"Keys for Success – Clinical Integration and Positioning for Accountable Care"

Integrated Physician Network
Hans Wiik, FACHE, President and CEO
David Ehrenberger, MD, Chief Medical Officer
iPN Vision and Mission

iPN Vision

To demonstrate value-based healthcare through focus on IHI's Triple Aim:

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of care

iPN Mission

To improve the health of our patients by creating a sustainable, clinically integrated network of independent primary care, specialty care, and hospital service providers. Using a common electronic medical record, an evidence-based quality improvement program and primary source data, community providers will deliver safer, more efficient and more effective care, across the continuum of care, and demonstrate the value their service brings to their patients and healthcare system.
integrated Physician Network

History and Evolution

• 1990–2004 Avista Medical Associates: Contracting IPA
• 2004–2005 iPN Formation: Private Practices, Community Hospital, large FQHC (Clinica Family Health Services)
• Selected one EMR Platform
  – Enterprise Community Health Record
  – ASP Model
• FTC compliance as Clinically Integrated network
• Sponsored PHO: Centura Health
• 2010 NextGen Large Practice Award Winner
  – Best Practices EHR Implementation
GOVERNANCE:

- iPN Board of Directors
  - 50% Primary Care physicians
  - 50% Specialty physicians
  - Hospital CEO – Ex Officio
- Voting power: Physician Board members
- iPN administration: Hospital
- iPN ownership: Hospital
- Hospital CEO reserve power: approval of Board nominees
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Structure and Organization

ADMINISTRATIVE SERVICES and FUNDING
• Single Signature Insurance Contracting for all Payers
• iPN Office-Administration, MSO Services, IT and CQI Support
• Funding:
  • Physician Membership Monthly Fees – Practices own EMR licenses
  • Grant Support – HRSA / OHIT, Colorado Health Foundation
  • Centura Health – Abiding by Stark Regulations – Expires 12/31/13
  • How did we get to over 200 providers paying significant annual dollars for EHR and Quality Support.
Membership Requirements: In Governing Bylaws, Physician Service Agreements, Policies and Procedures

1. Fully implemented and functioning on the EHR and Practice Management system: all providers, all documentation

2. Active and documented participation in iPN quality plan and designed quality initiatives
   - Practice Performance reports at General Membership Meetings

3. Quality Alignment Meetings: Prior to iPN membership approval... ongoing.
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Membership

Member Practices:

**North Denver Market** — Primarily Boulder, Broomfield, Adams, Jefferson and Denver Counties
- 26 Practices
- 40 Sites
- 200+ Providers – 125+ Primary Care, 75+ Specialists
- 1,000+ End-users
- Multi-Specialty – Family Practice, Internal Medicine, Pediatrics, OB-GYN, Cardiology, Orthopedics, Plastic & Reconstruction Surgery, General Surgery, Neurosurgery and Anesthesia
DENVER

Practice Locations

5 practices in Boulder

2 practices in Lafayette

9 practices in Louisville
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Standing Committees/Meetings

Physicians, Administration, Support Members

- Clinical Quality Improvement Committee
- Contracting – Credentialing – Single Signature Contracts
- EMR Application Steering Committee - Clinical HIT Improvement Collaborative (CHIC)
- Security Audit – Team and Committee
- PCMH Collaborative – 8 Level II PCMH practices
- Practice Managers’ Meeting
- Operations Council
- Board of Directors – bimonthly
- General Membership Meetings – quarterly (mandatory attendance)
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Medical Staff Office (MSO) Services

Four Key Areas:
- Revenue Cycle Management
- Group Purchasing
- IT/ISP Support
- Education and Training
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MSO Services

“The selected software is only 10% of the equation – the other 90% is internal support and best practices.”
iPN: integrated Physician Network
Services and Support

Information Technology – EHR/EPM
– Implementation and Training; local support; ASP Hosting

Clinical Quality Improvement
– Practice Training / Coaching / Best Practices
– Quality Metrics / Reporting / Benchmarking / Quality Boards
– Patient / Practice Satisfaction – Reports / Benchmarking
– NCQA Certification Support – Patient Centered Medical Home, Diabetes PRP, Ischemic Vascular Disease PRP

Practice Management
– Billing-Collections / Revenue Cycle Management
  • Billing Clearinghouse / Claims Management
– Support and Best Practices
– Coding Education and Support / Charge Capture
iPN: integrated Physician Network Services and Support

