The Future of health care through achieving the quadruple aim

Physician led integrated delivery systems doing the brilliant basics

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Goals: Quadruple Aim

mproved engagement and experience for the patient through all levels of care

Improved overall health of the patient and populations in a healthcare system with coordinated, patient centered care

Lower total cost of care

Goals cont: Quadruple Aim Plus

Engaged and Satisfied Physicians

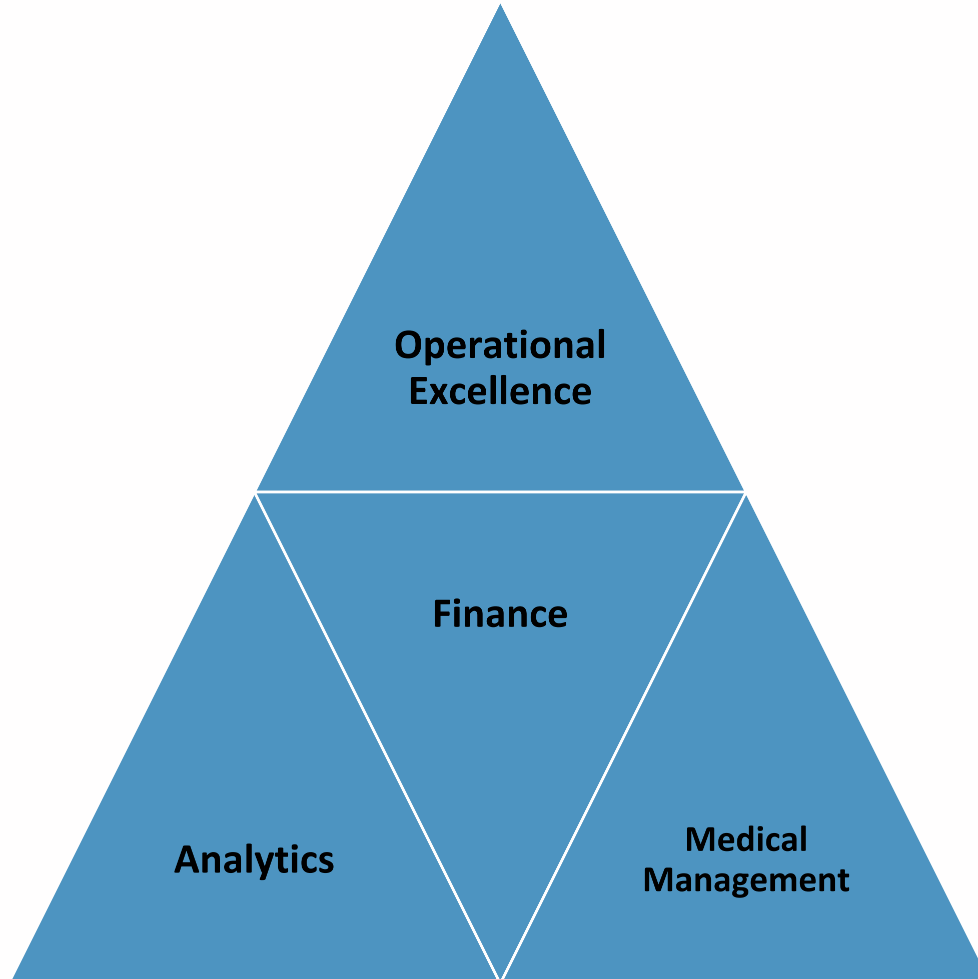
Change the long-term path of physician-led delivery systems

Use innovation for healthcare solutions including technology

Goals Continued

- Improved access to care and support for Patients and their Families to medical, mental health, social services and community-based services
- Provision for affordable and preventative care
- Processes supporting transitions of care - coordination of care across the continuum
- Assurance of appropriate utilization while adhering to the heath plan benefit
- Improved outcomes including:
  - Reduction in hospitalizations and SNF needs with preventative and Comprehensive Care
- Enhanced patient:
  - Self-management, independence and knowledge
  - Self -reported quality of life through CM support, education and coordination

