Value Re engineering Reducing Readmissions

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PHN Objectives

- Transform primary care from transaction to value focus

- Act as Value Vehicle (Integrator) to improve quality and efficiency across the spectrum of care

It Takes a Partnership: Each Party Doing What It Does Best…

GHP	CPSL
• Population analysis • Align reimbursement • Finance care • Engage member and employer • Report population outcomes • Take to market	• Identify best practice • Design systems of care • Educate patient and family • Deliver care • Report patient outcomes • Continually improve

PHN Expansion

	Sites	MA members	Commercial members	Medicare members	Total**
Phase 1	3	3,100	800	2,000	31,000
Phase 2	10	7,300	8,500	11,000	119,000
Phase 3	12	4,600	7,000	7,800	94,000
Phase 4	12	4,300	7,100	5,300	55,000
Phase 5	7	1,700**	5,400	3,000	61,000
Total	**47***	**21,000**	**28,800**	**29,100**	**360,000**

* 37 Geisinger primary care practices & 7 non-Geisinger primary care practices

**Total Geisinger patients, non-Geisinger patients not quantified

Partnership of PCP's & GHP provides 24/7 360 degree patient care and navigation

Geisinger's PHN model has five core components

Patient-centered primary care	• Patient and family engagement & education • Enhanced access and scope of services • ***PCP led team-based care*** • Chronic disease and preventive care optimized with HIT
Integrated population management	• Population segmentation and risk stratification • Preventive care • ***GHP employed in-office case management*** • Disease management
Value care systems	• Micro-delivery referral systems • ***360° care systems*** – SNF, ED, hospitals, HH, etc
Quality outcomes	• Patient satisfaction • HEDIS and bundled chronic disease metrics • Preventive services metrics
Value-based reimbursement	• Fee-for-service with P4P payments for quality outcomes • Physician and practice transformation stipends • Value-based incentive payments • Payments distributed on Quality Performance

GEISINGER

Primary Care Redesign

Physician-led team based care

- Accountability for cost, quality, and access
- Motivated, supported team

Advanced Primary Care Office

- Decision support at the point of care
- Actionable operational informatics

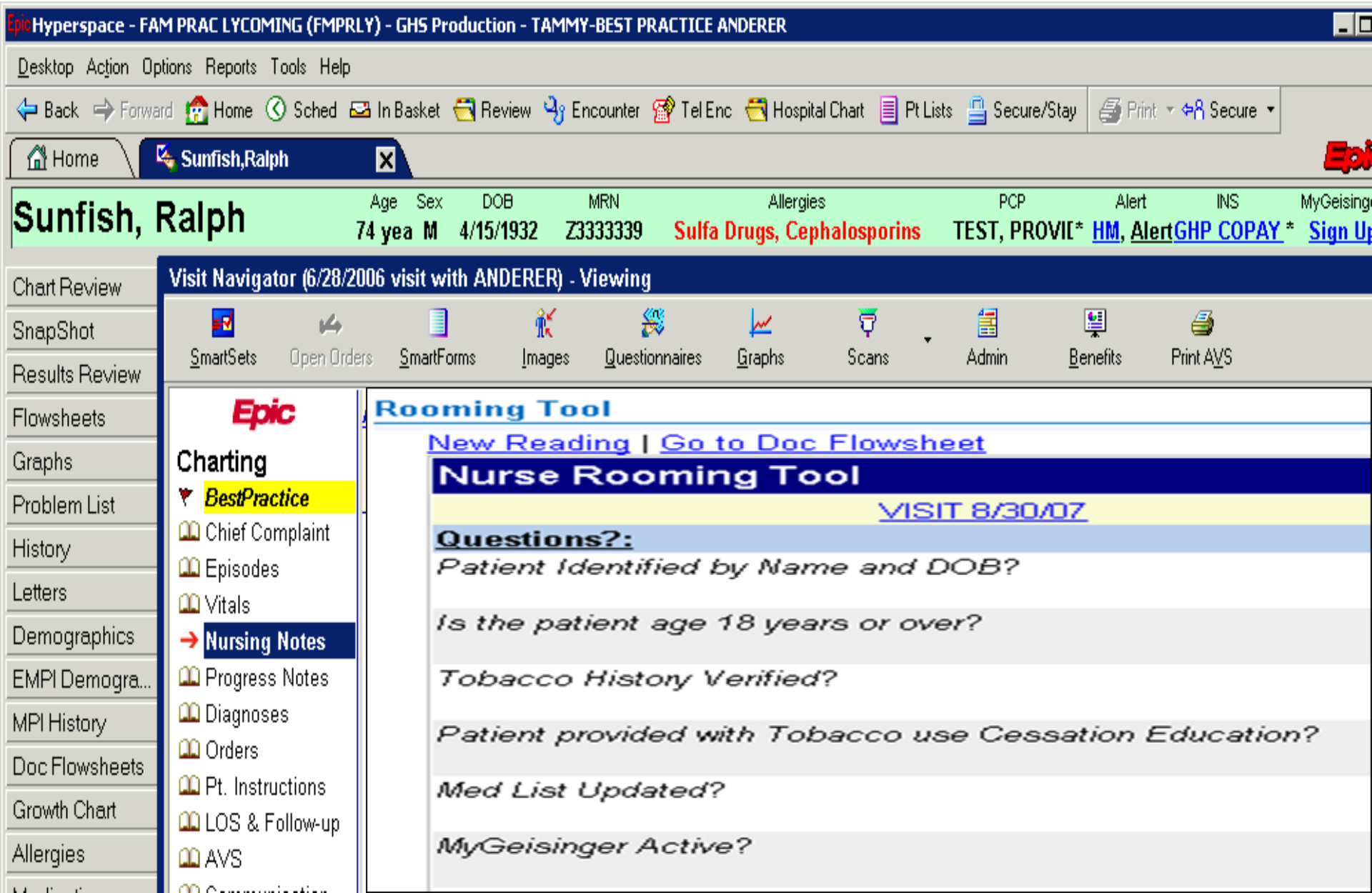
Systems of Care Approach

- ProvenCare® Chronic
- Proactive Prevention

Workflow Redesign

1. **Eliminate** non-value added work
2. **Automate** work that can be done by a computer or done outside an office encounter
3. **Delegate** work that is done at an office visit to trained non-physician staff when possible
4. **Incorporate** new workflows into the provider practice with reminders and EHR tools to enhance the reliability and efficiency of care
5. **Activate** the patient with EHR assistance when possible

