DATA DRIVEN HEALTH CARE TRANSFORMATION

Population Health Analytics as the Foundation for Primary Care Redesign

Sylvia Meltzer, MD, LSSGBC
Laura Spurr, MPS, PMP
Learning Objectives

• Organization description
• Change in industry landscape
• Population Health and Analytics
• Heart Failure and COPD
• New Care Models
• Transitions in Care
• Process change
• Primary Care Redesign
Organization Description

- Aurora Health Care is one of the largest not-for-profit, integrated health care systems in the United States.
- Wisconsin and northern Illinois.
- ~1.2 million patients
- 15 hospitals
- ~175 clinics
- 80 pharmacies
- 60 laboratories
- Home care services
- 1600 physicians
- 700 advanced practice providers
Accounting for a Change in Landscape

CURRENT STATE
Volume-based/Episodic care

Results in:
• Healthcare costs expected to reach $4.4T in 2018
• Unnecessary services
• Inefficient delivery of care
• Missed prevention opportunities

FUTURE STATE
Value-based/Continuous Care

Results in:
• Proactive care management of patient populations
• Leveraged caregiver teams working at top of license
• Easy access to care
• Efficient delivery of quality care
In Ambitious Bid, Walmart Seeks Foothold in Primary Care Services

By RACHEL ABRAMS  AUG. 7, 2014

Welcome to Walmart. The nurse will be right with you.
Increased Consumerism

Top Ten Preferred Primary Care Clinic Attributes

n=3,873

I can walk in without an appointment, and I’m guaranteed to be seen within 30 minutes

If I need lab tests or x-rays, I can get them done at the clinic

The provider is in-network for my insurer

The visit will be free

The clinic is open 24 hours a day, 7 days a week

I can get an appointment for later today

The provider explains possible causes of my illness and helps me plan ways to stay healthy in the future

Each time I visit the clinic, the same provider will treat me

If I need a prescription, I can get it filled at the clinic instead of going to another location

The clinic is located near my home

What’s 30 Minutes Worth?

- Walking in without appointment and being seen within 30 minutes ranked 1st (out of 56 attributes)
- Walking in without appointment and waiting 60 minutes ranked 39th

When Should We Be Open?

- Not surprisingly, a clinic open 24/7 is most appealing
- Consumers have slight preference for weekends over after-hours access

Where Should We Locate?

- Consumers prefer the clinic to be located near their home over near errands or work
- A clinic near errands is slightly preferred over a clinic near work

*From The Advisory Board Primary Care Consumer Choice Survey*
Changing Workforce and Demand

Looming Physician Shortage and Newly Insured Create Dual Threat

Percentage of Insured Non-Elderly Americans
n=267,000,000 (2010), 280,000,000 (2019)

Physician Shortage
Projected 2005-2025

2014 brings 12 million newly insured, largest increase in expansion over a single year


Current Model Does Not Support Need

Time Demands in Primary Care

- 2500 Patients
  Conservative time estimates
- Ten most common
  Chronic illnesses
- Preventive Care
  Level A and B recommendations
- Well controlled: 3.5 hrs/day
- Poorly controlled: 10.5 hrs/day
- 7.4 hrs/day

Add the 60% of patients with acute problems, plus paperwork, phone calls and charting

Cut panel size to 1250

= 24 hrs/day
= 12 hrs/day

Larry Mauksch, MEd University of Washington Department of Family Medicine
Provider Burnout

The Widespread Problem of Doctor Burnout

By PAULINE W. CHEN, M.D.
Shifting the Model

✓ To meet patient needs.
✓ To relieve provider burnout.
✓ To expand panel size (take on more patients).
✓ To provide better care at lower cost.
✓ To stay competitive in marketplace.
Start the Journey With Population Health

- Identifying what Population Health is for Aurora Health Care
  - Help patients live well.
  - Increase provider access to allow for expanded population based care models.
  - Providing a team approach to care.
  - Optimize our technology and practice to understand the patients we serve.
  - Improve care coordination.
  - Use **data as an asset to identify populations and make meaningful changes.**
Identified Population Health Initiatives

Disease Management & Transitions in Care
Heart Failure and COPD Disease Management Projects

PHASE 1
Purpose: Use Predictive Analytics to identify the highest risk populations forecasted to admit within 6 months for Heart Failure. Institute a disease-specific action plan to improve outcomes for this population.

