GEISINGER HEALTH PLAN®

Population Management

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Geisinger at a Glance

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Provider Facilities

- **Geisinger Medical Center**
  - ***Danville*** *– includes Hospital for Advanced Medicine, Janet Weis Children's Hospital, Women's Health Pavilion, Level I Trauma Center, Ambulatory Surgery Center*
  - ***Geisinger Shamokin Community Hospital***
- **Geisinger Northeast**
  - ***Geisinger Wyoming Valley Medical Center*** *includes Heart Hospital, Henry Cancer Center, and Level II Trauma Center*
  - ***Geisinger South Wilkes-Barre*** *includes Adult and Pediatric Urgent Care, Ambulatory Surgery Center, Inpatient Rehabilitation, Pain Management, and Sleep Center.*
  - ***Geisinger Community Medical Center***
- **Geisinger-Bloomsburg Hospital**
- **Marworth Alcohol & Chemical Dependency Treatment Center**
- **Mountain View Care Center**
- **Bloomsburg Health Care Center**
- **> 77K admissions/OBS & SORUs**
- **1,619 licensed inpatient beds**

Physician Practice Group

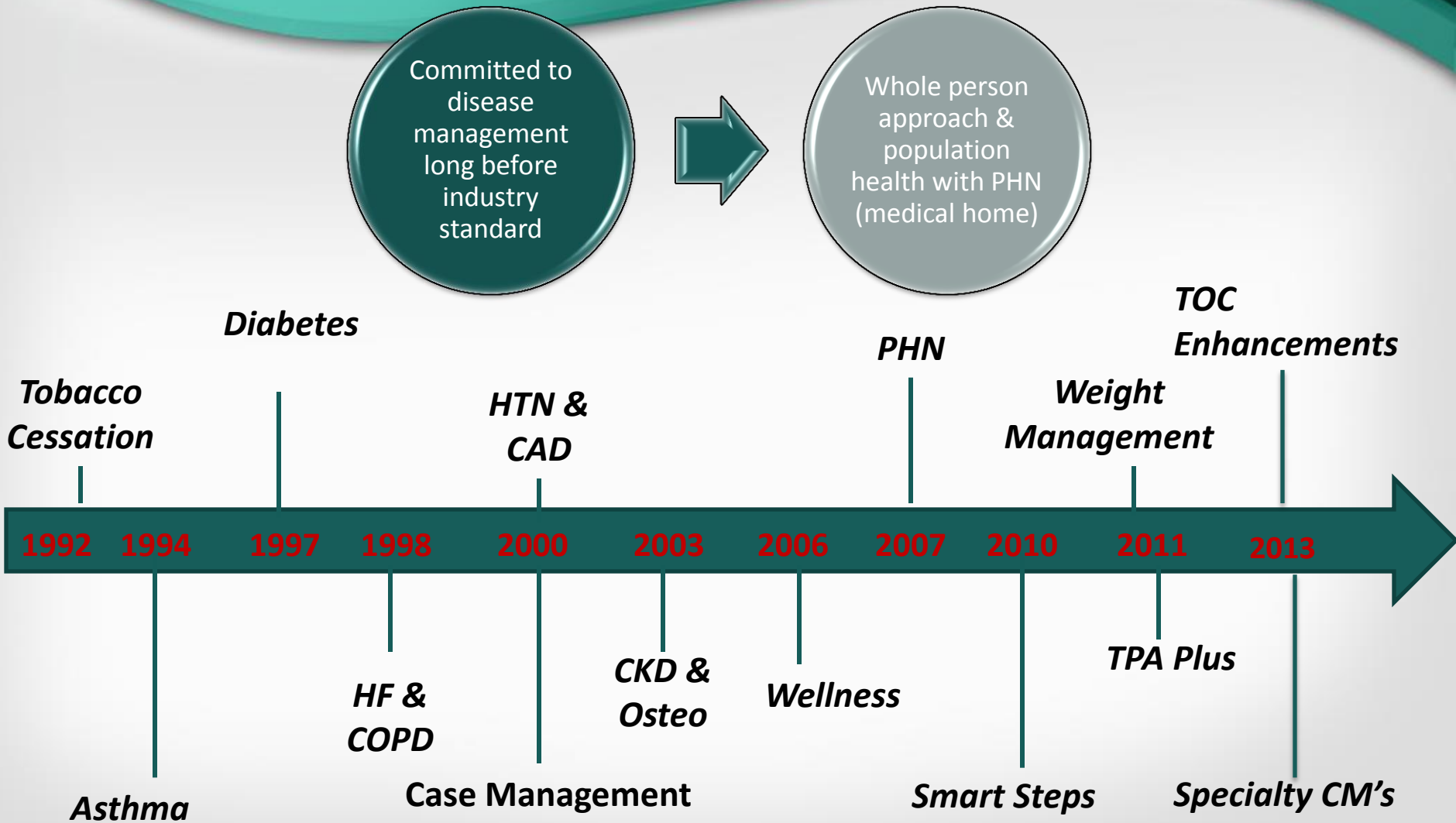
- **Multispecialty group**
- **~950 physician FTEs**
- **~560 advanced practitioners FTEs**
- **71 primary & specialty clinic sites (41 community practice sites)**
- **1 outpatient surgery center**
- **~ 2.3 million clinic outpatient visits**
- **~380 resident & fellow FTEs**

