GEISINGER
REDEFINING BOUNDARIES®

PREMIER

National Quality Award
2006 Award Recipient

Engineering the care delivery/management team across the continuum

Josh Bennett, MD, MBA
Principal, integrated care delivery
Premier healthcare alliance

Denise B. Prince, MBA, MPH
System vice president, value-based care
Geisinger Health System

ACO Congress
November 3, 2011

Roadmap for today's discussion

- Lessons from 100 accountable care assessments
- Geisinger case study
- Challenges
- Partnership between Premier and Geisinger: patient-centered medical homes

Introduction to Premier

A performance improvement alliance

Malcolm Baldrige National Quality Award 2006 Award Recipient

Uniting more than **2,500 hospitals** and nearly **76,000-plus other healthcare sites**

Quality Improvement	Cost Reduction	Risk Mitigation	Advocacy
Quality Measurement & Benchmarking, Safety Surveillance, Comprehensive Data	Group Purchasing & Supply Chain Improvement, Labor Management, Comprehensive Data	Liability, Benefits & Risk Management	Shaping policy and advocating for members

Execution Engine

Collaboration, Expertise, Results

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Premier's Collaborative Methodology™

The models and players can be very different

This is about more than just Medicare

STRUCTURES

- Integrated delivery systems/networks (IDN)
- Virtual physician organization
- Independent practice association (IPA)
- Multispecialty group practice
- Physician hospital organization (PHO)

PAYORS

Provider-sponsored Plans

- Geisinger Health Plan
- Presbyterian (NM) Health Plan
- Health New England (Baystate)
- SummaCare (Summa)
- Billings Clinic
- First Health

Private Plans

- Anthem/WellPoint
- HealthSpring/Bravo
- Cigna
- Coventry
- Medica
- United
- Aetna
- BCBS MT
- HMSA
- Horizon BCBS
- New West
- BCBS MA

Government

- CMS
- State Medicaid plans
- S-CHIP plans
- VA

Employers

- IBM
- Caterpillar
- Eastman Chemical
- UNITE HERE Local 54 representing:
  - Trump Entertainment Resorts, Inc.
  - Harrah's Entertainment
  - Hilton Hotels Corp.
  - MGM Mirage

**Source: Article by Stephen M. Shortell and Lawrence P. Casalino*

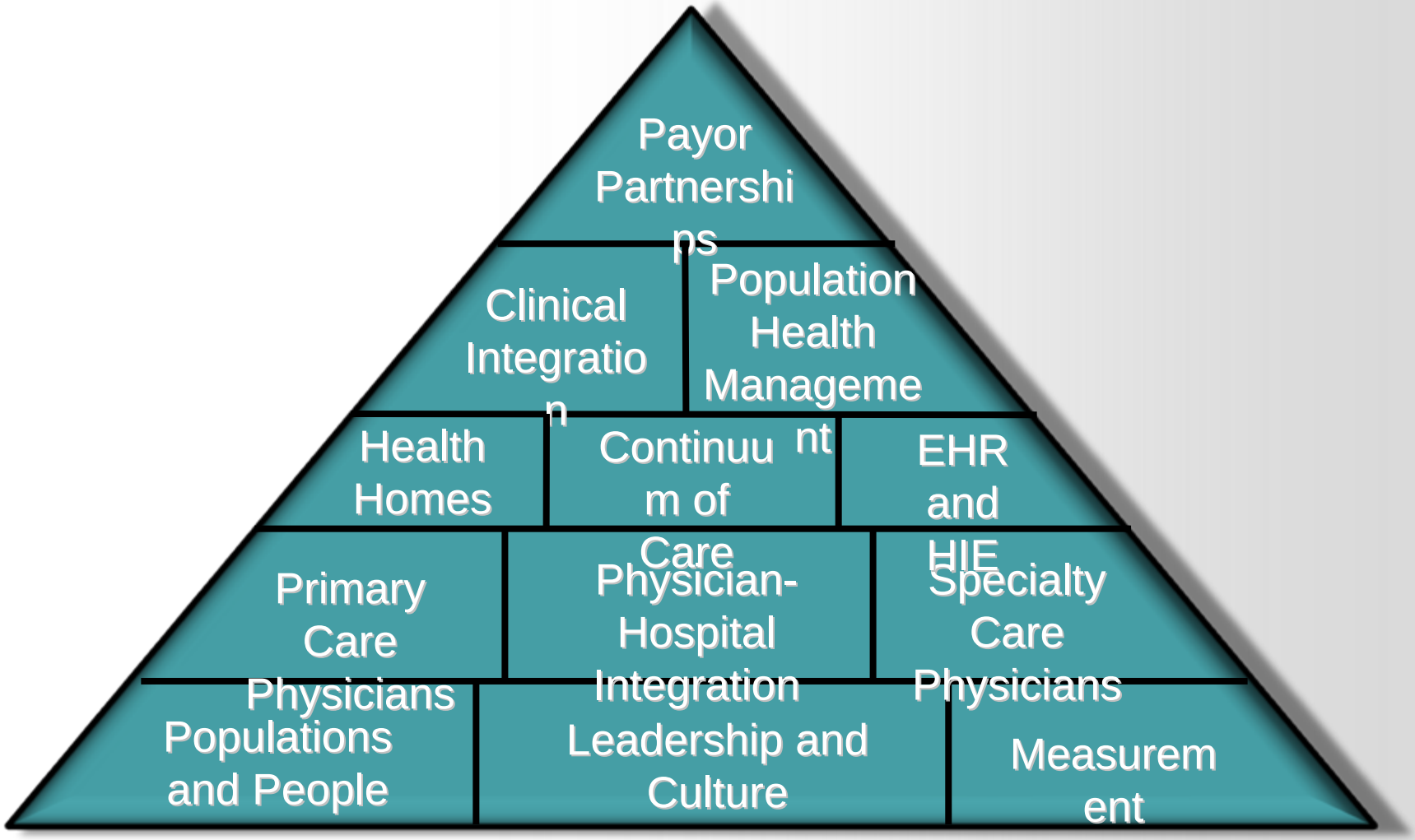
Premier integrated care operating principles

1. Integrated health care services are **centered on the people / population served**.
2. **Physician engagement and leadership are** critical success factors in implementing an integrated care system.
3. **Primary care services**, utilizing the health home delivery model, is the **foundation** for coordinating and facilitating care for the population and **physician alignment is the foundation for effectively integrating the health home** within the healthcare system.
4. **Promoting wellness and managing disease**, including chronic disease, for all patients across the continuum utilizing evidence-based care models is a **core competency**.
5. **Key metrics** (quality, outcomes, cost per capita, and the population's health status, satisfaction and engagement across the continuum) **are monitored** and actions are taken to improve the care and health of the population.
6. **Electronic health records are utilized & data exchanged across the continuum of care** for timely, seamless, quality and cost effective care delivery.

Integrated care operating principles *(cont.)*

7. Transforming healthcare organizations into organized delivery systems of care requires **well-aligned partnerships that clearly outline expectations of all providers** (e.g., physicians, hospitals, home health, behavioral health, etc.) to effectively deliver a full continuum of services.
8. **Partnerships with payor organizations and other administrators are necessary** to implement, evaluate, and manage the entire system of care.
9. All providers are engaged in a **culture of people-centered and team-based care** and provide clinical and administrative leadership across the continuum.
10. **Individuals are engaged in their care plans** and are actively involved in designing the care system and incentives to improve health and wellness.
11. **Health system leaders develop, communicate, and actively support the vision** of integrated care by ascribing to these operating principles, creating economic alignment and **transforming the organizational culture**.

Building blocks for integrated care



Building blocks for integrated care

#	Building Block
1	Define targeted **population**(s) and assess **people**'s needs, risks and costs
2	Develop and implement **leadership** structures and **cultural** alignment
3	Create **measurement** capacity to evaluate and model transformation impact
4	Recruit and engage **primary care physicians** to serve targeted population(s)
5	Establish **physician-hospital integration** to form authentic partnerships
6	Engage philosophically aligned and high value **specialty care physicians**
7	Build primary care **health homes** to coordinate care and support people
8	Engage a wide range of services across the **continuum of care**
9	Integrate **EHR and HIE** solutions to enable sharing of electronic health data
10	Forge **clinical integration** in care delivery processes across the continuum
11	Build and implement **population health management** capabilities
12	Develop **payor partnerships** on a foundation of shared benefit and value

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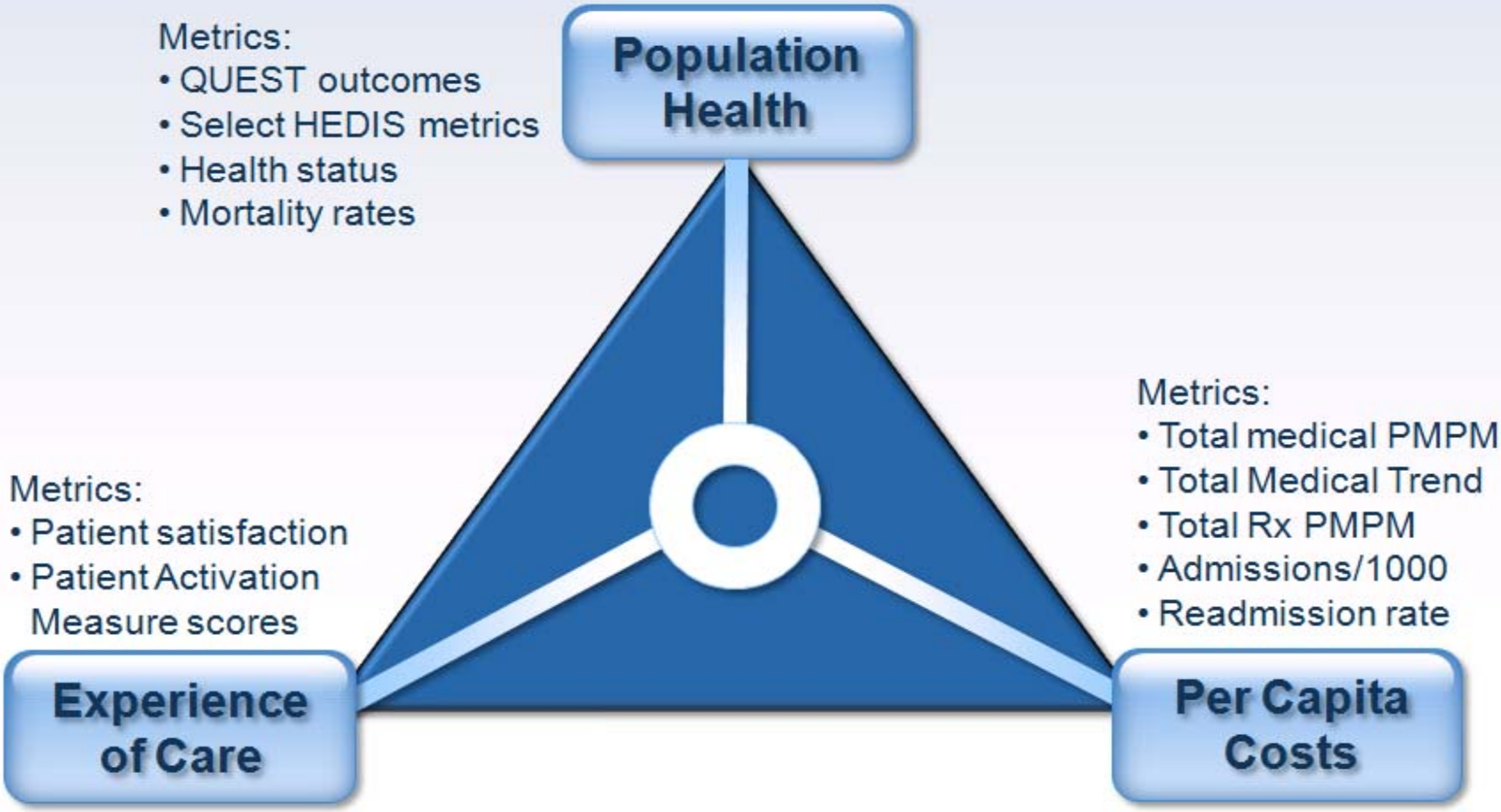
Definition of success:
Improving Triple Aim™ population outcomes

