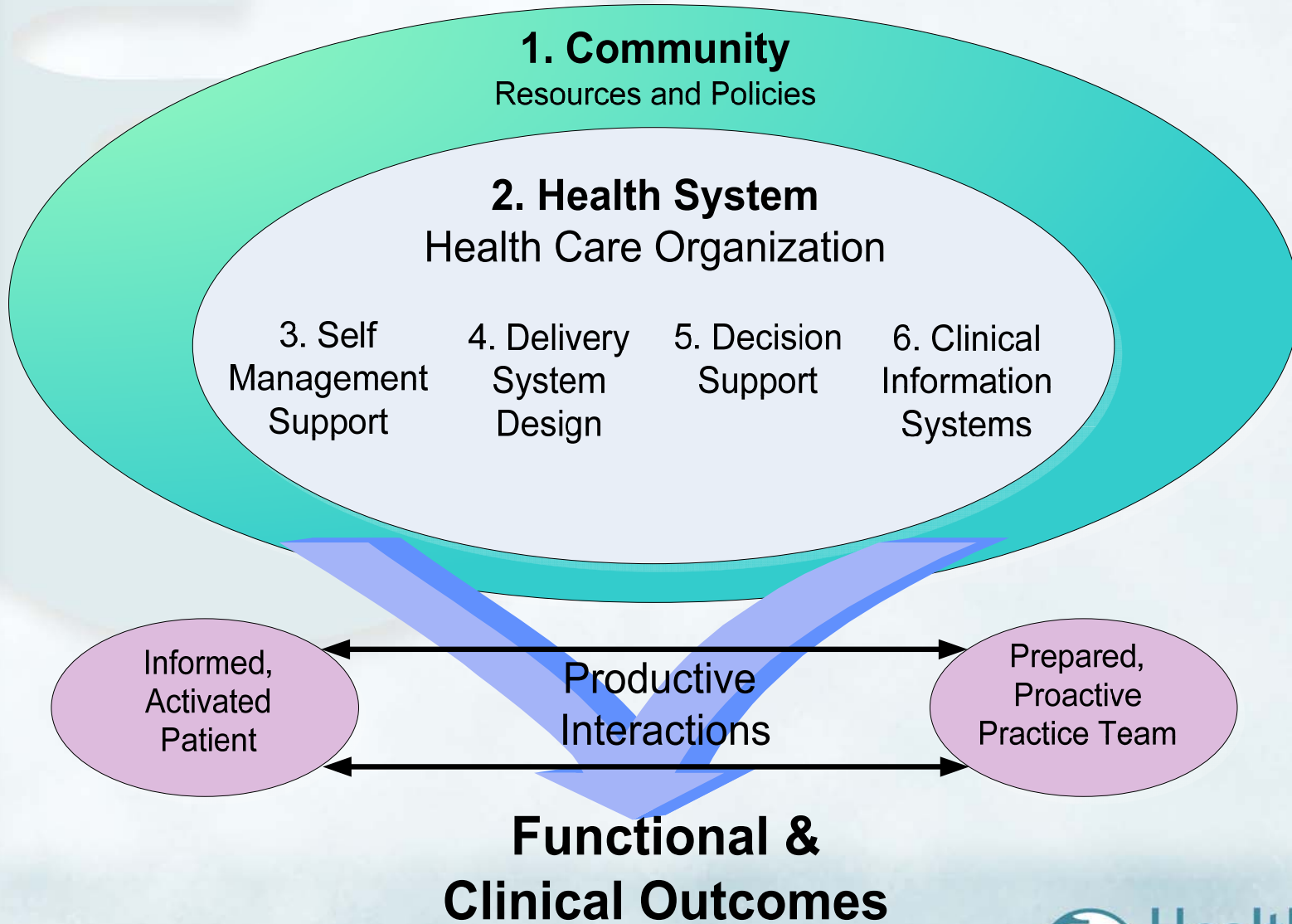
- **HCP is a leading integrated healthcare services company**
 - Aggregates services for physician affiliates, principally HCP-owned and related medical groups
 - Independent physicians associations (“IPAs”)
- **Provides comprehensive medical services to plan members and manages contracts with health plans**
 - Primarily under capitated (“pre-paid”) arrangements – assumes responsibility for patient treatment
 - Physician services
 - Hospital costs
 - Associated administrative services (claims, member services, billing, systems)
- **Ability to realize a multitude of cost savings opportunities while providing top quality healthcare**
 - Strong and patient-centered clinical programs including: same day access, disease management, preventive care education, urgent care centers, hospitalists, care management programs, high risk clinics, home care programs, telehealth services and staff selection and training
- **Track record of effective medical cost risk analysis and profitable medical expense management**
- **Solid financial results**
- **Geographic and Payor diversification**
 - California
 - Las Vegas
 - Central Florida

