Clinical Integration to Maximize Population Health Management

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HealthCare Partners.
Medical Group and Affiliated Physicians

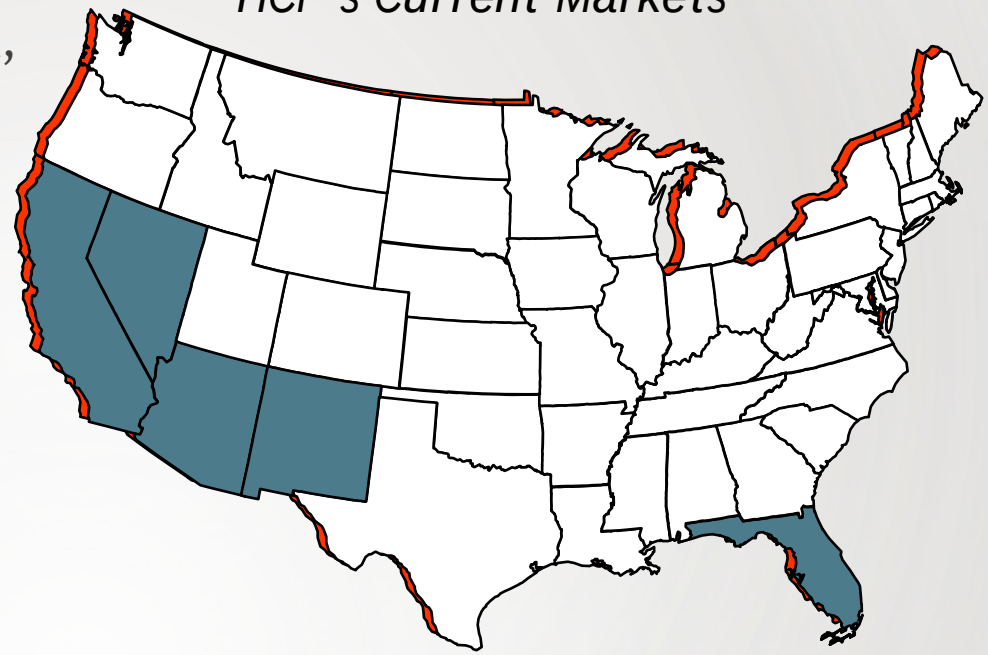
* Multi-State Physician Organization
* Delivery Model
  * Coordinated and Integrated Care
* Triple Aim:
  * Improve Health Care Quality
  * Patient Access & Satisfaction
  * Reduce costs
* Global Capitation Predominates
* Centrally Coordinated
* Regionally Driven
* Strong Medical Management Infrastructure
* Robust Business Support Units

*HealthCare Partners

* HCP Current Market Footprint

- Operates in 5 states: AZ, CA, FL, NM, NV
- Senior HMO MAPD Patients ≈ 270k
- Commercial HMO Patients ≈ 400k
- Medicaid HMO Patients ≈ 100k
- Employed Physicians >1,100
- IPA Primary Care Physicians > 2,900
- IPA Network Specialists: >7,000

