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Educational Webinar Series

Lightbeam Health Solutions

Your Roadmap to Building a Robust Health Equity Plan to Succeed in ACO REACH

Kent Locklear, MD, MBA, Chief Medical Officer, Lightbeam Health Solutions
Joe McDonald, MBA, Co-founder, President, CareSignal, a Lightbeam company

Learning Objectives

- Describe the technology and staffing considerations of a successful and scalable health equity plan
- Evaluate key data sources for identifying patients at significant risk for social vulnerability
- Identify methods for engaging vulnerable populations to proactively monitor and intervene on relevant chronic conditions and social determinants of health.

DR. KENT LOCKLEAR, MD, MBA
Chief Medical Officer
Lightbeam Health Solutions

JOE MCDONALD, MBA
President & Co-Founder
CareSignal, a Lightbeam company

Focus on Health Inequities

New changes that keep the focus on beneficiaries in underserved communities to help increase opportunity to optimal care

- **Health Equity Plans:** New requirement for REACH ACOs to develop and submit a formalized Health Equity plan
- **Benchmark Adjustments:** Application of health equity benchmark adjustment for ACOs serving patients in underserved communities to better support care delivery and coordination
- **Required Demographic Data Collection:** New requirement to capture and report demographic and social needs data (ties to social determinants)
- **Beneficiary Engagement Incentives and Beneficiary Enhancements:** Higher quality of care and support with engagement incentives, encouraging better management of chronic conditions and reduced readmissions

Focus on Reduction in Utilization

- No Clinical Measures
- 4 Claims Measures
  - All cause readmissions
  - Unplanned admissions for patients with multiple chronic conditions
  - Timely follow-up
  - Days at home (specific to High-Needs DCEs only)
- 9 CAHPS Measures

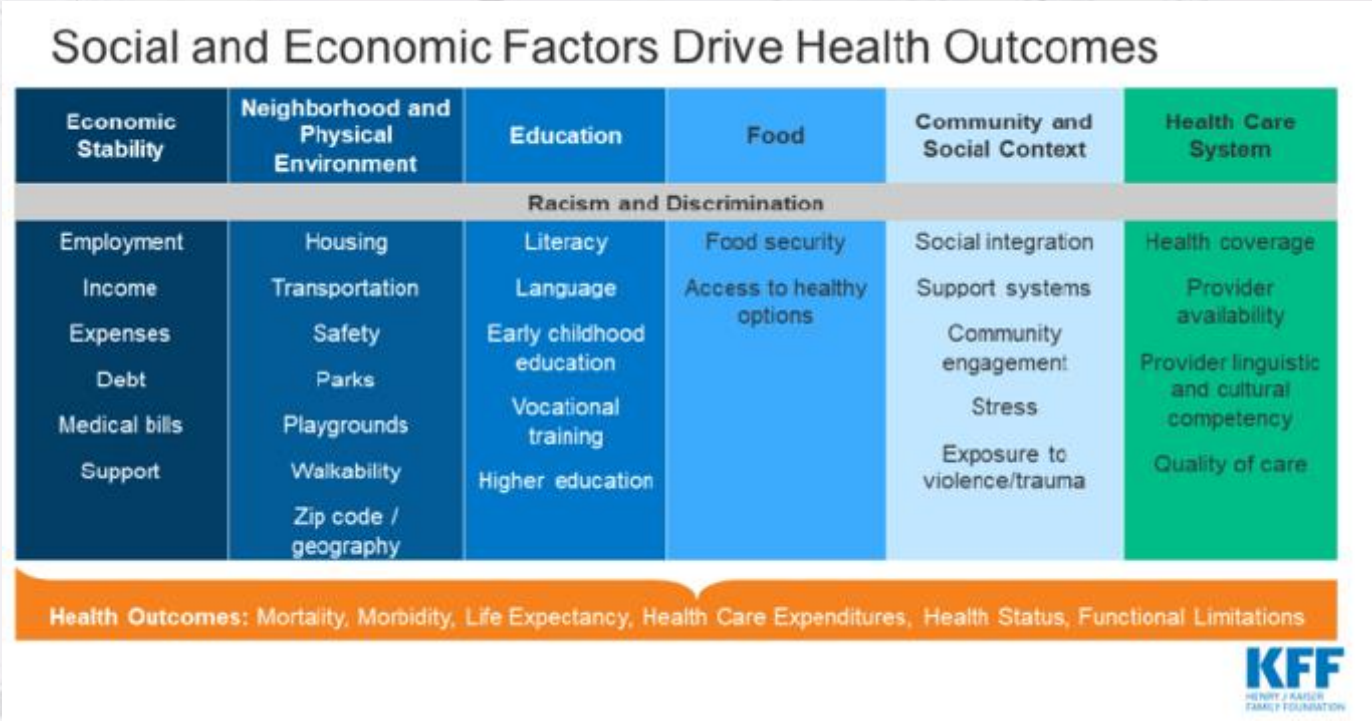
Five Pitfalls

Pitfall #1: Broad Risk Identification

ASSESS RISK

Challenge

- Identify which patients are most likely to readmit to the hospital
- Identify which social factors are most likely to be affecting each patient
- Identify which health social factors to address to have the greatest impact

