



Delivering High Value Care Through Clinical Integration

**NCIOM Annual Meeting
September 9, 2013**

www.TriadHealthCareNetwork.com

Triad HealthCare Network

History and Overview

- Began as a 20-member physician-led steering committee in fall 2010
- Developed over eight months as collaboration between independent and employed community physicians and Cone Health
- Formed officially in 2011 as a Clinically Integrated Network serving the Piedmont Triad area; Approved as a Medicare Shared Savings Program ACO in June 2012 (40,000+ beneficiaries)
- Is an affiliate of the Cone Health System, but governance and operations is led and driven by physicians
- Represents a new model of care – clinical integration - designed to align physicians and hospitals to improve access, improve quality and lower costs.

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Goals

- Allow physicians to lead and drive the necessary changes in healthcare
- Engage physicians to develop new models of care and true “transformation” of the local healthcare delivery system
- Provide resources to physicians to meet the growing demands of accountability and transparency
- Create greater collaboration and trust among physicians, hospitals, patients and payers
- Be renowned as a national leader in delivering exceptional health care value in terms of cost, quality and service

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Structure and Membership (as of August 2013)

- 776 Affiliated physicians; 324 employed by Cone (Epic)
- 231 Primary Care Physicians across the community
 - 180 Adult Medicine
 - 58 Unique clinic locations; 26 different EMR systems; 7 practices no EMR
 - 51 Pediatricians
 - 11 Unique clinic locations; 4 additional EMR systems
- Cone Health System – 6 Hospitals (Epic and Allscripts)

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Engaging Physicians to Drive Care Transformation

- Deployment of advanced IT resources to support population management
- Care Management team to support practices
- Assistance to achieve Patient-Centered Medical Home recognition and practice transformation
- Facilitate care process redesign
 - Care transitions, readmissions, chronic disease mgmt

Information Technology/Analytics Systems



Accountable
Care Solutions

Health Information Exchange ("HIE")

- Interfaces with community providers and aggregates clinical data
 - Hospitals
 - Physicians
 - Labs/Pharmacy/Radiology
- Master Patient Index ("MPI")
- Provides portal view to all providers



Clinical Performance Reporting System

- Reports performance to quality metrics
- Provides clinical protocol engine; Clinical recommendations
 - Point-of-care reports
 - Patient disease registries
- Claims data integration



OPTUMHealth™

Population analytics, utilization, case management module

- Case Management module – care documentation, communication
- Patient stratification; Predictive risk
- Utilization and cost efficiency analytics

Sample Clinical Decision Support at the Point-of-Care

Diagnoses and Meds are prioritized to highlight chronic conditions

Labs, Calculations and Diagnostic Procedures pertinent to the Action Items are displayed for easy reference

Action Items and Goals are highlighted for quick reference and visibility

Targeted reminders for nursing staff allow better leverage of provider time and more efficient workflow

Eagle Physicians and Associates
Patient Recommendation Report

96162 [REDACTED] **DOB: 05/11/1947** **Age: 65** **Sex: F** **Seen By: OSBORNE, JAMES MD**
 Appointment Date: 1/7/2013 11:45:00 AM Report Date: 1/7/2013 **PCP: OSBORNE, JAMES**

Active Diagnoses	Action Items
Diabetes mellitus without mention of Diabetes with neurological manifestations, Essential hypertension, benign Esophageal reflux, Fibromyalgia, Obstructive sleep apnea (adult) (pediatric), Polyneuropathy in diabetes	<input type="checkbox"/> Administer Fall Risk Screen (q 12 mos) ACO <input type="checkbox"/> Administer PHQ9 / Depression Screen (q 12 mos) ACO <input type="checkbox"/> Consider ABI Test due to PAD Risk Factors DM <input type="checkbox"/> Document last Bone Mineral Density test (DXA). PREV <input type="checkbox"/> Document / administer Flu vaccine (q yr), if applicable ACO <input type="checkbox"/> Due for Pneumococcal vaccine booster x1 if initial Pneumococcal vaccine received at < 60 yrs or Dx Risk requires booster ACO
	DOC: Document Obesity Dx and / or address Obesity Dx / Plan (q 12 mos) ACO MED: Change / titrate Lipid lowering therapy due to LDL or non HDL goal not met. NOTE: Contraindication to a drug class of lipid lowering therapy may exist. ACO PROC: Order or Discuss obtaining Bone Mineral Density test (DXA) (q 2 yrs) for Osteoporosis Dx or Risk, unless documented today PREV VAC: Consider Zoster vaccination, unless contraindicated PREV DOC: Document or Refer for Diabetic Education (1x) DM
Active Meds	
Metformin XR 500 MG ONCE 02/23/12 Lopressor 100 MG TWICE 10/11/11 Metoprolol Succinate ONCE 02/13/12 Atorvastatin Calcium 10 EVERY 02/23/12 Aspirin 81 MG ONCE 07/17/12 Calcium 600 + D ONCE 07/17/12 Cyclobenzaprine HCl 10 ONE 09/17/10 Fiber 07/17/12 Losartan 07/17/12 Lyrica 50 MG FOUR 07/17/12 MVI 07/17/12 Nasalrom 5.2 MG/ACT THREE 07/17/12 Prilosec OTC 20MG ONCE 07/10/12 Triamcinolone Acetonide TWICE 05/26/10 Tussionex Pennkinetic EVER 02/13/12	
Labs	
Trig 112 7/17/12 Chol 156 7/17/12 LDL 100 7/17/12 HDL 42 7/17/12 Glucose 84 7/17/12 HbA1c 5.9 7/17/12 MicroAlb/Cr 3.1 7/17/12 INR 7/17/12 GFR 60.51 7/17/12 GFR, AfAmer 73.21 7/17/12	
Diagnostic Tests	Goals
Colonoscopy 8/11/08 DM Eye 7/18/12 DM Foot 7/17/12 Bone Density 4/03/07 Mammogram 9/06/12 PAP Chlamydia	Goal not met: BMI >= 30 Goal not met: LDL >= 100 Goal Met: Microalbumin/Creat Ratio <= 30 Goal met: BP <140/90 Goal met: A1c < 7.5% Goal Met: Nonsmoker
Vaccines	Allergies
Tetanus 1/01/05 Tdap Pneumovax 1/01/98 Flu Herpes Zoster Hep B 1/01/05 HPV	Compazine Perordan
Measures/Calculations	Visits
BP 130/70 7/17/12 142/70 2/13/12 CHD Risk 3% BMI (Wt.) 31 (156lb) 7/17/12 Ideal Wt. 99-133 Est CrCl 67.51 7/17/12	Scheduled: 07/25/2013 Last Visit: 07/17/2012 Last Physical Exam: 07/17/2012
	Insurance
	BCBS NC STATE EMP BLUE MEDICARE

*--Unless contraindicated



Triad Healthcare Network

Physician Engagement

- Structure and Governance
 - Robust standing committees
 - Care Transformation initiatives
- Incentive Plan Requirements
 - Moving towards PCMH recognition
 - Connected and using of IT tools (POC, HIE)
 - Participation in meetings
 - Viewing educational materials/videos

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Hospital Engagement

- System-wide clinical initiatives
 - Readmissions
 - Length of Stay
 - Community Access to Care
- Evaluating ‘Impact to Enterprise’
 - Projecting financial impact to map reduction in necessary resources
- Changing clinical decision making workflow
 - Integrating THN/Cone/MEC
- Developing physician incentives to increase hospital efficiency and quality metric performance

Questions?

For further information, please visit
www.TriadHealthCareNetwork.com