Strategic Plan in Each Market Deploy the Team



Stratify, Prioritize, Intervene

Risk Stratify

- By Market
- Line of Business

Delegation with Health Plan

- Program requirements
- Financial Incentives

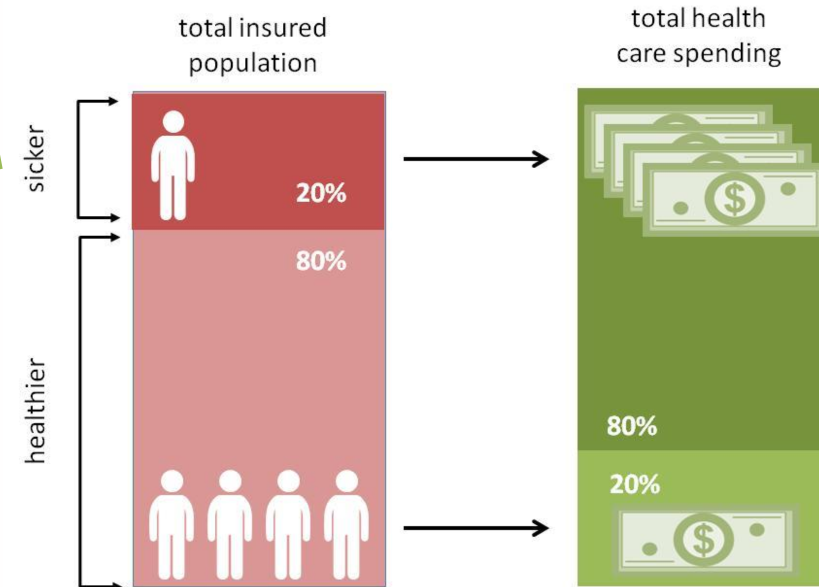
Determine Plan

- Prioritize
- Create Plan including ROI
- Implement

… in order to deliver a care model that is worthy of our family and friends

- 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"



Medical Management Infrastructure Tool Summary

Medical Management Infrastructure (MMI) tool has been used to evaluate every region by reviewing their current structure by LOB and scoring each markets Medical Management. Now that is completed, we are collaboratively developing an implementation/ execution plan and timeline for 2018.

MMI tool assesses each market by risk in the following areas:

- Hospitalist (Acute Hospital)
- Hospitalist (SNF)
- Hospital Care Management Program
- Post Hospitalization/High Risk Clinic
- Hospital
- Medical Director Leadership
- Urgent Care Centers and Specialty Clinic
- Ambulatory Case Management Program
- Physician Report Card / Incentive System

Medical Management Infrastructure (MMI) Tool Summary

Market Evaluation Tool – Current Market Scores

Medical Group/Market Name:		CORONA Professional financial risk	Fresno Medi-cal Professional Risk	Fresno Medicare Advantage Professional and Institutional Risk	Los Angeles Professional Risk	San Diego Professional Risk	Hawaii Professional and Institutional financial risk	Ohio - COPC	Texas - ARC
Date Assessed:		Dec-17	Dec-17	Dec-17	Dec-17	Dec-17	Dec-17	Dec-17	Dec-17
	Score indicates status of programs implemented that are required in agilon health Care Model as well as progress of implementation								
CRITICAL FACTORS	MAX POINTS	SCORE	SCORE	SCORE	SCORE	SCORE	SCORE	SCORE	SCORE
CATEGORY 1 (45 points)									
Hospitalist (Acute Hospital) - 12 points	12	0.75	0	0.5	0.5	0.75	1.75	8	0.5
Hospitalist (SNF) - 8 points	8	0	0	2	0	0	0.5	5	0
Hospital Care Management Program - 11 points	11	1.65	0.75	4.25	1.35	1.5	3	6	3
Post Hospitalization/High Risk Clinic - 10 points	10	0.35	0	0.1	0	0	0.75	3.5	0.5
Hospital - 1.5 pts	1.5	0	0	0	0	0	0	1	0
Medical Director Leadership - 2.5 pts	2.5	2.5	2.5	2	1.25	1.25	2.5	2	1
Total	45	5.25	3.25	8.85	3.1	3.5	8.5	25.5	5
CATEGORY 2 (39 Points)									
Urgent Care Centers and Specialty clinics - 6 pts.	6	1.25	0.3	0.6	0.75	0.75	1.75	2.5	2
Ambulatory Case Management Program - 33 pts.	33	3.96	5	2.95	3.5	3.5	3.5	14	5.25
Total	39	5.21	5.3	3.55	4.25	4.25	5.25	16.5	7.25
CATEGORY 3 (16 point)									
Physician Report Card/Incentive System - 16 pts.	16	0.5	0.5	0.5	0.5	0.5	1.75	8.5	4
Total	16	0.5	0.5	0.5	0.5	0.5	1.75	8.5	4
Final	100	10.96	9.05	12.9	7.85	8.25	15.5	50.5	16.25

- Ohio has the highest score of 50.5 / 100. All others are between 7 and 16 / 100.