Nurse Rooming Tool



DM HM Alerts for Patients

MyGeisinger.org — Your online health management tool

May 01, 2006, Maria Zasp — Back | Home | Logout | Help

Parent/Caregiver Access
- View Other Records

Health Record
- Health Summary
- Medications
- Lab Results
- Graphs
- Recent Visits
- Immunizations
- Health Reminders
- Referrals
- Past Medical History

Messaging
- Messages Received
- Letters Received
- Messages Sent
- Renew Medications
- Request Medical Advice
- Non-Medical Message

Appointments
- Directly Schedule Appt
- Request Appt
- View/Cancel Appt

Update Info
- My Info/Change Address
- Change Email

Health Reminders — Printer Friendly Page

The following Health Reminders are recommended for people of your age, gender, and medical history. **If the procedures and dates are different from what your doctor has discussed with you, please follow your doctor's recommendation.**

If you want to find previous dates that health reminders were completed, click date Last Done.

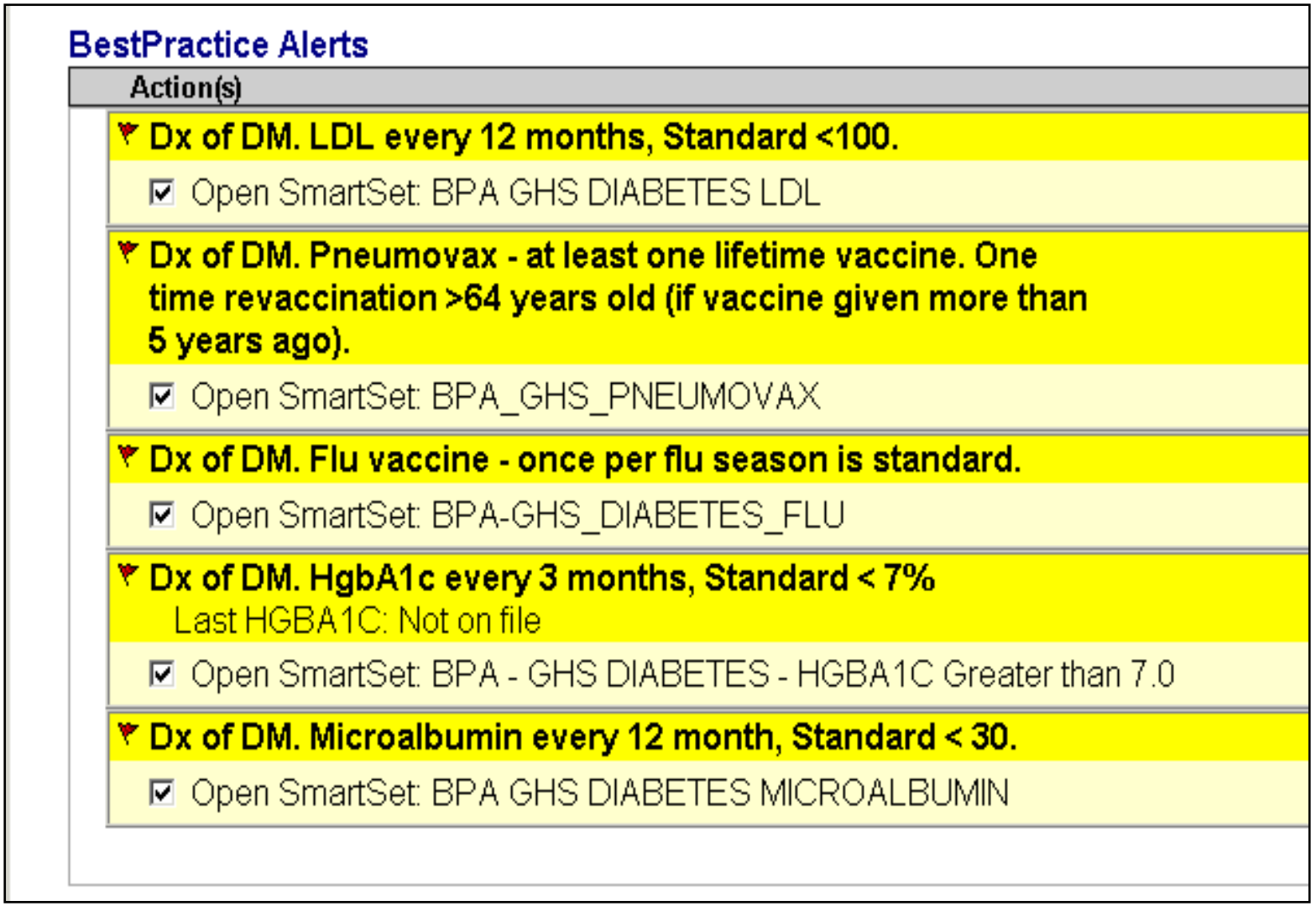
Schedule	Name	Due Date	Status	Last Done
☐	DILATED EYE EXAM (PERFORMED BY AN EYE DOCTOR)	03/06/1968	Overdue	
☐	URINE MICROALBUMIN (URINE PROTEIN)	03/06/1968	Overdue	
☐	DIABETIC FOOT EXAM (AT LEAST EVERY 12 MONTHS)	03/06/1968	Overdue	
☐	PNEUMONIA SHOT (ONCE IN A LIFETIME, MINIMUM)	03/06/1968	Overdue	
☐	HEMOGLOBIN A1C (3 MONTH BLOOD SUGAR AVERAGE)	03/06/1968	Overdue	
	Mammogram-yearly, Ages 40-75	07/07/2006		07/07/2005
	DILATED EYE EXAM (PERFORMED BY AN EYE DOCTOR)	10/01/2006		
	LDL CHOLESTEROL (BAD CHOLESTEROL)	01/28/2007		01/28/2006
	Pap Smear (Every 2 Years)	02/13/2008		02/13/2006

To request an appointment for one of the procedures listed above, check in the schedule column and click **Schedule**.