Medical Staff Office Services (cont.)
- Group Purchasing – Office Supplies and Equipment
- Physician Recruitment
- Health Plan Benefit Design
- Telecommunications
  - ISP – Broadband, Wireless Technology
  - Network Printers / Scanners
  - Encryption Technology and Support
- Waste Management / Records Storage
- Staff Training / Education
  - HIPAA/HITECH Compliance
  - EMR Meaningful Use
  - PQRI / E-Prescribing Incentive Payments & Reporting
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Design / Infrastructure Imperatives

- Over 80% of U.S. Medical Practices are still single providers or less than 5 total in number.
- Where is the IT, Quality or Contracting department in small medical practices?
- Only 10-15% of practices have fully installed and functioning EHR’s for Meaningful Use.
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"A Multi-Specialty, Clinically Integrated Clinic without walls"

**Financial Success**
- **MSO Services**
  - Group Purchasing
  - Revenue Cycle
- **EPM – Best Practices**
  - Practice Management
- **FFS / P4P Contracting**

**Clinical Success**
- Quality/CQI Foundation
- EMR Implementation
- Registries
- Patient Engagement/Self Mgmt.
  - Diabetes Education
- **Patient Satisfaction**
- **Collaboratives on Quality/P4P**
  - CCGC, CFMC, BTE, CBGH

**ACO – Accountable Care Organization**
- Risk and P4P Contracting
- Value for Employers/Payers/Patients

**Integrated**  **Physician**  **Network**  **accountability**  **value**  **sustainability**
integrated Physician Network
The Keys for Success

- **Market Perspective / Intelligence**
  - Which employers and payers are wanting a different model?
- **Hospital or Physician Centric**
- **Primary Care Focus**
- **Employed vs. Independent Practices**
  - EMR Support – Consistent Models
  - PCP and Specialty
  - Data and Quality Integration
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Waiting for “ACO”? 

- **Rules and Regulations – CMS**
  - Comment period ended June 7, 2011
- **Watch Nationally and Regionally**
  - But – lead locally
- **Employer Initiatives** - Boulder Valley Care Network, North Denver Market, Centura Employees / Carve Out
- **Payer Initiatives**
  - RMHP – Rocky Mountain Health Plans
  - Anthem/United – Low Back Pain Collaborative
  - Medicaid
  - Medicare Advantage
  - HCI3 / Prometheus
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So What’s Essential

• Trusted/Valued Physician Leadership
  – CMO/CMIO
  – CQO
• Primary Care – Geographic Critical Mass
• Quality Focus / Alignment
  – IHI Triple Aim
• If PHO – Trusted/Valued Hospital Sponsorship & Leadership
• Robust CCHIT Approved EMR with BI / Data Analytics
• EMR Trainers/Quality Managers and Coaches – “at the elbow”
• Emphasis on Best Practices – “Culture of Shared Knowledge”
On physician alignment and ACO recruitment, describing independent practices & providers…

“They are competing with each other and us in many ways, and it's tough to get them to actually believe in something other than their day-to-day survival.”

SUMMA Health Systems, Akron, Ohio – Health Leaders, June, 2011
Dr Michael Hillman, Chief Medical/Quality Officer
SUMMARY

• John Lennon - Connecting “Imagine” and the “Long and Winding Road”

• “A lot of design and new creation vs. hospital centric healthcare transformation”
What’s Missing in Population Health/Accountable Care

The Missing Pieces in the Continuum of Care

– **Pharmacy** – over 20% of the healthcare spend – medication adherence – Value Based Benefit Design – Formulary Design

– **Transitions in Care**
  - Skilled Nursing
  - Assisted Living
  - Hospice
  - Palliative Care

– **Care Coordination**
  - Predictive Modeling: “finding and engaging the frequent flyers”
  - Patient Engagement + Shared Decision Making
The Missing Pieces in the Continuum of Care (continued)

- After Hours / Urgent Care – patient education
- Benefit Design for Employers
  - Encouraging PCP/Practice Engagement
- Wellness / Health Promotion
  - Education / Family Support
  - Employer Incentives
- Behavioral Health
  - Substance Abuse – Rx Abuse
- Technology – Telehealth – Care Coordination/Improved Transitions

Hospital Integration
- And we still need the integrated acute care hospital for improved quality, patient safety, better outcomes and transitions of care.
So this leads us to...