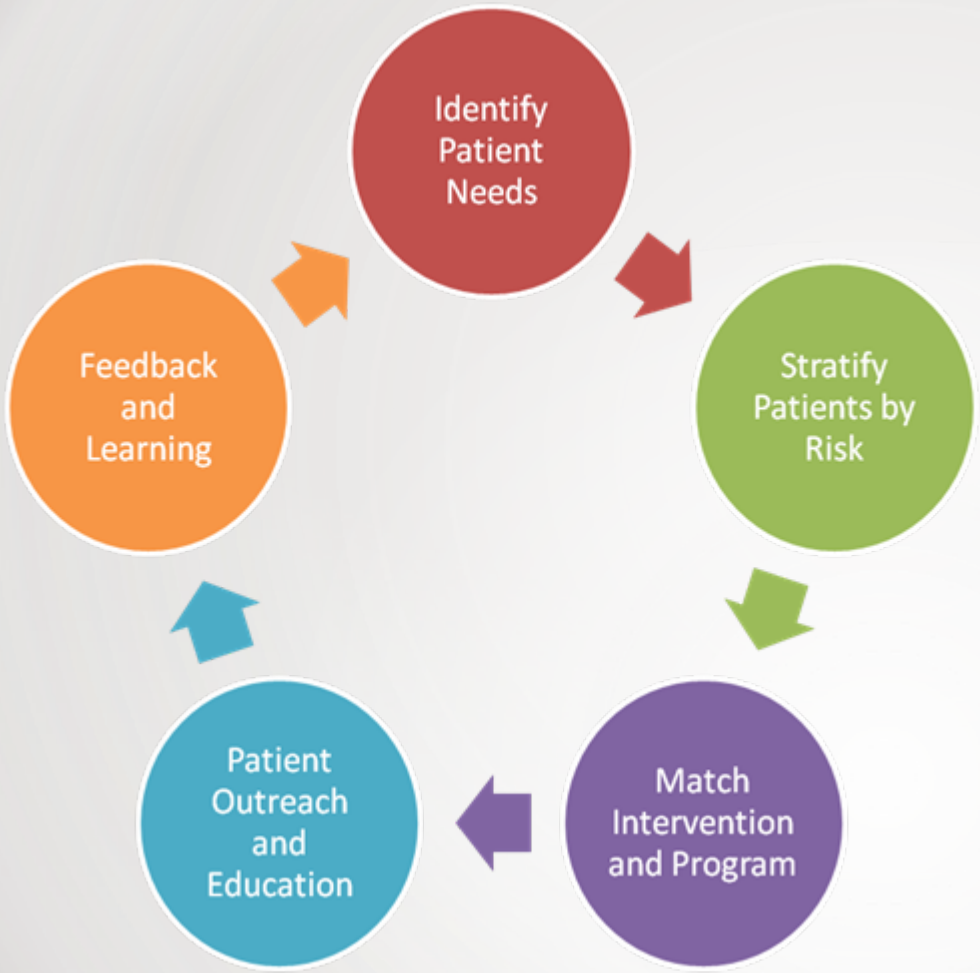
Largest Private Medical Group in each of HCP's Current Markets



Variety of physician and hospital payment arrangements	All employed physicians paid salary with incentives Contracted Physicians (PCPs & Specialists) paid on percent of Medicare or capitation or combination plus incentives

*Population Health Management Requirements

- *Technology Backbone
- *Registry – Must Know the Population
- *Stratify Patients
- *Actionable Data for the Population
- *Traditional and Innovative Programs to Improve Outcomes



The continuous "Virtuous Cycle" of improved care and outcomes is at the heart of HCPs proactive population management.

Continuous improvement to drive:

*Better Care

*Better Quality

*Better Efficiency

*Better Patient Experience

*Proactive Population Management

Allscripts/Enterprize EHR

- Fully deployed Group Model

NextGen/PACIS for Affiliated Model

- Currently supported in physician practices
- 400 Physicians/2500 Users

IDX Practice Management

Data Warehouse

- Integrated warehousing system for corporate wide reporting

Analytics geared to improved outcomes

Electronic clinical data is necessary to improve population health and the health of individuals

*Technology Backbone

All feeds to Integrated Data Warehouse

(Clinical EHR, Lab, Rx, Images, Encounters, Claims, Hospital A/D/C)

Patient Keeper Hospitalist System

Predictive Modeling (Patient Risk Stratification)

PIP

(Physician Information Portal)