Schedule

My Notes:

Diabetes Best Practice Alerts



Diabetes: Patient Letter / Report Card

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.

Diabetes Process Redesign

Automate

Computer/EHR
- **Alerts and Reminders As Previsit Planning**
- **Reminder letters – CareGaps Outreach**

Delegate

Clerical
- **Scheduling of Flu/Pneumococcal, Follow Up**

Clinic Nurse
- **Immunizations, Lab Testing, Foot Exam**

Case Manager
- **High Intensity Coordination/Education**

Incorporate

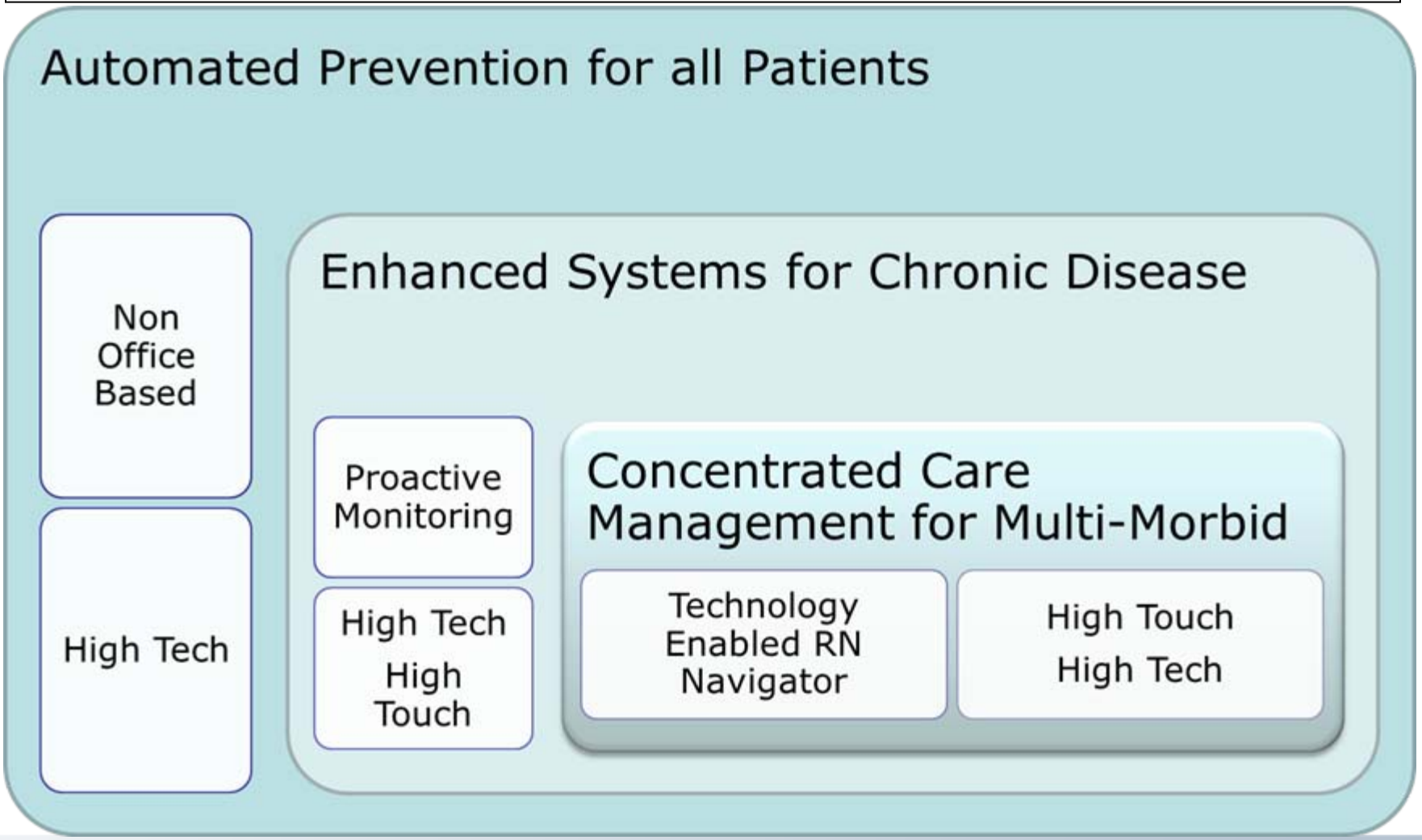
Nurses
- **Nurse Rooming Tool, Process Measure BPAs**