- **Data and Decision Support Tools**
  - Historical Quotes of Note: “with apologies to the authors”
    - *The notion that we can know everything and remember everything is ridiculous.*
    - *You cannot manage successfully what you cannot measure.*
    - *In God we trust, everyone else bring data*

- All of the described CQI efforts and new continuum areas require good, clinically relevant and validated data.
Integrating Care Delivery: The Notion of a Melting Pot ACO

David Ehrenberger MD CMO
Avista Adventist Hospital & Integrated Physician Network

accountability value sustainability
1. Most care in US provided in outpatient setting.
2. Most care delivered by small-medium private practices.
3. Primary Care “safety net” threatened by FFS model and by value-based payment systems…
4. Geisinger, Kaiser, Intermountain Healthcare work *deliver value*…what about the rest of us?

Francois de Brantes: *What we need is disruptive innovation… “transparency in cost and quality”*
Integrated Physician Network accountability value sustainability Transformational Change…

Clinical Integration and survival:
A seven year old Motto...

Accountable Care = provider-level responsibility for the patient-centric value of the Healthcare product.

Individual and regional

Quality, efficiency, safety, cost, patient experience
Organization *means* something:

An **Accountable Care Organization** stresses the critical roles that “organizations” play in delivering on the promise of patient-centric value.

**Organizational Hallmarks include:**

- Networked information systems (balanced transactional and analytical—data warehouse, BI tools and facile reporting).
- Learning systems (data-driven evolutionary improvement).
- Collaborative provider leadership.
- Provider mix, with a foundation of advanced primary care (e.g., PCMH), matters...as does patient empanelment.
- Notion of community healthcare utilities—in particular HIT and QI systems as a common good, essential to advance triple aim performance.
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The pain of healthy change:

Organizational “Clinical integration” of independent practices, primary and specialty care means...

1. Going digital: all electronic, same platform (ouch!)
2. Loss of autonomy and dirty laundry: Independent practices sharing data on clinical performance.
3. Some gains for primary care, gains and losses for Hospitals and specialty care.
4. New level of leadership and accountability.
5. “Courageous conversations”—e.g., transitions of care.
6. Moving from “practice-work” to “Teamwork” and systems of quality improvement.
Real tricks: overcoming classic barriers

- Clinical integration of independent practices around the Triple Aim—what makes engagement happen?
- How do we get 200 providers to spend $11000/yr each to be members???
- How do we get local community hospitals, PCPs, SCPs, FQHCs to collaborate???
- Getting to the source: primary source data—GIGO and Analytics/Business Intelligence.
- Bridging the FFS to Value-Based contracting gap...Making the case for Clinical Integration
- Creating practice-based, accessible resources and tools to make collaborative clinical integration happen
The Mission of iPN

To improve the health of our patients by creating a sustainable, **clinically integrated network** of independent primary, specialty care and hospital service providers. Using a **common electronic health record**, an **evidence-based quality improvement program** and primary source data, community providers will deliver safer, more efficient and more effective care, across the continuum of care, and **demonstrate the value** their service brings to their patients and healthcare system.
The iPN Toolset

The foundations of a melting-pot ACO:

1. Leveraging HIT across a community.
2. Population-based use of data: systems to drive performance improvement.
3. Organizational Mojo: building a community provider collaborative with a triple aim focus.
iPN as Macro-integrator

Population Health

Experience of Care

Per Capita Cost

collaborative leadership organization
The Community Health Record

- CHR (hosted model)
- Local, centralized, provider-responsive support and training
- CHIC—Clinical HIT Improvement Cte
- Common database
- Enterprise environment
- Private-public HIE
- Analytics (warehouse, BI/reporting)
Integrated Physician Network (iPN): Data in...

