ACO Accelerated Development Learning Session

San Francisco, CA
September 15-16, 2011

Module 1B: Describing and Understanding Your Population's Clinical and Risk Profile

September 15, 2011
1:00 – 3:00 p.m.

Matthew Mazdyasni, Executive Vice President
HealthCare Partners

HealthCare Partners Operates in California, Nevada, and Florida

- Senior members: 171,200
- Commercial members: 486,400
- Primary care physicians (PCPs)—Employed: 395
- Primary care physicians—Independent practice associations (IPAs): 1,190
- Specialists—Employed: 320
- Specialists—Contracted: 6,180
- Staff model facilities: (primary care, urgent care, walk-in, ambulatory surgery, pharmacy): 152
- IPA PCP medical offices: 856
- Health plans accepted: 17 Medicare Advantage, 10 commercial (HMO & POS)
- Affiliated hospitals: 111
- Languages spoken: More than 50

Mission

HCP partners with our patients to live life to the fullest by providing outstanding healthcare and supporting our physicians to excel in the healing arts.

Vision

HCP will be the role model for integrated and coordinated care, leading the transformation of the national healthcare delivery system to assure quality, access and affordable care for all.

HealthCare Partners Delivery System

The preeminent physician-owned, professionally managed, patient-centered coordinated care system and an important delivery system in the many communities we serve.

- Global capitation predominates
- Physician owned
- Centrally coordinated
- Regionally driven
- Strong medical management infrastructure
- Robust business support units

Technology Backbone

- Allscripts/Touchworks electronic health records (EHR)
  - Fully deployed group model
- NextGen/PACIS for affiliated model
  - Physician practices at 200+/year
- GE/IDX practice management
- EPIC practice management and EHR
- CCMIS—Complex Care Management Information System
- Patient Keeper hospitalist system

Technology Backbone *continued*

- All feeds to integrated data warehouse
  - Clinical EHR
  - Lab
  - Rx
  - Images
  - Encounters
  - Claims
  - Hospital A/D/C
- Predictive modeling
- PIP—Physician Information Portal
- POP—Patient Online/Portable PHR
- Ingenix ETGs
- Report center

Hospital Strategy

- HCP does not own hospitals
- HCP—long-term hospital partnerships > 10 years
- Innovative hospital contracting strategy including cost-plus model, where we share savings with hospital partners for increased efficiency
- Hospital TCUs with cost-plus reimbursement
- Hospital partnerships include hospital efficiency and through-put benefiting hospital Medicare FFS DRG management
- Hospitalist strategy with hospitals for non-HCP patients benefiting the hospitals and community physicians

HealthCare Partners – ACO

HealthCare Partners, in collaboration with Anthem Blue Cross, is one of the 5 entities in an ACO pilot project led by the Engelberg Center for Health Care Reform at Brookings and the Dartmouth Institute for Health Policy and Clinical Practice. The first year of the pilot program is 2011. HCP has agreed only to the first-year financial arrangement, which is shared savings based on achieving quality metrics.

Understanding Your Population

- Who is the population?
  - Medicare—attribution using PCP services
  - Private insurance—attribution or enrollment in a "product"
- Other issues:
  - What are the demographic characteristics of your patients?
  - With which other physician groups do you share patients?
  - With which insurance companies do you work?
  - How will a primary care attribution model affect you?
  - Is your organization at risk for adverse selection?

Individuals Will Be Attributed, Enrolled, or Assigned to Provider Networks

Attributed Members

Individuals attributed to the primary care provider they predominately chose for their health care (e.g., Medicare members)

Assigned Members

Individuals are directed to specific provider networks by their payor (e.g., private pay members)

Enrolled Members

Individuals have the choice to select a defined/limited network for care (e.g., Medicare Advantage members)

Who Are Your Patients and How Are They Aligned With You?

Enrolled in a product and:

- They select the ACO who is responsible for medical and care management

  or

- The patient pays more for out-of-ACO self-directed care

Assigned:

- They are assigned to an ACO, which has complete or some responsibility for medical and care management
- Patient has no penalty in seeking care elsewhere

Attributed:

- Patient based vs. episode based, which means provider is responsible for all care for the whole performance year
- Provider responsible for an episode, which means provider is responsible for specific episodes and specific time period

Understanding Your ACO

- Focus for an ACO changes from delivering services for patients to managing quality and cost of a population
- Organize strategies and resources that can foster comprehensive, successful accountability for the clinical, economic, and patient experiential outcomes of your attributed population
- Perform health risk assessments and predictive modeling, which create actionable information
- The information would enable the application of physician and case management services for patients with the greatest needs and who are at highest risk

The Healthcare Paradigm Shift

From

"Managing sickness"

- Caring for individuals
- Acute in- and outpatient care
- Hospital at center of delivery system
- Maximizing revenue
- Micromanagement of utilization, health care decisions
- Optimum individual provider performance

To

"Managing health"

- Accountability for a population
- Continuum of care
- Primary care provider at center
- Minimizing expenses
- Provider self management based on shared values, shared culture, CQI, and shared incentives
- Optimize system performance

What Are You Accountable For?

