Advanced Illness Management

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Health Solutions

- 2016 Covered Lives: **400,000**
  - Includes Governmental and Commercial Shared Savings, Shared Risk, Full Risk, Employer Sponsored and Pay for Performance contracts
- Health Solutions deployed clinical staff include:
  - Physicians
  - Nurse Practitioners
  - RN Care Managers
  - Social Workers
  - Behavioral Health Specialists
  - Patient Engagement Specialists
  - Health Coaches
- Care Management Strategies
  - Gaps in Care
  - Telephonic Care Management
  - Embedded Care Management
  - Transitional Care Management
  - Advanced Illness Management
- Care Management Programs
  - Healthy Transitions (CKD)
  - Health Home
  - Pioneer ACO
  - Bundled Payments for Care Improvement
  - Independence at Home

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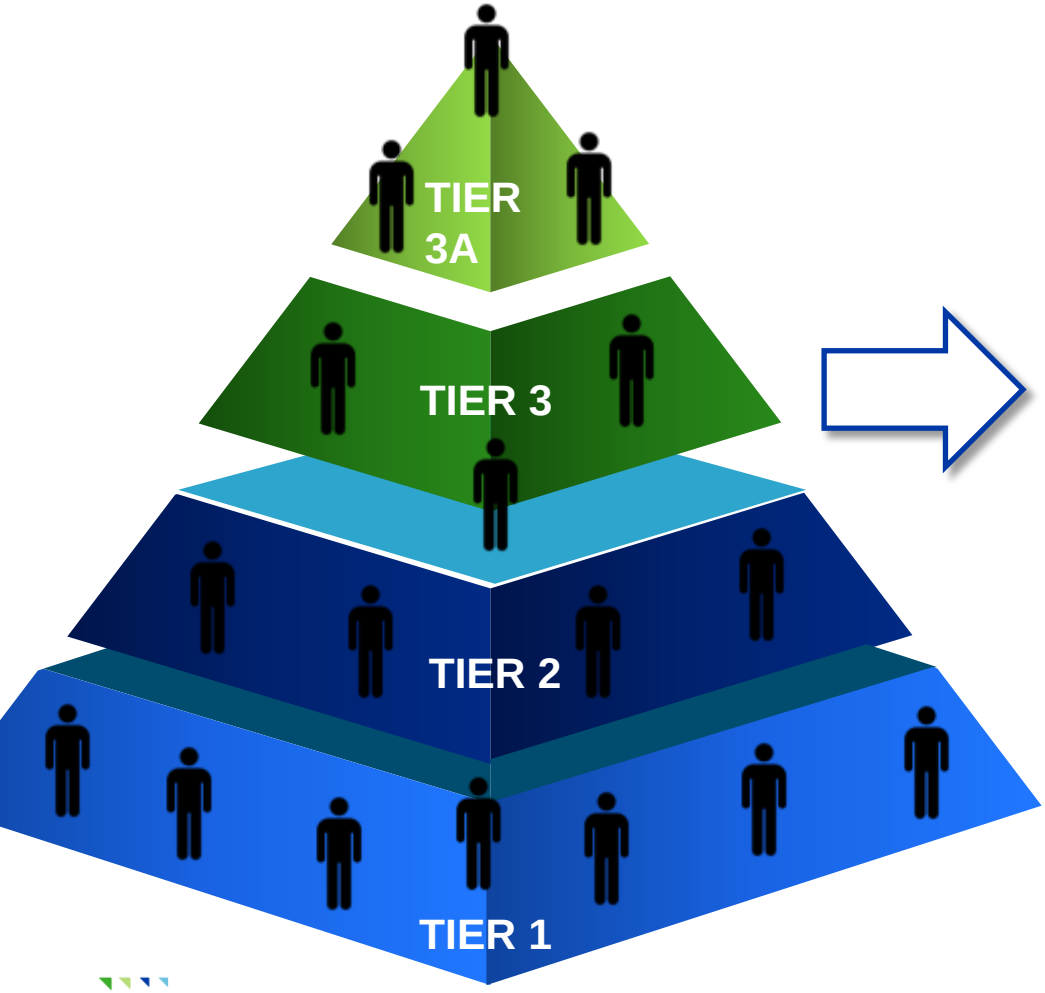
Risk Stratification and Determination of Program Eligibility

Full Range of Care Management Programs Tailored to Individual Patient Needs



TIER 3A

In-Person Care Management:

- Hospice 0 1 2 3
- Advanced Illness Mgmt 2 3
- Complex 3

TIER 3

In-Person & Remote Care Management:

