Managing Clinical, Population and Financial Risk as a Provider: Diverse Perspectives with Novel Uses of Data 
The Delegated Group Model and Global Risk

Stuart Levine MD MHA  
President & CEO, Medical Innovation Inc.  
Assistant Professor, Internal Medicine/ Psychiatry  
University of California, Los Angeles  
David Geffen School of Medicine  
Assistant Professor, Internal Medicine  
Stanford University School of Medicine
Care Model Overview:
Delivering Care in a Fundamentally Different Way
As a payer, we must deepen our provider partnerships in order to achieve our goals...

Our biggest opportunity to impact quality, member experience and affordability is through the “Core Four”:

- Top performing provider delivery systems have six essential elements - the “Core Four” plus optimized primary and specialty care
- These components are consistently implemented throughout ACO’s across all lines of business
- Best-in-class care for high-risk patients in particular will accelerate improvements in primary care for all patients
- All care components are interdependent in delivering the Quadruple Aim (cost, quality, patient experience, provider/physician satisfaction)
- Facilitating ACO’s to best practice and focus on clinical execution

In conjunction with optimized primary & specialty care
...stratify patients into the appropriate clinical programs...

**Hospice / Palliative Care**

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

**Complex Care and Disease Management**
Long-term, whole person care using a multidisciplinary team approach. Conditions include Diabetes, COPD, CHF, CKD [ESRD-PCMH], Depression, Dementia.

**Self Management, PCP**
EveryDay Care and self-management for people with chronic disease.

---

**Per Patient Treated Per Month**
- Level 4: Home Care Management (~$300)
- Level 3: High Risk Clinics (~$200)
- Level 2: Complex Care and Disease Mgmt (~$100 - $130)
- Level 1: Self-Management & Health Education Programs (~$50)
...stratify patients into the appropriate clinical programs, continued...
... and collaborate to ensure excellence at all levels of care delivery

Advanced technology integration into all aspects of care delivery is a critical success factor.

### 5. Acute & Sub-Acute Facility Care

<table>
<thead>
<tr>
<th>Patient Engagement &amp; Education</th>
<th>Embedded CM/ Health Coaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Care</td>
<td>Patient Advocates &amp; Health Coaches</td>
</tr>
<tr>
<td></td>
<td>Cross-functional Care Mgmt Team</td>
</tr>
</tbody>
</table>

#### Care Intensity

1. **Primary Care**
   - Everyday Care, Maternity & Pre-natal Care
2. **Case Mgmt**
   - Specialty Care Mgmt (Payment Reform); Chronic Condition Mgmt; Specialty Rx
3. **High Risk Clinic/Mgmt**
   - Care Mgmt, Rx/Generics; Wellness; Preventative Care; Integrated Behavioral Health; Advanced Care Planning
4. **Home Care**
   - Quality Improvement, Physician Engagement, Member Experience & Patient Satisfaction

#### Care Mgmt

- Palliative Care / Hospice
- ESRD Medical Home
- Long Term Home Care
- Intermediate Home Care
- Short Term Acute Care Transitions/Trauma Care

#### Complex Case & Disease Management (in person/telephonic)
- Long Term “Geriatric” / Chronic Condition
- Short Term (6 months or less): Chronic Pain, Cardio, Ortho, Oncology, Behavioral Health
- Group Visits / Specialist Collaboration: CHF, COPD, Diabetes
- Post Discharge Clinic
- Free Standing Infusion Centers & Wound Care
- Welcome/ Wellness / Prevention
## Physician Risk Stratification

### Employed

<table>
<thead>
<tr>
<th>“Great”</th>
<th>“Excellent”</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Embed Care Mgmt.</td>
<td>• Embed Care Mgmt.</td>
</tr>
<tr>
<td>• Shift 1%-2% Seniors/ 0.5% Comm*</td>
<td>• Shift 8%-10% Seniors/ 2-2.5% Comm*</td>
</tr>
<tr>
<td>• 30/1000 senior members on the Composite Scores for Ambulatory sensitive admission (12 categories as defined by AHRQ)</td>
<td>• 35/1000 senior members on the Composite Scores for Ambulatory sensitive admission (12 categories as defined by AHRQ)</td>
</tr>
<tr>
<td>• Readmission rates = 7%</td>
<td>• Readmission rates = 9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>“Good”</th>
<th>“Average”</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Embed Care Mgmt.</td>
<td>• Shift 20% Seniors/ 5% Comm*</td>
</tr>
<tr>
<td>• Shift 5%-8% Seniors/ 1.5-2% Comm*</td>
<td></td>
</tr>
</tbody>
</table>

### Contract

- Denotes shift of senior population to high risk care centers
- For Commercial Patients, target 5% of total patients for moving to high risk programs
Focus on key interventions for the 20% of the population that represent 80% of total spend

Build economic viability to enable primary care practices to perform critical interventions (e.g. advanced access, wellness/prevention, etc.)

Commercial/Medi-Cal spend breakdown:
  - 1% of the population represents 40% of spend → 5% of the population represents 80% of spend

Medicare spend breakdown:
  - 5% of the population represents 40% of spend → 20% of the population represents 80% of spend

Implement simple and effective interventions to touch the entire population in the near term, while the focus is still on the “sickest of the sick”

... in order to deliver a care model that is worthy of our family and friends
Introduction
New Integration of Medical Groups Solves Decades-Old Coordination And Incentive Problems...

Medical groups, ACOs, and IPAs are in need of a full suite of services to help them migrate to risk-based contracts with Payers...

