Four Data-Driven Strategies to Achieve Population Health 4.0

November 16, 2021

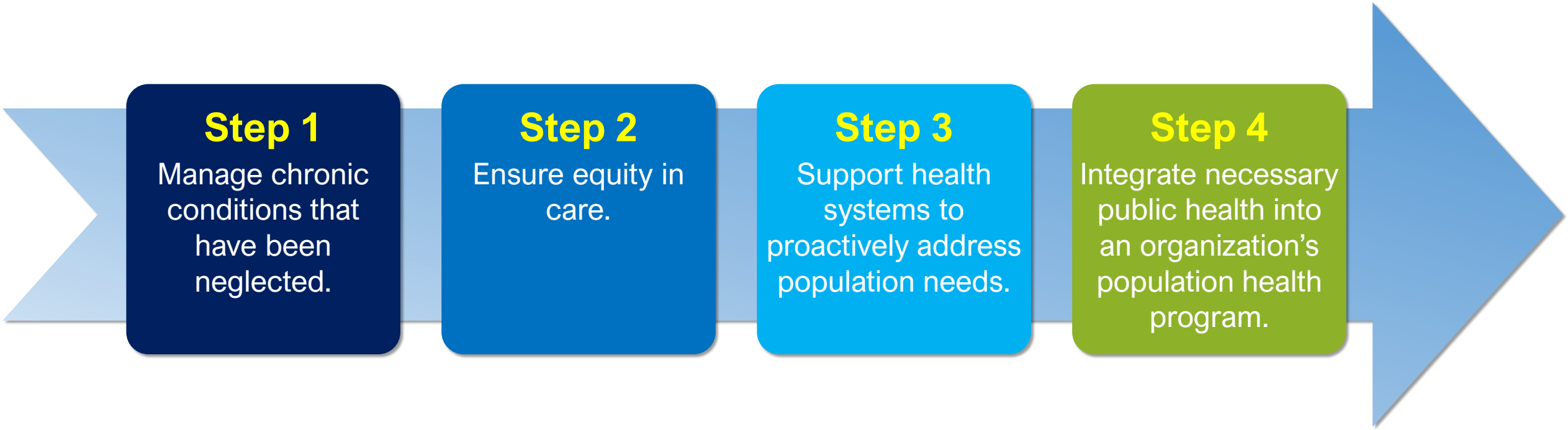
Today's Speaker

Sita Kapoor, Chief Information Officer, leads HealthEC's research & development team, applying mathematical and computing models in custom development of large-scale data integration and analytics solutions that empower physicians and healthcare organizations to identify and engage at-risk patients requiring closer follow-up. She is also involved in HIPAA workgroups, charged with defining consent and transaction standards. Sita was named by Health Data Management as a recipient of the Most Powerful Women in Healthcare IT Award for 2018 and 2019.

What Is Pop Health 4.0?

Population Health 4.0 is the recognition of health as a global entity and the focus on identifying and eliminating health disparities, unnecessary costs, and comorbidity. The focus in 4.0 is on **population** health management.

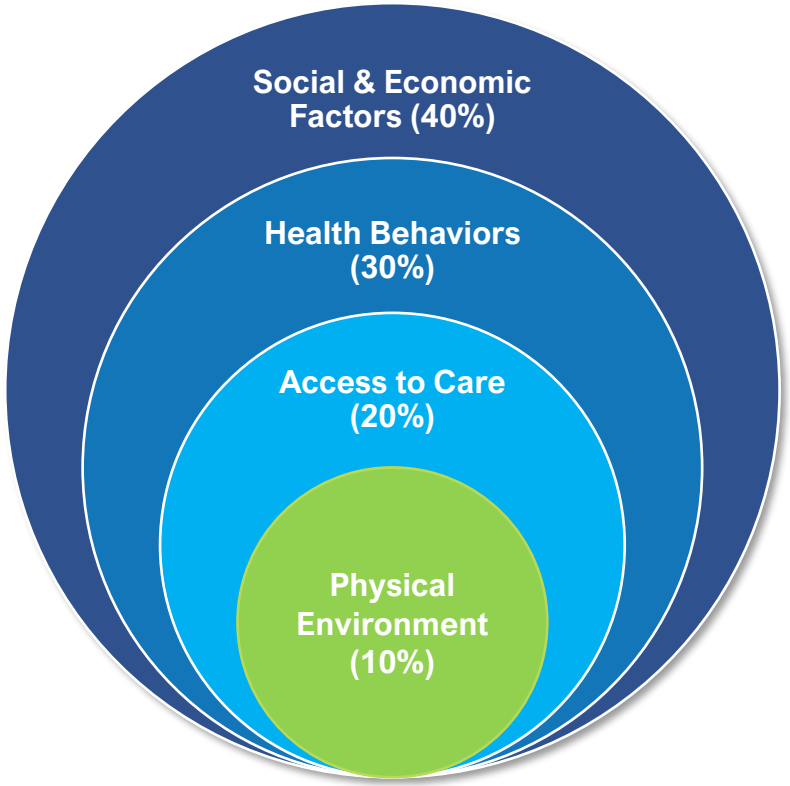
Data-driven Strategies for Success



1. Manage Chronic Conditions That Have Been Neglected

Measuring Health Disparities

- Gaps in health and healthcare are related to access and the social determinants of health (SDOH)
  - **Result in preventable morbidity, mortality and health care expenditures**
- Identify and measure health-related outcome indicators to assess progress in reducing barriers to health and closing gaps in health outcomes



Case Study: ACMG

The Accountable Care Medical Group (ACMG) of Florida is a privately held ACO that supports physicians serving diverse populations throughout Florida, South Carolina, Georgia, California, and Pennsylvania. ACMG utilizes HealthEC's PHM suite.

Goals

- Enable participating physicians to monitor utilization/quality performance throughout the year so GPRO reporting is less stressful
- Provide acute event notification services to physicians
- Guide care coordinators in day-to-day activities, including ER admits, risk prevention, and maintaining quality measures while ensuring current time markers for care coordination
- Optimize care coordination programs for the diverse populations served
- Improve individual service quality performance compared to historical benchmarks
- Reward physicians for quality performance so that better performing physicians receive larger shares of savings
- Educate physician participants of the financial, risk, and quality benchmarks required to maximize bonuses
- Identify and differentiate operational costs not directly attributable to physician services
- Build rapport and trust among physicians about the value of ACO program participation

Challenges

- **Data Usability:** Obtaining/converting beneficiary claims into usable forms was a challenge since ACMG's initial shared-savings agreement with CMS
- **Care Coordination throughout the Patient Experience:** ACMG needed to ensure timely notifications of acute care experiences, coordinate care in post-acute settings, and provide chronic care management services to mitigate risk.