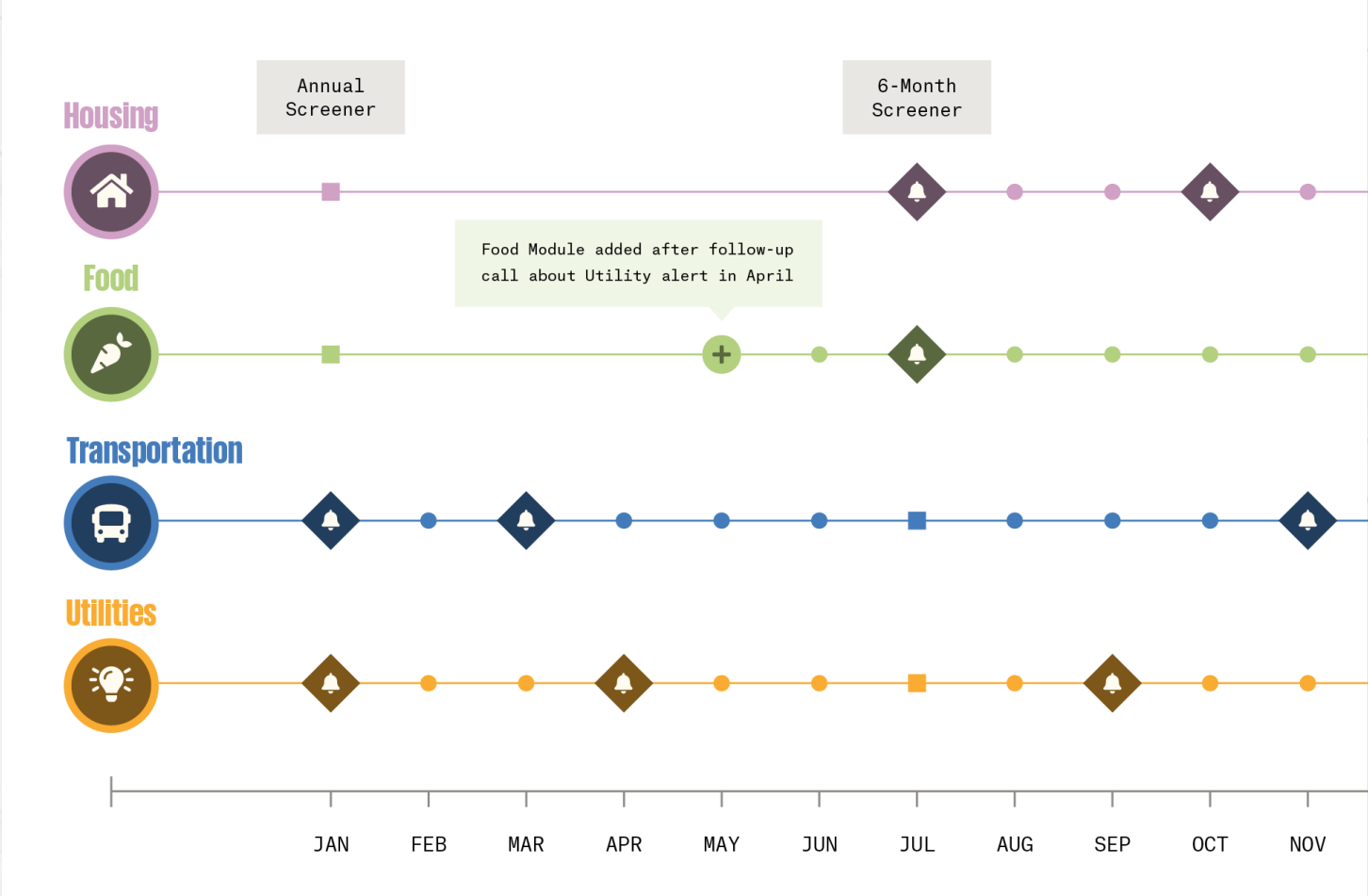


Pitfall #2: Disconnected SDOH Strategy

ASSESS RISK

Challenge

- Identify the social determinant factors most likely to be affecting each patient
- Manual SDOH data collection
  - One-time, outdated
  - Reactive
  - Traditionally long surveys place response burden on patient, white-coat effect – less accurate answers
  - PCP's traditionally clinically focused, limited LCSW's
- Connect patients to social services without switching platforms



Pitfall #3 Not Reaching the Most Vulnerable

ENABLE

Challenge:

- Relying only on face-to-face visits is an incomplete strategy
- Most technology solutions (apps, portals, telehealth) don't reach vulnerable populations
- One-way only communication

RAND CORPORATION

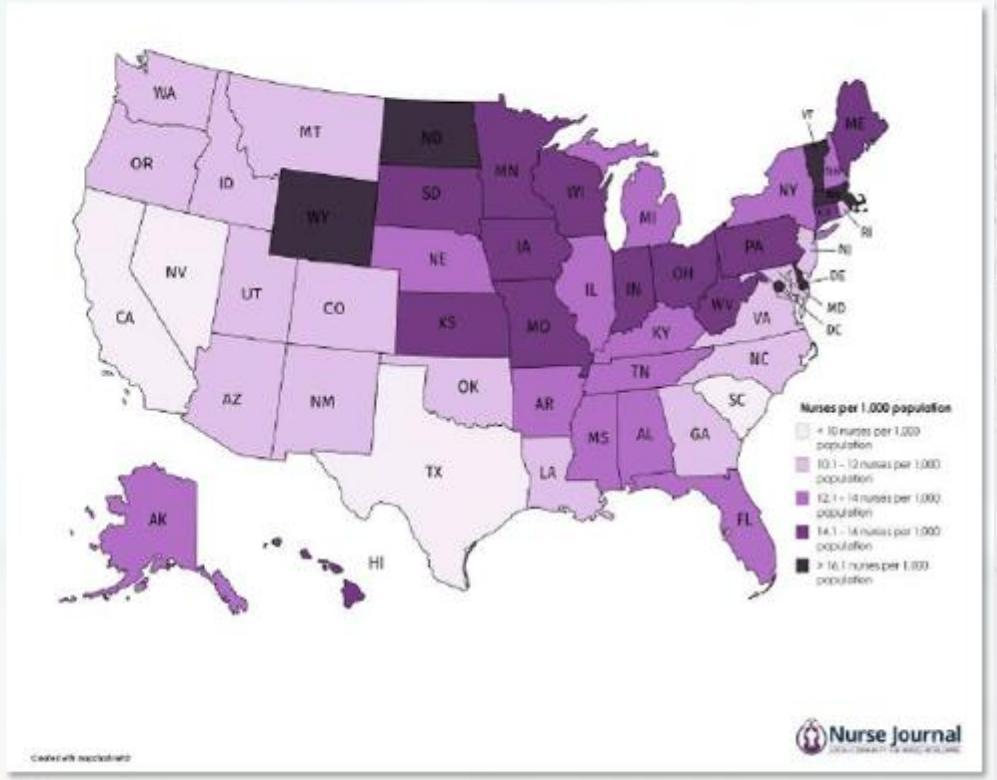
Telehealth use grew most in wealthy and metro areas, exacerbating disparities in access to care

24% of rural residents own a cellphone but not a smartphone

Pew Research Center

30 million U.S residents lack broadband access

Pitfall #4 Missed Opportunities Due to Staff Capacity



https://nursejournal.org/articles/the-us-nursing-shortage-state-by-state-breakdown/

Pitfall #5: Not Balancing Quality, Utilization, & Satisfaction Metrics

MEASURE

Quality Metrics

Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID#:236	Controlling High Blood Pressure	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 318	Falls: Screening for Future Fall Risk	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventable Healthcare Harm
Quality ID#: 110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface*	APM Entity/Third Party Intermediary	Prevention and Treatment of Opioid and Substance Use Disorders
Quality ID#: 113	Colorectal Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 112	Breast Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 370	Depression Remission at Twelve Months	CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health

- Average quality score of 94% for all MSSP ACOs in 2019

&

ACO REACH Metrics

- No clinical measures
- 4 Claims Measures:
  - All-Cause Readmissions
  - Unplanned Admissions for Patients with Multiple Chronic Conditions
  - Timely follow-up
  - Days at home (specific to High-Needs DCEs only)
- 9 CAHPS Measures

https://www.naacos.com/assets/docs/pdf/2021/ACO-QualityChanges2021_2022.012521.pdf
https://www.ajmc.com/view/cms-needs-to-rethink-how-medicare-assesses-quality

Roadmap to Health Equity

Step 1: Assess Risk

Don’t Just Identify Risk, Eliminate It

ASSESS RISK

Jvion Identifies Which Patients are at Risk, Why, and How to Intervene

Traditional Predictive Analytics Stop Here

Combine structured and unstructured data across the enterprise

Patients with obvious or hidden risks and factors that put them on an accelerated path to a poor outcome

Surface both WHY the patient is at risk and IF that risk can be changed - prioritizing those that are modifiable in terms of health improvement and cost avoidance

Enable ACTION by proposing prioritized and clinically validated interventions that can best change patient outcomes

Clinical & Financial Results

Reduction in Readmissions

Reduce Care Manager Call Time

Identify More Avoidable Utilization Events than EHRs

Cost Savings

Identify Patients Most At Risk: Community-level Data

ASSESS RISK

Demographical | **Environmental** | **Transportation** | **Lifestyle** | **Behavioral** | **Access**

U.S. Census Bureau
Includes American Community Survey. Last census update 2020.

U.S. Department of Agriculture
Retrospectively updated every 1-3 years. Last update 2019.

U.S. Department of Housing & Urban Development
Updated yearly. Last update 2019.

Environmental Protection Agency
Updated yearly. Last update 2021.

Centers for Disease Control & Prevention
Includes ATSDR Social Vulnerability Index and PLACES data. Last update 2021.

National Provider Identifier
Updated monthly, ingested every 6-months.

Jvion finds meaningful correlations between disparate data sources to help understand disparities, barriers to health & wellness and accelerating risk.