- Complex 3
- Disease Mgmt 1 2 3
- Telephonic 2 3
- Transitional 2 3
- Behavioral Health/SW 2 3
- Resource Coordination 1 2 3

TIER 1&2

Remote Care Management:

- Prevention & Wellness, Gaps in Care 1 2 3
- Utilization Management

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MCO Care Mgmt

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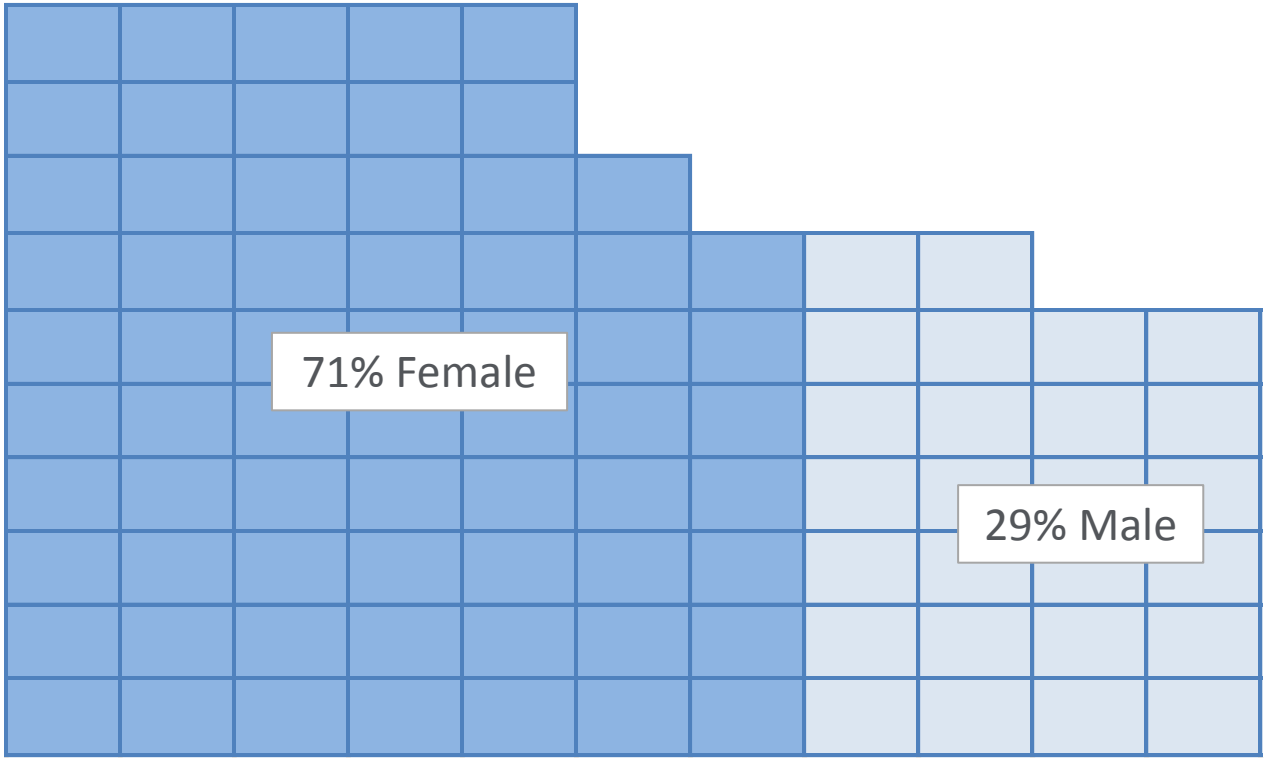
Advanced Illness Management

Complex medical management for approximately 1,400 homebound patients with multiple chronic conditions and functional impairment living in Queens, NYC and Nassau and Suffolk counties

- Interdisciplinary care teams, which include physicians, nurse practitioners, social workers, nurses, and medical coordinators deliver primary and palliative care in the patient's home in an effort to:
  - Understand wishes of the patient and family (advance care planning)
  - Maintain or improve functional status
  - Reduce unnecessary utilization or unwanted care
  - Increase days at home
  - Allow for death with dignity at home
  - Care for the whole person: social work and care coordination

Background

House Calls Patients, N=914



Age

109 Oldest

Median Age: 86

82 Average

19 Youngest

* December 2015 Census

Nassau, Suffolk and Queens counties

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Background

House Calls Stats*

Attrition

- 30% of annually (death and discharge)

