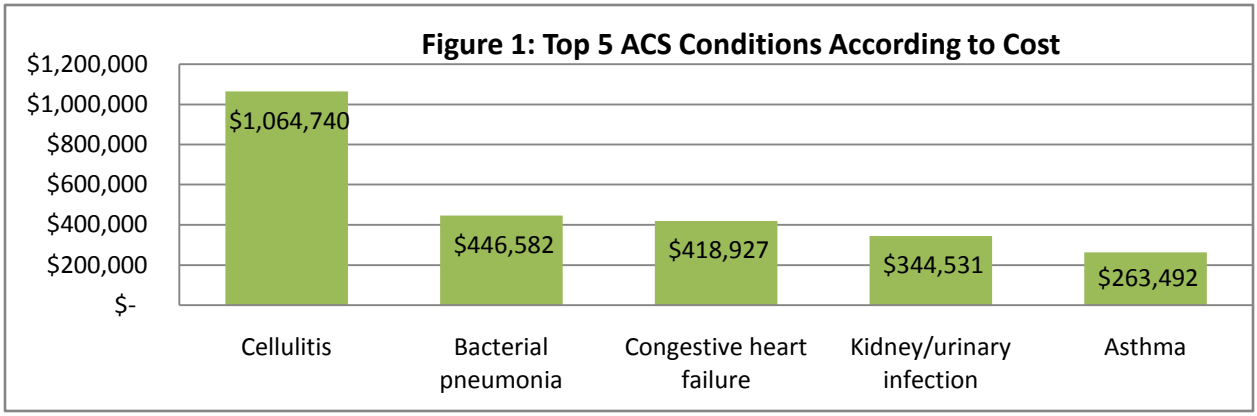
Integrated Delivery Network

The Integrated Delivery Network (IDN) model is a systems-focused approach to improve efficient access to the right care, at the right time, in the right place for patients within a region. It is rooted in the medical home concept that patients should have access to a primary care facility in their neighborhood that provides comprehensive primary care, specialty care and diagnostics, and which coordinates closely with network hospitals and other providers. The IDN provides care more efficiently, decreasing per-patient health care costs, improving access to care and enhancing patients' ability to navigate the system and manage their own care. COPE Health Solutions manages the IDN model for LAC+USC Medical Center, Kern County Coverage Initiative and replicated components in Long Beach and Kaiser (Hollywood, CA). Within Kern County, the Health Care Coverage Initiative program is called the Kern Medical Center Health Plan (KMCHP).

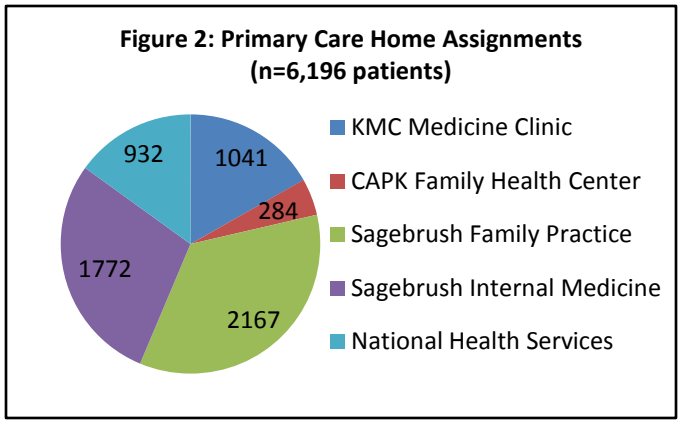
Primary Care Home Assignment

Objective: To reduce access barriers and streamline access to care. Kern Medical Center spent over $4,000,000 from September 2007- September 2008 treating patients for Ambulatory Care Sensitive Conditions (ACS Conditions) in the hospital. These are conditions for which patients sought hospital based care that could have been otherwise managed with timely outpatient care (figure 1).



Process: All patients are assigned a primary care home based on the patient's zip code upon enrollment into the program. Patients can be assigned to one of 14 clinics including 11 community clinics and 3 County owned clinics. KMC contracts with community clinics to provide primary and preventive care, including basic labs, x-rays, and medications. Patients receive an ID card at their time of enrollment that lists their primary care home location and contact information.