Solution

- ACMG selected HealthEC's PHM platform after many assessments of competitive solutions.
- Leadership wanted a vendor partner that would provide the ability to modify and adapt the platform to the evolving needs of the organization.

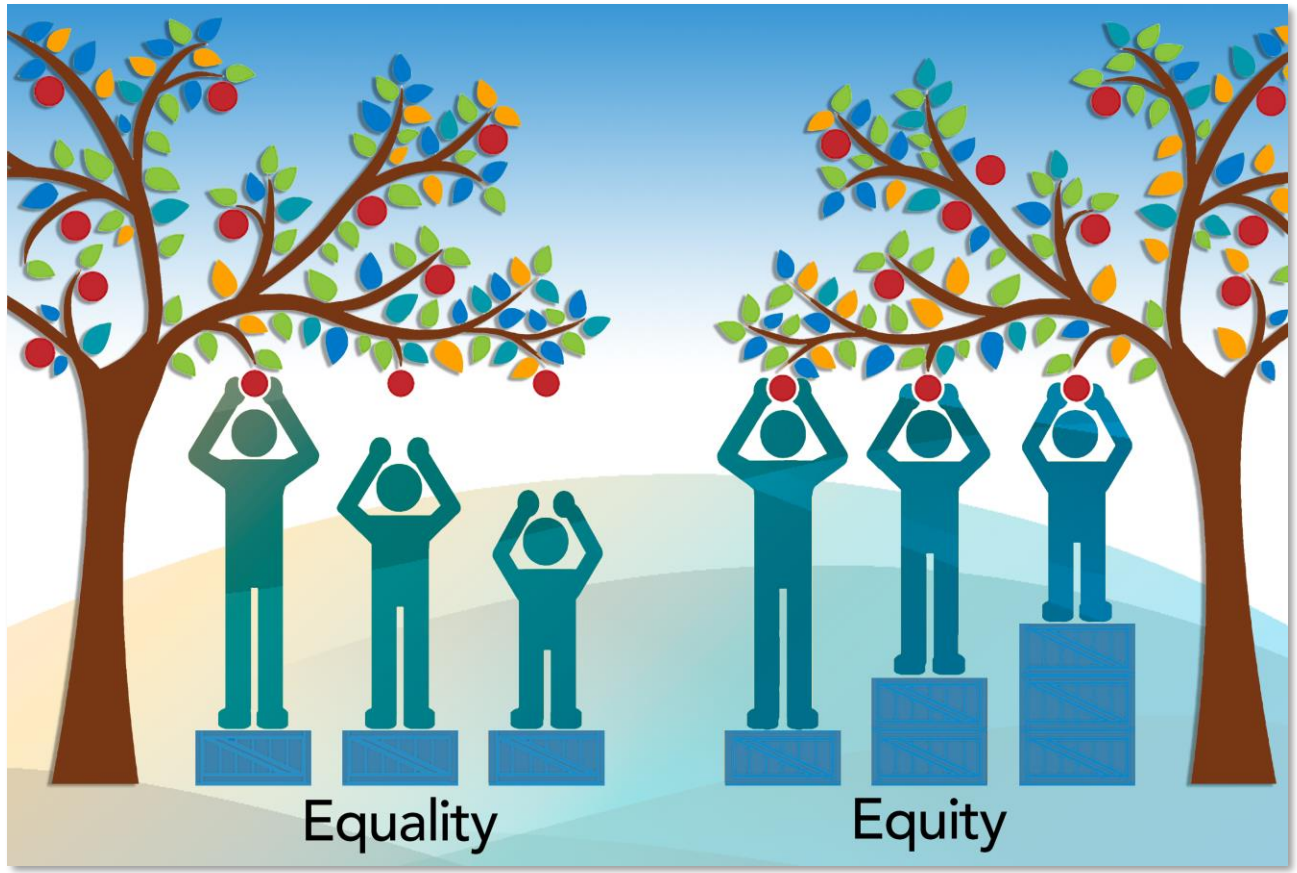
Results

HealthEC helped ACMG save more than $10 million in 2018 for 20,162 beneficiaries, averaging annual savings of $ 540 per beneficiary

29%	20%	17%	14%
Reduction in ER visits	Reduction in hospital admits	Increase if PCP visits	Reduction in PMPM

2. Ensure Care Equity

What Is Health Equity?

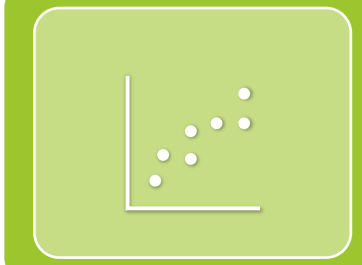


Health equity refers to the condition in which everyone has a fair and just opportunity to be as healthy as possible. ***(RWJF, 2017)***

Why Health Equity Matters

Gaps in health and healthcare nationwide are increasing and often related to disparities access and in the social determinants of health (SDOH).

US ranks 43rd in the world on average life expectancy at birth.



Critical to identify and measure health-related outcome indicators to assess progress in reducing barriers to health and closing gaps in health outcomes.