Managed Care Companies

- **~410,000 members**
  - **~68,000 Medicare Advantage**
  - **110,000 Medicaid Managed Care Contractor**
- **Diversified products**
- **~34,000 contracted providers/facilities**
- **44 PA counties**
- **Out of state expansion**
  - **Eastern Maine HS**
  - **West Virginia Univ.**
  - **Meridian HS, NJ**
  - **Christiana, DE**

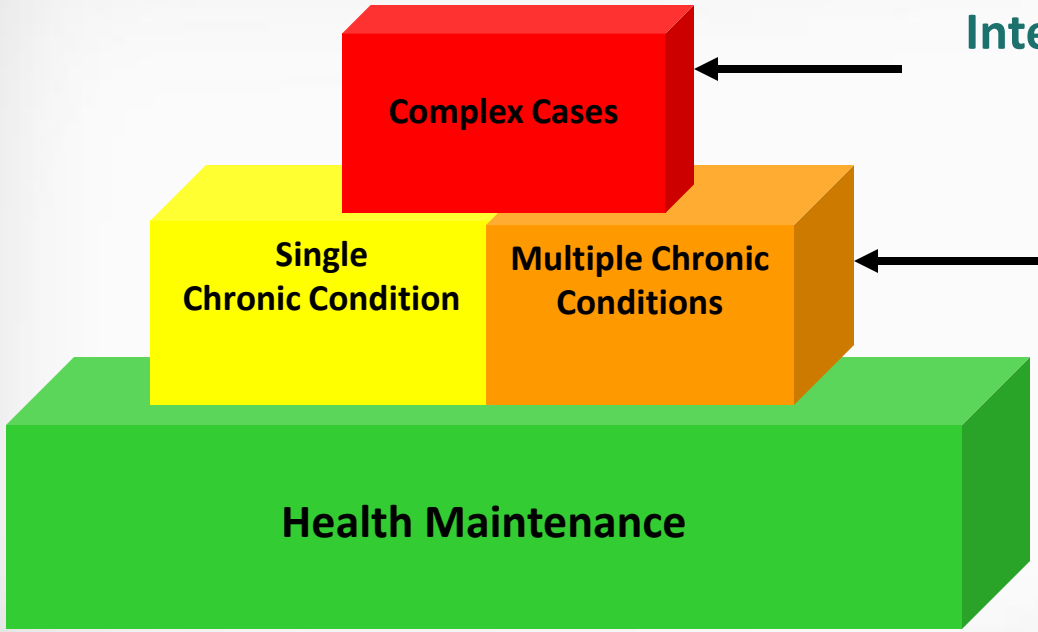
System
- **20,000 employees**
- **2.6 million ambulatory visits**
- **535,000 unique patients**
- **$337 million community benefit**

Evolution of Population Management at GHP



Proposed Risk Model

Risk Models analyze historical claims experience to divide population into four categories:

