Population Health :
"The Devil is in the Details"

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Who is HPN

- HPN – 33 years innovation
  - Patient centric – physician led
  - Risk bearing strengths
  - Integrated care delivery
  - 1,000,000+ covered patient lives
  - 3,000 employed Physicians in Groups
  - 30,000+ Physicians in IPA Contracts
  - California, New York and Arizona
  - New joint ventures:
    - Trinity, Fresenius, Wal-Greens, Rite-Aid and others to come nation wide

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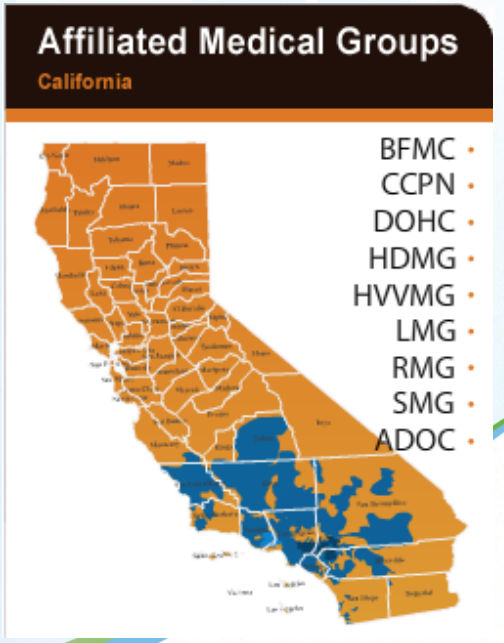
Who is HPN

- Heritage California ACO
  - Pioneer status
  - 120,000+ ACO lives
  - Part of Heritage Provider Network
  - 2 MSSP ACO's (AZ, NY)



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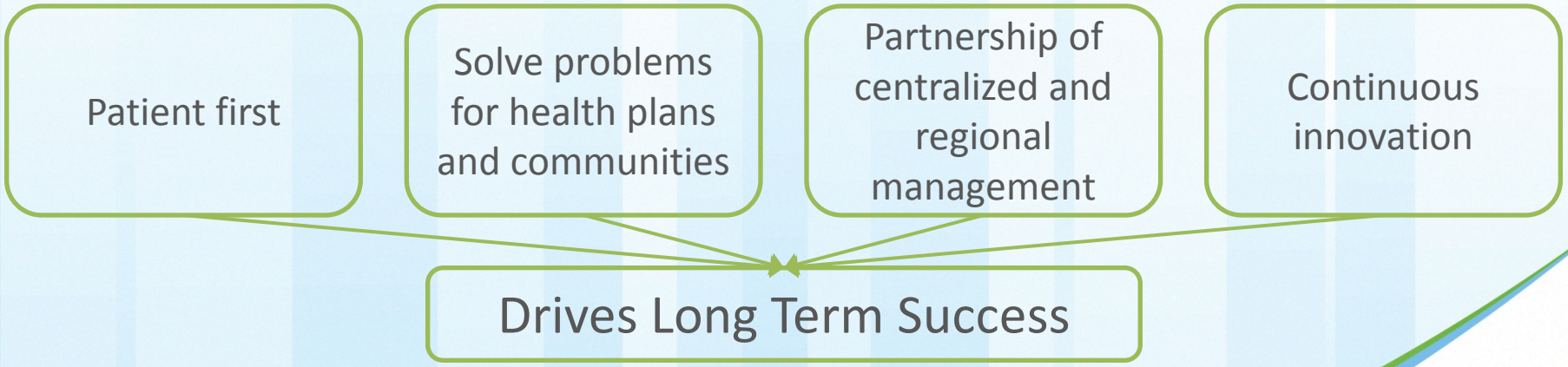
Key Operating Principles of HPN

- Healthcare is local and should be delivered locally
- Use technology to scale and expand operations
- Share best practices and benchmark against best performers