HCP Approach to Patients

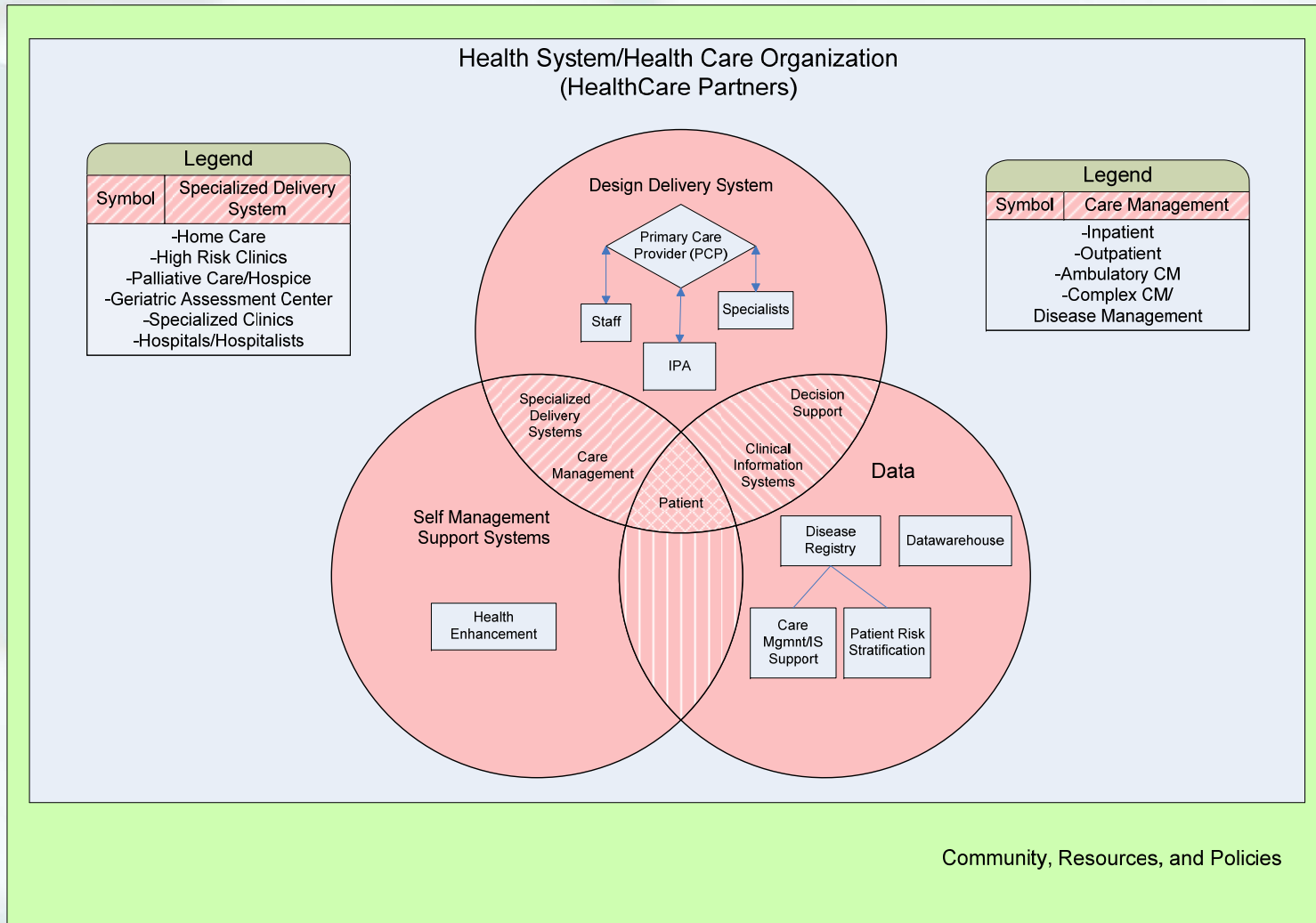
- Patient Centric- meet the needs of all patients
- Facilitate Access and Partnership with Patients and their families
- Not Benefit driven nor benefit demand mentality
- Right Care at the right time for the right medical situation
- Patient and Family Empowerment for their health
- Health Promotion, Education and Prevention
- Extensive Focus on Advanced Care Planning
- Build for the needs of Frail Seniors, Apply to All Patients

The HCP Chronic Care Model

(by Ed Wagner)