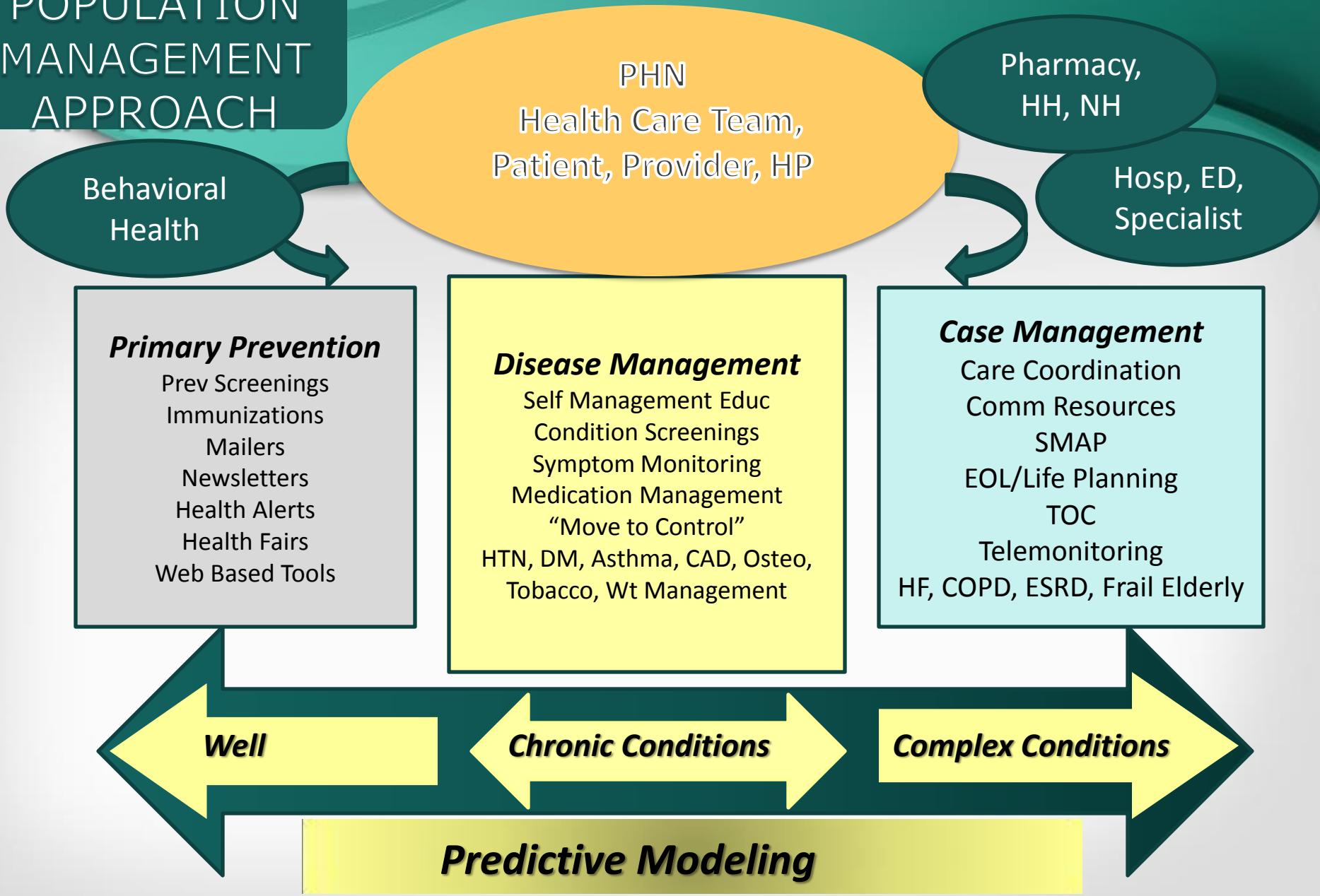


Intense case management services

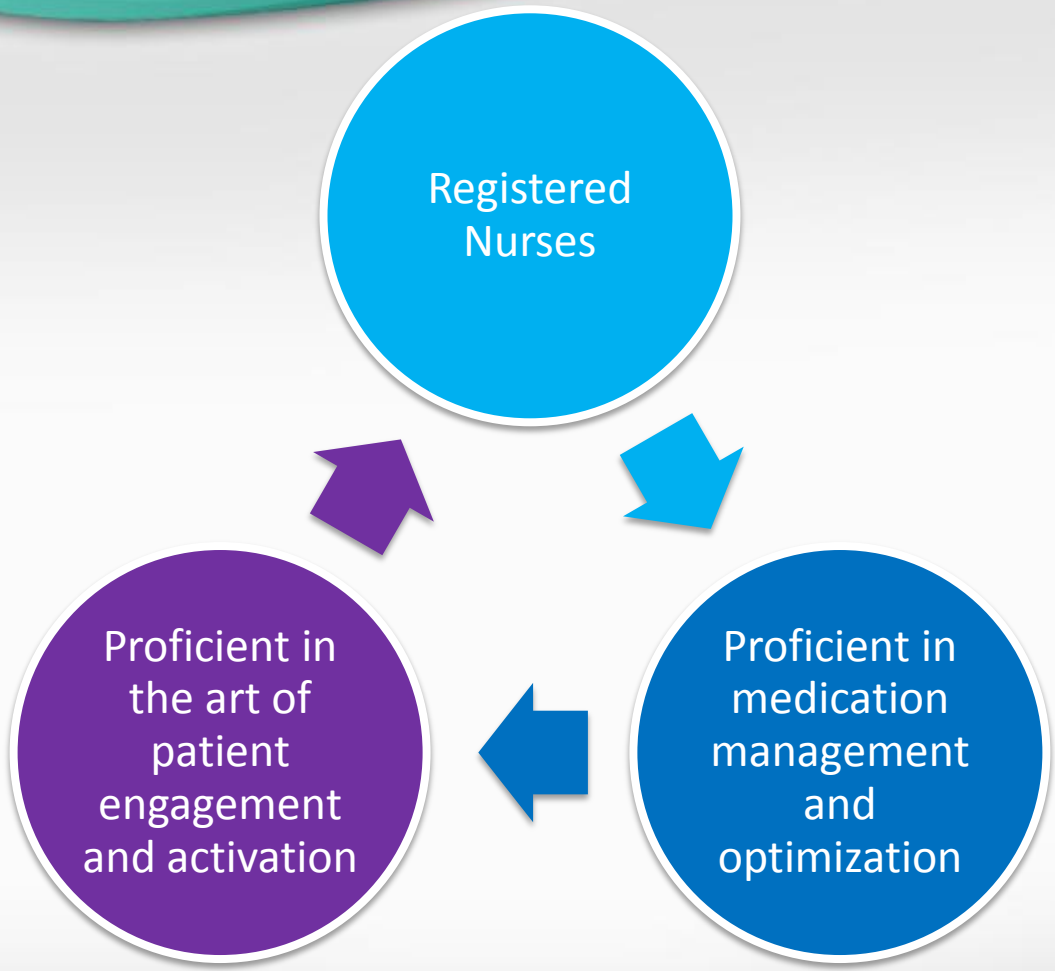
Disease management services

Focus on disease prevention, wellness

POPULATION MANAGEMENT APPROACH



Health Managers



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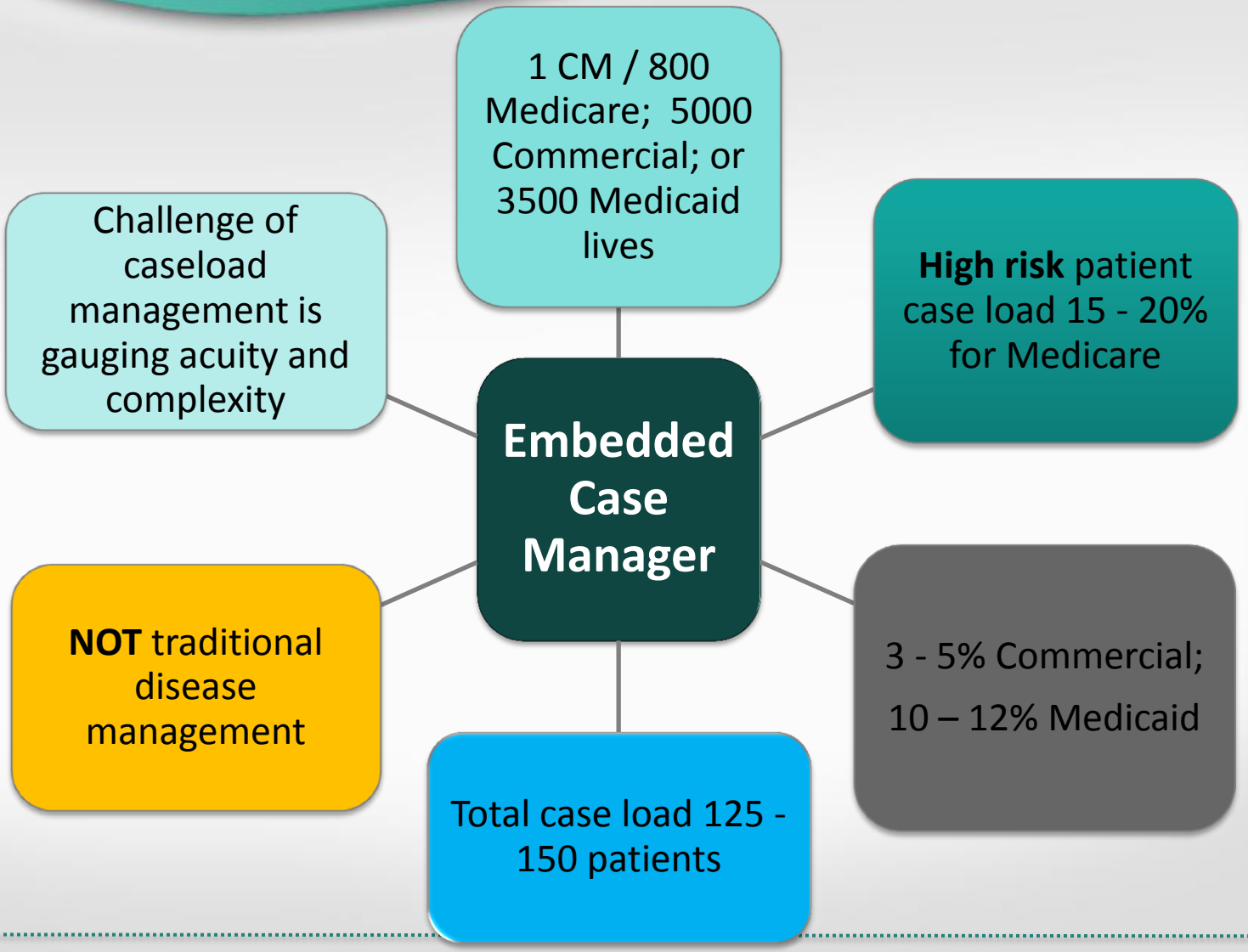
Case Management

Identifying and Managing the Highest Risk in Your Population

Geisinger's Approach to CM

High risk identification	Targeted populations	Comprehensive assessment	Team Care
• Predictive modeling • EHR data • Medical claims • Pharmacy data • HRA data	• HF, COPD, oncology, • Multiple trauma • ESRD, frail elderly • TOC	• Physical and psychosocial gaps • Readiness to change • Family/social supports • Driving issue behind case • Frequent follow-up with patient/family	• Daily interaction with provider • Active team member • Patient sees CM in practice • Top of the license

Embedded Case Managers are Key to Success