POP

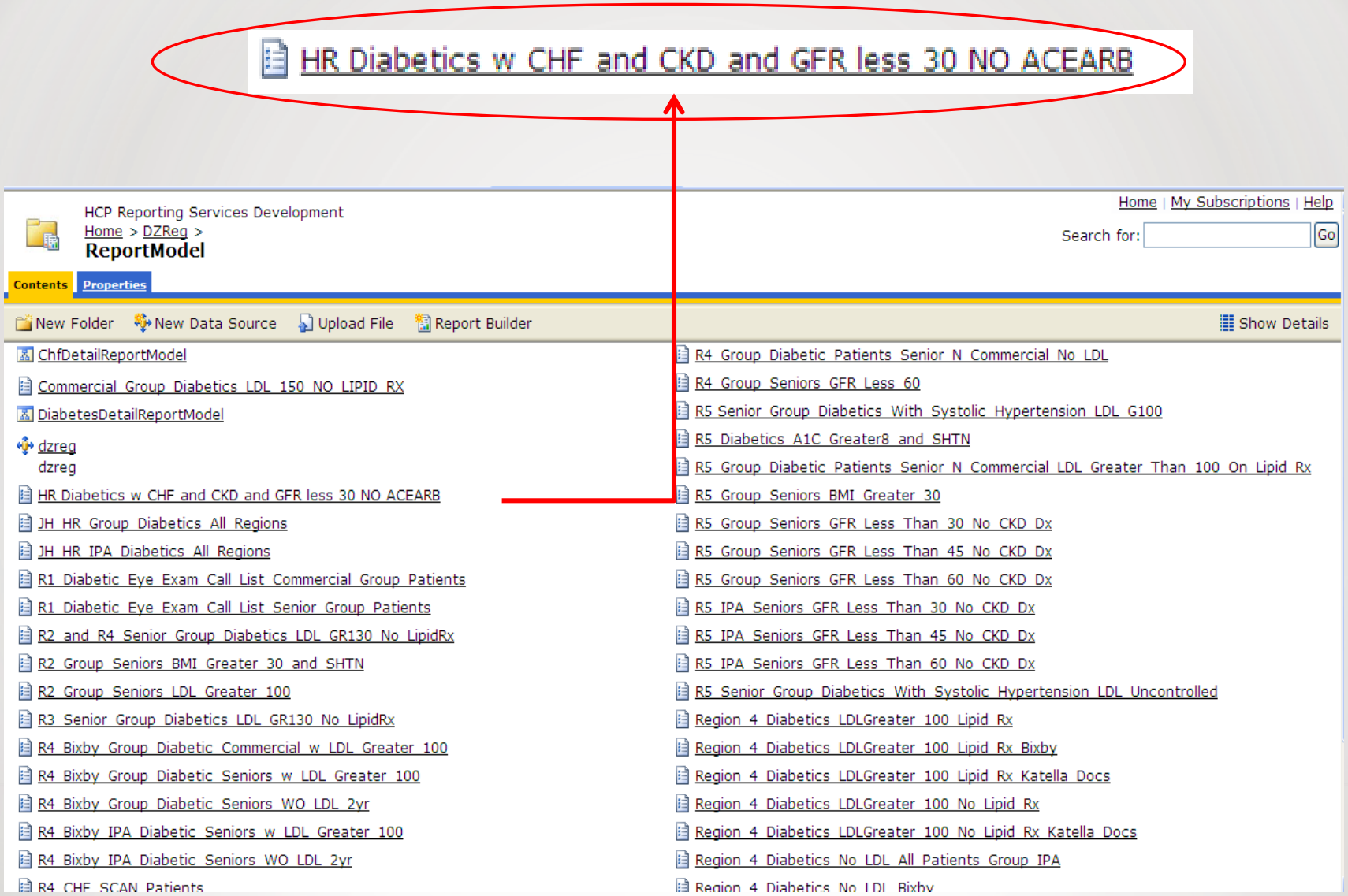
(Patient Online Portal/PHR)