HIE

iPN EHR: the Enterprise Record

Centura Labs/Documents

Transaction Data Base

Ancillary Services: MMD

Pharmacy Systems eRX Hub

Paper: FAX

Pharmacy

Integrated Physician Network accountability value sustainability

Labcorp

Quest

Data In
Integrated Physician Network accountability value sustainability

Analytical Data Base/Data Warehouse/Business Intelligence

iPN: Data out...

iPN Community Health Record

Data Mining + Reporting Crystal Reports

Patient Registries

GIGO

Integrated Physician Network accountability value sustainability
Integrated Physician Network
accountability value sustainability

Analytical Data Base/Data Warehouse/ Business Intelligence

Data Mining + Reporting

Patient Registries

iPN Community Health Record

ACO Quality Improvement Teams

1. Quality @ Population level
2. Per Capita Cost
3. Patient Experience

Primary Source, Formatted Data

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accountability value sustainability
Value demonstration across a community

- Population-based use of data: the new GIGO
  - “If data is King, then the King’s boss,...”
- Optimization of the EHR GUI--quality/efficiency
- Performance improvement—collaboration through the Quality Improvement Committee
- Transparency...it’s a journey
- Coaching as a service...
- The human factor

- Integrated Physician Network
- accountability value sustainability
The physician-data paradox

- Denial
  - “The data is wrong”
- Anger
  - “Don’t tell ME how to practice medicine”
- Bargaining
  - “OK – If I do this can I get paid more?”
- Depression
  - “OY VEY”
- Acceptance
  - “I had no idea….OK - let’s get going!”
Tobacco Cessation Counseling

TOOLS
### Vital Signs

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Temp F</th>
<th>Temp C</th>
<th>BP</th>
<th>Pulse</th>
<th>Rhythm</th>
<th>Respiration</th>
<th>Ht In</th>
<th>Ht Cm</th>
<th>Ht Lb</th>
<th>Ht Kg</th>
<th>Co</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/15/2011</td>
<td>10:43 AM</td>
<td>98.60</td>
<td>125/75</td>
<td>65</td>
<td>regular</td>
<td>25</td>
<td>66.0</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Tobacco Use
- **06/06/2011**
  - Yes

### Alcohol Use
- **05/10/2011**
  - Yes

### Depression Scren
- **06/04/2011**
  - Former

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**Meaningful Use**

**Tobacco, Alcohol and Depression Screening**

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**Integrated Physician Network**

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Heart Stroke: Depression Screening

**iPN**

**PHQ-2/PHQ-9**

Patient Depression Assessment

Over the past two weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things?</td>
<td></td>
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<tr>
<td>2. Feeling down, sad or hopeless?</td>
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<td>3. Trouble falling or staying asleep, or sleeping too much?</td>
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<td>4. Feeling tired or having little energy?</td>
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<tr>
<td>5. Eating too much or too little?</td>
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<tr>
<td>6. Feeling bad about yourself - or that you are a failure or let yourself or your family down?</td>
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<tr>
<td>7. Trouble focusing on things, such as reading the newspaper or watching television?</td>
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<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so restless that you have been moving around a lot more than usual?</td>
<td></td>
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</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way?</td>
<td></td>
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</tr>
</tbody>
</table>

Submit PHQ-2 Score: 3

Submit PHQ-9 Score: 
The new practice Vital Sign: **DATA**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>DOB</th>
<th>Visit</th>
<th>BP</th>
<th>BP Dia</th>
<th>Tobacco</th>
<th>Eye Exam</th>
<th>SM Goal</th>
<th>Foot Exam</th>
<th>LDL Date</th>
<th>LDL</th>
<th>A1c Date</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andy</td>
<td>04/06/1931</td>
<td>05/13/2008</td>
<td>142</td>
<td>64</td>
<td>Active</td>
<td></td>
<td></td>
<td></td>
<td>05/20/2007</td>
<td>118</td>
<td></td>
<td>6.60</td>
</tr>
<tr>
<td>Pete</td>
<td>11/21/1928</td>
<td>05/14/2008</td>
<td>110</td>
<td>70</td>
<td>Active</td>
<td></td>
<td></td>
<td></td>
<td>08/08/2007</td>
<td>75</td>
<td></td>
<td>6.20</td>
</tr>
<tr>
<td>Ron</td>
<td>09/10/1942</td>
<td>03/11/2008</td>
<td>115</td>
<td>58</td>
<td>Active</td>
<td>03/11/2008</td>
<td>02/21/2008</td>
<td>114</td>
<td></td>
<td></td>
<td></td>
<td>7.20</td>
</tr>
</tbody>
</table>
iPN Practice: the Data Wall

