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Insight Driven Health
Innovative Solutions & Critical Success Factors On Your Journey To Population Health Management
March 18, 2014

Critical Success Factors In Enabling Population Health Management (PHM): Have a Framework To Guide Efforts

Enabling successful Population Health Management capability involves deploying an effective guiding framework.

Segment and Target

Segment population with stratification, predictive and consumer analytics

Lines of Business
- Commercial
- Medicare
- Medicaid
- Dual Eligible

Health Continuum
- Well/Healthy
- At-Risk
- Chronic
- Complex
- Elderly/Aging

Predictive Samples
- Hospitalization Consumption
- Diabetes Risk
- COPD Risk
- Cancer Risk
- Asthma Risk
- CHF Risk
- Depression Risk

Consumer Orientation
- Behavior Segments
- Customer Needs
- Third Party Insights

Reach and Engage

Health Outreach

Patient Navigators
- Barriers to Care Removal

Care Coordinators
- Health Risk Assessment
- Scheduling with Care Team
- Program/Product Education
- Stars/ACO Quality Measure Outreach

Multi-Channel Patient Engagement

Coordinate Care and Apply Interventions

Intervention Support

Patient Navigators
- Non-Clinical Intervention Support
- Clinical Intervention Support

Care Coordinators
- Program Enrollment & Referral
- Unscripted Case & Chronic Condition Management
- Discharge Planning & Post Discharge Outreach
- Utilization Management
- Remote Monitoring
- Quality Monitoring

- Well / Healthy
- At-Risk
- Episodic
- Chronic
- Complex
- Elderly/ Aging

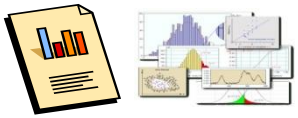
Workflow and Virtual/ Home Enablement

Evaluate and Improve

Outcomes Measurement
- Measure and Report Performance Quality Outcomes
- Measure and Report Clinical Quality Outcomes

Intervention Data
Clinical Outcomes Data

Outcomes Reports



Critical Success Factors In Enabling PHM: Community-Focused Capabilities Are Vital

Population Health Management outcomes benefit from new community-focused assets such as remote care units and multichannel service centers.

Traditional Models

New Models

Hospital

Physician/Nurse
- Hospitalization
- Emergency Dept.
- Specialists

Primary Care Center

Primary Care Physician
- Office Visits

Nurse
- Deliver Care

Remote Care Unit

Physician/Nurse
- Home Care

Patient Navigation

Lay Navigators
- Proactive coordination between levels of care and barrier removal

Virtual Care

- Mobile and other digital solutions to enable more self management

Multichannel Service Center

Multi-discipline Clinical & Non-Clinical Support Team:

Care Coordination
- Monitor patient (remotely)
- Support Home Care and Primary Care

Utilization Management
- Ensure care delivered in right care setting
- Provider support
- Care plan compliance

Critical Success Factors In Enabling PHM: Ensure Team-Based Care

Population Health requires new care delivery models which reduce costs, improve health outcomes and increase patient satisfaction.

Community/Lay Navigator

- Connects patient to appropriate resources to resolve barriers to access care
- Provides non-clinical intervention support