- Total or partial care accountability
- Type of services (i.e., medical, behavioral health, pharmacy)
- Understand any exclusion (e.g., end-stage renal disease) or individual re-insurance (e.g., neonatal cases over $100k) or aggregate re-insurance
- Compare age and sex factors of the population with your offerings and capacity
- Study the historical and trend for utilization by service, cost per unit of service, and cost per member
- Drill down to provider level to determine locations, services, specialty, and diagnosis
- Perform analysis for all services that can be segregated between internal and external
- Review the benefit structure for using out-of-ACO providers
- Analyze risk factors of the population

The Importance of Risk Adjustment

How Medicare risk adjustment works:

- ICD-9 codes grouped together based on diagnoses that are clinically related into approximately 804 Diagnosis Groups
- Each Diagnostic Group relates to a well-specified medical condition—for example, diabetes, congestive heart failure
- Diagnostic Groups are further aggregated into 189 Condition Categories (CCs)
- CCs are clinically related and have similar Medicare cost implications
- Hierarchy logic is imposed on certain disease groups (e.g., within pulmonary); thus, the model is known as the Hierarchical Condition Category (HCC) Model

How Are the Health Care Costs Established?

Based on:

- Attributed patients
- Historical patterns of care, as seen in claims data
- A trend factor to project into the performance year
- Any necessary adjustment for changes in population risk
- Any significant adjustment for benefit changes
- Adjustments for new entrants, deaths, and those leaving the ACO
- Value of exclusions and catastrophic cases

How Are You Getting Paid?

- Payment methods are changing:
  - Discounted fee-for-service
  - Episode payment
  - Value-based purchasing
  - Shared savings
  - Shared risk
  - Partial capitation
  - Global capitation
- How long are you committed?
- How often do you get to negotiate your arrangement?

Understanding the Information

- ACOs should focus initial medical management efforts on reducing leakage to hospitals and specialists that are not part of the ACO. This will increase volume to ACO providers and help offset revenue loss due to improved utilization management.
- For comprehensive risk, an ACO will need a data warehouse and provider profiling system to easily produce up-to-date reports on utilization and cost, physician report cards, and comparisons to targets.
- Regular, accurate, and reliable analysis and reporting of results is critical for success.
- Performance must be constantly measured against targets to evaluate the effectiveness of the management efforts and allow for adjustments if necessary.

Understanding Your Data

- An ACO will need to take the following steps to evaluate the feasibility of the financial budget established by the payor:
  - Use the designated population's historical data to build an actuarial cost and utilization model consistent with the base period that CMS (or other payor) will use to evaluate performance
  - Compare the historical data to actuarial benchmarks, appropriately adjusted for demographics and risk
  - Categorize the utilization data into meaningful and impactable service categories and site of service where indicated (hospital outpatient versus ambulatory surgical center)

Infrastructure Required to Care for the Health of the Population

Risk Evaluation, Stratification and Coding	Delivery and Access	Care Coordination	Admission Management	Coaching and Education	Analytics and Reporting
• Health Risk Assessment • Accurate claim/ medical record documentation • Medical and Rx claim review • Per patient risk score calculation • Best possible revenue calc. • Automated care plans • Patient social service determination • Rapid revenue/ cost detection and reporting	• Specialist efficiency evaluation • Local PCP leadership and governance structure • Comprehensive referral plans • Clinical protocol determination • Contract sub-specialties • Contract ancillary services • Community resources	• Post Discharge follow-up • Authorizations • Case Management • On-boarding • Home assessments • Referrals and Referral links to PCP • Scheduling • Medical necessity review • Pharmacy Management	• Hospitalist program / ED management • Daily census – Acute/Skilled/ LTAC • Patient review by facility • Length of Stay management • Discharge planning • Delivery system re-entry • Transitional care	• Provider service issues • Performance management – Revenue, Cost, Quality and Service review • Population-based opportunity reviews • Training and education on delivery • Benefit/Eligibility	• Utilization by all healthcare service types • P/L by Patient, PCP, Group Network • Benchmarks • Peer group analysis • Outlier determination • Quality scorecard • Pricing/Benefit evaluations • IBNR

How Much Opportunity to Lower Costs?