Impact of Health Equity

- Health disparities cost the U.S. ~$60 billion in excess medical costs and ~$22 billion in lost productivity in 2009
- COVID-19 response – vulnerable individuals, patients with chronic conditions, and persons facing economic, housing, insurance and food insecurity issues are disproportionately impacted

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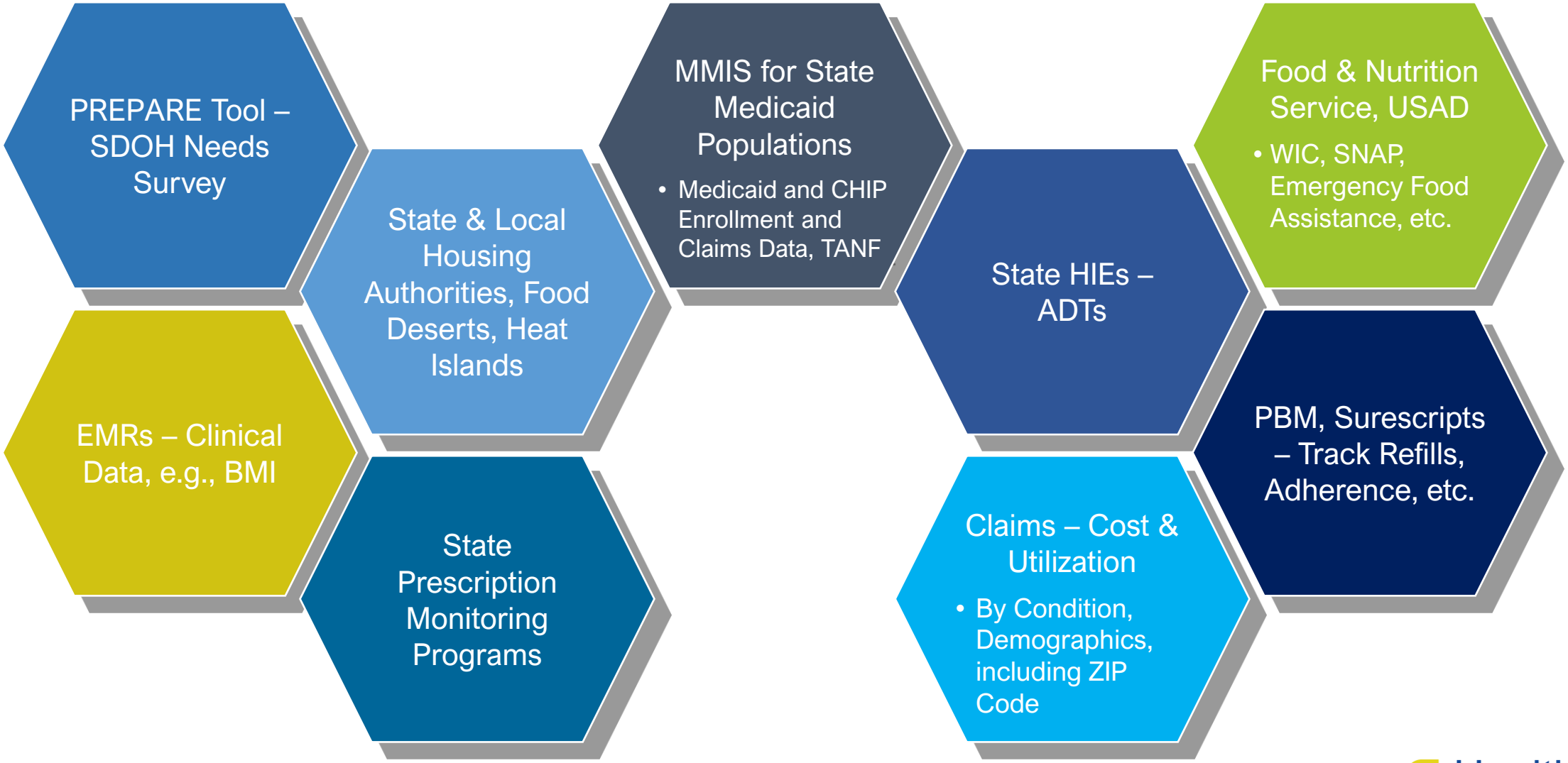
Leveraging Data to Support Health Equity Initiatives



Case Study: AICNY

The Alliance for Integrated Care of New York, LLC (AICNY) oversees the healthcare needs of individuals with intellectual and developmental disabilities (IDD). Comprising ~350 healthcare providers, AICNY cares for 4,464 with 2.757 dually eligible Medicare and Medicaid beneficiaries and 2,153 disabled adults and is the only MSSP-approved ACO of its kind in the country

Goals

- Identify and implement technology to create a centralized view of the patient's data, regardless of the originating system or setting of care
- Engage the physician community and illustrate opportunities for improved quality of care
- Manage care coordination and personalize patient communication for social determinants
- Reduce overall cost to serve a growing beneficiary population and geographic region
- Coordinate medical and behavioral health care

Challenges

- Integrating care solutions
- Alternative care setting dynamics with beneficiaries in Group Homes and group home data on paper
- Medical Care at multiple FQHCs
- Delivering proactive, personalized care
- Considering social determinants while maintaining privacy
- Medication Management
- Lack of focus on preventive care

Solution

- Integrated 7 CHCs and 25 licensed private practices, completing the patient record.
- HealthEC included two care manager trainers to augment AICNY's providers for coordinate care
- Installed Tele Triage kiosks connected to local ER or Urgent care Provider with access to beneficiaries' longitudinal record

Results

$2.9 million In savings

Risk-stratifying patients & targeted interventions using care coordinators interacting with providers lead to increased savings.

6.3% reduction in expenditures for 4,464 beneficiaries

AICNY saw a 6.3% reduction between 2017 and 2018, or $617 per beneficiary

ER visits dropped by 11% & admits dropped by 7%

Tele-triage kiosks in IDD group homes led to 11% reduction in ER use

Behavioral Health Care Management

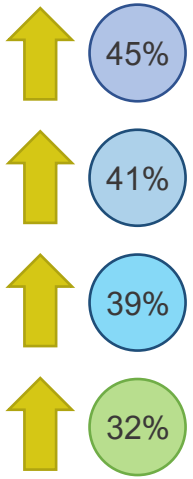
Egyptian Health

- Supporting the InCK (CMS Innovation Model for Integrated Care for Kids) and Certified Community Behavioral Health Centers (CCBHC) Demonstration programs
- Early identification and treatment of behavioral and physical health needs with multiple physical, behavioral or other needs
- Integrated case management with assessments and risk stratification to prioritize interventions that could impact functioning in school communities and Homes
- Real-time integration with:
  - **NowPow** (a personalized Community referral program)
  - **PatientPing** (tracks patients' use of community-based resource network)