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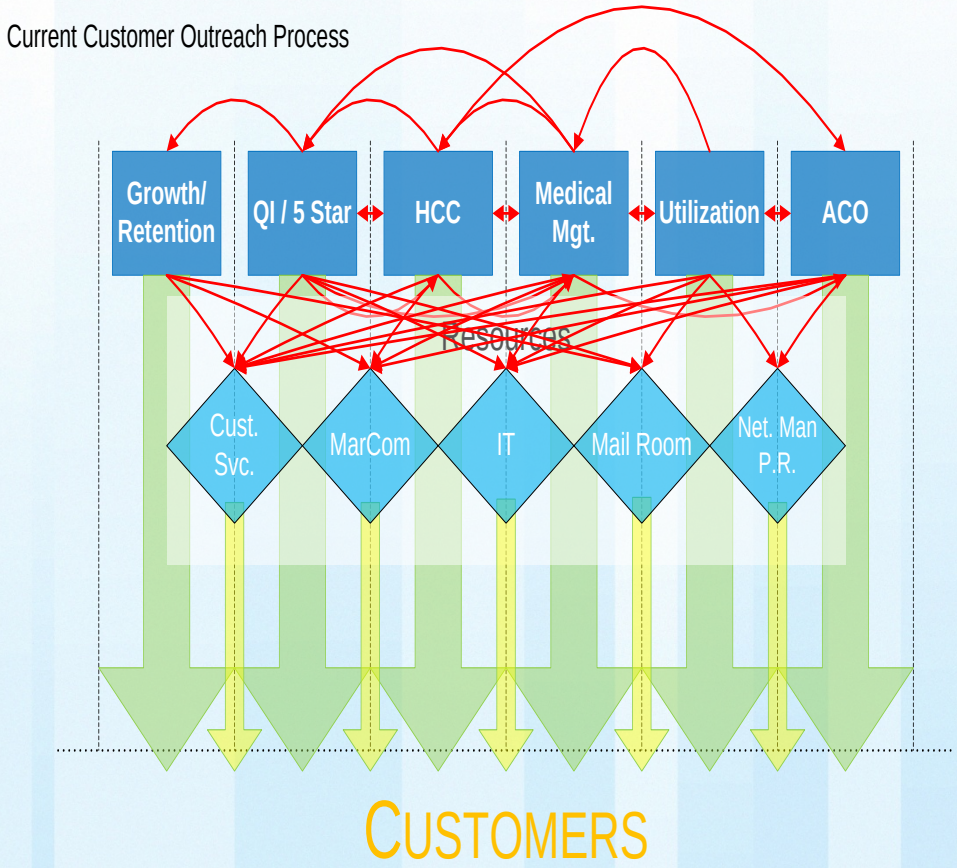
Detail 1

- In an HMO environment:
  - You control utilization
  - Prior authorization may be required
  - Provider network based
  - Full access to data on a close to real-time basis
- In an ACO environment:
  - Patient can visit any doctor they wish
  - There is no prior authorization
  - Patients are going to doctors outside the network
  - Much of the data you receive is months later
  - So, THE JOB IS MUCH MORE DIFFICULT

Typical Current Population Management System



- Disconnected
- Reactive
- Redundant
- Inefficient use of Resources
- Creates Patient Frustrations
- Patients get Lost within the system

