AMERICA'S PHYSICIAN GROUPS

New Care Management Models: The Cornerstone of Success

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Catholic Health Services (CHS) of Long Island

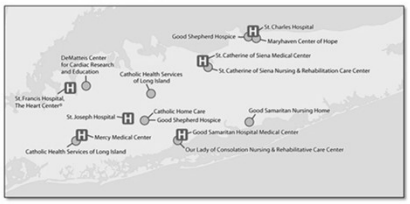
CHS Footprint on Long Island Is Concentrated in Large Population Centers

System Highlights

- 1,928 Certified Hospital Beds
- 790 Nursing Home Beds
- Approximately 18,400 Employees
- More than 4,300 Medical Staff
- More than 4,000 Nursing Staff
- Almost 3,000 Volunteers
- More than $2 Billion in Revenues

In 2018 at CHS, there were:

- 86,657 Hospital Admissions
- 5,486 Newborn Deliveries
- 400,000 Home Care Visits
- 56,312 Ambulatory Surgeries
- 25,958 Inpatient Surgeries
- 511,577 Ambulatory Outpatient Visits
- 17,135 Cardiac Catheterizations
- 4,958 Coronary Angioplasties
- 1,802 Open Heart Surgeries
- 237,178 Emergency Dept. Visits
- 126,199 Hospice Days of Care
- 147,397 Rehabilitation Visits
- Day & Residential Services for approximately 1,500 Individuals With Special Needs, Behavioral/Mental Health Concerns & Substance Abuse Issues



Catholic Health Services of Long Island

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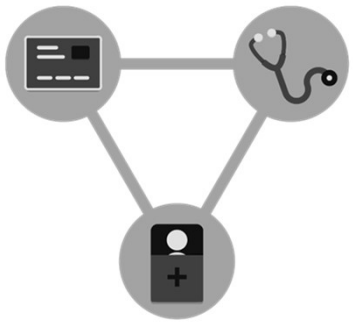
A Shared Vision

CHS Physician Partners is a LI -based financially and clinically integrated network of providers who share a vision to help its members achieve the best possible health at the lowest total cost of care.



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CHS Physician Partners

- Focused on Value-Based Contracts (VBCs):
  - Currently have ~ 137,000 covered lives in commercial/governmental VBCs as well as 105,000 lives in NYS Delivery System Reform Incentive Program (DSRIP)
  - MSSP (2 cohorts; one in Basic Level A, one in Basic Level B) ~ 40,000 attributed beneficiaries
  - CJR (currently in PY 4); over 3 years, 2,600 patients have received high-value care in this program
  - Currently evaluating participation opportunity in BPCI-A

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Key Levers

- Care Coordination
  - Clinical programs with longitudinal involvement of patients
- Quality Improvement
  - Higher degree of focus on preventative care and outcomes
- Network Performance Management
  - Reduce inappropriate overuse and practice pattern variation
    - ED, IP, SNF, readmissions
    - Advanced imaging, referrals to specialists, etc.
    - Increase domestic utilization
- Risk Adjustment
  - Comprehensively and accurately capture the illness burden of our cohorts
- Advanced Analytics
  - Added predictive/prescriptive capabilities

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Chronic Condition Management (C3) Programs

- Transitions of Care – TOC
- Chronic Condition Management – CCM
- Comprehensive Care for Joint Replacement – CJR
- Comprehensive Medication Management
- Behavioral Health
- Post Acute Care Management/Advanced Illness Care - WIP

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CHSPP Queue Criteria

TOC IDENTIFICATION CRITERIA

- Current admission or recent discharge (less than 30 days)
- Includes all Disease Registries
- Risk stratification of non-MSSP patients

CM HIGH RISK IDENTIFICATION CRITERIA

- One chronic condition and one inpatient admission in the last 31-90 days
- Chronic Conditions are:
  - COPD/Asthma
  - CAD/AMI/CHF
  - HTN
  - DM
  - Depression
  - ESRD
  - HIV
  - Cancer
- Manual review of queue and selection based on EPIC risk score

