

Partner Health

Care Enhancement Program

BCBSM PGIP Quarterly Meeting
March 13, 2009

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Partner Health

Overview and Objectives

- Program development at SJHP
- Current state
- Successes and Barriers
- Future steps

Who is St. John HealthPartners?

An umbrella Physician Hospital Organization (PHO) comprised of the following individual PHOs/IPA representing the St. John Health Hospitals:

- St. John Hospital PHO (St. John Hospital and Medical Center and St. John North Shores)
- SJ Macomb Center PHO (St. John Macomb-Oakland Hospital - Macomb Center)
- SJ Oakland Center PHO (St. John Macomb-Oakland Hospital - Oakland Center)
- St. John River District PHO
- Partners in Mission (Providence Hospital and Providence Park Hospital)
- Macomb St. Clair IPA

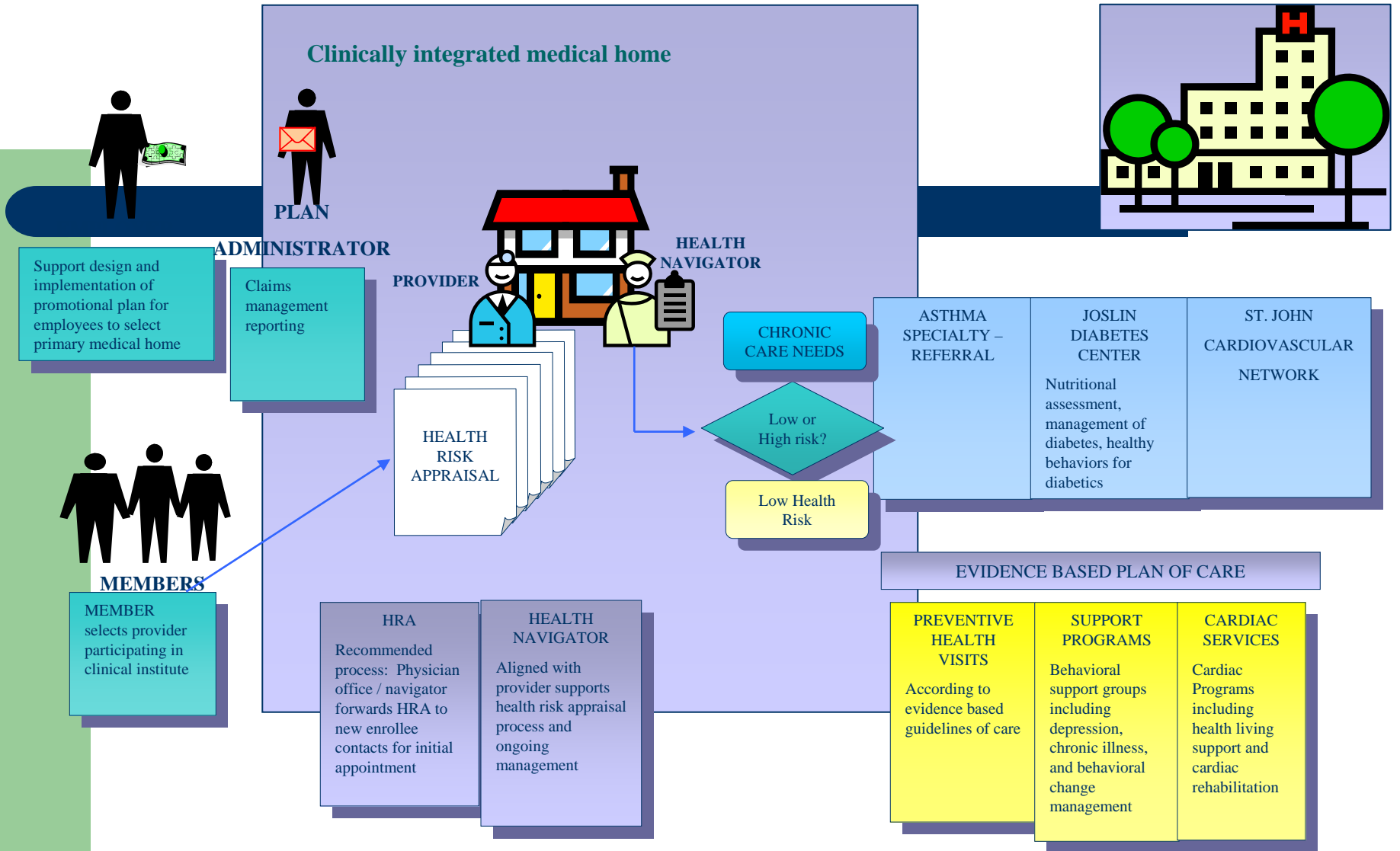
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Program development

