Transforming Care: A Population Health Approach
An Integrated Health System

MemorialCare Medical Foundation

- MemorialCare Medical Group
- IPA Division – Greater Newport Physicians
- Outpatient Imaging and Surgery Centers
Physician Groups

- 217 employed Providers
  - 183 Physicians
  - 34 Mid-Level’s
- >1300 specialists
- 32 clinical locations
  - 6 Urgent Care Centers
- 900+ IPA Physicians
Fragmented Care

- uncoordinated
- disease-focused
- unstructured
- understaffed
- not-patient-centric
- unhandled
- fragmented
- duplications
- non-Lean
- underfunded
- P4P-focused
- handoffs
- uncontrolled
- disease-registry
- limited-access
- community-gaps
- incentives
- misaligned-incentives
- social-issues
- inequities
- data-gaps
- cracks
- pockets
- PR-focus
- small-steps
- incomplete
- fragmented
- tool-gaps
- not-technical
- lost
- hard
- waste
- unmeasured
Coordinated Care
Health Care’s Triple Aim

1. Service Excellence
2. Improved Quality
3. Reduced Per Capita Cost
Population Health

• Access
• Connectivity
• Engaging Patients
• Care Management
• Team-based Care
Connected Care

- Electronic Medical Records are accessible to primary care and acute care teams
- Moving from episodic care to integrated care
Engaging Patients

myMemorialCare
myChart
NEXTGEN® Patient Portal
care team connect
Care Management

Risk Stratification and Predictive Modelling

- **High-Cost Patients**
  - 5% e.g., poorly controlled CHF with multiple comorbidities

- **Rising-Risk Patients**
  - 20% e.g., patient with diabetes and depression

- **At-Risk Patients**
  - 40% e.g., pre-diabetic patient

- **Healthy Patients**
  - 35% e.g., patient with no disease diagnosis
Care Management

- **Wellness & Prevention**
  - Health Coach ER Follow-up
  - Vaccination Outreach
  - Cancer Screening

- **Ambulatory Care Management**
  - 24/7 Telephone Advice Nurse
  - Clinic-based Case Management
  - Low Back Pain Program
  - Anti-coagulation Clinic

- **Specialty Care Management**
  - Complex Care Management
  - High Risk Care Management
  - Virtual Care Conference

- **Inpatient Care Management**
  - Dedicated 24/7 Hospitalists
  - Discharge Clinic
  - After hours RN Triage
  - Repatriation/Concurrent Review
  - Care Transitions Program

- **Disease Management**
  - COPD Program
  - CHF Program
  - Diabetes Program
  - Palliative Care Program
  - Pharmacist/Medication Reconciliation
Active Diabetes Program
Virtual Care Clinic

- Inpatient admissions lowered by 42%
- ER visits lowered by 82%
- Cost of claims paid decreased by 41%
- Average cost savings per case: $3,913
Team Based Care

- Patient Centered Medical Home
- Coordination of Care