

Accountable, Coordinated Care Organizations State of California 1115 Waiver Program

Stuart Levine MD MHA

Corporate Medical Director, HealthCare Partners

**Assistant Clinical Professor, Internal Medicine and Psychiatry, UCLA
David Geffen School of Medicine**



HealthCare Partners Delivery System

- **Full Risk and Capitation**
- **Physician Owned**
- **Centrally coordinated**
- **Regionally Driven**
- **Strong Medical Management Infrastructure**
- **Robust Business support units**
- **Long-term Win-Win Hospital Relationships**

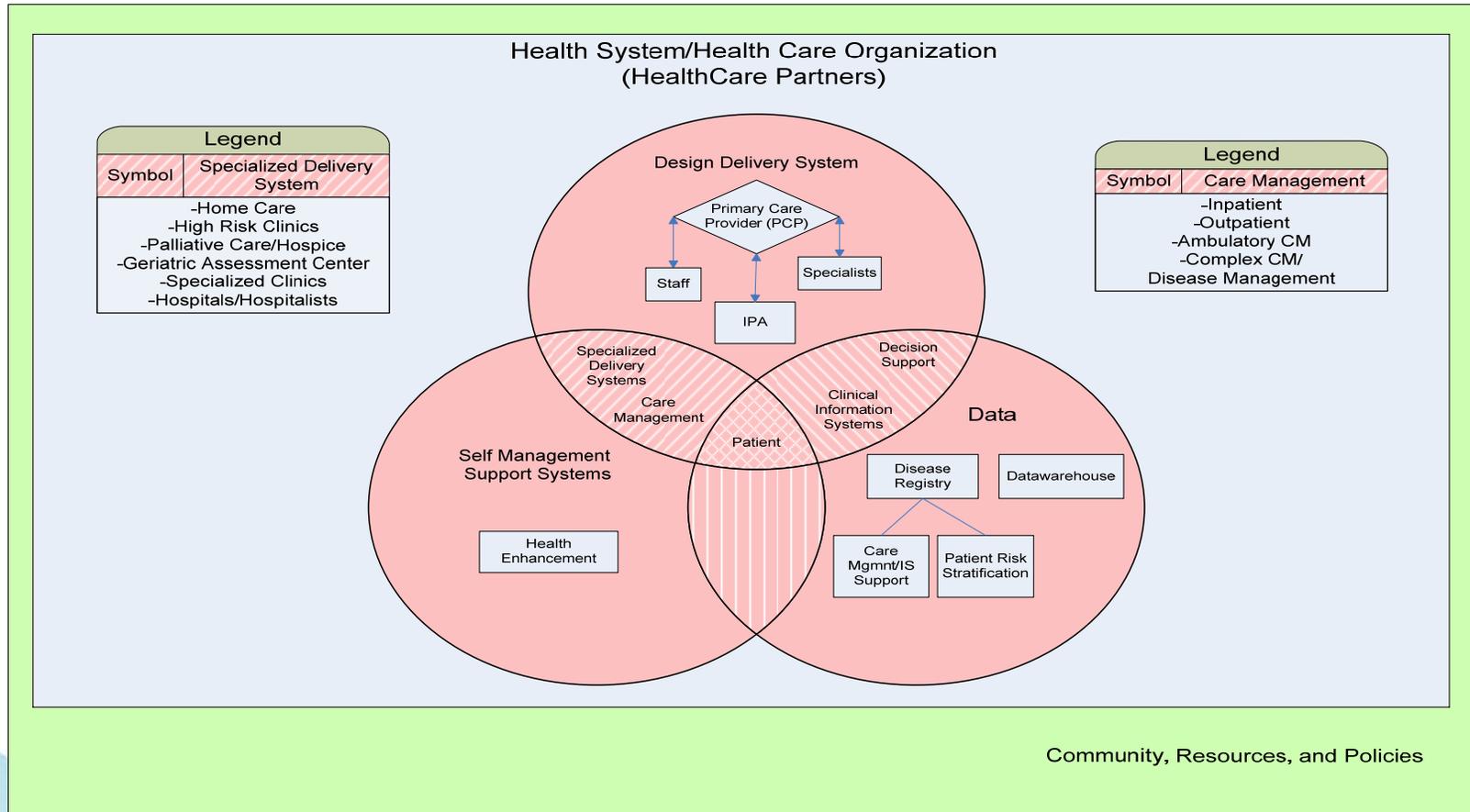
HCP Approach to Patients

- **Patient Centric- meet the needs of all patients**
- **Facilitate Access and Partnership with Patients and their families**
- **Not Benefit driven nor benefit demand mentality**
- **Right Care at the right time for the right medical situation**