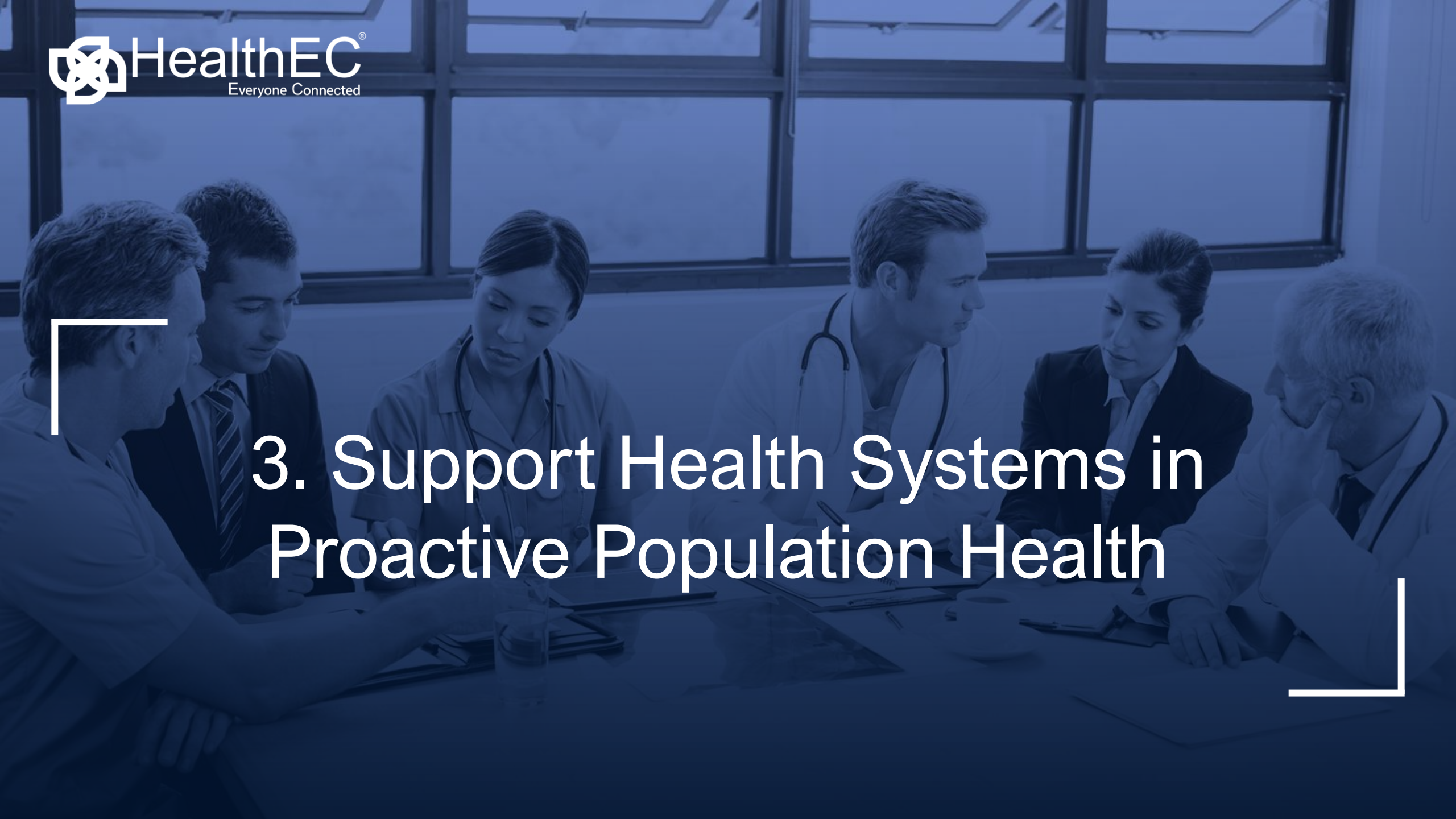
Illinois Health Practice Alliance (IHPA)

- Providers banded together to promote behavioral and physical health
- Serving over 40,000 Medicaid & other payers
- Integrated Health Homes to achieve Triple Aim

Within one year of implementing our initial health plan agreement, IHPA providers realized the following improvements:



- Increase in completed health risk assessments (HRAs)
- Increase in completed health risk screenings (HRSs)
- Increase in completed client care plans
- Increase in completed care transitions



3. Support Health Systems in Proactive Population Health

Platform Adaptability to Various Market Segments

Priority

Health Plans	HHS – States	IDNs and CINs	Value-based Contracts
Data Aggregation and Universal Data Warehouse	Data Aggregation and Universal Data Warehouse	Data Aggregation and Universal Data Warehouse	Quality Reporting
VBC Support and Performance Monitoring	MCO Performance Monitoring	VBC Support and Performance Monitoring	Utilization and Financial Performance Monitoring
Provider Engagement	Claims Analytics	Provider Engagement	Care Management and Coordination
Quality and Risk Reporting	Quality Reporting (Quality Improvement Program)	Quality Reporting	Provider Engagement