- Physicians and administrators interested in improving care of our employees
- Our own Medical Home model based on Ed Wagner's CCM and Len Frommer from the Clinical Institute.
- Established Board and Committees to support infrastructure development
- Identified need to focus on Diabetes and Heart Disease
- Process improvement/ LEAN
- IT> IT>IT

ST. JOHN HEALTH

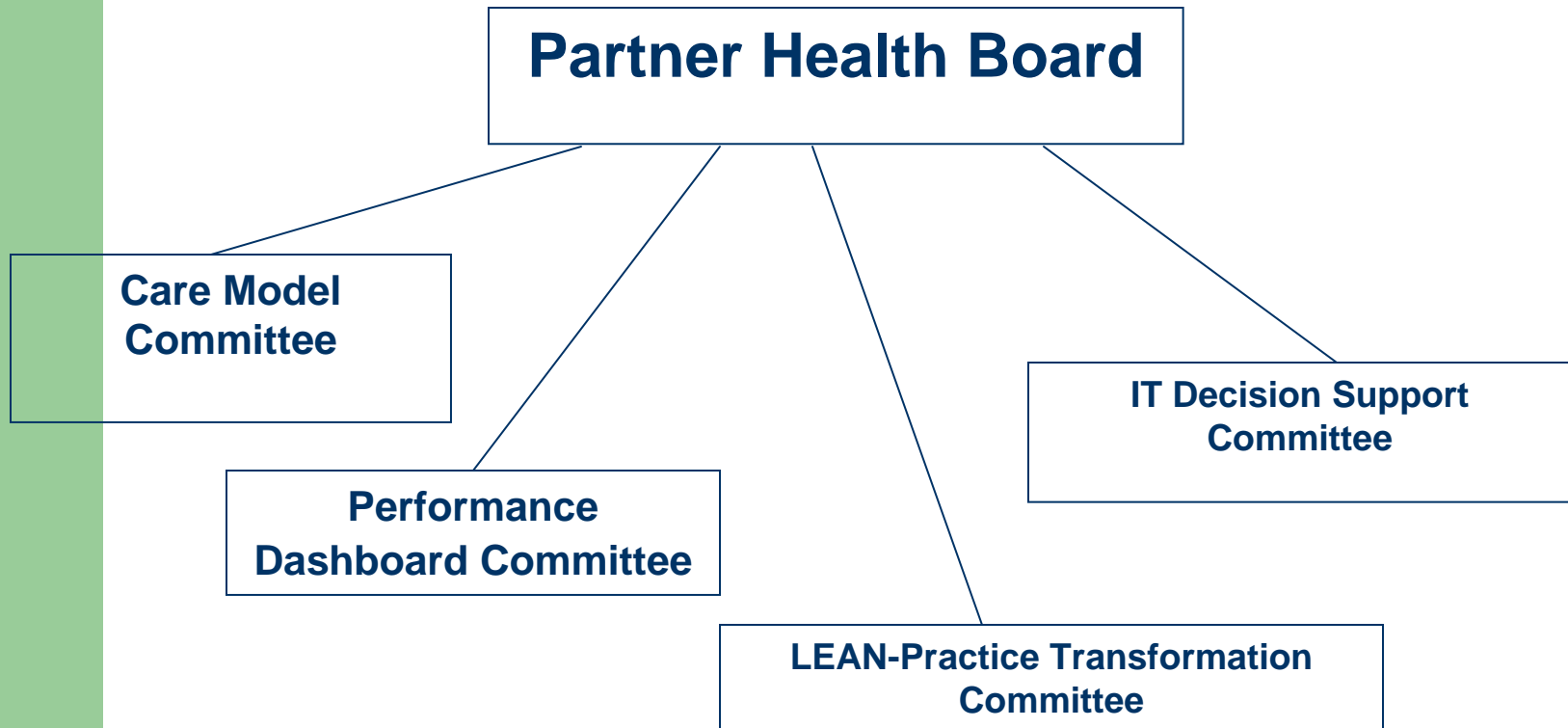
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Partner Health 2009