- **Patient and Family Empowerment for their health**
- **Health Promotion, Education and Prevention**
- **Extensive Focus on Advanced Care Planning**
- **Build for the needs of Frail Seniors, Apply to All Patients**

Technology to Improve Care Coordination

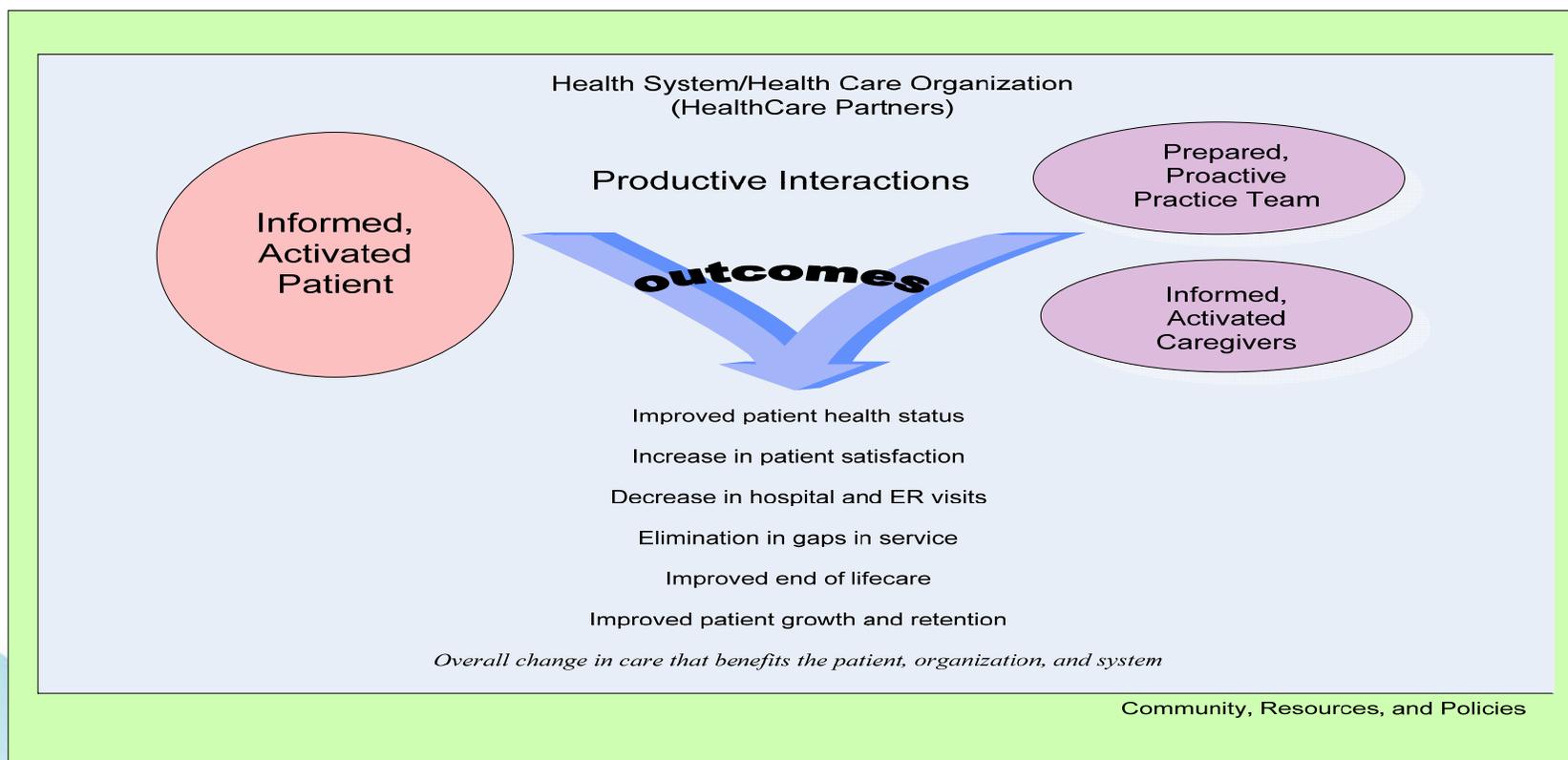
- **Electronic Medical Records and TouchWorks/ NexGen & CCMIS/ CM**
 - - Improved Communication
 - - Improved Documentation
 - - Protocol Driven Care ("Care Guides", embedded decision support tools)
 - - Disease Registry and Risk Stratification for Patients
 - - Patients for the Most Appropriate care
- **Use of the Internet**
 - - **PiP**- Physician Portal and **POP**- Patient Portal
 - - CME
 - - Patient and Family Access to Care and Education
- **Use of Home Technology**
 - - Home Monitoring of Patients
 - - Patient Education at Home
 - - Care Management "Eyes and Ears"