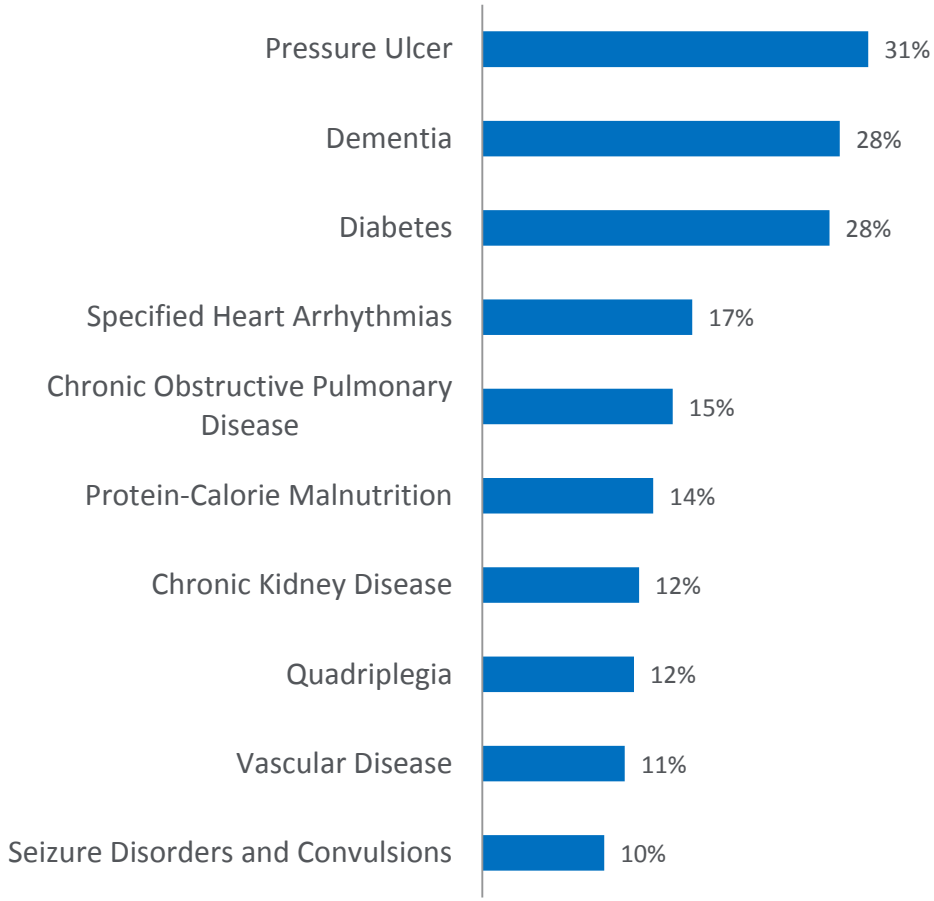
Death at Home

- 72% of patients who died, died at home

Activities of Daily Living

- 63% of patients have 5 – 6 ADL dependencies

HCC Categories



* Dec 2015 Census

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Multidisciplinary Teams

Medical Coordinators

Schedule appointments, facilitate DME and referrals, manage patient calls

Providers

- Primary accountability for the entire patient care caseload
- Engage proactively with RNs and MSWs to maximize caseload performance
- Provide timely support to co-manage care with RNs and MSWs
- Provide primary care for entire caseload

Social Work

- Initial assessments and coordination of services
- Initiate & coordinate advance care planning
- Behavioral health support
- Coordination of social support services and next level services (i.e. hospice)

Nursing (RN)

- Patient/family engagement
- Management of red flag medical problems
- Medication reconciliation and Stabilization of functions
- Follow-up care coordination

Care Pathways

Advanced Illness	• Advanced condition such as advanced cancer or heart, lung, kidney, liver, or cognitive failure **WITH** evidence of active decline: • Active decline is defined as any of the following: 2 hospitalizations/ED visits in the last 6 months **OR** Progressive and significant decline in one or more ADLs in the last 3 months **OR** Nutritional decline (albumin <3 g/d or 5% weight loss over 6 months) • Validation: PPS <60
Complex Care	• Assistance/Supervision of 2 ADLs • 2 Hospitalizations/ 6 ED visits in the last year • 1 Post/Sub-Acute Care episode in the last year • Low self-management (poor adherence, limited support network)
Stabled Chronic	• Assistance/Supervision of 2 ADLs • 1 hospitalization in the last year • 1 Post/Sub-Acute Care episode in the last year

What is Community Paramedicine?