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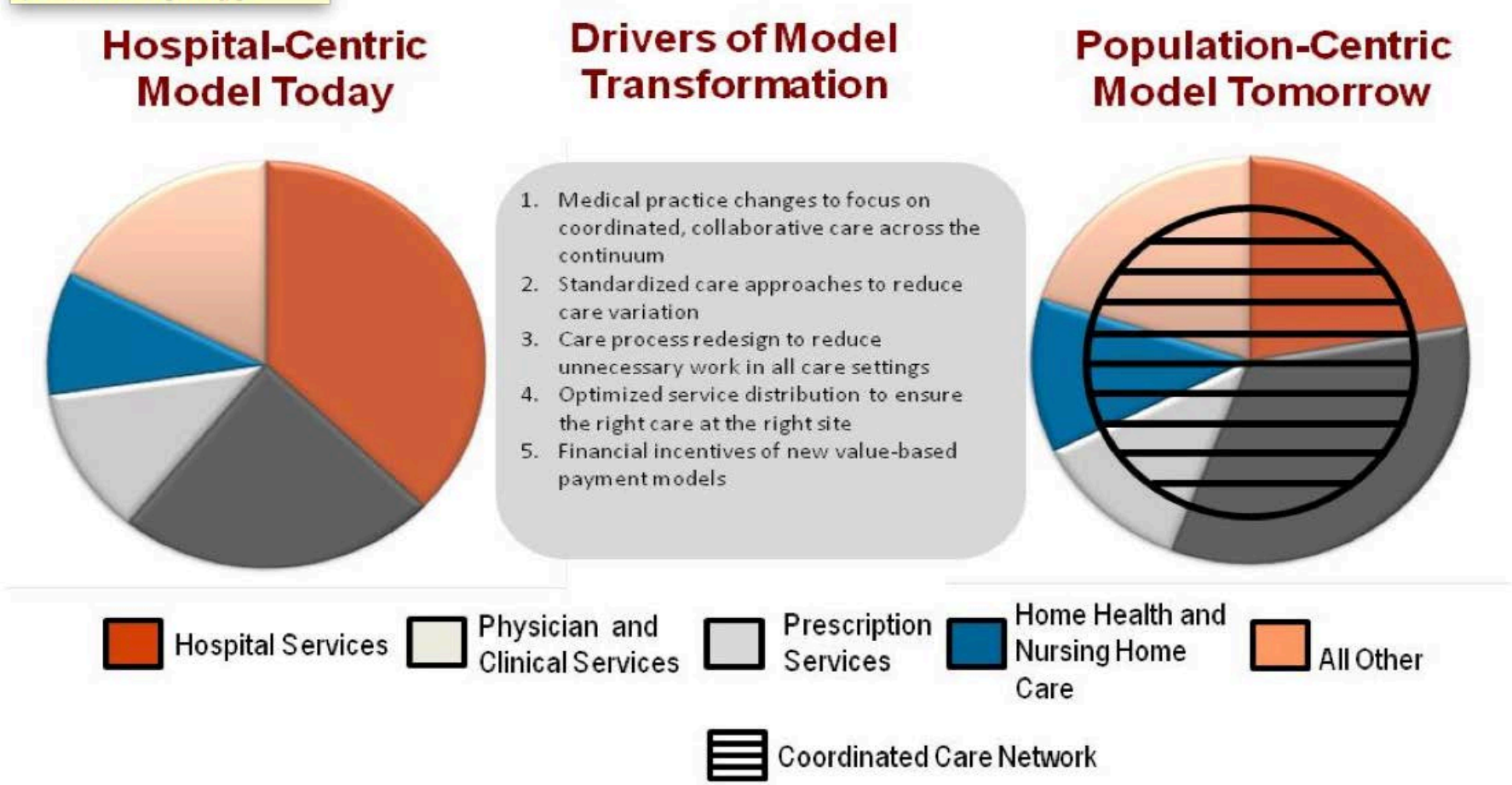
"The dogmas of the quiet past, are inadequate to the stormy present. The occasion is piled high with difficulty, and we must rise — with the occasion. As our case is new, so we must think anew, and act anew.–
December 1, 1862 – Lincoln's Second Annual Message to Congress

http://healthaffairs.org/blog/wp-content/uploads/Kaufman-Figure-1.jpg



Coordinating Care for Success

- Robust inpatient (hospitalist/nocturnist), SNF and outpatient management
- Physician-led utilization and quality management
- Focus on medical home and community care management
- Care coordination by interdisciplinary teams
- Rigorous real time decision support and data analysis
- All this must be connected and supported by data

What in the devil can you do?

- Prioritize patients by those for whom you can best change the care and cost trajectory.
- That requires three things:
  - And understanding of who can be affected (remember 5% of patients are responsible for 50% of the costs);
  - Robust data
  - A way to sort and stratify the data to focus on the effectible population
- This does not require perfect data for all beneficiaries

