The project described is supported by Grant Number 1C1CMS331047 – 01 – 00 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

The contents of this presentation are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
Stanford Coordinated Care

“Support the Patients, Manage their Care”

Ann Lindsay MD, Co-Director
August 10, 2015
Determinants of Health and Their Contribution to Premature Death

Schroeder, NEJM 357; 12
“Hot Spotting” in Employed Populations

• Boeing & Atlantic City Resorts (A. Milstein, Kothari, Fernandopulle)
  – AICU in 2 self-funded industries
    Capitation fee plus FFS for specialized MD-led teams within 3 MD groups and free-standing (Atlantic City)
  – 18%- 20% net reduction in per capita spending vs. propensity matched controls

• Humboldt (A. Glaseroff)
  – Partnered with PERS and PBGH (Anthem as ASO);
  – Disseminated rural county model within a distinguished IPA inserting RN care managers into 25 private practices
  – 16% net savings estimated in first year
### Better, Faster and Leaner: Boeing A-ICU Results After 1 Year

**Change in Combined Total Per Capita Health Care Spending, Functional Health Status, Patient Experience, and Absenteeism**

<table>
<thead>
<tr>
<th>% change from baseline in unit price-standardized total annual per capita spending by patients and Boeing, compared to a propensity-matched control group, net of supplemental fees to medical groups</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>+20%*</td>
<td></td>
</tr>
<tr>
<td>% change in SF12 physical functioning score for IOCP patients compared to baseline</td>
<td>+14.8%</td>
</tr>
<tr>
<td>% change in SF12 mental functioning score for IOCP patients compared to baseline</td>
<td>+16.1%</td>
</tr>
<tr>
<td>% change in patient-rated care “received as soon as needed” compared to baseline**</td>
<td>+17.6%</td>
</tr>
<tr>
<td>% change in average of patient-reported work days missed in last 6 months compared to baseline</td>
<td>−56.5%</td>
</tr>
</tbody>
</table>

* p = 0.11 after first 12 months for 276 chronically ill enrollees vs. 276 matched controls.

** From the Ambulatory Care Experience Survey – patients responding “always” or “almost always” to the question: “When you needed care for illness or injury, how often did the IOCP provide care as soon as you needed it?”
PBGH Intensive Outpatient Care Program in Brief

- **15,000**: number of patients enrolled May 1, 2012 to June 2015
- **23**: participating delivery systems / 500 practices
- **72%** patient engagement rate (range = 33% to 99%)
- **5**: states represented (CA, AZ, ID, NV and WA)
- Organizational variation - Independent Practice Associations, medical foundations, integrated and non-integrated systems
- Payment variation - Pioneer and MSSP ACOs, Medicare Advantage and fee-for-service
Effective Targeting of Care Management

Population Volume

Intensity of Illness

Healthy

Chronic Illnesses

Medically Complex High Utilizers

Area of Greatest Opportunity

Intensity and Specificity of Intervention

Clemons Hong MD, MPH
Complex Care Subtypes

- The "Pre"Complex Patient
- The Complex ED Patient
- The Ambulatory Complex Medical Patient
- The Home Bound Complex Medical Patient
- The Long Term Care Patient
- The Complex Rare Disease Patient
- The Primary Care Sensitive Visit Group
## Predictive Modeling

<table>
<thead>
<tr>
<th>RISK ADJUSTER TOOL</th>
<th>INPUTS</th>
<th>250K</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARA DxAdjuster</td>
<td>Diag</td>
<td>24.9%</td>
</tr>
<tr>
<td>ACG</td>
<td>Diag</td>
<td>19.2%</td>
</tr>
<tr>
<td>CDPS</td>
<td>Diag</td>
<td>14.9%</td>
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<tr>
<td>Clinical Risk Groups</td>
<td>Diag</td>
<td>17.5%</td>
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<tr>
<td>DxCG DCG</td>
<td>Diag</td>
<td>20.6%</td>
</tr>
<tr>
<td>MARA RxAdjuster</td>
<td>Rx</td>
<td>21.6%</td>
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<tr>
<td>DxCG RxGroups</td>
<td>Rx</td>
<td>20.4%</td>
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<tr>
<td>Ingenix PRG</td>
<td>Rx</td>
<td>20.5%</td>
</tr>
<tr>
<td>Medicaid Rx</td>
<td>Rx</td>
<td>15.8%</td>
</tr>
<tr>
<td>MARA CxAdjuster</td>
<td>Med+Rx</td>
<td>28.8%</td>
</tr>
<tr>
<td>ImpactPro (Ingenix)</td>
<td>Med+Rx+Use</td>
<td>24.4%</td>
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<tr>
<td>Ingenix ERG</td>
<td>Med+Rx</td>
<td>19.7%</td>
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<tr>
<td>ACG w/Prior Cost</td>
<td>Diag+$Rx</td>
<td>N/A</td>
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<tr>
<td>DxCG UW Model</td>
<td>Diag+$Total</td>
<td>N/A</td>
</tr>
<tr>
<td>MEDai (Service Vendor)</td>
<td>All</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Higher R-Squared is better.
** Lower MAPE% is better.