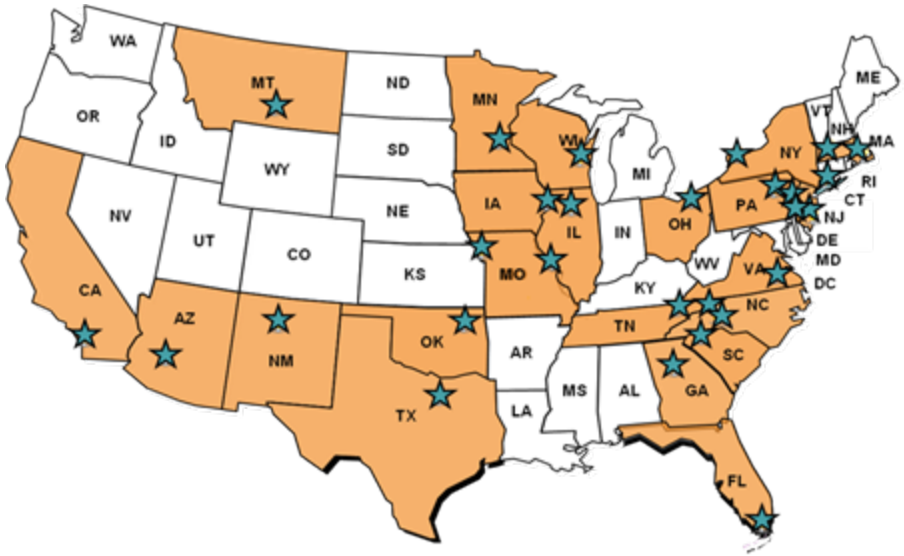


The term Triple Aim is a trademark of the Institute for Healthcare Improvement

Using lessons from HQID and QUEST
42 States collaborate to redesign care

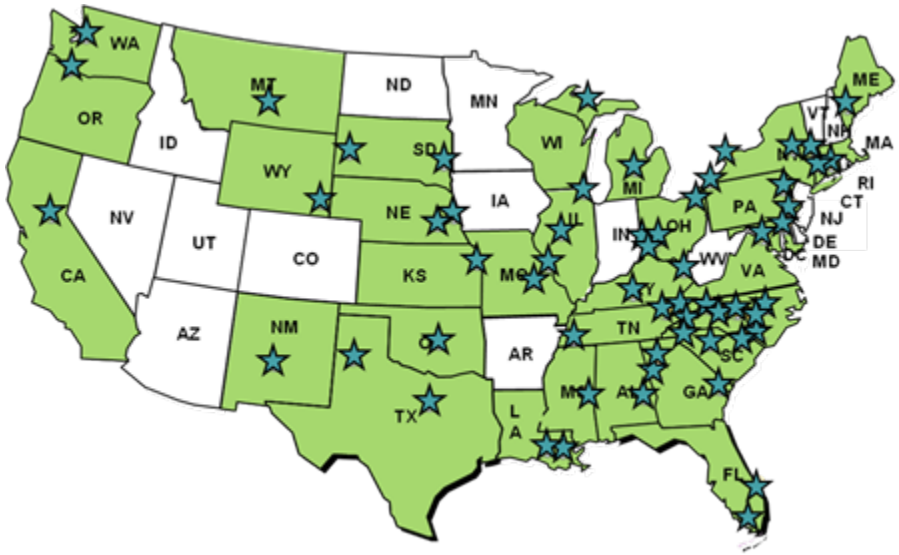
Partnership for Care Transformation

> IMPLEMENTATION COLLABORATIVE



28 systems in 29 markets representing 120+ hospitals, 5,000+ MDs and more than 1.5M accountable care covered lives

> READINESS COLLABORATIVE



67 systems in 86 markets representing 300+ hospitals, 12,000+ MDs and more than 3.6M accountable care covered lives

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Readiness assessments:
Qualitative vs. Quantitative

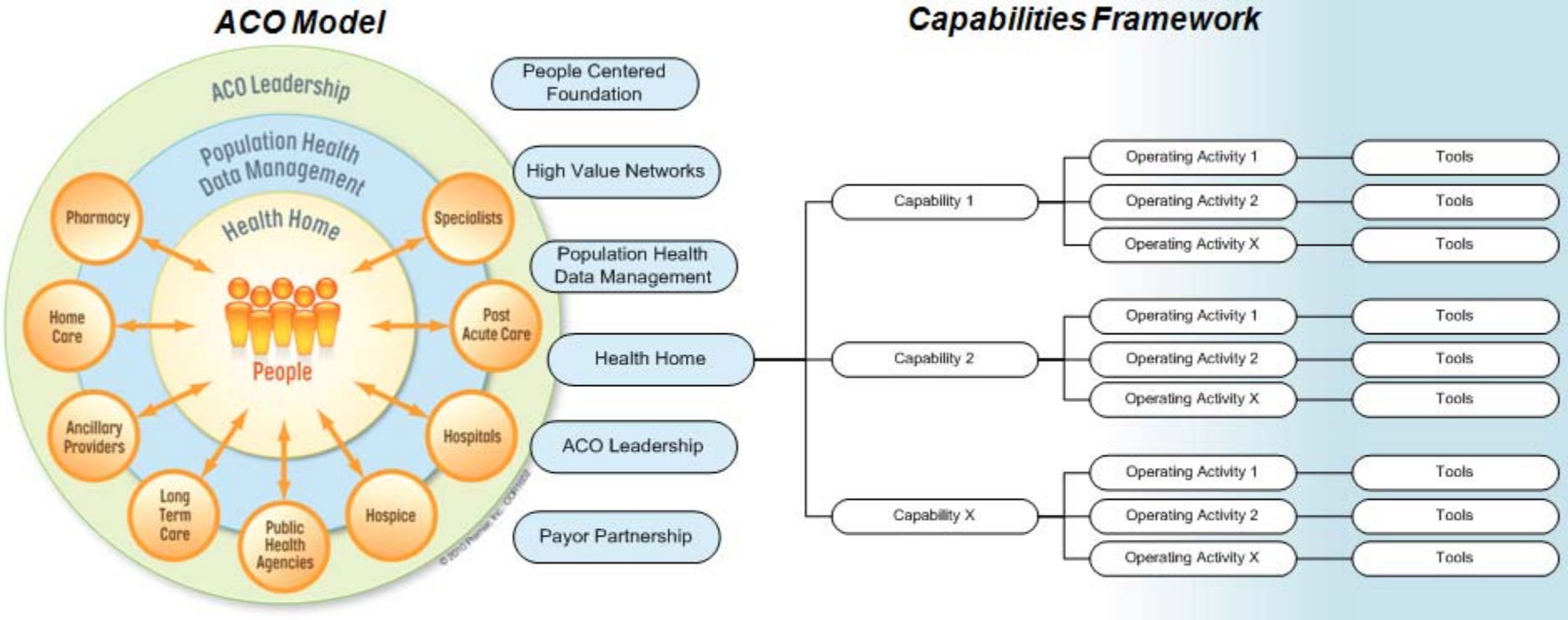
Qualitative Assessment

- A summary of key findings from a set of key open ended questions asked of a C-level representative (CEO, COO, CMO, CNO, etc), assessing their:
  - Market Environment
  - Organization Readiness
  - Strategic Commitment
  - Clinical Integration

Quantitative Assessment

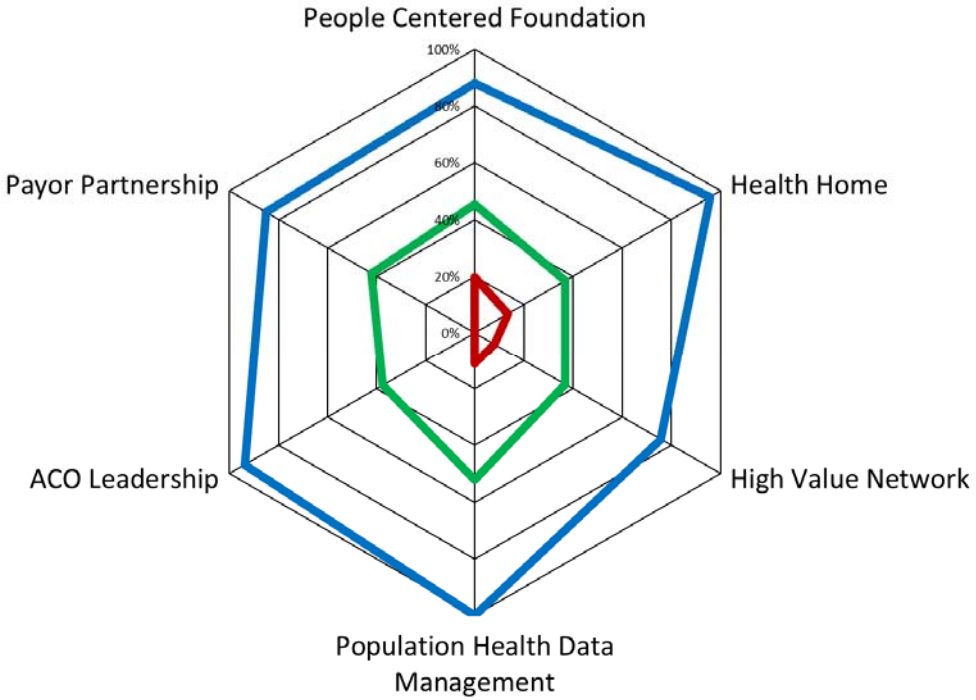
- For each of the six components:
  - Spider chart of assessment result for the component
  - Drivers for ACO development: top Priority Operating Activities for:
    - Readiness to negotiate contract with a Payor as an ACO (private or public)
    - ACO impact on the Triple Aim™ objectives
  - Brief qualitative summary of Readiness Assessment scoring results
- Attachment to report – Readiness Assessment Tool with scoring results