HealthCarePartners.com

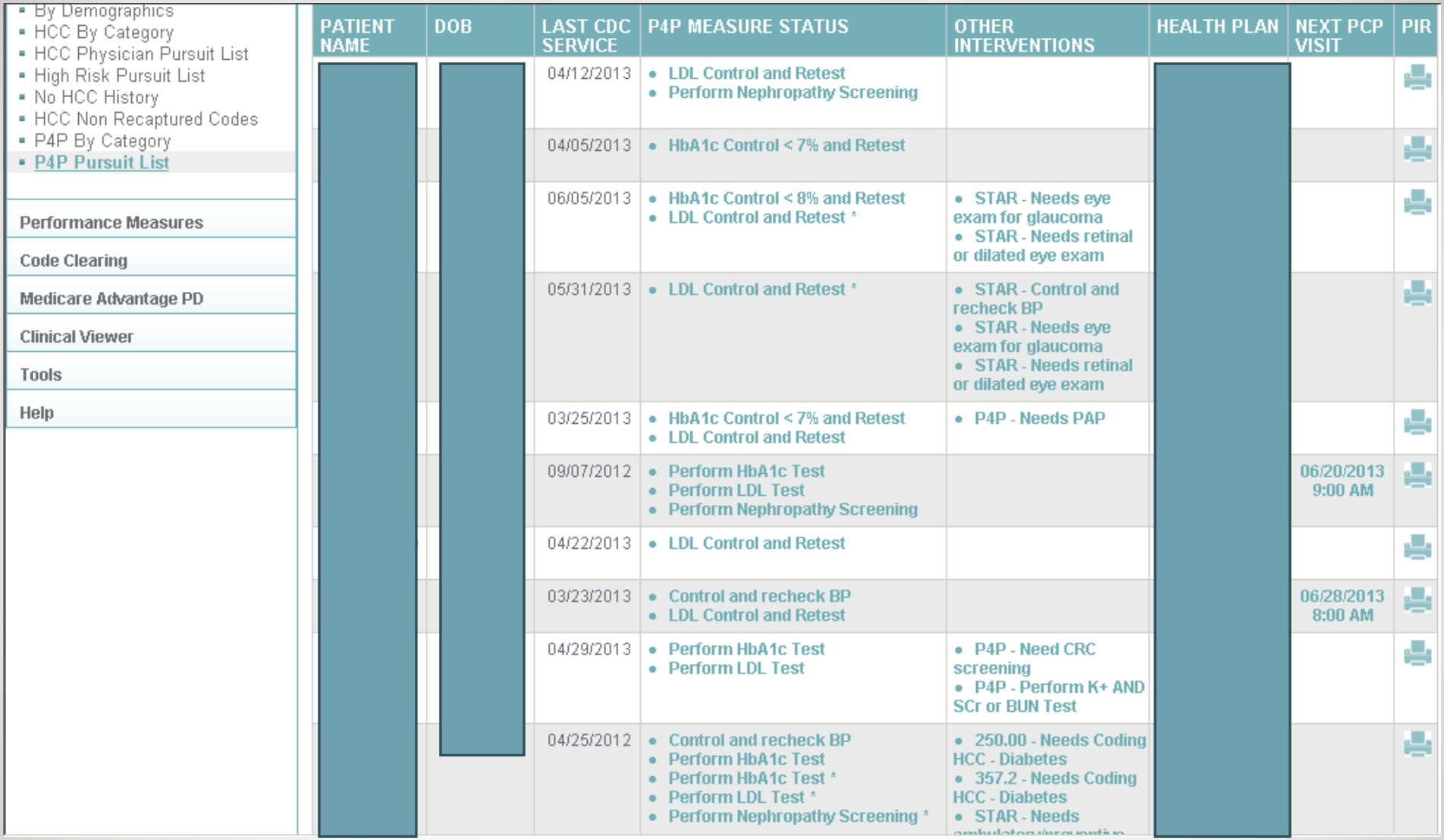
Corporate Webpage

*Technology Backbone

Continued



* Custom Registries Based on Specific Interventions



*Sample Pursuit List: PiP-Diabetes Management

HEALTHCARE PARTNERS

PATIENT INTERVENTION REPORT

REPORT DATE: 3/1/2012

Region(s): Region V

Site(s): HCP IPA - San Fernando Valley

PCP(s): [redacted]

Name	[redacted]	Telephone	[redacted]	Address	[redacted]
MRN		Enrolled		City/Zip	
DOB		Gender	M	Next PCP Appt	

Last ER/UCC visit

Last UCC/ER Visit Summary

DATE OF SERVICE	FACILITY NAME	FIRST DX
08/16/2011	WEST HILLS EMERGENCY MEDICAL ASSOCIATES	789.03 - ABDMNAL PAIN RT LWR QUAD

PIR Summary 2012:

Intervention Type	Description	Suggested Actions
P4P	Comprehensive Diabetes Care	Perform HbA1c Test Submit both Blood Pressure CPTII Codes
P4P/STAR	Comprehensive Diabetes Care	Perform HbA1c Test Perform LDL Test Perform Nephropathy Screening
STAR	Diabetes Care- Eye Exam	Needs retinal or dilated eye exam
	Glaucoma Screening in Older Adults	Needs eye exam for glaucoma
HCC	15 Diabetes With Renal Or Peripheral Circulatory Manifestation 250.40 Diabetes W/renal Manif, Type II Or Unspec, Controlled	Needs Coding
	19 Diabetes Without Complication 250.00 Diabetes W/o Complication Type II / Unspec, Controll	Needs Coding
	131 Renal Failure 585.3 Chronic Kidney Disease, Stage III (moderate)	Needs Coding
Chart Review	105 - VASCULAR DISEASE 440.0 - AORTIC ATHEROSCLEROSIS	Hospital Summary or Discharge Note - 02/07/2008 - West Hills Radiology. CT Angio with atherosclerotic vascular disease of the aorta. This would be consistent with aortic atherosclerosis. Also note on 10/15/207 CXR.