Aggregating Data from the Healthcare Ecosystem

Data from ANY SYSTEM

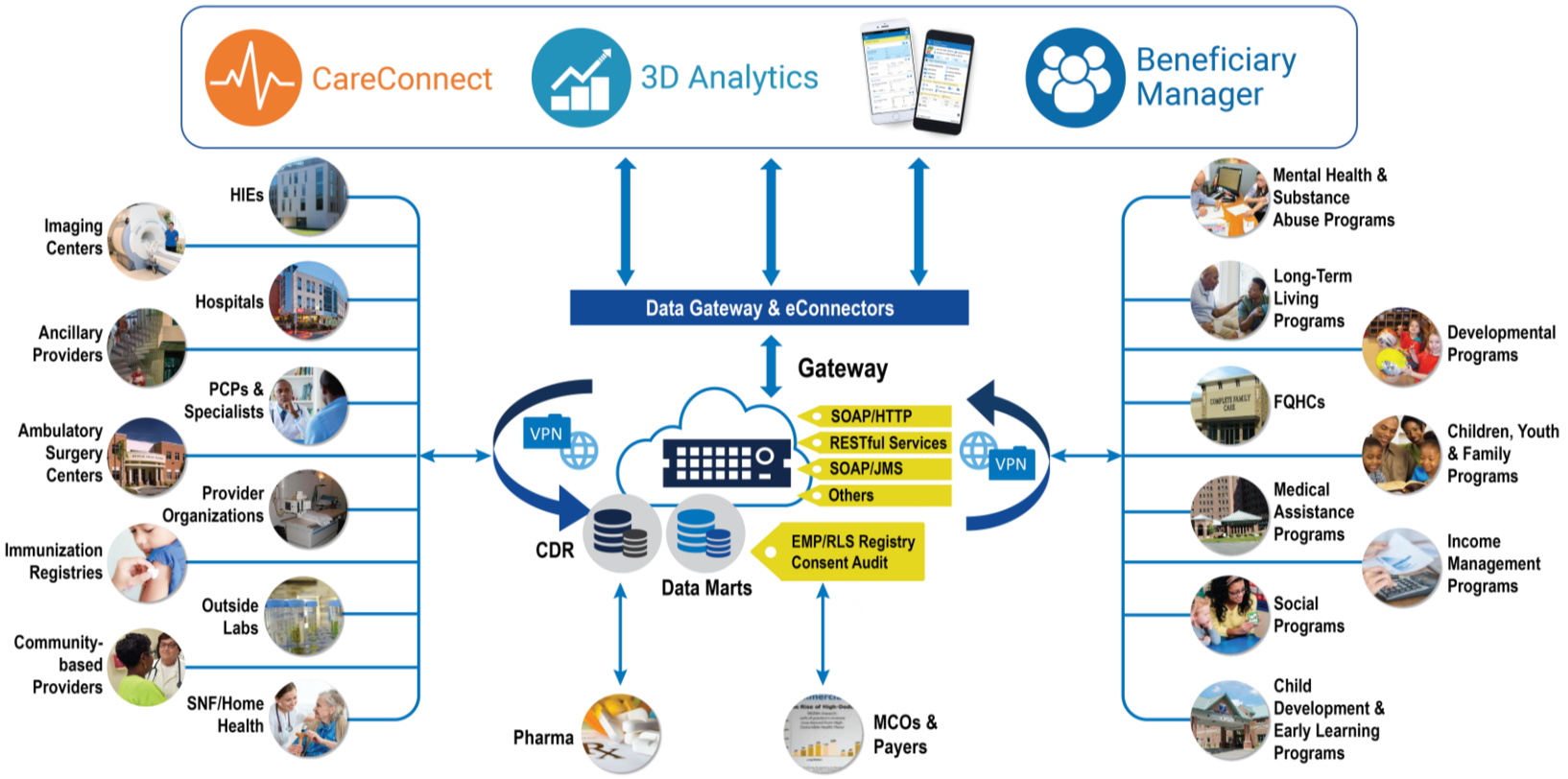
- ✓ EMRs/EHRs (200+ adapters live)
- ✓ Patient scheduling
- ✓ Laboratory
- ✓ Pharmacy benefits manager
- ✓ Claims and remittance, payer adjudication, MMIS
- ✓ Data warehouses
- ✓ Registries and local and regional HIEs

Data from ANY CARE SETTING

- ✓ Hospital (IP, OP, ER), ambulatory, and post-acute care (rehab, SNF)
- ✓ Behavioral health
- ✓ Home health
- ✓ Case management/care coordination
- ✓ County and state clinics
- ✓ Pharmacies and reference labs

Data in ANY FORMAT

- ✓ CCD/A, CCR
- ✓ EDI 837, 835
- ✓ HL7 ADT, ORU, ORM, FHIR
- ✓ Proprietary files
- ✓ CCLF, NCPDP, SQL statements
- ✓ Any protocol: Web service, batch, API, etc.



- Life Circumstance Data
  - Demographic and Socio-Economic Variables
  - Consumer Residential Profiling Variables
  - Lifestyle and Engagement Group Variables
  - Ethnicity and Language Variables
  - Household Unit Profiling Variables

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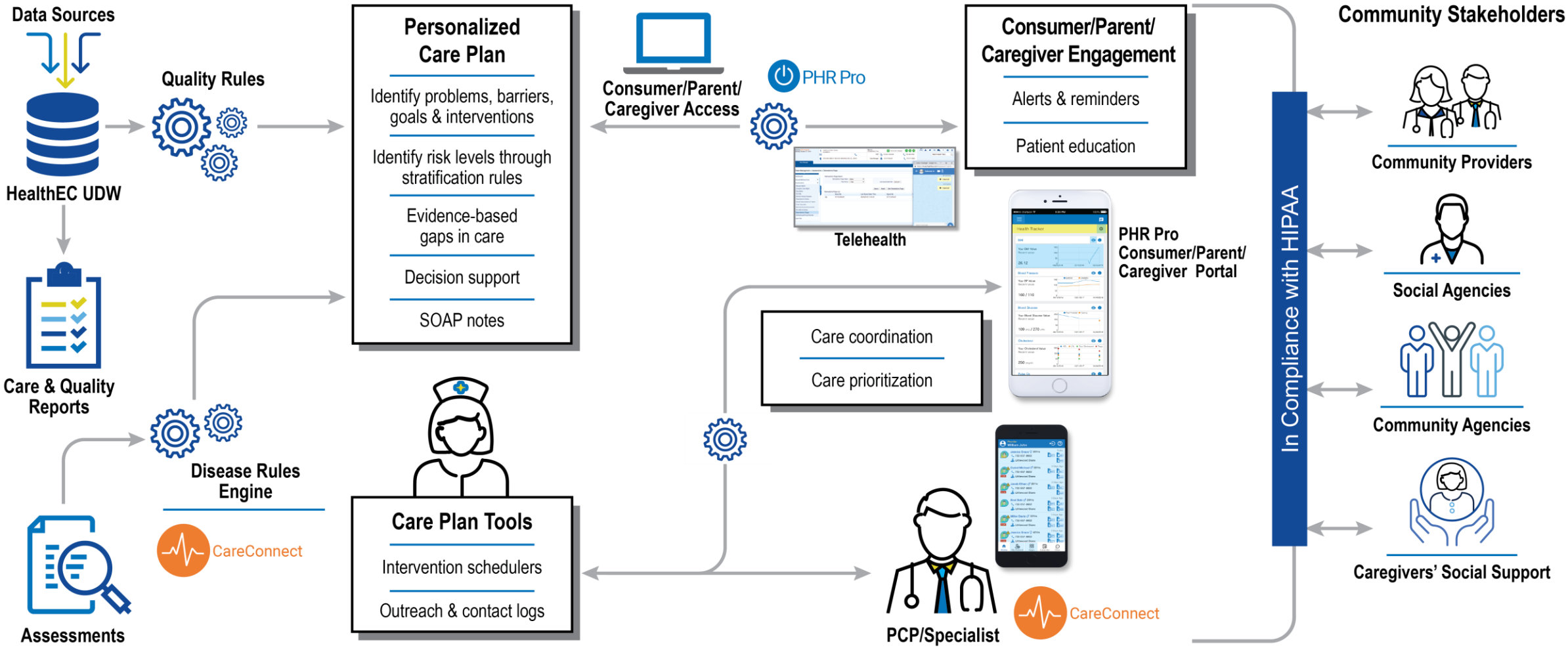
Community Health Record