Granular Community-level Data

ASSESS RISK

900+ Characteristics Included

- Care Access (over 100 facility and provider types)
- Block group risk
  - Relative to state and county
- Block group demographics
  - Age: 17 year or younger, 65 and older
  - Percent uninsured
  - Diversity: White, Black, Asian/Pacific Islander, Hispanic, Native American, Other
  - Disability
  - Employment
  - Household income
  - Poverty rate
  - Percent of individuals that speak English less than well
  - Languages
  - Internet Access
  - Education
- Environmental Conditions
  - Environmental health hazard
  - Water Quality
  - Water Pollution
  - Air Quality
  - Air Pollution
- Health Outcomes
  - Cancer
  - Cardiovascular
- Land Use
  - Industry
  - Agriculture
- Transportation & Activity
  - Commute time
  - Public transportation modes
  - Neighborhood walkability
- Neighborhood Access
  - Business
  - Schools
  - Civic organizations
- Food security
  - Food access
  - Vehicle Access
  - Healthy/Unhealthy food access
- Health Behaviors
  - Preventative Screen
  - Physical activity
  - Smoking
  - Binge drinking

Identify Patients Most At Risk: Individual-level Data

ASSESS RISK

Household | Media | Occupation | Product use | Life Stages | Interest

Product Propensity
Purchasing history and likelihood to use certain products. Includes elements derived from actual purchases and self-reported survey.

Rx Propensity
Filled location and propensity to prefer to fill. Also defines likelihood to inquire about prescription medication.

Occupational Detail
Details of the individual's occupation, aggregate of the overall.

Family Ties
Household characteristics about the individuals in the household including life associated milestones.

Digital Fluency & Relationship
Indicates the use of computers or software in the household, data about the household's phone behaviors and internet connection.

Health Interest
Derived from purchases and self-reported sourced. Includes common health-related household data such as allergies, diabetic focus, and arthritis needs.

Purchasing Propensity & Interest
Interest elements are derived from actual purchases and self-reported surveys (not time sensitive).

Vehicle Detail
Vehicle purchase and ownership data from dealer services and self-reported sources.

Homeowner Detail
Includes home-related events such as a recent home purchase or refinance. Data is from self-reported sources and public records.

Media Usage Propensity
Predictive models that indicate consumer's preference for various media channels, as well as health-related search engine propensity.

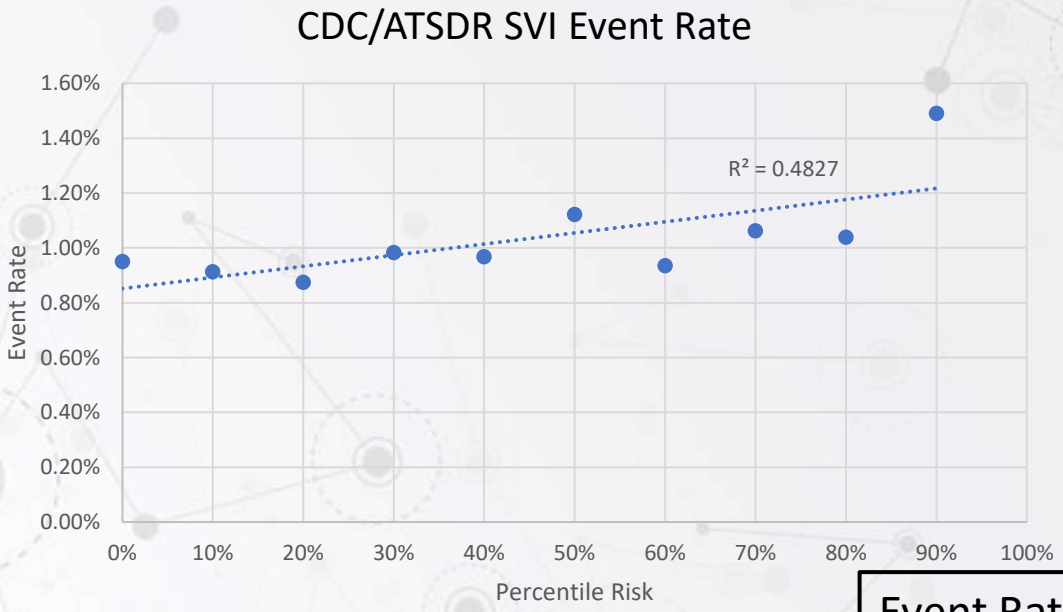
Stages of Life Characteristics
Identifies life-stage based on household level segmentation based on specific consumer behavior and demographic characteristics.

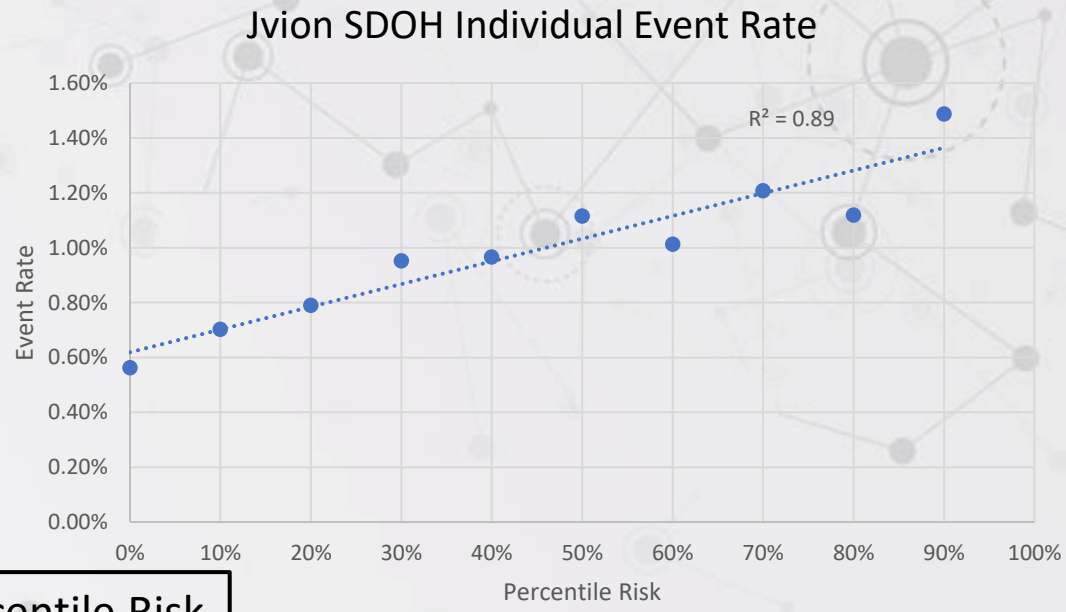
Household characteristics
Includes demographical information about the individual and household.

CDC SVI Comparison Against Jvion's SDOH Individual

ASSESS RISK

Jvion's models outperform existing models because they incorporate complex interactions among risk factors





Event Rate vs Percentile Risk

- R2 > 0.5 for correlation
- SVI has a R2 < 0.5
- Jvion R2 = 0.89

All-Cause Readmission Prediction Performance

ASSESS RISK

>40%
more accurate than LACE

63%
reduction in unnecessary clinician outreach

> 50%
reduction in variation of outcomes

10%
reduction in readmissions

Actionable Insights with Risk Stratification

ASSESS RISK

- Calculate each patient's risk acuity based on a combination of algorithms, protocols, and guidelines
- Predictive modeling algorithms highlight patients with preventable high-cost events
- Easily stratify quality and financial data by race/ethnicity using EMR and/or demographic data available through assignment lists
- Surface AI-driven socioeconomic, behavioral, and environmental data to find social factors affecting a patient's trajectory