Integrate: Operating System

Provider organizations are in need of an integrated "full stack" suite of services to help them migrate to a global capitation business model

Technology

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

Acute and Post Acute Care

Comprehensive MSO To Support Full Risk

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

Group

- Move specialists to capitation
- Incent them to provide great care

Reinvention of Specialist Care

Reinvention of Primary Care

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

Chronic Disease Identification, Treatment Planning, and Documentation

- 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

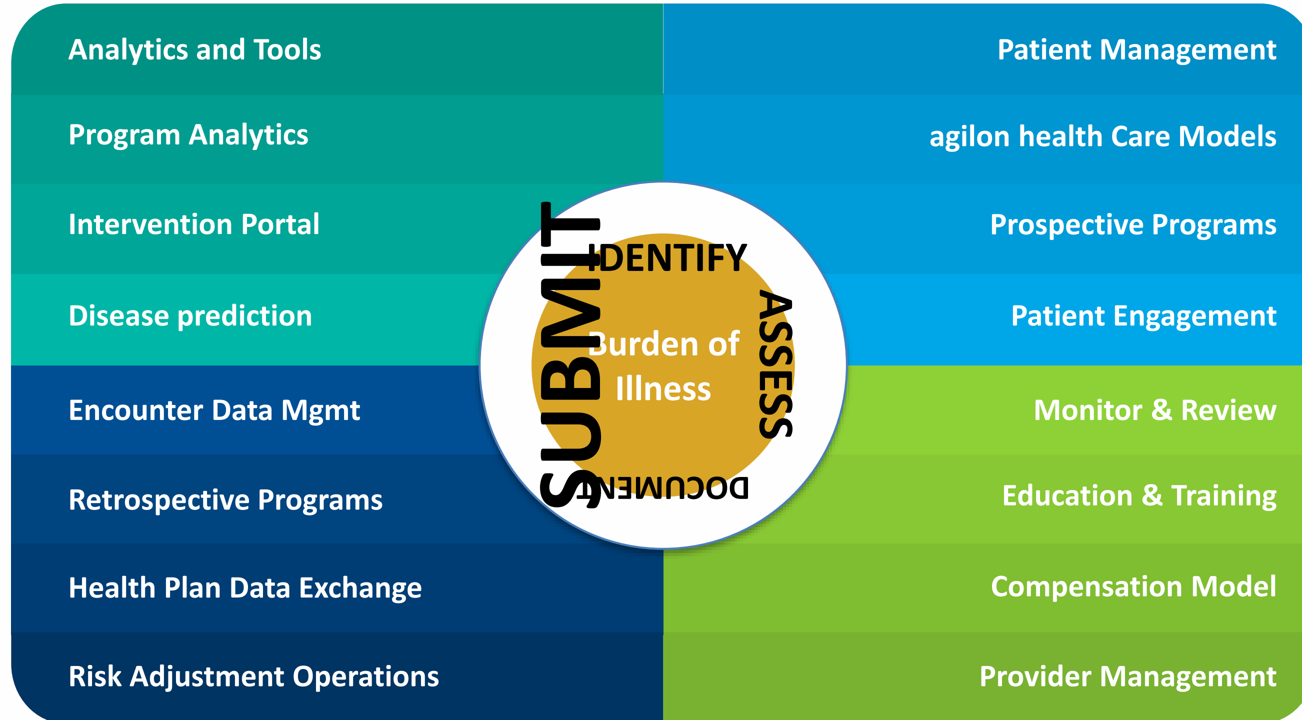
…including advanced technology to support the reengineering of care processes

Insightful analytics and actionable tools

Analytics and tools platform that enables efficient and effective BOI programs.

Improved health outcomes

Patient management programs which ensure assessment and treatment of significant and chronic diseases. Medical management infrastructure to support PCP and assist with complicated patients.



Accurate revenue

Risk adjustment operations which ensure capture, submission and payment of all significant and chronic disease.