Planning: 03/2013
Live date: 06/2013
Focus Area: 5 clinics
1 hospital
Target Group: 129 Patients
Caregivers: 32 Providers
6 Health Coach RNs
Leadership: Cross functional
Enterprise wide

PHASE 2
Purpose: Using Predictive Analytics to identify the highest risk populations forecasted to admit within 6 months for COPD. Institute a disease-specific action plan to improve outcomes for this population.

Planning: 10/2013
Live date: 01/2014
Focus Area: 5 clinics
1 hospital
Target Group: 263 Patients
Caregivers: 32 Providers
6 Health Coach RNs
2 Pharmacists
1 Home Care
1 Specialist
Leadership: Cross functional
Enterprise wide
Disease Management: Identify the Need

Cohorts

Cohort Prevalence

% Pop in Cohort (group)

% Pop in Cohort (comparator)

Avg Charlson (Diff from Comp)

Number of Pts

Displaying 7/7 cohorts

<table>
<thead>
<tr>
<th>Process</th>
<th>Result</th>
<th>Comp.</th>
<th># of Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pts w/ 1 or More BMI assessments (Last 12 Months)</td>
<td>89%</td>
<td>88%</td>
<td>879,362</td>
</tr>
<tr>
<td>Pts w/ 1 or More SBP &amp; DBP Tests (Last 24 Months)</td>
<td>90%</td>
<td>92%</td>
<td>879,362</td>
</tr>
<tr>
<td>Pts w/ 1 or More Lipid Panel Tests (Males Age 35+, Females Age 46+)</td>
<td>57%</td>
<td>60%</td>
<td>571,865</td>
</tr>
<tr>
<td>Pts w/ 1 or more colorectal cancer screenings (ages 50-75)</td>
<td>22%</td>
<td>24%</td>
<td>348,873</td>
</tr>
<tr>
<td>Pts w/ Smoking Status Recorded (Last 24 Months, Ages 18+)</td>
<td>21%</td>
<td>60%</td>
<td>879,362</td>
</tr>
<tr>
<td>Pts Who Ever Had a Pneumonia Vaccine (Ages 65+)</td>
<td>20%</td>
<td>25%</td>
<td>201,833</td>
</tr>
<tr>
<td>Females w/ 1 or More Bone Density Tests (Ages 65+)</td>
<td>16%</td>
<td>25%</td>
<td>116,209</td>
</tr>
<tr>
<td>Females w/ 1 or More Mammograms (Last 24 Months, Ages 40-69)</td>
<td>53%</td>
<td>37%</td>
<td>242,963</td>
</tr>
</tbody>
</table>

*example screen shots are from Optum Analytics
Determine the Focus
Predictive Analytic Risk Stratification

![Bar chart showing the percentage of patients by risk category for CHF-related hospitalization within 6 months. The chart indicates a high likelihood for the 0-79 (least) risk category, with lower percentages for higher risk categories.](screen_shots_are_from_Humedica_MinedShare®)
Old Delivery Model

1. Patient sees primary care provider in office
2. Patient goes to ER
3. Patient is admitted as Inpatient
4. Patient has an episode
5. Patient goes to ER
6. Patient is discharged from hospital
7. Patient is scheduled to see PCP

Treatment Regimen
Identify Opportunities in the Process

- Use Health Coach RN as the conduit between provider and care team.
- Institute a collaborative/team-based workflow.
- Engage the patient in their care in an enhanced way.
- Use Heart Failure and COPD protocols as well as quality-driven treatment plans to improve care.
- Integrated additional professional services
- Develop electronic tools to allow for ease in utilization as well as comprehensive documentation.
The New Model

Health Coach RN performs outreach call

Health Coach RN coordinates team members for the patient (Pharmacy, Home Care...etc.)

Patient arrives for primary care visit

Divide pt. list among Health Coach RN

Validate pt. inclusion with local providers

Patient sees Health Coach RN & Provider (co-visit)

Team develops the tx plan and visit schedule

Analytic reporting for target group

Health Coach RN continues to follow schedule and work with pt. daily or weekly
Patient Results

This **man has an EF 15%, DM, HF, CVA and multiple co-morbidities.** He started the HFCC pilot by **walking in with a cane with edema and severe SOB.** He stated that he was **SOB all the time.** Weight was up and down multiple admissions last 7/22/13. Since then and with HFCC he has now received all his medications covered for him through the VA (big cost savings for the patient). He qualified for Cardio/Pulmonary Rehab. He is understanding his HF and his medications. He is now on the treadmill with Cardio/Pulm rehab 25-30 min at 2.5% incline at 2.5 MPH 3 days/wk. He is back to working 9 hr days 2-3 days per week as a machine operator. He told me today that "**I feel like he did when I was 50**". **Patient understands how to manage his weight and watch his symptoms and likes being kept in check with his disease process.**

