



“The Role Physicians Play in the Evidence Based Medicine Agenda”

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 **HealthCare Partners.**



The Value Proposition of EBM

EBM:

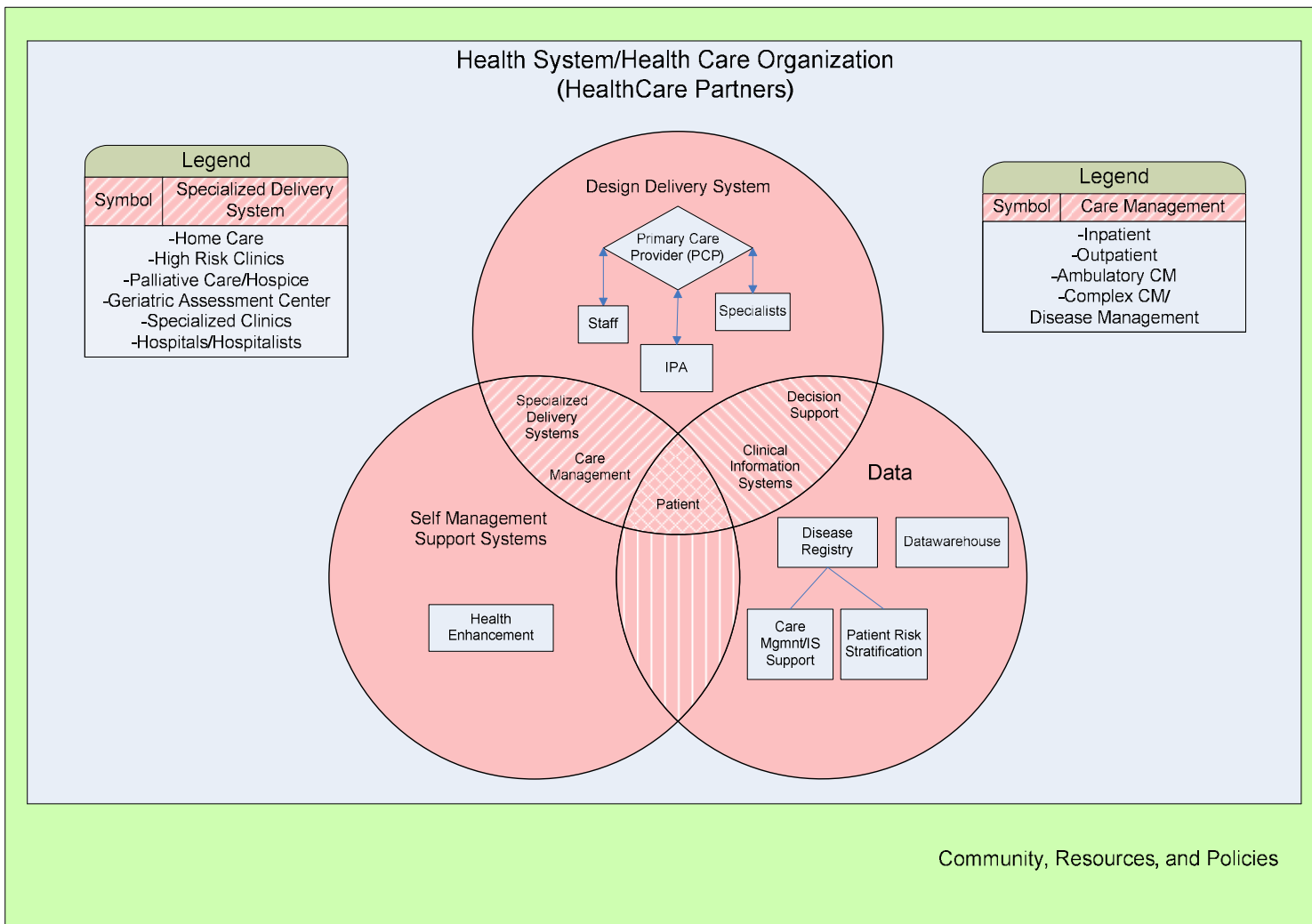
*Integrated and Coordinated Care programs **meaningfully apply EBM to reduce the upward trend of total health care costs** for healthcare providers, while providing a valuable service for their patients by:*