- Determine the specific areas by comparing utilization data to the actuarial information by type of services
- Decide your benchmark based on best practice
- Access your population data to determine the avoidable services with intervention (e.g., ambulatory care sensitive admissions [ACSAs], nonemergent ER visits)
- Target high-risk patients for follow-up and active disease management
- Identify your most efficient providers using ETG or similar claims analysis tools
- Use predictive modeling to analyze and understand your population's needs
- Evaluate utilization changes by improving access to the physician services (e.g., same-day access); when at your "access target" track and monitor them since it is challenging to maintain same-day access

Actuarial Cost Model – Commercial

2010 National Average—Loosely Managed			
Service Category	Total Utilization Per 1,000	Allowed Average Charge	PMPM Claim Cost
Inpatient Facility	217.1 days	$4,140.03	$74.90
Outpatient Facility	1,477 cases	$642.65	$79.10
Professional	13,820 visits	$102.41	$117.94
Other	8,189 visits/cases	$110.61	$75.48
Total			$347.42

Source: Milliman's 2010 Health Cost Guidelines calibrated to Milliman Medical Index (MMI)

Actuarial Cost Model – Commercial *continued*

2010 National Average—Well Managed			
Service Category	Total Utilization Per 1,000	Allowed Average Charge	PMPM Claim Cost
Inpatient Facility	161.0 days	$4,668.82	$62.64
Outpatient Facility	842 cases	$653.44	$45.85
Professional	11,907 visits	$89.36	$88.67
Other	7,923 visits/cases	$81.00	$53.48
Total			$250.64

Source: Milliman's 2010 Health Cost Guidelines calibrated to Milliman Medical Index (MMI)

Actuarial Cost Model—Commercial *continued*

2010 National Average—Moderately Managed			
Service Category	Total Utilization Per 1,000	Allowed Average Charge	PMPM Claim Cost
Inpatient Facility	189.1 days	$4,407,02	$69.44
Outpatient Facility	1,162 cases	$652.98	
Professional	12,871, visits	$96.64	$63.23
Other	8,057 visits/cases	$96.17	$64.57
Total			$300.89

Source: Milliman's 2010 Health Cost Guidelines calibrated to Milliman Medical Index (MMI)

Actuarial Cost Model – Commercial *continued*

2010 National Average—Moderately Managed			
Service Category	Total Util. Per 1,000	Allowed Avg. Charge	PMPM Claim Cost
Outpatient Facility			
Emergency Room	135 cases	$1,230.96	$13.85
Surgery	86 cases	$3,326.56	$23.84
Radiology			
General	210 cases	$298.12	$5.22
CT/MRI/PET	45 cases	$1,261.82	$4.73
Pathology	272 cases	$142.27	$3.22
Pharmacy	83 cases	$699.36	$4.84
Cardiovascular	28 cases	$572.80	$1.34
PT/OT/ST	82 cases	$146.20	$1.00
Psychiatric	14 cases	$237.99	$0.28
Alcohol & Drug Abuse	13 cases	$183.01	$0.20
Other	194 cases	$291.16	$4.71
			$63.23

Source: Milliman's 2010 Health Cost Guidelines

Areas of Opportunity

- ACSAs are those for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.
- ACSAs are considered a measure of the quality of ambulatory care delivery in preventing medical complications. High rates of ACSAs might indicate inadequate access to high-quality ambulatory care, including preventive and disease management (DM) services.
- ACSAs that involve complications of diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), asthma, and hypertension are admissions that are directly affected by effective DM/primary care coordination efforts.
- Based on a Milliman analysis of Medicare claims data, 15% of total admissions are considered ACSAs.

