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Website: www.lightbeamhealth.com

Lightbeam Health Solutions

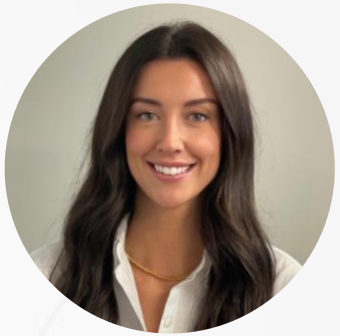
Overcoming Population Health Pitfalls: 5 Proven Strategies for Value-Based Care Orchestration

June 18, 2024

VBCExhibitHall.com

Educational Webinar Series

Presenters & Overview



Melissa Tyler

Director of Advisory Services, Lightbeam Health Solutions

Jennifer Newell, MSN, RN, MBA

Clinical Transformation, Lightbeam Health Solutions

Amidst resource constraints and increasing risk exposure, discover how population health leaders can make data-driven decisions to overcome these challenges.

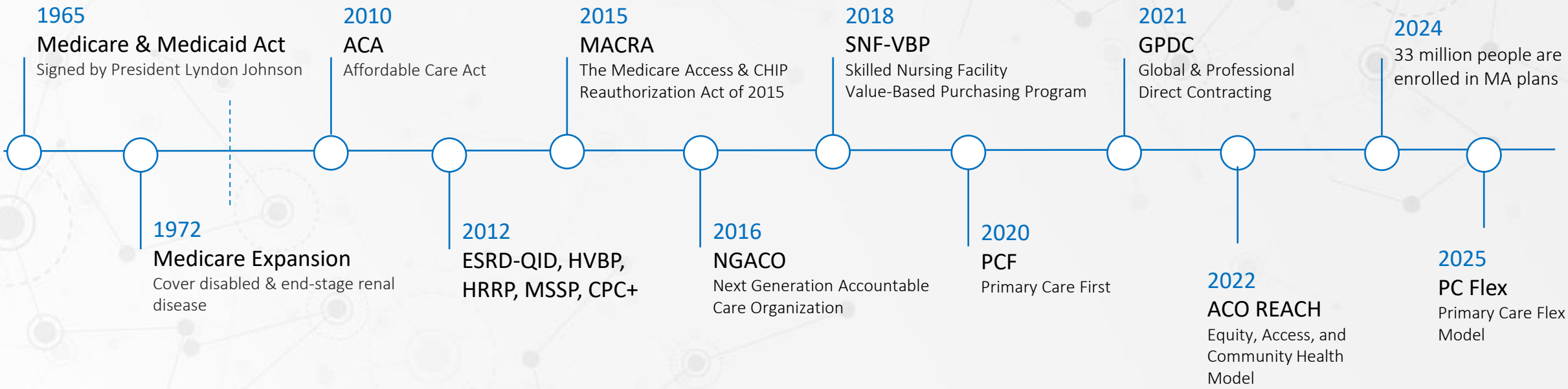
This webinar will identify five common population health pitfalls holding many organizations back and the five strategies to unlock the full potential of your population health initiatives.

Industry Trends

Evolution of Value-Based Programs

Medicare has experimented with numerous value-based programs since the passage of ACA in 2010.

CMS wants every Medicare beneficiary in a value-based care model by 2030.

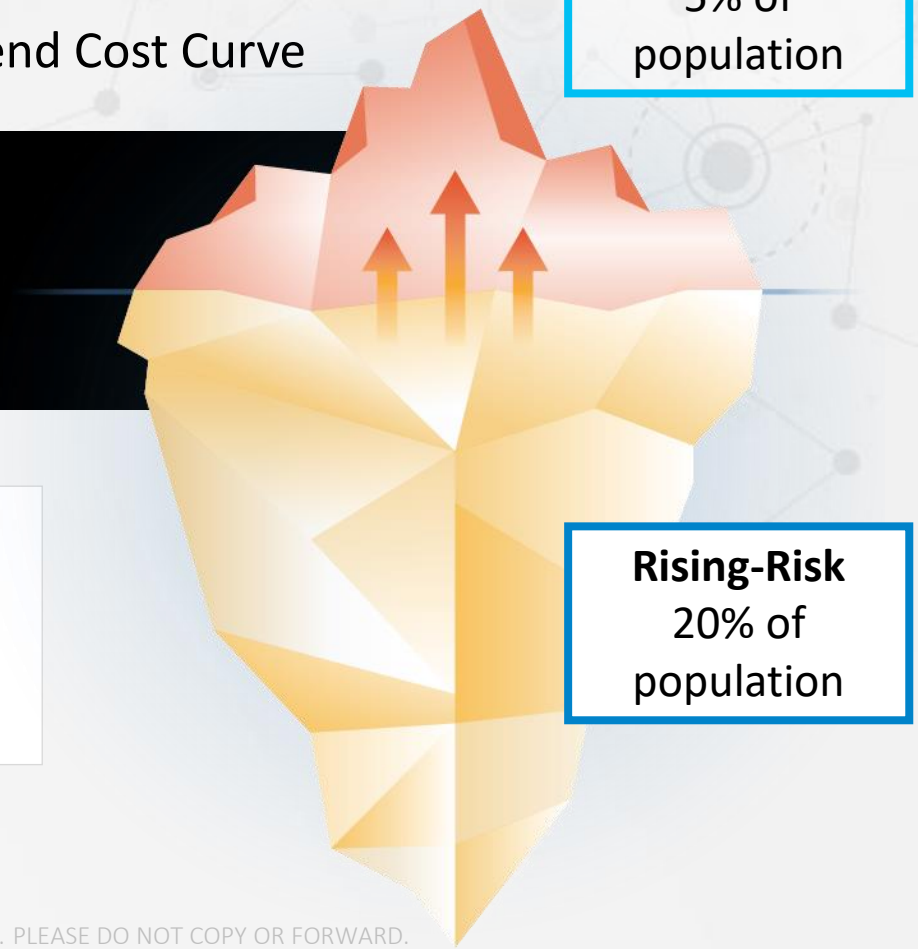


VBC Necessitates a Whole-Population Approach

Success in value-based care requires proactive management of rising-risk patient populations

Care Management Only Focused on High-Risk Patients Will Not Bend Cost Curve

Each year, 1 in 5 rising-risk patients become expensive, high-risk patients.[1]



The NEW ENGLAND JOURNAL of MEDICINE

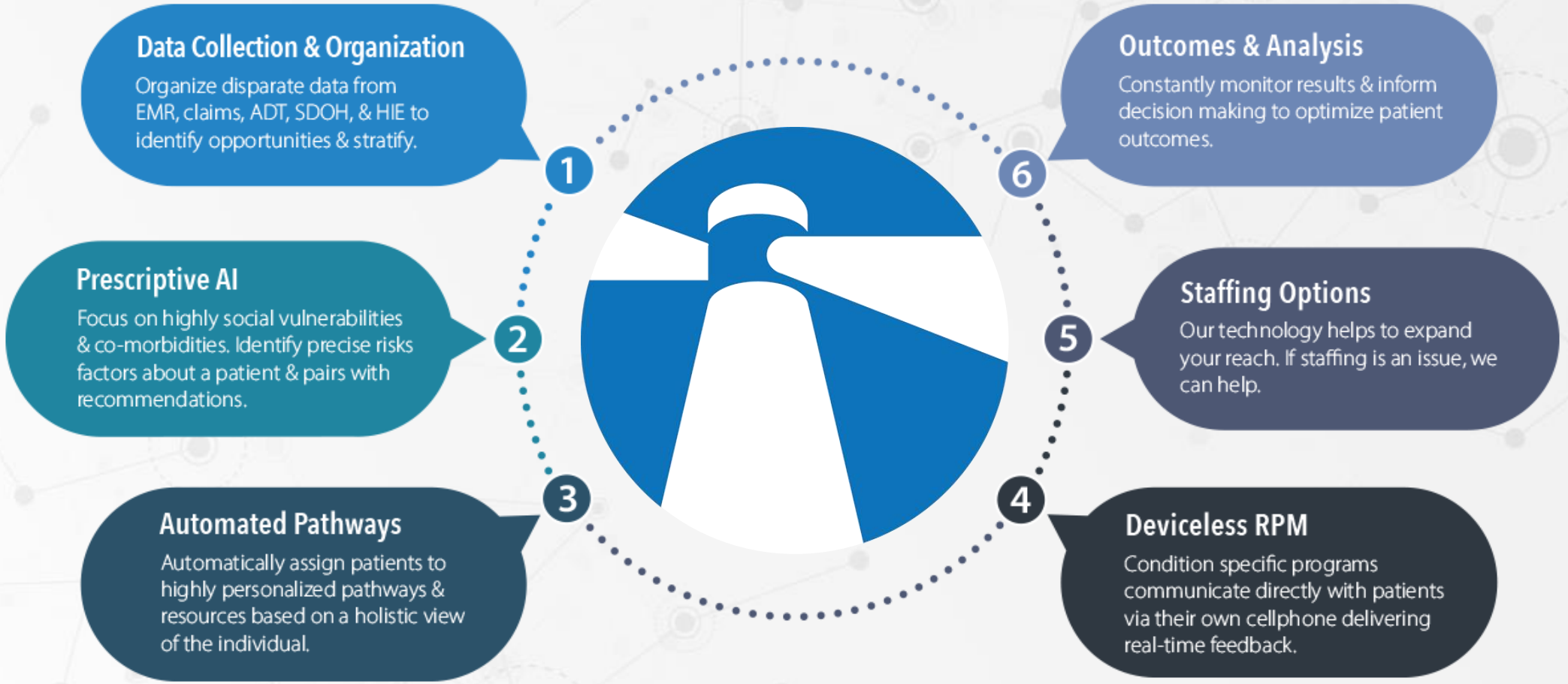
"Our findings may also reflect fundamental challenges with the strategy of targeting super utilizers: **many patients whose medical costs are high today will not be as high in the future**."[2]