Predictive Modeling – Sample Report

Forecasted Risk Index	AIS	CIS	Risk Rank	Sex	Age	Total Paid	Forecasted Cost	Primary ETG Group	Program Status
4.1	91	35	5	M	82	$42,187.00	$44,456.00	Cerebrovascular Accident	MHOpen
4	80	37	5	M	68	$46,972.00	$43,405.00	Cardiovascular Surgery	MH CL - Need met
6.21	100	28	5	M	67	$137,724.00	$67,387.00	Infectious Disease	MHIdentified
3.19	93	25	5	F	75	$70,344.00	$34,563.00	Degenerative Ortho disease	MHCL- Needs meet
4.53	94	60	5	M	81	$49,157.00	$49,173.00	Cerebrovascular Accident	
10.2	97	51	5	F	71	$133,870.00	$110,630.00	Renal Failure, Chronic & Nephrosis	MHOpen
5.59	90	62	5	M	81	$25,981.00	$60,613.00	Renal Failure, Chronic & Nephrosis	MHIdentified
8.87	95	50	5	F	79	$113,895.00	$96,235.00	Renal Failure, Chronic & Nephrosis	MHCL- CC

Functions of a Case Manager

- Transitions of care
- Self management
- Chronic Care
- Telephonic and/or device monitoring
- Exacerbation management
- Frequent follow up