Application of EBM to:

- Improving the health of populations and individual patients
- Enhancing patient satisfaction and care experience
- Enhancing physician satisfaction and delivery experience
- Improving work force productivity and variability in care
- Reducing total health care cost

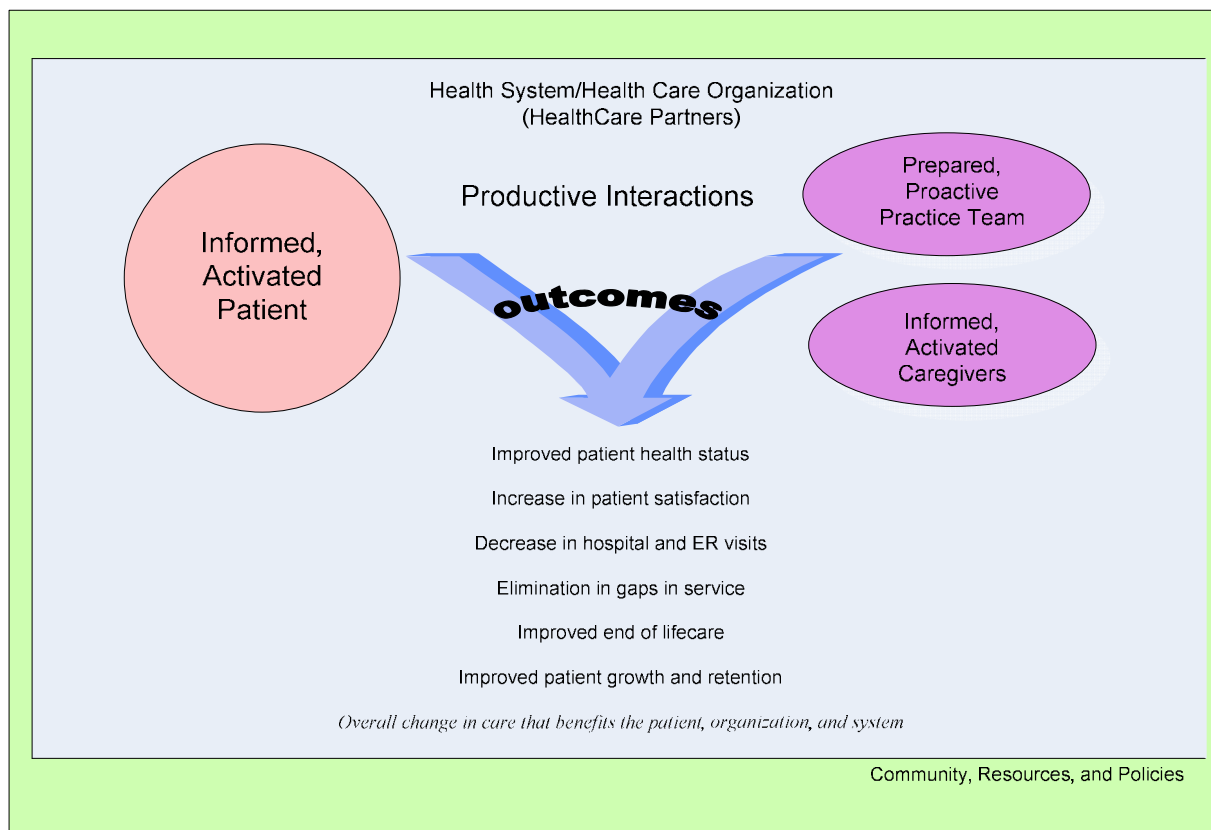


Chronic Care Model





EBM: Drives Chronic Care Model Outcomes Improvement





Stratifying Patients into the Appropriate Program: Direct Application of EBM to a Population and the Individual Patient

HomeCare Management

Provides in-home medical and palliative care management by Specialized Physicians, Nurse Care Managers and Social Workers for chronically frail seniors that have physical, mental, social and financial limitations that limits access to outpatient care, forcing unnecessary utilization of hospitals..