The capabilities framework

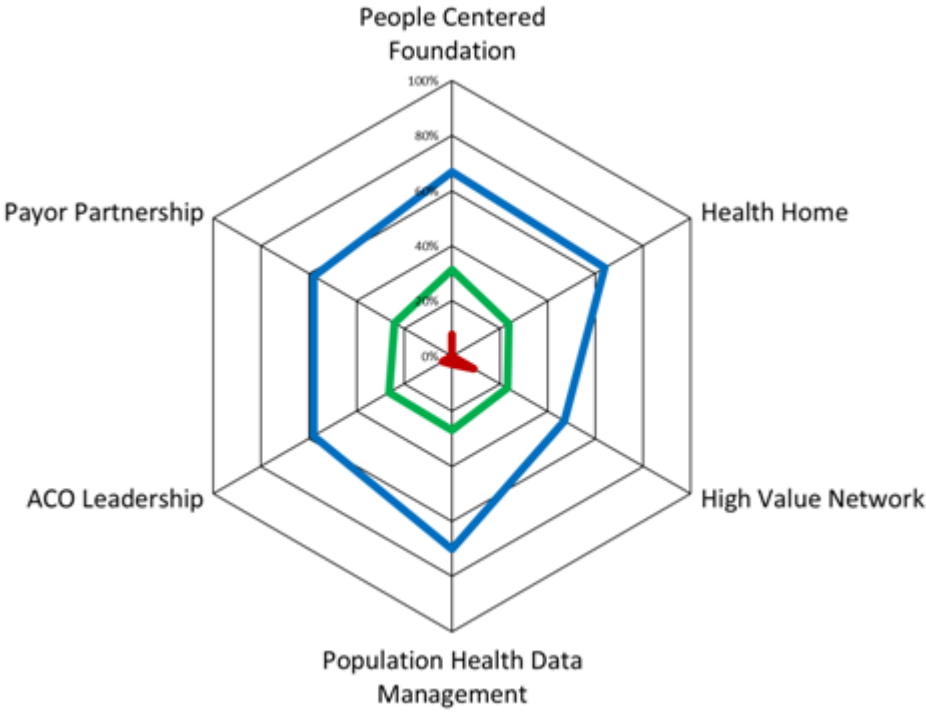


Partnership for Care Transformation
Baseline assessment

Implementation Collaborative Overall Assessment*



Readiness Collaborative Overall Assessment**



Blue = High
Green = Average
Red = Low

*Data from 24 markets
**Data from 51 assessments

Lessons learned:
Environmental assessment

- Start with environmental assessment

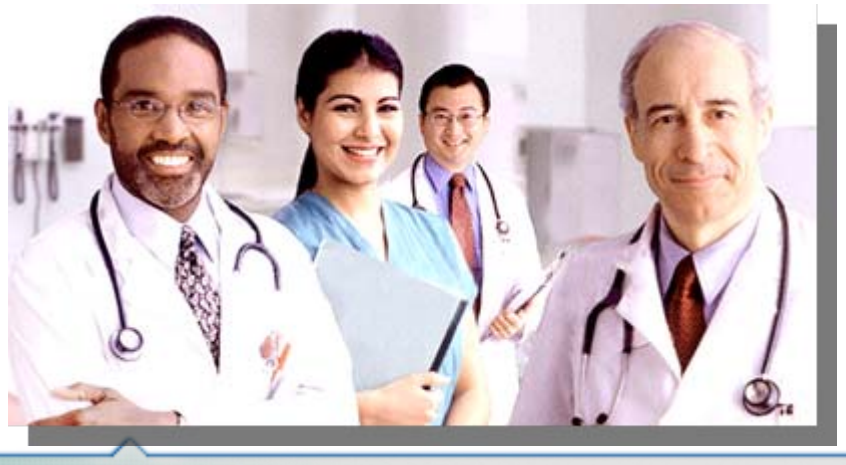
- Review available comparable data (external)
  - Quality (HQID / QUEST / CMS / HCAHPS / Other)
  - Cost / Payment (CMS)
  - Population Data / Cost, Utilization – Dartmouth Atlas

- Perform cultural assessment (internal)

Lessons learned:
Primary care network

- Health (Medical) Home

- Physician-Hospital Partnership
  - Physician Relations / Engagement
  - Physician Leadership Roles / Development
  - Primary Care and Specialists
  - Clinical Integration
  - Alternative Models



Lessons learned:
Clinical integration

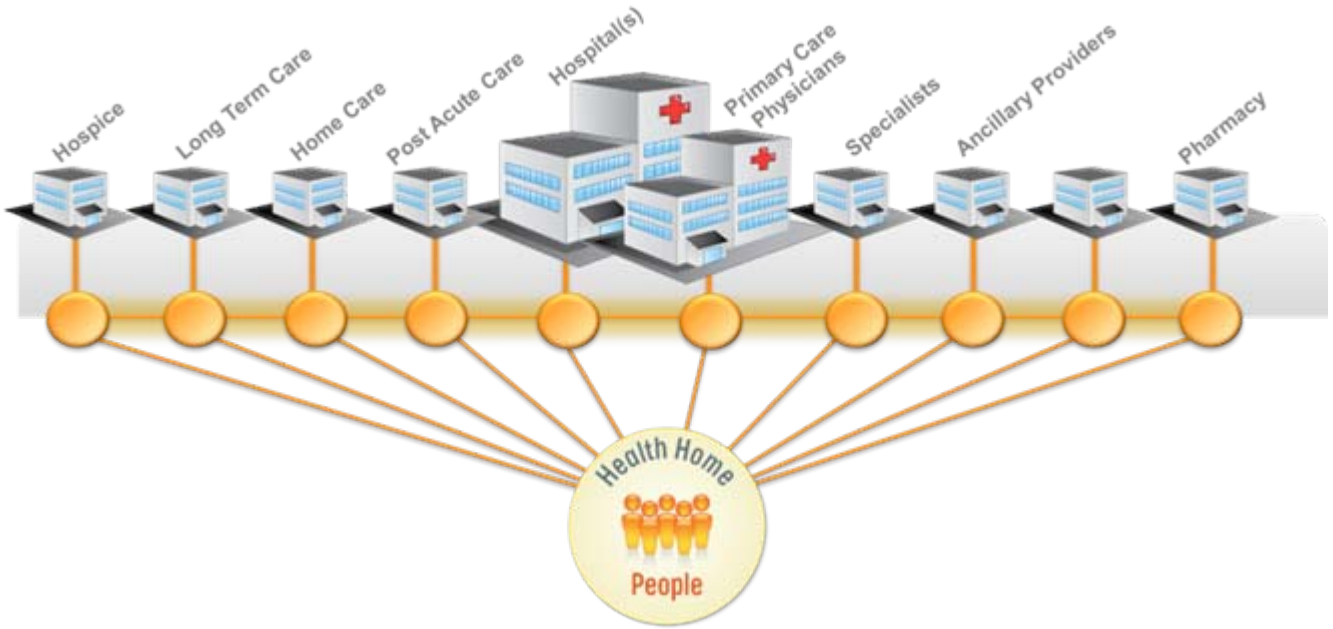
- Joint venture structure (mission, goals, etc.)
- Creates Interdependence/cooperation to control cost/ensure quality
- Ongoing Program evaluates/modifies practice (EBM) patterns
- Mechanism (pathways/care management) to monitor/control utilization/quality of services
- Selectively choose partners who further efficiencies
- Significant capital investment (IT) to realize efficiencies
- Joint payor contracting

Lessons learned:
Information technology

- Development of ACO IT Plan
- Implementation of Hospital EMR (including CPOE)
- Physician Office EMR alternatives
- Integrating the Hospital and Physician Office EMR
- Integration Engine or HIE?
- Population Measurement Health Data System
- Quality Measurement System (across the Continuum)
- Cost Measurement across the continuum
- Consumer Health Platform development

Lessons learned:
High value network development

- Owning vs. Contracting
- People Centeredness
- Coordinated Care Management
- Electronic Health Record (across the continuum)



Lessons learned:
Education / cultural transformation

- Accountable / Integrated Care Concepts (educate)
- Hospital vs. Population-Centric
- Physician-centric Culture
- Balance between Specialty and Primary Care

Lessons learned:
Payor partnerships

- Which population segments are we going to target?
- What role should the payor play (care management, etc.)?
- What criteria should we use to evaluate potential payor partners?
- What are the important areas in contracting with a payor?
    - Transparency
    - Timely and comprehensive data
    - Shared savings
    - Care management role