Comprehensive Data Reduces ER Visits

Beaumont Health

- Beaumont Health is Michigan's largest healthcare system (based on inpatient admissions and net patient revenue) with eight hospitals, 145 outpatient locations, over 5,000 physicians, and more than 38,000 employees, with 222,000 managed lives.
- **Tools:** Enterprise Data Warehouse, 3D Analytics, CareConnect
- **Clinical** data sources: eCW, Epic

- **Payers:** BCBSM, BH Employee Health Plan, Botsford, OHSCare
- **ADT** alerts from regional
- **HIE** (MiHIN) integration

- **Results:** Since adopting CareConnect for care coordination, Beaumont Health has reduced ER utilization, ER readmissions, and increased ROI.

Beaumont ACO

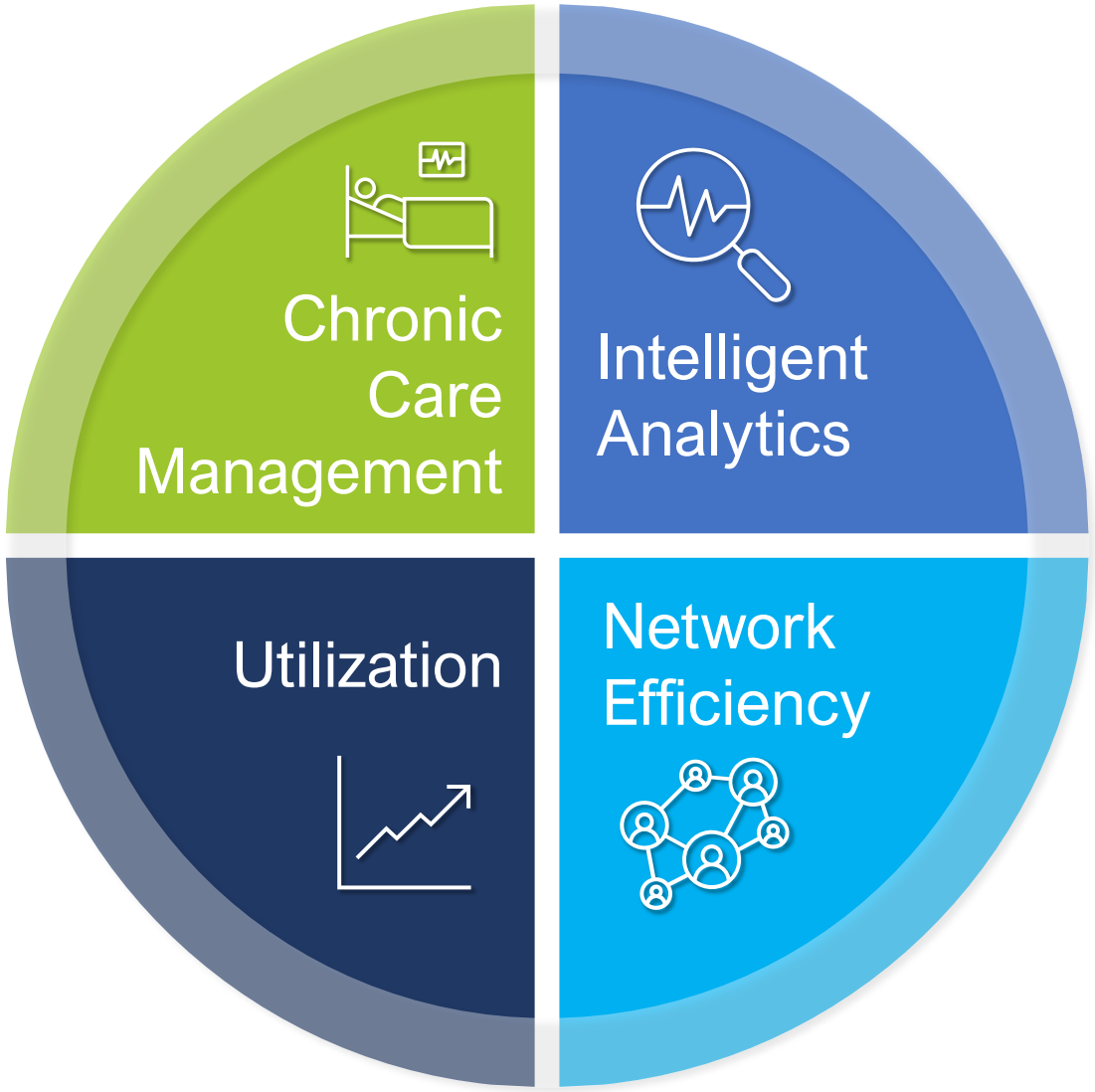
- Beaumont ACO is a physician-health system ACO partnership with ~1,900 physician members managing113,000+ lives

- **Tools:** 3D Analytics, CareConnect, Measure Registry – HealthEC's system replaced the previous system, WellCentive.
- **Clinical** data sources: eCW, Epic, Quest, JVHL, Practice Fusion, and Care Quest 360, MiHIN
- **Payers/programs:** MSSP, BCN, Humana, Priority
- **ADT** alerts from regional
- **HIE** (MiHIN) integration

- **Results:** The ACO generated $27.8M in gross savings for contract year and retained $14.2M with a 92.2% quality rating