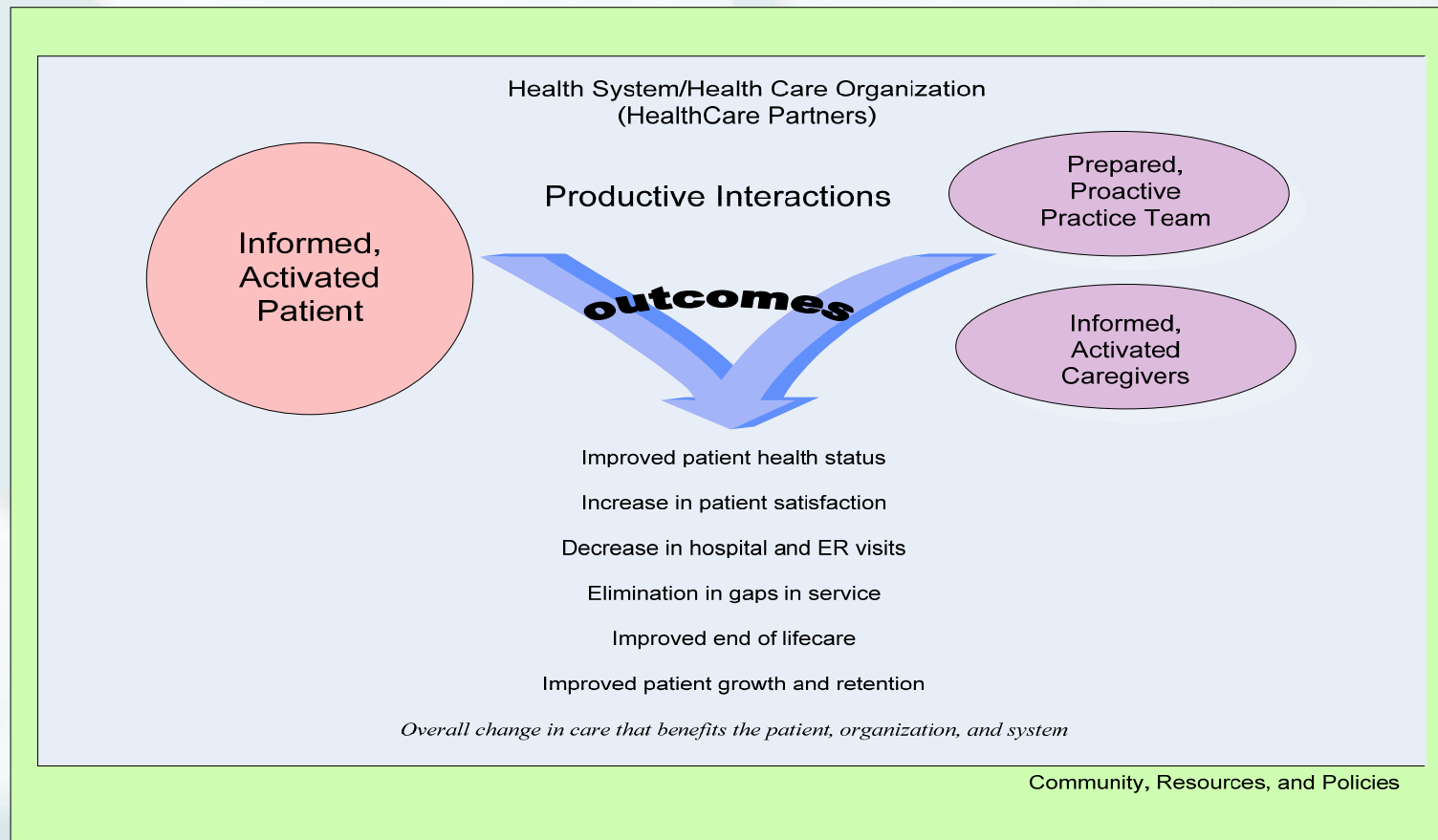


Chronic Care Model



EBM: Drives Chronic Care Model Outcomes Improvement

Chronic Care Model



The Chronic Care Model “Applied”

- The Chronic Care Model (CCM) is:
 - a framework for producing healthy communities;
 - a multi-dimensional solution to a complex problem;
 - like an evidence-based guideline—a synthesis of system changes to guide quality improvement;
 - intended to be flexible and subject to change when new evidence emerges.

There is no one way to implement the components of this model. For example, there are several successful designs for effective Clinical Information Systems or Self-Management Support techniques.

The CCM is a guide, not a cookbook.