Engineering the Care Delivery/Management Team Across the Continuum

Denise B. Prince, MBA, MPH

System Vice President, Value-Based Care

November 3, 2011

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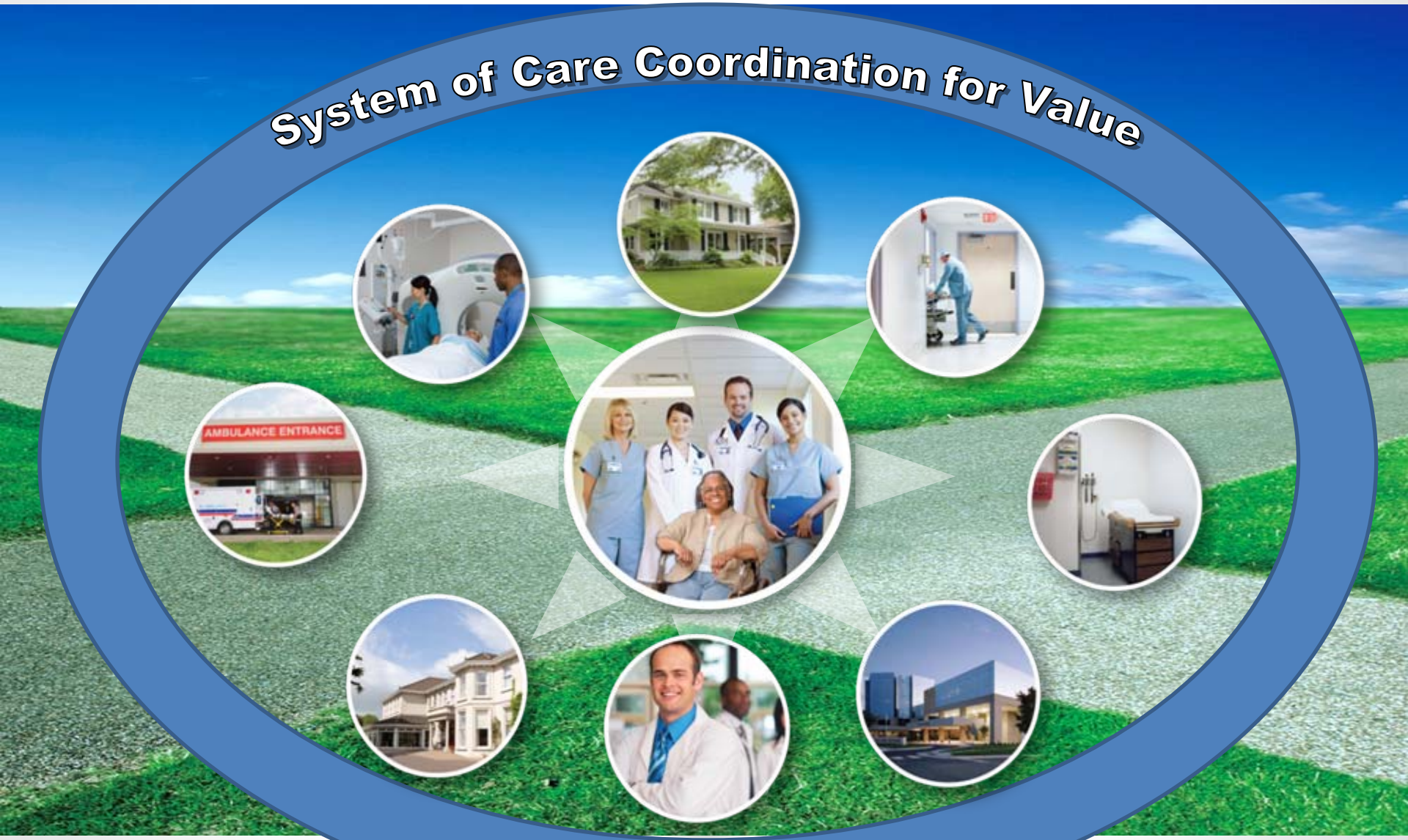
Partnering in the Accountable Care Organization



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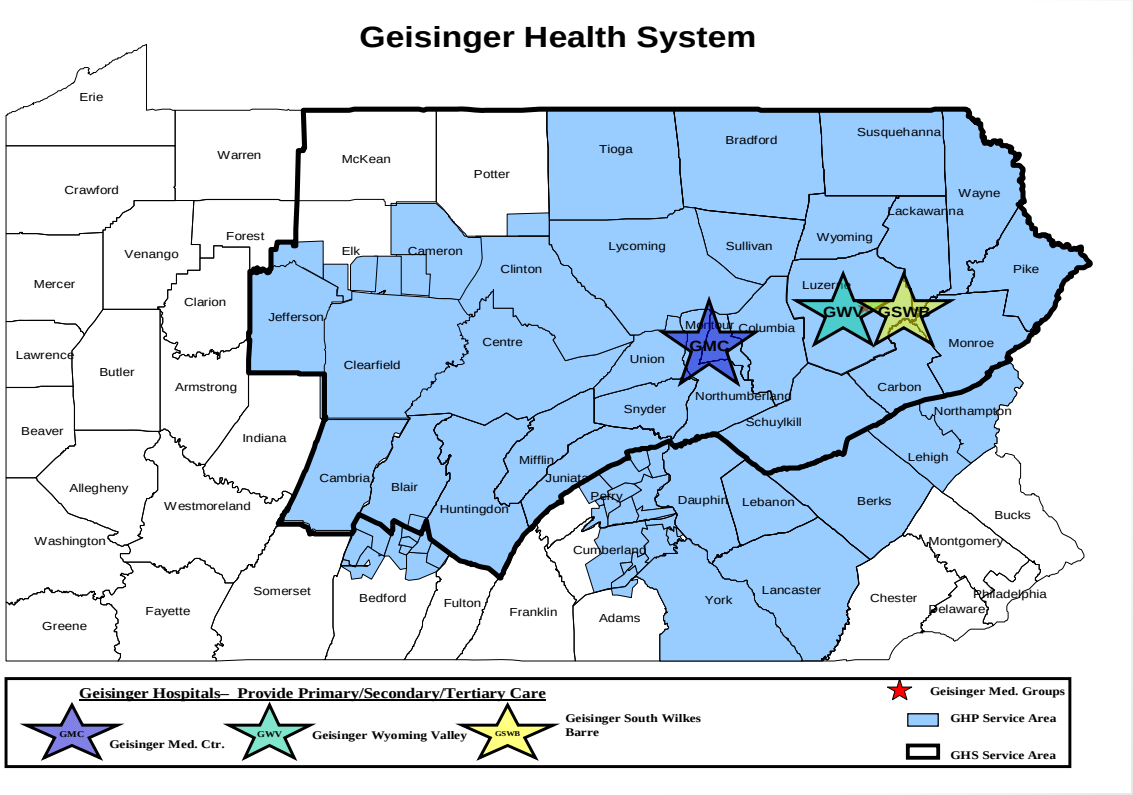
Intro to Geisinger

Geisinger, headquartered in Danville, PA, is an integrated health service organization serving central and northeastern Pennsylvania since 1915.



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Geisinger Background

Community Clinic Sites	**37**
Hospitals	**3**
Health Plan	**~250,000 members**
Employees	**14,408**
Physicians/Scientists	**799**
Nurses	**2,914**
Surgeries	**35,464**
Births	**3,131**
Beds	**819**
Revenues	**$2.7 Billion**
LifeFlight® emergency aeromedical service	**6 air ambulances**

Stats June 30, 2011

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Partnerships in Accountable Care

From the perspective of

- The Patient
- Primary Care Physician and Practice

Mrs. B

Dr. G

So Many Partners!

- Redesigned primary care team
- Insurer
- Hospitals
- Specialists
- Post Acute Providers
- Research
- Government

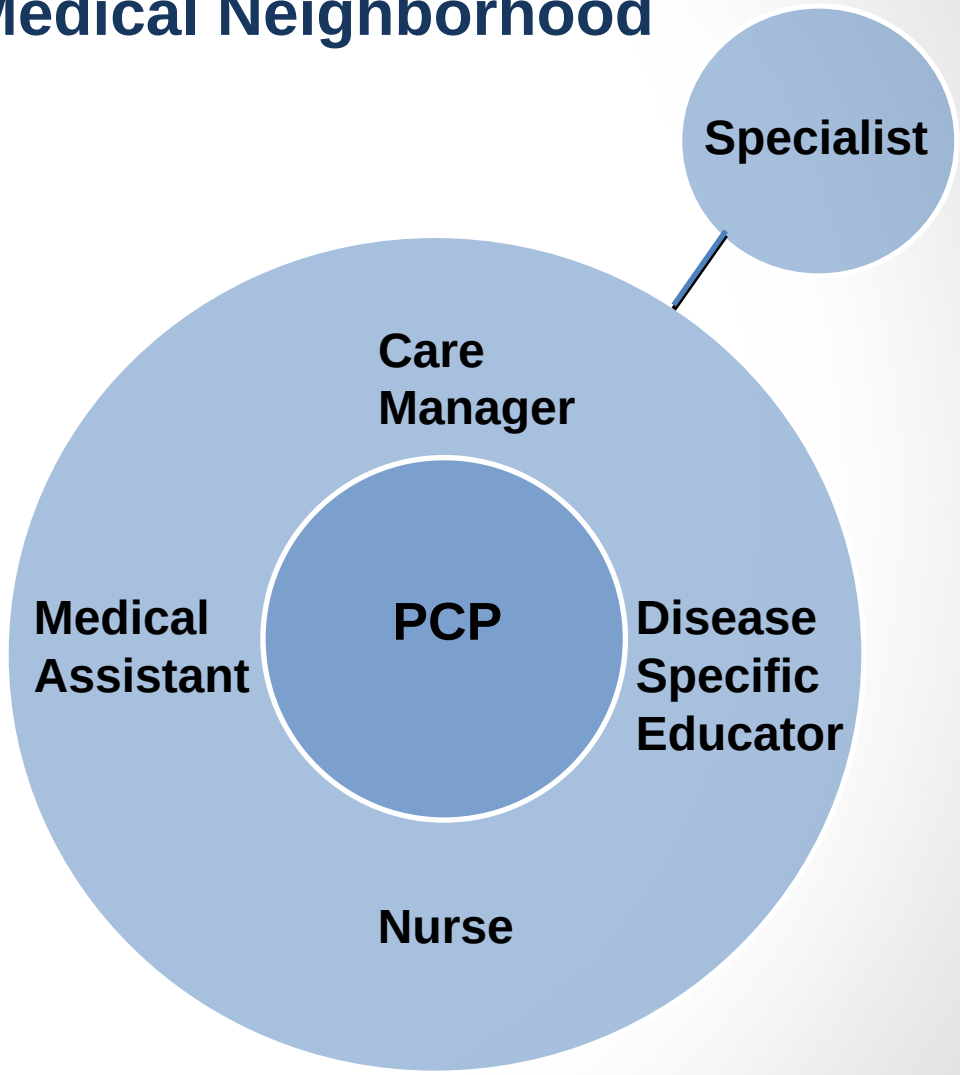
To Mrs. B, Getting Healthcare Services Used to Mean Seeing Her Doctor – One Partner

Mrs. B

Dr. G, her PCP

In an ACO, Mrs. B Partners with a Team Enabled by Technology ~ Her Medical Neighborhood

Mrs. B



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Mrs. B's Team Uses Technology to Help Her Stay Healthy Even Before She Steps into the Exam Room