A 24/7, on-demand clinical response for medically frail seniors living in the community

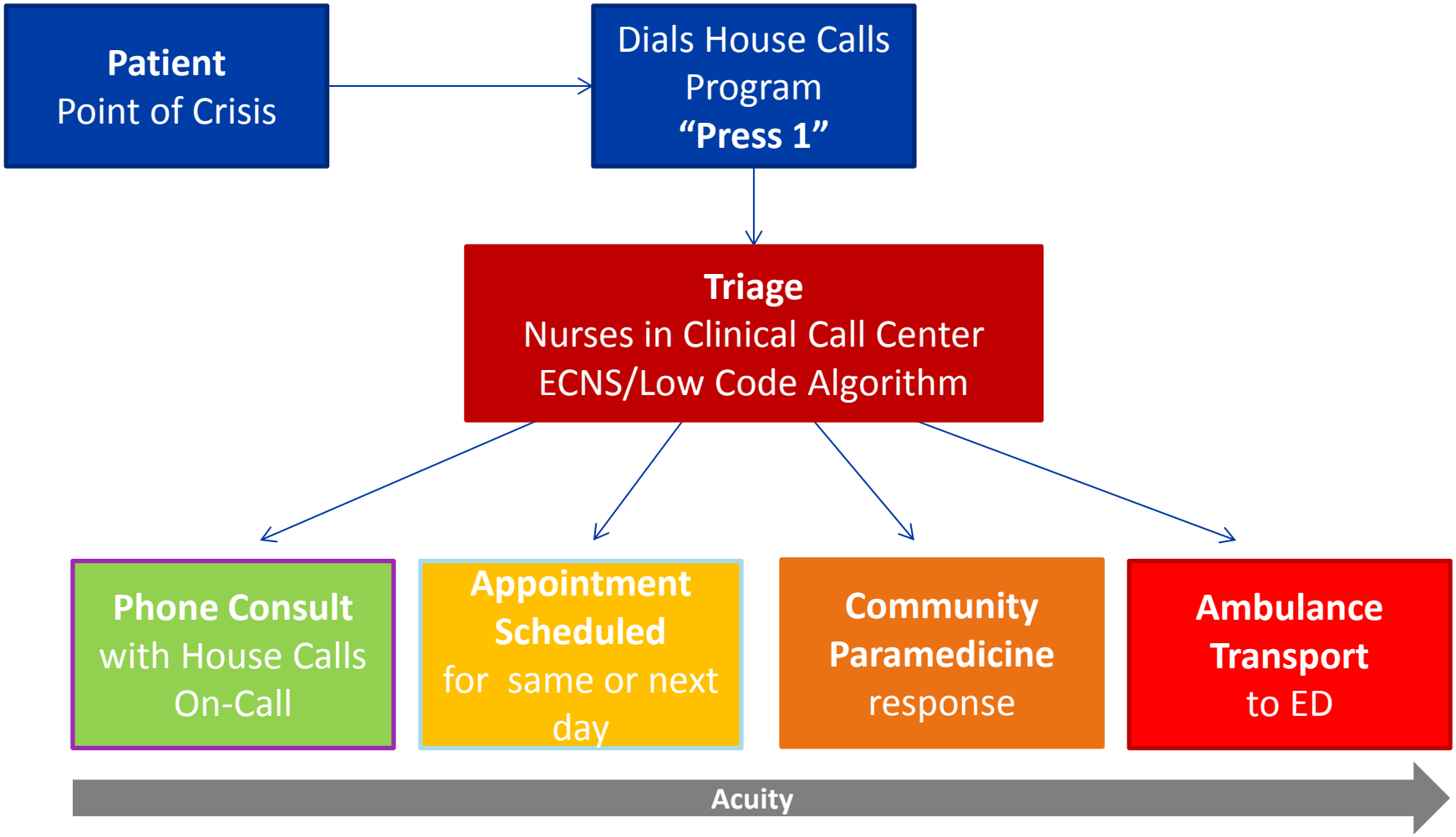
A transformation of the critical care paramedic workforce into *physician extenders* through telemedicine-guided consultation with primary care physicians

An effective means of:

- providing a meaningful clinical response within the hour
- increasing patient, caregiver, and provider satisfaction
- decreasing care costs