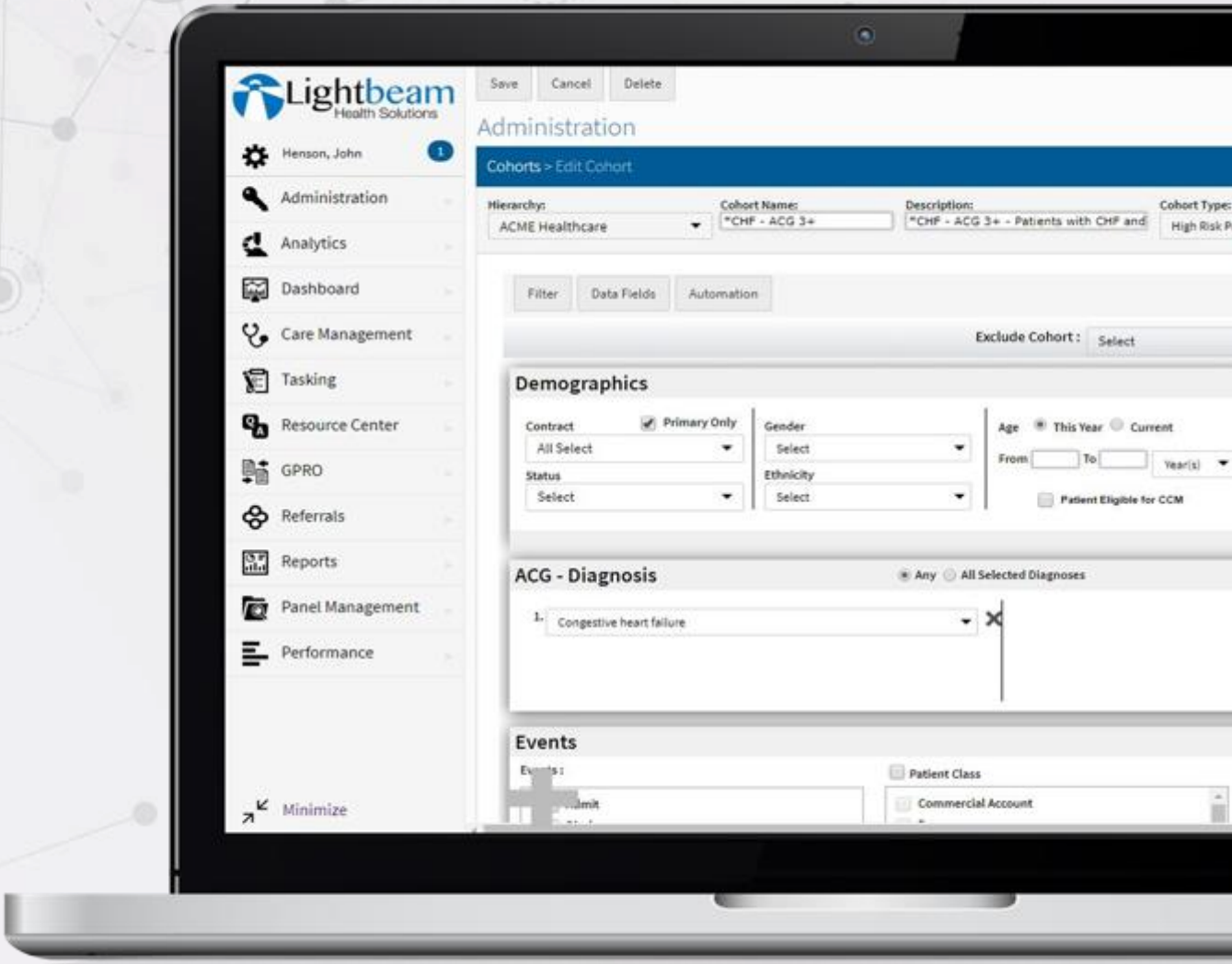
Roadmap to Health Equity

Step 2: Monitor

Cohort-Driven Engagement

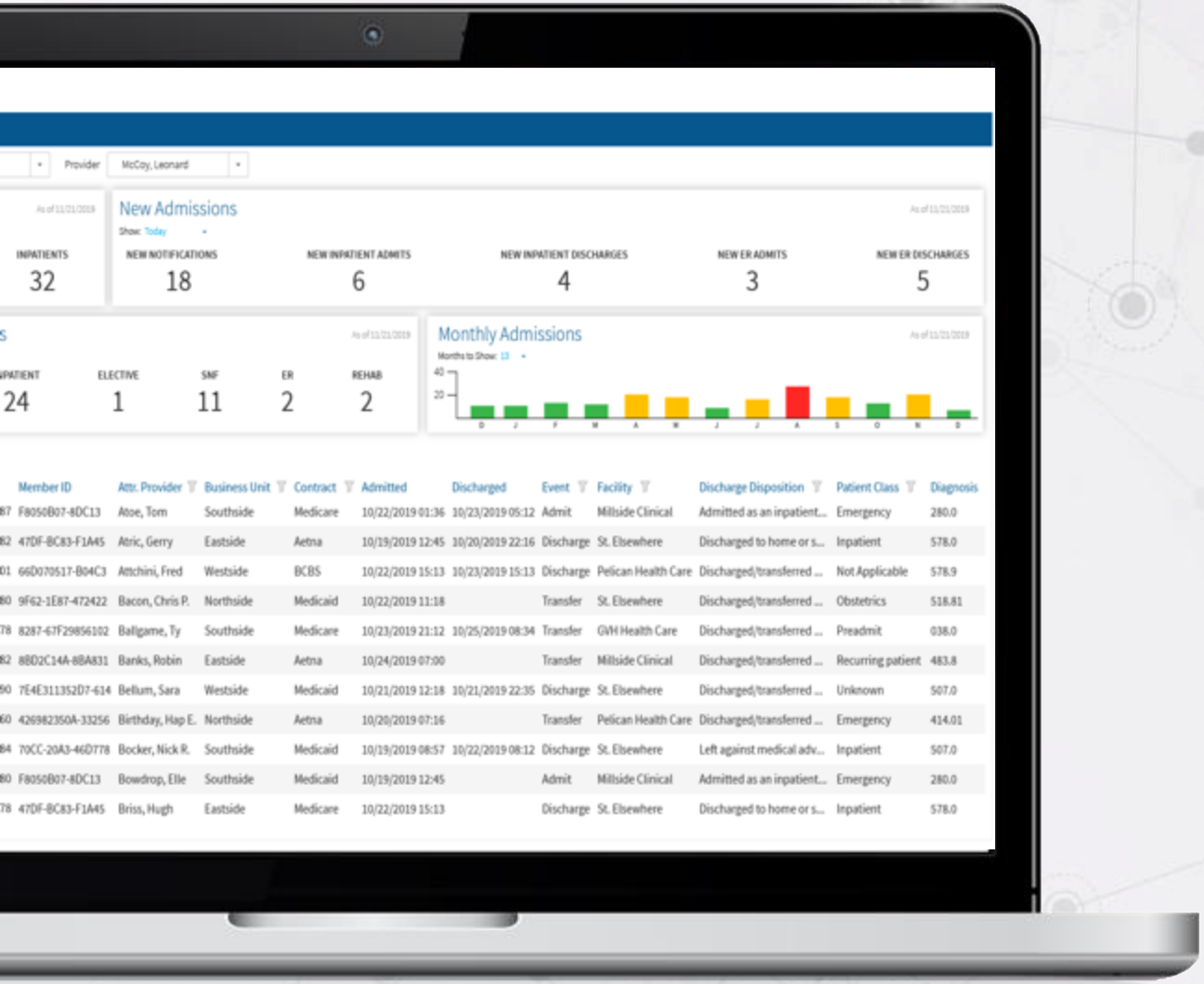
MONITOR

- Automates clinical workflows by serving as the conduit between the EDW, care management, and patient engagement.
- Automatically identifies patients for intervention, coaching, or care management
- Automatically assign patients to resources
- Automatically reach out to patients w/ Patient Engagement
- Patient Data Export used to transport data for 3rd party integration



ADT Insights for Real-time Intervention

MONITOR



ADT / ED Insights provides near real-time notifications of admission, discharge, and transfer events in a centralized view as patients present, enabling providers and care managers to quickly engage patients for transitions of care.