Devil is in the Data

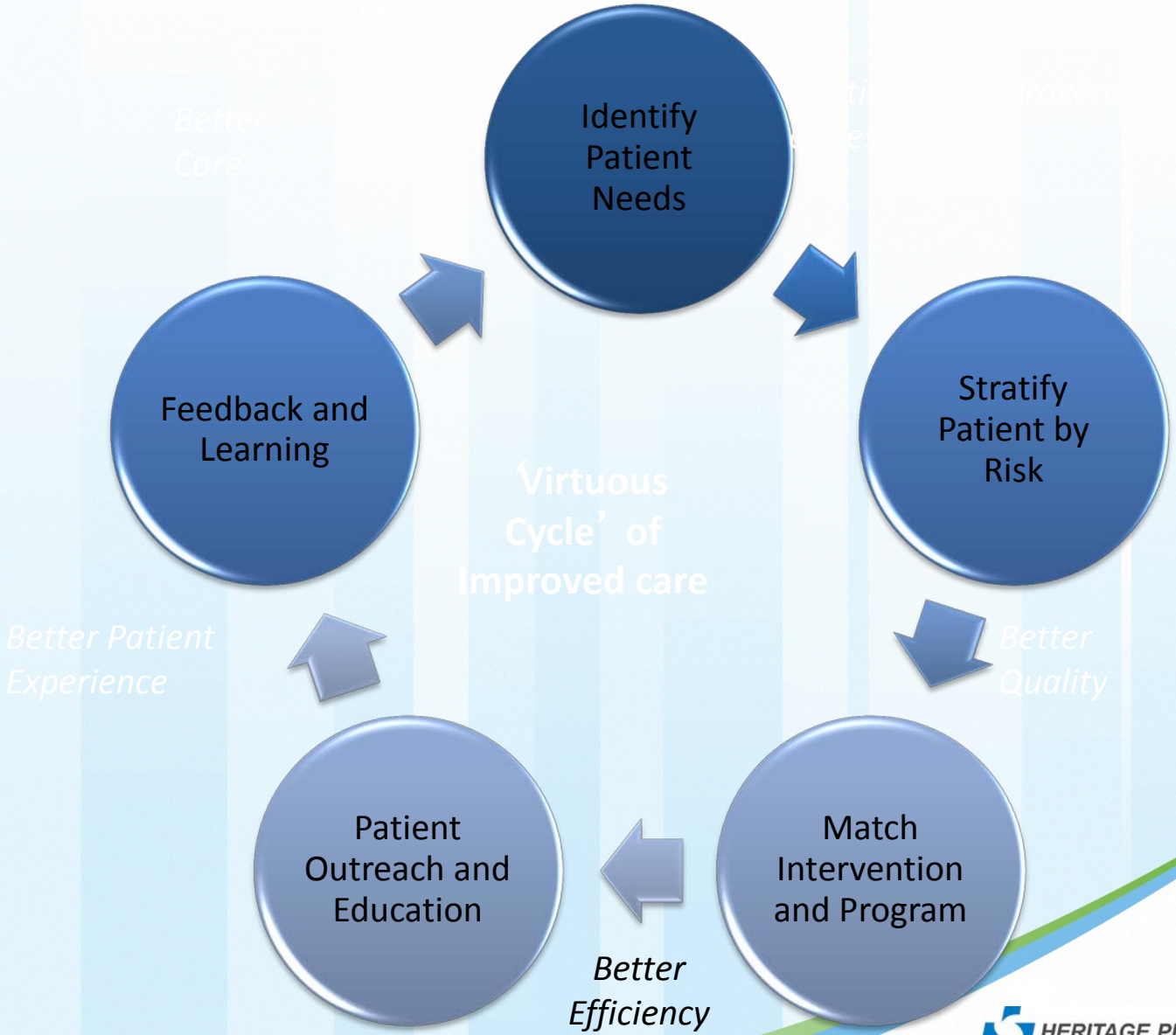
- You need to obtain as much relevant data, as quickly as possible
- Claims – but comes months late
- Pharmacy – need real time adjudication data
- Labs – contracted provider interface
- Utilization data – before you get it from claims (Passport, Emdeon)
- Single source of “healthcare related truth”
  - Care coordination and management vehicle (q.HMO)

- Replicable across regions
- Enables scalable operations
- Supports clinical programs
- Reduces clinical variation
- Enforces compliance

How do we address the problem?

- Not just program infrastructure
- Not just bricks and mortar
- Coordination of Health Care = Outcomes in Health Care
- Concentrates on the 1% but easily expands to the 99%