4. Integrate Public Health into Population Health Program

Executing SDOH Strategy



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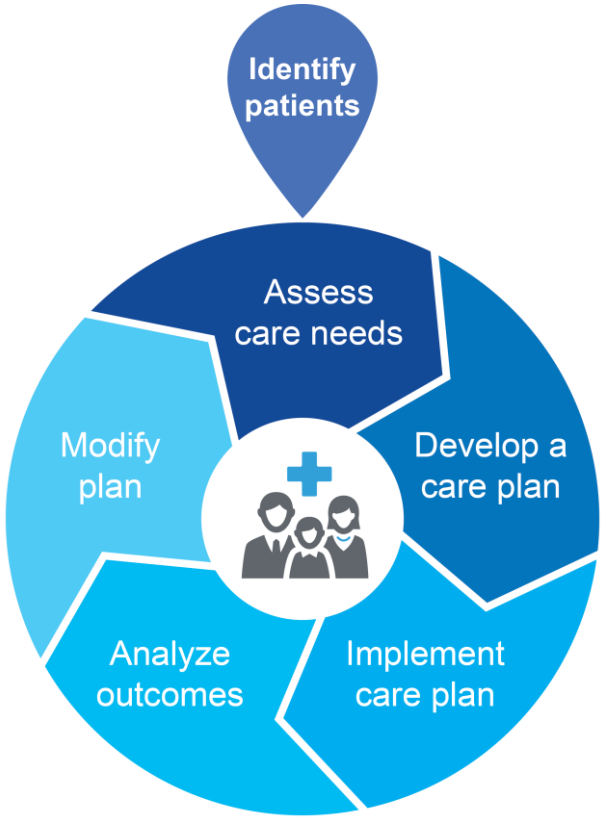
Community-based Services



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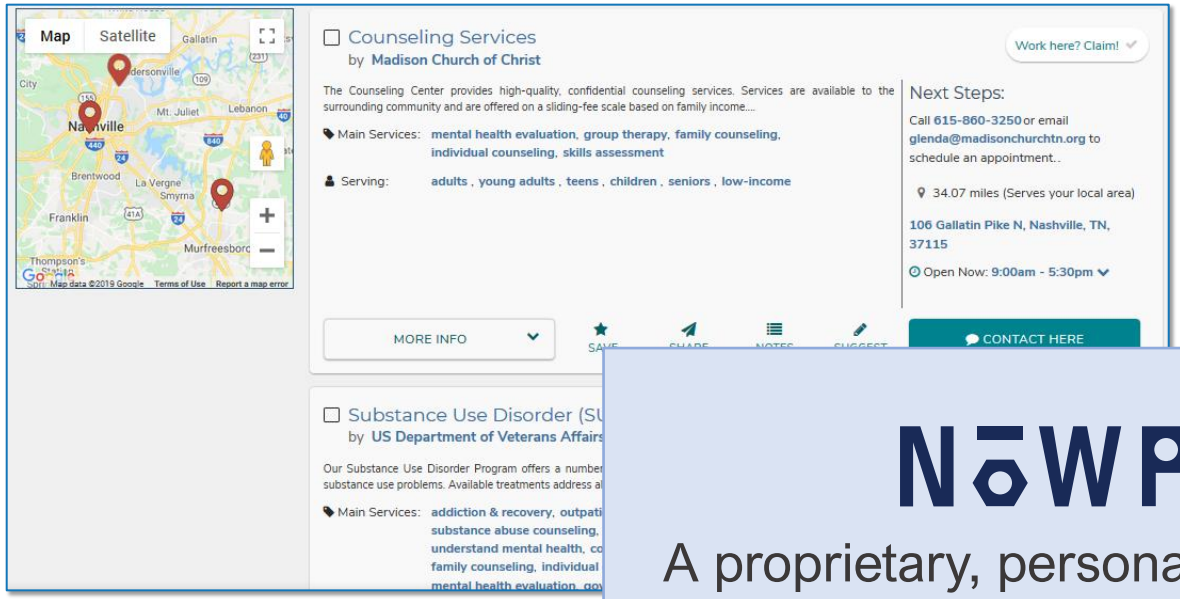

NOWPOW

A proprietary, personalized community referral platform

Other Community-type Organizations

FreeRehabCenters.org

HSD Helping the Needy

HOMELESSSHELTERDIRECTORY
Helping The Needy of America

goodmap

COMMUNITY COMMONS

purplebinder

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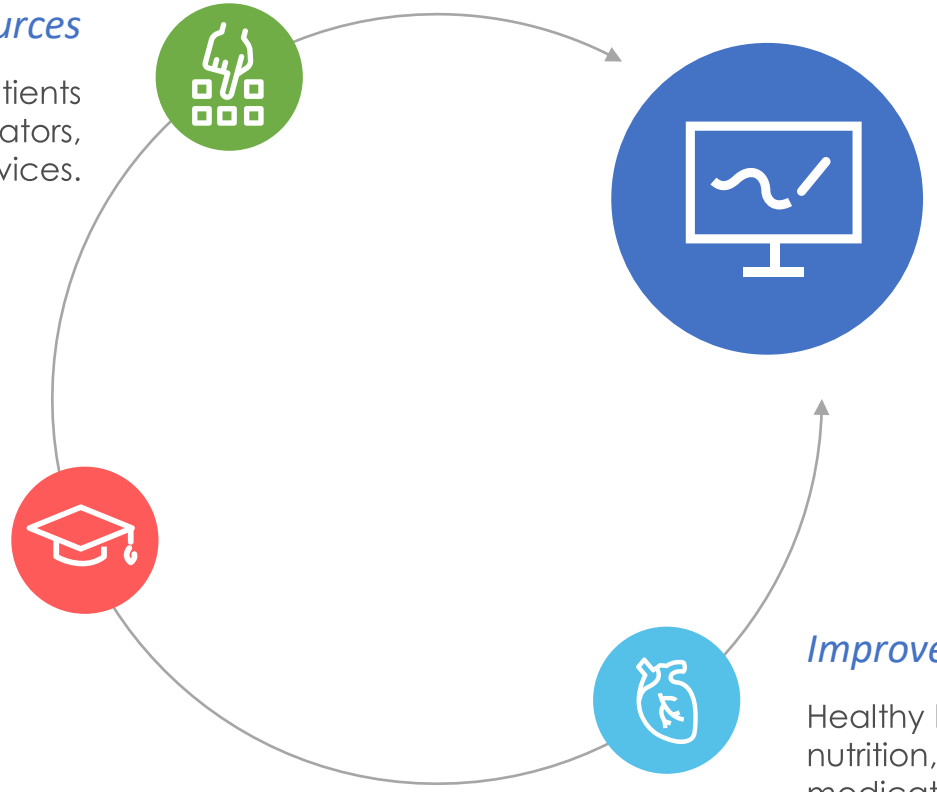
Community based

Link to community resources

There is great value in connecting patients to community services, care coordinators, and communication services.