- Reduce hospital admissions
- Reduce readmissions

ENABLE

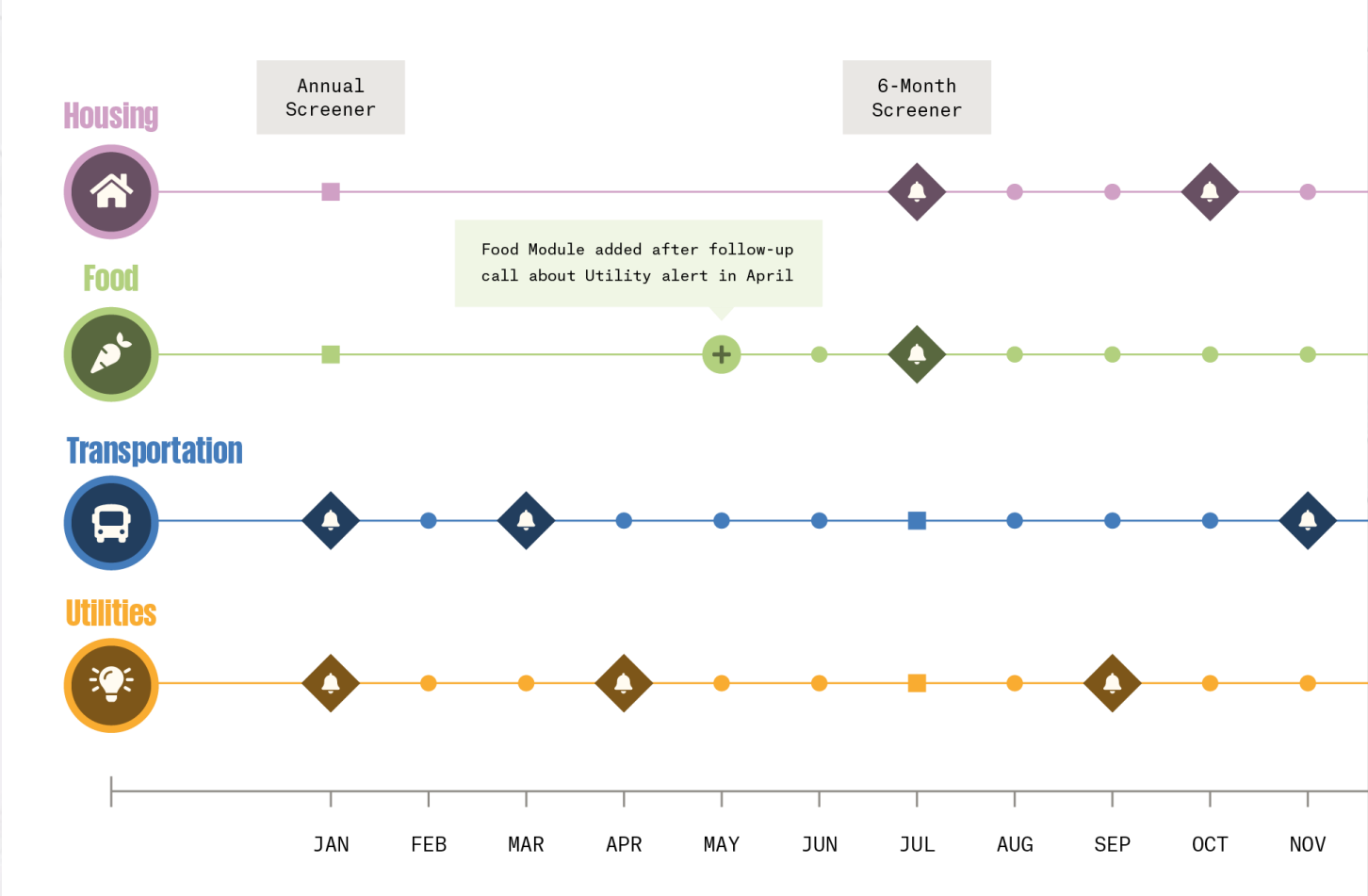
Roadmap to Health Equity

Step 3: Enable

Create a Robust SDOH Strategy

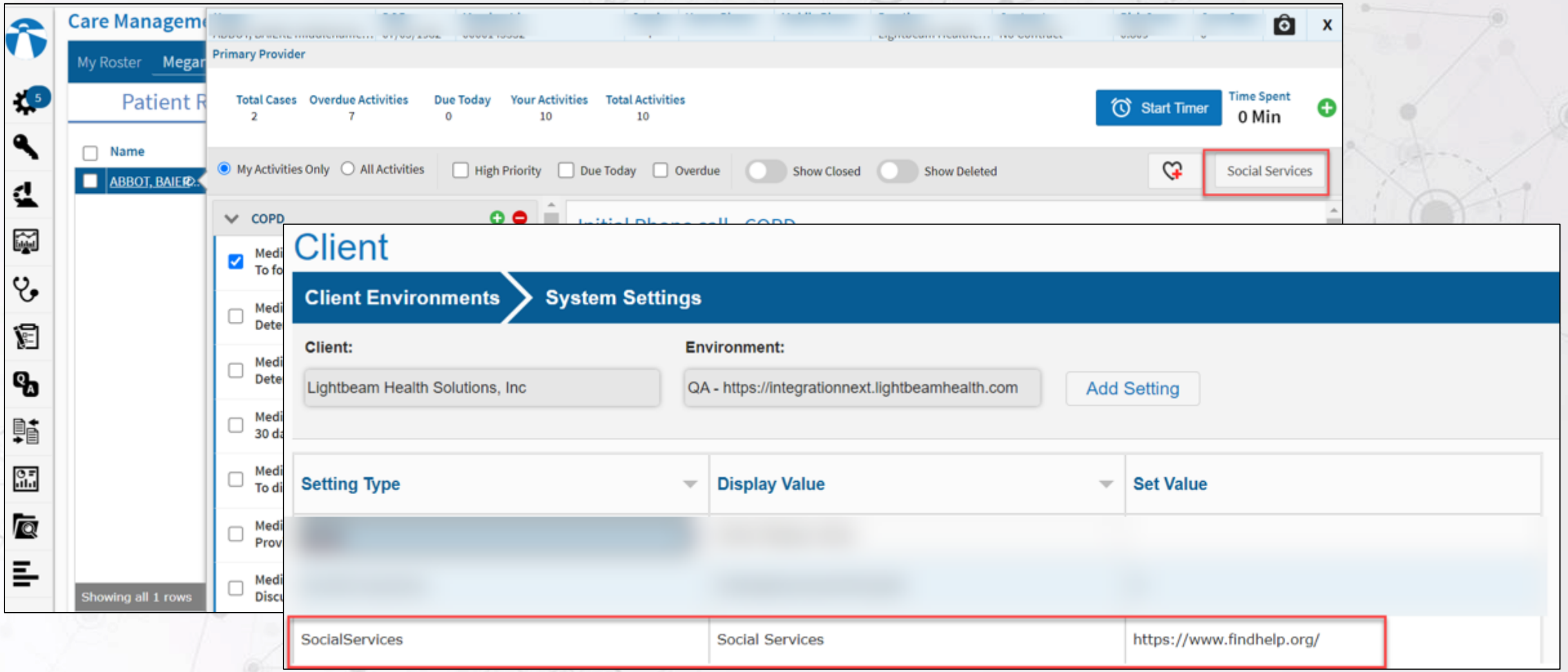
ENABLE

- Identify which social determinants are most likely to be affecting each patient
- Automate collecting SDOH data
  - Staff Resources (2% alert rate)
  - Longitudinal
  - Proactive
  - Real-time
  - Ask only relevant questions to reduce patient response burden
- Address acute patient needs and with seamless connection to NowPow, UniteUs for resources