Providers
- **Alerts and Reminders for Complex Decisions**

Activate

Patients and Families
- **MyGeisinger, Patient Report Cards**

Population Primary Care



Integrated Population Management

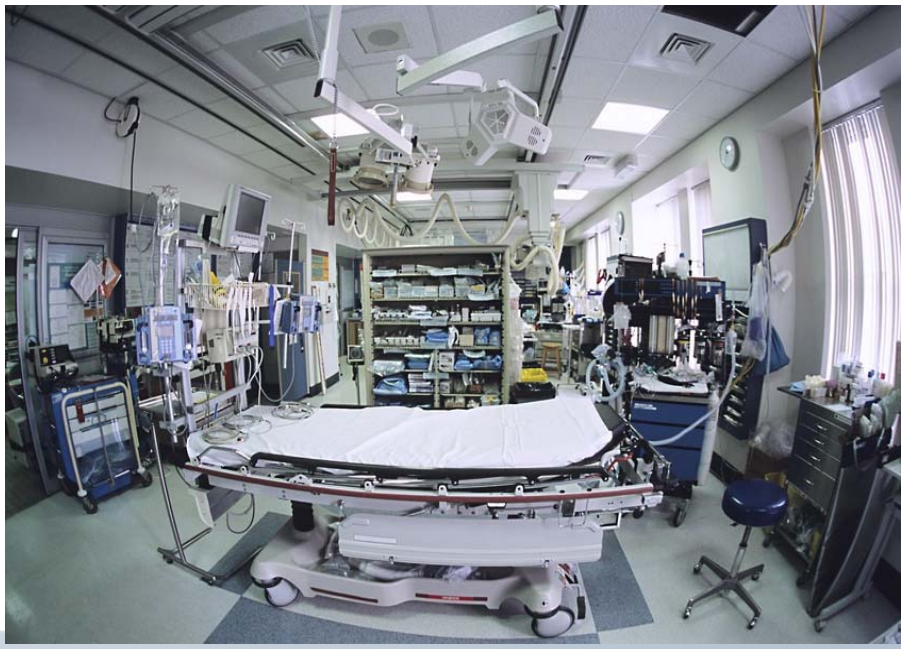
Components	Core Activities
Population Segmentation	Predictive modeling Risk stratification
Health Promotion	Preventive care & Screenings
Disease Management	Self-management education Medication management
Case Management	Care coordination Exacerbation management TOC Tele-monitoring
Pharmacy Management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

Transitions of Care

- Pt contact within 24-28 hrs post discharge
- Telephonic outreach
  - Medication reconciliation
  - Ensure safe transition post discha
    with appropriate services in place
    - o Home Health
    - o DME
    - o Safe to be in their home?
  - Facilitate post hospital PCP appt within 3 - 5 days

Value Care Systems

- Micro-delivery referral systems
  - High volume specialties
  - Ancillary services – Radiology, Lab
- 360 degree care systems
  - Hospital care
  - Home Health
  - SNF's
  - ER coverage
  - Community resources



Expanded focus as we build out add'l opportunities in PHN

Opportunities for Innovation Exist in the Nursing Home

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

Creating a New Delivery Model is Critical

- Daily presence of an advanced practitioner
- Focus on care redesign
  - 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

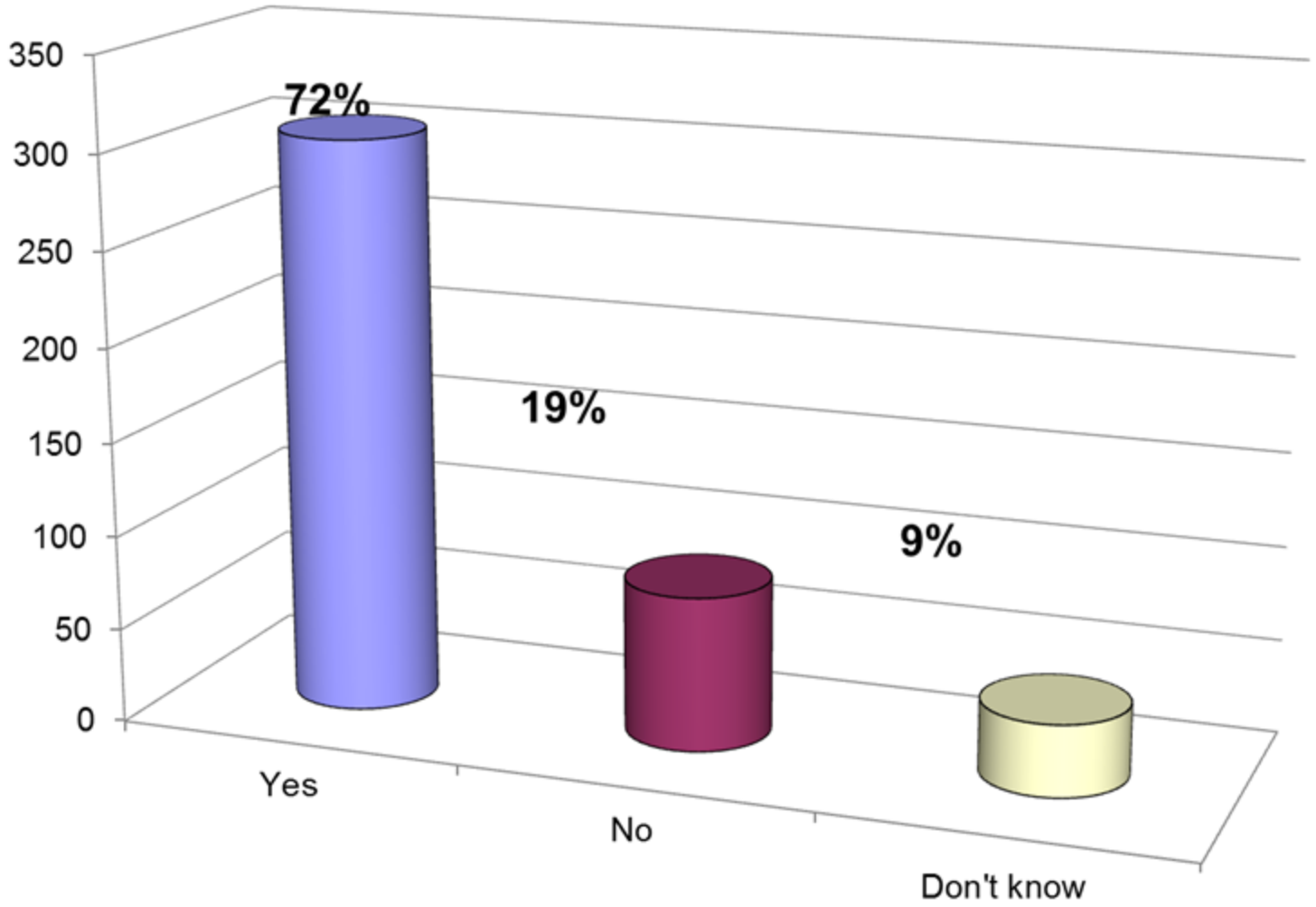
Early Results for Nursing Homes Look Promising