High Risk Clinics and Care Management

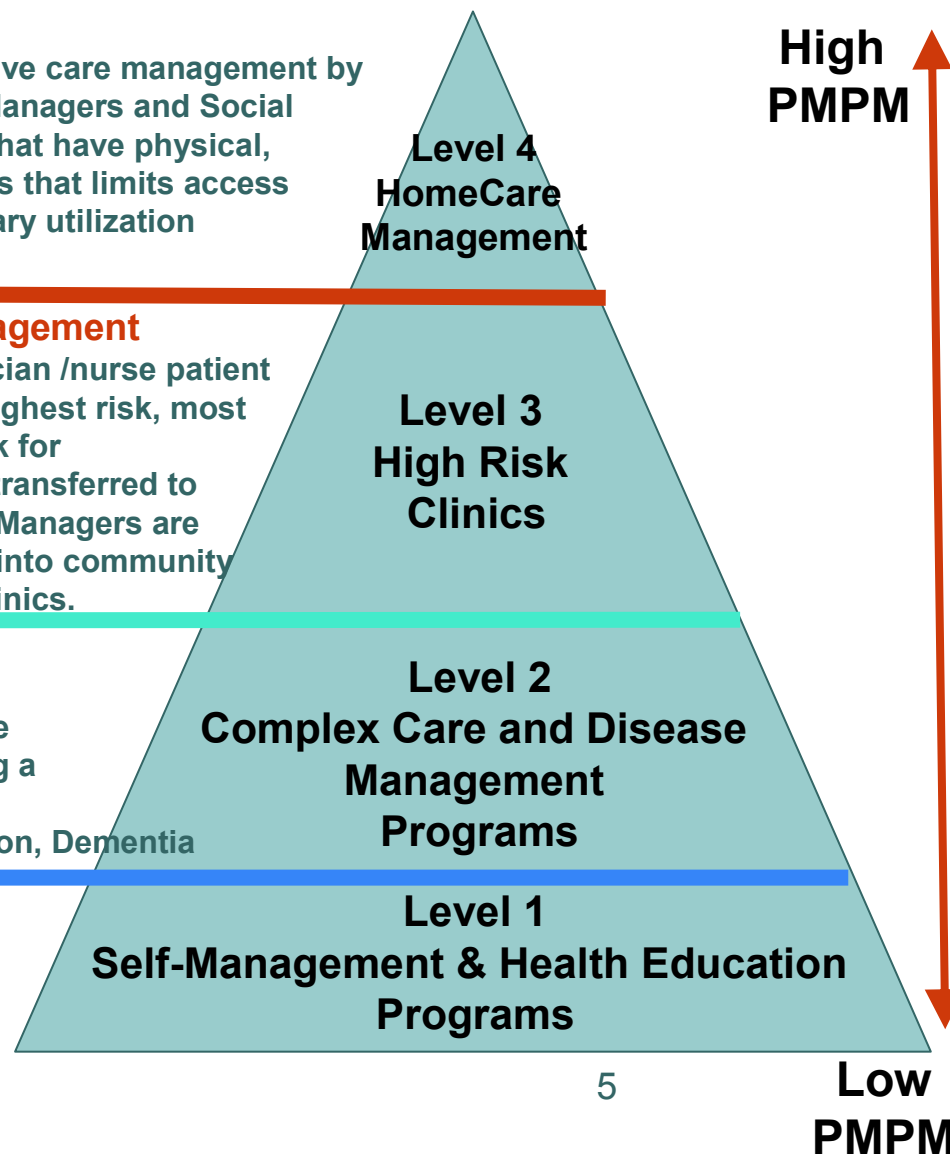
Provides intensive one-on-one physician /nurse patient care and case management for the highest risk, most complex of the population. As the risk for hospitalization is reduced, patient is transferred to Level 2. Level 4 Physicians and Care Managers are highly trained and closely Integrated into community resources and Physician offices or clinics.

Chronic Complex Care and Disease Management

Provides long-term whole person care enhancement for the population using a multidisciplinary team approach.
Diabetes, COPD, CHF, CKD, Depression, Dementia

Self Management

Provides self-management for people with chronic disease.