Chronic Care Model



EBM: Drives Chronic Care Model Outcomes Improvement

Chronic Care Model



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 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

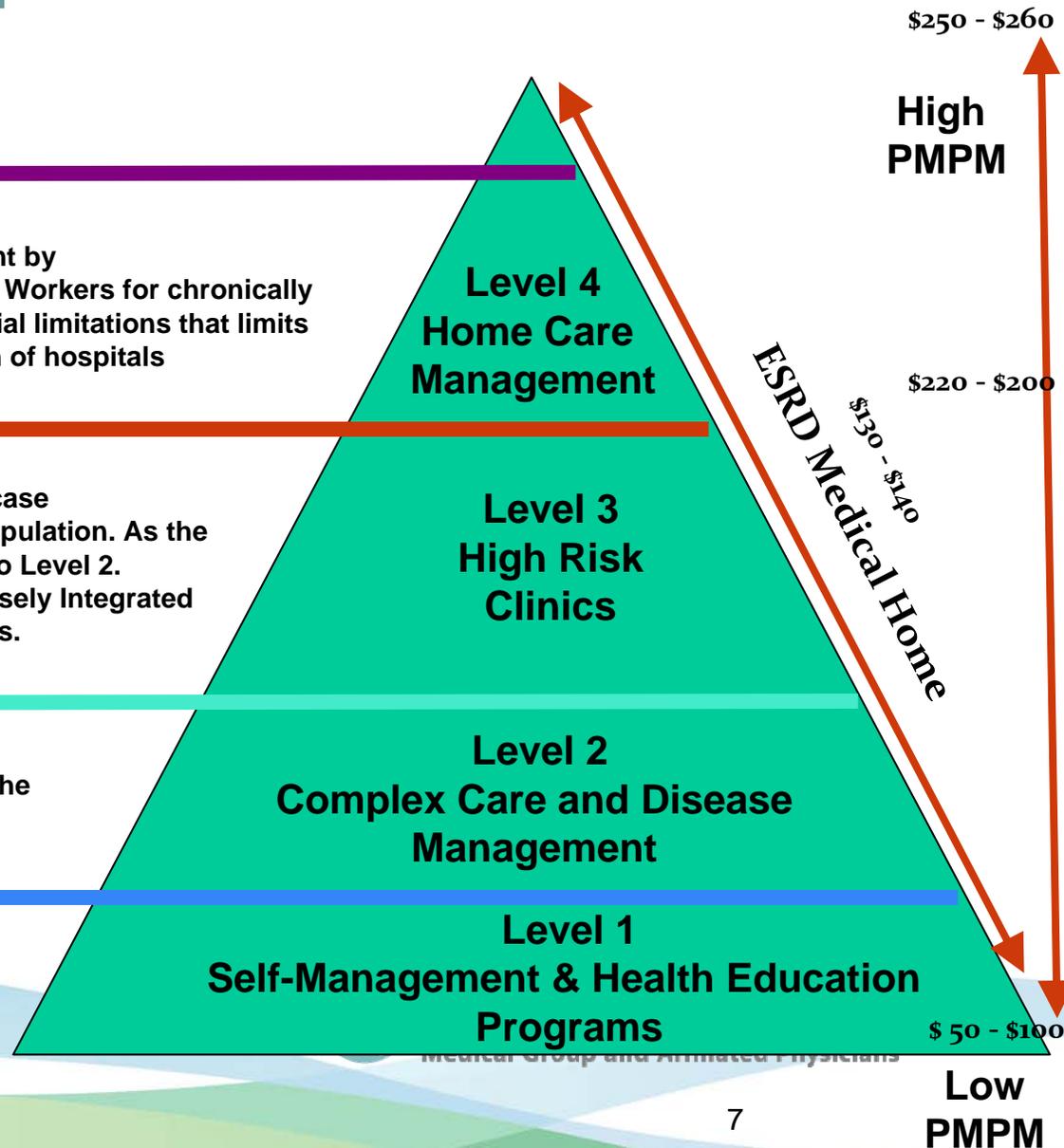
intensive one-on-one physician /nurse patient care and case management for the highest risk, most complex of the population. As the risk for hospitalization is reduced, patient is transferred to Level 2. Physicians and Care Managers are highly trained and closely Integrated into community resources and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