The Team and their work
### iPN system-level performance

**May 2011**

<table>
<thead>
<tr>
<th>Quality: Diabetes</th>
<th>CRC</th>
<th>Mammo</th>
<th>Pneumovax</th>
<th>Flu vaccine</th>
<th>IVD</th>
<th>Patient Experience</th>
<th>Cost Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QUALITY OF CARE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Diabetes (evidence based care)</strong></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>One HbA1c (&lt;365 days)</td>
<td>&gt;90%</td>
<td>77%</td>
<td>52%</td>
<td>20%</td>
<td>Oct-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two (or more, &lt;365 days)</td>
<td>&gt;75%</td>
<td>45%</td>
<td>84%</td>
<td>43%</td>
<td>Oct-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average HbA1c (last test) looking for downward trend</td>
<td>&lt;7.5%</td>
<td>7.8</td>
<td>7.11</td>
<td>-9%</td>
<td>Oct-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c &gt;9% in the last 365 or no HbA1c in the last 365</td>
<td>&lt;=20%</td>
<td>20%</td>
<td>28%</td>
<td>40%</td>
<td>Oct-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c &gt;9 (poor control) looking for downward trend</td>
<td>&lt;=20%</td>
<td>23%</td>
<td>18%</td>
<td>-20%</td>
<td>Oct-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP &lt;140/90 mm Hg</td>
<td>&gt;65%</td>
<td>74%</td>
<td>76%</td>
<td>3%</td>
<td>Oct-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP &lt;130/80 mm Hg</td>
<td>&gt;35%</td>
<td>39%</td>
<td>40%</td>
<td>4%</td>
<td>Oct-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One LDL (in last 365 days)</td>
<td>&gt;85%</td>
<td>58%</td>
<td>78%</td>
<td>35%</td>
<td>Oct-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL &gt;= 130 mg/dl (poor cont) looking for downward trend</td>
<td>&lt;=37%</td>
<td>18%</td>
<td>12%</td>
<td>-33%</td>
<td>Oct-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer screenings (CMS project)</td>
<td>n=14406</td>
<td>n=21109</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Screening</td>
<td>&gt;=67%</td>
<td>26%</td>
<td>41%</td>
<td>58%</td>
<td>Mar-09</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=5698</td>
<td>n=9693</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td>&gt;=77%</td>
<td>30%</td>
<td>47%</td>
<td>57%</td>
<td>Mar-09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=3680</td>
<td>n=6692</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations (CMS project)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza (flu)</td>
<td>&gt;=70%</td>
<td>29%</td>
<td>53%</td>
<td>130%</td>
<td>Mar-09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=3662</td>
<td>n=6666</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumovax (pneumonia)</td>
<td>&gt;=86%</td>
<td>31%</td>
<td>44%</td>
<td>42%</td>
<td>Mar-09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IVD / CAD (2 practices)</td>
<td>n=308</td>
<td>n=600</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of IVD patients with blood pressure less than 140/90 mm Hg</td>
<td>&gt;=75%</td>
<td>75%</td>
<td>73%</td>
<td>4%</td>
<td>Jun-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of IVD patients who were queried about tobacco use one or more times</td>
<td>&gt;=80%</td>
<td>81%</td>
<td>86%</td>
<td>6%</td>
<td>Jun-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of IVD patients who were identified as tobacco users who received cessation intervention one or more times within 730 days</td>
<td>&gt;=80%</td>
<td>68%</td>
<td>73%</td>
<td>7%</td>
<td>Jun-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of CAD patients who were prescribed lipid lowering therapy</td>
<td>&gt;=80%</td>
<td>83%</td>
<td>72%</td>
<td>-12%</td>
<td>Jun-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PATIENT EXPERIENCE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Satisfaction with the Practice</td>
<td>4.60</td>
<td>4.31</td>
<td>NA</td>
<td>NA</td>
<td>Feb-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Satisfaction with your medical care</td>
<td>4.64</td>
<td>4.40</td>
<td>NA</td>
<td>NA</td>
<td>Feb-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Rating of care from your provider</td>
<td>4.87</td>
<td>4.45</td>
<td>NA</td>
<td>NA</td>
<td>Feb-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you recommend the provider to others</td>
<td>4.78</td>
<td>4.57</td>
<td>NA</td>
<td>NA</td>
<td>Feb-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SAVINGS OPPORTUNITY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic pharmacy (PP)</td>
<td>%</td>
<td>78%</td>
<td>79%</td>
<td>1%</td>
<td>Nov-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=9762</td>
<td>n=10778</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic pharmacy (stats)</td>
<td>%</td>
<td>64%</td>
<td>66%</td>
<td>3%</td>
<td>Nov-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=21009</td>
<td>n=24037</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Diabetes Patients with One HbA1C in the last year