The Six Components of the Chronic Care Model

1. **The Community:** public and private resources and policies;
2. **The Health System:** how health care is organized, integrated and coordinated including its payment structures;
3. **Self-Management Support:** education, tools, motivational techniques, patient empowerment
4. **Delivery System Design:** the structure of the provider organization (hospital system, clinic, doctor's office) and the organization of patient encounters;
5. **Decision Support, Risk Stratification and Disease Registry:** clinicians can access and adhere to evidence-based guidelines for care;
6. **Clinical Information Systems, Physician and Patient Portal:** computerized information, medical records, decision support tools, reminders, etc.

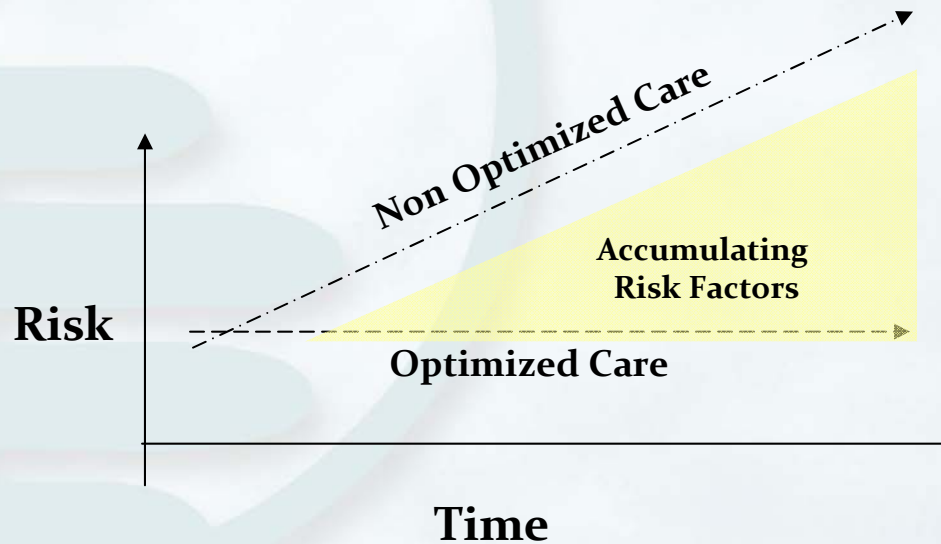
There are thousands of examples around the United States of places that have successfully instituted *pieces* of this model, but no region has yet succeeded in putting all the components together. - Dr. Edward Wagner

HCP's Goal is to complete the puzzle



Clinical Risk and Optimizing Care

The Use of Disease Registries and Risk Stratification to Drive EBM



Risk is Driven by:

- Disease Burden (conditions and comorbidities)
- Non-optimized care
 - Inappropriate or inadequate treatment
 - Non-adherence (Rx, preventive care appointments)