Technology and EBM 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 Patients for the Most Appropriate care
- **Use of the Internet for improved adoption of EBM**
 - PiP- Physician 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"



EBM Current HCP Clinical Individual Physicians Programs

- Hospitalists- Critical Care Pathways
- Primary Care Physicians- Clinical Algorithms for Chronic Disease
- Specialist Physician- Best Practice Clinical Algorithms for both Acute and Chronic Disease
- Chronic Care Algorithms for Team Physician Care
- Home Care Physicians- Algorithms for managing the care at home of the Chronically Frail
- High Risk Clinic- Algorithms for managing the complicated high risk frail/ near-frail patient
 - Multiple Comorbid Disease
 - Single Disease



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

COPD Best Practice

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

Depression and Dementia Best Practice

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

Advanced Care Planning and Palliative Care Best Practice



EBM Patient, Family and Caregiver Education

- Diabetic Education
- CHF Education
- COPD Education
- CKD Education
- Depression and Dementia Education Programs
- Advanced Care Planning and Palliative Care Initiatives
- Frailty Intervention and Prevention
 - Falls Prevention
 - Incontinence
 - Dementia
 - Depression



HomeCare Services: Example of Focused EBM for the Homebound Frail Senior

Patients Will Benefit

- House Calls
- 24-Hour Contact with HomeCare Team
- Care Planning
- Medication Monitoring
- Coordination of Care
- Communication and Education
- Access to Community Resources
- Caregiver support, education and coordination

HCP Outcomes and Benefits

- Reduction in Hospital Admits and Days
- Reduction in ER Utilization
- Reduction in Deaths in Hospital and ICU
- Improved Advanced Care Planning and Documentation
- Improved Patient Satisfaction and Quality of Life
- Improved Treatment Adherence



The High Risk Clinic-The Patient Evaluation and Follow up using EBM Chronic Care Management

20 minutes

40 minutes

60 minutes

80 minutes

100 minutes

- **Geriatric Team Assessment**
 - Greeter signs patient in at the clinic
 - MA takes vitals/weight
 - Care Manager (30-60 minutes)
 - Orientation
 - Tour of clinic (while assessing gait)
 - Assessments
 - Medications review & reconciliation
 - Hand off to Clinician
 - Clinician (30-60 minutes)
 - Care Manager
 - Reinforces information
 - “Closure”
 - Addresses next visit
 - MA scheduled next visit
- **Return/follow-up visits**
- **Home visits**
 - Early home visit strongly suggested
 - Nurse or Social Worker responsibility
- **Follow-up calls**
 - Dedicated times for MDs to return phone calls
- **“Tuck” time calls**
 - Dedicated times on Thursday or Friday afternoons to “tuck” patients in for the weekend
- **Additional access**
 - On-Call 24 hours/7 days
 - Internet (email) communication outreach



HealthCare Partners' Diagnosis and Treatment Protocols using Evidence-Based Medicine

Anticoagulation therapy: ACCP

Asthma: NHLB

Cardiovascular (A-Fib/CHF, etc): ACC/AHA

Diabetes: AACE/ADA guidelines

Dyslipidemia: NCEP

Immunizations: ACIP, CDC

Osteoporosis: ACOG, NOF

ACC – American College of Chest Physicians, NHLB – National Heart Lung and Blood Institute, ACC – American College of Cardiology, AHA – American Heart Association, AACE – American Association of Clinical Endocrinology, ADA – American Diabetes Association, NCEP – National Cholesterol Education Panel, ACIP - Advisory Committee on Immunization Practices, CDC – Centers for Disease Control and Prevention, ACOG – American College of Obstetricians and Gynecologists, NOF – National Osteoporosis Foundation



HealthCare Partners' Population Based Management Programs that Drive the Application of EBM

Anticoagulation Clinics

Ambulatory Care Management – other examples..

Congestive Heart Failure

Diabetes Clinic

ICARE

Home Care Program



Patient Education using Evidence-Based Medicine

Health Education Classes:

- Cholesterol Awareness
- Diabetes Management
- Joint Fitness and Flexibility
- Menopause
- Stress Management
- Stop Smoking
- Walking Groups
- Weight Control

Patient Education:

- Allergies
- Cardiovascular
- Diabetes
- Health & Wellness
- Family Health
- Men's Health
- Women's Health
- Hepatitis
- Medication Safety
- Mental Health
- Physical Therapy
- Respiratory