- 82 primary care providers in 21 SJHP practices (private and employed)
- Additional 25+ physicians enrolled in 2009
- All PH practices nominated for BCBS PGIP PCMH 2009 designation
- Various IT tools to support practice transformation implemented or in progress (Cielo, eRx, EMR)
- PH Care Management of referred Diabetics patients have shown improvement in process and outcome measures

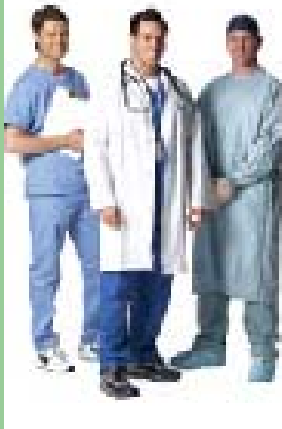
PartnerHealth Organizational Chart



Welcome to PartnerHealth!



As the current healthcare system continues to evolve in response to rapidly changing market forces, healthcare providers are exploring new and innovative ways to deliver high quality, efficient and service-oriented care to the patients and communities they serve. PartnerHealth is one such group of providers dedicated to being a driving force in the transformation of healthcare. As a partnership between primary care and specialty providers and the St. John Health system, PartnerHealth is leading innovative changes in all aspects of healthcare, with a focus on designing systems of care around the needs of the consumer. By placing the patient at the center of all that we do, PartnerHealth strives to redesign care delivery that achieves outstanding outcomes in care using evidence-based models, integrated information technology process re-engineering principles and a service orientation. In doing so, our practices are positioning themselves to be successful in the rapidly evolving market and more consistently provide outstanding care to their patients.



On behalf of the PartnerHealth Board, leadership and physician members, we invite you to explore what membership in PartnerHealth can do for you, your patients and your practice. Representatives are available to meet with you and your staff to provide greater detail about the services provided to PartnerHealth members.

Care Enhancement Program



Goals with Patients

- Actively engage patients in their own care
- Encourage ownership for their own health outcomes
- Work with patients to develop their role as a key partner in managing their disease
- Coach toward healthy lifestyle changes



Benefits to Physicians

- Facilitate appointments
- Monitor status between appointments – reduce gaps in care
- Improved patient outcomes – promote treatment plan compliance
- Improved patient satisfaction
- Improved quality of care
- Higher physician satisfaction
- Maximize use of St. John Health and community resources