Comprehensive POC reminders for the PCP – based on established best practices (e.g. P4P)

Stratifying Patients into the Appropriate Program

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

Level 4
Home Care Management

High Risk Clinics and Care Management

Intensive 1:1 physician, social worker, & case management for the high risk, and/or post-discharge population. Patient is transferred to Level 2 when stable. Physicians and Care Managers are highly trained and closely Integrated into community resources and Physician offices or clinics.

Level 3
High Risk Clinics

Complex Care and Disease Management

Provides whole person care enhancement for the population using a multidisciplinary team approach. Diabetes, COPD, CHF, CKD, Depression, Dementia, CAD, organ transplant

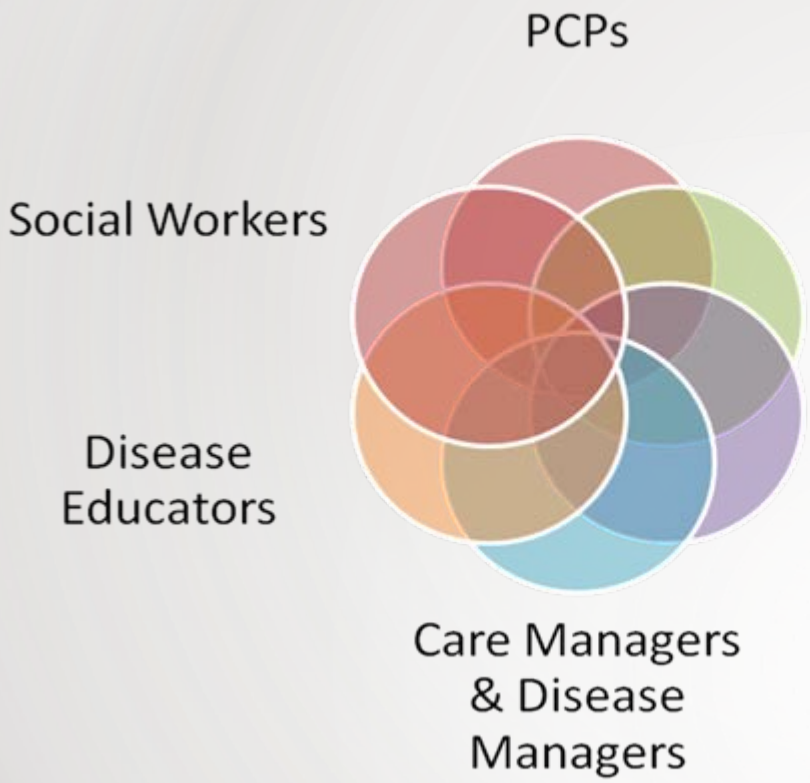
Level 2
Complex Care & Disease Management

Self Management, PCP

Provides self-management for people with chronic disease.

Level 1
Self-Management & Health Education Programs

*The HCP Care Team Approach



* Interactive and collaborative teams support clinical programs.