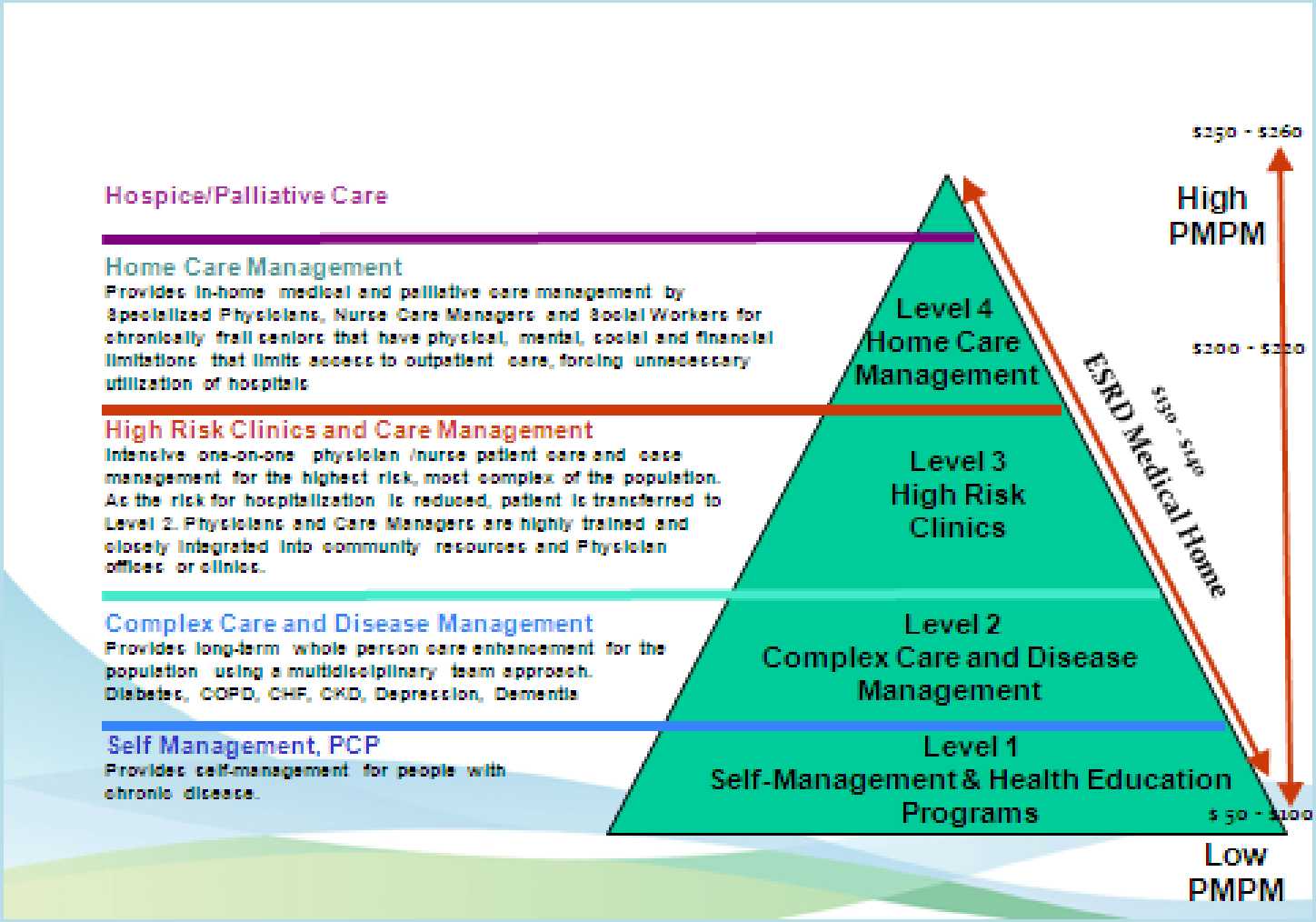
Areas of Opportunity *continued*

- Potentially preventable hospital readmissions are an important indicator of quality care and cause unnecessary expense.
- Preventable readmissions can occur because of inadequate discharge planning, inadequate post-discharge follow-up, or lack of coordination between inpatient and outpatient healthcare teams. Transition of care programs, case management, and disease management services aim to coordinate care at discharge and after.
- The rate of preventable readmissions within 30 days has been reported at 11% from a study of all hospital admissions in Florida.
- The rate of all readmissions reported from a recent Medicare analysis is 19%, with the majority reported to be preventable.