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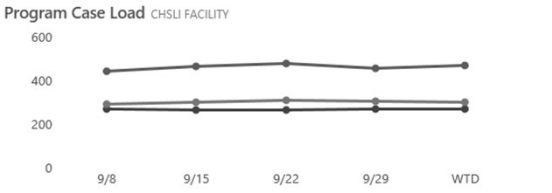
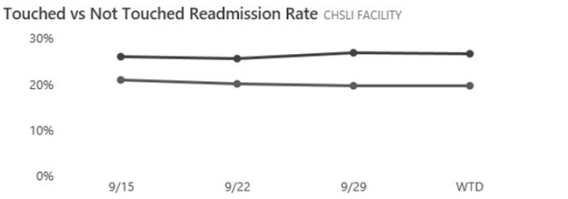


	9/8	9/15	9/22	9/29	WTD
TOC	442	463	474	454	466
CM	267	262	265	268	268
CJR	289	297	307	303	299

	9/8	9/15	9/22	9/29	WTD
CHF	38%	39%	38%	40%	39%
COPD	27%	29%	29%	29%	28%
CAD	48%	48%	48%	50%	49%
Diabetes	39%	39%	39%	40%	40%
Myocardial Infarction	7%	7%	7%	8%	8%
Pneumonia	12%	12%	13%	13%	13%
Sepsis	8%	8%	8%	7%	7%

Program	Enrollment Rate on Touched Cases*
TOC	73.3%
CM	52.5%
CJR	84.9%
Overall	70.3%

*Enrolled Cases over Total Cases assigned to coordinator. Excludes overflow and other cases where the coordinator declined before taking on



	9/15	9/22	9/29	WTD
Touched by coordinator	20.7%	19.8%	19.5%	19.4%
Not touched by coordinator	25.9%	25.4%	26.6%	26.4%

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Challenges

- How to identify truly impactable high – risk (and rising risk) patients with a higher degree of accuracy?
  - Is a new model needed?
  - What Predictive/Prescriptive analytics capabilities would add value and currently exist?
- What's the interaction/intervention method that produces the best results?
  - F2F (embedded/co-located/episodic) vs telephonic vs telehealth vs hybrid…

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Challenges

- How long to engage?
- How to get higher (patient/provider) engagement rates?
  - Can applying Behavioral Economics principles help?

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Patient Segmentation Models

Current	Another	Another
Current admission (or recent DC within 30 – 90 days)	Utilization (IP/ED over last 12 months)	Terminal Condition/Process
Certain Chronic Conditions	Conditions	Severe Chronic Disease Process/Acute Event
EPIC Predictive Model Risk Score	Clinical Data (A1c, GFR changes)	Stable chronic disease/condition, controlled or not
Physician Referral	Rx	High risk lifestyle or behavior or episode
Other	SDoH	Generally well
	Engagement (PAM)	

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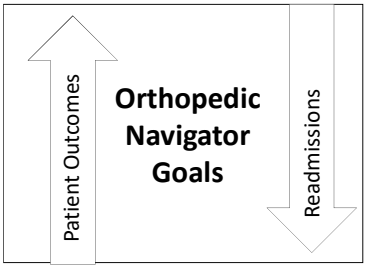
A Problem:

- Increase in post discharge Emergency Department (ED) visits in CJR patients
- Increasing 30-day readmissions:
  - Performance Year 2: 4.9%
  - Performance Year 3: 5.9%

Strategy:

- Incorporated the use of a predictive risk assessment tool to identify CJR patients that are at a **higher** risk for ED visit / readmission
- Ensure patients having elective joint replacements were medically and socially managed pre-operatively at an **earlier** date to minimize ED/readmissions.



Maximize outcomes while minimizing readmissions

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Actions Taken

- During June 2019, implemented the use of the "EPIC Predictive Model" that calculates a patient's risk for ED visit or hospital readmission within the next year
- Contains 19 variables correlating with readmissions and ED visits
  - COPD, CHF, Diabetes, Depression, etc.
- Scoring:
  - **High Risk** = 40-100
  - **Medium Risk** = 20-39.9
  - **Low Risk** = 0-19.9

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Actions Taken

- We revised CJR Orthopedic Navigator workflow

Previous workflow for ALL patients

Initial Outreach	1 week before surgery
First 30 days post-op	Weekly outreach
30-60 day post-op	1 outreach
60-90 day post-op	1 outreach and close

Workflow for High Risk Patients

Initial Outreach	When surgery is booked
Surgery booking –date of surgery	Weekly outreach
First 30 days post-op	Weekly outreach
30-60 day post-op	Weekly outreach
30-90 day post-op	Weekly outreach

Constantly monitored by Orthopedic Navigators weekly for 90 days

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Results (Since June 17, 2019)

- 29 patients have been identified as "**HIGH RISK**" to date

- None of these patients have been readmitted within 30 days post-op

Informed and engaged patients and physicians drive lower readmissions!