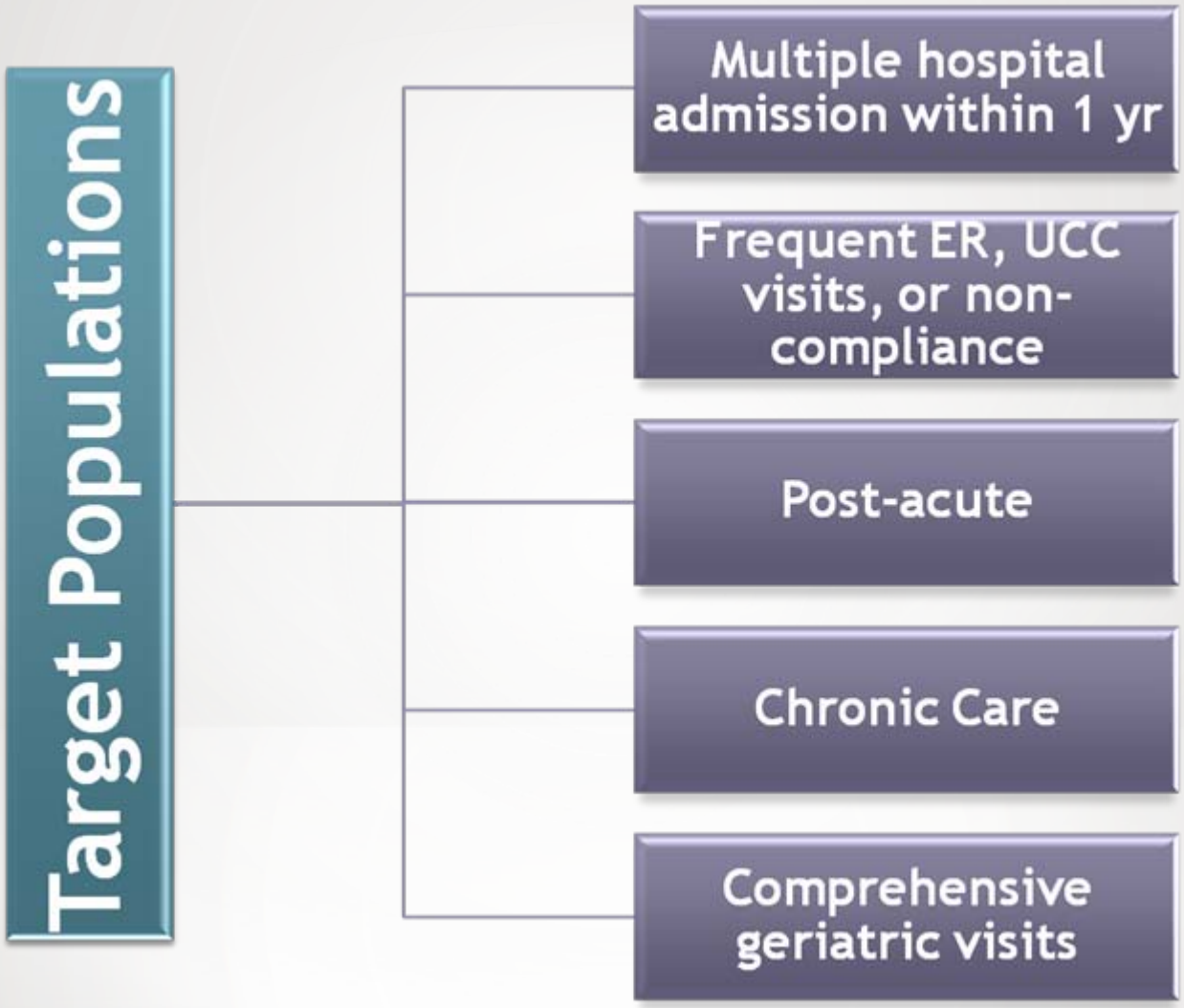
* **High Risk Programs:**
  * Home Care/ House Calls
  * ESRD
  * Comprehensive Care Center
  * Post-Acute Comprehensive Care
  * Collaborative Care for Chronically Mentally Ill

* **Disease Management Programs:**
  * Diabetes
  * CAD
  * CHF
  * COPD
  * Dementia
  * Depression

*Focus on Population

- **62% of older people – 2 or more chronic illnesses**
- **75% of all hospital admissions attributable to chronic conditions (accounts for over $75 billion of overall healthcare costs)**
- **High Risk Program**
  - Multiple admissions
  - Patients discharged from the hospital with multiple medical conditions
  - For the chronically ill and frail patient

* High Risk Clinics
Comprehensive Care Clinic

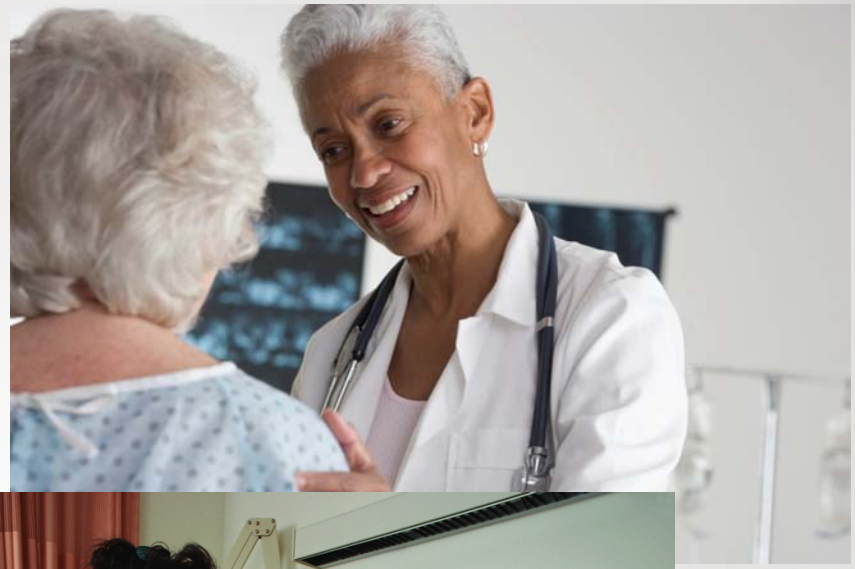


High Risk Programs
Comprehensive Care Clinic (CCC)