About Lightbeam Health Solutions

Solution: Fully Integrated Health Enablement

Lightbeam Health Solutions

Lightbeam's fully integrated solutions and services provide organizations with the capabilities needed to efficiently monitor and proactively care for their entire population.



About Advisory Services

Advisory Services - Introduction

Population Health Advisory

Collaborate with clients to create a population health strategy that aligns with their organizational and contractual obligations

Analyze client data to pinpoint opportunities for quality and cost saving interventions and establish baseline performance

Operationalize and streamline workflows of adopted initiatives and disseminate the best practices

Conduct quarterly ROI analysis of adopted initiatives to ensure goals are being met and perform pre-post management analysis

Clinical Transformation Advisory

Streamline workflows for adopted clinical programs including Prescriptive AI models

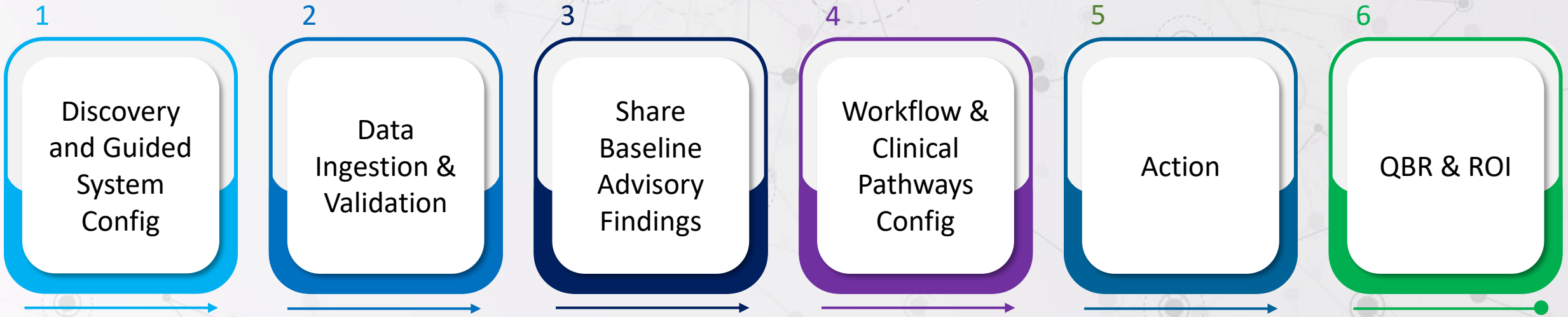
Enhance productivity and ensure efficient, top of license work by leveraging data and automation for role appropriate tasking

Ensure programs built meet best practice recommendations for documentation and assist with KPI reporting

Identify patients who would benefit from enrollment in Care Management, advise on Cohort builds, and monitor and measure program effectiveness

Leverage the Value in Patient Data → Develop a Strategy → See Tangible Results & Demonstrate Outcomes

Implementation Model



Documenting requirements and unique needs drives optimal platform configuration

Aggregation of contributing data sources, including shared validation reporting

Readout of data-driven opportunities, determination of initial programs at launch

Workflow design, configuration, deployment to support selected programs

Recipients take action on insights (Care Management, DRPM, Point of Care, etc.)

Quarterly review of performance outcomes, selection of additional programs

5 Population Health Pitfalls & Strategies to Implement

Pitfall #1: Relying on Delayed Claims, Lacking Real-Time Insights

- **Pitfall**
  - Many organizations strictly rely on claims data. They lack a streamlined and aggregate way to gauge performance across their value-based contracts along with the inability to obtain real-time data on admissions, discharges and transfers.
- **Importance**
  - ADT data improves patient outcomes, cost containment, and support care coordination.
  - Studies show that a successful TCM program can reduce rehospitalization rates by 5.6% and cost of care by 7.8%

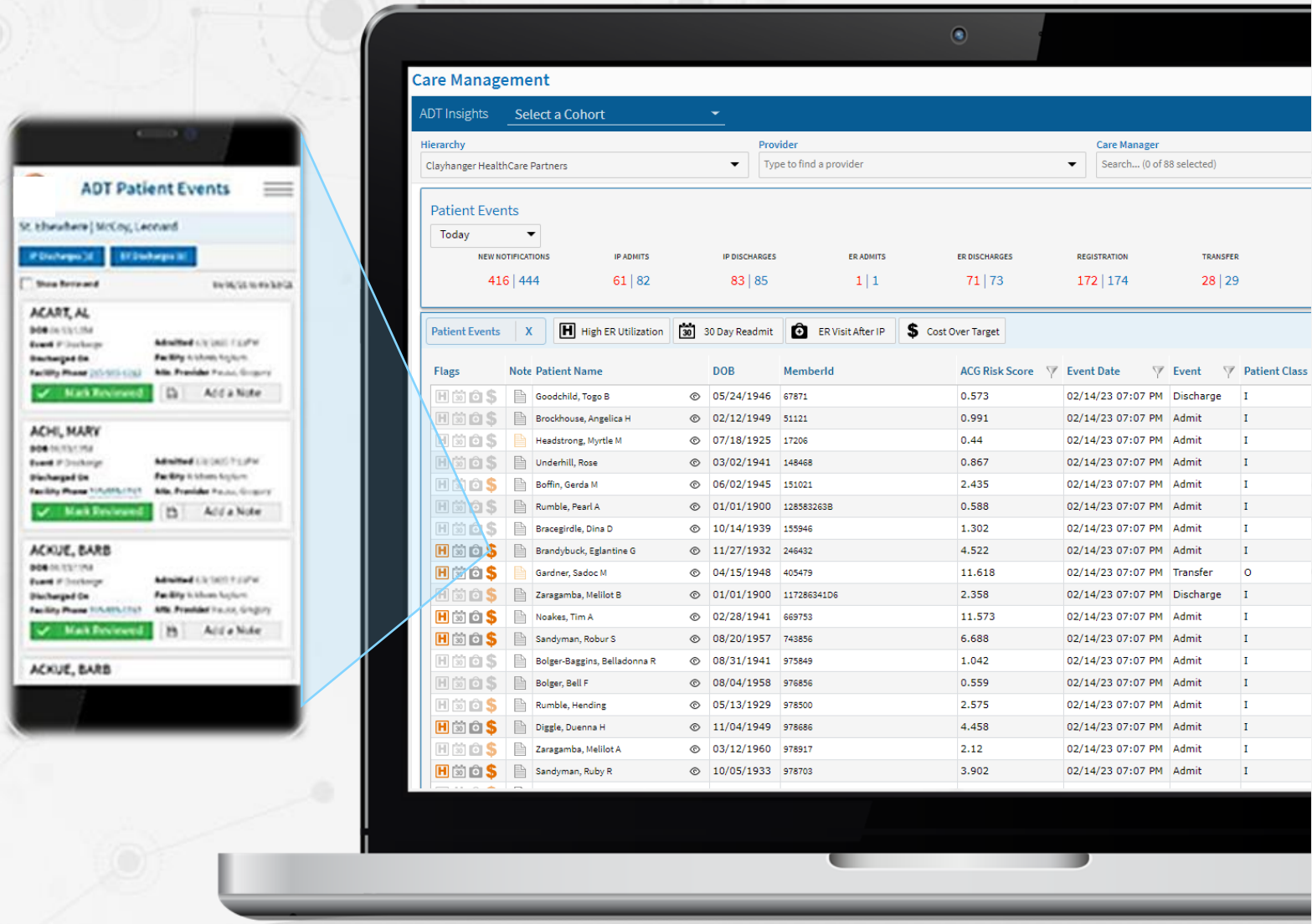
Strategy: Ability to Access Real-time Data & Integrate Clinical Data