Proactive Population Health Management



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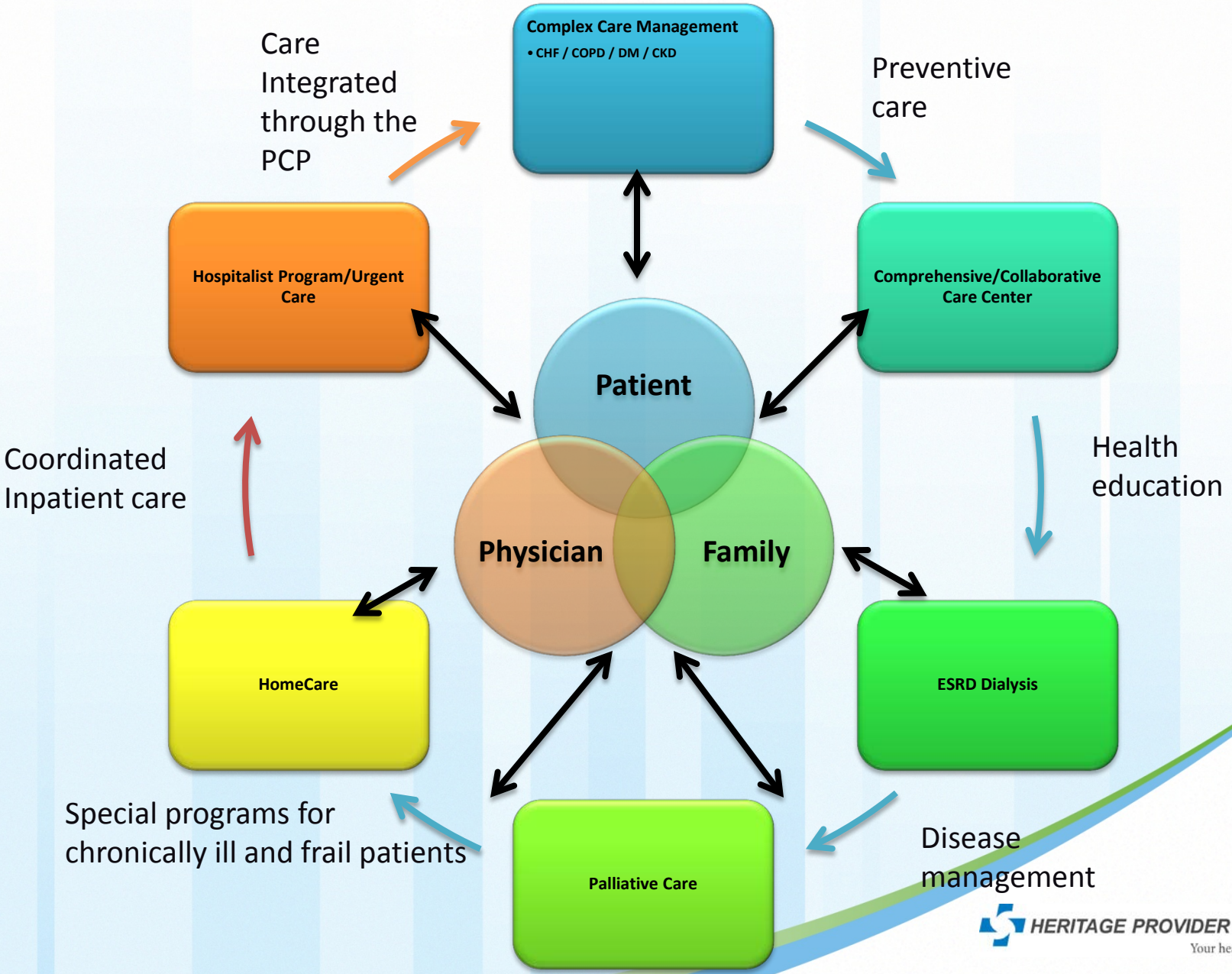
Care Coordination Model