- Post-hospitalization clinics/appropriate transitions of care
- Medication reconciliation
- Access to additional community resources
- Psycho-social health assessment
- Disease and care plan education
- Advanced care planning
- Communication with PCP, specialists, and patient/family

High Risk Programs: Home Care

- **Top 2-3% most at-risk patients**
- **Comprehensive assessment:**
  - Living conditions
  - Social and financial needs
  - Medication regimen
  - Medical and behavioral health
- **Advanced care planning**
- **Palliative care**



High Risk Programs have shown a decrease in hospital days & ER utilization

Example of CCC Outcomes

- 25% decrease in Days per Thousand
- 26% decrease in Admits per Thousand
- 27% decrease in ER visits

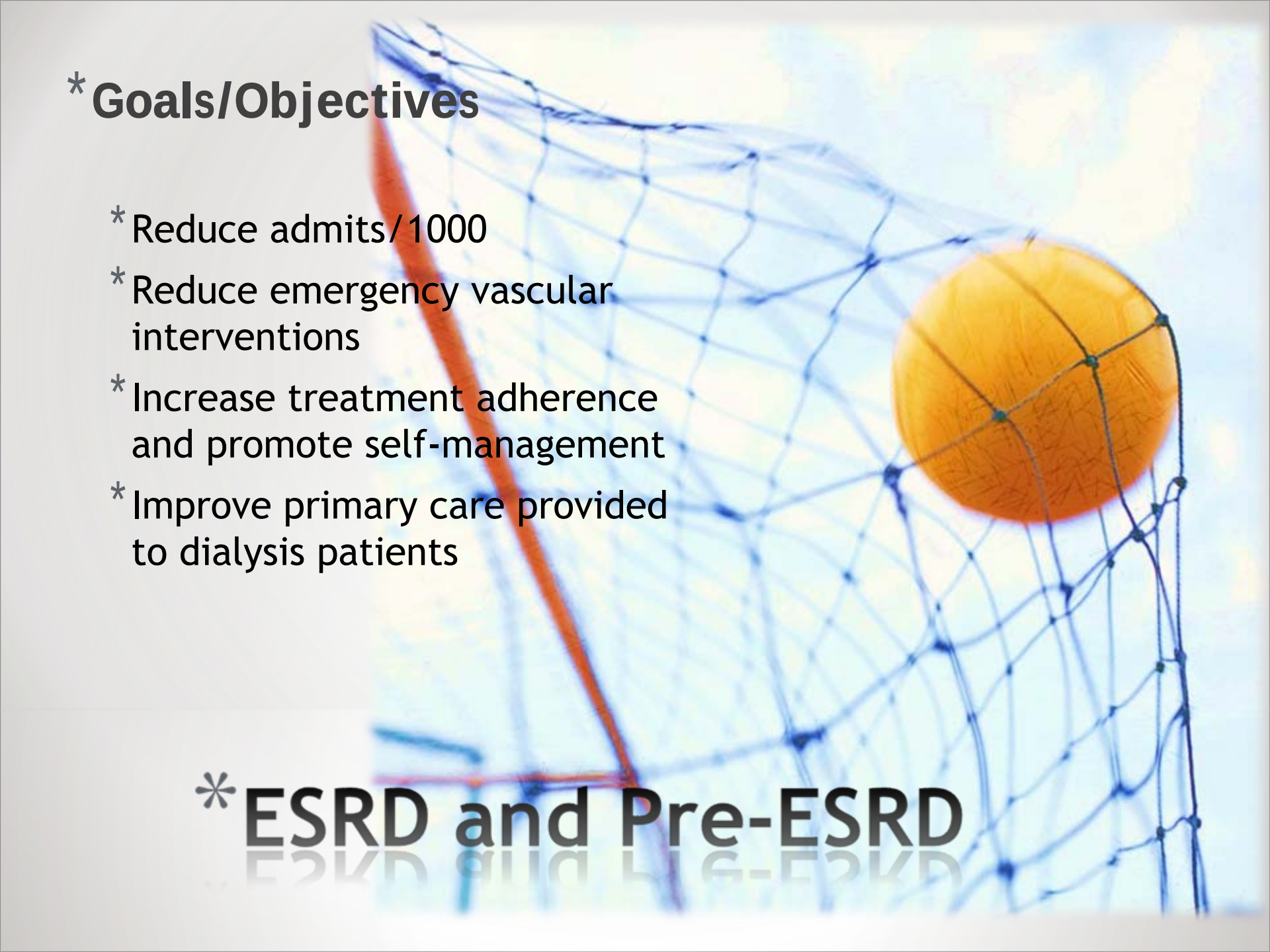
*High Risk Program Outcomes

High Risk Programs: ESRD

- Target CKD Stage IV and V – provide complex care management
- Improve primary care provided to dialysis patients
- Emotional and physical preparation for patients and caregivers prior to dialysis
- Establish early access placement
- Reduce emergency vascular interventions
- Increase treatment adherence and promote self-management
- Advanced care planning

*High Risk Programs: ESRD

* ESRD population is our highest risk and highest cost population
* ½ of all ESRD patients accounted for all utilization costs (pre-program). The challenge is to identify those patients prior to an event.
* Need to engage community nephrologists
* Need to engage our PCP community to address the pre-ESRD patients
* Education on “access” to prevent crash dialysis
* Education on dialysis options; peritoneal dialysis



Goals/Objectives

- Reduce admits/1000
- Reduce emergency vascular interventions