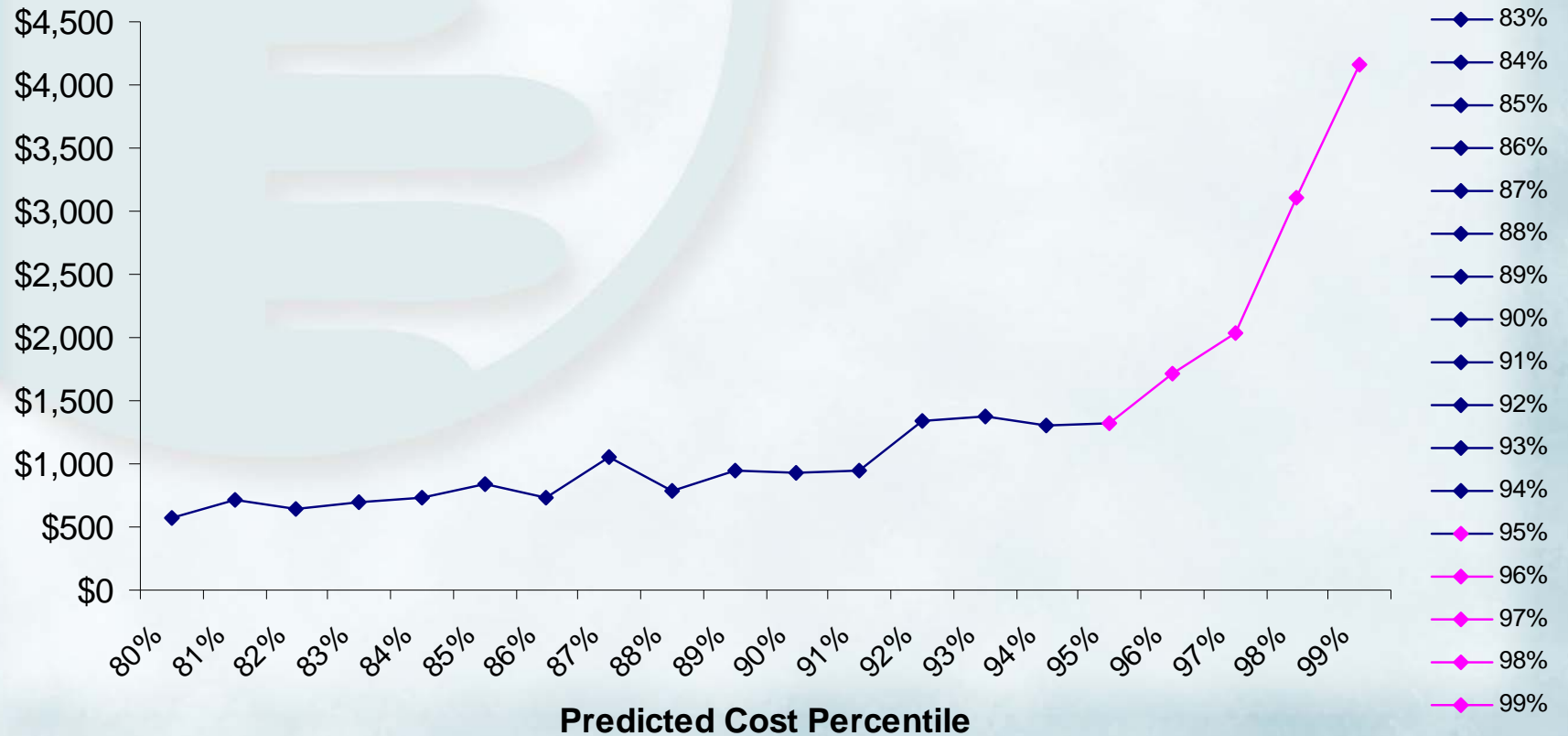
Risk Index

Adjusted Risk Index

Target Patient Population

Risk Stratification PMPM Costs

RiskStrat PMPM



Stratifying Patients into the Appropriate Program

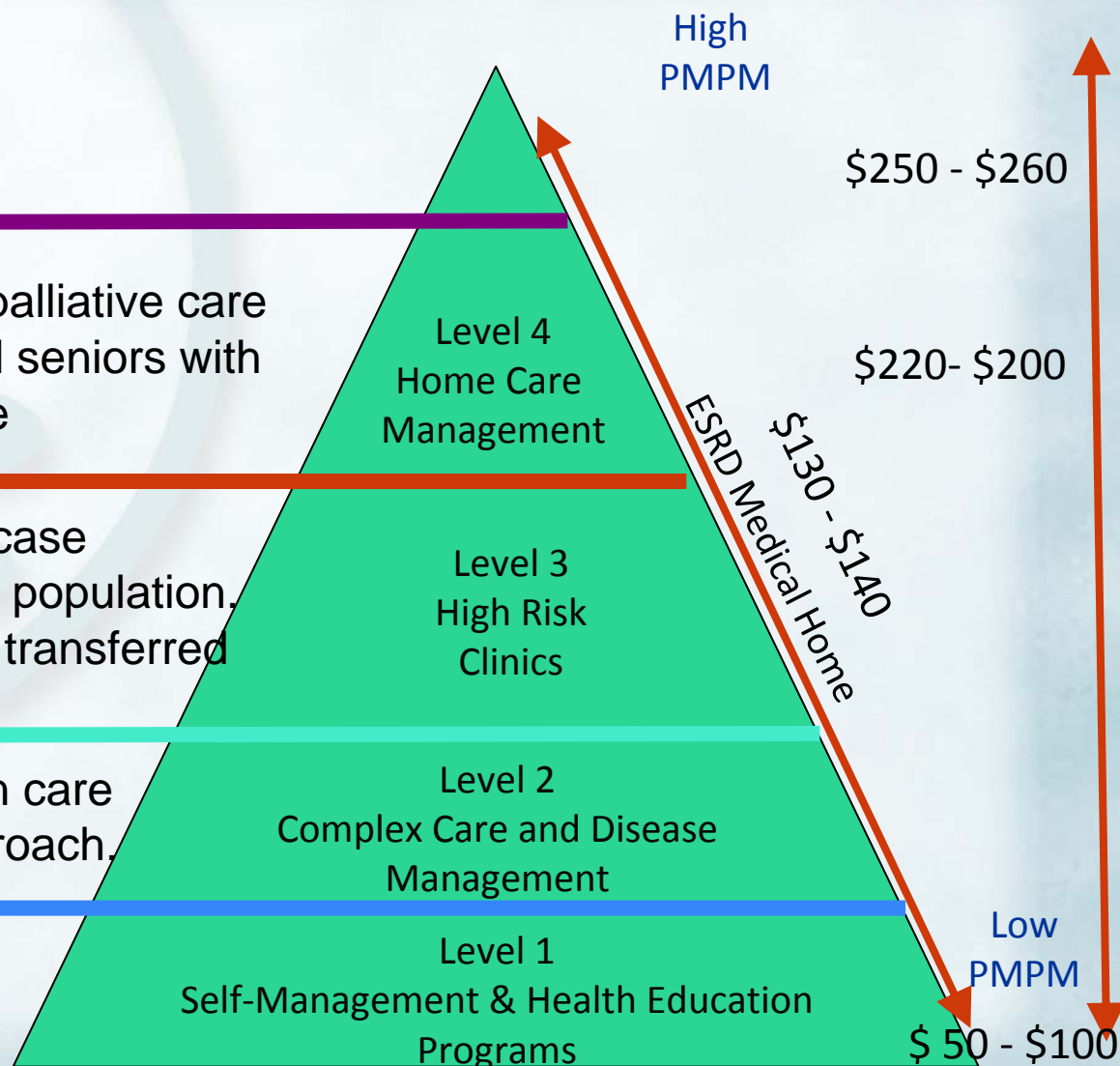
Hospice/Palliative Care