Community Paramedicine Workflow

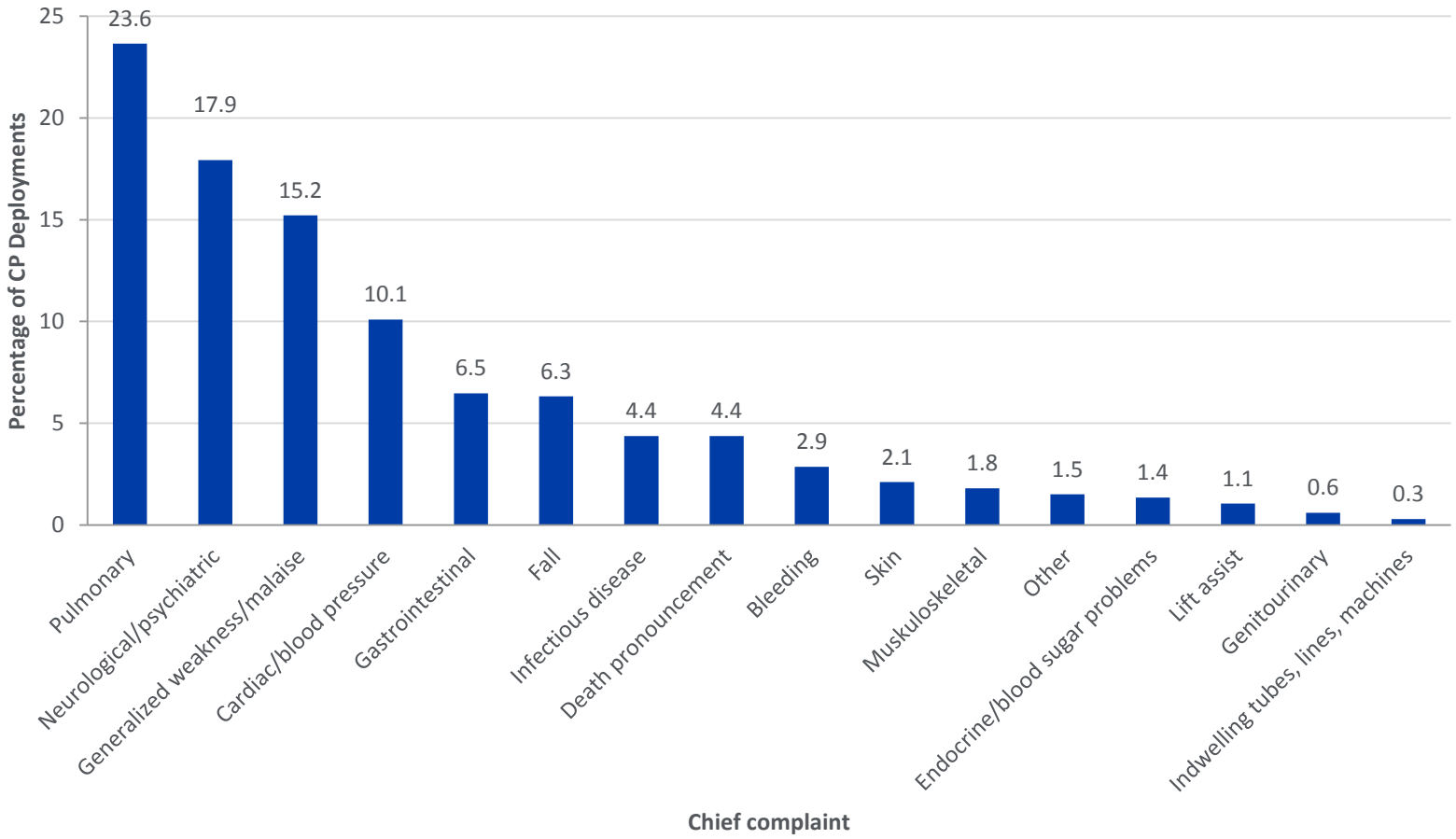
Provides urgent in-home response at all hours of day and night through utilization of the marginal capacity of CEMS and Clinical Call Center



Community Paramedicine Results

- Since program start, over 1250 CP responses deployed.
- Average Community Paramedic response time is 22 minutes. Average time on scene is 65 minutes.
- 81% of CP responses resulted in a meaningful change in medical management
- Only 23% of cases resulted in transport to the ED setting, as compared to a 90% transport rate across CEMS generally.
- For those that were transported to the ED, 61% were considered “non-avoidable”
- 86% of patient satisfaction survey respondents state they would have turned to ED for care.
- CP resulted in potential cost savings of $3.8M in avoided admissions, ED visits, and ambulance transports.