- Increase treatment adherence and promote self-management
- Improve primary care provided to dialysis patients

ESRD and Pre-ESRD

Overview of Pre-ESRD Program

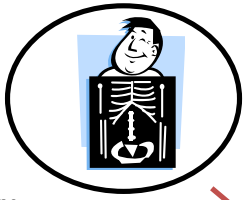
- **Pre-ESRD (CKD)**
  - Monitoring patients approaching dialysis; and those ready for dialysis (GFR & Dialysis Reports; monthly); targeting patients with GFR < 30
  - Identifying patients without a referral for nephrology and those without a referral for vascular surgery; facilitating referrals for those patients
  - Promote education to the patient

*Overview of ESRD Program

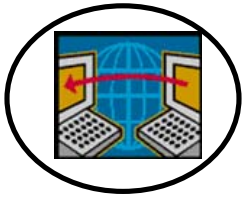
* Work with patients at dialysis centers
* Focus on those patients admitted within the past 12 months
* Focus on dialysis new-starts
* Focus on problematic patients
* Address vascular access issues timely
* Managing comorbid conditions, preventative care
* Coordinators assist with specialist visits, transportation needs
* Supported by Nurse Practitioners

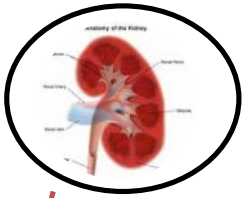
Patients	Pre Program	In Program	% change
Distinct Patients		488	
Member Months	5,653	5,804	
Acute			
Inpatient Admits/1000	1295	970	25%
Days/1000	5702	3,581	37%
Sub Acute			
Sub Acute Days/1000	4,203	3,118	26%
Total Days/1000 (acute, sub acute)	7,304	4,855	34%
ER/1000	469	616	31%

*2012 ESRD Program Outcomes

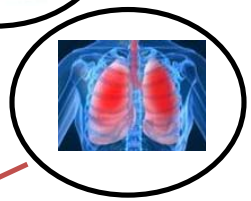

Radiology


Behavioral Health


IS Data


ESRD Program


Lab


COPD Program

UCC

Innovation


Medical Assistant

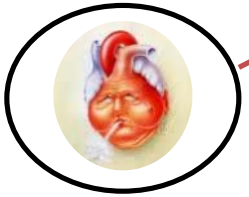

Nurse Care Manager

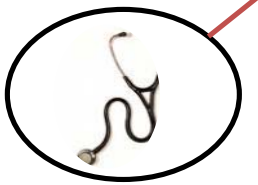

Diabetes


Hospital


Administrator

Commitment


CHF Program


Specialty Care


High Risk Clinic


Receptionist Outreach


Home Care


P4P Steering


Palliative Care

*Thank You!