Engaged provider network

Provider network alignment with assessing, treating, documenting and submitting significant and chronic diseases.

Stratifying patients into the appropriate clinical programs

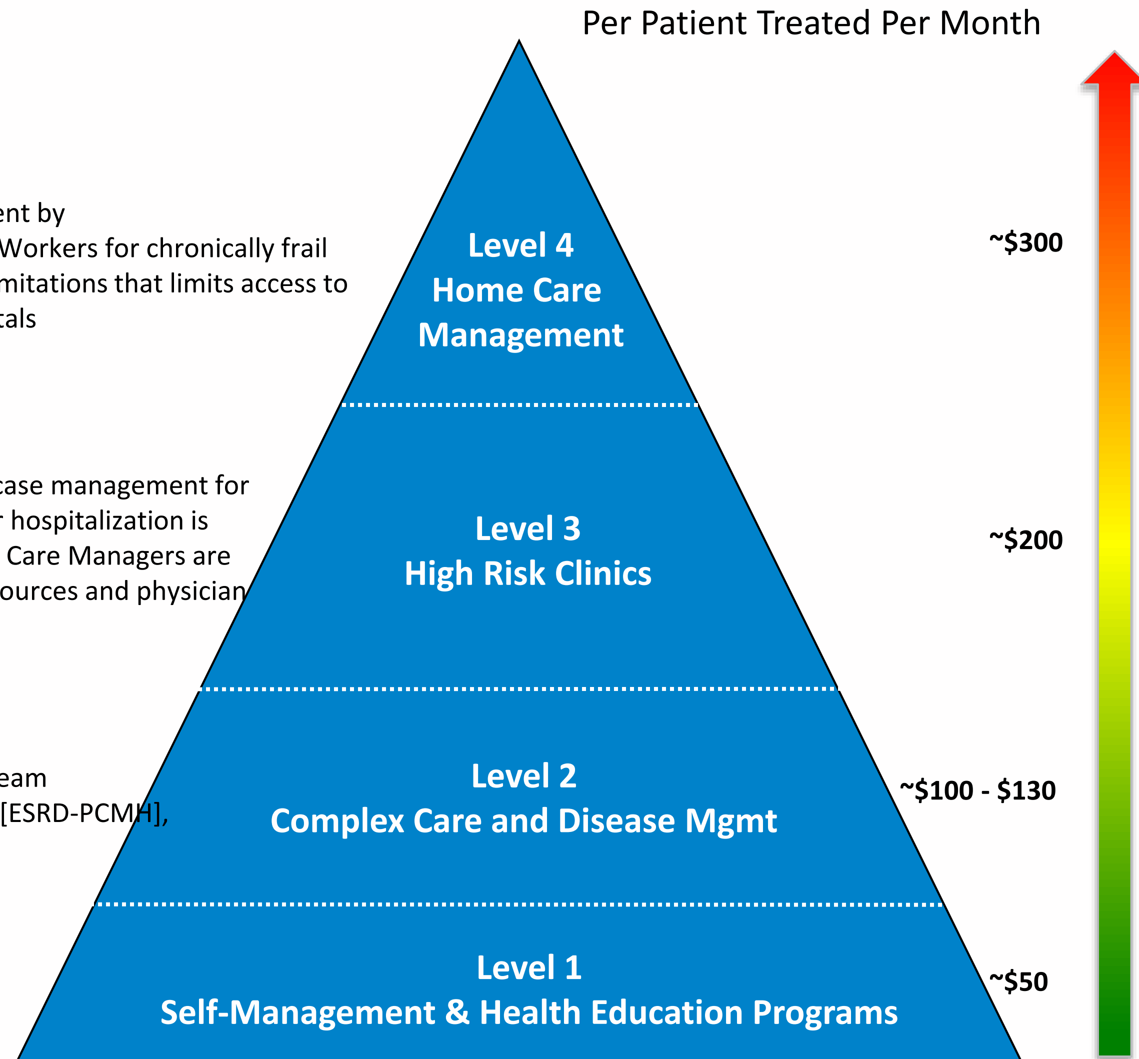
Hospice / Palliative Care

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
Every Day Care and self-management for people with chronic disease.