Connect Patients to Community Resources

ENABLE



Engage Patients with Deviceless Remote Patient Monitoring

ENABLE

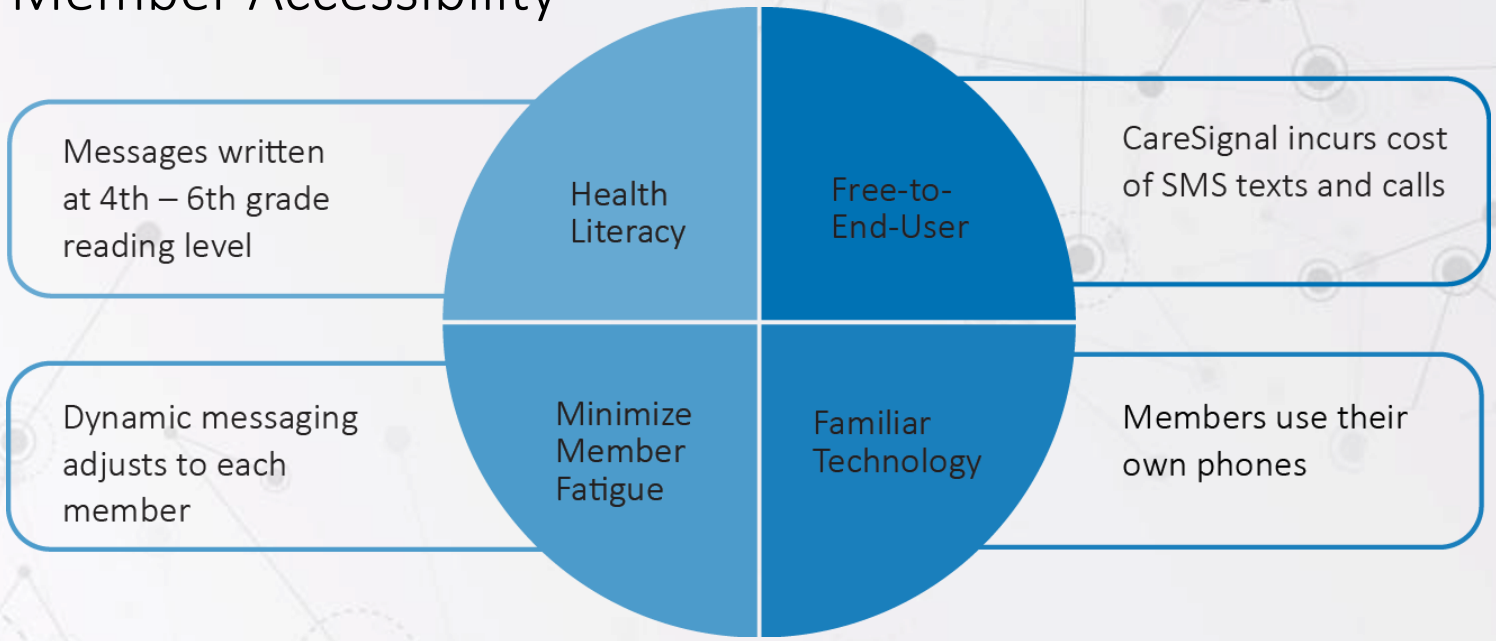
Affordable | Accessible | Scalable

- **No new devices required**
  No apps, downloads, or passwords
- **Accessible for all patients**
  Promote & elevate health equity
- **Clinically validated**
  13+ Peer reviewed publications
- **30 Programs | One Portfolio**
  Pre-built & evidence-based
- **Engagement powered by AI**
  Predict & prevent drop-off
- **White-labeled for patient/member**
  High-quality, credible experience

Deviceless Remote Patient Monitoring

ENABLE

Member Accessibility



verizon

T-Mobile

Sprint

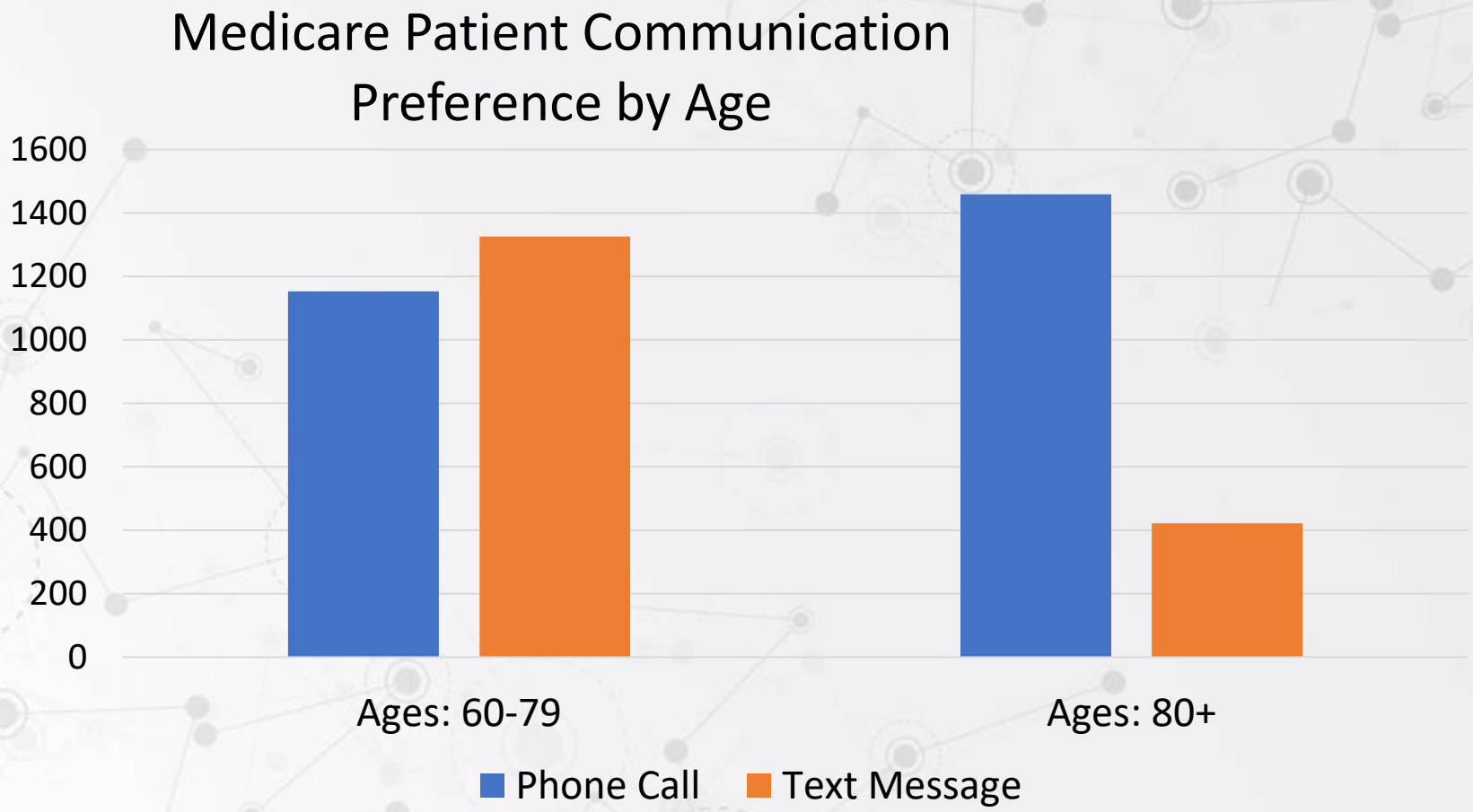
AT&T

boost mobile

metro by T-Mobile

Improve Access with the Right Technology

ENABLE



Familiar technology builds trust; patients continue to engage with systems they trust and can access