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%

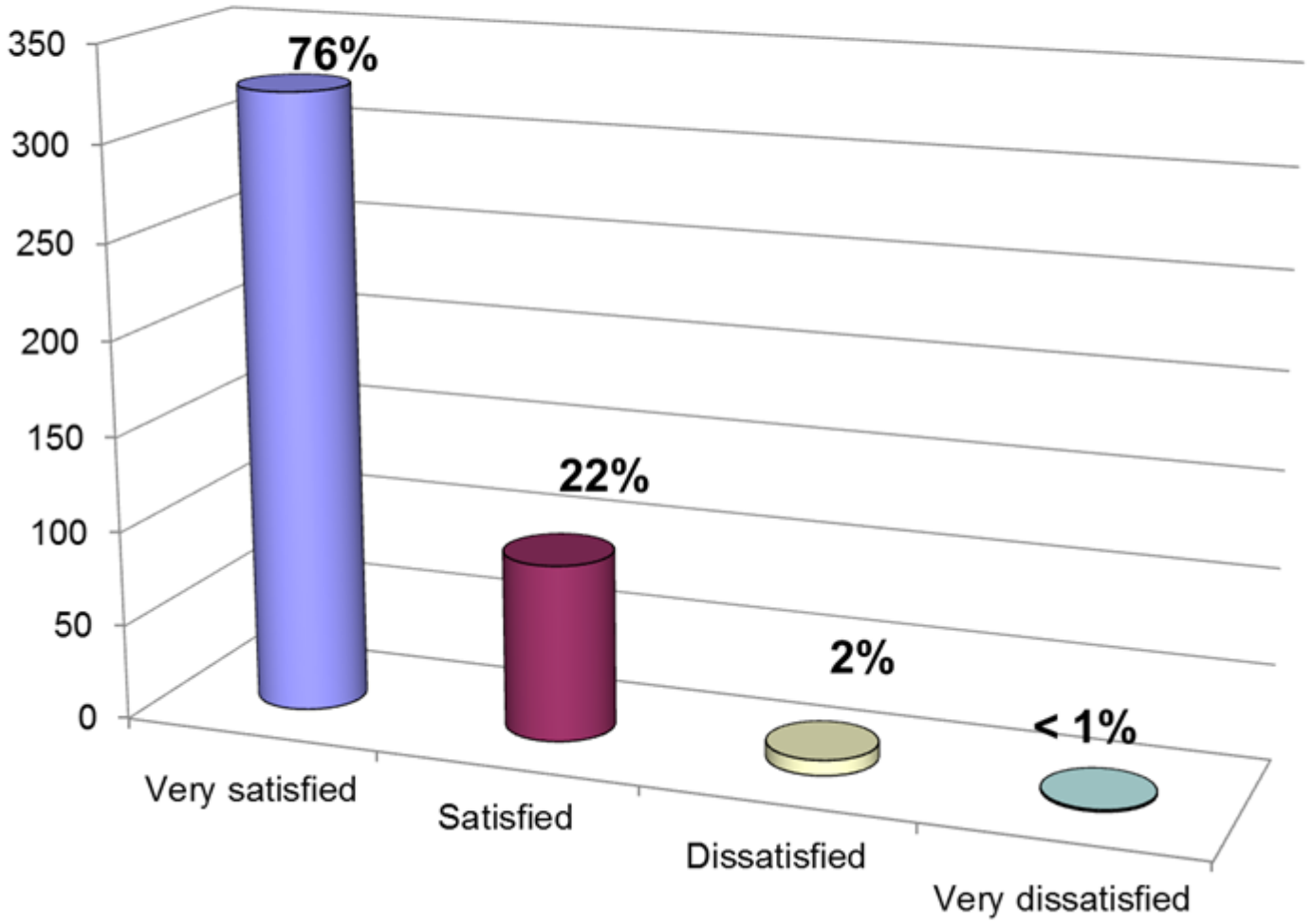
What do patients say about PHN?

PATIENT EXPERIENCE

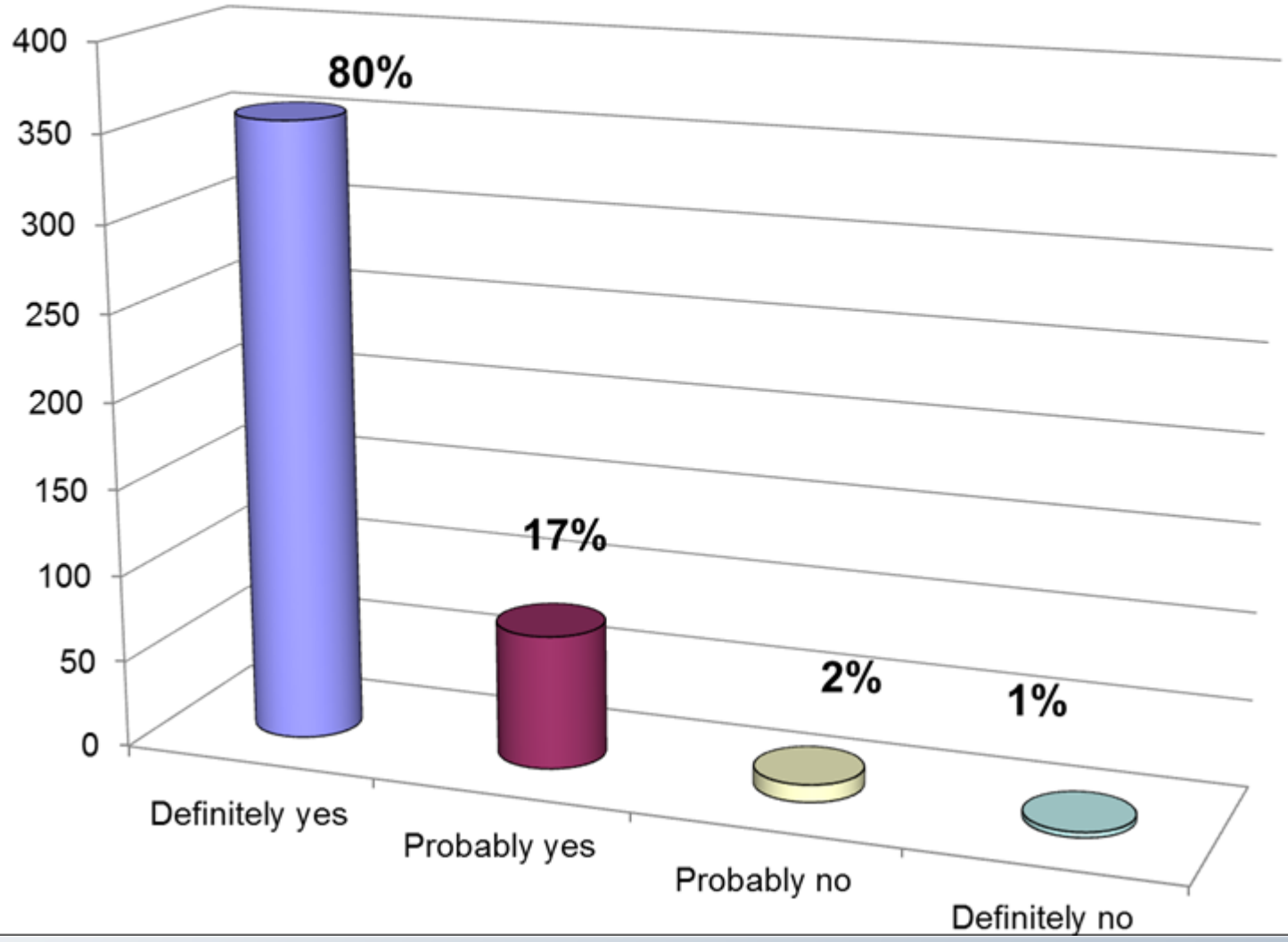
Is quality of care different and better than the past?