Care Coordination Technology Platform

Comprehensive view of clinical and operational data provides instant access to more comprehensive data.

Improved health behaviors

Healthy behavior changes including nutrition, exercise, sleep, hygiene, medications, etc.

Provide education

Align education programs to help patients change their health behaviors to optimize individual and community wellness.

Case Study: Prince George's County Health Department

- 3500 patient care coordination pilot
- 2015 to 2018
- Enrolled 492 high risk clients
- Completed over 13,500 client contacts (phone, in-person, etc.)
- Created 2,800 pathways with Over 100 outreach events
- Conducted disease self-management and health literacy seminars
- Documented in HealthEC, tracked and measured outcomes

HEALTH DEPARTMENT
Prince George's County

Results

"This contributed to a **21% reduction in hospital and** emergency department visits for two local hospitals, and a **17% reduction in healthcare costs** for the high-risk patients receiving our care coordination services."

—Dr. Ernst Carter

6 Months Pre/Post

Hospital Utilization Volume

VOLUME	6 mo pre-	6 mo post-
ED Visits	241	223
Admissions	238	156
Obs Stays	61	43
Hospital Utilization	**540**	**422**

21.9% reduction in overall hospital utilization

Hospital Utilization Costs

CLAIM PAYMENTS	6 mo pre-	6 mo post-
ED Visits	$122,828	$120,727
Admissions	$2,814,199	$2,350,541
Obs Stays	$216,162	$140,040
Hospital Utilization	**$3,153,189**	**$2,611,307**

17.2% reduction in overall hospital utilization costs

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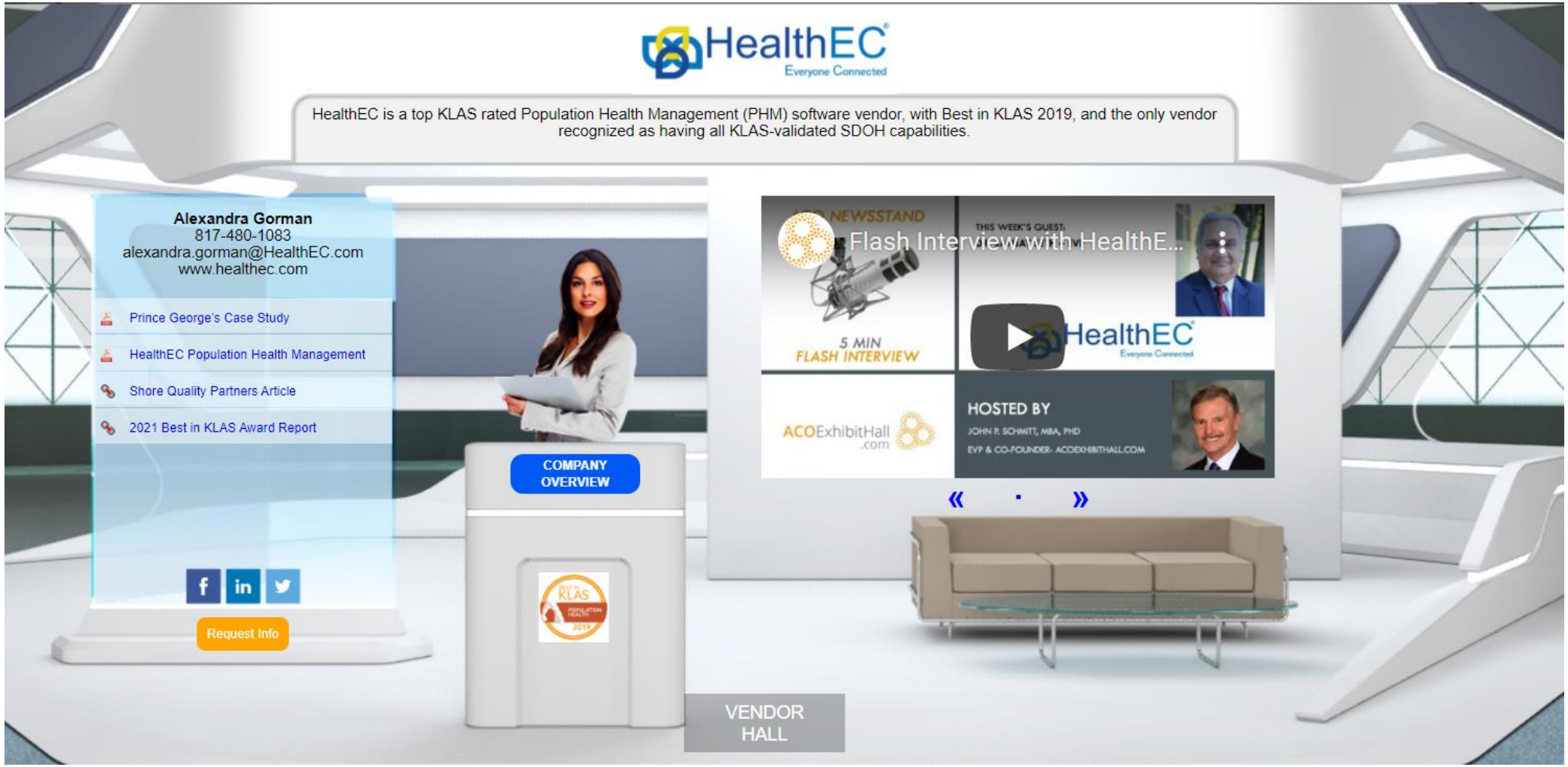
Q&A

Stop by our ACOExhibitHall.com Virtual Booth



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