- ADT feeds ingest patient discharge data from multiple channels for all attributed lives into one location integrated into care management's workflow.
    - ADT alert feeds identify opportunities for timely TCM outreach to prevent readmissions
- Combining clinical and claims data provides an almost real-time picture of a patient's health status
    - The combination is so powerful because it shows a holistic view of a patients' health status to understand how they are doing.

Solution: ADT Insights & TOC

The ADT Insights dashboard provides near real-time notifications of ADT events in a centralized view as patients present, enabling providers and care managers to better address the transitional care needs of their members.

- Reduce hospital admissions
- Reduce readmissions
- Monitor Discharges and Transitions
- Provider ADT alerts inform care teams of critical activities



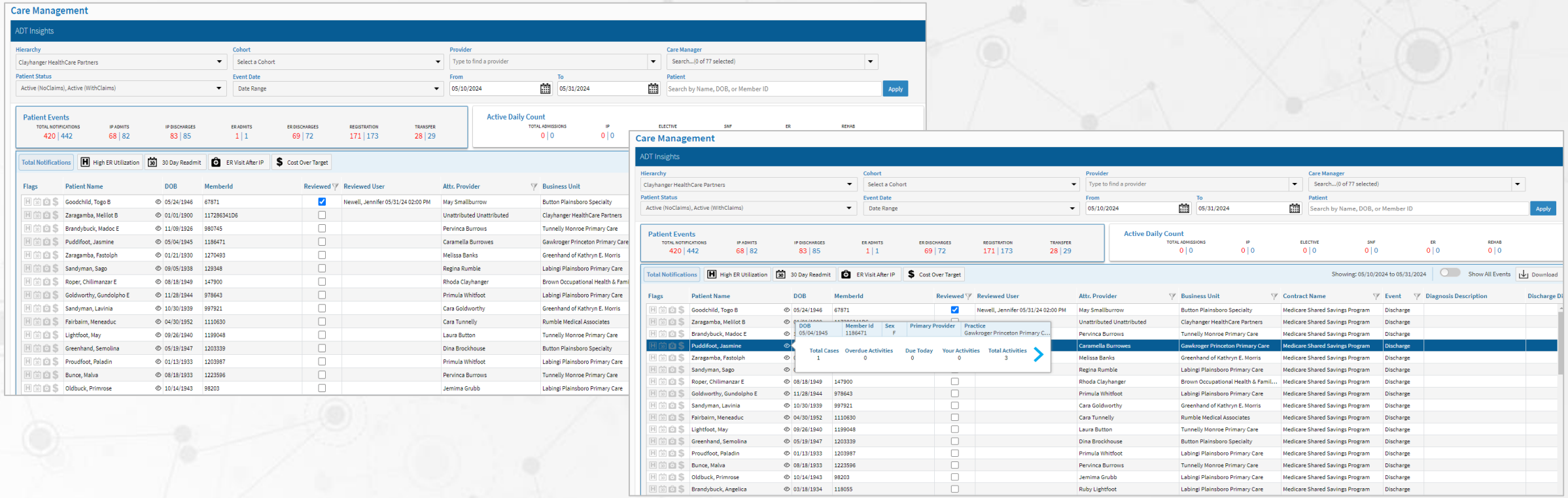
Solution: ADT Insights Workflow

Automated Transition Event Identification/Enrollment via Cohort Builder

Identify Patient for Outreach

Mark ‘Reviewed’ Checkbox to Indicate Start of Outreach

Utilize Patient Panel Icon to Initiate Transitions Workflow



Client Outcome: Reduced Readmissions

3.2%

In 12 months, a multi-state health plan using ADT Insights reduced the 30-day readmission rate in a contracted ACO by 3.2% compared to a matched control group

> *A lot of our providers do not have access to ADT feeds, so the fact that we can alert them immediately is instrumental. Lightbeam's staff has been there every step of the way to not only help us with our strategic initiatives for value-based care, but also helping us understand the functionalities to achieve those goals.*

Brea Rockwell,
Manager of Population Health Operations at Vytalize Health

Pitfall #2: Limited Risk Stratification Capabilities

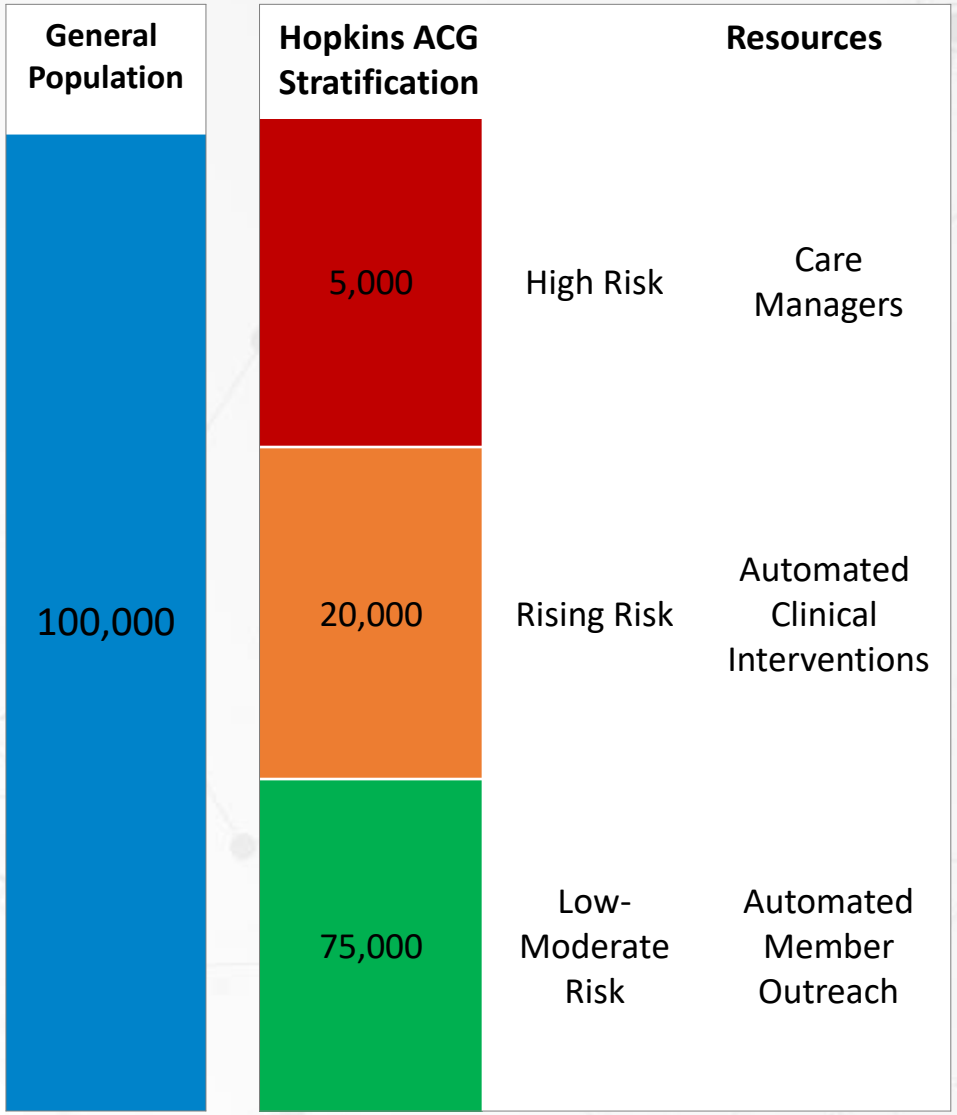
- **Pitfall**
  - Traditional risk stratification is limited in segmentation ability, understanding of patient risk, and focuses on concurrent risk, which keeps organizations stuck in a reactive care model
- **Importance**
  - VBC leaders need to understand which populations are driving risk across the enterprise and the key drivers to implement appropriate programs to mitigate risk.