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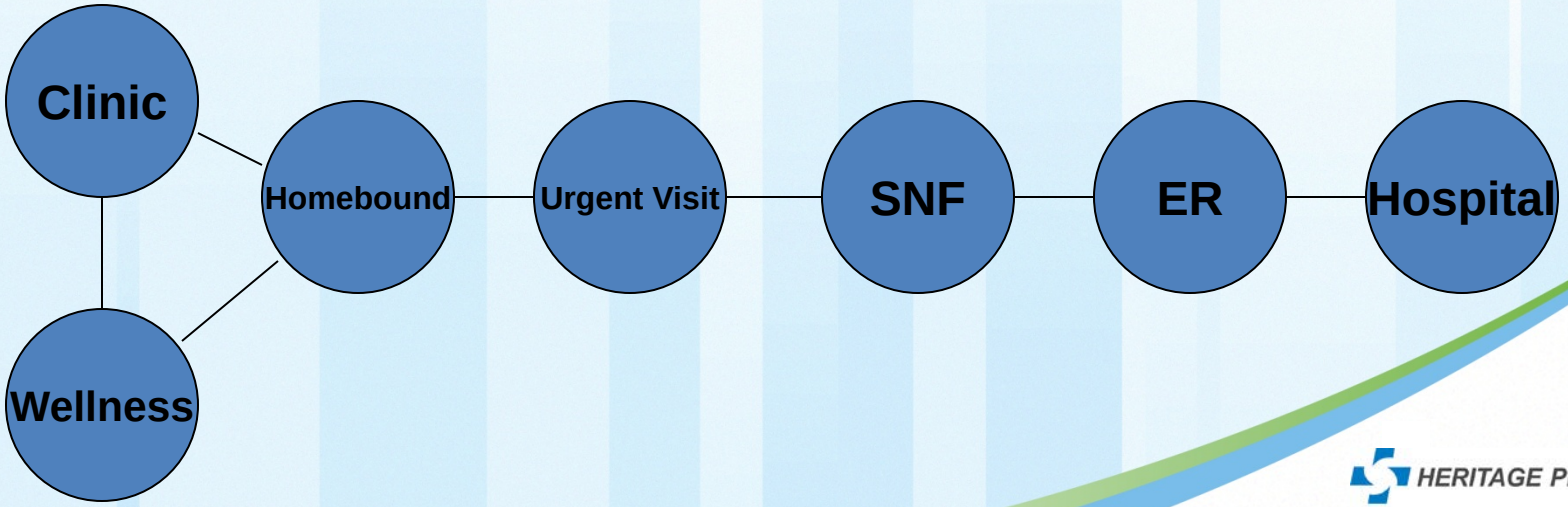
What makes us Different?

- Accountable
- Immediate
- Alignment of goals with PCP
- Patient engagement
- Dynamic transitions and oversight
- Individualized relationship-based care plans
- Transportable

Systems of Care

- Target the admission rate
- Take care of the patient at all points of care, including the hospital
- Ownership of patient care at each point



Stratifying Patients into the Appropriate Clinical 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 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

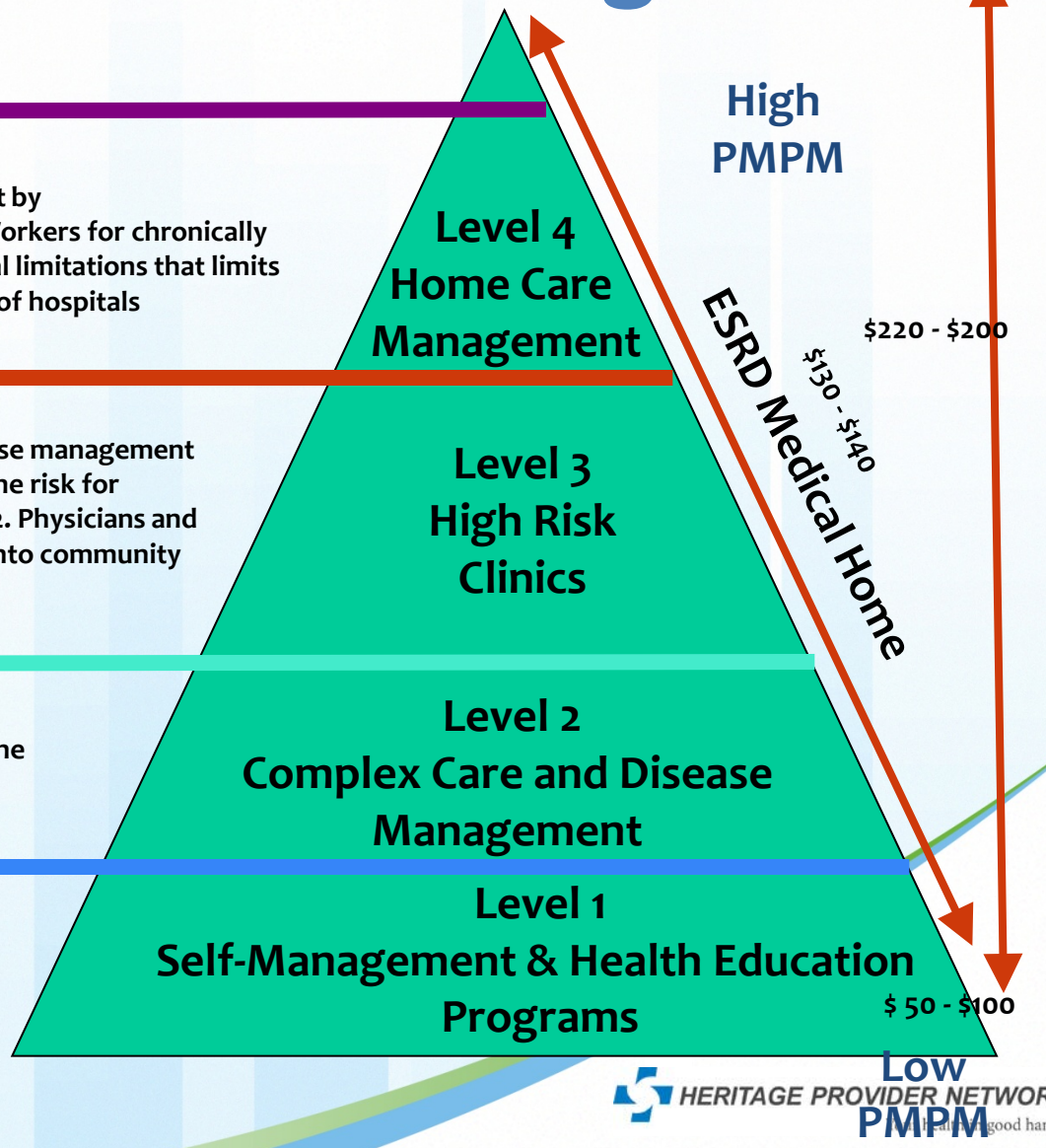
intensive one-on-one physician /nurse patient care and case management for the highest risk, most complex of the population. As the risk for hospitalization is reduced, patient is transferred to Level 2. Physicians and Care Managers are highly trained and closely Integrated into community resources and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