Integrated Physician Network

Diabetes Care: Process (blood sugar-A1c-measurement)

- iPN Overall (n = 3918)
- Target (90%)
- Best
Diabetes Patients with HbA1c >9% (poor control)
N = 3605 (Patients with at least one HbA1c in the last year)

Diabetes Care: clinical outcomes (blood glucose-A1c-poor control)
integrated Physician Network
Diabetes Patients with One LDL in the last year

Diabetes Care: process (LDL cholesterol measurement)

- iPN Overall (n = 3918)
- Target (85%)
- Best
Diabetes Care: clinical outcomes
(LDL cholesterol poor control)

iPN Overall

(n = 3918)

Target (37%)

Best
Change management and “best practice practices”

Colorectal Cancer Screening: process
Mammography: process

PDSA example: imaging center scheduling

integrated Physician Network
Mammography
n = 9693 overall iPN
Pneumococcal Vaccination

n = 6586 overall iPN

Pneumovax: immunizations

Proprietary & Confidential
Integrated Physician Network
accountability value sustainability

Ischemic Vascular Disease
BP less than 140/90 mm Hg

n=600

<table>
<thead>
<tr>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-10</td>
<td>Aug-10</td>
<td>Sep-10</td>
<td>Oct-10</td>
<td>Nov-10</td>
<td>Dec-10</td>
<td>Jan-11</td>
<td>Feb-11</td>
<td>Mar-11</td>
<td>Apr-11</td>
<td></td>
</tr>
</tbody>
</table>

Ischemic Vascular Disease:
(good blood pressure control)
Ischemic Vascular Disease:
(tobacco screening and counseling)

Patients who were queried about tobacco use one or more times
Patients who were identified as tobacco users who received cessation intervention one or more times within 730 days
1. Generic Rx improved 66% to 71% (over 6 mos)
2. Estimated annual savings = $50,000
Diabetes Patients with HbA1c >9% or no HbA1c in the last year (poor control)

Impact of practice "engagement" and of new practices…

Diabetes Care: A1c poor control (practice-level)
Patient Experience

F. YOUR OVERALL SATISFACTION WITH:

<table>
<thead>
<tr>
<th></th>
<th>Previous</th>
<th>Current</th>
<th>Database</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Our practice</td>
<td>4.31</td>
<td></td>
<td>4.60</td>
</tr>
<tr>
<td>2. The quality of your medical care</td>
<td>4.40</td>
<td></td>
<td>4.64</td>
</tr>
<tr>
<td>3. Overall rating of care from your provider</td>
<td>4.45</td>
<td></td>
<td>4.67</td>
</tr>
<tr>
<td>4. Would you recommend the provider to others</td>
<td>4.57</td>
<td></td>
<td>4.78</td>
</tr>
</tbody>
</table>
Diabetic Education Class

Diabetic Class Patient Survey Scores (out of 5)

1.00 2.00 3.00 4.00 5.00 6.00


This class was well worth my time
The materials presented was valuable to me
The power point presentation was effective
The pharmacist was knowledgeable and professional
The length of the class was acceptable
The facility was reasonably comfortable
I feel more capable of managing my diabetes now

Patient feedback: “Thank you, I was a person with diabetes and now I am a person with hope.”
Organizational Mojo

- IPA as ACO: growing physician leadership
- The “in or out” commitment (EHR, QI efforts, membership participation)
- Outcomes/performance transparency (culture shift)
- Membership accountabilities
- Change management—listen and respond
- Bringing value to the membership: HIT, Clinical integration and new payment methodologies
- “Meaningful use:” a given
- Common Ground—our collaborators...
Stakeholder Engagement

- Centura Health and Avista Adventist Hospital: ...Safe Harbor subsidization
- Clinica Family Health Services
- HealthTeamWorks
- Payers: UHC, Aetna, Cigna, Anthem…
- CACHIE
- Colorado Foundation for Medical Care
- Colorado RHIO
- American Heart Association
- Colorado Business Group on Health
- Bridges to Excellence/Prometheus
Regional Provider Laboratory for value demonstration projects