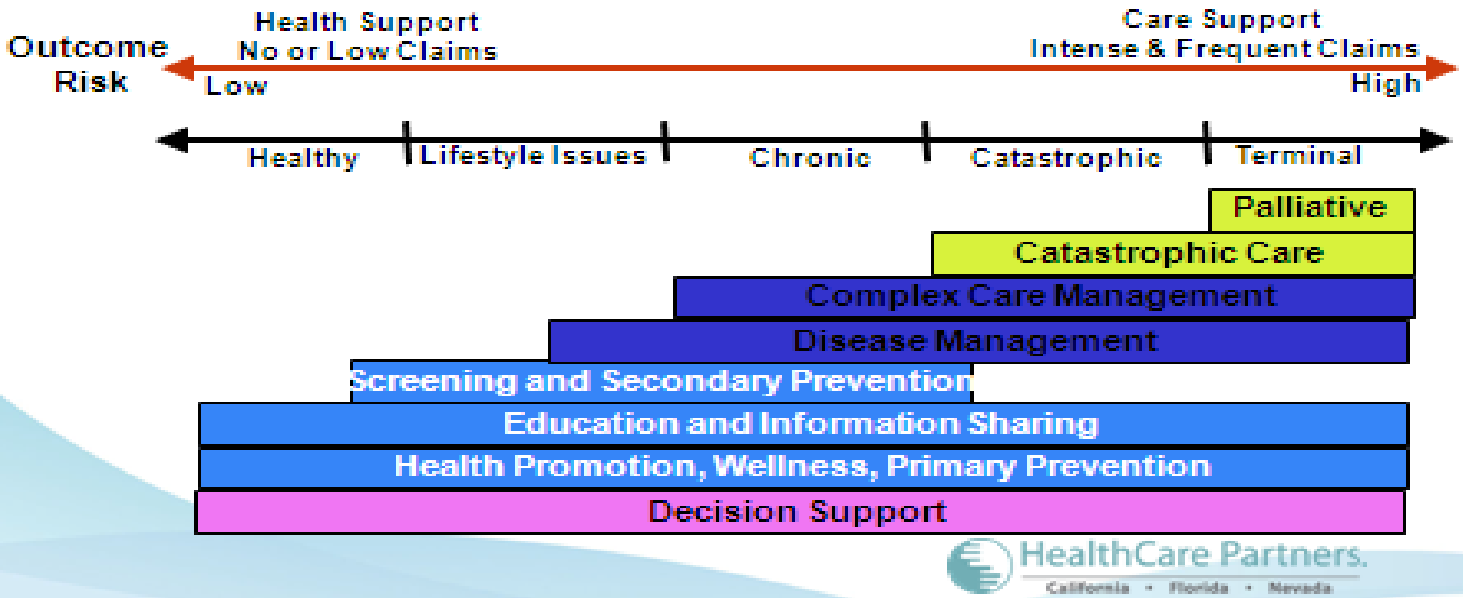
Areas of Opportunity *continued*

- Preference-sensitive admissions are admissions for elective surgical procedures where the evidence does not suggest greater efficacy between surgical management and medical management for treating particular conditions in some patients.
- Examples include spinal fusion, joint replacement, hysterectomy, bariatric surgery, cardiac catheterization, percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass graft (CABG), benign prostate surgery, and others.
- There is significant variation in the rate of these procedures by region, suggesting that local medical opinion and practices have a strong influence on the choices of treatment.
- There has been a recent focus on the need for patients to be better informed about the treatment options along with consideration for a patient's personal values and preferences when making medical treatment decisions.
- A Milliman analysis identified that, for a commercial population, approximately 16% of non-maternity admits are preference-sensitive admissions.

Stratify Patients Into Appropriate Programs



Programs Overlap



Areas of Opportunity

- The amount of utilization reduction, site-of-service shifting, and steering to ACO providers that will be needed to meet or beat financial targets will depend on the current level of population management and the aggressiveness of the proposed financial budget. If the historical data show a lot of "low-hanging fruit" (e.g., care provided to the population in the base period is loosely managed), it will take less work to meet targets. If the data show little room for improvement, this should be taken into account when negotiating financial terms with payors, particularly if the required utilization targets are aggressive.

Areas of Opportunity *continued*

- Referral management for specialist consults, including managing consultation follow-up
- Preauthorization for ambulatory and inpatient elective surgery
- High-tech imaging, specialty drugs, home care
- Electronic medical records could allow services to be screened against best practice criteria in real time and reduce the formal preauthorization process that typically occurs
- Inpatient concurrent review to facilitate efficient length of stay management and prevent medically unnecessary admissions

Areas of Opportunity *continued*

- Demand-side medical management services optimize a population's health so that demand for services will be lower.
- In particular, these services can ACSAs, preference-sensitive admissions, readmissions, and ER visits.
- Essential demand-side medical management operations include
  - PCP office-based telephone triage and advice, as well as e-visits and e-consults, to prevent unnecessary testing, specialty consults, office and emergency room visits
  - Case management aimed at coordinating care and enhancing compliance with treatment plans
  - Patient decision aid programs, including those targeting preference-sensitive procedures (e.g., decision support systems to educate patients regarding alternatives to surgery)

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Areas of Opportunity *continued*

- Transition of care programs to reduce readmissions
- Wellness and preventive services with proven value (e.g., smoking, cessation, obesity management, and cancer screening)
- Disease registries and disease management for chronic conditions

Now What?

- Identify and prioritize potential opportunities for
  - Reducing utilization by service category
  - Shifting utilization to alternative lower-cost sites of service
  - Steering utilization to ACO providers
- Monetize those opportunities and calculate the overall financial impact to create incentive for your system to achieve them

Real Experience: CalPERS
(California Public Employees' Retirement Systems)

- 49 years of providing health benefits
- 1.35 million members from 1,400 public agencies
- $6.7 billion annual spending
- 52% of members with health care costs below $1,000 accounted for 4% of total spending
- 8.5% of members (100,000) accounted for 67% ($3.4B) of health care costs, including 5,100 members above $100K amounting to $1.1B
- Chronic conditions (asthma, diabetes, CAD, COPD, depression, CHF) are a major cost driver
- In 2009, commercial plan members with chronic conditions accounted for 42% of commercial health plan costs; Medicare members accounted for 68% of Medicare plans' costs
- 1 in 4 CalPERS members was treated for one or more chronic conditions; 1 in 5 commercial members and 1 in 2 Medicare members