- Hospitalist
- SNFist
- Care Transition Program
- High risk clinics
- Home Care
- Care management
- Utilization management

- Actuaries
- Financial systems and informatics
- Predictive analytics
- Payer / Provider contract manager
- Division of Financial Responsibility expertise

- High-touch, concierge service for all patients
- Re-invented compensation structure to reduce facility costs, better collaborate with specialists, and support patient engagement

- Move specialists to capitation
- Incent them to provide great care, not great utility

- Physician chart review and coaching
- Focus on “full evaluations” able to capture more HCC codes

- Improved advanced care planning
- Create uniform coding practices to drive risk stratification

...including advanced technology to support the reengineering of care processes
**Hospitalist (Acute Hospital) = 12 Points**

Case Load per Hospitalist: = 1:12

Hospitalist coverage on-site 7am-7pm

- **a)** Hospitalist Coverage On-Site 7am-7pm
- **b)** Hospitalist Coverage Monday – Friday only
- **c)** Hospitalist Coverage Saturday, Sunday, & Holidays
- **d)** Full Coverage for all Contracted Hosp. in Service Area

ER Intercept Program at Primary Hospital

- **a)** ER Intercept at Adjoining Hospital w/in 5 Miles
- **b)** Hospitalist Available for Evening/Family Rounds

Employed vs. Not Contracted

Contracted Differential Case Rate Pay Net for ER Intercept

<table>
<thead>
<tr>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Load per Hospitalist: = 1:12</td>
<td>1</td>
</tr>
<tr>
<td>Hospitalist coverage on-site 7am-7pm</td>
<td>1</td>
</tr>
<tr>
<td>a) Hospitalist Coverage On-Site 7am-7pm</td>
<td>1</td>
</tr>
<tr>
<td>b) Hospitalist Coverage Monday – Friday only</td>
<td>1</td>
</tr>
<tr>
<td>c) Hospitalist Coverage Saturday, Sunday, &amp; Holidays</td>
<td>1</td>
</tr>
<tr>
<td>d) Full Coverage for all Contracted Hosp. in Service Area</td>
<td>1</td>
</tr>
<tr>
<td>ER Intercept Program at Primary Hospital</td>
<td>1</td>
</tr>
<tr>
<td>a) ER Intercept at Adjoining Hospital w/in 5 Miles</td>
<td>1</td>
</tr>
<tr>
<td>b) Hospitalist Available for Evening/Family Rounds</td>
<td>1</td>
</tr>
<tr>
<td>Employed vs. Not Contracted</td>
<td>2</td>
</tr>
<tr>
<td>Contracted Differential Case Rate Pay Net for ER Intercept</td>
<td>1</td>
</tr>
<tr>
<td>Subtotal</td>
<td>12</td>
</tr>
</tbody>
</table>
Information Systems

Electronic Medical Record

Use of Internet

Use of Home Technology
Care Model Detail:
What does each care component entail?
Access

High risk clinics & home care provide members with immediate access to high risk programs/care

Advanced access is a 3-year + journey to change the entire delivery system

“Core Four” creates capacity for primary care providers to care for the remaining population

E-consults and telehealth may provide additional capacity as part of a longer-term access improvement play

Retail clinics create better day-to-day access for the non-critically-ill
Robust Hospitalist Program

- A hospitalist is a physician dedicated to delivering comprehensive medical care exclusively in the hospital setting.
- Key components of a robust hospitalist program:
  - Hospitalist sees patients in Emergency Room prior to their admission
    - This allows the hospitalist to assess if the admission is appropriate or can be handled at a lower level of care, e.g. a Skilled Nursing Facility (SNF).
  - Ideally hospitalists are employed by a medical group or contracted directly with them
    - Having a direct relationship between the medical group and the hospitalist overseeing care in the hospital allows for greater coordination of care.
  - Hospitalists round daily with both an in-patient care manager and an outpatient care manager to coordinate the patient's care while they remain in the hospital and to prepare for their discharge.
    - Rounds are a form of communication between multiple disciplines in the medical field, e.g. a nurse, a physician, a social worker, a pharmacist, etc. that allows all members of the care team to be aligned and coordinating the patient's care.
  - Hospitalists will ideally carry a caseload of about 12 patients to ensure adequate time and coordination can be spent overseeing the patient's care.
Readmission Prevention Program
- Evidence based programs are used to identify members who may be at a high risk for readmission
- Medications delivered bedside prior to discharge
  - Patients who cannot afford to refill medications or delay in refilling medications after discharge are at higher risk of being readmitted
- Weekly review of readmissions to determine cause and mitigate future risk of reoccurrence
- Comprehensive discharge planning
  - Teach back – a method of discharge teaching where the health professional provides discharge instructions and then has the patient teach back the instructions to the medical provider
  - Providing clear points of contact if the patient has questions after leaving the hospital

Inpatient Care Management Program
- Case managers are located onsite, in the hospital
  - Dedicated to managing patient from pre-admission to discharge
  - Work closely with the hospitalists

Skilled Nursing Facility (SNF) Program
- A hospitalist who is dedicated to providing medical care in the SNF is called a SNFist
  - Round on patients twice a day
- Care Manager onsite to develop plan of care and coordinates with outpatient care manager
- Family meetings with the care manager and SNFist
- Palliative Care Consults
  - Palliative care is an approach to care that improves the quality of life of patients, who have serious illness, by providing relief from their symptoms and stress
# Advanced Facility Care - Sample Implementation Plan