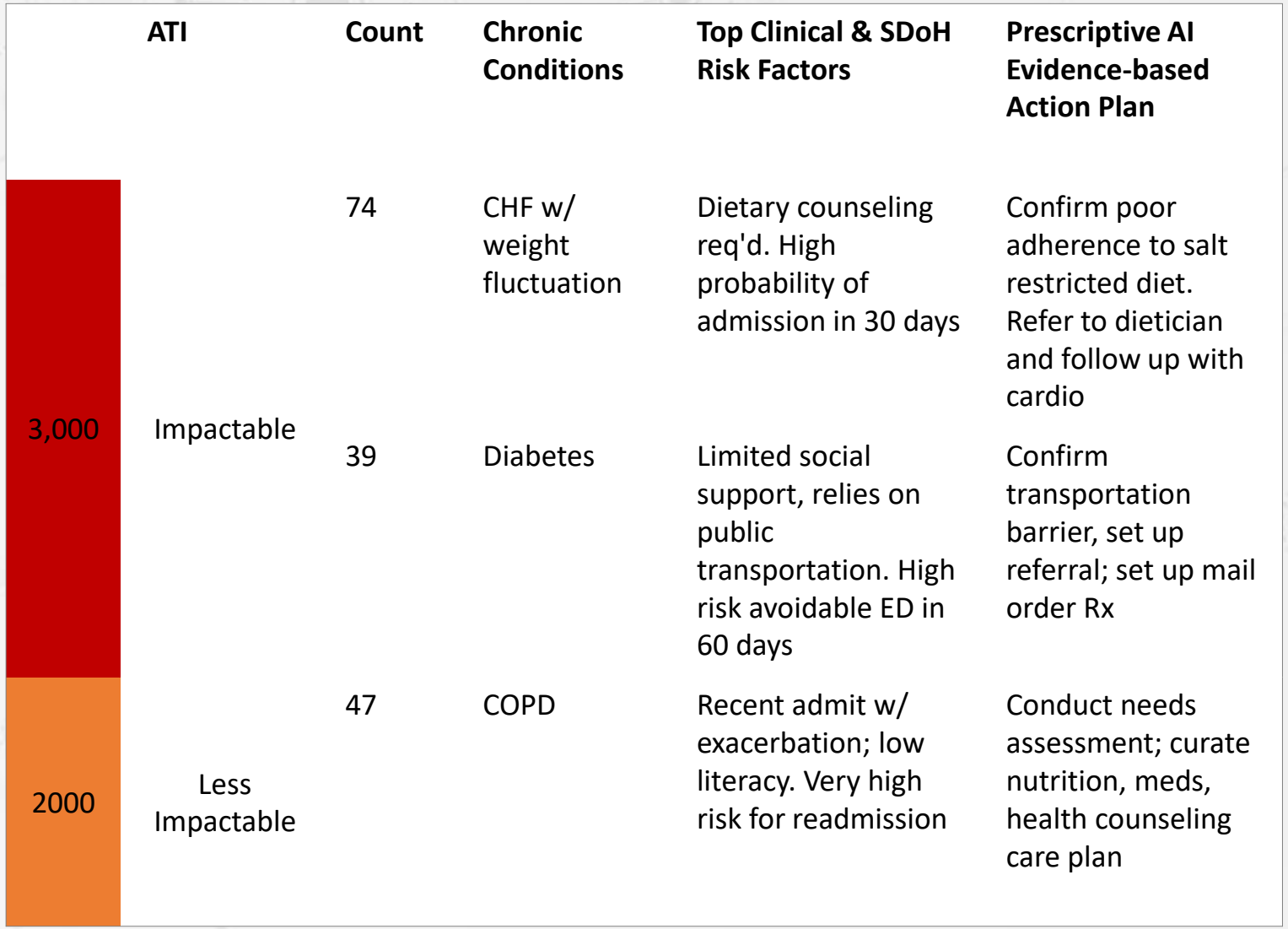
Strategy: Risk Stratify by Prospective & Modifiable Risk

- Prospective and modifiable risk assessments enable a more proactive care model
- Identify Cost/Utilization outliers
- Manage High/Rising Risk populations
- Improve patient outcomes of chronically ill
- Categorize risk stratification by contract type (e.g., MA, REACH) to meet contract obligations
- Identifying and outreaching populations with impactable risk factors enable a larger impact on cost and quality
- CM teams can have limited capacity; enhanced risk stratification capabilities grow efficiency and effectiveness

Solution: Risk Stratification 2.0: ACG + ATI + AI

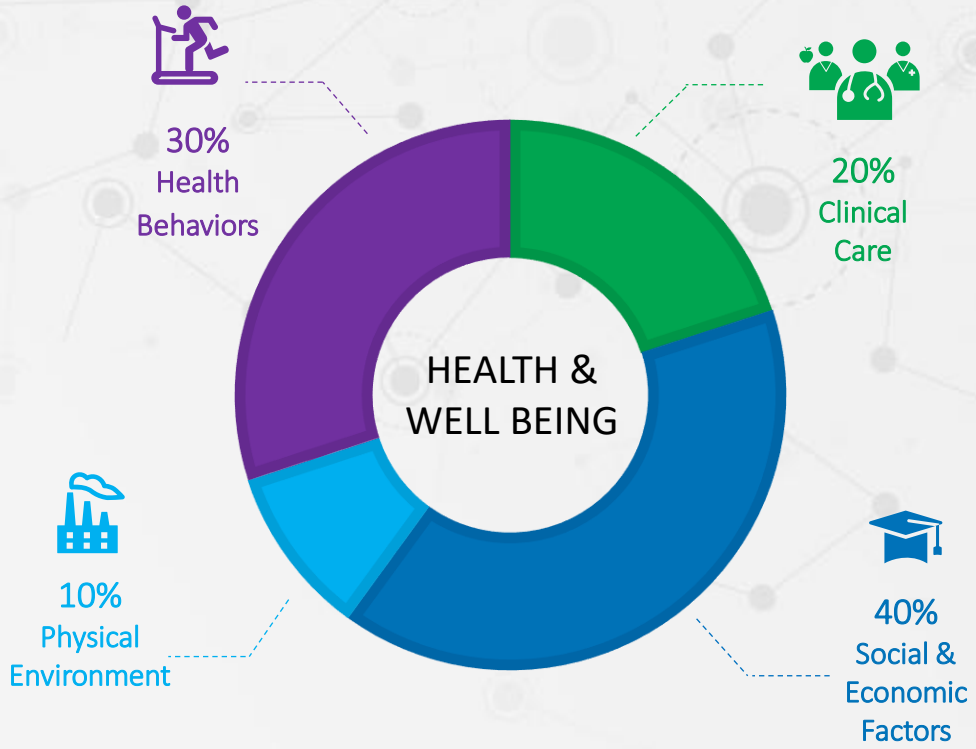
Lightbeam Health Solutions





Pitfall #3: Lack of Whole-Patient Health Insights

- **Pitfall**
  - Social Determinants of Health (SDoH) are social factors such as transportation and food that often go unreported
- **Importance**
  - Missed risk factors lead to incomplete care
  - SDoH factors drive up to 80% of the variability in health care outcomes, yet shame can prevent issues from being identified
  - Only 3% of Medicare beneficiaries have Z-codes reported