Complex Care and Disease Management

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

Self Management, PCP

Provides self-management for people with chronic disease.



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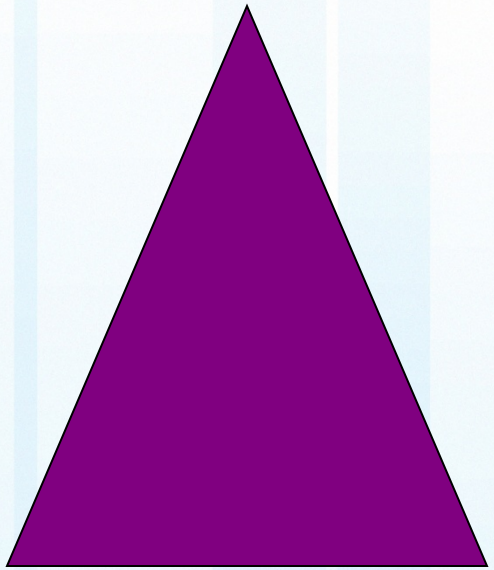
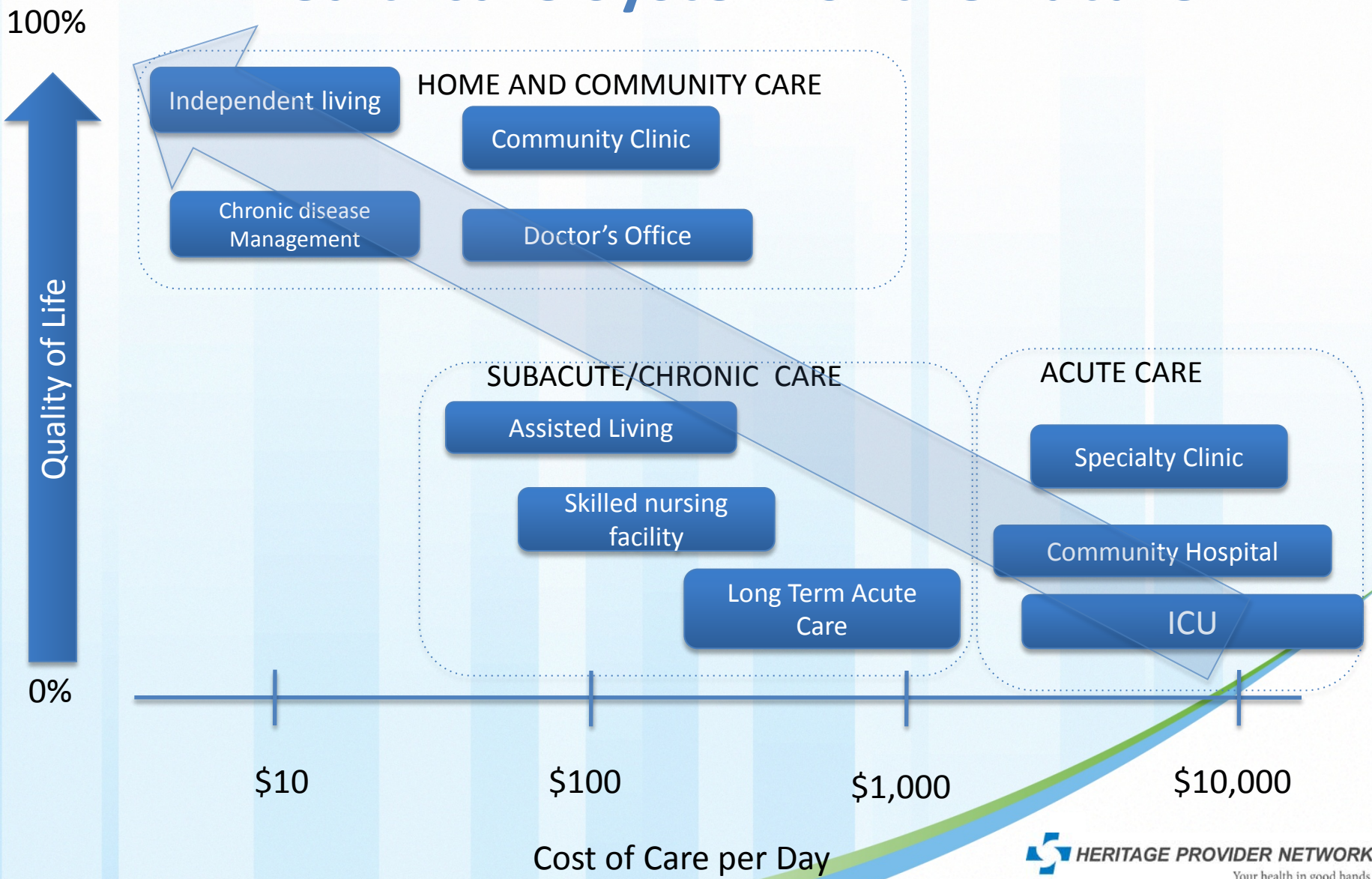
HPN Clinical Services Programs