Reasons for Community Paramedicine Visits

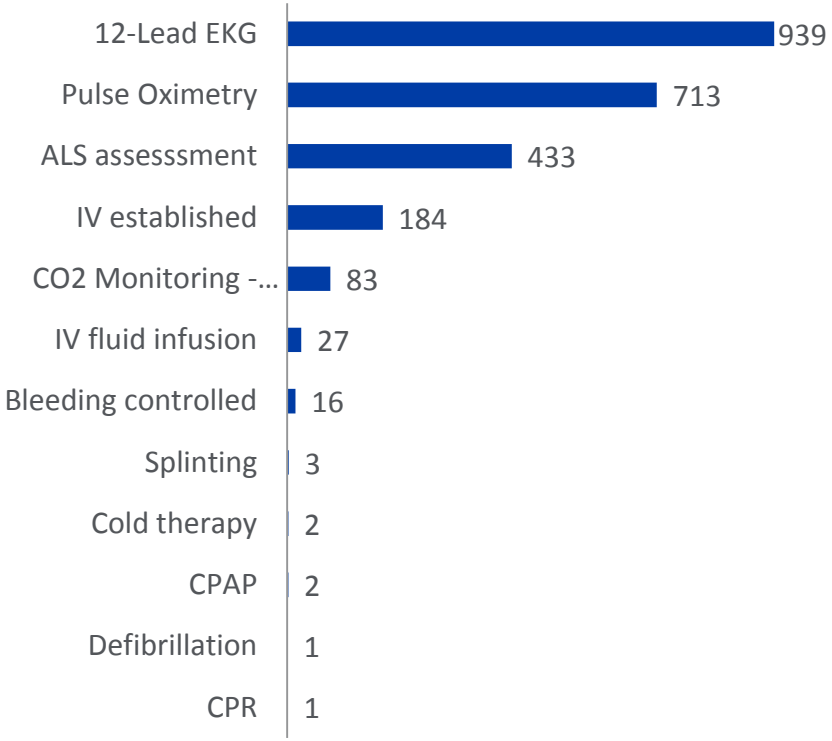


Based on 664 CP visits between January 1, 2014 – April 30, 2015

Procedures and Medications Administered

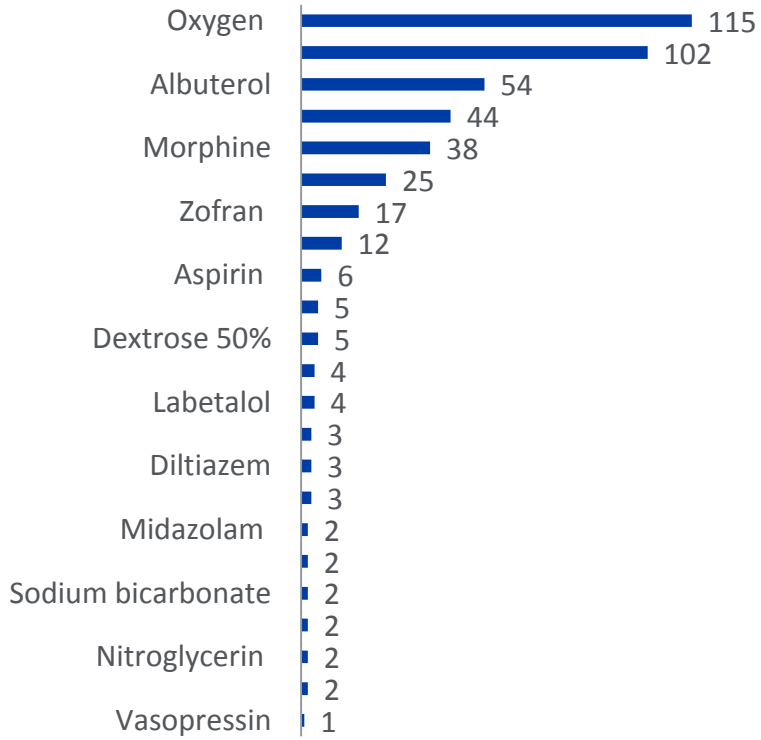
Procedures Performed by Community Paramedics