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Prospective Risk: from Claims Data

High Concurrent/Low Predictive: "Regression to the mean"

High Concurrent/High Predictive: Main target - can demonstrate ROI

Low Concurrent/Low Predictive: "Care too expensive"

Low Concurrent/High Predictive: "Avoiding avoidable care"
### CRG Status by Tier

<table>
<thead>
<tr>
<th>CRG Status</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Healthy</td>
<td>21,701</td>
<td>301</td>
<td>8</td>
<td>22,010</td>
<td></td>
</tr>
<tr>
<td>2 - History of Significant Acute Disease</td>
<td>2,604</td>
<td>52</td>
<td>8</td>
<td>2,664</td>
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<tr>
<td>3 - Single Minor Chronic Disease</td>
<td>1,466</td>
<td>2,748</td>
<td>5</td>
<td>4,219</td>
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<tr>
<td>4 - Minor Chronic Disease in Multiple Organ Systems</td>
<td>1,383</td>
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<td>3</td>
<td>1,386</td>
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<tr>
<td>5 - Single Dominant or Moderate Chronic Disease</td>
<td>272</td>
<td>10,420</td>
<td>577</td>
<td>65</td>
<td>11,334</td>
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<tr>
<td>6 - Significant Chronic Disease in Multiple Organ Systems</td>
<td>11,633</td>
<td>3,717</td>
<td>629</td>
<td>15,979</td>
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<tr>
<td>7 - Dominant Chronic Disease in 3 or more Organ Systems</td>
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<td>57</td>
<td>1,796</td>
<td>1,853</td>
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<tr>
<td>8 - Dominant, Metastatic and Complicated Malignancies</td>
<td>422</td>
<td></td>
<td>91</td>
<td>513</td>
<td></td>
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<tr>
<td>9 - Catastrophic Conditions</td>
<td>567</td>
<td>220</td>
<td>213</td>
<td>1,000</td>
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<tr>
<td>Totals</td>
<td>26,043</td>
<td>27,526</td>
<td>4,571</td>
<td>2,818</td>
<td>60,958</td>
</tr>
</tbody>
</table>

Report Name: Count_by_CRG_Status.rdi
Hospital Admission Risk Multiplier Screen (HARMS-8): To identify further risks, ask the following questions:

1. In general, how would you rate your current health?
   - ☐ Excellent  ☐ Very Good  ☐ Good  ☐ Fair  ☐ Poor
   For all, “Why do you rate it that way?”

2. How many prescription medications are you currently taking every day?
   - ☐ None (SKIP to question 3)  ☐ 1-2  ☐ 3-4  ☐ 5 or more
   2_a) During the past WEEK, how often did you forget to take or decide not to take one or more of these medications?
      - ☐ Never  ☐ Sometimes  ☐ Usually  ☐ Always
   2_b) How sure are you that you understand the purpose of each medication you are taking?
      - ☐ Very Sure  ☐ Somewhat Sure  ☐ Not very sure
   Unless Never/ Very Sure: “What is most difficult for you in taking your medications?”

From CareOregon
3. Think about your usual daily activities, such as bathing, toileting, dressing, grooming, feeding, housework, family or leisure activities. Which of the following best describes your situation in the last MONTH:

- I have no problems with performing my usual activities.
- I have some problems with performing my usual activities without assistance.
- I am unable to perform my usual activities without assistance.