Physician Risk Stratification

Employed	Contracted
"Great" - Embed Care Mgmt. - Shift 1% – 2% Seniors/ 0.5% Comm* - 30/ 1000 senior patients on the Composite Scores for Ambulatory sensitive admission (12 categories as defined by AHRQ) - Readmission rates = 7%	"Excellent" - Embed Care Mgmt. - Shift 8% – 10% Seniors/ 2-2.5% Comm * - 35/ 1000 senior patients on the Composite Scores for Ambulatory sensitive admission (12 categories as defined by AHRQ) - Readmission rates = 9%
"Good" - Embed Care Mgmt. - Shift 5% – 8% Seniors/ 1.5-2% Comm*	"Average" - Shift 20% Seniors/ 5% Comm*

- Denotes shift of senior population to high risk care centers
- For Commercial Patients, target 5% of total patients for moving to high risk programs

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 / Hospitalist & SNFist

1. Primary Care	2. Case Mgmt	3. High Risk Clinic/Mgmt	4. Home Care
Embedded CM/ Health Coaching	*Complex Case & Disease Management (in person/ telephonic)*	*Long Term "Geriatric" / Chronic Condition*	*Palliative Care / Hospice*
Patient Engagement & Education	*Care Transitions*	*Short Term (6 months or less): Chronic Pain, Cardio, Ortho, Oncology, Behavioral Health*	*ESRD Medical Home*
Preventative Care	*Patient Advocates & Health Coaches*	*Group Visits / Specialist Collaboration: CHF, COPD, Diabetes*	*Long Term Home Care*
	Cross-functional Care Mgmt Team	*Post Discharge Clinic*	*Intermediate Home Care*
		Free Standing Infusion Centers & Wound Care	*Short Term Acute Care Transitions /Trauma Care*
		Welcome/ Wellness / Prevention	

Care Intensity

Patient Acuity

Everyday Care, Maternity & Pre-natal Care

Specialty Care Mgmt (Payment Reform); Chronic Condition Mgmt, Specialty Rx

Care Mgmt, Rx/Generics; Wellness; Preventative Care; Integrated Behavioral Health; Advanced Care Planning

Quality Improvement, Physician Engagement, Patient Experience & Patient Satisfaction

Promote Physician Excellence: 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…

Sickest patients referred to "Extensivist" model

Extensivist program allows PCPs to refer "high-risk" patients to the appropriate site of care

Physician able to allocate more time to "average" patients

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

Patient satisfaction improves

Patients receive concierge-level service and care from their primary care physicians which leads to improved satisfaction, loyalty, and word-of-mouth referrals

Physician profitability improves with managed care

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 patients to managed care

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

Stratify Patients and Provide Service

		Care Model Intervention
Stage 4 – High Acuity	• 3 admissions and 4 ER visits in 6 months • Unable to see Primary Care • Immobile • Oxygen dependent, Hospital bed • High admission rate • Potential Hospice referral • Wellness Visit to be completed • Assessment for Next Steps	• House Call Visit to address urgent needs • Educate family regarding After Hours number and Urgent Care available • Initiate discussion regarding Hospice and Palliative care • Complete Wellness visit and assessment for Care Plan
Stage 3 – Moderate Acuity	• 1 admission and 3 ER visits in 6 months • Able to mobilize and has seen Pulmonologist • Oxygen dependent	• Comprehensive Care Clinic visit • Complete Wellness Visit • Complete Assessment • Enroll in COPD Program and initiate education • Educate family regarding After Hours number and Urgent Care available
Stage 2 – Stable with Chronic disease	• 1 admission in 12 months	• Admit to COPD Program • Educate family regarding After Hours number and Urgent Care available
Stage 1 – Newly diagnosed	• Diagnosed with COPD	• Found on report with COPD diagnosis • Care Management - Outreach call to ensure patient has information on disease • Educate family regarding After Hours number and Urgent Care available •

Utilize Change Management Tactics for Buy-in and Rapid Speed to Market

agilon health and market leaders create the climate for change	• Create the understanding for urgency for rapid change • Ensure teams understand that change is not negotiable
agilon health and market leaders engage the market teams – leaders, front line, physicians – based on market	• Communicate frequently • Empower team for quick wins • Create funding for employees and management in the first year to facilitate rapid change, retain staff • Maintain motivated team of long term employees for market
Implement and Sustain	• Build on changes • Measure pre go-live and routinely post go live with program implementation • Report outcomes • Celebrate Success • Improve on areas with potential