Mrs. B

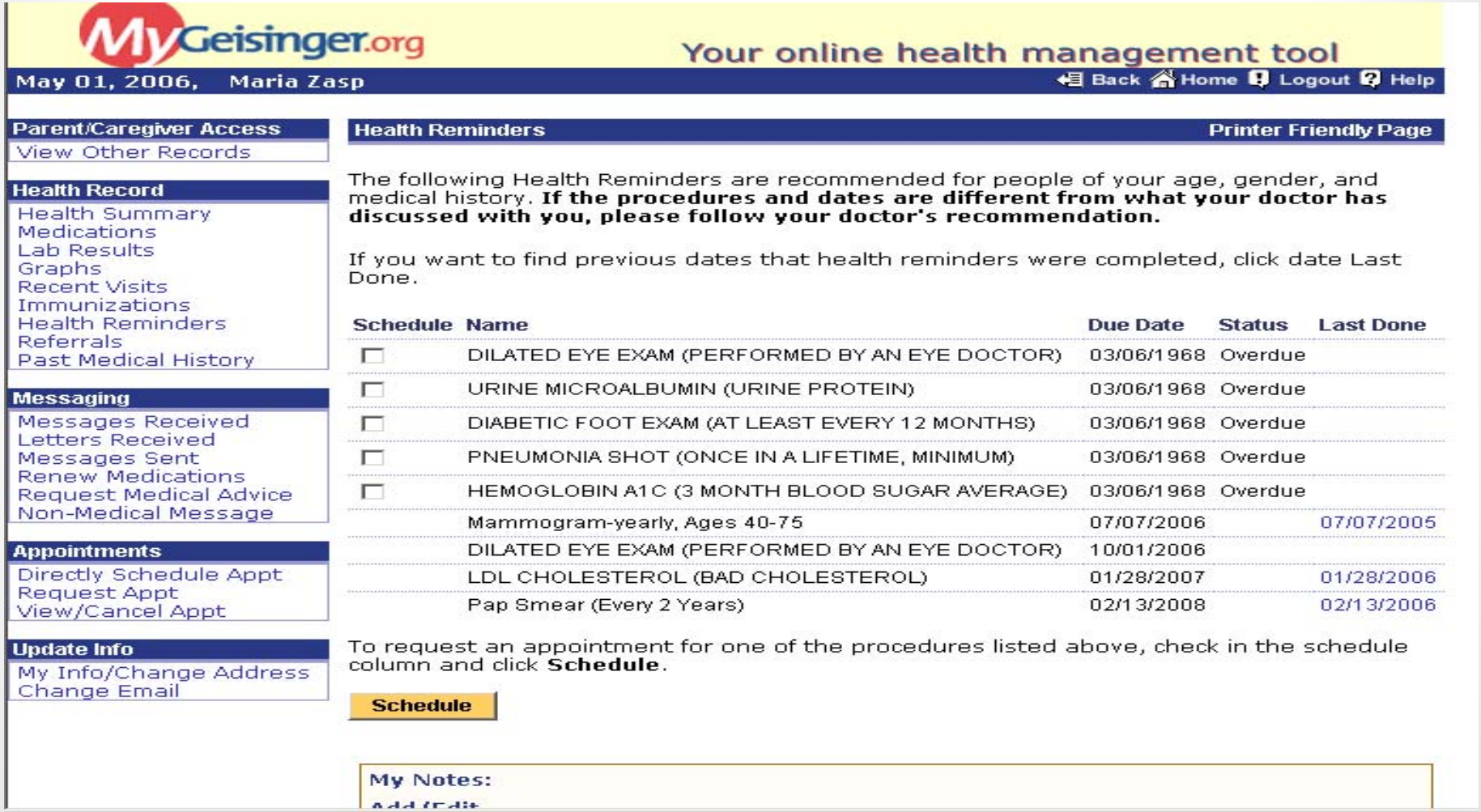
Access to her health record
- E-messaging
- Alerts
- Patient Education materials

Mail, phone interaction
- Birthday letter
- Interactive voice response

Technology in the PCP office
- Screenings
- Pre-visit health assessments
- Report cards

Telemedicine
- In-home monitoring (e.g. scale for CHF)

Mrs. B May Receive Alerts Through the Patient Portal



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Mrs. B is Asked for Information to Inform Her Care Plan

Patient data capture

- Patient reported outcomes
- Treatment adherence
- Preferences

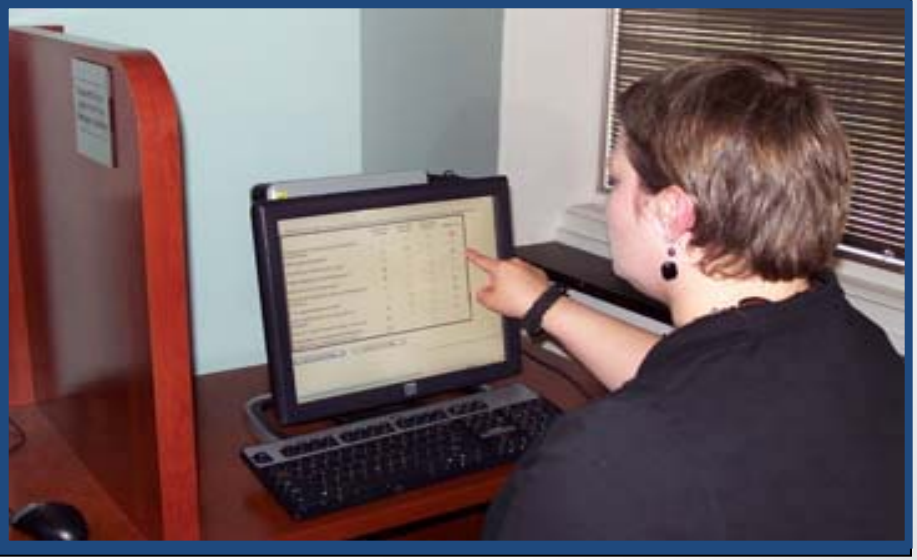
Process

- Completed in exam room
- Help button linked to instant messaging
- Status indicator

Uses

- Actionable data
- Guideline rules applied to data
- Visual display of advice
- Shared decision making
- Post-exam messaging

- Why are you here?
- What do you have?
- What do you want?
- How are you doing?
- What are you taking?
- How is your medicine working?
- What are your risk factors?
- What are your barriers to improving outcomes?
- … and the list goes on.



Mrs. B Completes E-forms Specific to Her Situation

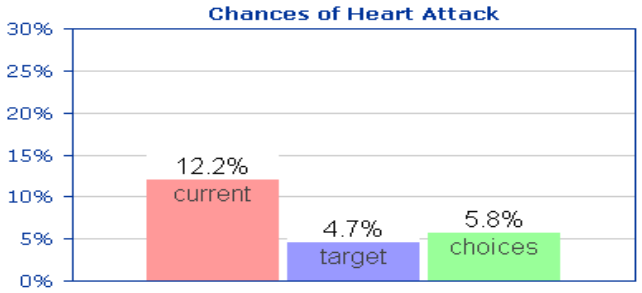
Geisinger Center for Health Research — *Our mission is to improve the efficiency and quality of health care to patients.* — eCVD

Welcome | Introduction | Instructions | **Blood Pressure** | Cholesterol | Smoking | Weight | Review | Record | debug

How do you want to lower your blood pressure ? Patient: 2

Your blood pressure may be higher than normal. Lower your blood pressure and improve your health by reducing your salt intake and increasing physical activity.

Choose up to 3 ways to lower your blood pressure. As you choose, the green bar will show you the benefit.



You currently have a **1 in 8** chance of a heart attack in the next 10 years.

The good news is, you could get your risk down to **1 in 21**

- [x] I want to take medication (one or more) to lower my blood pressure.
- [x] I would like to see a dietician to help me lower my blood pressure.
- [ ] I want to lower my blood pressure with a low fat diet that is high in fruits and vegetables.
- [ ] I want to lower my blood pressure with a low salt diet.
- [x] I would like to exercise to lower my blood pressure.
- [ ] I want to use one-on-one counseling to lower my blood pressure.
- [ ] I want to monitor my blood pressure at home.
- [ ] I want to use one-on-one Internet coaching.
- [ ] I do not want to do anything.

Submit for Review | Reset | Clear

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Mrs. B Receives “Take Home” Education

Patient	Age	Sex	MRN	Insurance	PCP	Today's Date
JOHN DOE	57	M	9876543	Geisinger Health Plan	YOUNG, DARA	9/29/2009

OUTCOMES GENERAL | OUTCOMES COMPOSITE | MONITORING | DEMOGRAPHICS | BEST PRACTICE | TODAYS VISIT CONSTRUCTION | TODAYS VISIT NOTE | TODAYS VISIT AVS

RHEUMATOLOGY FOLLOW-UP VISIT SUMMARY

For: John Doe

During my visit to the Geisinger Rheumatology Clinic on 9/29/2009, I saw Natasha Smith, RN. This note summarizes my rheumatic problems and how I am doing.

What Do I Have?

My medical record indicates that I have the following rheumatic conditions:

Rheumatoid Arthritis, or A chronic immune disease causing inflamed joints, and possibly affecting other body systems

Osteoporosis, or A disease of decreased bone strength and increased risk of fracture.

How Am I Doing?

We decide whether you are getting better by the measures summarized below that we decided were most important to you.

MHAQ - The MHAQ score tells me how well I am able to move and do my daily functions. This score ranges from a low of 0 to a high of 10. A value of 0 means I am doing very well. A value of 10 means I am functioning poorly.
Score Range: 0 to 10
My Goal: 1
My Score on 9/29/2009: 0.33
My Score on 5/1/2009: 0.33
Interpretation: My function score is about the same
Goal Met: yes

Pain - The Pain score tells me how much pain I am having. This score ranges from a low of 0 to a high of 10. A value of 0 means I am having no pain. A value of 10 means I am having a lot of pain.
Score Range: 0 to 10
My Goal: 3
My Score on 9/29/2009: 2
My Score on 5/1/2009: 3
Interpretation: My pain score is getting better
Goal Met: yes

What Should I Do?

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Mrs. B Receives "Take Home" Information

Last 2-3 values displayed

LDL values and goals

Last BP readings

Personal Diabetic Report Card: Abigail L George

4/28/2006

Below is a summary of relevant Diabetes values that we feel could help you manage your health better. Feel free to discuss this with your care provider.

HEMOGLOBIN A1C

Your most recent Hemoglobin A1c values are:

HEMOGLOBIN, A1C(%)

Coll Dt/Tm	Resulted	Value	Status
3/2/06 11:23A	3/2/06	6.6*	FINAL
11/21/05 4:21P	11/22/05	8.7*	FINAL

The above values should be **LESS than 7 (< 7)**. If these are more than 7 then you have a higher chance of having eye, kidney, and heart problems in the future.

CHOLESTEROL

Your most recent LDL cholesterol (bad cholesterol) results are:

LDL (CALCULATED)(mg/dL)

Coll Dt/Tm	Resulted	Value	Status
11/15/05 8:20A	11/15/05	110	FINAL

The above values should be **LESS than 100 (<100).** If these are consistently higher than 100, then your chance for heart attack and stroke increases yearly.

BLOOD PRESSURE

Your most recent Blood Pressure readings are:

Last 3 BP Readings:

Date:	BP:
04/28/2006	100/60
04/25/2006	140/80
03/02/2006	124/80

The above values should be **LESS than 130/80**. Contact me if your readings at home are consistently higher than this.