Provides in-home medical and palliative care management for chronically frail seniors with limited access to outpatient care

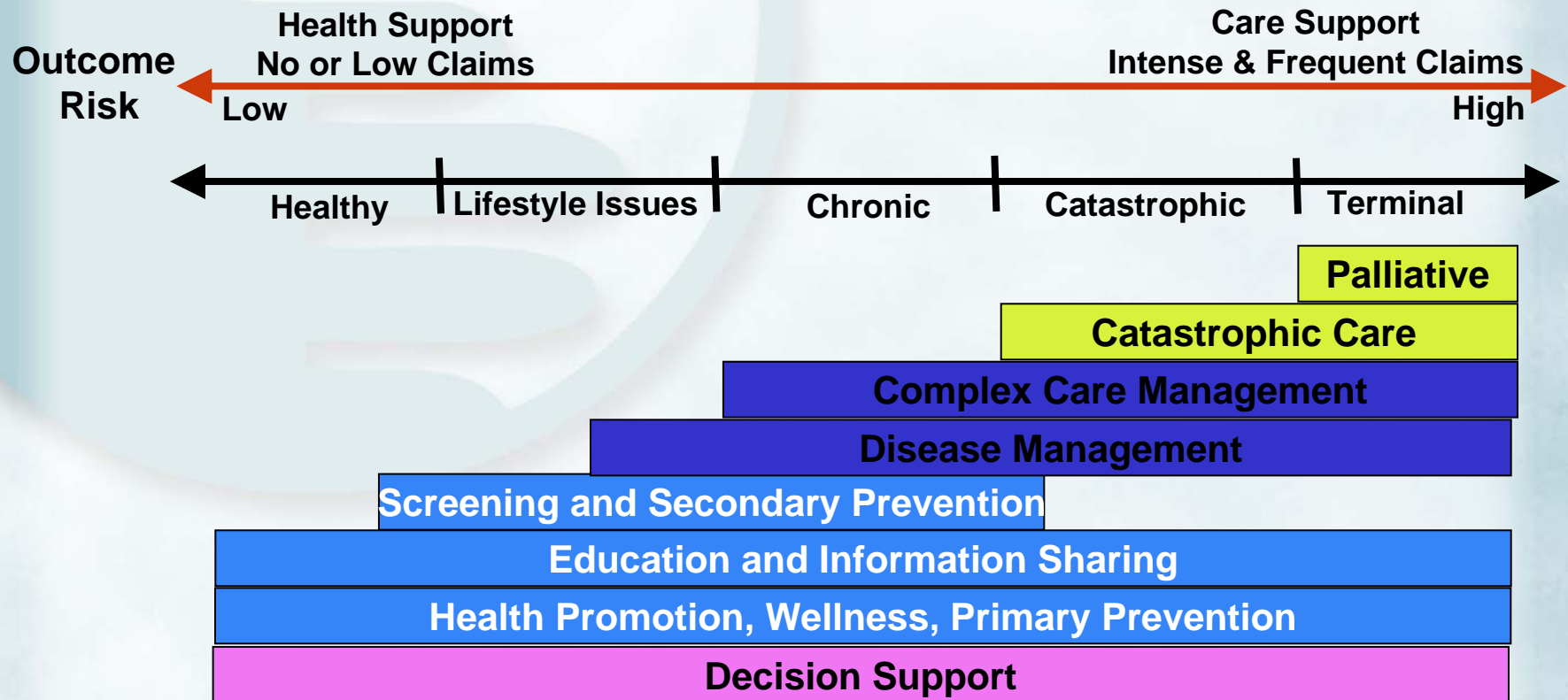
intensive one-on-one care and case management for the highest risk population. As the risk is reduced, patient is transferred to Level 2.