- Project RED
- State QIO (CFMC)—DOQ-IT, Prevention 9th SOW
- Back Pain Initiative
- Boulder Valley Care Network
- PCMH—Multi-stakeholder, FQs
• **Discharge Advocate:** creation and empowerment
• **Med Reconciliation:** Pharmacy Department to manage throughout hospitalization.
• **“Transition Collaboration Document:”** redesign of the “Discharge Summary” to explicitly define the After Hospital Care Plan, pending labs/imaging, Discharge Med Reconciliation, PCP and/or Specialty Care follow-up care and appointment, barriers and risks to care, etc.
• **Multidisciplinary Care Team** rounds with all hospitalist patients (Med Surg initially).
• **Real-time auditing** and root cause analysis of unplanned re-hospitalizations within 30 days (Utilization Management).
Problem: management of back pain patients demands system-ness and EBM...current “system” is fragmented, incentivized to do more, PCP marginalized.

Work Plan:

1. EHR enhancement tool: Back Pain Planned Care management Flowsheet.
2. Back Pain Collaborative Team: PCPs, Avista Hospital PTx, DC, Physiatrist, Ortho.
3. At all invasive decision points (MRI, injection, surgery), mandatory shared decision making by all Collaboration Team members—including the patient.
Patient Centered Medical Home: growing team-based systems and advance primary care

iPN PCMH Collaborative: 8 Level III NCQA Medical Homes
A1c improved by 15% (compared to 3% for all BFP diabetics)
# Meaningful Use

<table>
<thead>
<tr>
<th>2011 Phase 1 Objectives</th>
<th>TATU</th>
<th>IPM Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use CPOE</td>
<td></td>
<td>Doctor orders diagnostic tests, lab tests, etc.</td>
</tr>
<tr>
<td>Implement drug-drug, drug-allergy, drug-formulary checks</td>
<td></td>
<td>Native NestGen functionality</td>
</tr>
<tr>
<td>Maintain an up-to-date problem list of current and active diagnoses based on C.D.3-CM or SNOMED CT®</td>
<td></td>
<td>Native NestGen functionality</td>
</tr>
<tr>
<td>Generate and transmit permissible prescriptions electronically (eRx)</td>
<td></td>
<td>Medication Module</td>
</tr>
<tr>
<td>Maintain active medication list</td>
<td></td>
<td>Medication Module</td>
</tr>
<tr>
<td>Maintain active medication allergy list</td>
<td></td>
<td>Native NestGen functionality</td>
</tr>
<tr>
<td>Record demographics</td>
<td></td>
<td>Native NestGen functionality</td>
</tr>
<tr>
<td>Record and chart changes in vital signs</td>
<td></td>
<td>Native NestGen functionality</td>
</tr>
<tr>
<td>Record smoking status for patient 10 years or older</td>
<td></td>
<td>Native NestGen functionality</td>
</tr>
<tr>
<td>Incorporate clinical lab test results into EHR as structured data</td>
<td></td>
<td>Doctor has to use Lab Module</td>
</tr>
<tr>
<td>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach</td>
<td></td>
<td>Native NestGen functionality</td>
</tr>
<tr>
<td>Report ambulatory quality measures to CMS or the State</td>
<td></td>
<td>Diabetes Fa$hion Star Program, Tolkier system in EMR, or PNCAT Plan in EPIM</td>
</tr>
<tr>
<td>Send reminders to patients per patient preference for preventive/ follow-up care</td>
<td></td>
<td>CP03 is testing this functionality now with</td>
</tr>
<tr>
<td>Implement five clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules</td>
<td></td>
<td>Native NestGen functionality</td>
</tr>
<tr>
<td>Check insurance eligibility electronically from public and private payers</td>
<td></td>
<td>Navicare</td>
</tr>
<tr>
<td>Submit claims electronically to public and private payers</td>
<td></td>
<td>Native NestGen functionality</td>
</tr>
<tr>
<td>Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request</td>
<td></td>
<td>Native NestGen functionality</td>
</tr>
<tr>
<td>Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies)</td>
<td></td>
<td>Native NestGen functionality</td>
</tr>
<tr>
<td>Provide clinical summaries to patients for each office visit</td>
<td></td>
<td>Patient Plan Document, Enterprise Chart, CHS, P-NED, P-VE</td>
</tr>
<tr>
<td>Capability to exchange key clinical information (e.g., problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically</td>
<td></td>
<td>Patient Plan Document</td>
</tr>
<tr>
<td>Perform medication reconciliation at relevant encounters and each transition of care</td>
<td></td>
<td>Doctor has to use the Medication Module</td>
</tr>
<tr>
<td>Provide summary care record for each transition of care and referral</td>
<td></td>
<td>Patient Plan Document, we can send CSV, Excel, Intersite, whatever registry, etc.</td>
</tr>
<tr>
<td>Capability to submit electronic data to immunization registries and actual submission where required and accepted</td>
<td></td>
<td>ONC has not determined the document format yet but</td>
</tr>
<tr>
<td>Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice</td>
<td></td>
<td>AbKu7 satisfies this requirement</td>
</tr>
</tbody>
</table>
| Protect electronic health information maintained using certified EHR technology through the implementation of appropriate technical capabilities |      | }
<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Dose To Take</th>
<th>Generic Name</th>
<th>Strength</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lotrel 5/10 Mg Capsule</td>
<td>1 Cap</td>
<td>Amlodipine Besylate/Enal</td>
<td>1 Cap</td>
<td>Oral</td>
<td>Daily</td>
</tr>
<tr>
<td>Prozac</td>
<td>10 Mg</td>
<td>Fluoxetine Hcl</td>
<td>10 Mg</td>
<td>Oral</td>
<td>Daily</td>
</tr>
<tr>
<td>Coumadin Tab</td>
<td>6 Mg</td>
<td>Warfarin Tab</td>
<td>2 Mg</td>
<td>Oral</td>
<td>Daily</td>
</tr>
</tbody>
</table>
PATIENT PLAN