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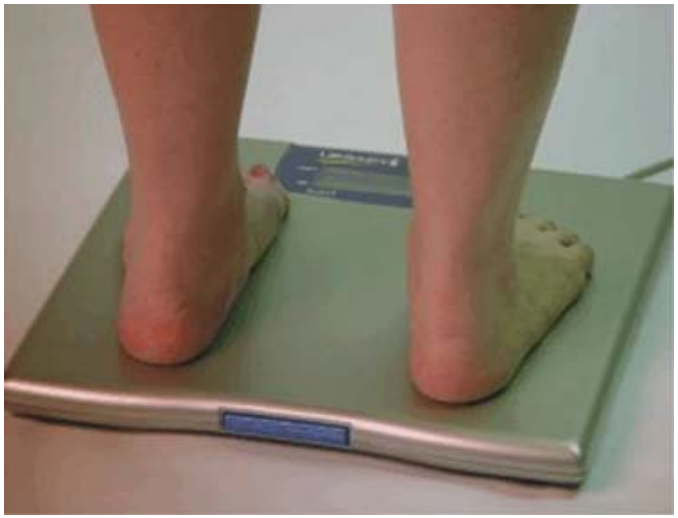
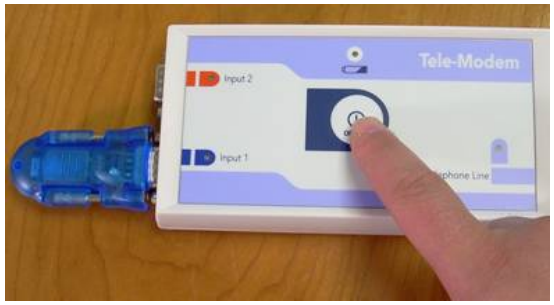
Mrs. B May Have Technology at Home





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When Mrs. B Visits Dr. G, a Whole Team of Health Care Partners Support Her Care

Some partners are visible to her, some are not

Partnering at the PCP Office

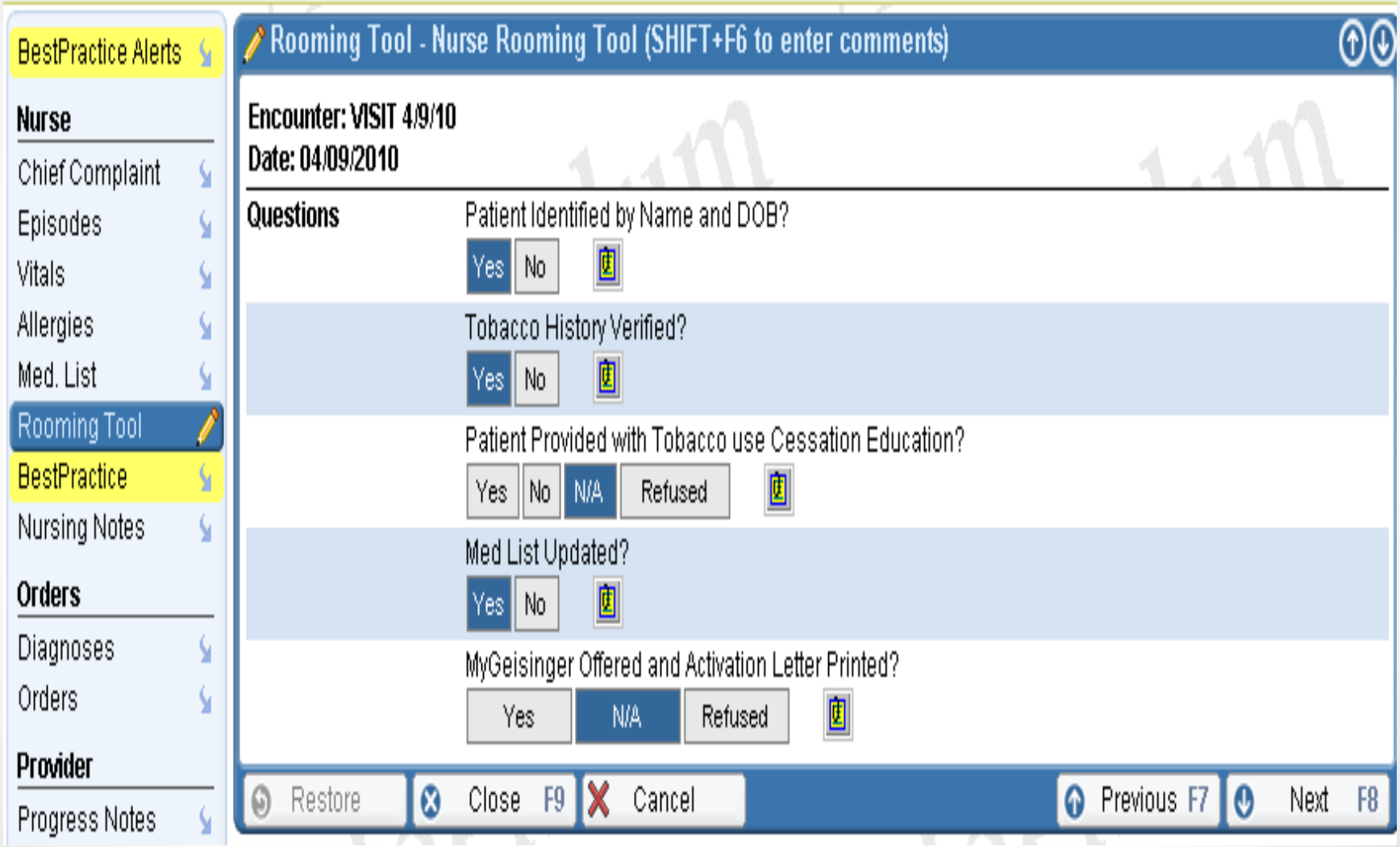
Dr. G

- Automate work that can be done outside of an office encounter
- Distribute work that is done at an office visit to trained non-physician staff when possible
- Create reminders and EMR tools to enhance the reliability and efficiency of care provided at the office encounter

Practice Partner: Medical Assistant / Nurse

- Educates about available tools – EHR
- Gathers data for visit
  - Medications
  - Heights / weights
- Implements standard protocols
  - Lab tests
  - Immunizations
  - Foot exam

Nurse Rooming Tool



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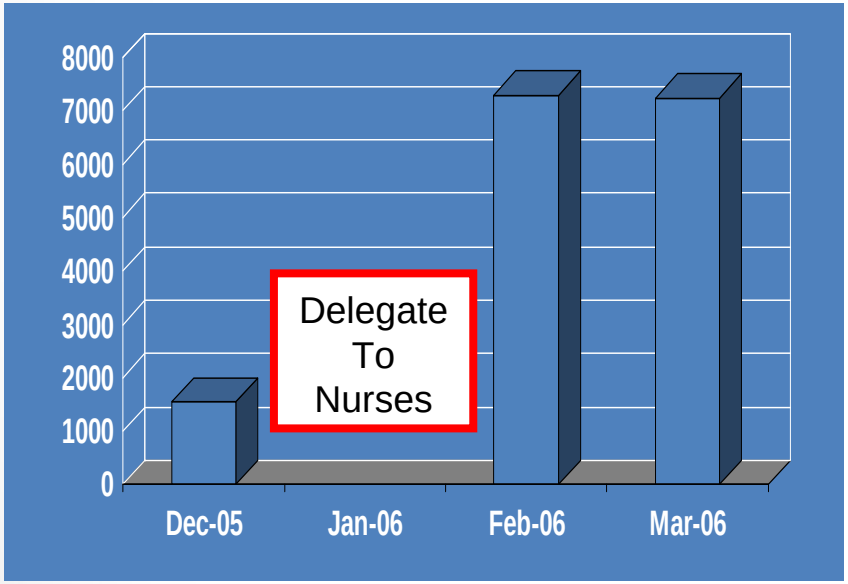
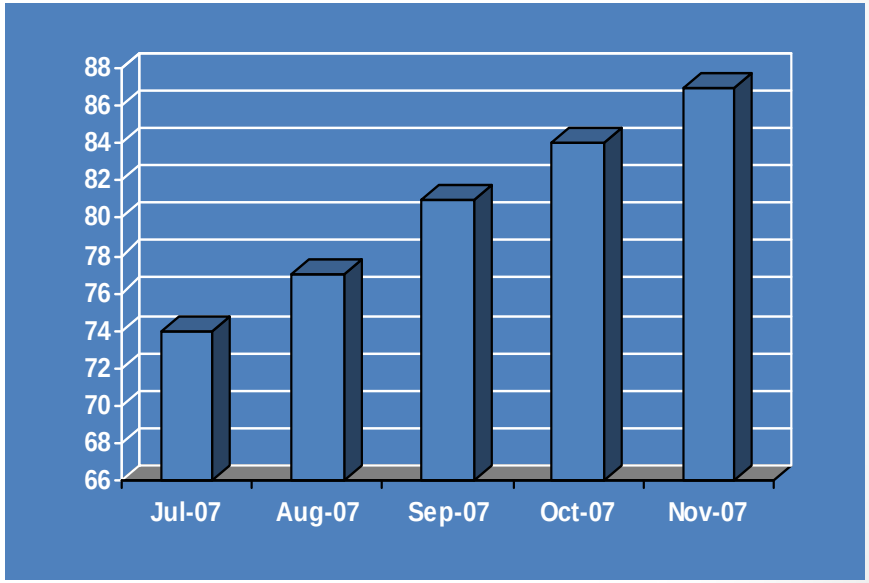
Nurse Rooming Tool Improvements

MyG Enrollments



Urine Microalbumin



Practice Partner: RN Care Manager

- Provides a personal link to the health care system
- Part of the primary care practice team