Benefits to Staff

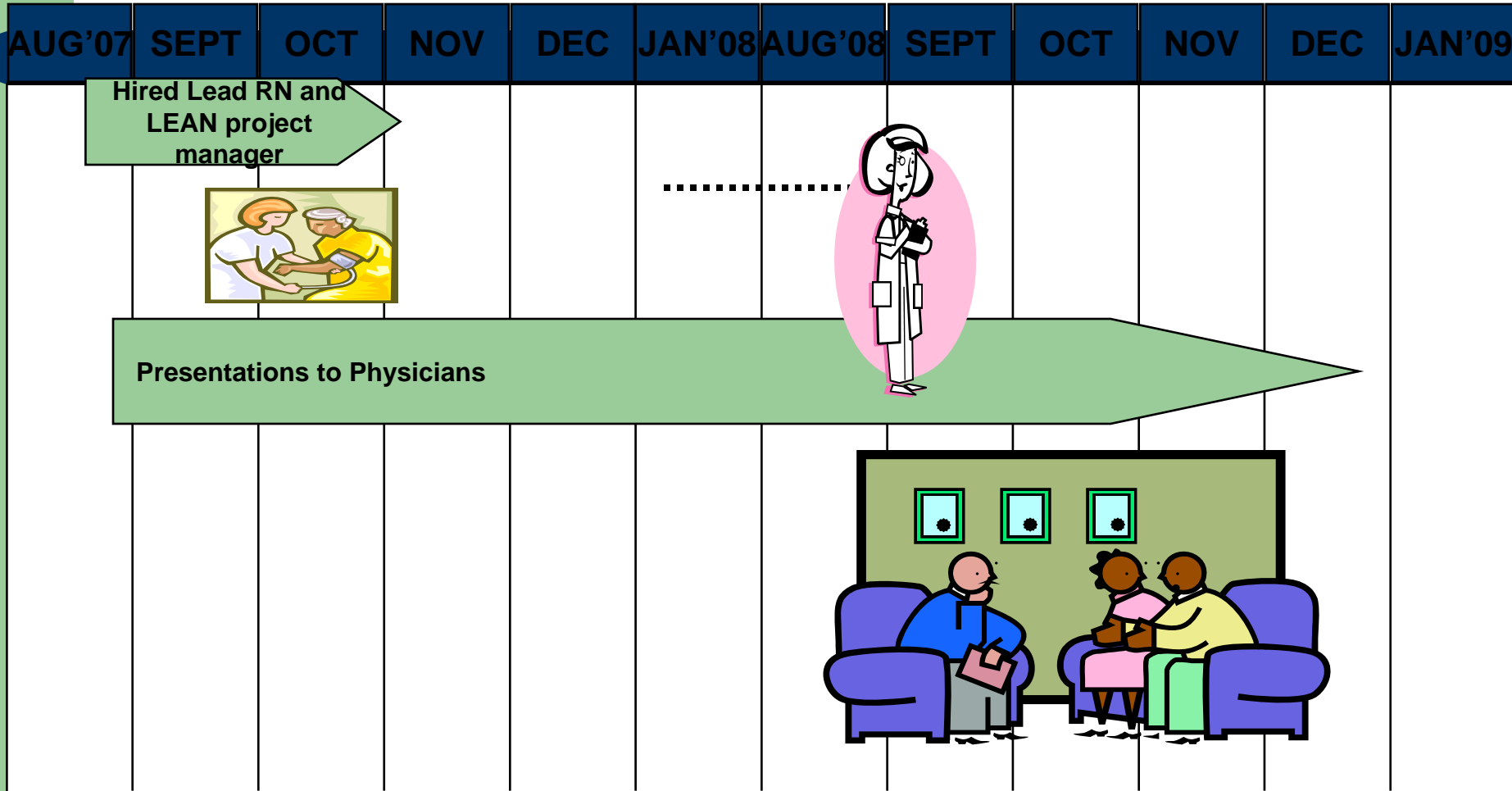
- Increased involvement in patient care
- Higher associate satisfaction
- Improved teamwork and shared decision

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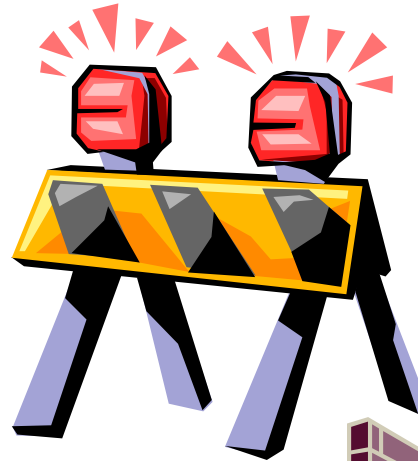
Care Enhancement Program

- Integral component of the Patient-Centered Medical Home
- Designed to assist physician 'close the gaps of care' between medical office visits-coordination of care
- Helps to assure patient receives the evidenced-based care as prescribed by the physician
- Individualized goal-setting with patient, promotes self management using Stanford Self-Management program
- Medication evaluation and management
- Nurse provides motivation, education, and direction towards healthy lifestyles

