New Models of Care

What We Can Do Together
September 30, 2014

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Challenge creates a sense of urgency to **transform** our care delivery practices across the healthcare continuum.

- **23 Million Beneficiaries**
  - Spending $1,130 each
  - Total Spending = 5% ($26 B)

- **16.1 Million Beneficiaries**
  - Spending $6,150 each
  - Total Spending = 20% ($104 B)

- **7 Million Beneficiaries**
  - Spending $55,000 each
  - Total Spending = 75% ($391 B)
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Care Delivery Transformations: Emerging From Home Care

Integrated Care Management

Advanced Illness Management

Person Centered, Evidence Based, Coordinated Care

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AIM® MODEL DESIGN CHARACTERISTICS

**Target Population**
- > 2 Chronic Illnesses; >1 Illness Advancing
- Poly-pharmacy
- Clinical, Functional, and/or Nutritional Decline
- High Symptom Burden leading to repeat utilization
- MD ‘Surprise Question’ 12 Months

**Model Principles**
- Personal Goals
- Person & Physician Relationship Central
- Dual Therapeutic Approach Curative + Palliative
- Evidenced Based Clinical Care and Care Management
- Simplify and Drive Communication

**Pillars of Care**
- Advanced Care Plans
- Self Management Plan of Red Flag Symptoms
- Medication Management
- Ongoing Follow Up Visits
- Engagement & Self Management Support
- Resting on Curative + Palliative Care Foundation

**Drivers of Outcome**
- Aware and Skilled in Health Literacy & Patient Engagement
- Continue During Periods of Illness and ‘Wellness’, across all settings
- Frequent & Predictable MD Communication
- Teams Without Borders

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Health Care Innovations Awards

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AIM Utilization and Cost Outcomes

12 month rolling average
Ending March 2014
Change in Utilization 90 Days Post AIM Enrollment

9 of 10 sites reporting; Q2 2013-Q1 2014; n=1544
(Results not yet confirmed independently by CMS Evaluators)

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AIM Pre/Post Cost Analysis

AIM 90 Day Cost of Care Impact Per Enrollee (N=1,544)
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