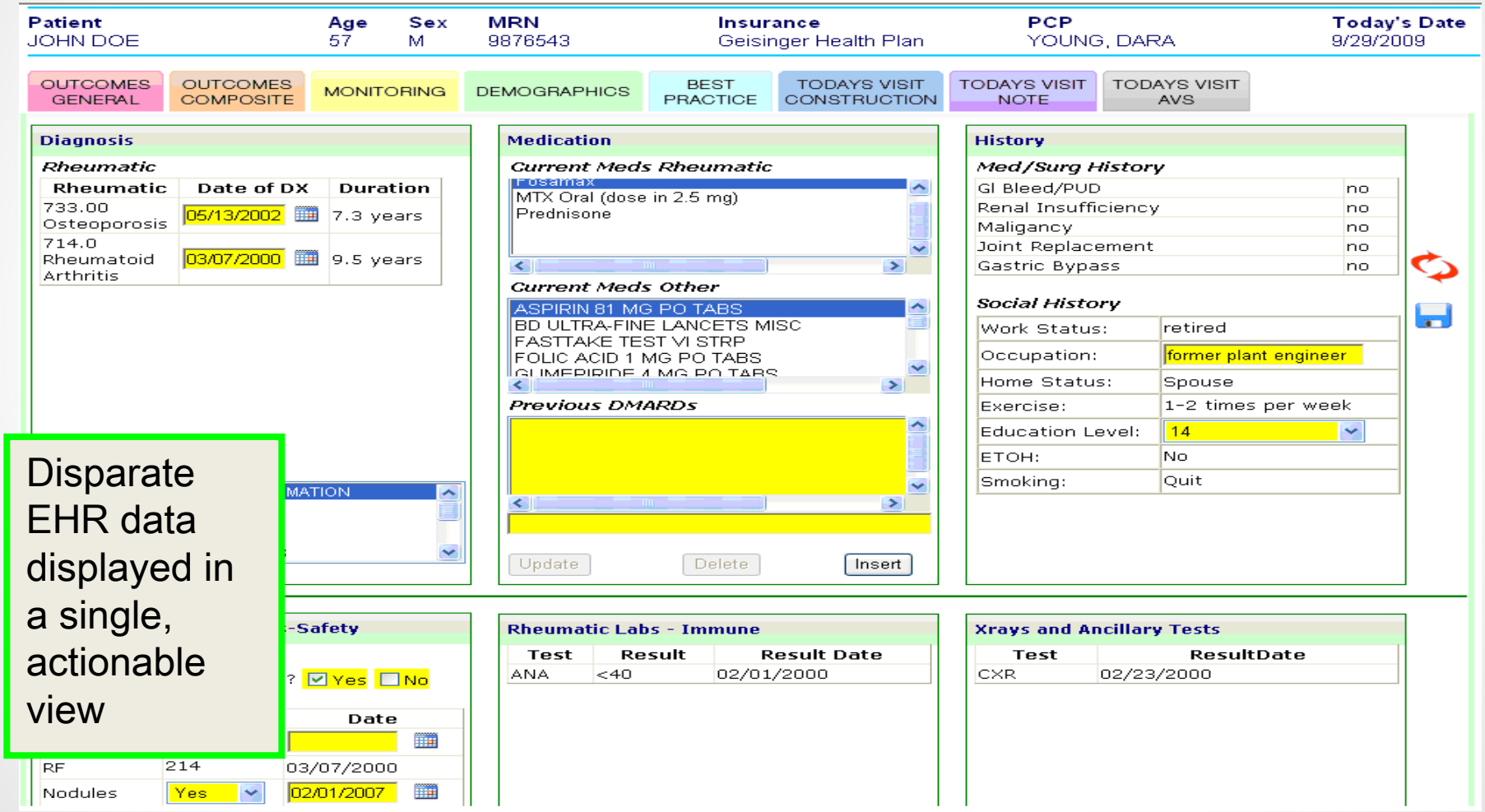
A Key Primary Care Practice Partner: Embedded Case Management

Personal Care Link	Embedded Case Manager	Recognized Team Member
Comprehensive Care Review – medical, social support	• **High risk** patient case load • 15 - 20% Medicare • 5% commercial • 125 - 150 pts per CM	Regular follow-up of high risk patients
TOC follow-up – acute care, SNF, ED	• 1 CM per 800 Medicare lives • 1 CM per 5000 commercial lives	Facilitates access – PCP, specialist, ancillary
Direct phone access – questions, exacerbation protocols	• Not disease management focused • Focus on those at most risk • Focus on driving issue within the case	Facilitate special arrangements – home care, hospice, AAA
Patient, family support contact		Links health care team to payer

Dr. G's Practice Works Closely with Partners from IT

- Integrated visual display tools
- Decision support
  - Health Maintenance Alerts
  - Best Practice Alerts
- Patient registries
  - Identify Care Gaps
  - Report on progress
- Health Information Exchange

Tools: Working with Outcomes Research, Better Visual Displays Help Physicians be More Productive



Disparate EHR data displayed in a single, actionable view

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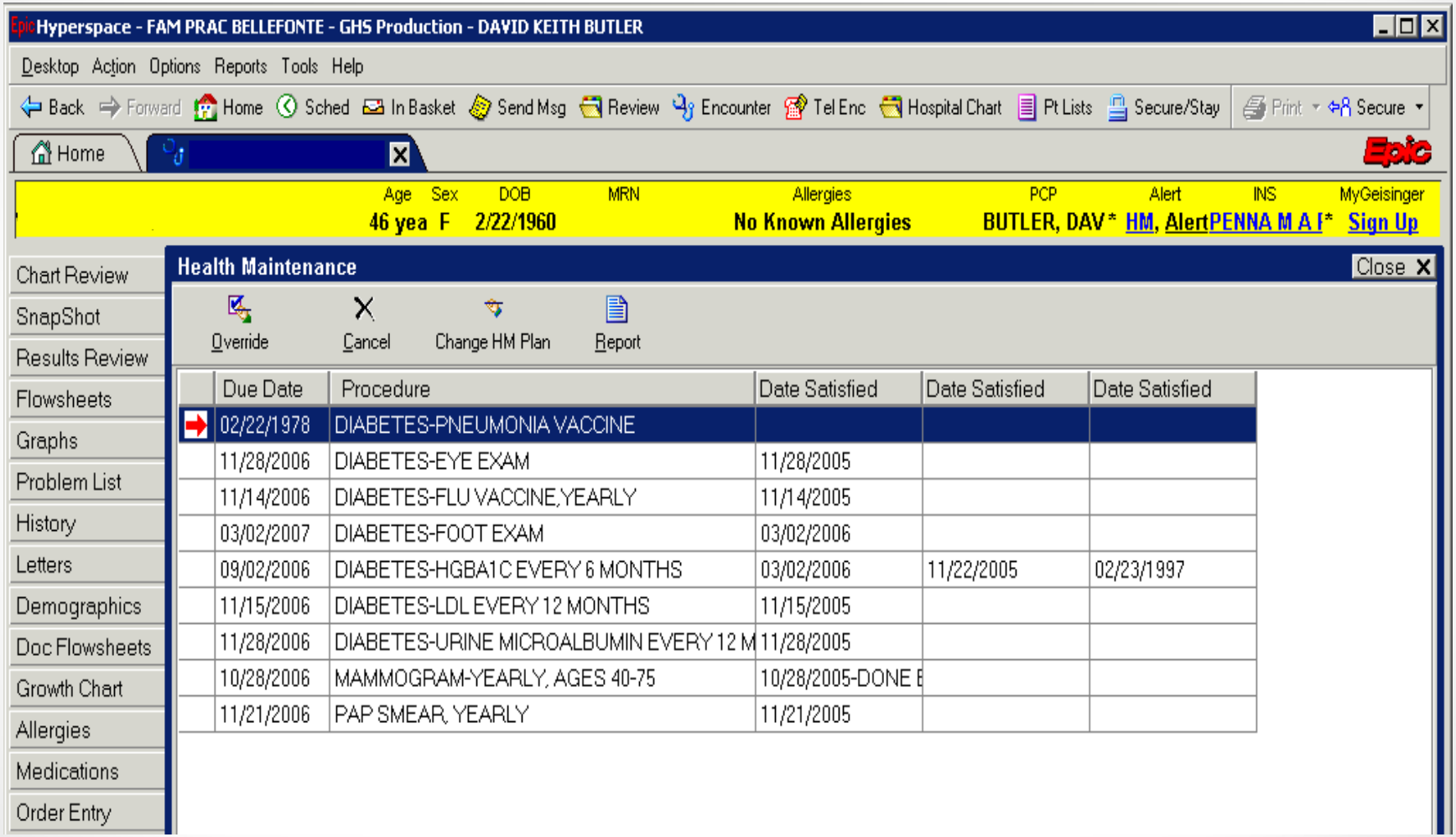
Tools: Disease Management Alerts



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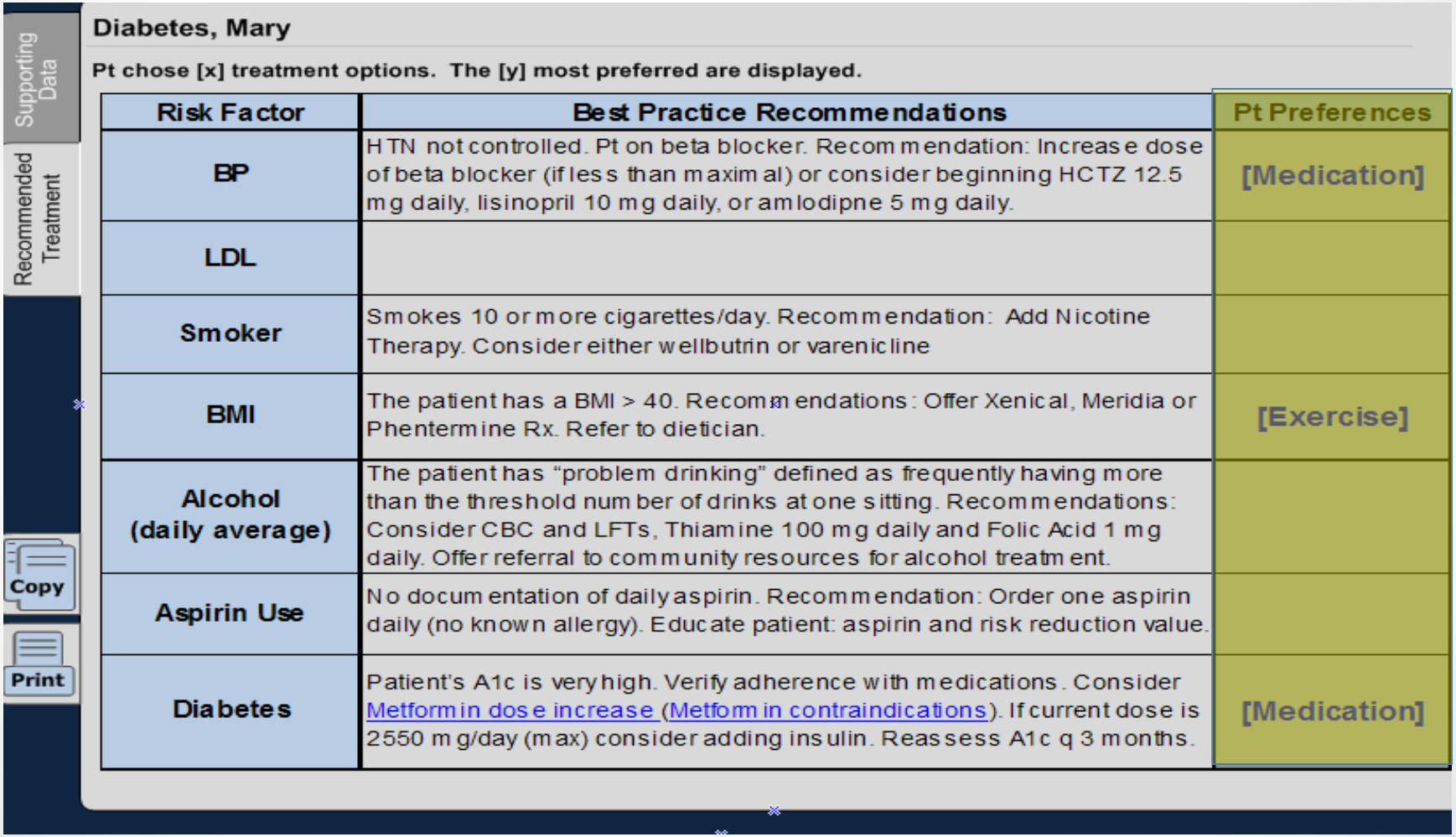
Tools: Clinical Decision Support



Supporting Data

Recommended Treatment

Copy

Print

Diabetes, Mary

Pt chose [x] treatment options. The [y] most preferred are displayed.