<table>
<thead>
<tr>
<th>ACO Provider Transformation Schedule</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>1) Advanced Facility Care, continued</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalists (NOTE: hospital-specific)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Evaluate hospitalist program across the system and also at the hospital level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II. Analyze how much they are spending on their current hospitalist program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Determine what they are getting for current program, the number of ER visits, number of specialty consultations and follow up to hospitalization to determine total amount they are spending</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Develop pro forma for developing a leading class program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) In order of decreasing preference, make decision to 1) build its own hospitalist program going forward, 2) manage it for its own contracted population, 3) manage for the entire hospital (at cost), 4) contract it out to a hospitalist company by itself, 5) contract out to a hospitalist company with hospital, 6) use current hospitalists in the hospital in an incentivized case rate program (in the interim or long-term)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III. Leverage MMI guidelines for contracting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) If enough census in a hospital and enough willingness on the part of the group and hospital to embrace it, then should go to employed model (by the group) to meet our MMI-defined process for care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) If not employed model, then build into contract the business case mandate to influence behavior and ensure following the MMI-defined process for care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV. Leverage MMI guidelines for investment and clinical implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Determine investment required (comparing to hospital days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Create physician leadership program to ensure appropriate mentorship of SNFist team</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transitions / ER Diversion Care Managers (NOTE: hospital-specific)**

I. Care management to manage transitions

| I. Leverage MMI-defined guidelines for staffing model (for CM’s and support clerks) |      |      |      |      |      |      |      |      |
| II. Work with hospitals to do this with their CM’s (if applicable), or bring in our own CM’s (preferable route) |      |      |      |      |      |      |      |      |
| III. Ensure that care managers are focused on patient care (not admin tasks), and follow care transitions guidelines in their work |      |      |      |      |      |      |      |      |
| IV. Ensure that care managers are focused on care transitions and ER diversion; s/he has appropriate connections to outpatient nurses for follow-through |      |      |      |      |      |      |      |      |
### Advanced Facility Care - Sample Implementation Plan, continued

<table>
<thead>
<tr>
<th>ACO Provider Transformation Schedule</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Advanced Facility Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNFists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Evaluate SNFist program across medical groups (and regions)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II. Analyze how much medical group is spending on their current SNFists program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Determine what they are getting for current program, and the number of transfers from ER to SNFs with</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Develop pro forma for developing a leading class program, with goal that 50% of patients in SNFs are medical patients (not rehab) with ALOS of 10 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) In order of decreasing preference, make to 1) staff their own CM’s in the SNFs, 2) contract it out to a SNF company by itself, 3) contract out to a hospitalist company, 4) BSC provides, 5) use current SNF physicians and/or community physicians on an incentivized case rate to do it on their own</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III. Leverage MMI guidelines for contracting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Use employed model (by the group), contracted to meet our MMI-defined process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) If not employed model, then build into contract the business case mandate to influence behavior and ensure following the MMI-defined process for care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV. Leverage MMI guidelines for investment and clinical implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Determine investment required (comparing to hospital days and SNF days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Create physician leadership program to ensure appropriate mentorship of SNFist team</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 1) Advanced Facility Care - Supplemental Detail

<table>
<thead>
<tr>
<th><strong>Scope/Description:</strong></th>
<th>Advancements in facility care represent the greatest immediate opportunity for improved quality and reduced costs across the system (&quot;biggest bang for the buck&quot;)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population:</strong></td>
<td>• Entire patient population of our PCP panels and non-paneled patients</td>
</tr>
</tbody>
</table>
| **Staffing Ratio (est.):** | • ~3 - 3.4 FTE Hospitalists per 12 ADC (daytime staffing 1 Hospitalist (physician) for every 12 average daily census)  
  • 1 SNFist for every 25 average daily census (~1.3 FTE SNFists per 25 ADC)  
  • 1.8 Care Managers for every 3 -3.4 Hospitalists concentrating on Care Transitions and Inpatient Care Coordination |
| **PMPM Investment Equivalent Estimate (additive):** | • Medicare Advantage: $20 PMPM  
  • Commercial/Medi-Cal: $5 PMPM |
| **Potential Provider Partner Organizations:** | • ACO Medical Group in overlapping service areas  
  • Non-ACO Medical Group in overlapping service areas  
  • Currently contracted Hospitalists serving the hospitals  
  • Hospitalist company  
  • Extensivist company |
| **Key Services Provided:** | • Emergency Room evaluation/triage & Urgent Care/ IED  
  • SNF Sub-Acute Care  
  • Hospitalists program  
  • Care Management & Care Transitions |
| **Key Implementation Steps:** | 1. Combine the efforts to look for one professional corps/organization to do all of our Hospitalists/SNFist work in each geography  
  2. Conduct a competitive RFP bidding process by geographic region for Hospitalist and SNFist services [See Potential Provider Partner Organizations section for options]. Note: A regionalized, tailored approach to provider engagement greatly increases the likelihood of success because incentives are aligned and contract supports the right behavior (inclusive of ED and hospital who can be aligned with appropriate and meaningful programs “baked into” the new hospitalist approach)  
  3. As a longer-term effort, evaluate Hospitalist companies or Extensivist companies to deploy across multiple regions across the state (i.e., larger footprint than local providers)  
  4. Execute performance based incentives and case rates and/or PMPM contracting that are innovative, targeted and prescriptive:  
  • Engagement and incentives for emergency room physician groups and support staff at targeted hospitals to ensure better alignment and support of hospital initiatives  
  • Improved engagement with hospitals to ensure better collaboration and cooperation via outcome-driven hospital incentives  
  • Excellent physician-aligned contracts ("compact") with ED and hospital physicians with rapid “hassle free” hospital payments when they agree to participate in the compact  
  • Enhanced coordination with PCPs  
  • Incentives on quality and admission/readmission reduction put in place to improve outcomes  
  • Using as an example Fresno community hospital has 3000 admissions a year, implement 3 FTE hospital program – 125 bed day savings out of 3000 bed days per year to break even on the cost of a full time devoted hospitalist program  
  5. Deploy MCS resources as onsite care management to relevant high utilization hospitals to ensure most effective SNFist/hospitalist programs  
  6. Utilize prescriptive staffing and performance standards per MMI |
Home Care - Summary

Overview: Programs focusing on patients who are elderly, frail or too sick to regularly tolerate travel to a physician’s office or even a high risk clinic for services/care. Home care programs are not the same as a home health program where a nurse is assigned to make a few visits for some very specific short-term needs. These programs are most often led by a Nurse Practitioner (this is an advanced practice nurse) and a Social Worker. There is physician oversight but the majority of care is delivered by the Nurse Practitioner and the Social Worker with support from a Registered Nurse and a Coordinator.