How satisfied are you with your Primary Care site overall?



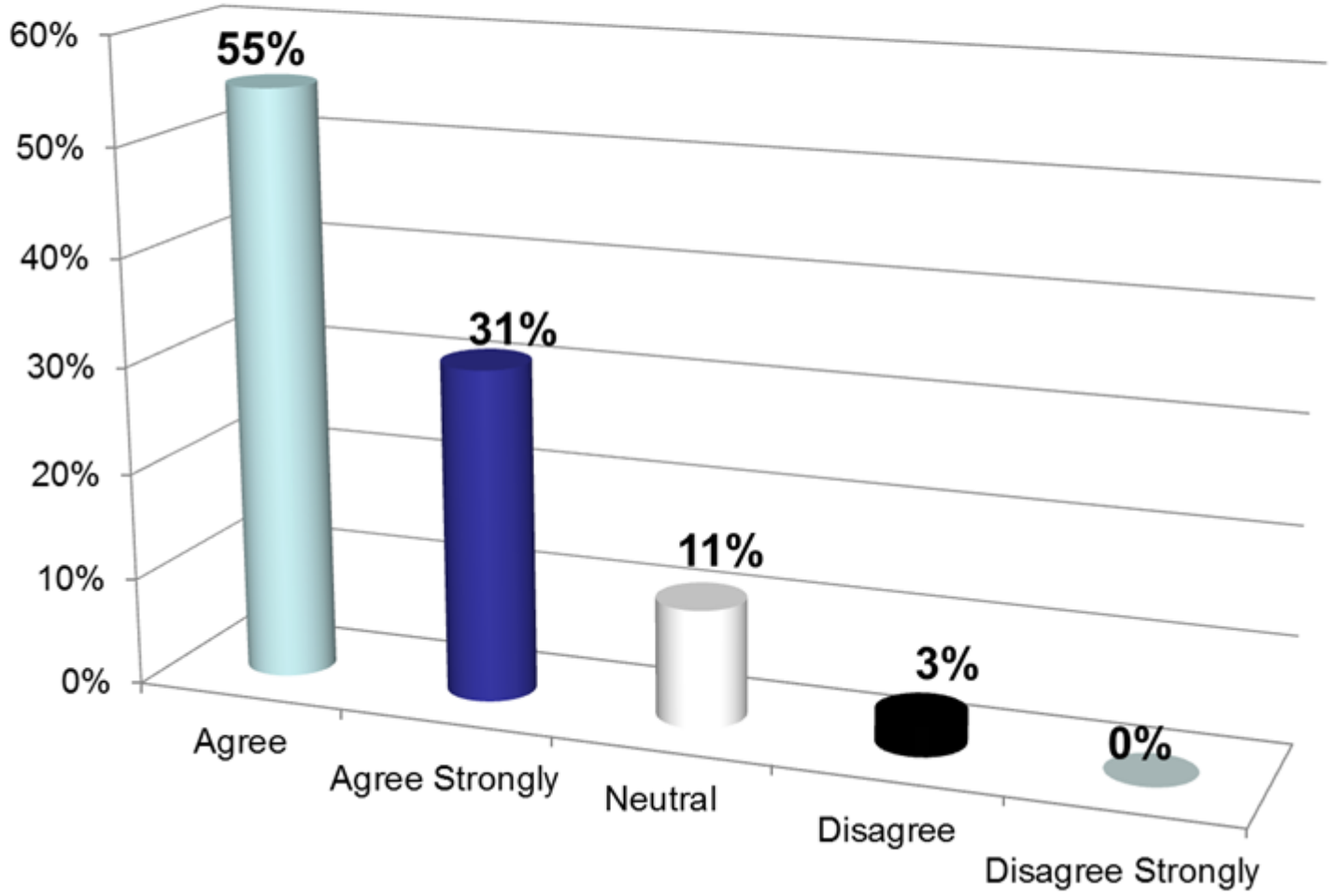
Would you recommend your PCP to family/friends?