Partner Health Care Enhancement Program

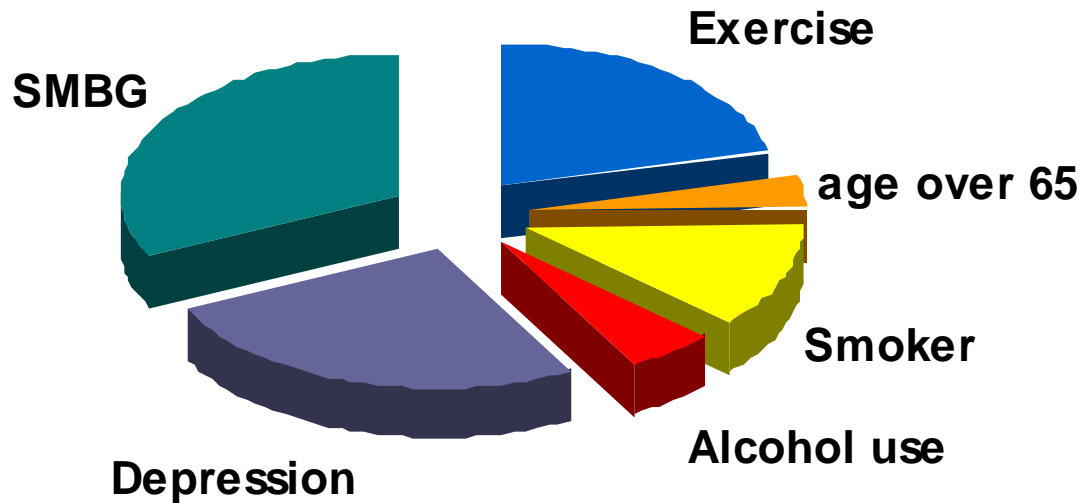


Successes and Barriers



Care Enhancement Program

Current Enrollees



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Care Enhancement Program

- Interventions
 - 3,024 interventions: phone calls, emails, interactions with physicians, specialists, Joslin
 - Average 27.9 interventions per patient
 - Total time per patient averaged 4.36 hours
 - 10-11 minutes per intervention

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Care Enhancement Program

Care Enhancement Program-comprehensive Diabetes Care				
Metric	Baseline	at 4months	at 6 months	SJHP Target
A1C annual	99%	100%	100%	95%
A1C < 7%	44%	50%	64%	75%
A1C > 9%	17%	11%	8%	15%
LDL annual	95%	100%	100%	91%
LDL < 100	35%	39%	64%	64%
Nephropathy screen	61%	89%	93%	59%
Eye Exam	39%	61%	95%	41%
BP < 130/80	33%	33%	53%	56%
Pneumonia vaccine	56%		67%	95%
Influenza vaccine	47%	75%	86%	95%

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Care Enhancement Program

- Successes
 - A1C decreased on average 5.1%
 - Average LDL decreased 14.7%
 - Nephropathy screening improvement 48%
 - Most marked improvement seen in Retinal eye exams- increased 55%

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Care Enhancement Program

- Successes
 - Weight loss of 446# (average 11# per patient)
 - 52% report increase in exercise and physical activity
 - 1 out of 3 completed DM and Nutrition Education

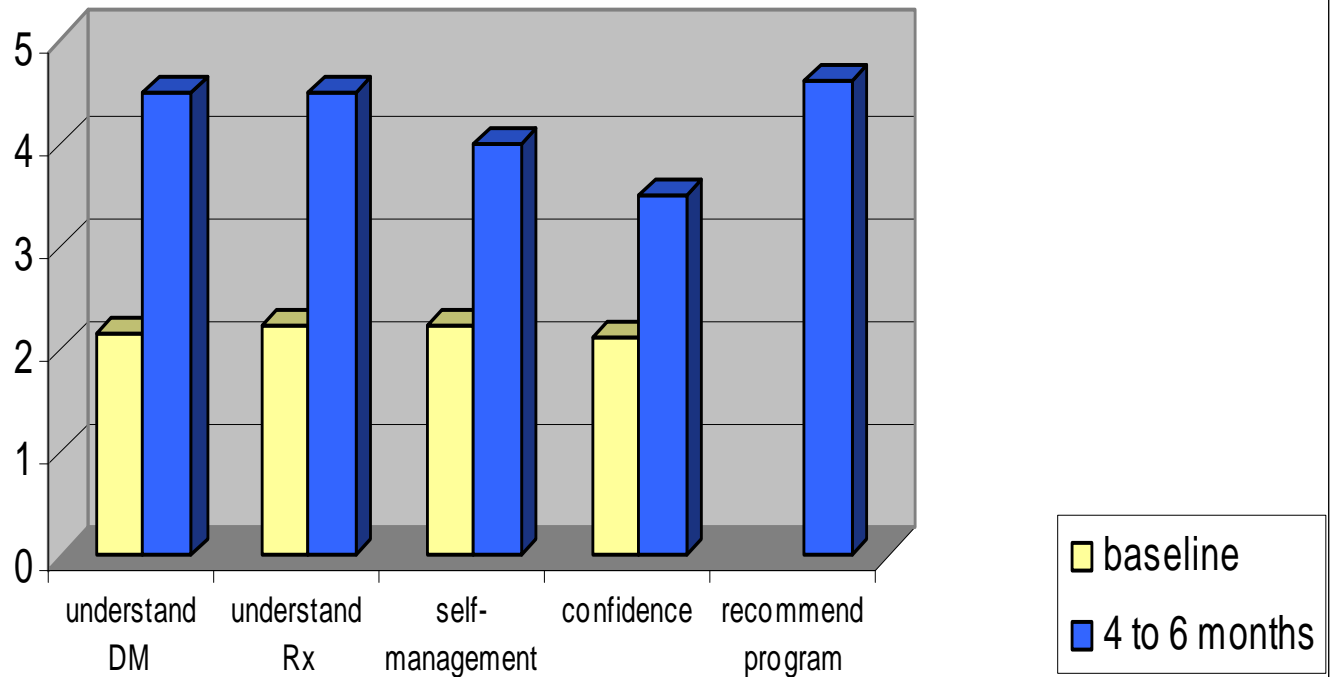
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Care Enhancement Program