-Aurora Health Coach, RN

*note the term “Health Coach” and “PCMH RN” in this presentation are interchangeable.*
Clinical Successes

• Drop in disease specific admissions:
  • 60% reduction in HF admissions compared to previous year.*
  • 20% reduction in COPD admissions after 5 months.**

• Significant decrease in disease specific readmissions.
• 20% decrease in all-cause admissions.
• Decrease in ER utilization.
• Increase in Patient Wellness (moving to lower risk).
• Increase in Patient Satisfaction
• Enhanced care coordination model with expanded delivery team.

*Heart Failure measurement period is over 12 months.
**COPD measurement period is 5 months.
## Readmission Impact

- ~30% decrease in all-cause readmissions from 2012 to 2013!

<table>
<thead>
<tr>
<th>Month</th>
<th>Readmission Rate 2012</th>
<th>Readmission Rate 2013</th>
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</thead>
<tbody>
<tr>
<td>June</td>
<td>12.1%</td>
<td>11.6%</td>
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<td>July</td>
<td>10.7%</td>
<td>6.4%</td>
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<tr>
<td>August</td>
<td>12.9%</td>
<td>8.8%</td>
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<tr>
<td>September</td>
<td>11.9%</td>
<td>7.4%</td>
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<tr>
<td>October</td>
<td>13.73%</td>
<td>6.41%</td>
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<tr>
<td>November</td>
<td>11.25%</td>
<td>8.16%</td>
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<td>December</td>
<td>8.90%</td>
<td>7.26%</td>
</tr>
</tbody>
</table>

**average** ~11.64% ~8.0%
Show Me the Money!

✓ Avoiding diversion – opportunity costs.

✓ Avoiding readmission penalties.

✓ Increase in clinic efficiencies and ability to care for larger panel size.

✓ Improved access for new patients.

✓ Improved resource allocation.

✓ Significant financial savings in value based contracts
Population Health: Transitions in Care
PHASE 1

**Purpose:** Use Analytical Software to identify gaps in care. Institute an enhanced care coordination plan to improve outcomes for patients discharged from the hospital.

- **Planning:** 03/2013
- **Live date:** 06/2013
- **Focus Area:** 8 clinics
  - 1 hospital
- **Target Group:** non-surgical discharges
- **Caregivers:** 47 Providers
- **Leadership:** Cross functional

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PHASE 2

**Purpose:** Use Analytical Software to identify gaps in care. Institute an enhanced care coordination plan to improve outcomes for patients discharged from the hospital. Expanded scope.

- **Planning:** 10/2013
- **Live date:** 12/2013
- **Focus Area:** 11 clinics
  - 2 hospital
- **Target Group:** non-surgical discharges
- **Caregivers:** 53 Providers
- **Leadership:** Cross functional
Patients Discharged From Hospital Missing 7 Day Follow Up Appointment

AVG 65% missing

*screen shots are from Optum Analytics
How the Process Began

• Identified opportunity in our regions.
• Presented the hospital and surrounding clinics with the data.
• Gathered a cross functional work team comprised of caregivers from the hospital, clinic and quality areas.
• Reviewed the current model and identified the opportunities for improvement.
• External industry research for “best practices”
• Researched Transitional Care Management requirements and applications.
• Inpatient and clinic training.
• EMR build.
• Aligned with Quality initiatives.
• Developed the workflow as one uniform team – hospital, clinic and system.
Old Model

- Patient Discharged from hospital with instructions for follow up.
- PCP may or may not be aware

Post Discharge Contact
- Hospital based

No standard process for follow up appointment scheduling.

? Clinic Visit within 7 days
New Model

- Hospital schedules directly with PCP within 7 days
- Automated message sent to clinic queue

48 business hour phone call

- Scripted to meet CMS guidelines
- Key clinical indicators reviewed
- Message sent to PCP

Patient ready for discharge

Clinic Visit within 7 days

- Scripted visit and tools to meet CMS guidelines
- TCM visit codes used.
Results

✓ Increasing follow up appointment with PCP within 7 days
  ~35% → ~85%

✓ Reduction in readmission rates.
  ~1 - 4 percentile point decrease

✓ Improved patient satisfaction.

