



Partnered RN Care managers with those MA patients that predictive analytics (Verscend) stratified as highest risk to be hospitalized within next 3 months

Result

Cost of care for patients engaged with a RN Care manager was 50% less than patients who declined RN care manager support





Welcome Wagon: comprehensive member onboarding home visits

Result

Effective member engagement and retention with lower utilization and early RAF capture





Delivering after-hours and weekend urgent care visits to complex chronic patients in their homes

Result

Reduced avoidable inpatient admissions and ED visits enabling patients to stay healthier and happier at home



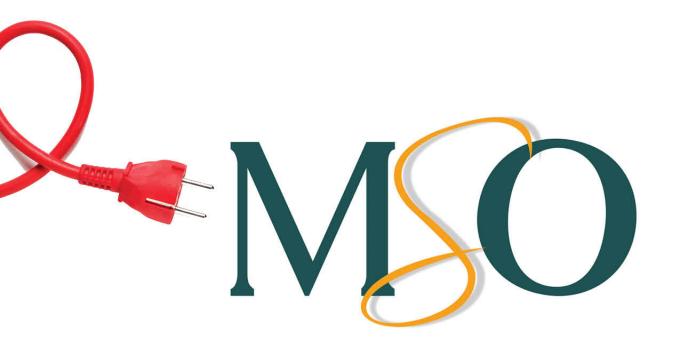


Symmetrical upside-downside risk program for SNFs to create full alignment and share in incremental savings generated in the post-acute space reduction in inappropriate utilization and avoidable readmissions

Result

Total Cost per case (SNF + Readmissions) reduction of -5% vs. 3% increase for the control group; nearly a third of Preferred SNFs earn the maximum distribution, able to reinvest in care redesign; higher patient satisfaction





Breaking the Cycle: Managing High Cost Chronically ill Patients back to IPA/Health Plan Profitability through an Interdisciplinary Chronic Care Model

Result

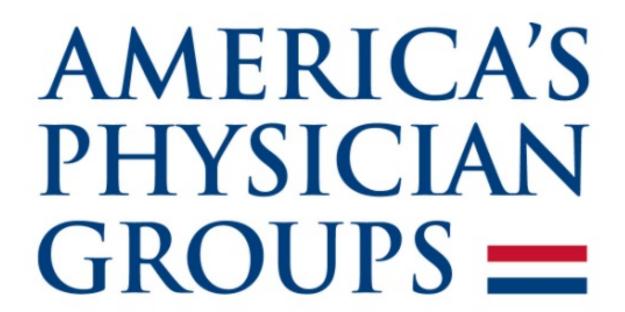
Performance Metrics	
Readmission	↓ 15.1%
ER visits per 1,000	↓ 13.1%
ALOS	↓ 8.7%
RAF	10.2%
PMPM Costs	↓ 7.2%
MLR %	↓ 18.4%



AMERICA'S PHYSICIAN GROUPS ==



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Save the Date

ANNUAL 2019 Conference

Quality and Efficiency: How to Succeed in Risk-Based Models

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