Provides long-term whole person care using multidisciplinary team approach.

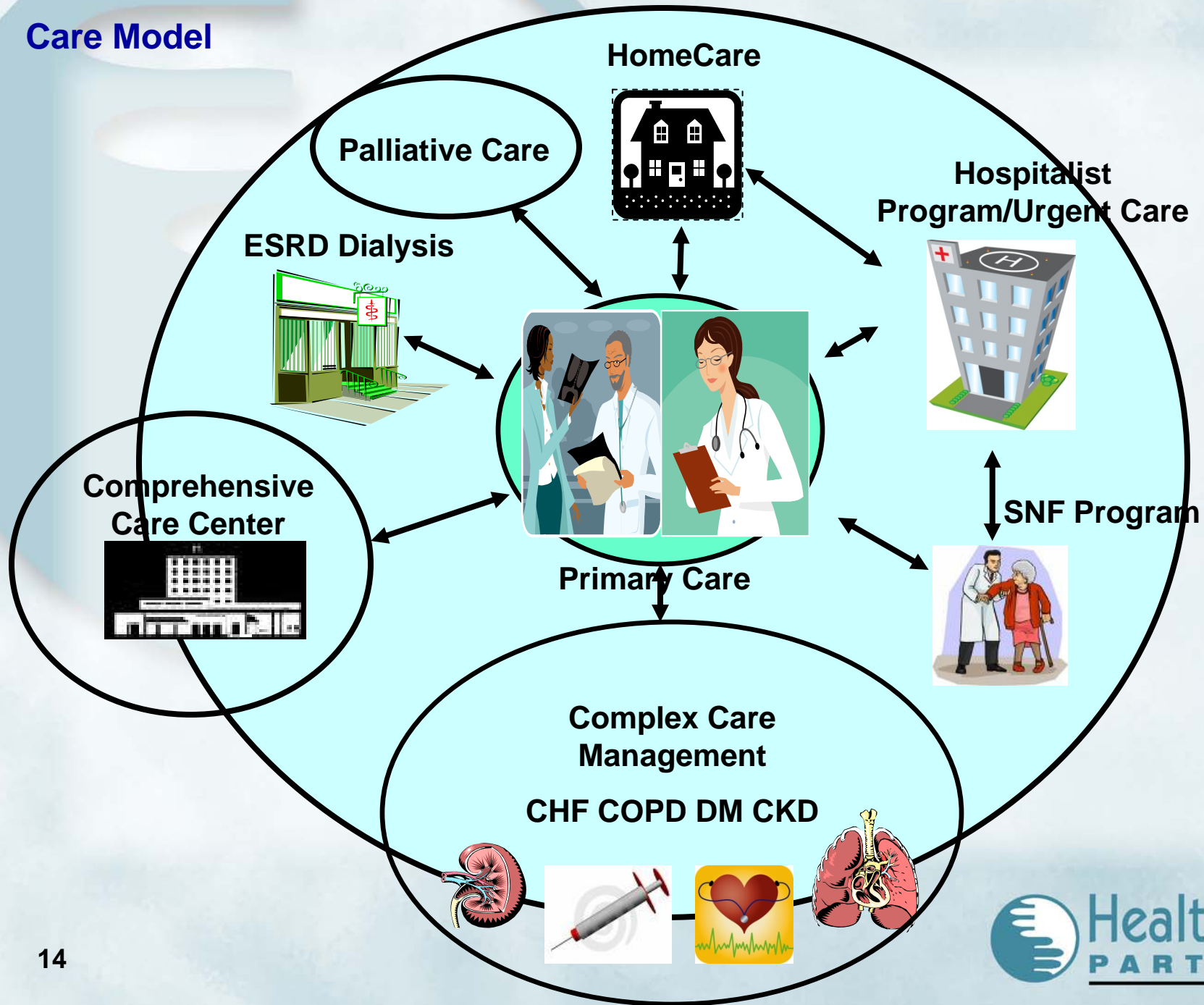
Provides self-management for people with chronic disease.