Support Whole-patient Health: Chronic Conditions & SDOH

ENABLE

30+ Evidence-based Programs | One Portfolio

Chronic Conditions
- Heart Failure
- COPD
- Diabetes
- Hypertension
- Asthma

Behavioral Health
- Depression
- Anxiety
- Substance Use
- Opioid Management
- Caregiver Support

Specialty Support
- SDoH
- Maternal Health
- Dialysis
- Surgery
- HIV/AIDS

Post Discharge
- Post Discharge
- General Medical
- Vital Signs
- Pneumonia

Care Coordination
- Screening Reminders
- Appointment Reminders
- Referral

General Programs
- COVID Suite
- Influenza
- Fall Risk
- Wellness
- Medication Adherence

13 Publications
in Peer-Reviewed Medical Journals

62% decrease in hospitalizations for patients with COPD

46% decrease in CHF ED visits

1.15% drop in HbA1c over 4 months

50% improvement in blood pressure control over 12 weeks

28% drop in PHQ-9 for patients with depression

>2.1x increase in follow-up appointment adherence

Enhance Your Clinical Staff & Provide Proactive Care Management

ENABLE

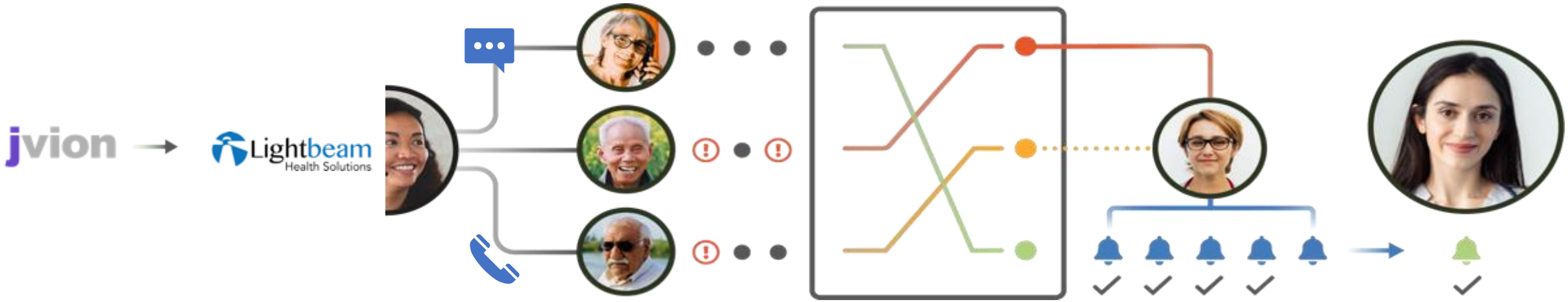
Lightbeam Clinical Services offers staffing augmentation and patient engagement programs designed to work under the general supervision of the organization's providers

Annual Wellness Visits	Chronic Care Mgmt.	Transitional Care Mgmt.
A Medicare-based program designed for providers to perform annually for patients. Included in this visit are key items which include preventive services, health risk assessments, and more.	Medicare has several care management programs designed to support patients with two or more chronic conditions in achieving an improved quality of life.	A Medicare-based program designed to support patients who have recently been discharged from an in-patient setting to decrease the likelihood of readmission.

End to End Solution Supported by Cohort Builder and RPM Tools

Workflow: Insights to Outcomes

ENABLE



Jvion
Predictive analytics surface top health inequities and readmission risk

Lightbeam
Aggregate data and Identifies cohort of target patients for CareSignal

Engagement Specialists
Enroll patients via text, email, mailers, and direct phone calls

Patients
Answer automated SMS and phone call prompts, sending in clinically-relevant data

Deviceless RPM
Categorizes at-risk patients and triggers alerts in real-time

Client or LCS
Care Managers monitor dashboard and follow standard operating procedures

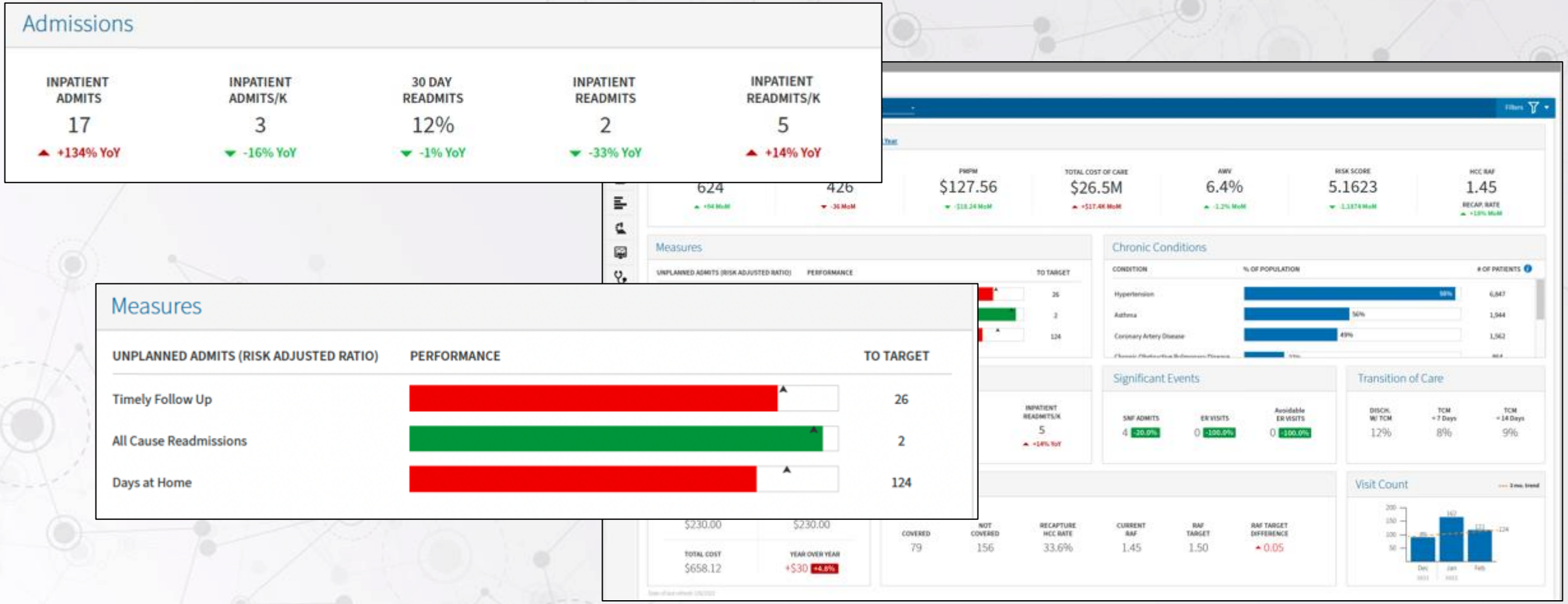
Providers
Receive escalations, only as needed