✓ Enhanced provider efficiency and satisfaction.
Readmission Rate Reduction

PRIOR: 11% AVG

POST: 7% AVG
Show me the Money

✓ Increased office visits.
✓ Ability to use TCM codes with 2x the RVU value compared to traditional E&M codes.
✓ Ability to code E&M services at time of TCM visit if new issues exist.
✓ Reduced readmission rates.
The Reason Why

I had a patient discharged from the hospital after having a **pulmonary embolism**, but she thought she was just in the hospital for a panic attack. The patient was sent home on **Coumadin**. The clinic performed the 48 hour phone call and found out that the **patient was not taking Coumadin** because she did not understand the medication or why she should be taking this. They were able to get her back on her medications right away. **Without the 7 day process, she would have just been seen in a week or two and easily could have had a recurrent episode and died before then.**

Dr. Julia Hester-Diaz
Next steps
Evaluate Primary Care Model

Medical Groups Must Win the Battle for Primary Care

- Retail Care
- Primary Care
- Specialty Care
- Hospital/Emergency
- Urgent Care
- Competitors pushing toward full-spectrum primary care
- Medical groups risk relegation to acute and specialty care

Source: Medical Group Strategy Council interviews and analysis
Primary care capacity and competency are critical elements in the successful transformation to accountable care and a value-based health care market.
Primary Care Redesign
Objectives

- Help patients live well, providing **high quality care**.
- **Improving patient experience**, providing ongoing guidance to the right care at the right time.
- Improve patient **access** and **increase Aurora population base**.
- Enhance engagement through **top of license, team-based care**.
- Prepare our organization to **manage risk**.
- **Optimize outcomes relative to cost** and spending.
- Instill a culture of sustainable, **self-improving operational excellence**.
Making the Triple Aim Happen

- Better Health for the Population
- Better Care for Individuals
- Lower Cost Through Improvement
Redesign Program Components

- Population Health
- LEAN foundations
- Top of license practice
- Schedule Optimization
- Prevention and Wellness
- Quality improvement
- Patient Base

12 month process development process
Primary Care Redesign

PILOT ALPHA
Purpose: Implement various workstreams aimed to establish a foundation for enhanced care, focused on patient wellness, caregiver empowerment, and value based models.

Planning: 09/2013
Live date: 01/2014
Focus Area: 2 clinics
2 hospital
Caregivers: 18 Providers
Deployment Team: Project Management
Physician Champions
Quality
Operations Improvement
Educational Development
Change Management
Informatics
Nursing
Growth Development
Strategic Planning
Administration

PILOT BETA
Purpose: Implement various workstreams aimed to establish a foundation for enhanced care, focused on patient wellness, caregiver empowerment, and value based models.

Planning: 03/2013
Live date: 05/2014
Focus Area: 5 clinics
5 hospital
Caregivers: 27 Providers
Deployment Team: Project Management
Physician Champions
Quality
Operations Improvement
Educational Development
Change Management
Informatics
Nursing
Growth Development
Strategic Planning
Administration
Patient Experience

Overall patient experience has increased, with some outlier decreases due to staffing.

Care Management Impact Score increased or remained the same for all sites during this deployment’s measurement period.
**Volume**

Clinic visits increased for all sites

wRVUs increased for all providers.
## Tracking Outcomes
(example)

<table>
<thead>
<tr>
<th>Measure (14 total Measures)</th>
<th>July 2014 Actual</th>
<th>July 2014 Budget / Target</th>
<th>Variance - Actual to Budget</th>
<th>Last Month - June 2014</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Last Year</th>
<th>Current Year End Projections</th>
<th>Current Year End Goal</th>
<th>Variance - Projection to Goal</th>
</tr>
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<tbody>
<tr>
<td><strong>Patient Experience (CGCAHPS)</strong></td>
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<tr>
<td>Service Impact Score</td>
<td>59%</td>
<td>65%</td>
<td>6%</td>
<td>72%</td>
<td>66%</td>
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<tr>
<td>% Access Satisfaction</td>
<td>43%</td>
<td>65%</td>
<td>22%</td>
<td>46%</td>
<td>45%</td>
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<td><strong>Quality</strong></td>
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<tr>
<td>Care Management Impact Score</td>
<td>3.9</td>
<td>3.3</td>
<td>0.6</td>
<td>3.8</td>
<td>3.85</td>
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<td>Breast CA Screening</td>
<td>82%</td>
<td>81%</td>
<td>1%</td>
<td>81%</td>
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<tr>
<td>Cervical CA Screening</td>
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<td>82%</td>
<td>1%</td>
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<td>Colorectal CA Screening</td>
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<td><strong>Process Improvement</strong></td>
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<td>My Aurora</td>
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<td>Transitional care % completion of 2d call</td>
<td>86%</td>
<td>90%</td>
<td>4%</td>
<td>83%</td>
<td>85%</td>
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<tr>
<td><strong>Population Health Outcomes</strong></td>
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<td>Readmission Rate- Global</td>
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<td>Readmission Rate- COPD</td>
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<td>Readmission Rate- CHF</td>
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<td>Panel Size</td>
<td>15,530</td>
<td>14,394</td>
<td>1,136</td>
<td>13,008</td>
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<td><strong>Financial</strong></td>
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<tr>
<td>TOTAL Additional Contribution Margin*</td>
<td>$1,336.00</td>
<td>$1,819.00</td>
<td>$483.00</td>
<td>$1,890.00</td>
<td>$3,226.00</td>
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</tbody>
</table>