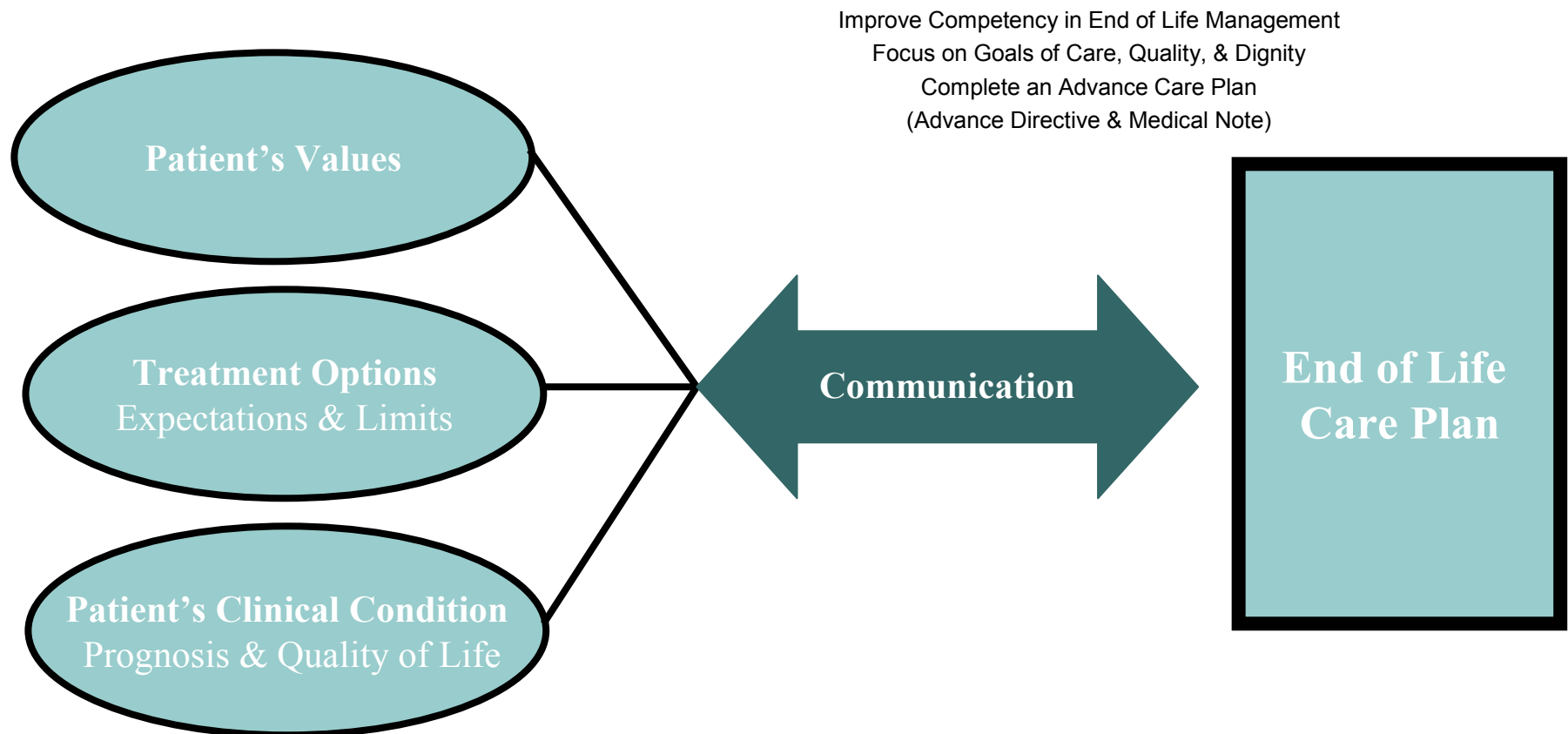


Quality Initiatives that Emphasize the Application of EBM

- Quality Improvement Initiatives
- HCC driven Improved Diagnosis and Documentation of Chronic Disease in Medicare
- California IHA Pay for Performance Quality Initiatives
 - Diabetes Measures and Outcomes
 - Asthma Process and Outcomes Measure
 - PAP Smear
 - Depression Screening
 - Colorectal Screening
 - Pediatric and Adult Immunizations
 - Mammograms



Advanced Care Planning and Palliative Care Ways to Improve End of Life Care via EBM





Program Overlaps