Key Components/Examples
- Chronic conditions, medication management, labs, home infusion, palliative care, cancer patients, kidney failure patients, neonates (babies born extremely prematurely)
2) Home Care

I. Evaluate Home Care program across the medical group (and regions)
II. Analyze how much they are spending on their current Home Care program
   a) Determine what they are getting for current program, the number of total patients for this group that will need Home Care for the key categories (long term care, ESRD, palliative care, care transitions, chronic care, care transitions, wellness exams), advanced access for emergent care
   b) Develop pro forma for developing a leading class Home Care program
   c) In order of decreasing preference, make decision to 1) hire resources locally for relatively small geographies, 2) contract through hospitalist program, or 3) hire/contract with home care company (e.g., Health Essentials), 4) hire or contract with an extensivist company

III. Leverage MMI guidelines for contracting
   a) If enough census in a hospital and enough willingness on the part of the group and hospital to embrace it, then should go to employed model (by the group) to meet our MMI-defined process for care
   b) If not employed model, then build into contract the business case mandate to influence behavior and ensure following the MMI-defined process for care

IV. Leverage MMI guidelines for investment and clinical implementation
   a) Determine investment required (comparing to hospital days)
   b) Develop plan for decided entity (build vs. buy) is fully integrated into the medical group’s care delivery system (hospitals, clinics, PCPs, specialists, etc.)
   c) Create physician leadership program to ensure appropriate mentorship of SNFist team
### 2) Home Care - Supplemental Detail

<table>
<thead>
<tr>
<th>Scope/Description:</th>
<th>Driving more care out of facilities and into other less costly settings is key to achieving the triple aim and delivering on our own bold vision. Expansions in home care provide Blue Shield with a huge single lever to achieve this goal for the greatest number of highest-cost, sickest patients and focus on palliative care.</th>
</tr>
</thead>
</table>
| **Target Population:** | - 2-4% of Seniors (of the 20% highest risk identified patients)  
- 0.5% of Commercial/Med-Cal (of the highest risk 5% identified patients) |
| **Staffing Ratio:** | - 1 Physician, 4 NPs, 4 LCSWs, 2 CMs and 2 Coordinators for every 500 patients*  
*Collectively, equates to approximately $300 per patient treated per month |
| **PMPM Investment Equivalent Estimate (additive):** | **Medicare Advantage:** $6 PMPM  
**Commercial/Medi-Cal:** $3 PMPM |
| **Potential Provider Partner Organizations:** | **ACO Medical Group** (non-branded) in overlapping service areas  
**Non-ACO Medical Group** in overlapping service areas  
**Home Care company** |
| **Key Services Provided (MA vs. Commercial):** | **Medicare Advantage:** homebound, palliative care, senior wellness visits, lower intensity care redirected from hospital/facility (e.g., cellulitis, etc.)  
home medical services (e.g., home infusion, home dialysis), “ICU at home,” dementia and other severe mental illnesses, short-term care transitions, intermediate care stabilization, ESRD medical home, long-term care, home ventilator patients  
**Commercial/Medi-Cal:** neonatal care, palliative care, chronically and persistently mentally ill, oncology, transplant, short term care transitions, post trauma, acute cardiovascular rehabilitation, home ventilator patients |
| **Key Implementation Steps:** | 1. Combine the efforts to look for one professional corps/organization to do all of our Home Care work in each geography  
2. Conduct a competitive RFP bidding process by geographic region for Home Care services [See Potential Provider Partner Organizations section for options]  
3. As a longer-term effort, evaluate Home Care companies to deploy across multiple regions across the state (i.e., larger footprint than local providers)  
4. Execute performance-based incentives, case rates and/or PMPM contracting that are innovative, targeted and prescriptive:  
   - Improved engagement with hospitals to ensure better collaboration and cooperation via outcome-driven hospital incentives  
   - Improved palliative and hospice care engagement  
   - Enhanced coordination with PCPs  
   - Appropriate integration with home and community-based services  
   - Improved patient access and response time  
   - Incentives on quality and admission/readmission reduction put in place to improve outcomes  
5. Implement robust telemedicine and home monitoring as critical components to ensure successful implementation of the programs  
6. Utilize prescriptive staffing and performance standards per MMI |
Overview: A healthcare delivery system designed to provide care to patients with comprehensive and complex needs. The high risk clinic can be a physical building which only sees high risk patients, e.g. CareMore Centers, it can also be dedicated space at a physician’s office or even an urgent care location that has space repurposed to provide ongoing care.