Outcomes: To date, 6,196 patients have been assigned to various primary care homes within Kern County (figure 2). Kern Medical Center Health Plan will soon be evaluating quality measures among patients being managed in primary care homes as well as hospital utilization of patients being managed in primary care homes. COPE Health Solutions will also be implementing a Balanced Scorecard for the LAC+USC Network to align strategies and monitor progress towards goals among community clinics and the Medical Center.



Lessons Learned:

Challenge	Solution
Clinics are contractually obligated to provide and coordinate ongoing patient care, but many services and medications were initially unavailable to clinics due to limited resources.	1. Referral process developed for clinics to refer patients for medications, labs and other services at KMC 2. Outpatient authorization policy was created
Lack of communication between providers and staff of KMC and community clinics caused gaps in continuity of care for patients	1. Regular collaborative meetings between administration and providers of KMC and clinics, such as Network Advisory Boards 2. Use of information technology for communication between providers at different sites

Care Management

Objective: Decrease rate of hospital utilization related to primary care and ambulatory care sensitive needs and improve health outcomes for frequent users of hospital services.[1] Figure 3 illustrates the number of KMCHP frequent users of the ED and inpatient services and their utilization in a year.

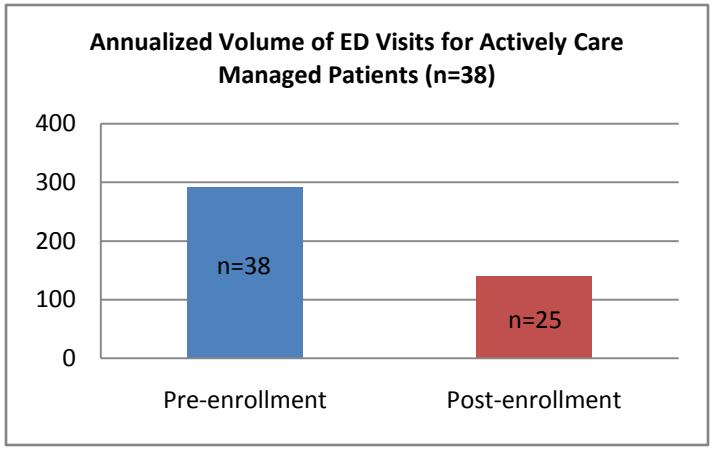
Figure 3: KMCHP Frequent Users of Hospital Services

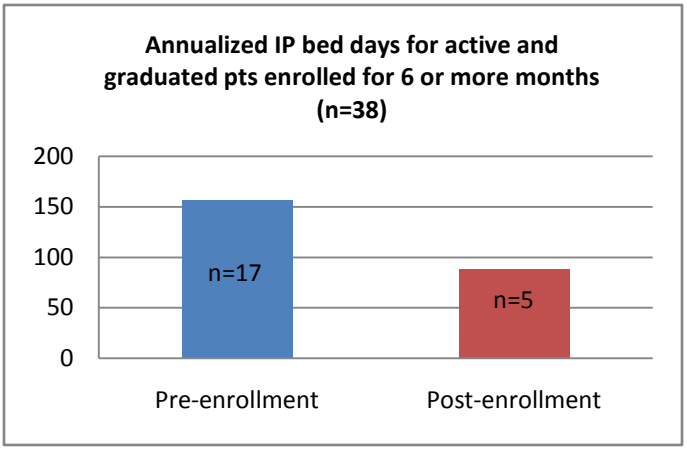
Frequent Users	**325**
Total ED visits among frequent users	**1,619**
Average ED visits per frequent user	**5**
Highest ED utilizer	**24 Visits**
Highest utilizer of inpatient services	**10 Admissions**

Process: Patients are assigned a care manager, who assigns patients to a primary care home, provides tiered and individual care planning and links patients to other community resources. Care management is provided within the community and represents a hands-on, culturally sensitive approach to meeting patients' social and medical needs.