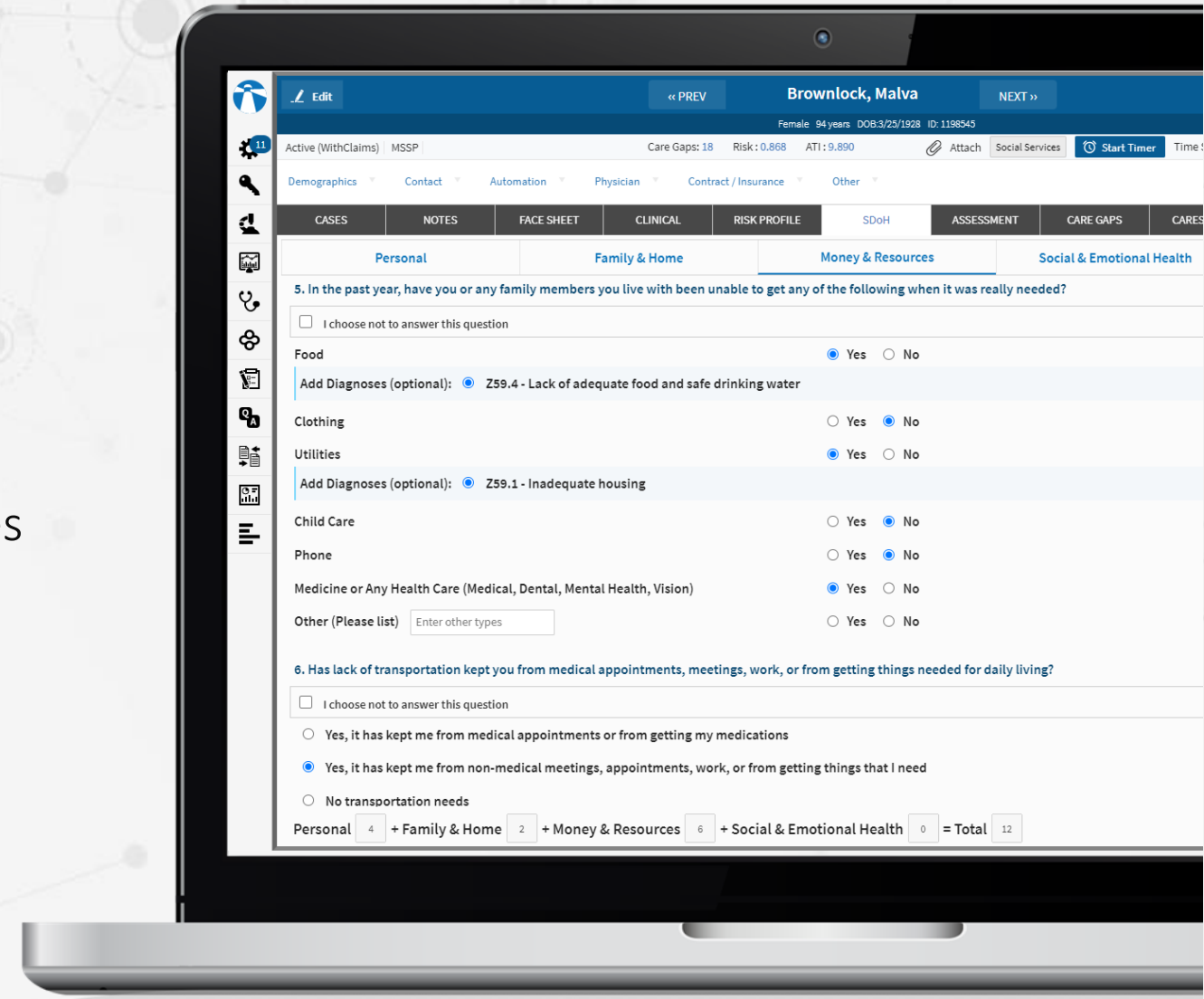
Strategy: Integrate SDoH Data into Risk Profile

- Collect and integrate this data into patient risk stratification to understand the complete picture of a patient's needs
- Conduct SDoH assessment and collection into care workflow
- Augment existing demographic and claims data
- Launch educational program to clarify who can document Z codes

Solution: Cohort Builder + PRAPARE

Nationally standardized and stakeholder-driven, the *Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences* (PRAPARE) form is designed to equip healthcare organizations and their community partners to better understand and act on individuals' social drivers of health (SDOH)

- Key responses surface additional ICD10 codes
- Automatic scoring of responses generate a Healthy Equity risk score
- All responses and data flow into the Cohort Builder to allow for the creation of initiatives to close health equity gaps

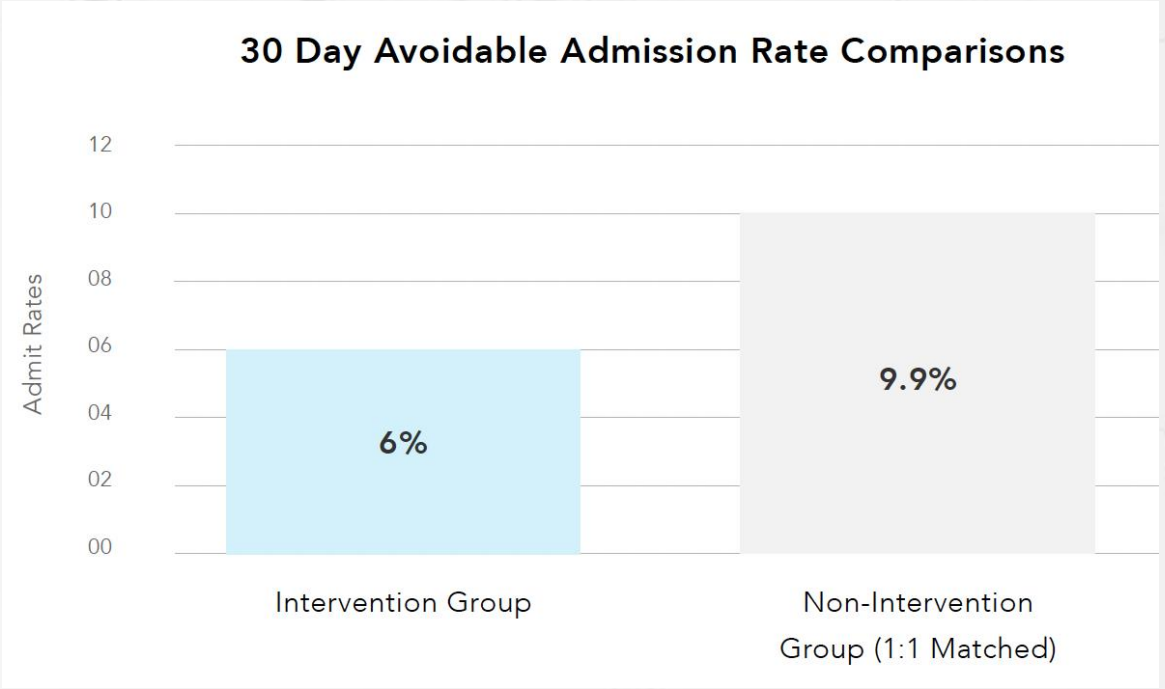


Client Success: Acting on SDoH Data

Accessing Hard to Reach Social Determinants of Health Data to Deliver Whole-Patient Care

Previously, we tried to get social determinants data by calling patients and asking them, but it was hard because they don't want to disclose it and it's hard to start those conversations unless you have background data," the care manager shared. Lightbeam's recommendations added an extra layer to help start and guide the conversation.

Before Lightbeam, we were calling to say hey I saw you were in the ED 6 months ago, as a result, we wouldn't get a lot of engagement. Now, when we say hey, I see that not only clinically these things are happening, but maybe socially these things may become a barrier so I wanted to check in on you and see how things are. Patients are way more inclined to engage then.



Pitfall #4: Not Prioritizing Patient Engagement

- Pitfall
  - Budget and staffing pressures driving trend in organizations reducing care management and pop health teams yet orgs till need to maintain patient engagement.