Key Components/Examples

- **High risk discharge follow up visits**
  - Appointments available and scheduled within 24 hours of discharge
  - When appropriate, patient can be seen for multiple visits

- **Care of complex patients**
  - Specialized team of physicians, nurses, pharmacist and social workers dedicated to providing care to medically complex patients with chronic conditions or long term needs
  - Diabetic group visits
  - Pain Management

- **Services requiring medical oversight**
  - Wound care
  - IV Infusion Therapy
    - Certain medications and treatments that must be delivered via an IV can be monitored onsite and do not require hospitalization
  - **Coumadin**
    - Coumadin is a medication that requires very close monitoring to ensure the levels in the blood remain in a therapeutic window. A Coumadin clinic can prevent hospitalizations and ensure patients have a place to go for close monitoring

- **Annual Wellness Exams**
  - These are yearly exams for seniors to ensure proactive identification of conditions and gaps in care
    - Gaps in care are prevention and wellness screenings that have not been completed, required testing that has been missed, etc.
### High Risk Clinics - Sample Implementation Plan

#### 3) High-Risk Clinics

I. Evaluate geography for transportation ("drivers" and psycho-social barriers to care by neighborhood/region)

II. Identify for opportunities for shared services in an unbranded manner

III. Evaluate specific patient populations and business line status around high risk clinics in each geography (e.g., Senior, Commercial, etc.); to identify predominant drivers of medical costs

IV. Identify which hospitals are in each neighborhood in order to design cooperative-collaborative or non-cooperative-collaborative relationship with neighboring hospital partner/non-partner

V. Evaluate the hospitalization and admit rate utilization per 1000, and design services around specific drivers of hospitalization rate and targets for how successful this clinic needs to be to meet return on investment (develop financial model, etc.)

VI. Determine appropriate setting for high risk clinics, in order of increasing investment required: 1) rent urgent care space for limited time per day/week to service populations for limited services, 2) find provider (geriatric clinic or PCP clinic) that dominates that geography that is willing to contract with the delivery system to provide similar/same services, 3) rent space from hospital partner, 4) build new clinics

VII. Determine appropriate resourcing to staff the high risk clinics (re-appropriating existing resources, hiring new) to either staff full-time/part-time, rotating/non-rotating among clinics

VIII. Evaluate High Risk Clinics program (if existing) across the regions to determine gaps

IX. Analyze how much they are spending on their current High Risk program
   a) Determine what they are getting for current program, the number of total patients for this group that will need High Risk programs (from previous market assessment analysis)
   b) Refine the pro forma financial model for developing a leading class High Risk program
   c) In order of decreasing preference, based on population density and existing partner network, make decision to 1) contract through existing program, 2) BSC to develop and subsidize to deploy best practice post-acute, extensivist services, 3) find company that performs high-risk clinic support as part of an extensivist model and partner (acquire, JV, etc.)

X. Leverage MMI guidelines for contracting and/or deployment of services to develop and deploy services and protocols to ensure proper implementation of high risk clinic services in a prescriptive and scalable manner

XI. Develop patient enrollment approach (may require PCP re-contracting to ensure referrals)
3) High Risk Clinics - Supplemental Detail

<table>
<thead>
<tr>
<th>Scope/Description:</th>
<th>Greatest opportunity for “catching” highest risk patients under one roof to reduce readmissions, hospitalizations, improve data capture (HCC’s) and immediately increase patient access for an inadequate PCP network. This also represents an area for Blue Shield to provide substantial value to providers requiring ground-up development and guidance.</th>
</tr>
</thead>
</table>
| Target Population: | • 6 – 8% of Seniors (of the top 20% identified high risk patients)  
• 1– 2% of Commercial/ Medi-Cal (of the top 5% identified high risk patients) |
| Staffing Ratio: | • 1 Physician for every 375 Seniors or 975 Commercial equivalents  
• 1 NP for every 250 Seniors or 600 Commercial equivalents  
• 1 Physician, 3 NPs, 0.5 Pharmacists, 2 LCSWs for every 1000 Seniors or 3000 Commercial equivalent patients*  
* Collectively, equates to approximately $200 per patient treated per month |
| PMPM Investment Equivalent Estimate (additive): | Medicare Advantage: $20 PMPM  
Commercial/ Medi-Cal: $5 PMPM |
| Potential Provider Partner Organizations: | • ACO Medical Group (non-branded) in overlapping service areas  
• Currently contracted Hospitalist providers serving the hospitals  
• Extensivist company  
• National retail chains with clinic capabilities |
| Key Services Provided (MA vs. Commercial): | **Medicare Advantage:** senior wellness visits, chronic geriatric clinics, dementia and other severe mental illnesses, chronically and persistently mentally ill, co-morbid medical illnesses, short term post-hospitalization stabilization, intermediate chronic condition management, chronic disease management groups (e.g., diabetic, COPD group visits), palliative care, infusion centers, wound care, urgent care  
**Commercial/ Medi-Cal:** annual wellness exam and new member welcome visit, infusion centers, post discharge clinic, chronic pain, cardiovascular disease management, orthopedic and rehabilitation, oncology, wound care, urgent care |
| Key Implementation Steps: | 1. Combine the efforts to look for one professional corps/ organization to do all of our HRC work in each geography  
2. Conduct a competitive RFP bidding process by geographic region for High Risk services (full-time or part-time in nature) [See Potential Provider Partner Organizations section for options]  
3. As a longer-term effort, evaluate an Extensivist company to deploy across multiple regions across the state (i.e., larger footprint than local providers)  
4. Execute performance based incentives, case rates and/or PMPM contracting that are innovative, targeted and prescriptive:  
   • Improved engagement with hospitals to ensure better collaboration and cooperation via outcome-driven hospital incentives  
   • Enhanced coordination with PCPs  
   • Improved patient access for the high risk patients and improved access for PCPs by freeing up capacity within their clinics  
   • Incentives on quality and admission/readmission reduction put in place to improve outcomes  
   • Enhanced patient engagement, retention, growth and experience (e.g., welcome visit for new members)  
5. Deploy MCS resources as onsite care management to support services and staff at the high risk clinics, and could offer backroom care management support  
6. Utilize prescriptive staffing and performance standards per MMI |
Care Management/Coordination - Summary

Care Management: Provides care to members while inpatient, outpatient and as they transition in-between. Care management can be short term or longer term. The longer term often transitions into a high risk clinic or a home care program.