Assessment
Sprain/strain, knee, cruciate ligament (844.2), Acute
Probably just a little ouchy. Better send to Ortho!

Medications:

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand</th>
<th>Dose</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zolpidem Tartrate</td>
<td>Zolpidem Tartrate</td>
<td>10 Mg</td>
<td>take 1 tablet (10mg) by oral route every day at bedtime</td>
</tr>
<tr>
<td>Azithromycin</td>
<td>Zithromax</td>
<td>250 Mg</td>
<td>take 2 tablet (500mg) by oral route every day for 1 day then 1 tablet (250 mg) by oral route once daily for 4 days</td>
</tr>
</tbody>
</table>

Diagnostics:

<table>
<thead>
<tr>
<th>Status</th>
<th>Order</th>
<th>ICD9</th>
<th>Timeframe</th>
<th>Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ordered</td>
<td>X-ray exam, ankle, complete, 3+ views Right</td>
<td>844.2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Plan:

<table>
<thead>
<tr>
<th>Status</th>
<th>Order</th>
<th>Completed</th>
<th>Interpretation</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>completed</td>
<td>Td 1 mL IM</td>
<td>06/07/2011</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lab Studies:

<table>
<thead>
<tr>
<th>Status</th>
<th>Lab Study</th>
<th>Timeframe</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ordered</td>
<td>LIPID PANEL</td>
<td></td>
<td>06/07/2011</td>
</tr>
</tbody>
</table>
The value of membership...
What do we have to show for it…

Return on Investment

- Contract Performance
- Clinical Integration: better care and...
- Charge capture
- Appropriate coding
  - Single signature contracting (charges/visit increased 6.3%)
- UHC Stars Program
- NCQA Recognition—Diabetes, IVD, PCMH
- Payment Methodology Reform…being part of the Solution—P4P, PCMH, BVSD,…BTE/Prometheus
The take-home message...

- It takes a village
  - regional collaboration of providers—a new culture
- The village requires *common utilities*
  - QI, HIT—technical and human support
- Village leadership and governance is key
  - “by the people, for the people”
  - providers, primary care, common vision and commitment to Value-Based Healthcare.
- It is *in the village* that sustainability is found
  - The product: market-relevant value.
“Data is a campfire around which organizations huddle for heat and light. The irony is that neither the heat nor the light yield the solution. The solution emerges out of the huddling”

--Stolen shamelessly from the 2009 Vancouver IHI Office Summit--
Q&A

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