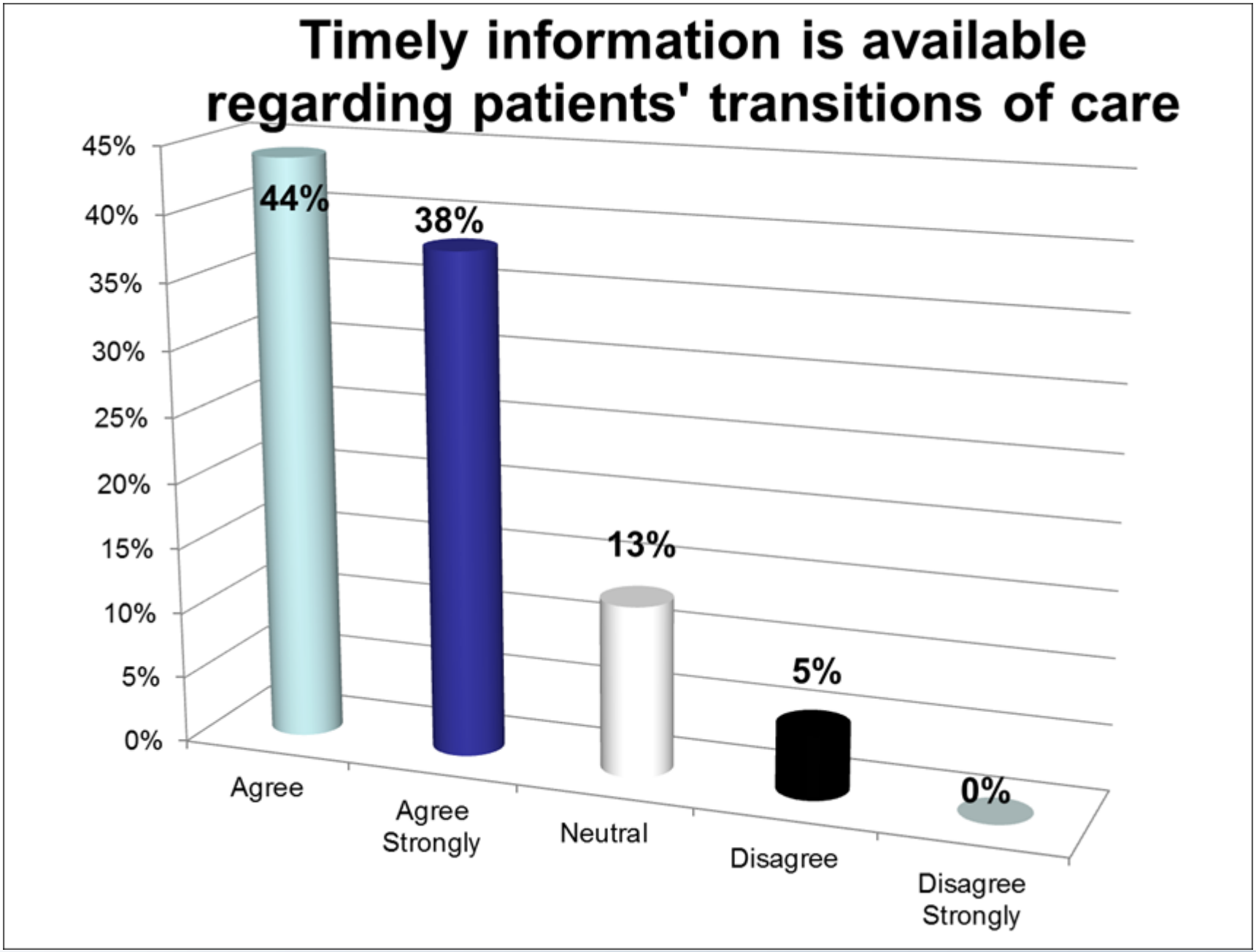


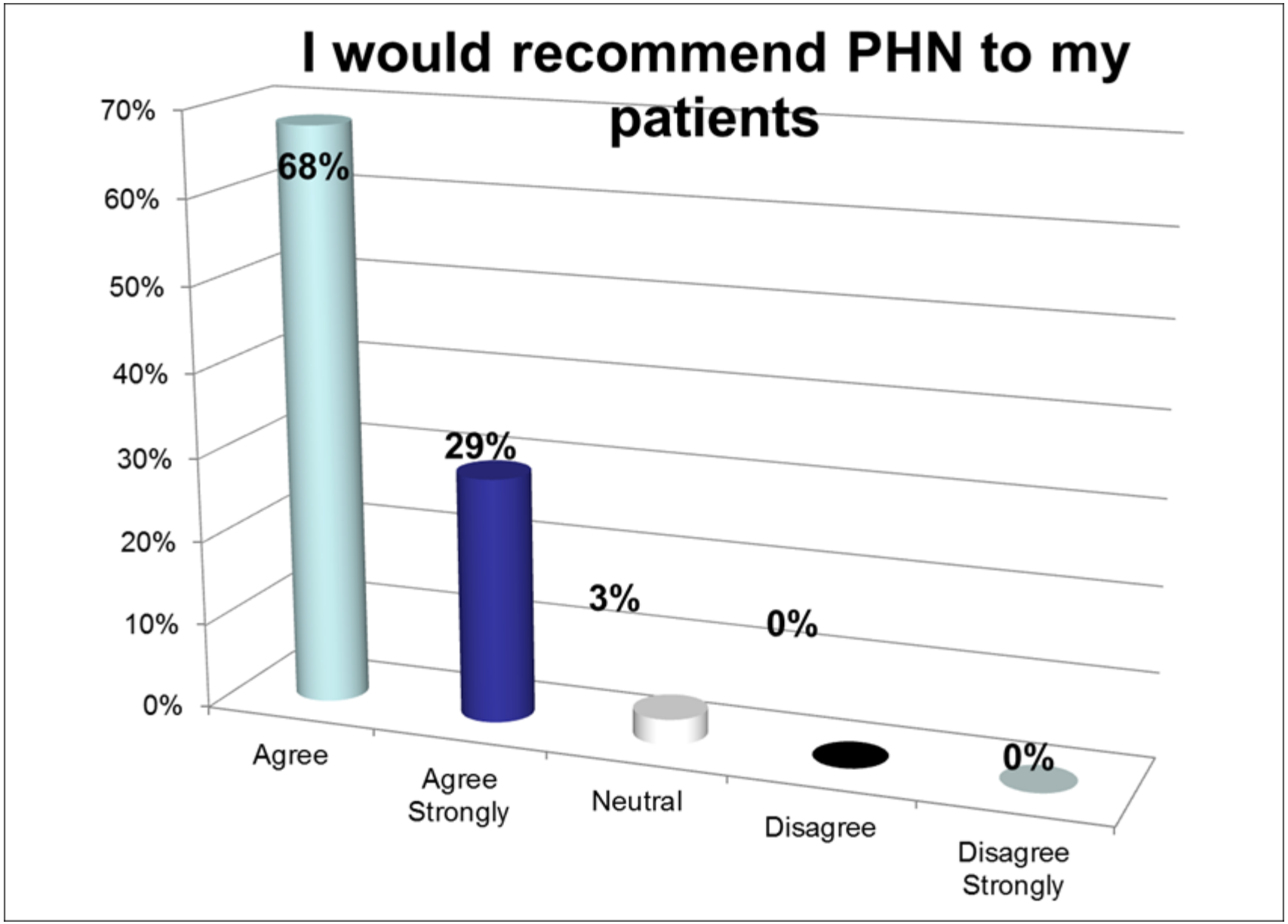
What have Providers said about PHN?