Risk Factor	Best Practice Recommendations	Pt Preferences
BP	HTN not controlled. Pt on beta blocker. Recommendation: Increase dose of beta blocker (if less than maximal) or consider beginning HCTZ 12.5 mg daily, lisinopril 10 mg daily, or amlodipne 5 mg daily.	[Medication]
LDL		
Smoker	Smokes 10 or more cigarettes/day. Recommendation: Add Nicotine Therapy. Consider either wellbutrin or varenicline	
BMI	The patient has a BMI > 40. Recommendations: Offer Xenical, Meridia or Phentermine Rx. Refer to dietician.	[Exercise]
Alcohol (daily average)	The patient has "problem drinking" defined as frequently having more than the threshold number of drinks at one sitting. Recommendations: Consider CBC and LFTs, Thiamine 100 mg daily and Folic Acid 1 mg daily. Offer referral to community resources for alcohol treatment.	
Aspirin Use	No documentation of daily aspirin. Recommendation: Order one aspirin daily (no known allergy). Educate patient: aspirin and risk reduction value.	
Diabetes	Patient's A1c is very high. Verify adherence with medications. Consider Metformin dose increase (Metformin contraindications). If current dose is 2550 mg/day (max) consider adding insulin. Reassess A1c q 3 months.	[Medication]

GEISINGER
REDEFINING BOUNDARIES

Tools: Care Plans

Patient Data | Physical Exam | Recommended Care | Progress Note

eLowBack, Mary

RECOMMENDED CARE PLAN

ADF

The patient is concerned that their back pain means they damaged their back, will interfere with their ability to exercise and these concerns should be discussed. The patient should be reassured that at this time there does not appear to be any problems with muscles, vertebrae, or nerves. The back pain may have been caused by overuse or strain and this should improve with proper care. Back pain can cause some patients to worry. Reassure that there is not a serious problem. It may be useful to schedule a follow up visit to make sure nothing is missed. The patient is not taking enough pain medication. This may be because they think OTCs are harmful. Inquire about concerns. Emphasize that medications like ibuprofen reduce pain and inflammation. If the inflammation is not reduced it will continue to cause pain. Patient may worry that movement is going to make the back pain worse or cause damage. If the pain is extreme, patient may want to avoid positions and activities that are a cause. Staying active will usually make the back pain get better.

Patient Instructions:

Ordering Recommendations	Guideline Recommendation	Relevant Patient Data
MEDICATIONS		
☐ Aleve 220 mg po q 12 hours [35290] 1-2 tablets every 12 hours as needed ☑ Ibuprofen (Motrin) 600 mg q 6 hr [10519] 1 by mouth every 6 hours with food, Disp-58 Tab, R-1, Normal	NSAID is recommended for back pain lasting less than 6 weeks.	LBP less than 6 weeks; Nonspecific LBP; Patient is not using enough OTC and has concerns. Opioids are not recommended for non-specific back pain, do not reduce inflammation. Use may reduce activity level.
IMAGING ORDERS		
		Imaging is not recommended for non-specific LBP that will usually goes away with activity and proper use of NSAIDs. A follow-up visit may help to ensure that pain level declines as expected.
REFERRALS		
☐ SPINE REHAB MED REFERRAL OP ☐ PAIN THERAPY REFERRAL OP ☑ PHYSICAL THERAPY REFERRAL OP	Spine Rehab, Pain Therapy, or PT is recommended for significant limitation of functional activities.	

Push once to submit orders to Epic

GEISINGER
REDEFINING BOUNDARIES

Tools for Population Health Management ~ Improving Preventative Care for 214,117

	11/07	12/10
Adult Preventive Bundle	9.2%	29%
Breast Cancer Screening (q 2 40-49, q 1 50-74)	46%	62%
Cervical Cancer Screening (q 3 yr Age 21-64)	64%	72%
Colon Cancer Screening (Age 50-84)	44%	65%
Prostate Cancer Discussion (Age 50-74)	72%	76%
Lipid Screening (Every 5 yr M > 35, F > 45)	75%	86%
Diabetes Screening (Every 3 yr > 45)	85%	88%
Obesity Screening (BMI in Epic)	77%	96%
Documented Non-Smokers	75%	78%
Tetanus Diphtheria Immunization (every 10 yr)	35%	69%
Pneumococcal Immunization (Once Age >65)	84%	87%
Influenza Immunization (Yearly Age >50)	47%	56%
Chlamydia Screening (Yearly Age 18-25)	22%	35%
Osteoporosis Screening (every 3 yr Age > 65)	52%	73%
Alcohol Intake Assessment	84%	89%

Partnerships with Other Care Providers

- Hospitals
- Specialists
- Post-acute providers

Hospitals as Key ACO Partners

- Efficiently & effectively manage the acute care episode
- Accept accountability for care transitions
  - ED
  - Post-discharge
  - Pre-surgical
- Participate in HIE

Hospitals Must Optimize Transitions of Care

Proven Transitions®Pathway

Welcome to Discharge! Your Care Team has developed your Plan of Care ….

Mrs. B Care Plan

- PCP scheduled appt – one week
- Specialists scheduled appt's
- Home Health Agency
- Medical Home CM assigned
- Scheduled diagnostics
- DME
- Medications/Prescriptions
- D/C summary & Instructions
- Restrictions & limitations
- Daily Telephony weight monitoring

For "emergencies"…

- For _____ call _____
- IF _____ do _____
- Take medication list to all visits
- Take Care Plan to all visits
- Emergency Contacts
- Advanced Directives

D/C today	**MHCM** to phone tomorrow	**Home Health** in 48 hours	**PCP** in one wk	**Cardiologist** in one month

GEISINGER
REDEFINING BOUNDARIES

Efficient Specialists: Key ACO Partners

- Help PCPs
  - Know when to refer
  - How to manage low acuity patients
- Manage complex patients
  - Communicate with PCPs / Medical Home Care Managers
  - Be attentive to resource utilization
    - ED visits
    - Admissions
    - Diagnostic tests
    - Acknowledge and help address end of life issues
    - Patient communications
    - Palliative care
- Link in with available IT and technology tools
  - Home monitoring
  - Patient registries / population management
  - HIE

Key Partnering Opportunity: The Skilled Nursing Facility

Current state of care in nursing homes

- Skilled: 1 in 3 patients are readmitted back to acute care
- LTC: Average 2-4 hospital admissions annually
- Opportunities exist to improve quality – wounds, falls, infection, pain, etc
- End of life poorly managed
- Mandatory 3 day acute care stay

Creating a New SNF Delivery Model is Critical

- Daily presence of an advanced practitioner
- Focus on care redesign
  - Eliminate acute care stay need
  - Medication reconciliation
  - Earlier identification of acute exacerbations
  - Prevention focus – good skin care, I's & O's, fall prevention
  - Enhanced connectivity to case manager & primary care team for discharge planning

Redesigning care in the Nursing Home as we have done in Primary Care

Geisinger's Early Results for Nursing Homes Look Promising

Nursing Home	Baseline Readmissions 2008	PY 1 Readmissions 2009	Reduction
Nursing Home A	34%	18.5%	- 45.5%
Nursing Home B	18.5%	14.5%	- 21.6%
Nursing Home C	27%	9%	- 66.6%
Nursing Home D	44%	33%	- 25%
Nursing Home E	42.5%	31%	- 27%
Nursing Home F	27.5%	24%	- 12.7%

Partnerships with All Care Providers

Need to synchronize communications and care plans with:

- Home Health nurses, therapists
- Other post-acute providers – rehab hospitals, LTACHs
- Pharmacists
- Caregivers in other residential / outpatient settings
  - Dialysis visits
    - Group homes
    - Outpatient therapists

The Primary Care Practice / Insurer Partnership: Each Party Doing What it Does Best

Insurer

- Population analysis
- Align reimbursement
- Finance care
- Engage member and employer
- Report population outcomes
- Take to market

Primary Care Provider

- Identify best practice
- Design systems of care
- Educate patient and family
- Deliver care
- Report patient outcomes
- Continually improve

The Insurance Partner Enables Population Management

Components	Core Activities
Population Segmentation	Predictive modeling Risk stratification
Health Promotion	Preventive care & Screenings
Disease Management	Self-management education Medication management
Case Management	Care coordination Exacerbation management TOC Tele-monitoring
Pharmacy Management	Gap Coverage Brand vs. generic

Insurers Report Results

Commercial Quality Compass Results 2010	National 90th Percentile	GHP	Geisinger Clinic Rates	
Childhood Immunizations Combined Rate #2	84.26 %	92.46%	92.96%	
Appropriate Treatment of URI	92.18%	96.78%	98.56%	
Breast CA Screening	77.76%	80.14%	86.94%	
Cervical CA Screening	81.58%	82.68%	86.13%	
Colorectal CA Screening	69.9%	67.01%	77.43%	
Adult BMI Assessment	69.59%	69.85%	81.90%	
Physical Activity Counseling	62.29%	73.44%	75.24%	
Persistence of Beta Blocker Treatment	83.83%	100%	100%	
Controlling High Blood Pressure	72.68%	74.58%	83.8%	
HbA1c Poor Control (>9.0%) - Lower is better	19.16%	19.2%	17.24%	
HbA1c < 8.0%	70.17%	70.2%	72.07%	
Kidney Disease Monitored	88.27%	89.58%	92.76%	
F/u Care for ADHD Initiation	44.57%	47.86%	57.14%	
Spirometry Testing - COPD	48.12%	49.29%	53.17%	

Other Partners

- **Administrative Partners**
- **Health Information Exchanges**
- **Research**

Conclusion: There are Many Partners Across the Continuum of Care That Work Together to Keep Mrs. B Healthy

Discussion and Questions

Contact information

Josh Bennett, MD, MBA
Principal, integrated care delivery
Premier healthcare alliance
Josh_bennett@premierinc.com
704.816.4098

Denise B. Prince, MBA, MPH
System vice president, value-based care
Geisinger Health System
dprince@geisinger.edu
570.214.9492