- Importance
  - Patient engagement maintains trusting care team-patient relationships and patient satisfaction
  - Proactive outreach for preventive services and access to care
  - Quality of Life improvements – less hospitalizations
  - Provide more care options within the home

Strategy: Engage Patients with Automated RPM

- Patient engagement can be augmented with automated means such as RPM to reach more patients with fewer staff resources
- Ensure RPM is accessible, consider cost or technology and health literacy barriers
- Emphasize RPM that can support the entire population
  - High and medium risk patients with chronic disease self-management, and low risk patients with preventative communication (e.g., screenings, AWVs)

Solution: Deviceless RPM

Transform care management from manual outbound outreach to automated inbound insights with Lightbeam's Deviceless RPM™, CareSignal

- **No new devices required**
  No apps, downloads, or passwords
- **Accessible for all patients**
  Promote and elevate health equity
- **Clinically-Validated**
  13+ Peer Reviewed Publications
- **Engagement powered by AI**
  Predict and prevent drop-off

Client Success: Health System Case Study

Lightbeam Health Solutions

Midwest Health Saves $53M in Total Cost Savings

Outcomes

Leveraging Lightbeam's Population Health Solutions

$53M
In Cost Avoidance

800
Patients Per FTE

5X
Increase in Care Team Efficiency

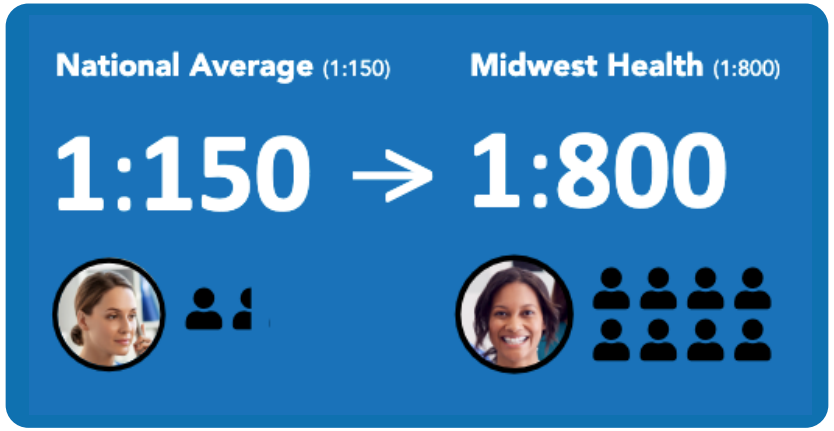
Drivers

Care managers operating at full capacity could only manage 100 patients per FTE.

Zero engagement with rising risk patients, leaving those patients unmanaged.

Automated patient outreach and real-time data alerts allowed us to scale our Population Health program to serve thousands of additional patients without adding additional resources, while focusing on patients needing the most support."

Executive Director, Population Health Navigation, Midwest Health



With an average alert rate of 2.5%, care team members were able to address the acute needs of the patients who alert each day, while supporting a substantial portion of our at-risk Population

Pitfall #5: Lack of POC Tools and Automated Reporting

- **Pitfall:**
  - When reporting is pulled manually across different sources of truth it creates friction hampering an organization's ability to identify areas of improvement and regularly measure performance and progress to create a cycle of continuous improvement

- **Importance:**
  - Clarity and accuracy of initiatives
  - Optimize staff efficiency and decision making
  - Prevent opportunities from slipping through the cracks

Strategy: Automated Reporting, Facesheets

- Understand the why and who behind current performance
- Review performance at the practice level, do we have outliers? Is there a provider that is not doing their part?
- Review performance at the patient level; provider and patient are often connected
- Measure program effectiveness at program, practice, patient level to inform program resource allocation and educational efforts.
- Empower teams to improve performance with automated POC data, such as facesheets

Solution: Automated Facesheets, Analytics & Reporting

- Facesheets simplify coding at the point of care
- Quality Measure Performance
- Monitor HCC Impact
  - Enterprise-wide
  - Provider level
  - Patient level

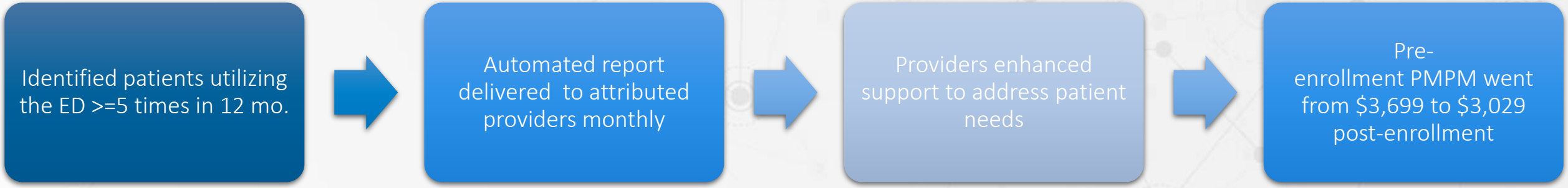
Measure	Denominator	Numerator	Performance Rate
Adult BMI Assessment	1,172	34	2.90%
Breast Cancer Screening	223	147	65.92%
Cervical Cancer Screening	517	407	78.72%
Colon Cancer Screening	511	462	90.41%
Comprehensive Adult Diabetes Care - A1c > 9 Screening	72	57	79.17%
Comprehensive Adult Diabetes Care - BP Control < 140/90	72	34	47.22%
Comprehensive Adult Diabetes Care - Eye Exam	72	20	27.78%
Comprehensive Adult Diabetes Care - Nephropathy	72	43	59.72%
Controlling High Blood Pressure	241	192	79.67%
Total	**2,952**	**1,396**	

Name is the lowest granularity of BU that the Provider is associated with	HCC V24			HCC V28			HCC Financial V24			HCC Financial V28			HCC Financial Difference		
BU	Recaptured Conditions	Not Recaptured	Recapture Rate	Recaptured Conditions	Not Recaptured	Recapture Rate	HCC Financial Recaptured	HCC Financial Not Recaptured	HCC Financial Total	HCC Financial Recaptured	HCC Financial Not Recaptured	HCC Financial Total	HCC Financial Difference	Average Change Per Provider	Average Change Per Patient
[redacted]	154	527	22.61%	119	198	37.54%	$82,250.33	$170,118.66	$208,275.24	$74,465.01	$98,719.00	$134,479.75	$73,795.49	$73,795.49	$585.68
[redacted]	58	148	28.16%	50	45	52.63%	$29,630.82	$48,600.51	$60,800.78	$26,477.30	$28,469.99	$39,622.91	$21,177.87	$10,588.94	$470.62
[redacted]	374	950	28.25%	280	235	54.37%	$176,328.25	$323,053.14	$404,401.36	$151,124.33	$150,773.07	$222,933.01	$181,468.35	$60,489.45	$659.88
[redacted]	321	883	26.66%	233	245	48.74%	$178,870.09	$307,986.04	$389,967.88	$159,578.17	$155,752.50	$238,807.90	$151,159.98	$37,790.00	$543.74
[redacted]	212	636	25.00%	166	264	38.60%	$106,533.15	$199,844.73	$247,924.32	$100,759.33	$145,924.76	$191,876.67	$56,047.65	$28,023.83	$320.27
[redacted]	6	17	26.09%	4	3	57.14%	$2,922.35	$6,195.99	$8,127.75	$2,844.01	$1,795.03	$3,538.39	$4,589.36	$4,589.36	$1,529.79
[redacted]	54	184	22.69%	47	56	45.63%	$30,899.53	$65,430.31	$83,744.27	$33,370.10	$36,001.19	$57,676.83	$26,067.44	$26,067.44	$1,042.70
[redacted]	50	146	25.51%	37	39	48.68%	$24,672.84	$48,672.70	$58,082.24	$22,041.91	$27,322.21	$35,398.93	$22,683.31	$22,683.31	$581.62
[redacted]	6064	17972	25.23%	4544	5953	43.29%	$3,261,842.20	$5,972,243.04	$7,385,934.34	$2,922,723.88	$3,363,434.70	$4,718,780.46	$2,667,153.88	$34,638.36	$539.25
[redacted]	2	5	28.57%	1	0	100.00%	$706.37	$1,172.03	$1,568.59	$582.57	$354.68	$582.57	$986.02	$986.02	$986.02
[redacted]	211	697	23.24%	174	226	43.50%	$120,818.61	$240,886.15	$286,528.69	$109,799.90	$138,898.19	$188,748.94	$97,779.75	$24,444.94	$470.09
[redacted]	10	33	23.26%	9	5	64.29%	$5,930.86	$9,497.40	$13,978.81	$6,508.98	$2,721.95	$8,314.86	$5,663.95	$5,663.95	$1,132.79