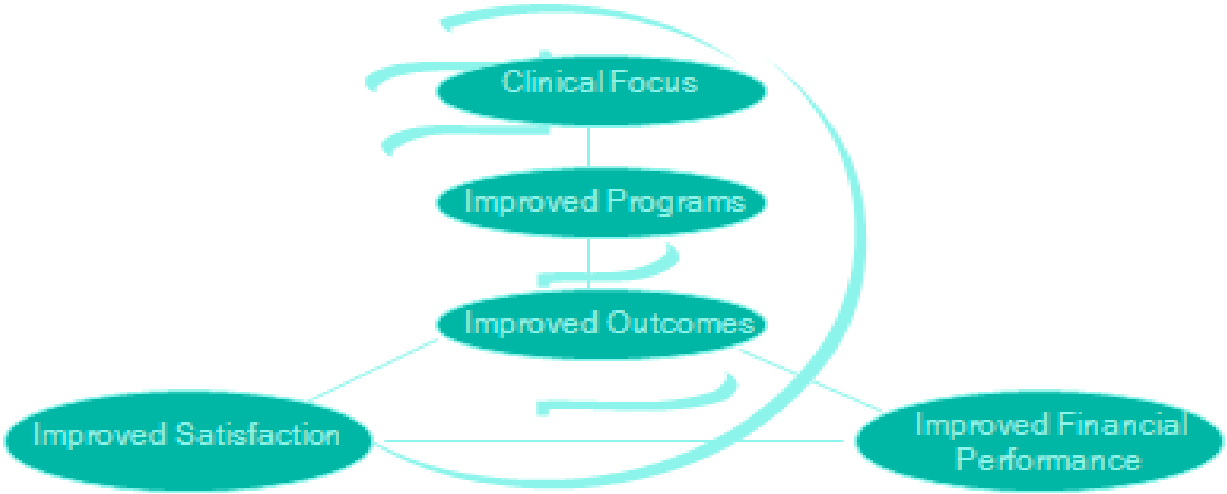
CalPERS Pilot Program

- Hip and knee pilot with a plan for PPO members:
  - Value-based benefit design change
  - Facility cost ranges from $15K to $110K
  - $30K threshold set by CalPERS and health plan
  - 46 facilities accepted throughout CA
  - Will be expanded in 2012

CalPERS Pilot Program *continued*

- ACO among HMO, hospital system & physician organization
- Created integrated model of care, which includes 42,000 members
- Approximately 740 physicians and 4 hospitals
- ACO results after 1 year:
  - Inpatient readmissions down 22%
  - Average length of stay (LOS) for admissions down by nearly ½ a day
  - ER and urgent care admissions down by 8%
  - Total bed days down by 13%
  - Percentage of discharges that had no physician follow-ups dropped from 93% to 60%