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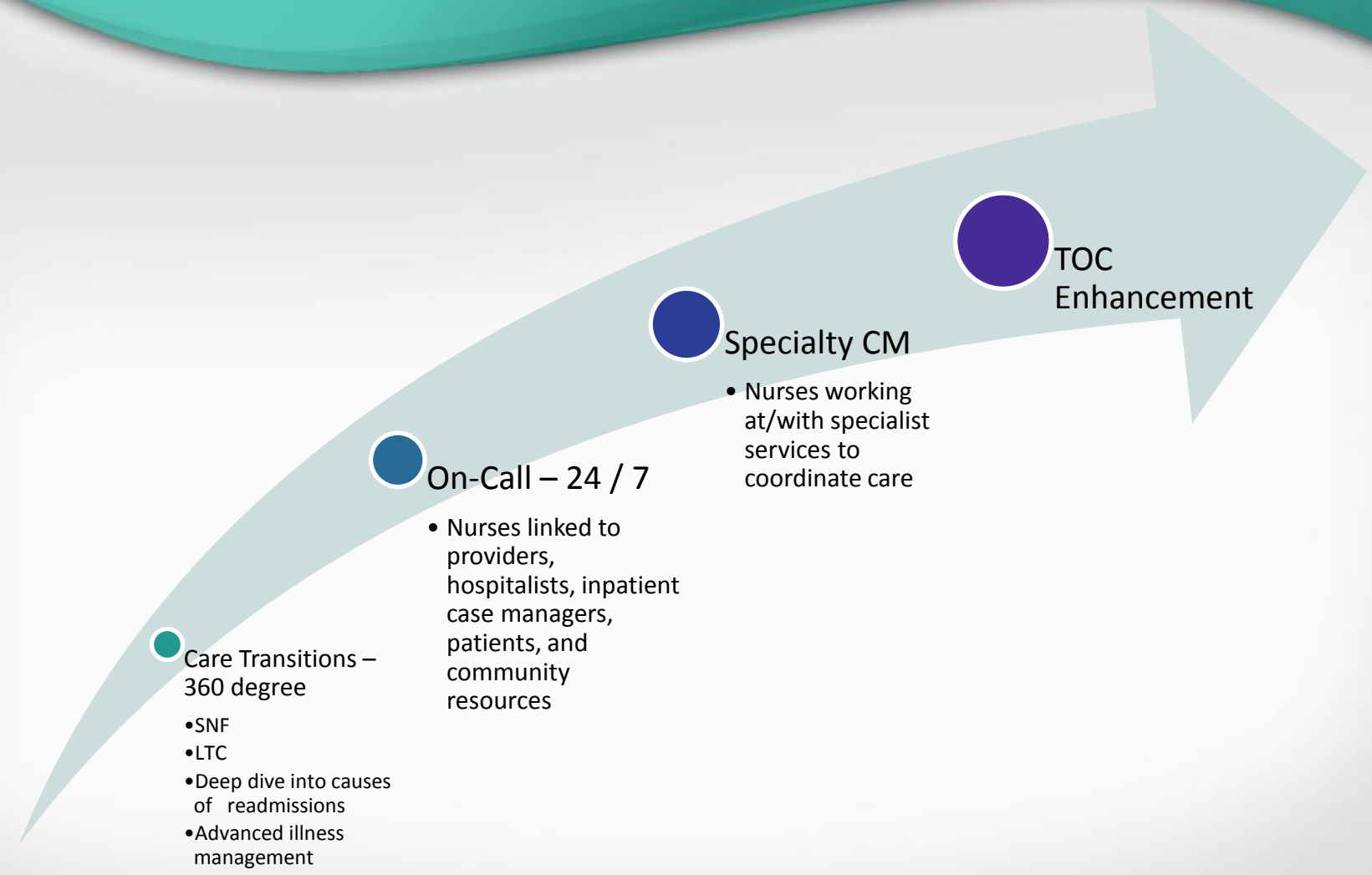
Tele-Monitoring Tools

Blue tooth scales	Managing HF	Transmits daily weights to EHR
Nurse sees weight real time	Diuretic titration protocols	Trending
Interactive Voice Response (IVR)	Outbound calls post discharge	HF IVR
Blue tooth blood pressure cuff		

Vertical Build of Case Management



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Case Management

Finding the Right Person for the Role

Choosing the Right Case Manager

Must be a good fit for clinic

Clinic Nurse

Providers need to be involved in selection

SNF/ LTC experience

Prior case management experience not a must

Home Health nursing

Hospital

*Often don't find a case manager – rather you help **create** a case manager*

Essential Skills of Competencies

Strong communication skills to include the ability to:

- Problem solve
- Think critically
- Engage patient
- Activate conversation
- Negotiate and resolve conflict

Must be able to think out of the box

Case Manager Skill Set

Interpret clinical information and assess implication of treatment

Develop and implement Plan of Care

Determine appropriate level of care

- PCP office
- Hospital
- Assisted Living /SNF/ LTC
- Palliative Care, Hospice

Investment in Case Management

- **Dedicated staff needed to drive outcomes**
  - Manager
  - Trainer
- Resources to support development
- Dedicated clinic space
- Dedicated phone line
- Administrative support