Unless no problems: “Do you think you need help managing at home? If so, what kind?”

4. In the last MONTH, how often did you have trouble with remembering or thinking clearly?

- Never  - Sometimes  - Usually  - Always

Unless Never, “What do you do when that happens?”
7. During the past 6 months, how many times did you go to the emergency room?

☐ None (SKIP to question 8)  ☐ 1 or more times

7_a) Do you think it is likely you will need to go to the emergency room again in the next 6 months?

☐ Not likely  ☐ Somewhat likely  ☐ Very likely

Unless Not likely, “What do you think would help to keep you from needing to go to the emergency room?”

8. During the past 6 months, how many times did you stay in the hospital overnight as a patient?

☐ None (END)  ☐ 1 or more times

8_a) Do you think it is likely you will need to be hospitalized again in the next 6 months?

☐ Not likely  ☐ Somewhat likely  ☐ Very likely

Unless Not Likely: “What do you think causes your condition to get so bad you need to be in the hospital?”
5. If you needed immediate help for a health problem, how many friends or relatives do you feel close to such that you could call on them for help?
   - None  
   - 1  
   - 2  
   - 3 or more
5_a) Who are they?
5_b) How often do you communicate with them?
   If None or unclear, “Is there someone who might be willing to help if they were asked?”

6. Think about your current medical conditions. How confident are you that you can manage these medical conditions day-to-day?
   - Very confident  
   - Somewhat confident  
   - Not very confident  
   - I don’t have any health problems
   Unless Very confident: “What is most challenging for you about your health?”
Stanford Coordinated Care

- “Ambulatory complex patients”
- Employees and dependents of self-insured plan
- Capitated services with shared savings agreement
- Established 4/2012
  - Dr Arnie Milstein, Clinical Effectiveness Research Center
  - Now 450 patients and growing
Primary Care Plus

Services:

- No co-pays for SCC services
- 24/7 access to Primary Care Physician
- Coordination with specialists so everyone is on the same page
- Care transition planning at hospitalization with home visit if needed
- Contact with SCC staff once a week on average
- No charge to health plan for in-office lab
- Management of coagulation medication with home lab testing
Care Support

Services:
• FREE to those with Stanford health plans
• Counseling services as needed
• Health coaching and goal setting
• Assistance with ongoing health conditions like asthma, weight loss, high blood pressure, high cholesterol and stress
• Care transition planning at hospitalization with home visit if needed
• Coordination with primary care physicians and specialists so everyone is on the same page
<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling alone</td>
<td>Becoming an empowered patient</td>
</tr>
<tr>
<td>Forced to be at the center</td>
<td>Supported and confident</td>
</tr>
<tr>
<td>Feeling studied</td>
<td>Feeling listened to</td>
</tr>
<tr>
<td>Facts</td>
<td>Hands-on action</td>
</tr>
<tr>
<td>Passed between providers</td>
<td>Creating personal relationships</td>
</tr>
<tr>
<td>Stalling</td>
<td>Thriving</td>
</tr>
<tr>
<td>Resource intensive</td>
<td>Streamlined</td>
</tr>
</tbody>
</table>
From Our Lips to Whose Ears at Stanford?

From
• Chronic diseases
• Ambulatory ICU
• Group visits
• Care management
• My (MD) care coordinator
• “...coordinate your care”

To
• Ongoing conditions
• Coordinated Care
• Seminars
• Care support
• Your (patient) care coordinator
• “...care with you at the center”
“Why wouldn’t a person with a chronic condition do everything in their power to live long and feel well?”

Stop overeating, stop drinking, stop staying out late, stop fighting, stop worrying, stop eating sweets, stop gambling...
Patient Variation – what the patient faces

Domains

Medical Neighborhood
- Access to Care
- Experience with Provider(s)
- Getting Needed Services
- Coordination of Care
- Medical Home / Services Risk

Medical Status & Health Trajectory
- Medications & Treatments
- Chronicity
- Symptom Severity & Condition Factors
- Diagnostic/Therapeutic Challenges
- Utilization Factors

Self Management & Mental Health
- Engagement / Coping
- Adherence to Treatment
- Mental Health History
- Mental Health Symptoms
- Self Management & Mental Health Risk

Social Support
- Home Environment
- Job & Leisure
- Social Support
- Social Relationships
- Social Support Risk

The Team = Patient, Providers, RN Care Manager, patient's support network

From CareOregon, Intermed, and Humboldt IPA
Activation Level - What the Patient Brings

10-15% of the population*

Starting to take a role
Individuals do not feel confident enough to play an active role in their own health. They are predisposed to be passive recipients of care.