- **Barriers**
 - Co-morbidities - aggravation of one condition by the treatment of another.
 - Medical record and data access - still limited to paper more than electronic.
 - Patients report loss of insurance / reduction in insurance benefits, costs of medications & diabetes supplies as major impediment.
 - Financial – Limited reimbursement by Payors. Program cannot continue without additional funding and support.

Partner Health Promotes Self-Management of Diabetes

Partner Health Care Enhancement Program
Patient Survey: Understanding of Diabetes



Partner Health Diabetes Management Summary Report Sample

St. John Partner Health
Comprehensive Diabetes Care

Baseline Report
Medical and RX Claims Data - HAP

Report Name: RPT066-08 SJPH Comp Diabetes Care - HAP2.rep

Run Date: 10:49:55 AM

Paid Thru: 03/31/2008

05/09/2008

Source Member ID	Member Last Name	Member First Name	Enrollment Date	Min Medical Service Date	Min RX Service Date	Inpatient Hospital	Physician Office	Others	Medical Paid Amount	Rx Paid Amount	Medical & Rx Grand Total
1			03/04/08	04/02/08	04/02/06	90,271.25	1,816.10	36,939.89	129,027.24	\$6,176.76	135,204.00
2			01/04/08	05/02/08	01/14/06	17,676.08	940.32	3,759.42	22,375.82	\$3,775.75	26,151.57
3			01/05/08	04/11/08	02/03/06		471.21	5,403.61	5,874.82	\$3,668.83	9,543.65
4			02/03/08	02/11/08	02/09/07		1,513.51	3,482.94	4,996.45		4,996.45
						107,947.33	4,741.14	49,585.86	162,274.33	\$13,621.34	175,895.67

St. John Partner Health
Comprehensive Diabetes Care

Post Enrollment Report
Medical and RX Claims Data - HAP

Report Name: RPT066-08 SJPH Comp Diabetes Care Post Enroll - HAP2.rep

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Paid Thru: 03/31/2008

05/09/2008

Source Member ID	Member Last Name	Member First Name	Enrollment Date	Max Medical Service Date	Max RX Service Date	Inpatient Hospital	Physician Office	Others	Medical Paid Amount	Rx Paid Amount	Medical & Rx Grand Total
1			03/04/08								
2			01/04/08	03/04/08	03/01/08			0.00	0.00	\$699.05	699.05
3			01/05/08		03/04/08					\$216.11	216.11
4			02/03/08	02/02/08	02/22/08		88.10		88.10		88.10
							88.10	0.00	88.10	\$915.16	1,003.26

Next Steps

- Diabetes Continuum of Care
- Train key office personnel to support and continue program
- Expanding care model to include CAD, asthma, any chronic disease
- Working with community partners
- EMR connections
- Reimbursement models