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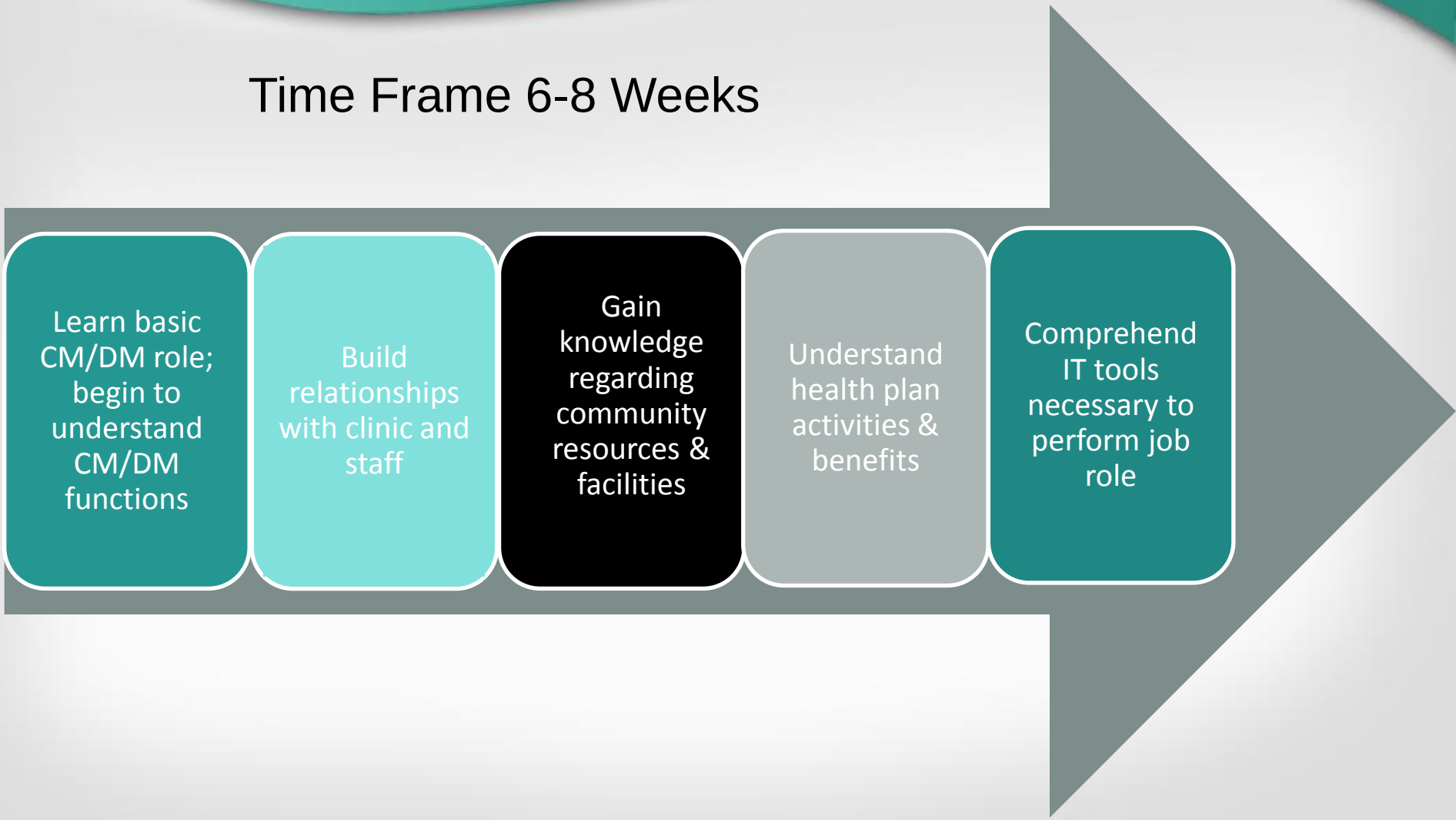
Training for Success

Approaches to CM Training

Orientation & Onboarding Process

Time Frame 6-8 Weeks



Maximizing Success of Your Staff

Monthly 1:1 time with each staff

- Reviewing cases/documentation
- Evaluating CM's understanding of the driving force of cases
- Provider/staff interaction
- Troubleshooting

Productivity and caseload management

- Nurse visit summary sheets
- Areas of opportunity – Readmissions trending up - Why?
- Gaps in role
- Patient engagement and ongoing follow-up

Ongoing Staff Development

Four CE days per year

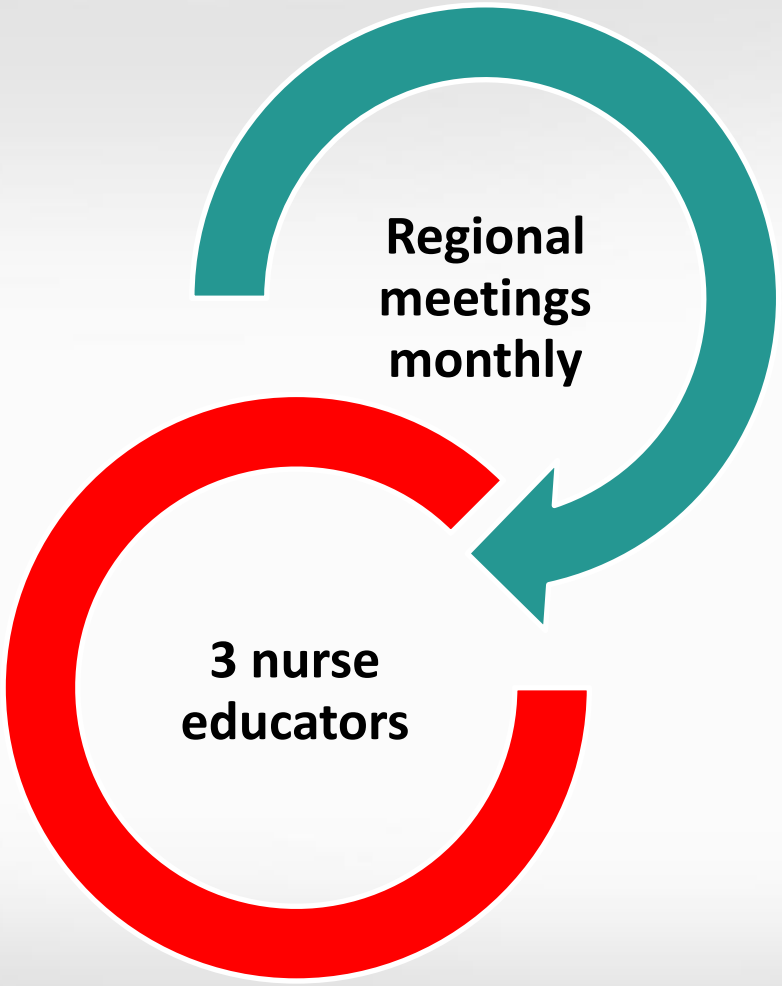
- All staff come on site for training
- CE and CCM credits
- Outside speakers
- Topics relevant to disease and case management