Complex Care and Disease Management

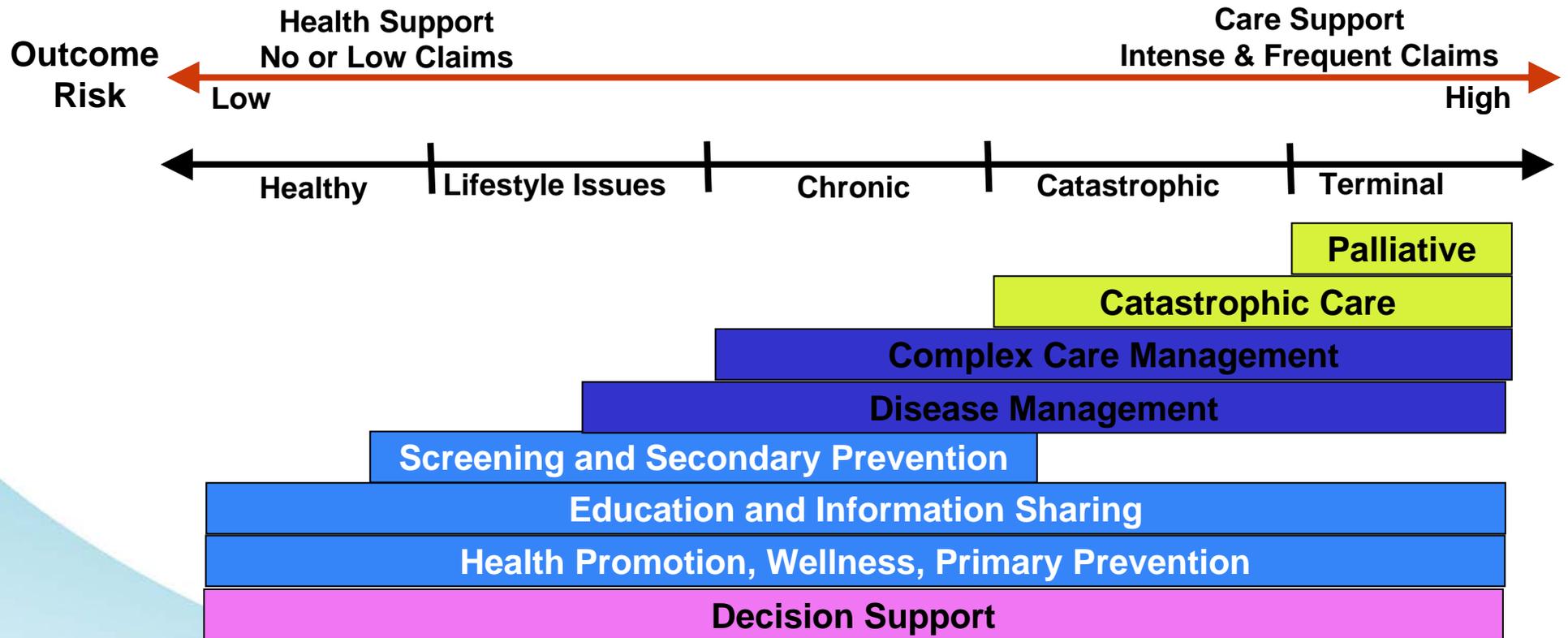
Provides long-term whole person care enhancement for the population using a multidisciplinary team approach. Diabetes, COPD, CHF, CKD, Depression, Dementia