- PCP HOTLINE
- PRIORITY CARE & SPECIALTY CLINIC
- COMMUNITY BASED MEDICAL HOME
- PRIORITY HOME CUSTODIAL PROGRAM
- PATIENT HELP-LINE
- SPECIALTY TEAM
- INTENSE CASE MANAGEMENT
- FACILITY CASE MANAGEMENT
- DISCHARGE CALLING PROGRAM
- DISEASE MANAGEMENT
- TELEPHONIC CASE MANAGEMENT
- HEALTH CARE ADVOCATES
- SOCIAL SERVICES
- MEDICATION MANAGEMENT
- HOME HEALTH



The Value Proposition for the Healthcare System of the Future



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Medicare Advantage, Dual Eligible's, and ACOs

- The new frontier and challenges in health care
- Patient experience is the “essence”
- Improved quality
- Improved patient satisfaction
- Improved Physician satisfaction
- Making it more affordable not just cheap
- Constant improvement engineering and re-engineering of the health care system and medical management infrastructure

Quality and Cost

- ✓ Average Medicare FFS Hospital Days/ 1000- 2500
- ✓ Best Practice Medicare Advantage Hospital Days/ 1000 in Full Risk Provider Organizations- 500
- ✓ 60 million Medicare patients saving 2 days / patient/ year X $6000/ hospital day= $720 B
- ✓ Total Cost of Care reduction= $712 B

The Benefits of Linking Clinical Risk to Financial Risk

- ✓ Quality Care is always less expensive
- ✓ Do anything that is better for the patient in exchange for a hospital admission, hospital day, ER visit, etc.
- ✓ The One Hundred Cent Health Care Dollar is the Pathway to Managing Care
- ✓ Managed Care is a Patient Focused Approach to Care- IT IS NOT AN INSURANCE PRODUCT
- ✓ Investing in Medical Management, Patient Engagement and Social/ Behavioral Support

Just a few of the details

- ✓The patients are waiting
- ✓Is your organization part of the solution or part of the problem?
- ✓The time to decide, and act, is NOW