20-25% of the population*

Building knowledge and confidence
Individuals lack confidence and an understanding of their health or recommended health regimen.

35-40% of the population*

Taking action
Individuals have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

25-30% of the population*

Maintaining behaviors
Individuals have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

* Medicaid and Medicare populations skew lower in activation

From Judith Hibbards (OHSU) and Insignia Health
• “Depression significantly increases the overall burden of illness in patients with chronic medical conditions... depression is associated with a 50-100% increase in health services use and cost.”

Depression is Often Not the Only Health Problem Our Patients Face

- Depression
- Neurologic Disorders: 10-20%
- Chronic Pain: 10-20%
- Geriatric Syndromes: 20-40%
- Heart Disease: 20-40%
- Diabetes: 10-20%
- Cancer: 10-20%
- Geriatric Syndromes: 20-40%
- Chronic Pain: 40-60%

2010 University of Washington – AIMS Center
The Often *Hidden* Driver:
Adverse Childhood Events

**ACE Score** = 1 point each for positive responses to 10 questions inquiring about exposure to:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Physical neglect
- Emotional neglect
- Divorce/separation
- Domestic violence in the home
- Parent that used drugs or alcohol
- Parent that was incarcerated
- Parent that was mentally ill

From: www.acestudy.org
How does ACE play out later in life?

• Increased smoking:
  – The higher the ACE score, the greater the likelihood of current smoking

• COPD:
  – A person with an ACE score of 4 is 2.6 x more likely to have COPD than a person with an ACE score of 0

• Depression:
  – A person with an ACE score of 4 was 4.6 x more likely to be suffering from depression than a person with an ACE score of 0

• Suicide:
  – There was a 12.2 x increase in attempted suicide between ACE 4 vs. 0; at higher ACE scores, the prevalence of attempted suicide increases 30-51 fold!
  – Between 66-80% of all attempted suicides could be attributed to ACE.
SCC Approach: “The Activation Model”

• From:
  “What bothers you the most?”

• To:
  “Where do you want to be in a year?”

First step  Next step  Getting there…
Predicted Average Per-Capita Costs 2 Years Later by Change in PAM Level

Predicted costs are based upon regression models with log transformed costs that control for age, sex, chronic conditions, natural logarithm of income and percent of care that was received in-network. Costs were retransformed from log dollars using the Duan smear factor.
Patients with lower activation associated with higher costs; delivery systems should know their patients' scores.


• http://www.ncbi.nlm.nih.gov/pubmed/23381513
How was this achieved?
Preliminary Patient Activation Measures (PAM) Results through June 2014

Distribution of Baseline and Follow-up PAM Levels - All IOCP through 6/15/14

Based on 847 patients with repeated assessments

- 32% increased overall activation
- 14% decreased overall activation
- 54% same overall activation

*Additionally, preliminary independent group findings (Wave 1 sites) show lower admission and ED utilization from IOCP participants.
Comparative Values by PAM Levels

- **Level 1**: Initial 20, Repeat 10
- **Level 2**: Initial 30, Repeat 20
- **Level 3**: Initial 100, Repeat 50
- **Level 4**: Initial 150, Repeat 100

Legend:
- Green: Initial
- Purple: Repeat
IOCP Metrics

VR-12

- 3.3% improvement in physical health functioning
- 4.2% improvement in mental health functioning

PHQ (depression score)

- 31% improvement

PAM

- 37% increase
- 45% same
- 11% decrease

- 30% increase in graduation among patients whose PAM score increased

The research presented here was conducted by PBGH
SCC Value: Patient Experience

- 99th percentile in Press Ganey Likelihood to Recommend 19 out of last 20 months
- Employees and dependents appreciate the service
- 95% of MyHealth Medical Advice Requests responded to within 24 hours
SCC Value: Clinical metrics