October, 2013 - September, 2015



Frequency of Medication Administration by Community Paramedics

October, 2013 - September, 2015



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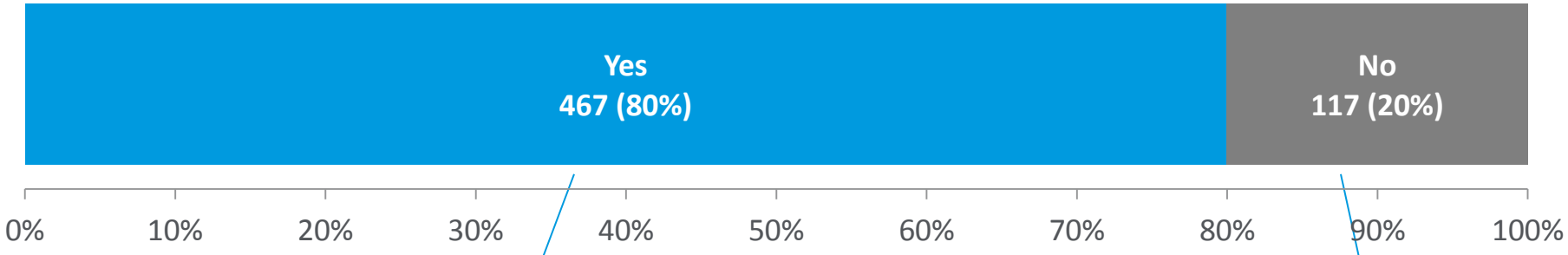
Physician Survey Responses: Medical Management

Did the information provided by the Community Paramedicine evaluation change your medical management?



- *"The clinical picture changed between the dtr's call and the paramedics eval, allowing me to confidently advise to keep pt home.""*
- *"Pt had acute bronchitis, was able to get 1st dose of steroids by CPmedic IM, get neb treatment. If not for those treatments, would have been hard for patient to stay safely at home, as he was refusing to go to hospital."*
- *"CPmedic was able to keep pt home by giving IVF for hyperglycemia and assessing probable location of infection to allow correct antibiotics to be given. Also was able to check fingerstick and identify that pt, who does not have diabetes, [just] had [an] extremely high glucose level."*
- *"Pt with hyperkalemia, was able to get 12 lead EKG and then to stay home with aggressive medication management, was able to see EKG by video conference."*

- *Death pronouncement*
- *Reassurance for overwhelmed or distressed caregiver*
- *Public assist*
- *Patient is on hospice; has no intention of being hospitalized*

