

Right Care  
Initiative

Arch Health Partners – A Progress  
Report



**4<sup>th</sup> Annual Right Care Initiative  
Clinical Quality Improvement  
Summit  
October 3, 2011**

## Who is Arch Health Partners?

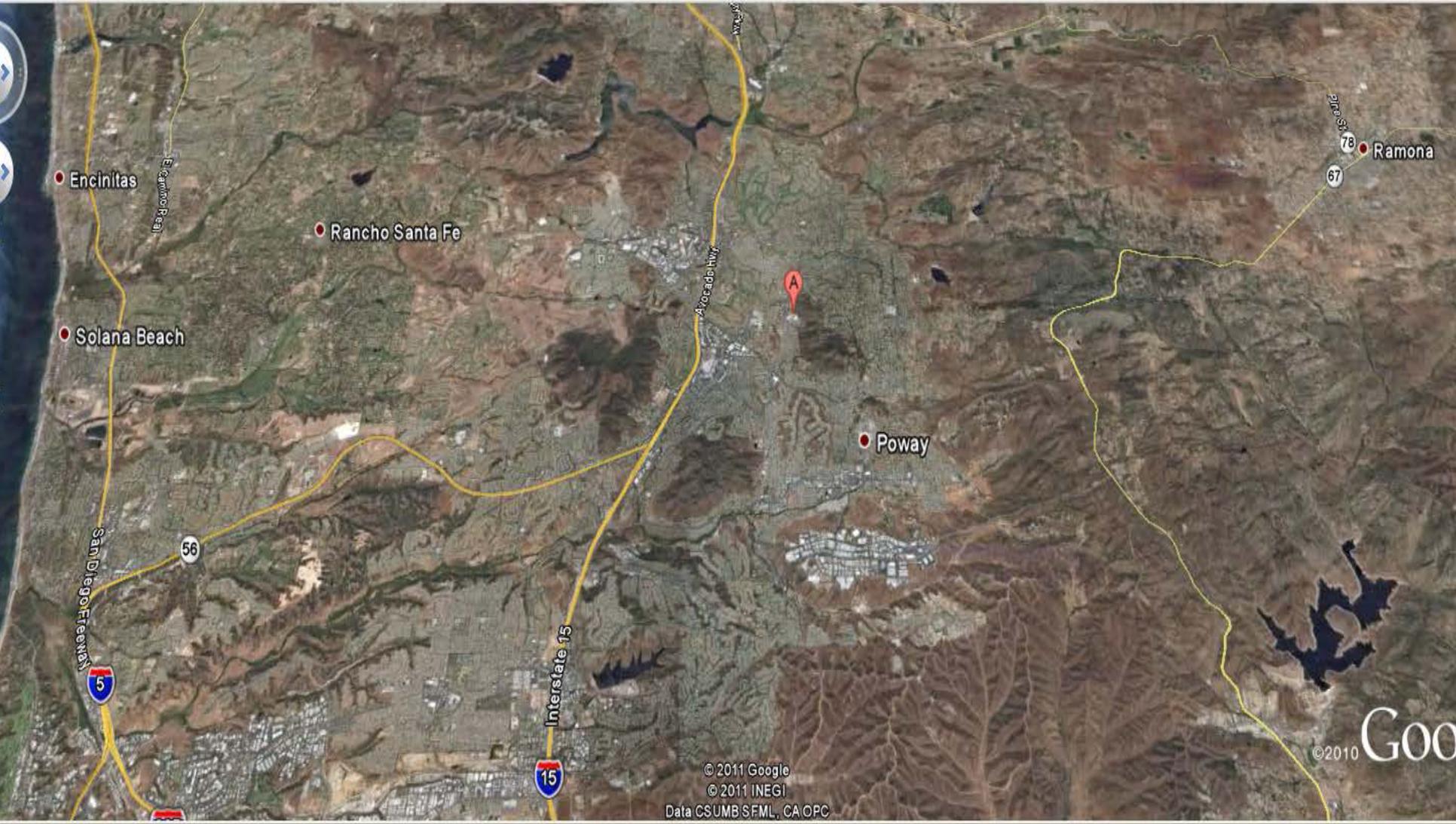
A medical foundation formed by Palomar-Pomerado Health and PIMG, a 20 year old multi-specialty medical group formerly known as Centre for Health Care.