- >90th percentile HEDIS in 9 out of 10 process measures
- 83% colon cancer screening rate
- Improved screening can contribute to increased costs initially
Run Chart to Track Quality Improvement

Systolic Blood Pressure Control

SBP

Will be updated monthly and posted on the Vis Wall
Foundation for Success

- Senior leadership support
- Dedicated physician champion
- Identify appropriate patients
- Take-up is greater in risk environments
- Most effective when there is provider-hospital integration
- Most successful when integrated into entire population health strategy
- Strong analytic capacity for program monitoring
- Adapt to local environment after meeting requirements
Financial Elements of Sustainability

- Financial and performance incentives create provider demand for new models - and provider demand leads to sustainability
  - Continue evolution toward global or bundled payment and Total Cost of Care
  - New care coordination code helps, but doesn’t offset all cost
- Medical neighborhood reimbursement needed
- Continued alignment of public and private payers
  - Creates consistency of care regardless of payer
  - Provides reliable revenue stream
  - Better communication, greater efficiencies
From “Cup Runneth Over”…

Provider

Medical Assistant/Care Coordinator

Nurse

Behavioral Health

Clinical Pharmacist

Physical Therapist
To “Share the Care”

- Provider
- Medical Assistant/Care Coordinator
- Nurse
- LCSW/Behavioral Health
- Physical Therapist
- Clinical Pharmacist
General Rules for Team Care

- Panel management: accountability
- Staff work to limits of their credential
Key Elements of Team Building

• Defined goals
  – Overall mission
  – Measurable operational objectives

• Systems
  – Clinical
  – Administrative

• Improvement methodology at frontline

• Division of labor
  – Definition of workflows
  – Assignment of roles

• Training

• Communication
From MA to Care Coordinator

• “Artisanal” vs. assembly line
  – Coach, advocate, MA, scribe, outreach worker, pop health manager combined in single person: relationships are key

• Empanelment

• Training: onboarding and ongoing

• Case presentations at team meetings

• Staying with the patient – few handoffs
  – Scribing the visit: learning as the patient learns

CREATE NEW JOB CATEGORY AND PAYSCALE to reflect greater skills and responsibility
EPIC Charting

Problem List

Clark Superman is 45 Y with a PAM level of 4

Patient Goals:
1. Become weightless
2. Avoid krypton
3. Get married to Lois when I am healthy

Action Plans:
1. Fly three times a week for stress reduction
2. Try a lighter weight cape to help with shoulder pain

Follow up:
1. Stool test for colon cancer screen
2. See Deborah for shoulder pain

Diagnosis:
- Diabetes mellitus type II, uncontrolled

- Hypertension
  - Overview: On meds since 2006. Stable on lisinopril and metoprol

- Morbid obesity
  - Overview: BMI 35.2. Referred to Healthy eating class and dietitian. Will not eat after 8 pm

- Hyperlipidemia
  - Overview: LDL 135.

Mark as Reviewed: Last Reviewed by Lindsay, Ann D, MD on 5/14/2014 at 12:24 PM
HEDIS: SCC results

Overall Composite: 84%
Diabetes Composite: 84%
Cardio Composite: 67%
Preventative Composite: 84%
Meds Mgmt Composite: 97%