Roadmap to Health Equity

Step 4: Measure

Track Performance with Real-time Dashboards

MEASURE



Achieve Success In ACO REACH

MEASURE

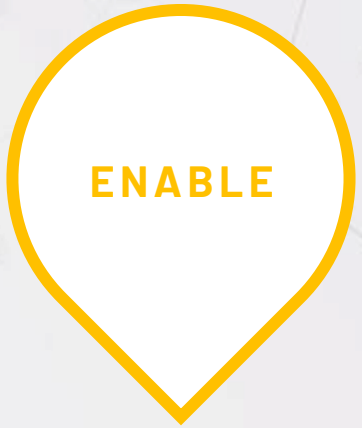
Assess social and physical health risk across your entire ACO population, identify care gaps, enable proactive outreach, and empower care teams to reduce avoidable utilization

Identify Patients Most At Risk With Prescriptive AI-Driven Insights

- Access data 3x more granular than the CDC / ATSDR Social Vulnerability Index
- Analyze and identify which patients are at-risk, why they are, and how to intervene
- Surface top 5 clinical and social risk factors for each patient

Monitor Patient Discharge and Dynamic Risk Level

- Leverage ADT Insights to Identify patient discharges
- Build patient cohort lists according to propensity to readmit to the hospital



Reach Vulnerable Populations With Deviceless RPM® & Clinical Staff Augmentation

- Proactively monitor patient chronic condition symptoms and SDOH challenges within a single solution
- Enable staff to more efficiently provide care and resources to the right patients
- Augment clinical staff with RNs and LCSWs

Track Performance with Real-Time Dashboards Specifically Designed for ACO REACH

- View real-time key metrics like Total Cost of Care and Risk Score within Lightbeam's ACO REACH Dashboard
- Monitor performance vs targets for Quality Measures, Admissions, RAF Score, and more
- Easily access up-to-date counts and percentages of your patient population by Chronic Conditions

Evidence

- Reach Vulnerable Populations
- Improve Care Management Efficiency
- Reduce ED Visits
- Reduce Costs

Patient Success Story

Top Patient Risk Factors

Ms. Johnson
64-year-old female

Clinical Risk Factors:
- T2DM
- HTN
- A-fib
- Obesity

"The patient was telling me that she was compliant with her medications, and that her biggest issue was chronic pain."

SDOH Risk Factors
- Single. Likely without support from spouse.
- Highly unlikely to be digitally fluent.
- Low individual income.
- Low transportation availability.
- Education likely limited to high school

Top 3 Recommended Interventions

Focus on medication compliance & access
Uncovered issues with medication compliance
- Removing insulin pump
- Not taking medication as prescribed
- *Met with patient and PCP*

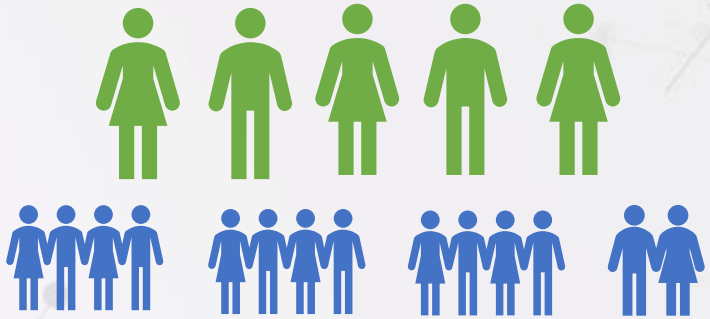
Nutrition consult
Helpers prepare inappropriate foods
- *Set up homecare*

Difficulty with activity
- *Referred for home PT; ~20 lb. weight loss*

Depression screening
Completed PHQ-9; patient scored high
- *PCP notified*

Uncovered transportation issues, cancels appts
- *Ride services now provided*

Proven Effective & Efficient Case Management



Case Management Outreach:
Jvion accurately predicts 5 Admissions out of 32 members versus 5 out of 600 members

Jvion insights allow for more effective outreach – 2.7x as many calls/hr – and fewer members to outreach, resulting in a savings of over $8,800 to prevent the same 5 admissions

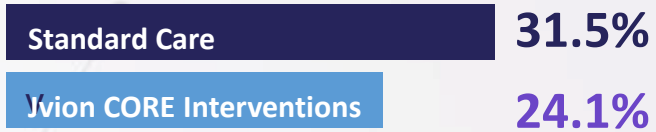
With Jvion

Without Jvion ***One group = 10 patients

Impact Story: Northwell Health Reduced Readmissions by 23.6%

The CORE recommends interventions that reduce readmissions:

Readmission Rates:



The CORE reveals hidden risk factors for readmission:

- Inability to afford medication
- Social isolation
- Poor health literacy
- Lack of access to transportation

By actioning the CORE's recommendations, Northwell saved:

$459,200
over 4 months

Seeing the Hidden Risk for Readmission

This comprehensive approach reveals hidden risk for readmissions that Transitions of Care Management (TCM) teams would otherwise miss.

Targeting Patient-Centric Outreach

These insights empower the TCM team to more effectively target their patient outreach post-discharge.

Proven Results and Higher Quality Care

Patients that received interventions recommended by the CORE had 23.6% fewer readmissions than the matched control group.

1. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb259-Potentially-Preventable-Hospitalizations-2017.pdf 2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6250243/

Midwest Virtual Case Study

One of the Largest RPM Implementations in the US: 35,000 Patients & $32M in Cost Savings

Automation Enabled Management of 10x More Patients than the National Average Caseload

National Avg. 1:150

Midwest Virtual 1:1,000

Programs	Asthma	CHF	COPD	Diabetes	Gen Med
ED Visits Avoided per 1,000 Patients	255	329	183	402	475
Relative ED Reduction	-31.8%	-26.4%	-20%	-37.9%	-27.1%
Change in ED Visits Per 1,000 Patients Per Year					
Before CareSignal	803	1241	912	1058	1752
After CareSignal	547	912	730	657	1277
Total Cost Savings	$1.40MM	$17.70MM	$1.55MM	$9.77MM	$2.25MM

Midwest Virtual's Deviceless Remote Patient Monitoring Utilization

2016 - 2021

35,959
Total Number of Patients Enrolled

2.9MM
Total Automated Patient Touches

2.0MM
Total Automated Text Messages

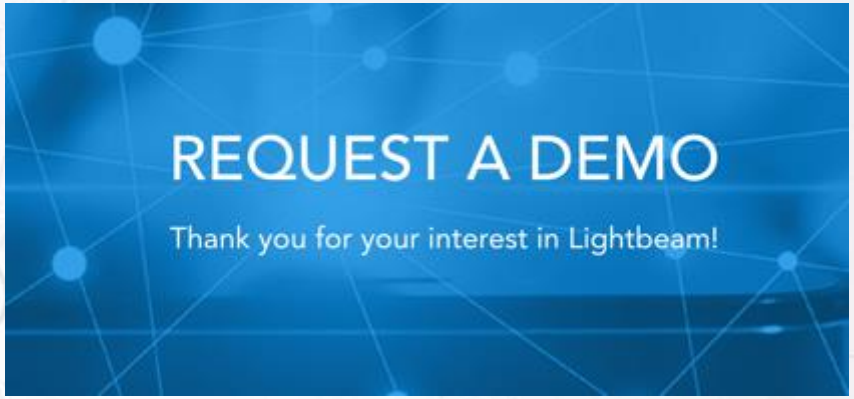
963,900
Total Automated Phone Calls

80,000
Proactive Alerts Raised

19 Programs
Currently Utilized by Midwest Virtual

Q&A

- Request a demo with an ACO REACH Expert: https://lightbeamhealth.com/request-a-demo/



- Scan QR Code by opening your phone's native camera app and holding it up to the QR Code

Visit Our VBCExhibitHall.com Virtual Booth

[Visit the CareSignal – a Lightbeam Company exhibit booth]

VBCExhibitHall.com

Lightbeam Health Solutions

Your Roadmap to Building a Robust Health Equity Plan to Succeed in ACO REACH

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Joe McDonald, MBA, Co-founder, President, CareSignal

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