Currently, Arch Health Partners has over 50 physicians, including 24 PCPs and multiple specialties in two locations - Poway and Ramona.

AHP has a very capable Urgent Care Center available 12 hours a day 7 days a week.

“Arch Health Partners will bring together the best physicians, hospitals, and employees to provide care of the highest clinical quality. Our focus will be to provide an exceptional patient experience where healing begins and health is restored.”

# Where is Arch Health Partners?



### 2011 California Statewide Goals: Preventing Heart Attacks and Strokes

**Achieve National HEDIS 90th Percentile Targets:**

70% of hypertensive patients with blood pressure controlled  
<140/90

70% of patients with cardiovascular conditions with lipids  
controlled LDL-C < 100

81% of diabetic patients with blood sugar controlled HBA1C < 9%

52% of diabetic patients with lipids controlled LDL-C < 100

## Arch Health Partners Emphasizes Quality Improvement

Our goal is to be a Top Performing medical group in terms of quality, patient experience and appropriate resource use.

## Key Activities

- Clinical data registries for population management
  - Balanced Scorecard Reporting and Incentives
    - Patient Engagement and Outreach
- Care Management Programs to support medical management

Our initial clinical scores from California's P4P program did not represent the type of care we felt we were delivering, nor what our patients deserved.

Diabetes and cardiovascular metrics were prominent

Multi-disciplinary team established to:

1. Ensure reported data reflected actual performance
2. Establish action plans by clinical measure for improvement

### Clinical Data Registries Implemented for Population Management

- Data integrity issues resolved and data supplemented with extensive chart review.
  - Did not wait for “perfect” data
- 2009: Next Gen EMR implemented to simplify chart review process
- 2010: Hypertension Registry established

**Clinical  
Quality**

**Patient  
Experience**

**Appropriate  
Resource Use**

**Professional  
Development**

### Balanced Scorecard Implemented

- PCP maximum increased from \$500 to \$10,000
- 24+ metrics reported quarterly by MD
- Medical Assistant incentive developed for achieving positive outcomes in chronic disease and preventive care metrics

### **Patient Activation and Outreach Programs Strengthened**

- Importance of Education by PCP within Office Visit regarding Diabetes self-management stressed
- Monthly Diabetes Support Groups to supplement Ongoing Educational Series
- Certification as “Chronic Care Professional” within Care Team RNs initiated to strengthen patient activation skills



## Arch Health Partners Care Management Services

A proactive approach that promotes health and



### Health Promotion

- Support healthier lifestyles with Wellness promotion classes, chronic disease management, and patient education
- MD-specific Preventive Care registries and lists
- Preventive care reminders
- Website health library

### Disease Management

- Anti-Coagulation Clinic, including Lovenox self-injection teaching
- Diabetes, CHF, COPD/Asthma, Chronic Disease and co-morbid depression
- Direct Telephone access to RN or CDE for questions/concerns
- Medication titration Co-management
- Chronic disease registries to identify gaps in care
- Personalized self-management consultations using motivational interviews

