Advocate Health Care

Clinical Integration to Maximize Population Health Management

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Advocate Health Care

- $4.9 Billion Annual Revenue
- AA Rated
- 12 Hospitals
  - 11 Acute Care Hospitals
  - 1 Children’s Hospital (2 campuses)
  - 5 Level 1 Trauma Centers
  - 4 Major Teaching Hospitals
  - 5 Magnet Designations
- Over 250 Sites of Care
- Over 4000 APP Physician Members
Advocate’s Physician Platform

Total Physicians on Medical Staffs ~ 6,000

Total APP Physicians ~ 4,000

Employed / Affiliated ~ 1,300

Independent APP ~ 2,700

Independent Non-APP ~ 2,000

AMG (Employed) ~ 1,100

Affiliated (Dreyer) ~ 200
Just Over Two Years Ago ...

• Blue Cross & Advocate/APP faced 2 choices:
  – Lower unit cost now
  – Partner together/reduce waste

• Employers demanding change even if reform overturned
  – “Unstoppable market force unleashed”

• Prepares us for ACOs in 2012

• Better patient care → fulfills 2020 vision
Advocate Physician Partners: A Strong Foundation for Accountable Care

• APP: Collaboration between Advocate and physicians (1995)
• 4,000 engaged APP physicians
  – Employed and non-employed
• Nation’s largest & most successful clinical integration program (P4P)
• Extensive registry use
• Regulatory approval
• Strong governance & culture
• Strong physician & business community support
• Annual quality bonuses paid to physicians
Advocate 2020

Mission, Values, Philosophy

A faith-based system providing the best health outcomes and building lifelong relationships with those we serve

Operational Excellence
Health Outcomes
Advocate Experience
Funding our Future

Growth
Partnerships
Loyal Patients
Brand Development

Coordinated Care
Access
Smooth Transitions
Innovative Care Models

Strong Physician Engagement
What We’ve Accomplished

• Successful Year 1 of Blue Cross shared savings contract, Year 2 data pending
• Advocate Centered Plans
• Named nation’s largest ACO by Modern Healthcare Magazine
• Built a scalable infrastructure for assuming greater levels of risk
Blue Cross/Advocate Health Care
ACO: Year 1 Outcomes

• Outperformed unadjusted cost trend by 2.1%
• Maintained targeted high-level performance on clinical quality and service metrics
• Used shift from volume to value to drive ongoing investments in enabling technology and services
• Market Share Growth
  – 2% HMO membership growth; market dropped >10%
  – 11% PPO attributed patient growth
  – PPO in-network use up 3.4% points
  – 412 new APP physician members
ACO Strategies

Outpatient
- Dedicated Care Managers
- Patient Centered Medical Home
- Practice Operations Coaches

Acute Care
- ED Care Coordination
- Inpt Care Coordination
- ED
- Hospital
- ED Care Coordination Optimization
- Alternative Site Of Care Transitions
- Readmission Risk Assessment And Focused Interventions
- Inpatient Care Coordination Redesign
- Acute To Post Acute

Post Acute
- Post Acute Transition Program
- SNF Care Model
- Palliative Care

Data & Analytics
Population Health Management

Care Coordination Transitions
Key Metric: The AdvocateCare Index

- Admits/1000
- ER Visits/1000
- Average Length of Stay
- Readmissions/1000
- Increase Inpatient Days within Advocate Hospitals
Progression Of Value Creation

1. Target LOS, readmissions and target high-cost DRGs: Inpatient CM
2. Reduce Readmissions: Post-Acute Partnerships and Coordination
3. Decrease PAAs and ED Visits: Outpatient CM

Source: SG2, 2011
Priority Post Acute Programs
Post Acute Programs

- Transition Coach Program
- Skilled Nursing Facility Program
- Palliative Care Pilot
Transition Coach Program

• Enrollment voluntary and based on risk score > 8
• Assessed for Home Health Criteria and either
  – Traditional home health approach
    OR
  – One in-home visit shortly after discharge and additional contacts as needed during the first 30-days after leaving the hospital
• Close physician follow-up
Skilled Nursing Facility Program

- Retention: back to AMG/APP SNF attending
- Collaborate on Process Improvements
- Attending Quarterly Meetings with Advocate Hospital

Highest Volume
4-8 SNFs

- MD-APN on-site
- Case Reviews
- Retention: back to AMG/APP SNF attending
- Collaborate on Process Improvements
- Quarterly Meetings with Advocate Hospital
The SNF Care Model

1 Physician FTE + 2-3 APN FTE = Capability to manage SNF Census
SNFist Program at Advocate Lutheran General Rolling 12 Months

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<th>BASELINE</th>
<th>RESULTS as of 5/2013</th>
<th>ACHIEVED</th>
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<td>Medicare Readmission Rate</td>
<td>20.30%</td>
<td>15.20%</td>
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<tr>
<td>Medicare SNF ALOS</td>
<td>30</td>
<td>18.6</td>
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<tr>
<td>Home Care Capture</td>
<td>66%</td>
<td>71%</td>
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Palliative Care Pilot

• July 2012 – July 2013, focused on BCBS and Medicare patients in Lutheran General, Christ and Trinity areas with a mix of employed and independent primary care physicians

• PC services including MD, APN, Social Work and Chaplain
# Palliative Care Metrics

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<th>Baseline</th>
<th>Goal</th>
<th>Result</th>
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<td>% of Discharged Patients Transitioned from PC to Hospice</td>
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<tr>
<td>Average length of Stay PC patients on Hospice</td>
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<td>AD/ACP conversation %</td>
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<td>100% discussion 50% completion</td>
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<td>ER visits per 1,000</td>
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<td>ROI calculation</td>
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Readmission Rate Trend

Sherman included in System results beginning April 2013