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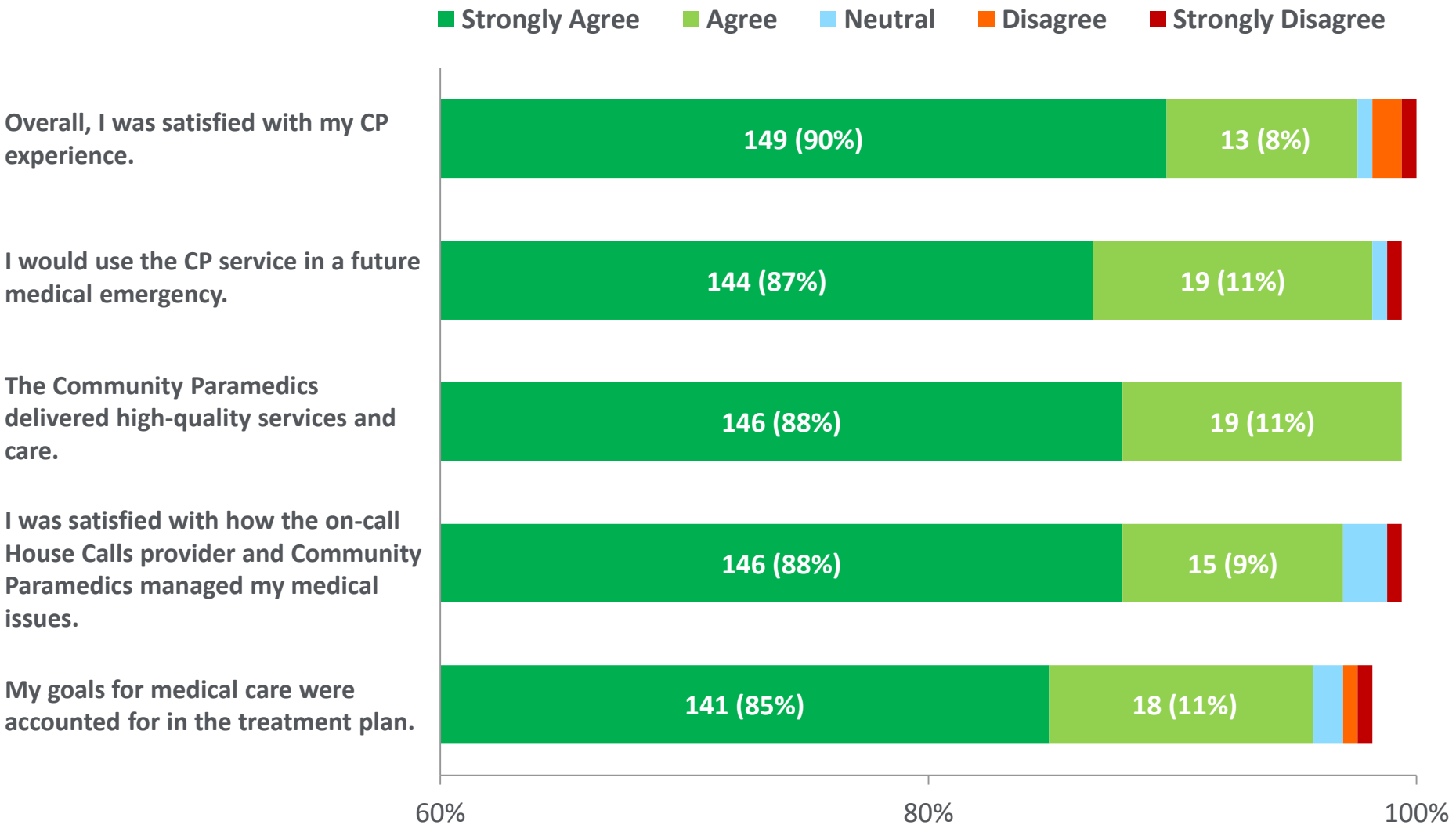
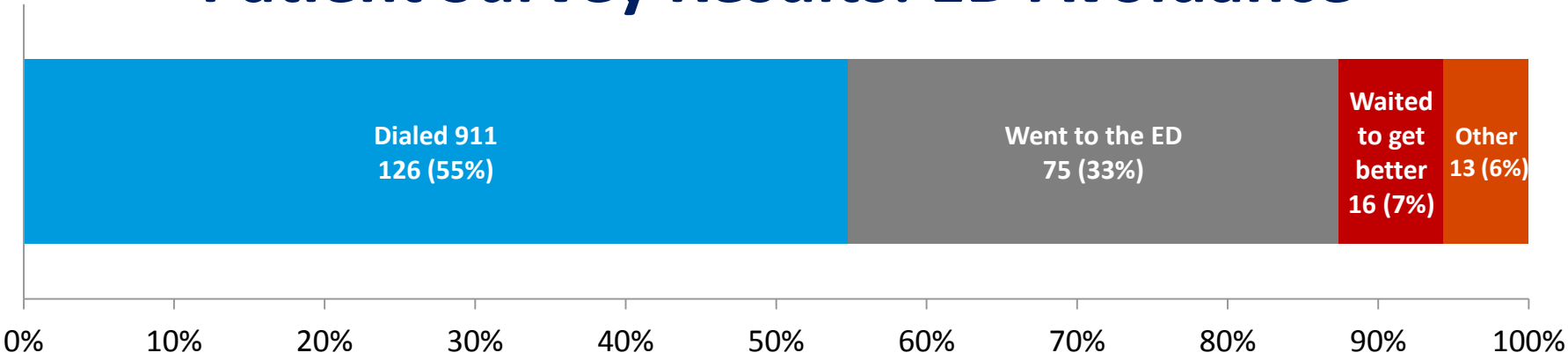
* Data from Aug 2014 – August 2015.

Patient Survey Results: Satisfaction



"We are extremely satisfied with the experience. The paramedics were reassuring, intelligent, and caring. We more than strongly agree with every evaluative statement."

Patient Survey Results: ED Avoidance



- *"This is the best way to prevent unnecessary ER visits. This service should be a prerequisite before dialing 911 for people who are ill at home. 911 should be left for what it was intended for - severe accidents."*

- *"The experience was excellent. The team worked together in a very professional and knowledgeable manner. I felt they really 'cared.' They checked back with phone calls also."*

- *"I was very impressed with the program. I am an RN and I truly appreciate the level of professionalism and caring that was shown to my father. Bernard (our paramedic) made my father feel at home immediately. This is a wonderful program."*

- *"I am the daughter of an elderly patient. The House Calls program and Community Paramedics have been an absolute lifesaver - for all of us. With your amazing care, we have been able to keep my mother at home, out of the hospital, comfortable, and incredibly well cared for."*

Community Paramedicine: Financial Metrics

- Costs based on leveraging existing CEMS infrastructure
- Calculated using fixed and variable costs per visit
- Approximately $450 per visit @ 1.25 hours which includes:
  - Vehicle, maintenance and fuel
  - Salaries, wages and benefits
  - Medications, supplies and equipment
  - Dispatch services and specialized software
  - Integrated call services
  - Other general expenses