Self Management, PCP

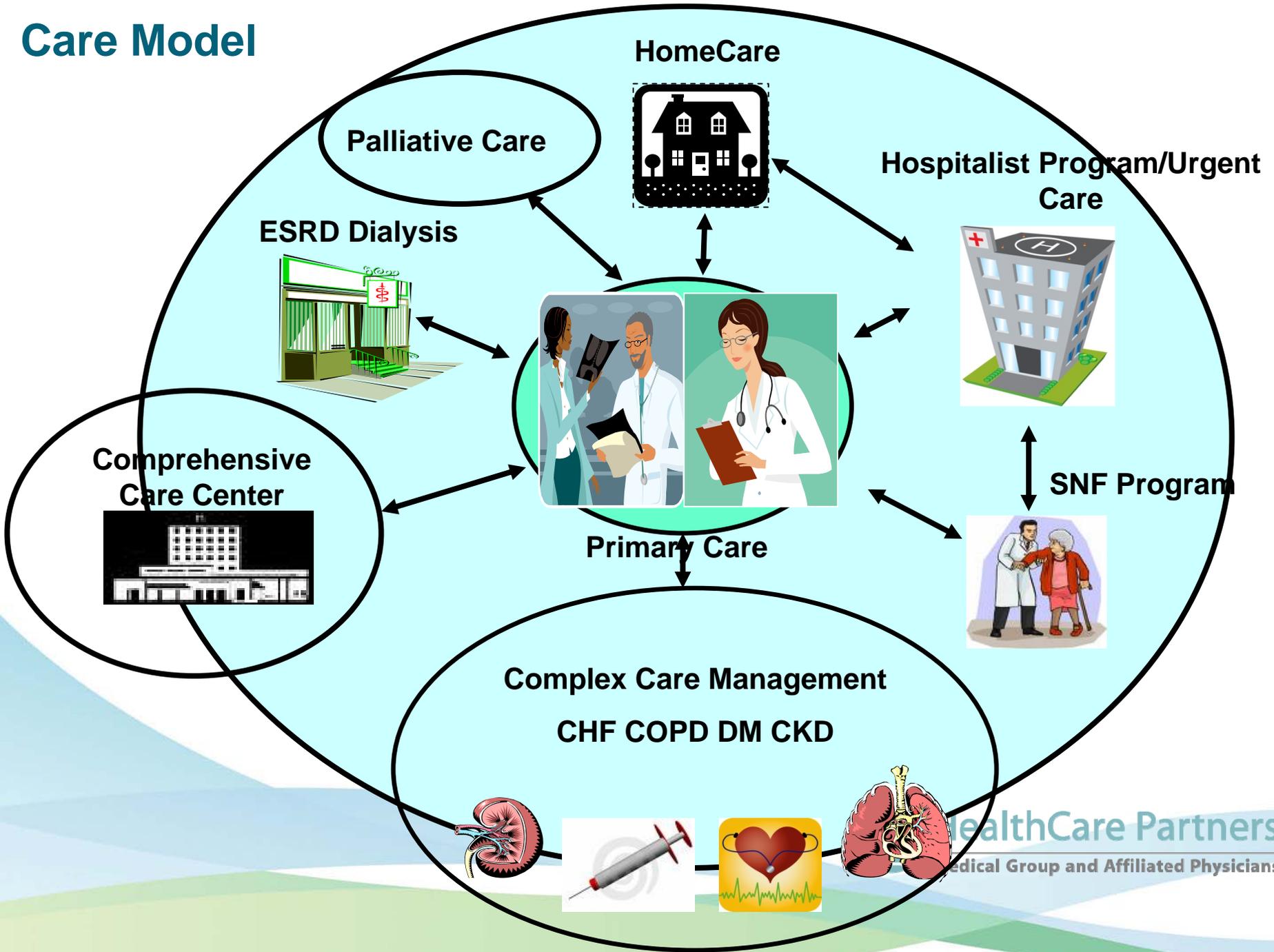
Provides self-management for people with chronic disease.