Learning packets

- Current articles pertinent to chronic condition
- Medications

Outside CE programs

Local Team Building



- Less time away from office for staff
- Provide updates, mini educational sessions
- Pharmacy integration
- Round table to discuss cases in more informal setting
- Develop staff relationships

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PHN Outcomes

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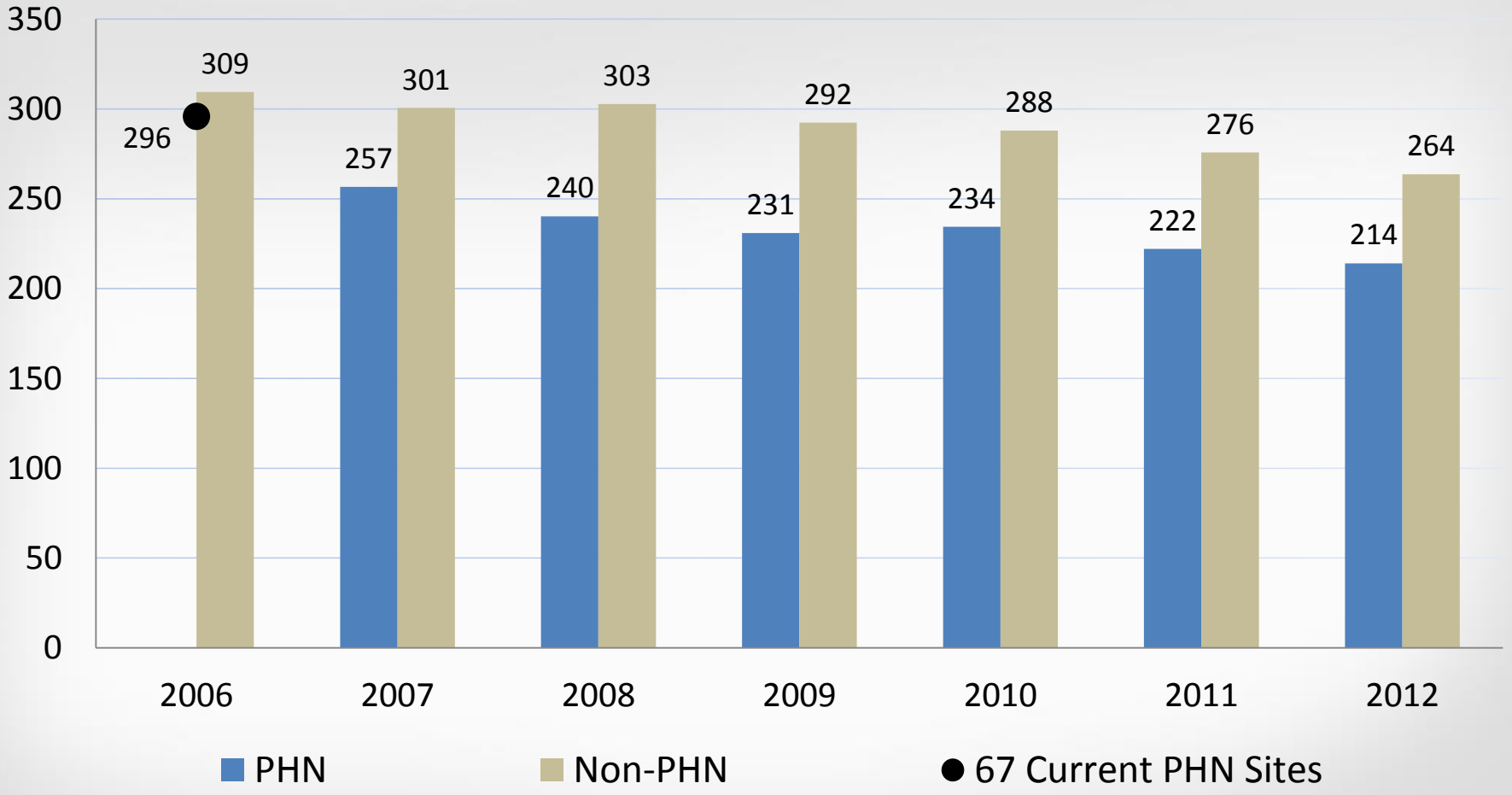
Medicare
Risk Adjusted Acute Admissions / 1000