Key Components/Examples:

- **Disease Management**
  - Patients are generally in a disease management program for 3-12 months with the goal of stabilizing/improving the patient’s condition and teaching them to self-manage.
  - Patients who unable to remain stable generally move into a more intensive program, e.g. high risk clinic or home care.

- **Complex Case Management**
  - A patient is typically considered complex when they have multiple conditions, are on medications that require close monitoring or they have a condition that needs to be tightly monitored or may cause a significant adjustment to their daily living.
  - Patients with persistent mental illness.
  - Typically, a Registered Nurse will monitor these patients along with the patient’s primary care physician.

- **Transitions of Care**
  - As members move throughout the care delivery system and transition from level of care to another, e.g., hospital to home, hospital to long-term care, etc., care management can help to coordinate the care and facilitate smooth transitions.
  - Screenings and preparations for patients who will be undergoing procedures or surgeries.
4) Care Management/Coordination

I. Evaluate capabilities of Care Management program(s) across broad geographic regions
   a) Telephonic: Episodic/Acute, Disease Management, CCM, UM (hospital/outpatient), Supportive High-Risk programs
   b) Embedded: Inpatient care transitions, outpatient primary/specialty care, driving high-risk programs (in addition to above categories of interventions)
   c) Combination

II. Analyze patient population (risk profile, commercial vs. MA, disease prevalence, etc.)

III. Assess provider organization characteristics (Medical Group vs. IPA, etc.)

IV. Evaluate level of technical capability (physician portals, care management systems, home monitoring, etc.), identify shortfalls and determine any potential areas for improvement

V. Develop and/or adapt proven interventions and associated protocols

VI. Analyze short-term/long-term ROI analysis and prioritization targeted interventions accordingly

VII. Define cross-organizational roles & responsibilities (group, BSC, combination)

VIII. Assess timeline for full implementation of remaining care components and adapt care management implementation plan accordingly

IX. In order of decreasing preference, make decision to 1) hire resources locally for relatively small geographies, 2) contract through hospitalist program, or 3) hire/contract with home care company (e.g., Health Essentials), 4) hire or contract with an extensivist company

X. Develop tailored change management plan to ensure physician adoption

XI. Develop, implement & execute patient enrollment approach (may require PCP re-contracting to ensure referrals)
## 4) Care Management/Care Coordination - Supplemental Detail

### Scope/Description:
Care Management is essential (“the glue, safety net and traffic cop”) to the overall implementation of the other Care Components. Most provider partners are doing some level of care management today, though the focus will be on elevating their programs to leading practice level in the near future - focused on treating the right patients, at the right time, for the right amount of time to reduce overuse and leveraging shared decision making protocols.

The overall design is based on strict patient stratification with clinical oversight and shared decision-making, evidence-based medicine to drive interventions and outcomes, support from health advocates and health coaches, and has a time-limited nature (e.g., patient stays in the program for <1 year and then “graduates” to less intensive non-physician monitoring; if they cannot graduate then they are immediately elevated to higher levels of care like home care or high risk clinics).

### Target Population:
- 8 – 12% of Seniors in addition to those patients managed by the other high risk patient interventions
- 2.5 – 3.5% of Commercial/Medi-Cal in addition to those patients managed by the other high risk patient interventions

### Staffing Ratio:
- Depends on the program. Generally RN CM manage about 100 patients at a time. Care management ratios are 1:10000 commercial patients max and 1:2500 Senior patients max depending on the population.

### PMPM Investment Equivalent Estimate (additive):
- **Medicare Advantage:** $4 PMPM
- **Commercial/Medi-Cal:** $2 PMPM

### Potential Provider Partner Organizations:
- ACO Medical Group in overlapping service areas
- Expanded or regionally deployed MCS
- Care Management company

### Key Services Provided (MA vs. Commercial):
- **Medicare Advantage:** Complex Care Management, CHF, COPD, Oncology, Chronic Pain, Dementia, CPMI, Transplant, CKD/ESRD, Stroke, Palliative Care Support, Home and Community Services, Care Transitions, Complex Diabetes and complications all with supportive group visits as necessary
- **Commercial/Medi-Cal:** Targeted care management including asthma, high risk pregnancy, chronic pain, oncology, CAD, complex diabetes, orthopedics, behavioral health (Affective disorders, anxiety disorders, chemical dependencies) etc = focusing on short-term disease management and rehabilitation

### Key Implementation Steps:
1. Evaluate the appropriateness of leveraging a care management company to deploy across multiple regions across the state, or whether to leverage existing ACO partners or an expanded MCS organization
2. Conduct a competitive RFP bidding process by geographic region for Care Management services [See Potential Provider Partner Organizations section for options]
3. Execute performance-based incentives and case rates and/or PMPM contracting that are innovative, targeted and prescriptive:
   - Improved engagement with hospitals to ensure better collaboration and cooperation via outcome-driven hospital incentives
   - Enhanced coordination with PCPs
   - Incentives on quality and admission/readmission reduction put in place to improve outcomes
   - Performance measures around time spent or cases delivered in-person care management (vs. telephonic)
4. Deploy an expanded and regionally-based MCS organization into the field as onsite care management and leverage telephonic options as needed
5. Utilize prescriptive staffing and performance standards per MMI
Reinvention Of Primary Care Concept

A world-class partner can align primary care incentives to deliver a superior patient experience at lower cost

Virtuous cycle of a next generation managed care program...

Physicians benefit from managed care programs to such a degree that they begin to convert patients. Ultimately, physicians convert entire panel and/or refuse to see patients who refuse to convert.

Physicians receive bonuses for improved patient satisfaction, panel growth from word of mouth referrals, and new ability to take on more patients from extensivist resources.