Client Success Story: Automated Reporting Enables Provider Focus

Lightbeam Health Solutions

Implemented an ER Diversion Program for Frequent ER Utilizers



$670 PMPM Reduction

Summary: 5 Strategies

Lightbeam Health Solutions

- Real-Time Data Insights
- Risk Stratification & Management
- Whole-Patient Health
- Patient Engagement
- Measurement

Q&A

For More Information Scan the QR Code *or visit Lightbeamhealth.com*

Or reach out directly at:
info@lightbeamhealth.com

Stop by our VBCExhibitHall.com Virtual Booth

Visit Booth

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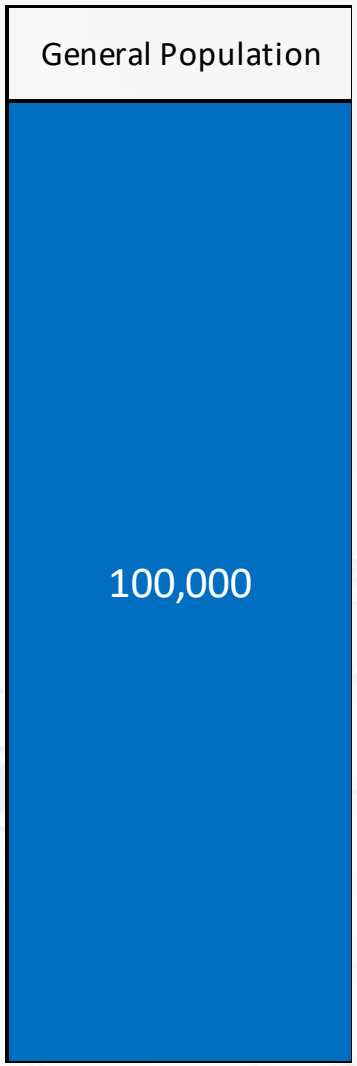
Population of 100,000 patients



Hopkins Leading indicators – LB Rules Engine

- 23 Standard Predictive Models
  - Patients with Emerging/Rising Risk
  - Using ER For Primary Care
  - Medication Therapy Management - 3
  - At Risk for High Utilization – No PCP w > 1 IP Admit
  - Diabetes based on Pharma only – no appropriate EDC

- Probability of High Pharmacy Spend
- Probability of Inpatient Hospitalization
- Probability IP Hospitalization in 6 mos
- Probability of ICU Hospitalization
- Probability of Injury Hospitalization
- Probability of Extended Hospitalization
- Probability of Unplanned 30 day readmit

Solution: Risk Stratification 2.0 – ACG + ATI

Hopkins ACG Stratification		Resources	FTE
5000	High Risk	Care Managers	40
20000	Rising Risk	Automated Clinical Interventions	160
75000	Low - Moderate Risk	Automated Member Outreach	

ACG + ATI		Resources
3000	Impactible	Care Managers
2000	Less Impactible	Pain Management Paliative Care Hospice Social Workers Counselors Care Managers

Risk Stratification 2.0 – ACG + ATI + SDOH + AI

Social Determinants of Health + AI modeling

- Precise Identification of patients needing engagement today
- Prescriptive guidance on exact actions to take

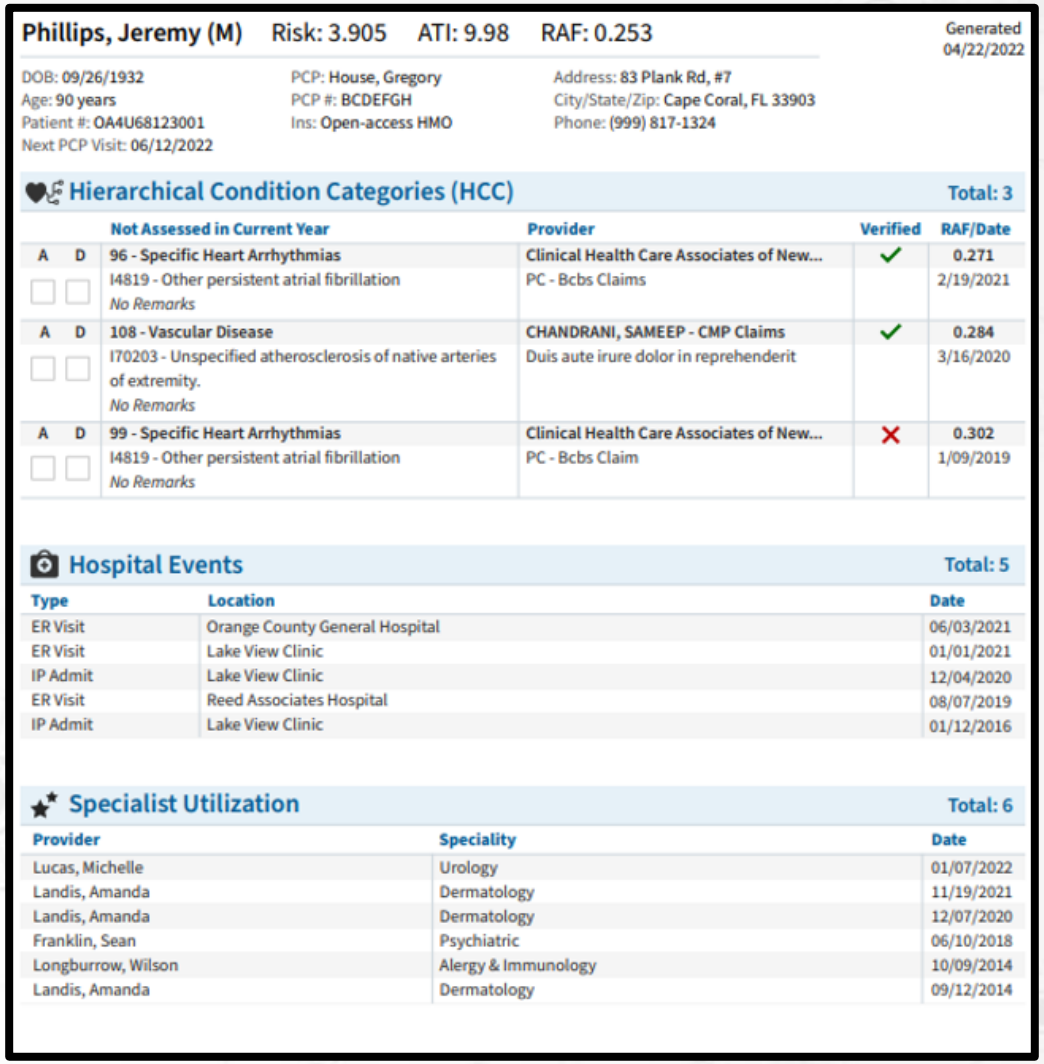
ACG + ATI + SDOH + AI		Member	Chronic Condition(s)	SDOH / AI	Prescribed **AI** Generated Action Plan
3000	Impactible	74	CHF w weight fluctuation	Dietary counseling req'd **AI -** High Probability Admission in 30 days	CM call patient confirm poor adherence to salt restricted diet Refer patient to Dietician + FU with Cardiologist within 7 days
		39	Diabetes	Limited Social Support Relies on Public Transportation **AI** - High Risk Avoidable ED 60 days	CM call patient to confirm transportation barrier to get meds and make PCP visits. CM facilitates trasnportation and sets up 90 day Rx fills via mail order.
		47	COPD	Recent admit w exacerbation - Low Literacy **AI** - Very High Risk for Readmission	CM calls patient and performs needs assessment. Curates longitudinal care plan includes nutrition, meds, and health counseling.
2000	Less Impactible	64	Behavioral Health with substance abuse issues	Lack of Medication Adherence **AI** - High risk of admission in 30 days	CM outreach to develop a safety plan, facilitates PCP engagement, and med reconciliation
		224			

Client Success Example: ACO Focuses on the Most Impactable Patients

- Drilling down further, Lightbeam identified the 830 patients within the top 5% of highest-risk profile and how many patients the ACO would need to intervene with to reduce avoidable admissions.