Programs Overlap



Care Model



EBM- Clinical Pathways for Population and Disease Management- Current and Evolving Future of HCP

Diabetes Best Practice

- Group Visits
- Diabetic Health Education
- Diabetic Disease Management

CHF Best Practice

- CHF Health Education
- CHF Specialty Disease Intervention
- CHF Disease Management

CKD Best Practice

- ESRD Disease Management
- CKD Disease Management
- CKD Health Education

EBM- Clinical Pathways for Population and Disease Management- Current and Evolving Future of HCP

COPD Best Practice

- COPD Disease Management
- COPD Specialty Disease Intervention
- COPD Health Education

Depression and Dementia Best Practice

- IMPACT Collaborative Care
- The Indiana Dementia Project
- CALM Anxiety Program

Advanced Care Planning and Palliative Care Best Practice

HomeCare

High Risk Clinic/ Post-Hospital Clinic

CHF Disease Management Program Overview – Enrollment Period – Patient Role and Visit with Nurse Telephonic Complex Care Management Follow up Physician Coordination of Services and EBM Driven Care

- Evaluate Patient for NYHA Class
- RN Case Manager Review , Monitor and Educate Patients around:
- Current Medications; Action, Importance of Medication and Titration, Current Dose & Potential Side Effects
- Daily Weights with Tracking and Parameters on When to Contact Clinician or CM
- Diet, Signs and Symptoms and when to URGENTLY call Clinician and HF CM
- Advance Directive
- Patient Specific Care Plan Goals
- HF Program Goals and Process
- Evaluate for Appropriate HCP High Risk Program

COPD Disease Management Program

COPD Data-Mining Statistics

- Data-mining criteria
- Chronic oxygen utilization
 - Pulmonary medications for Patients > 60 years
 - Nebulizer
 - Inhaler
 - Theophylline
 - Non-pulmonary medications (comorbid conditions/exacerbations)

Managed Care Management (MCM) Champion

- Nurse DM is regional working with MD champion
 - Training on evidence-based treatment program
 - Cross training in related diseases
 - Uses information system (IS)-supported decision trees, patient records, and algorithms
 - Coordinates care management of other diseases within the same patient – COPD is the entry disease and a focus but not the totality of care

COPD Disease Management Program

MCM/patient interaction

- Initial Face-to-face visit essential with all patients at initiation of program
- Caregiver Support and Education
- Schedules home visit by nurse (NP or RN) or respiratory therapist (RT) at least once initially – RT useful for follow-up visits
- For safety inspection, use of medicines, and determining intensity of home follow-up

Outcome Measurements

- Reduction in ER and Hospital Admissions/ Readmissions
- Improved Quality of Life and Patient Satisfaction
- Improved Treatment Adherence
- Improved Advanced Care Planning

Technology to Improve Care Coordination

- **Electronic Medical Records and TouchWorks**
 - Improved Communication
 - Improved Documentation
 - Protocol Driven Care ("Care Guides", embedded decision support tools)
 - Disease Registry and Risk Stratification for Targeting Most Appropriate Patient for the Most Appropriate care
- **Use of the Internet**
 - PiP- Physician Portal
 - POP- Patient Portal
 - CME
 - Patient and Family Access to Care and Education
- **Use of Home Technology**
 - Home Monitoring of Patients
 - Patient Education at Home
 - Care Management "Eyes and Ears"

Results

- Medical Home- PCP driven system
- Extensive use of Care Management to connect the dots
- Patient Advocacy
- Team Approach to Health Care
- Physician driven and incentives- trading each hospital day for rewarding physician behavior around patient focused care
- Accountable, Coordinated and Integrated Care

Benefits to Patients for All High Risk Programs

- **24 Hour Access**
 - Cell Phone #s
 - Weekend Coverage
- **Assessment Tools**
 - Initial Telephonic Tool: PRA
 - Face to Face Tool: SCAN Geriatric Health Assessment
 - Mailed to Patient Tool: UCLA Selg Assessment Tool
- **Home Evaluation of:**
 - Patient Health Status
 - Living Conditions
 - Level of Caregiver Support
 - Medications Management
- **Reduction in Hospitalization of at least 20%**
- **Increased Patient & Physician Satisfaction**
- **Improved Advance Care Planning**

What Did We Learn?

- Innovation
- How to work in teams
- Change Management
- Fabric of clinical programs (sum is greater than each individual program)
- How to plan for future

Future Innovations

1 or more new innovation/s planned and included for implementation for 2010 as a pilot in at least one region

- PACE Program
- Hospice
- Palliative Care Program
- Electronic Home Monitoring
- Care Transitions
- Application of Risk Stratification of Patients and appropriate targeting of patients with clinical innovations