Programs Overlap



Care Model



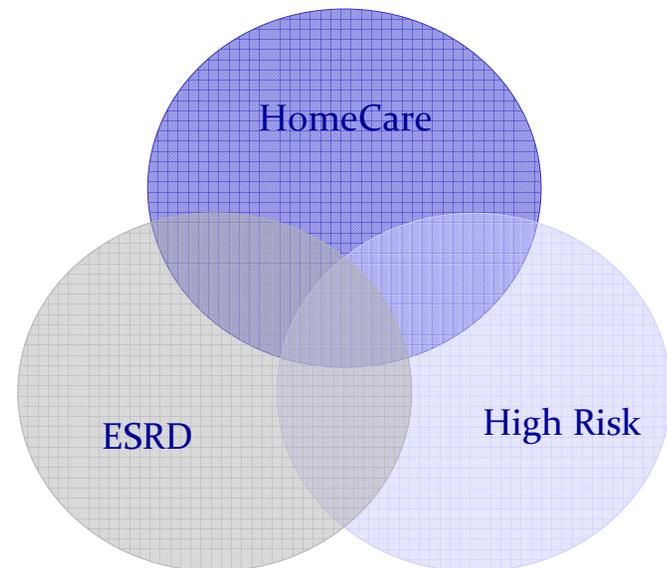
HealthCare Partners.
Medical Group and Affiliated Physicians

How do all Programs fit together?