Financial – Insurance Coordination

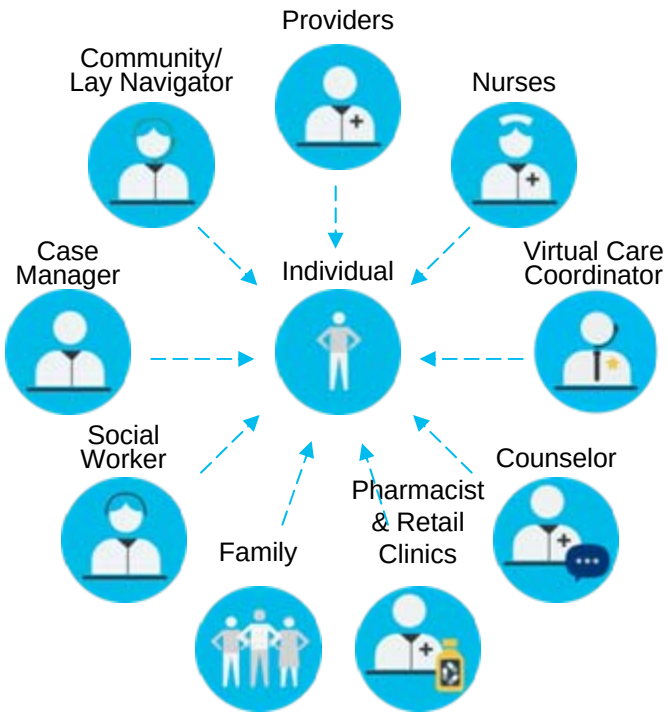
Logistical Transportation

Social Childcare

Connected Technology

- Stratification, Predictive and Outcomes Analytics
- Care Collaboration Workflow System & EMR Integration
- Multi-channel Patient Engagement Support
- Remote Monitoring Devices

Integrated & Leveraged Care Team



Virtual Care Coordinator/ Health Advisor

- Provides inbound/outbound support including intervention-based targeted outreach; improves STAR, ACO and other quality measures
- Assists care transitions to prevent readmissions
- Monitors chronic and aging patients remotely to reduce Inpatient and long-term facility care

Home Care Team

- Doctors and nurses to treat identified Chronic, Aging and Palliative patients in the Home

Enabling:

- Patient-centric approach through higher collaboration amongst clinicians and other care givers
- Empowerment through education, training and coaching
- New, more efficient ways of interaction amongst care team
- Removal of low value added activities from clinician agendas
- Low intensity, high frequency interactions by lower cost care team members

Case #1: Large National Healthcare Provider

US-based Population Health Management efforts have shown success with leveraging Patient Navigators to realize meaningful outcomes.

Large National Healthcare Provider:

Improving health outcomes and impacting the bottom line by targeting diabetes care

Objective(s)

Reduce the number of patients in a large diabetic population with A1C levels above the targeted rate

Role of PNs

Recommended interventions based on each patient profile and facilitated execution of interventions, such as directing patients into diabetes education classes and insulin clinics

Solution

Target population profiled and segmented based on issues causing high A1C levels, followed by focused interventions addressing each group's needs

Outcomes

- Abnormal A1C level down by 32% on average
- Improved A1C test compliance
- 50% decline in no show appointments (ophthalmology exams, podiatry exams, etc.)

Community-Deployed Patient Navigators Make Impact

Patient Navigators can identify and overcome the barriers that prevent individuals from gaining access to the timely, quality care they need.

Lay Patient Navigators

- Identify & remove barriers
- Determine required services
- Outreach
- Support & monitor care plan

Barriers to Accessing Care

FINANCIAL

- Coverage for care
- Out-of-pocket expense
- Rx set-up / refill
- Authorization requirements

LOGISTICAL

- Appointment scheduling
- Transportation assistance
- Child care coordination

COORDINATION AND EDUCATION

- Coordination of care plans
- Education services
- Community services

CULTURAL

- Awareness and understanding
- Emotional
- Language / Ethnic preferences

Case #2: Basque Country (Spain) Population Health

Some characteristics of the region

Context

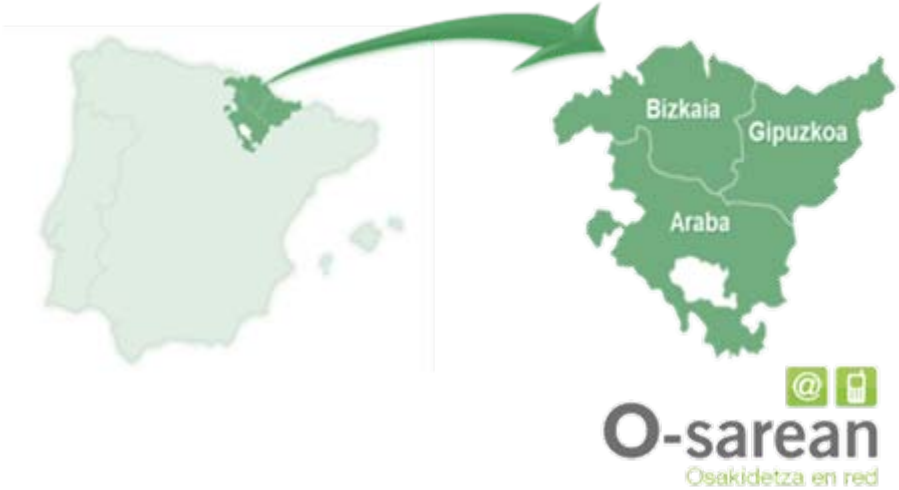
- Population of 2.2M - 18% are +65 years old
- Average life expectancy at birth: 81.2 - highest in the world, after Japan and Hong Kong.
- High prevalence of Chronic Diseases:
- 80% of patient interactions with the public health system are related to chronic diseases
- Drive 77% of the total Health expenditure
- Patients with more than one chronic condition cost six times more than those with only one
- Healthcare cost expected to double by 2020 – outpacing taxable affordability

