Accountable, Coordinated Care Organizations
State of California
1115 Waiver Program

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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

Health System/Health Care Organization
(HealthCare Partners)

Legend
Symbol | Specialized Delivery System
---|---
-Home Care
-High Risk Clinics
-Palliative Care/Hospice
-Geriatric Assessment Center
-Specialized Clinics
-Hospitals/Hospitalists

Legend
Symbol | Care Management
---|---
-Inpatient
-Outpatient
-Ambulatory CM
-Complex CM
-Disease Management

Design Delivery System
Primary Care Provider (PCP)
Staff
IPA
Specialists

Self Management Support Systems
Care Management
Clinical Information Systems
Disease Registry
Care Mgmt/MS Support
Patient Risk Stratification

Data
Patient
Health Enhancement

Community, Resources, and Policies

HealthCare Partners
Medical Group and Affiliated Physicians
EBM: Drives Chronic Care Model
Outcomes Improvement

Chronic Care Model

Health System\Health Care Organization
(HealthCare Partners)

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Informed, Activated Caregivers

Improved patient health status
Increase in patient satisfaction
Decrease in hospital and ER visits
Elimination in gaps in service
Improved end of lifecare
Improved patient growth and retention

Overall change in care that benefits the patient, organization, and system

Community, Resources, and Policies
Stratifying Patients into the Appropriate Program

**Level 4**
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 limit access to outpatient care, forcing unnecessary utilization of hospitals.

**Level 3**
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, patients are transferred to Level 2. Physicians and Care Managers are highly trained and closely integrated into community resources and Physician offices or clinics.

**Level 2**
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

**Level 1**
Self-Management & Health Education Programs

**Hospice/Palliative Care**

**High Risk Clinics and Care Management**

**Complex Care and Disease Management**

**Self Management, PCP**
Provides self-management for people with chronic disease.
Programs Overlap

Outcome Risk

Health Support
No or Low Claims

Care Support
Intense & Frequent Claims

Risk Low High

Healthy Lifestyle Issues Chronic Catastrophic Terminal

Decision Support
Health Promotion, Wellness, Primary Prevention

Education and Information Sharing

Screening and Secondary Prevention

Disease Management

Complex Care Management

Catastrophic Care

Palliative
How do all Programs fit together?

Before

- HomeCare
- High Risk
- ESRD

Integrated

- HomeCare
- ESRD
- High Risk
Target Patient Population

- Risk Stratified Patients
- HomeCare Graduates
- PCP/Specialist/CMCC Referrals
- Post-Discharge Patients (Hospital, ER, UC, SNF)

Comprehensive Care Center
Hospitalist Program

Enter Emergency Department

Admit Procedure

Admitted to Hospital

Admitted to SNF

Discharged

CM Team coordinates follow-up outpatient Care

SW and CM Intervene to address social and medical needs

CM Team coordinates care with outpatient setting

Hospitalist lead and coordinate the patient’s work-up and involve care manager and social worker in utilizing appropriate community resources
Advanced Care Planning and Palliative Care

- Patient’s Values
- Treatment Options
  Expectations & Limits
- Patient’s Clinical Condition
  Prognosis & Quality of Life
- Communication
- End of Life Care Plan

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