Risk Level	IP30 Admits	Total Patients	NNE	Admission Rate	Coverage
High Risk	198	2,515	13	7.9%	21%
Medium Risk	198	5,079	26	3.9%	21%
Low Risk	550	44,255	80	1.2%	58%
Grand Total	946	51,849	55	1.8%	100%

Simplify Coding at the Point of Care



Phillips, Jeremy (M) Risk: 3.905 ATI: 9.98 RAF: 0.253 Generated 04/22/2022

DOB: 09/26/1932
Age: 90 years
Patient #: OA4U68123001
Next PCP Visit: 06/12/2022

PCP: House, Gregory
PCP #: BCDEFGH
Ins: Open-access HMO

Address: 83 Plank Rd, #7
City/State/Zip: Cape Coral, FL 33903
Phone: (999) 817-1324

Hierarchical Condition Categories (HCC) Total: 3

A	D	Not Assessed in Current Year	Provider	Verified	RAF/Date
☐	☐	96 - Specific Heart Arrhythmias I4819 - Other persistent atrial fibrillation *No Remarks*	Clinical Health Care Associates of New... PC - Bcbs Claims	✓	0.271 2/19/2021
☐	☐	108 - Vascular Disease I70203 - Unspecified atherosclerosis of native arteries of extremity. *No Remarks*	CHANDRANI, SAMEEP - CMP Claims Duis aute irure dolor in reprehenderit	✓	0.284 3/16/2020
☐	☐	99 - Specific Heart Arrhythmias I4819 - Other persistent atrial fibrillation *No Remarks*	Clinical Health Care Associates of New... PC - Bcbs Claim	✗	0.302 1/09/2019

Hospital Events Total: 5

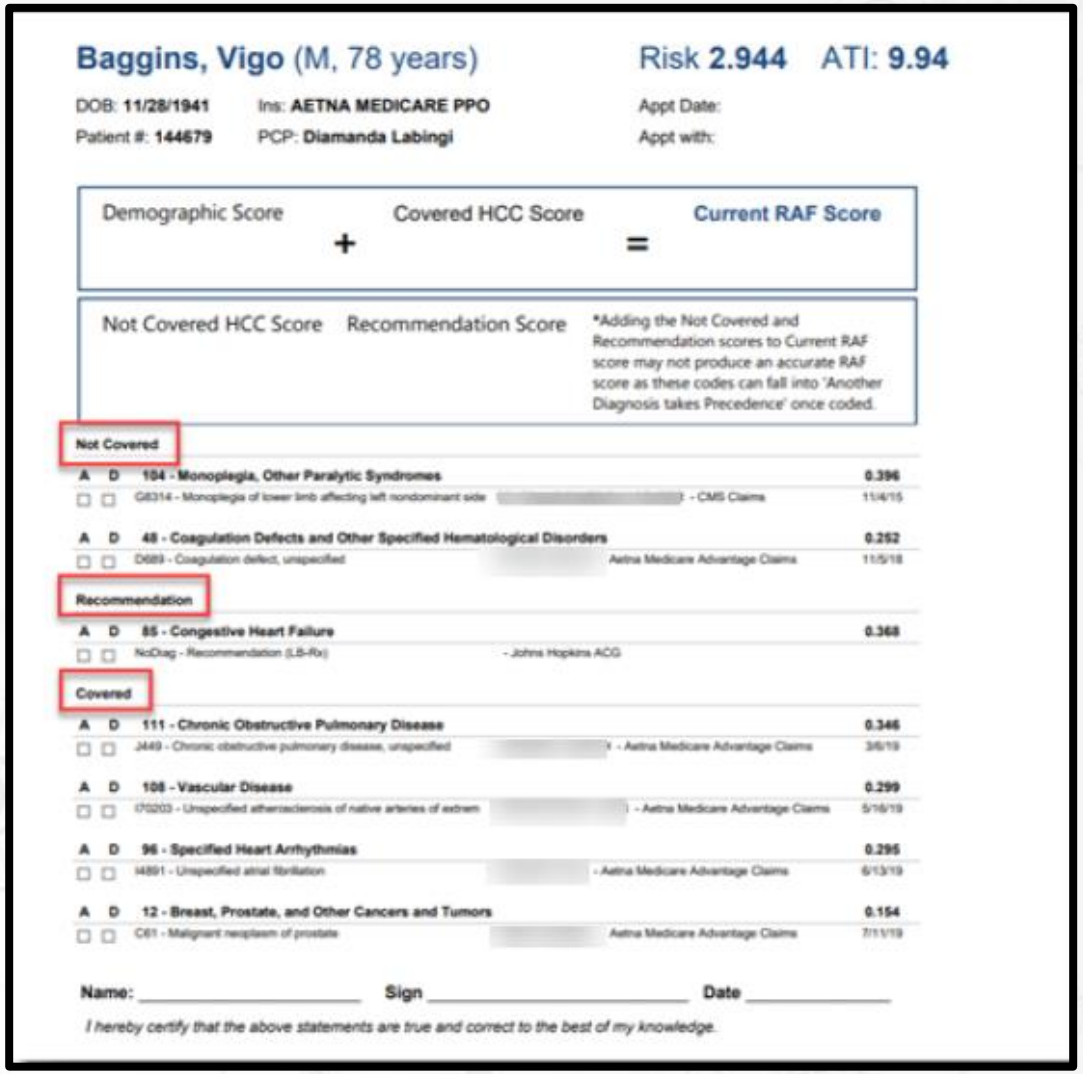
Type	Location	Date
ER Visit	Orange County General Hospital	06/03/2021
ER Visit	Lake View Clinic	01/01/2021
IP Admit	Lake View Clinic	12/04/2020
ER Visit	Reed Associates Hospital	08/07/2019
IP Admit	Lake View Clinic	01/12/2016

Specialist Utilization Total: 6

Provider	Speciality	Date
Lucas, Michelle	Urology	01/07/2022
Landis, Amanda	Dermatology	11/19/2021
Landis, Amanda	Dermatology	12/07/2020
Franklin, Sean	Psychiatric	06/10/2018
Longburrow, Wilson	Alergy & Immunology	10/09/2014
Landis, Amanda	Dermatology	09/12/2014

- **Patient Facesheets**
  - Provides individual patient RAF score
  - HCC codes not assessed in the current year
  - Hospital and provider utilization

Simplify Coding at the Point of Care



Baggins, Vigo (M, 78 years) Risk **2.944** ATI: **9.94**

DOB: **11/28/1941** Ins: **AETNA MEDICARE PPO** Appt Date:

Patient #: **144679** PCP: **Diamanda Labingi** Appt with:

Demographic Score	+	Covered HCC Score	=	Current RAF Score

Not Covered HCC Score	Recommendation Score	*Adding the Not Covered and Recommendation scores to Current RAF score may not produce an accurate RAF score as these codes can fall into 'Another Diagnosis takes Precedence' once coded.

Not Covered

A	D		
		104 - Monoplegia, Other Paralytic Syndromes	**0.396**
		G8314 - Monoplegia of lower limb affecting left nondominant side - CMS Claims	11/4/15
		48 - Coagulation Defects and Other Specified Hematological Disorders	**0.252**
		D689 - Coagulation defect, unspecified - Aetna Medicare Advantage Claims	11/5/18

Recommendation

A	D		
		85 - Congestive Heart Failure	**0.368**
		NoDiag - Recommendation (LB-Rx) - Johns Hopkins ACG	

Covered

A	D		
		111 - Chronic Obstructive Pulmonary Disease	**0.346**
		J449 - Chronic obstructive pulmonary disease, unspecified - Aetna Medicare Advantage Claims	3/6/19
		108 - Vascular Disease	**0.299**
		I70203 - Unspecified atherosclerosis of native arteries of extrem - Aetna Medicare Advantage Claims	5/16/19
		96 - Specified Heart Arrhythmias	**0.295**
		I4891 - Unspecified atrial fibrillation - Aetna Medicare Advantage Claims	6/13/19
		12 - Breast, Prostate, and Other Cancers and Tumors	**0.154**
		C61 - Malignant neoplasm of prostate - Aetna Medicare Advantage Claims	7/11/19

Name: _____ Sign _____ Date _____

I hereby certify that the above statements are true and correct to the best of my knowledge.

- **Action Overview Facesheets**
  - Describes what providers need to do at the point of care to accurately code open HCCs