Clinically Driven Model for Achieving Outcomes



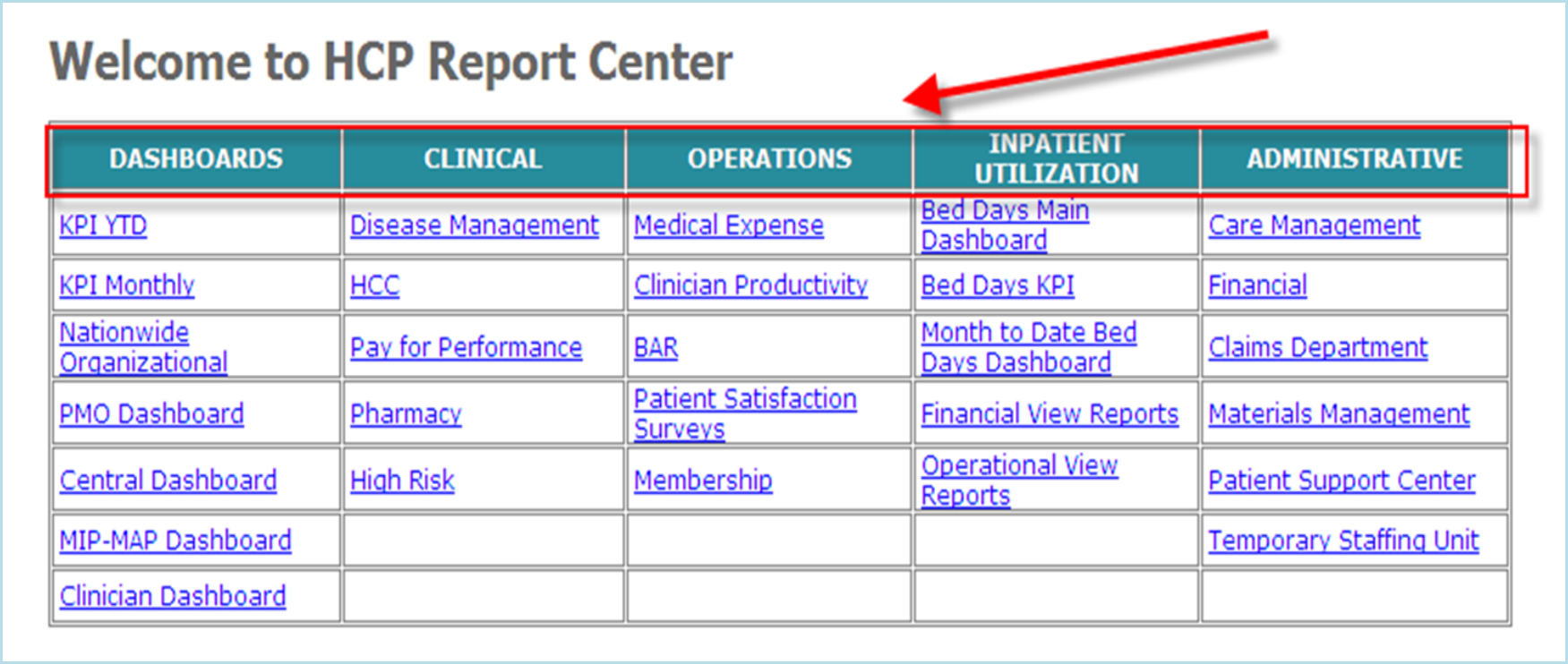
Requirements for ACO Success

- Physician ownership or buy-in
- Understanding cash flow
- Operationalizing contract's unique terms (plan, hospital and provider)
- Auditing "their data"
- Adopt the "mini" insurance company philosophy
- Capturing and reporting meaningful data
  - How to collect the data?
  - What do you do when you've got it?
  - How do you make it mean anything?

Requirements for ACO Success *continued*

- Data
- Governance
- More data
- Leadership
- More data

Data and Analytics Are the Key



Welcome to HCP Report Center

DASHBOARDS	CLINICAL	OPERATIONS	INPATIENT UTILIZATION	ADMINISTRATIVE
KPI YTD	Disease Management	Medical Expense	Bed Days Main Dashboard	Care Management
KPI Monthly	HCC	Clinician Productivity	Bed Days KPI	Financial
Nationwide Organizational	Pay for Performance	BAR	Month to Date Bed Days Dashboard	Claims Department
PMO Dashboard	Pharmacy	Patient Satisfaction Surveys	Financial View Reports	Materials Management
Central Dashboard	High Risk	Membership	Operational View Reports	Patient Support Center
MIP-MAP Dashboard				Temporary Staffing Unit
Clinician Dashboard				

HealthCare Partners Vision for Data

By 2013 HCP will make 5 “any things” happen with our data (clinical, administrative, financial, and others):

- Any data
- Any time
- Any person
- Any device or system
- Any where in the world

Tracking Customer Complaints

Access:

101 After-hour appointments: Complaining about location for an after-hours appointment.

102 Routine appointments: Complaining about never being able to see his/her PCP.

103 Same day appointments: Patient ill, complains about not being seen by doctor on same day.

104 Cancellation by provider: Pt. complains MD office canceled their appt. at the last minute.

105 Hold time on telephone: Patient states he/she has been on hold "too long."

106 Telephone system problems: Patient states he/she gets disconnected when calling.

107 Multiple telephone transfers: Patient states being transferred multiple times.

108 Exam room wait time: Patient states he/she waited in the exam room for a long time.

109 Reception wait time: Patient complains of long wait from the time of the scheduled appointment and not being told doctor is running late.

110 Emergency Care/UCC: Patient complains about waiting too long before being seen.

111 Hours in general: Patient complains office is never open when they need to see a doctor.

112 Self-referral: Patient having difficulty obtaining direct access appointment when referral not necessary.

113 Provider left Medical Group: Patient states their PCP left the Group.

114 Specialty Access: Too long to get an appointment with specialist.

199 Other:

Tracking Customer Complaints *continued*

Ancillary:

201 DME: Pt. did not receive appropriate DME equipment (e.g., wheelchair, oxygen, etc.).

202 Home Health: RN/Aide/Therapist did not show; refused to visit; unacceptable care.

203 Lab: Phlebotomist did not wear gloves; discussed test in front of other patients, etc.

204 Medical Record issues: Patient requests copies of records for secondary office – records did not arrive.

205 Prescription issues: Delay or error in new or refill prescription.

206 X-ray: Tech was rude; touched patient inappropriately; patient did not receive proper test prep.

299 Other:

Appeals:

301 Claim denied by claim admin.: Appealing that the claim payment was denied.

302 Authorization not in system: Complains that authorization has not been processed, but request was not received in Care Management.

303 Referral denial: Appealing denial of referral.

304 Prior complaint resolution: Not happy/satisfied, appealing resolution.

399 Other:

Tracking Customer Complaints *continued*

Authorizations:

401 Authorization requested by pt.: MD has not submitted request; request is not medically indicated.

402 Authorization not in system: Complains that authorization has not been processed, but request was not received in Care Management.