Physician converts members to managed care

Physician able to allocate more time to “average” patients

Physician profitability improves with managed care

Patient satisfaction improves

Sickest patients referred to “Extensivist” model

Extensivist program allows PCPs to refer “high risk” patients to the appropriate site of care

Virtually removing high risk patients from their panel, primary care physicians are now able to offer increased availability in the form of next- or same-day appointments and more attention to non-high risk patients.

Members receive concierge-level service and care from their primary care physicians which leads to improved satisfaction, loyalty, and word-of-mouth referrals.
Re-invented Primary Care

Incentive-laden PCP contracts to include:

1. Capitation (small) Base
2. FFS payments for each visit
3. Patient panel management incentive with size and exclusivity
4. Quality incentive
5. Access
6. Citizenship
7. Admission/readmission/ER reduction incentive program(s)
8. HCC or equivalent reimbursement + documentation incentive
9. Continuity of Care incentive
10. Patient and physician peer satisfaction incentive (gatekeeper for all other incentive programs)
11. Base capitation for patients triaged to high risk programs
Re-invented Primary Care - Sample Implementation Plan

5) Re-Invented Primary Care

I. Assess PCP practice capabilities across the provider partner system (medical groups and/or independent practices), financial reimbursement models, differentiation between employed model vs. IPA, and penetration of value-based reimbursement patients within the regions

II. Develop tailored operational plan for bringing PCP improvement programs to leading practice level (e.g., Patient-defined medical home/ neighborhood, Embedded care management, Preventive care, Advanced maternal medical home, retail clinics, advanced access, etc.)

III. Instill team based approach and protocols within the practices, building primary care bandwidth to allow individuals to practice at the maximum level of their licenses, supported by 4 components of high risk programs

IV. Develop and deploy processes and technology to support leading practice capabilities (e.g., physician portal, decision support, telephonic tools, etc.)

V. Develop and implement innovative PCP contracts (e.g., enhanced payments, Direct ACO, etc.) to incentivize leading practice patterns and behaviors

VI. Develop wellness and prevention programs, building upon primary care bandwidth released from operational improvement and efficiencies
<table>
<thead>
<tr>
<th><strong>5: Re-invented Primary Care – Supplemental Detail</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scope/Description:</strong> Re-invented primary care is the essential enabler to the total system of care. It fosters an environment and ecosystem that enhances the ability of PCPs and their care teams to practice at the top of their licenses. This is a long-term strategy by Blue Shield to become the champion in California that reinforces primary care and patient relationships.</td>
</tr>
<tr>
<td><strong>Target Population:</strong> Entire patient population of our PCP panels and non-paneled patients</td>
</tr>
<tr>
<td><strong>Staffing Ratio:</strong> 1 PCP per 1700-1800 commercial equivalents</td>
</tr>
<tr>
<td><strong>PMPPM projected total professional costs in So CA Equivalent Estimate (additive):</strong></td>
</tr>
<tr>
<td>- <strong>Medicare Advantage:</strong> $100 PMPM</td>
</tr>
<tr>
<td>- <strong>Commercial/Medi-Cal:</strong> $20 PMPM</td>
</tr>
<tr>
<td><strong>Potential Provider Partner Organizations:</strong></td>
</tr>
<tr>
<td>- ACO Medical Groups</td>
</tr>
<tr>
<td>- Non-ACO Medical Groups</td>
</tr>
<tr>
<td>- BSC to provide certain elements directly or contract with local independent physicians to incent certain behaviors</td>
</tr>
<tr>
<td><strong>Key Services Provided:</strong></td>
</tr>
<tr>
<td>- Team-based, patient-defined medical home/neighborhood</td>
</tr>
<tr>
<td>- Embedded care management when possible, if sufficient patient density</td>
</tr>
<tr>
<td>- Focus on preventive care</td>
</tr>
<tr>
<td>- Advanced maternal medical home</td>
</tr>
<tr>
<td>- Advanced access (longer-term strategy)</td>
</tr>
<tr>
<td>- E-consults and telehealth give additional capacity as part of a longer access improvement play</td>
</tr>
<tr>
<td>- Retail clinics give better access to day-to-day non-critically ill</td>
</tr>
<tr>
<td><strong>Key Implementation Steps:</strong></td>
</tr>
<tr>
<td>1. Evaluate the appropriateness of leveraging existing medical groups or if BSC should provide services directly (or through contracting) company to PCP panels depending on level of sophistication and engagement by ACO/non-ACO medical group’s PCPs</td>
</tr>
<tr>
<td>2. Execute performance-based incentives and case rates and/or PMPM contracting that are innovative, targeted and prescriptive:</td>
</tr>
<tr>
<td>- Innovative PCP payments focused on value with additional incentive payment (patient/peer satisfaction, continuity of care, specialist utilization, diagnostic testing, ER visits/1000, Readmission rates, HCC risk adjustment, deaths in hospital, quality/HEDIS/STAR, COHC)</td>
</tr>
<tr>
<td>- Instill and reward team-based approach and protocols within the practices, building primary care bandwidth to allow individuals to practice at the maximum level of their licenses, supported by 4 components of high risk programs</td>
</tr>
<tr>
<td>- Improved engagement with hospitals to ensure better collaboration and cooperation via outcome-driven hospital incentives</td>
</tr>
<tr>
<td>- Incentives on quality and admission/readmission reduction put in place to improve outcomes</td>
</tr>
<tr>
<td>3. Utilize prescriptive staffing and performance standards per MMI, and be directly managed by BSC staff (PM’s and Clinicians). BSC will give provide the support tools (e.g., leading practice protocols, reference materials, pro forma models, physician portal, decision support, telephonic tools, etc.), and dedicate resources to participate in the execution of the programs</td>
</tr>
<tr>
<td>4. Develop wellness and prevention programs, building upon primary care bandwidth released from operational improvement and efficiencies</td>
</tr>
</tbody>
</table>
6 Optimized Specialty Care