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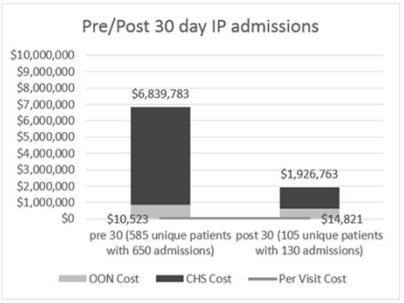
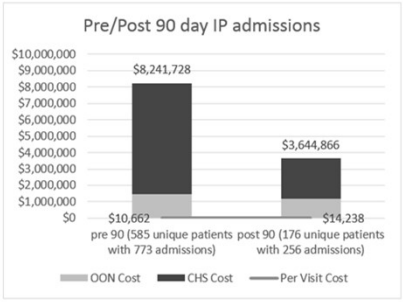
Catholic Health Services
Care Coordination Pre/Post Analysis
September 2018 through June 2019
Sources: Health Endeavors, 9.23.2019 YM

MSSP patients enrolled in Care Coordination within 30 days following a IP Admission

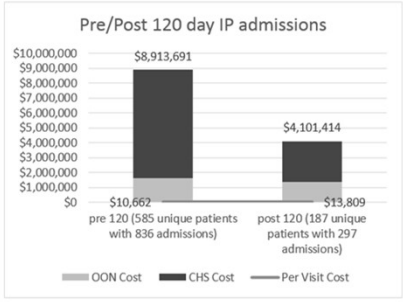
enrolled in Care Coordination between Sep '18 - Jun '19



	Pre 30	Post 30
Admits/1k	1,111.1	222.2
30 day readmit rate	17.9%	



	Pre 90	Post 90
Admits/1k	1,321.4	437.6
90 day readmit rate	30.1%	



	Pre 120	Post 120
Admits/1k	1,429.1	507.7
90 day readmit rate	32.0%	

Prepared by CHSPP Data Analytics

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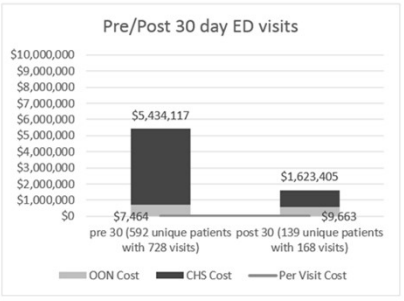
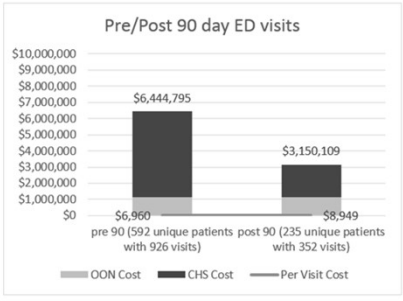
Catholic Health Services
Care Coordination Pre/Post Analysis
September 2018 through June 2019
Sources: Health Endeavors, 9.23.2019 YM

MSSP patients enrolled in Care Coordination within 30 days following an ED Visit*

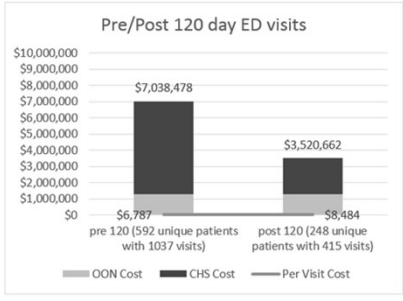
enrolled in Care Coordination between Sep '18 - Jun '19



	Pre 30	Post 30
ED Visits/1k	1,229.7	283.8
30 day readmit rate	23.5%	



	Pre 90	Post 90
ED Visits/1k	1,564.2	594.6
90 day readmit rate	39.7%	



	Pre 120	Post 120
ED Visits/1k	1,751.7	701.0
90 day readmit rate	41.9%	

* When the ED visit leads to an IP admission, visit cost is inclusive of the IP portion of the claim

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Questions?

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