Outcomes: To date, 60 patients are being actively care managed. ED visits and bed days were analyzed in April 2008 for patients who were enrolled in the program for at least six months (figure 4).

Figure 4: Utilization Decrease Among Actively Care Managed KMCHP Patients
(As of May 31, 2009)





[1] Frequent User defined as KMCHP patient with >4 ED visits in a year, >3 ED visits + 1 admission, or >3 admissions in the previous 365 days.

COPE Health Solutions has also implemented the care management program in Los Angeles, and is currently managing programs for the LAC+USC Medical Center, Kaiser Sunset Hospital and Long Beach Memorial Hospital. Similar results from these programs substantiate evidence of replicability for different patient populations and health care systems (Figure 5). The care management program at the LAC+USC Medical Center started in 2006, and continues to show a decrease in utilization (Figure 6).

Figure 5: Utilization Decrease Among Actively Care Managed Patients -- Kaiser Sunset
(As of April 30, 2009)

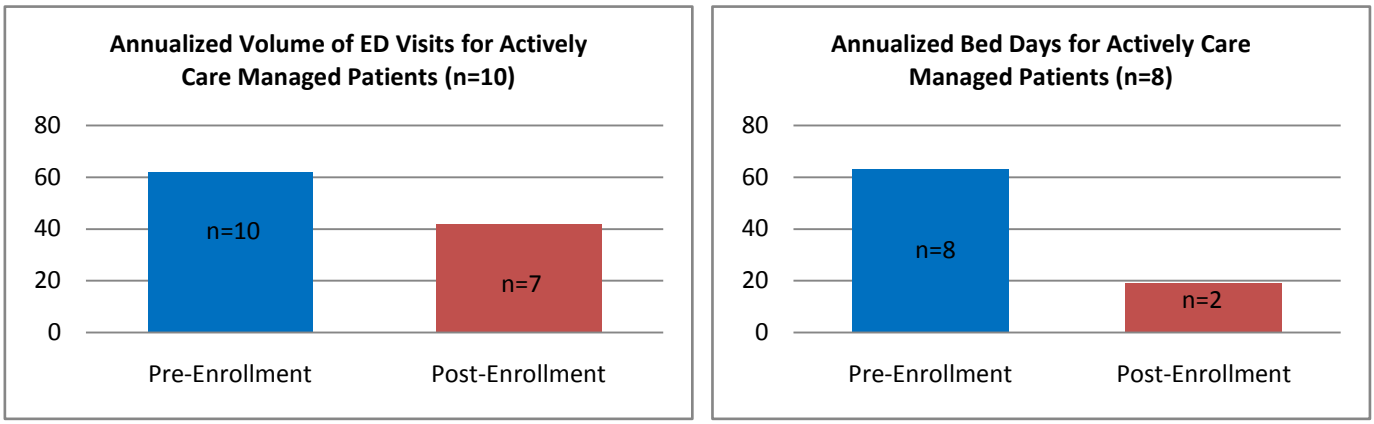
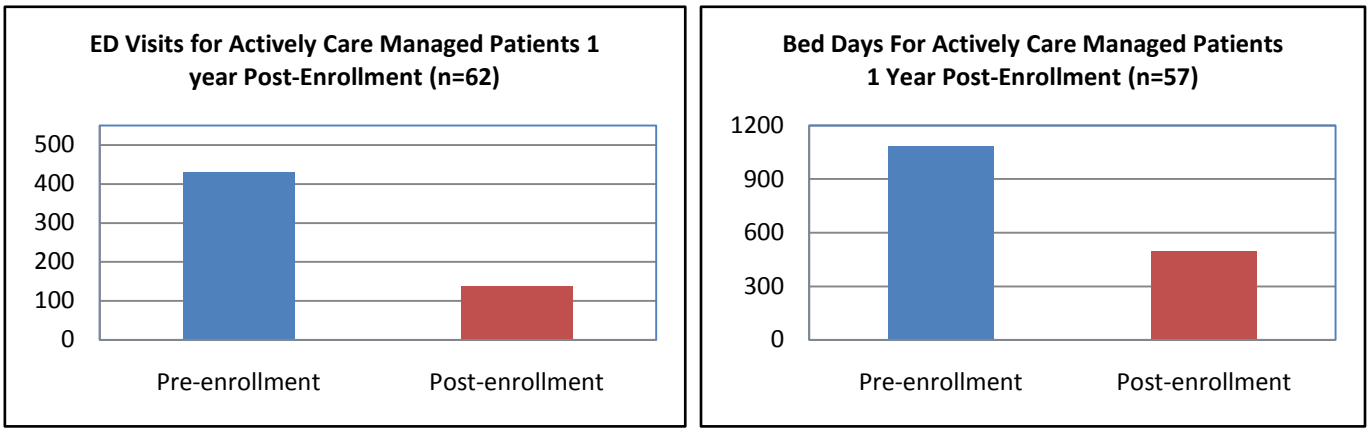