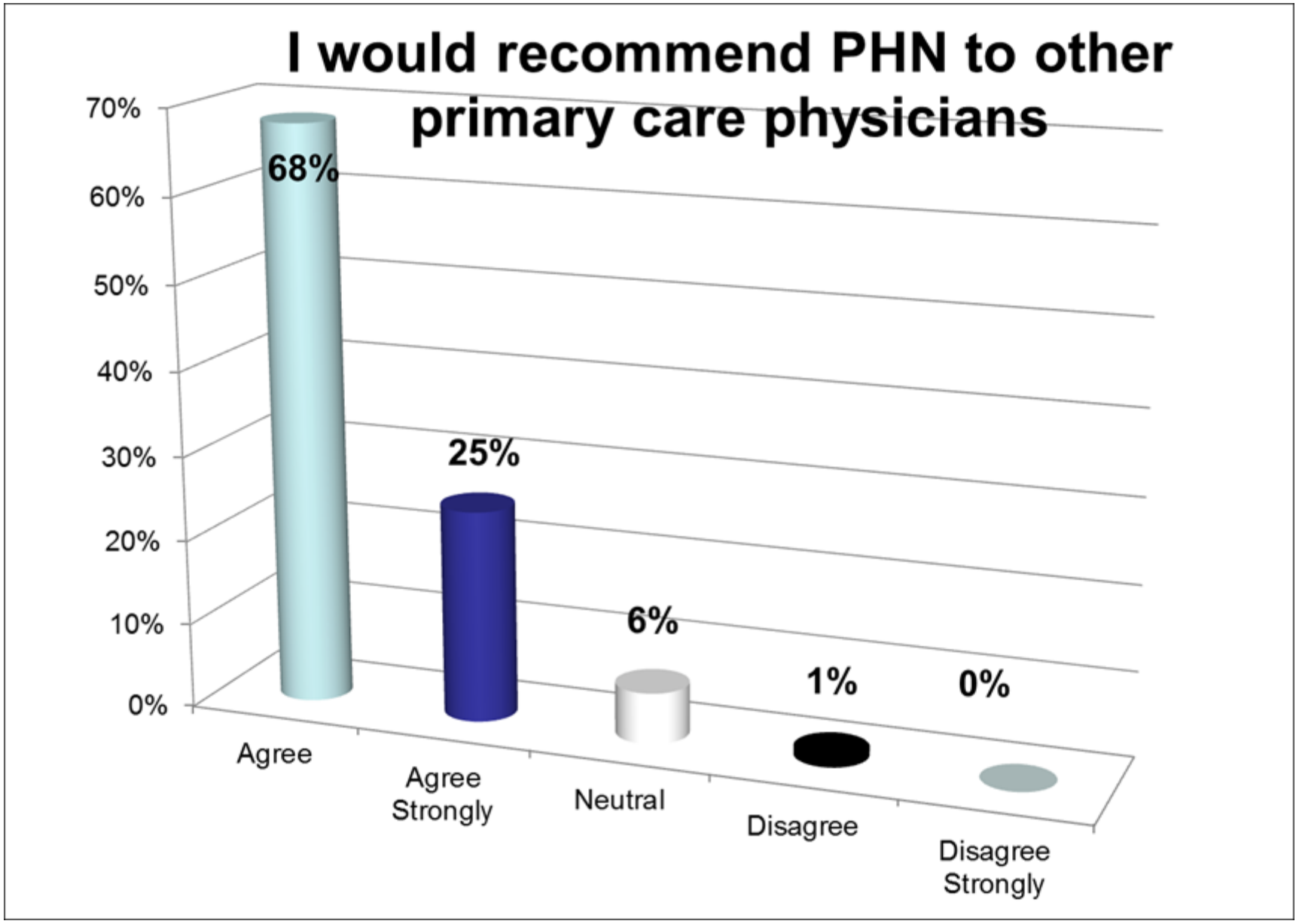
PROVIDER EXPERIENCE

PHN has allowed you to provide more comprehensive care than the previous system









PHN Experience with Geisinger's Commercial Members

Metric	Baseline (2008)	Performance Year (2010 YTD)	Percent Difference
PHN (~9,000 members)			
Acute Admissions / 1000	65.10	52.54	**-19.3%**
Readmission Rate	12.7%	9.9%	**-22%**
ED Visits / 1000	192	166	**-13.5%**
Comparison Group			
Acute Admissions / 1000	75.07	62.32	**-16.9%**
Readmission Rate	8.3%	9.2%	+10.8%
ED Visits / 1000	243	232	**-4.5%**

Readmissions are Lower