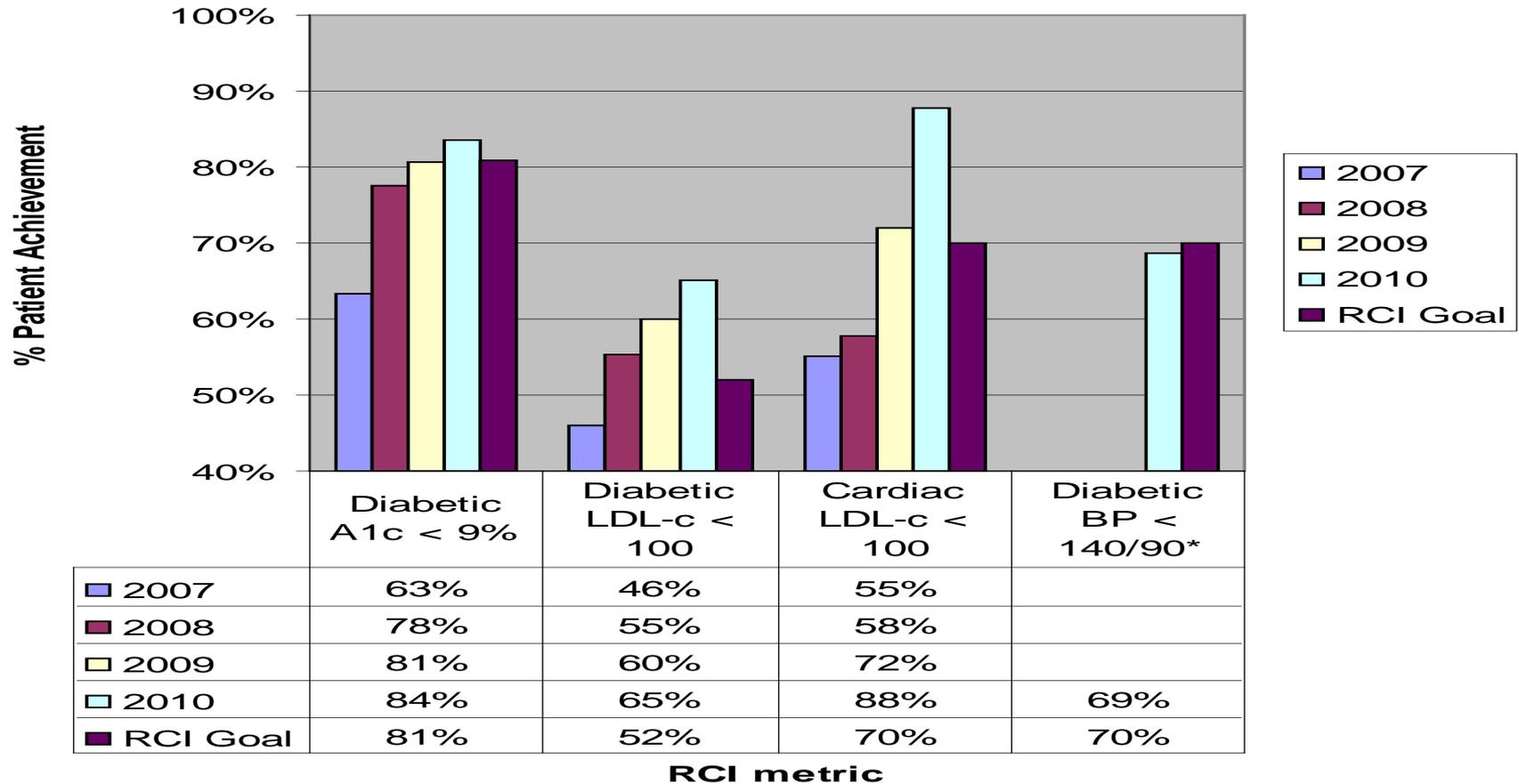
### Safe Transitions

- Post Hospital outbound calls to assess status, ensure follow-up care, record
- Coordination of services post transition
- Patient-specific discharge plans

### Complex Case Management

- At-risk patients are assigned to a Care Manager.
- A comprehensive assessment and care plan is developed and patients are followed up to assess progress and ensure continuity of care

## Right Care Initiative Trends - Arch Health Partners



- Continue to develop improvement plans for each clinical metric to achieve at least top level performance
- Participate in year long collaborative with AMGA on the Management of Patients with Multiple Chronic Conditions
- Continue journey toward Patient-Centered Medical Home to further strengthen population management skills within our practice

## Questions?

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