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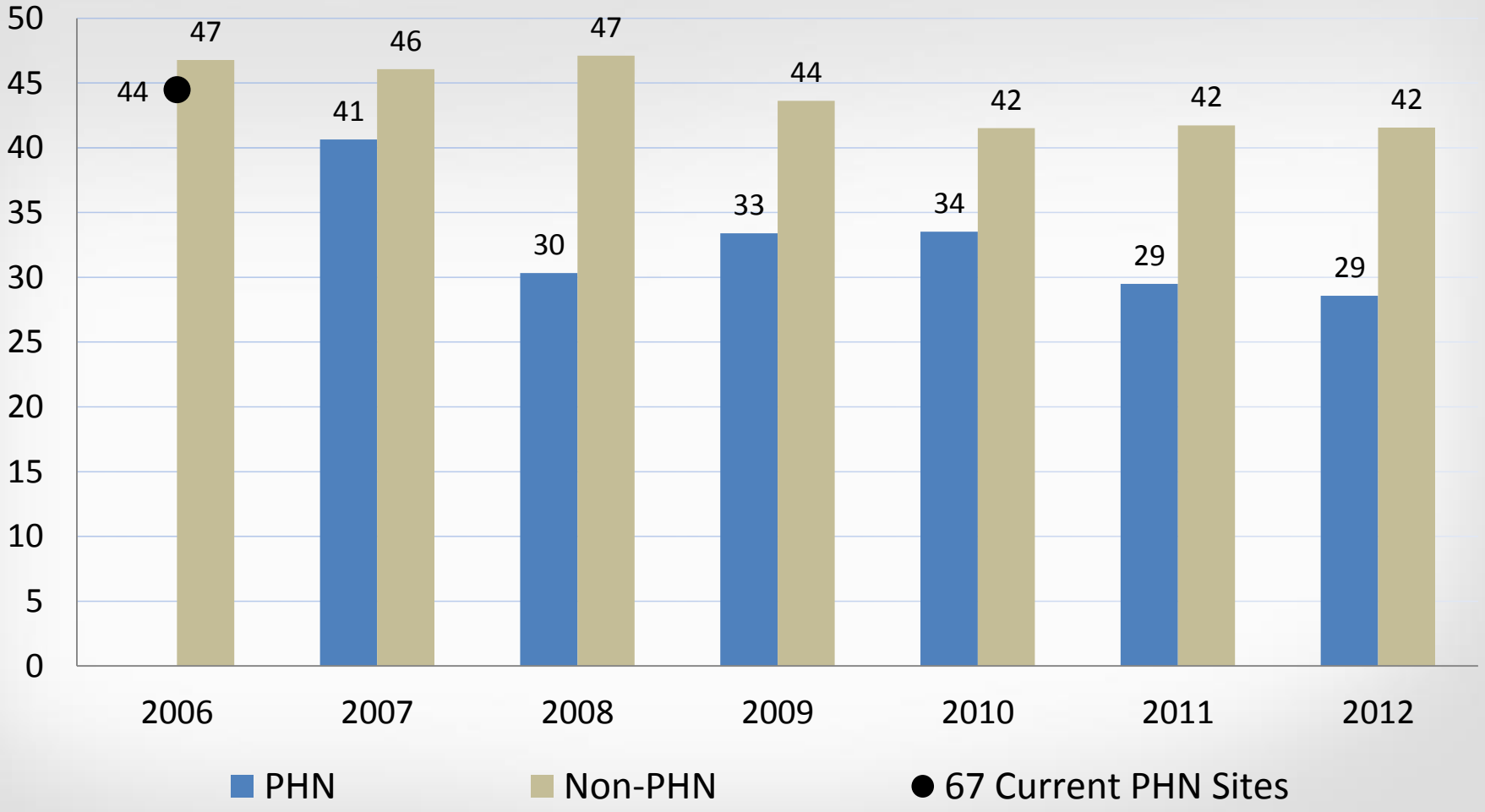
Medicare
Risk Adjusted Readmissions / 1000



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The Payer/Provider Transition

- An evolution toward healthcare partners with a focus on aligning reimbursement with outcomes
- Optimizing touch points to reduce unnecessary hospital admissions
- Collaborative and “full circle” communications to ensure consistent care plan

Pay-For-Performance Incentives

Physician Quality Summary (PQS) Program

- PQS is a multi-million dollar incentive program for participating Primary Care Providers based on Quality and Efficiency metrics.
- Physicians are evaluated on 5 core measurement areas.
- Physicians receive an overall star rating which determines the incentive amount.

Benefits observed

- Over 50% of GHP's membership is assigned to a 3 star physician.

Home Health Care

Creation of a pay for quality program that helps overcome care challenges such as:

- Timely & coordinated referral acceptance and admission visit across continuum
- Disease Management programs to assist with specific diagnoses
- “Kitchen table” medication reconciliation to reduce med errors
- Customized Recidivism approach created for each patient based on their functional status and disease state

% of reimbursement is at risk prospectively for measures not met in future terms of relationship

Skilled Nursing Facilities

- Long-term care is evolving to short term, post-acute rehabilitation
- Federal reimbursement reductions, causing SNF's to seek other avenues for revenue
- Focus on transitions of care and quality
  - Tying reimbursement structures to and rewarding providers for:
    - Required Discharge communication across all touch points
    - Higher acuity services & product niches geared to move patients across the continuum (lower acute LOS) and reduce acute admissions
    - Advanced care planning *(POLST, Advanced Directives, etc)*
  - Embedding Advanced Practitioners/SNFist physicians to assist with patient care management while in the SNF

Patient and Provider Satisfaction: What are they Saying?

Patients state:

- "The quality of care I receive has improved since I have a case manager."

Providers state:

- "PHN has allowed me to provide more comprehensive care than the previous system and information regarding my patients transitions of care is much more timely"

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Discussions / Questions?