Figure 6: Utilization Decrease Among Actively Care Managed Patients—LAC+USC
(As of April 30, 2009)



Lessons Learned:

Challenge	Solution
Patients can become dependent on assistance from care managers	1. Create a process for graduating patients from the program once they have learned to appropriately utilize the healthcare system, allowing for sustainability of the program
Patients often have social and economic problems that impact their health and their healthcare choices	1. Patients are linked with other resources, such as housing, legal aid, and substance abuse programs 2. Care managers assist patients in applying for Medi-Cal, food stamps, and other benefits

Provider Practice Redesign

Objectives: Provider Practice Redesign (PPR) aims to increase and optimize care in the primary care setting, expand primary care treatment and decentralize specialty care services & diagnostics. Limited clinic capacity, inappropriate referrals and a lack of specialty guidelines cause barriers for patients attempting to access critical specialty care and diagnostic services (figure 7).

Figure 7: Average Wait Times for KMC Patients to Access a Specialty Care Appointment

	Referral processing (date referral sent to date clinic receives a response)	Total Wait for Patient
Average wait for 5 most impacted specialty clinics	**3 months**	**7 ½ months**

Process: To improve quality of care within a patient's medical home, PPR focuses on expanding and decentralizing specialty care services to primary care facilities. The core operating components include:

- Development of collegial relationships between specialists and primary care providers
- Development of Consensus Care Guidelines and flow processes
- Implementation of Mini-Fellowships, phone consultations and chart reviews
- Decentralization of diagnostics

Outcomes: KMCHP is currently in the process of rolling out Provider Practice Redesign. Guidelines for diabetes and rheumatology have been created, approved by KMC and will be placed on the web for other providers. PPR has been successfully implemented for the LAC+USC Network with notable successes:

- Successful implementation of Specialty Care Models in Rheumatology and Cardiology
- Guidelines for Rheumatoid Arthritis, Chest Pain, Heart Failure and Colorectal Cancer Screening
- Training of 8 Cardiology Champions and 6 Rheumatology Champions
- Provision of over 660 echocardiograms to uninsured patients in the community through the Network's Mobile Echocardiogram Service
- Expansion of specialty care and diagnostic resources in the community, including:
  - Two optometry units at a partner community clinic
  - Two colonoscopy suites at a local specialty care center
  - One cardiac treadmill at a local specialty care center

Lessons Learned:

Challenge	Solution
Lack of incentives/means for providers to manage higher acuity patients in the clinics setting due to financial pressure to increase number of visits per day and decrease time per patient.	1. Provide increased reimbursement to designated primary care "champions" to compensate for increased time in managing each patient 2. Provide credit for Continuing Medical Education (CME) for attending mini-fellowships
As a result of the high volume of referrals sent to the Medical Center, referrals were being lost, duplicated or pending for months.	1. KMCHP is expanding and training all providers on an E-referral system to improve the flow 2. Provide KMC with increased reimbursement for specialists to review referrals

The IDN model and the successes achieved to date may be scaled and replicated for safety net regions throughout California. By leveraging existing infrastructure and coordinating developments in health information technology, new negotiated partnerships and improved resource sharing among various levels of care and service sectors, the IDN model redesigns health care delivery within the Safety Net.