Incentive-laden specialist contracts to include:

1. Capitation or Contact Capitation Base/Case Rate when not applicable
2. Patient panel management incentive with size and exclusivity
3. Quality incentive
4. Admission/readmission/ER reduction incentive program(s)
5. HCC or equivalent reimbursement + documentation incentive
6. Testing (MRI, etc), procedures, pharmacy/ specialty pharmacy
7. Access/ Collaboration
8. Citizenship
9. Patient and physician peer satisfaction incentive (gatekeeper for all other incentive programs)
10. Incentives for triage of patients to high risk programs
6) Optimized Specialty Care - Sample Implementation Plan

<table>
<thead>
<tr>
<th>ACO Provider Transformation Schedule</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
</tbody>
</table>

6) Optimized Specialty Care

I. Evaluate SPC practice capabilities across the provider partner system (medical groups and/or independent practices), financial reimbursement models, differentiation between employed model vs. contracted physicians, and penetration of value-based reimbursement patients within the regions.

II. Determine appropriateness of a narrow network (or virtual narrow network) for specialists.

III. Determine evidence-based practice patterns of specialists.

IV. Develop tailored operational plan for bringing SPC improvement programs to leading practice level (e.g., Specialty Practices of the Future, OP/IP specialty consultation, Specialty-to-PCP collaborative care model).

V. Develop connectivity to high risk, facility-based, and home programs.

VI. Develop and deploy processes and technology to support leading practice capabilities (e.g., physician portal, decision support, telephonic tools, etc.).

VII. Develop and implement innovative SPC contracts (e.g., bundled payment, capitation, case rate for primary targeted specialties) to incentivize leading specialist practice patterns and behaviors.
### Optimized Specialty Care - Supplemental Detail

**Scope/Description:** Optimized specialty care as collaborators and supporters of primary care to reduce unnecessary healthcare utilization and improve overall quality. This is also a long-term strategy and evolution of practice change.

Day-to-day health care to include:
- Based on Excellence and total cost of care management
- Augmented with econsults and telehealth
- Team-based coordination across multiple healthcare providers ("top of license")
- Capitation and Case Rate driven
- Include responsibility for total cost of care of specialty-testing, medication, interventions
- PCP collaboration
- Build into high risk programs

**Target Population:** Patients who are too complex for management by PCPs are co-managed by extensivists in collaboration with specialty network (i.e. hospitalists, SNFists, high-risk/home care clinicians)

**Staffing Ratio:** N/A - Consultative and collaborative in nature

**PMPM projected total professional costs in SoCA Equivalent Estimate (additive):**

- Medicare Advantage: $100 PMPM
- Commercial/Medi-Cal: $30 PMPM

**Potential Provider Partner Organizations:**
- ACO Medical Groups
- Non-ACO Medical Groups
- BSC to provide certain elements directly or contract with local independent physicians to establish innovative specialty contracting; PCP incentives; use of high-risk programs; possible narrow high-value specialty network

**Key Services Provided:**
- Specialty Practice Advances (e.g., Oncology, Cardiology, etc.)
- OP/IP specialty consultation
- Specialty-to-PCP collaborative care model
- Connectivity to high risk, facility-based, and home programs

**Key Implementation Steps:**
1. Evaluate the appropriateness of leveraging existing medical groups or if BSC should provide services directly (or through contracting) company to SPC panels depending on level of sophistication and engagement by ACO/non-ACO medical group’s SPCs
2. Execute performance-based incentives, case rates and/or PMPM contracting that are innovative, targeted and prescriptive:
   - Innovative SPC contracts (e.g., bundled payment, capitation, case rate for primary targeted specialties) to incentivize leading specialist practice patterns and behaviors
   - Increased focus on total cost of care management, including responsibility for cost of testing, procedures and medications
   - Improved engagement with hospitals to ensure better collaboration and cooperation via outcome-driven hospital incentives
   - Incentives on quality and admission/readmission reduction put in place to improve outcomes
3. Utilize prescriptive staffing and performance standards per MMI Develop wellness and prevention programs, building upon specialty care bandwidth released from operational improvement and efficiencies
Results Driven Clinical Metrics

- Increase utilization over time in Control population
- Home Care reduction of APT and DPT
- CCC – DPT and APT reduction
- ESRD: significant reduction APT and DPT
- All Programs show reduction in ER and UC
- Incredible Increase in Patient and Physician Satisfaction
Lessons Learned

- Physician ownership of the patient - Team Care
- Motivate and Incent Physicians and the Entire Health Care Team
- Build Medical Management Infrastructure to Care for the 20 - 30% Highest Risk Patients as if the current delivery system will fail
- Appropriate transitions of care - entire continuum
- Communication
- Teamwork
- Vigilance
- It is not one thing that lessens admissions but many things and most of all, it is all the Pieces - 1+1 = 10 ...
- Try until you get it right...
- Fail Often and Early and **LEARN**
- Heightened awareness of the entire care team...
Lessons Learned (contd.)

✓ Population and Patient Management
✓ Patient selection
✓ Right clinical intervention for the right patient
✓ Technology versus personal touch = BOTH
✓ Patients as part of an ecosystem
✓ Building a Village
✓ Pay for Performance
✓ Care management versus Utilization management

You can provide the patient a lot of out patient care for the price of one hospital day and Improve the Quality & Cost Effectiveness of Health Care = HEALTH REFORM
Cadillac Care
Remember

Purpose  Motivation  Aligned Incentives

Team Approach  Innovation  Shared Best Practices
Conclusion

✓ Clinical Excellence and Quality Results
✓ Variability reduction with evidence based medicine but more variation due to innovation
✓ Put your money where your mouth is…
✓ Collaboration
✓ Teamwork
✓ Data support
✓ Innovation