*Content is for illustrative purposing only and not real data*
Establishing the foundation for change

Primary Care Redesign
Two Converging Initiatives

HIGH QUALITY SERVICES & TEAM BASED CARE

EFFICIENT OPERATIONS & INCREASED REVENUE

DECREASED ER VISITS & HOSPITALIZATIONS

TRIPLE AIM

ACCESS & INCREASED POPULATION

INNOVATIVE REDESIGN

1-2 PILOT CLINICS

System Wide

Establishing the foundation for change
Innovative Redesign

• Design a transformative/new model primary care clinic.

• Leverage resources towards better health for the population, better care for individuals and lower costs of care through continuous improvements.

• Extend well beyond the physical walls of the clinic.

• Integrate with other key service lines such as behavioral health.
<table>
<thead>
<tr>
<th>Major Processes</th>
<th>Access</th>
<th>Patient Encounter (Before, During, After)</th>
<th>Population Management</th>
<th>Patient Engagement</th>
<th>Care Team Models</th>
<th>Clinic Management</th>
<th>Clinic Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduling</td>
<td></td>
<td>Rooming</td>
<td>Managing Chronic Disease</td>
<td>Proactive Care – Person-oriented Education/Motivation</td>
<td>Team Communication</td>
<td>LEAN-driven Performance Criteria (patient wait times, etc.)</td>
<td>Patient/Provider Flow, Wayfinding, etc.</td>
</tr>
<tr>
<td>New Patient Onboarding</td>
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<td>AVS – Communicating Outcomes</td>
<td>Medication Management</td>
<td>Enabling Self-management</td>
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<tr>
<td>Connecting with AHC system/PCP (marketing related)</td>
<td></td>
<td>Registration</td>
<td>Care Coordination – Consults/Referrals, Hospital Transitions, Specialists, Handoffs</td>
<td>Understanding your Patient (whole person)</td>
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<tr>
<td>Components</td>
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<tr>
<td></td>
<td></td>
<td>What’s Going on in the Exam Room</td>
<td>Comprehensive Chronic Disease Care (across all conditions)</td>
<td>Whole Person Care</td>
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<td>Integrated Behavioral Health</td>
<td>Answering Questions</td>
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<td>Listening</td>
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<td>Connection for Ongoing Support</td>
<td>Coaching Self-care</td>
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<td>Conducting Tests and Communicating Results</td>
<td>Community Connection</td>
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<td>Common</td>
<td>IT</td>
<td>Staying Connected/Information Sharing</td>
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How Does Facility Design Fit In?

• Helps support an efficient, patient-centric delivery model.
• Workflows influence design of model
• Patient input helps focus facility on ease of use, comfort, flow
• New clinic locations are an opportunity to put some of these processes in place
## Milestone Timeline

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<tr>
<th>ACTIVITIES</th>
<th>TIMELINE</th>
<th>STATUS</th>
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<tbody>
<tr>
<td>Primary Care Redesign System roll out</td>
<td>SEPT 2014 - OCT 2015</td>
<td>IN PROGRESS</td>
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<tr>
<td>Innovative Pilot Redesign Development</td>
<td>Q3 2014 – Q2 2015</td>
<td>IN PROGRESS</td>
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<tr>
<td>Innovative Pilot Redesign Implementation</td>
<td>Q3 2015 – Q4 2015</td>
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Questions