403 Benefits: Complaining about services not covered by insurance.

404 Choice of Specialist/Provider: Not happy with current specialist and wants a referral to a different one.

405 Authorization process delay: Patient says it took "too long" to process authorization.

406 Transfer to other level/hospital: Admitted to out-of-network hospital and does not want to transfer in-network. Does not want to be transferred to lower level of care.

408 Extension of Authorization: Patient requests to see specialist to whom he/she has been referred, but authorization has expired, or authorization was never used and has expired.

409 Request Pending Retro Review: Authorization is in the system and is pending retro review.

499 Other:

Tracking Customer Complaints *continued*

Benefits:

1077 Co-pay/coinsurance discrepancy: Co-pay/coinsurance listed in IDX is inconsistent with patient's ID card and/or health plan.

1078 Benefit based on medical necessity: The service may or may not be covered. The determining factor is whether the service is medically necessary.

1079 Service exceeds annual benefit: The service has limits on how many times it can be rendered within a year, and this number has been exceeded.

1080 Benefit discrepancy: Plan vs. IDX - Benefit listed in IDX is inconsistent with health plan.

HIPAA:

1095 Unauthorized release of records: Medical records were given to provider, employer, or insurance without patient's authorization.

1096 Disclosure to unauthorized person: Pt. information given to someone other than patient.

1097 Failure to provide Notice of Privacy Practices

Tracking Customer Complaints *continued*

Business Office:

105 Hold time on telephone: Patient states he/she was on hold "too long."

501 Account is incorrect: Wrong balance or service; insurance paid incorrectly or not billed.

502 Art of caring: Pt. could not understand staff; given wrong info.; staff rude or unresponsive.

504 Collection agency: Patient disagrees on being sent to collections or wants to settle.

505 Co-pay paid but not recorded: Pt. paid co-pay at site, but site did not record payment.

506 Not advised of non-covered benefit: Patient states he/she was not informed that a certain procedure, service/benefit is not covered.

599 Other:

1102 Coordination of Benefits: Insurance update and enrollment issues.

Eligibility:

701 Eligibility verification: Pt. states coverage is in effect.

702 Eligibility waiver dissatisfaction: Patient dissatisfied about signing waiver holding them responsible for payment —do not want to sign.

703 Patient demographic update: Patient's personal information in system is not up to date.

704 Member expired: Patient died and family continues receiving information from HCP.

799 Other:

Tracking Customer Complaints *continued*

Claims:

105 Hold time on telephone: Patient states he/she was on hold "too long."

504 Collection agency: Patient disagrees on being sent to collections or wants to settle.

601 Bill is HCP responsibility: Patient received bill that should have been sent to HCP.

602 Bill is Plan's responsibility: HCP denied claim for payment.

603 Bill reimbursement: Patient paid in order to avoid collections, now wants reimbursed.

607 Vendor balance billing: Patient receives a balance bill from a vendor that HCP paid at contracted rate, but vendor is not contracted.

618 Claims/Bill collection agency: Patient is in collections for service not paid by HCP.

699 Other:

1152 Waive of co-pay requested

Facility:

801 Cleanliness: Office/facility dirty/upkeep.

802 Comfort: Not enough seating space in waiting areas, rooms too cold or too hot, etc.

803 Forms: Forms too complex, too long, etc.

804 Location: Doctor's office is too far from home or office.

805 Parking: Not enough parking spaces; too far to walk to office.

806 Facility Change: Patient dissatisfied, requesting a change of facility.

899 Other:

Tracking Customer Complaints *continued*

Provider:

901 Patient was not seen in the office: Was given medical information over the phone.

902 Art of caring: Rude doctor, poor "bed-side" skills, etc.

903 Delay in diagnosis: Patient had several appointments with same or similar complaints.

904 Explanation of Test(s): Provider did not explain purpose or outcome of lab work or tests.

905 Language problem: Patient could not understand provider.

906 Not returning calls: Patient states provider does not return phone calls.

907 Notification of treatment: Patient says further treatment requirements were not communicated, i.e., next appt. time

908 Thoroughness of exam(s): Patient states provider did not perform a physical exam (e.g., listen to heart, lungs, etc.).

909 Time spent with patient/family: Provider was only in the room for 5 minutes.

910 Treatment expectation not met: Patient feels their problem was not resolved.

911 PCP Change: Patient dissatisfied with PCP, requests change.

999 Other:

Tracking Customer Complaints *continued*

Support Staff:

Art of caring, involving:

909 Time spent with patient/family: Patient states staff would not assist them in scheduling appointment and was asked to call back later.

1001 ❒ Front office staff 1002 ❒ Back office staff 1003 ❒ Referral Coordinator

Patient states staff rushed them, did not assist onto exam table, not helpful, rude, etc.

1003 Referral Coordinator art of caring: Did not take the time to explain referral process.

1005 Triage/phone advice: Patient had to wait too long for information; explained issue to many people; had to call several times to get help, etc.

1099 Other:

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