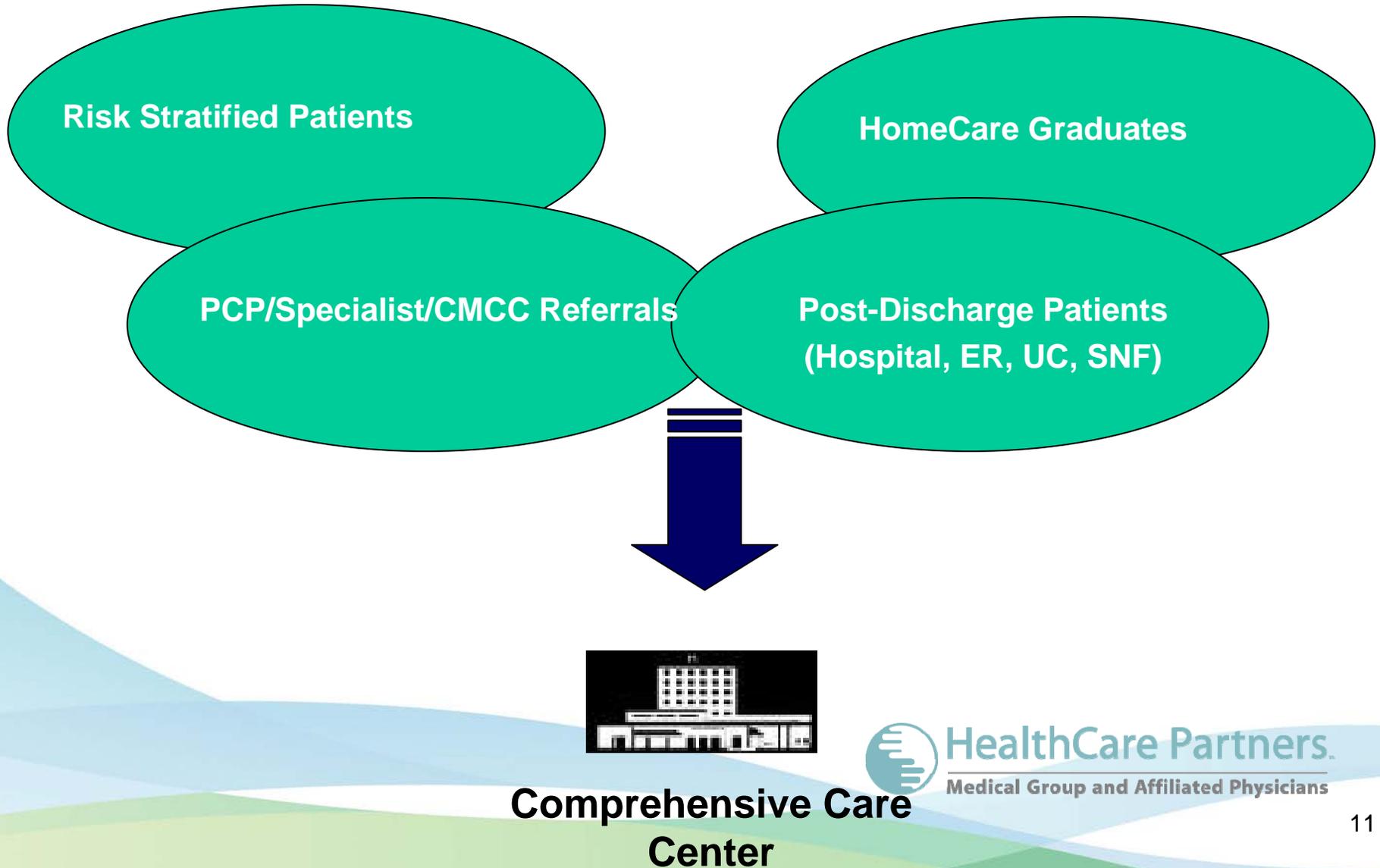
Before



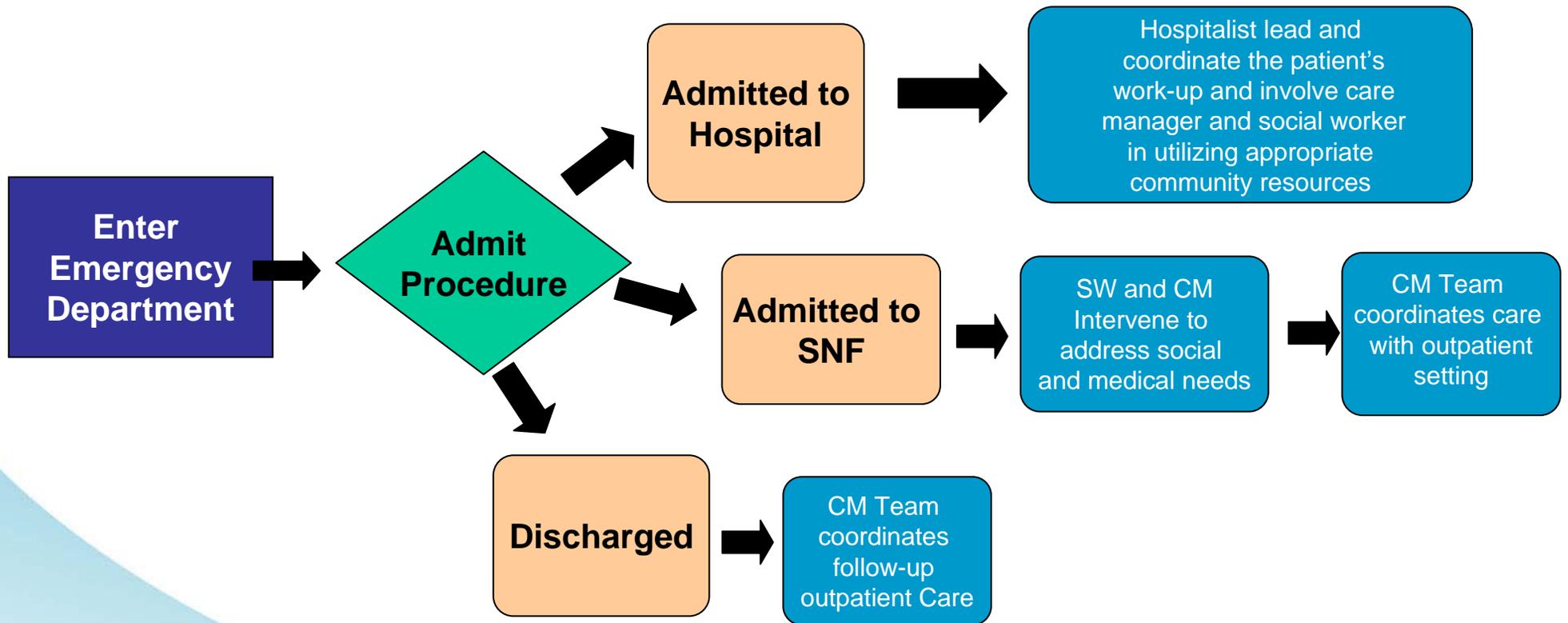
Integrated



Target Patient Population

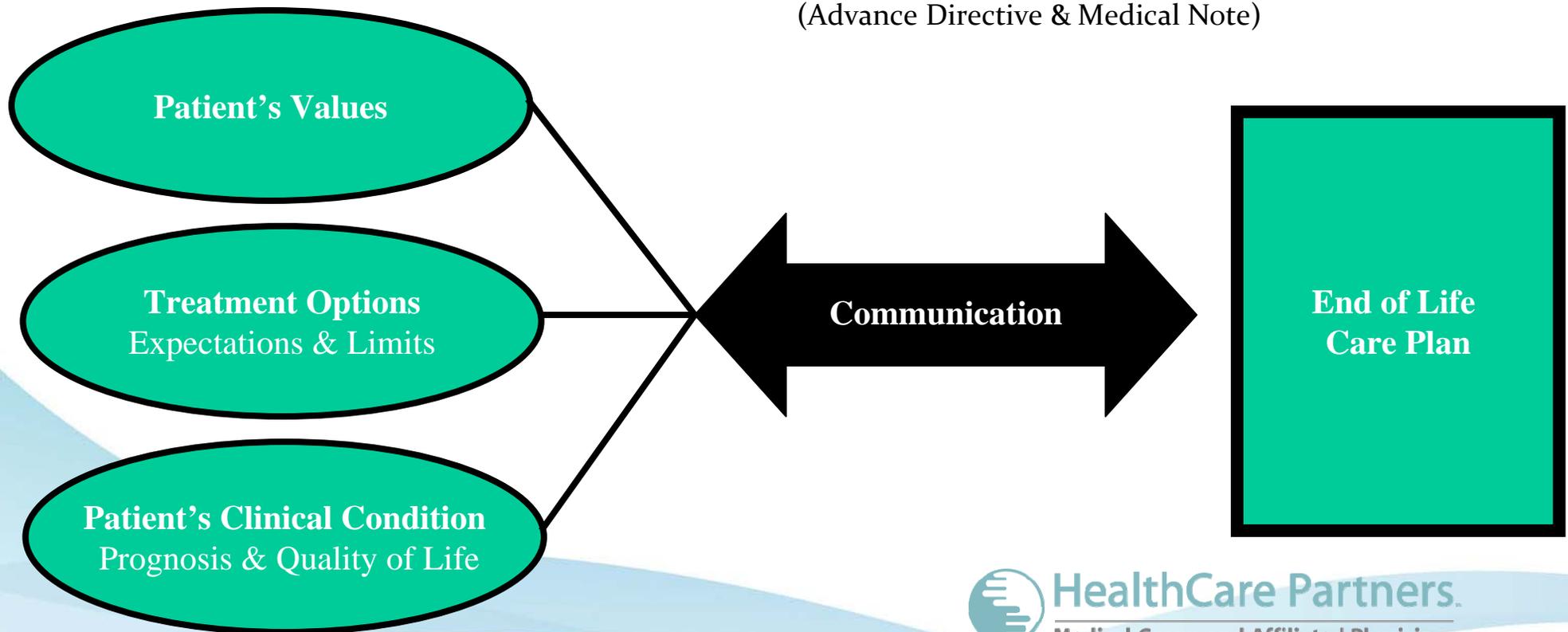


Hospitalist Program



Advanced Care Planning and Palliative Care

Improve Competency in End of Life Management
Focus on Goals of Care, Quality, & Dignity
Complete an Advance Care Plan
(Advance Directive & Medical Note)



Future Innovations

All of these innovations are planned and included for implementation for 2010 as a pilot in at least one region

- **PACE Program**
- **Hospice**
- **Palliative Care Program**
- **Electronic Home Monitoring**
- **Care Transitions to Care Management Areas**
- **Application of Risk Stratification of Patients and appropriate targeting of patients with clinical innovations**