Patients: 292
Patients: 63
Patients: 15
Patients: 291
Patients: 97

Distance from Goal

Measure | Percentage to Goal | Current Rate | Goal | Patients to Goal | Percentile Ranking (Estimated)
---|---|---|---|---|---
Overall | 33.3% | 84.3% | 59.5% | 292 | n/a
Diabetes | 90.1% | 83.9% | 74.8% | 63 | n/a
Cardio | 13.0% | 66.7% | 53.7% | 15 | n/a
Preventative | 43.6% | 83.5% | 40.9% | 291 | n/a
Meds Mgmt | 3.2% | 95.9% | 93.7% | 97 | n/a
Diabetes | HbA1c Screening | 5.4% | 98.4% | 93.0% | 62 | n/a
| HbA1c Control | 9.9% | 90.5% | 81.0% | 63 | n/a
| LDL Screening | -1.1% | 88.9% | 89.9% | 63 | n/a
| LDL Control | -1.6% | 94.0% | 95.6% | 63 | 2
| Nephropathy Monitoring | 7.2% | 92.2% | 89.0% | 62 | n/a
| BP Control | -5.4% | 76.2% | 81.6% | 63 | 4
Cardio | LDL Screening | 5.3% | 86.7% | 82.6% | 15 | 1
| LDL Control | 9.5% | 83.7% | 37.2% | 15 | 1
Preventative | Flu Immunization | 11.9% | 71.9% | 61.0% | 291 | 0
| Pneumococcal Immunization | 11.9% | 96.6% | 84.7% | 59 | 0
| Chlamydia Screening | -8.0% | 50.0% | 58.0% | 4 | 1
| Cervical Cancer Screening (ERB) | 9.9% | 91.9% | 82.0% | 124 | 0
| Breast Cancer Screening | 9.7% | 89.7% | 80.0% | 107 | 0
| Colorectal Cancer Screening | 17.7% | 87.7% | 70.0% | 187 | 0

Print - Colorectal Cancer Screening

Legend

- 0-24th
- 24.5th
- 50-74th
- 75th
- 90th

Percentile Ranking (estimated)
### HEDIS: Care Gaps Tool

**Care Coordinator:** COLEMAN, DELILA

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>PCP</th>
<th>Next Appot Date</th>
<th>HbA1c</th>
<th>LDL</th>
<th>Nephro pathy</th>
<th>LDL</th>
<th>Diabetes (Screening)</th>
<th>Cardio (Screening)</th>
<th>Preventative (Screening/Immunization)</th>
<th>Med. Mgmt.</th>
<th>SCC</th>
<th>PAM</th>
<th># Overdue</th>
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<tbody>
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<td>15</td>
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<td>Overdue</td>
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<td>04/17/20[015]</td>
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<td></td>
<td></td>
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<tr>
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Analytics Risk Dashboard

Population Health Dashboard

Panels Health Indicator

Time: Q1, Q2, Q3, Q4

Chronic Condition
- Asthma
- CAD
- CHF
- COPD
- Diabetes
- Hypertension

Panel Summary

Visit Detail

Progress

Clinic Performance By Measure

Current Selections
- Clinician: AGPZ, K X K CAYE P F T
- BZCI, KRB, W, N, G
- IUR, ODBC, Q1, L, G, Q, F, DDW
- JYXY, M, IN, B, S, C, D, I
- LNG, G, M, M, N, S

View Patient Record
Monthly “Speed Dating”

Each care coordinator conferences with relevant clinician on CC panel they share

- Each CC works with each clinician – allows for cross-coverage
- Focus on “red” areas – immediate risk for poor outcome
- CC panel ~100
- No one “falls through the cracks”
- Care gaps also addressed
A quote from a patient:

“Stanford Coordinated Care focused on the little things that were leading to my needing to be hospitalized.”

**SCC Case Study**

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<th>Before enrolling in SCC</th>
<th>After enrolling in SCC</th>
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<td><strong>01/24/2012 – 06/24/2012</strong></td>
<td><strong>06/25/2012 – 12/25/12</strong></td>
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<td>4 Urgent inpatient admission (syncope, sepsis, peritonitis, osteomyelitis)</td>
<td>No (0) inpatient stays or surgeries</td>
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<td>1 PCP and 5 Specialists</td>
<td>1 PCP and 2 Specialists</td>
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<td>$627,076 billed charges</td>
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<td>$104,513/month</td>
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**Care Management Interventions**

- PCP pared foot callouses (source of osteomyelitis)
- Conference call with providers to adjust immune suppression drugs to reduce sepsis risk
- Family conference with PCP about importance of not cancelling specialist visits or risk falling off transplant list
- Development of an Action Plan with patient
- Regular patient contact from the Care Coordinator

A quote from the PCP:

“By getting the specialists together on a conference call we were able to reduce the patient’s risk of sepsis.”

**Conditions:**
- Corns and Callosities
- Osteomyelitis
- Systemic Lupus Erythematosis
- Lupus anti-coagulant disorder
- Vitritis of right eye
- Chronic Kidney Disease (stage IV - severe) on hemodialysis
- Immunosuppressed status
- Hx Peritonitis
- Pericarditis in SLE
- Gout
- Anemia