Benefits Achieved

- Reversed trend in increasing annual healthcare cost (starting in 2011)
- Saved $55M by reducing hospital stays
  by 52,000 between 2009-2011
- Increased home hospital usage by 49%
- Decreased pharmaceutical prescription cost between 2010-2011 by 2.5%

Solution Summary

- Developed a five point strategy anchored by stratifying population
- Applied new technologies, core interventions and innovative solutions
- Implemented during multi-year journey through 14 major projects



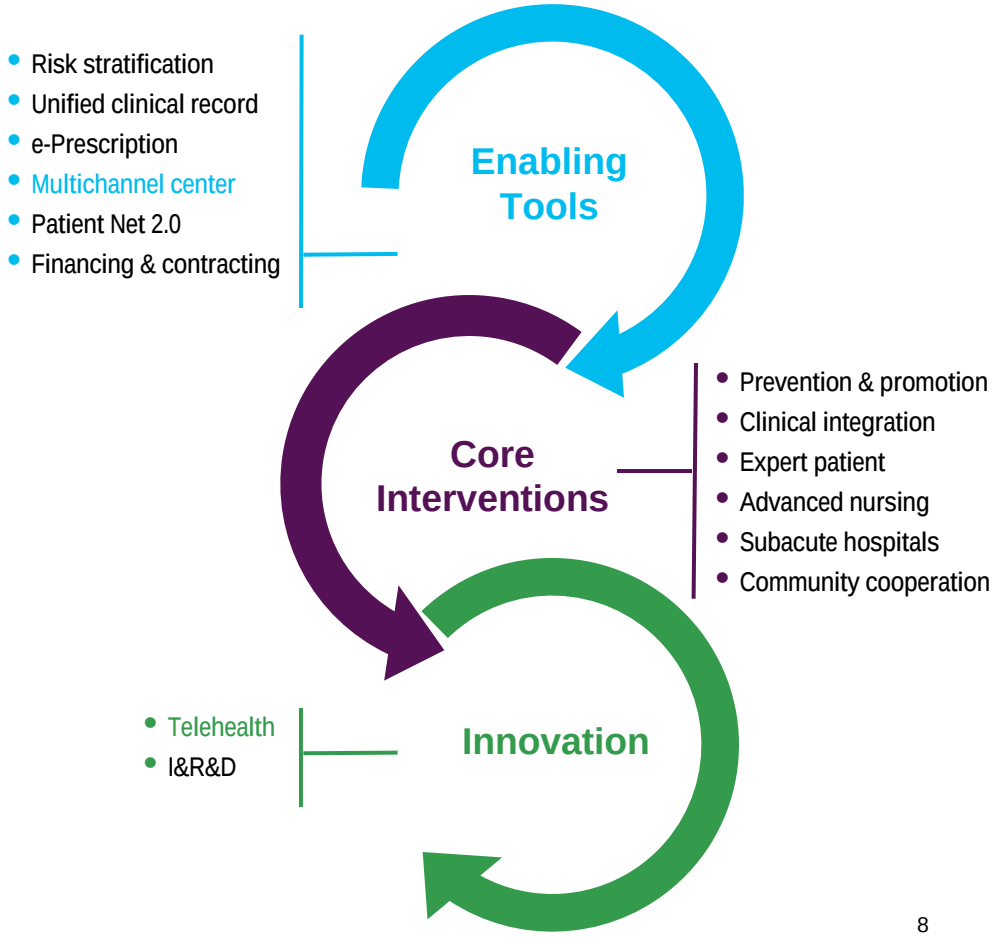
Case #2: Basque Country (Spain) Population Health

The Basque Country team developed a five point strategy with enabling tools, core interventions & innovation.

Five Point Strategy

1. **Focus on stratified population heath**
2. **Promotion & Prevention of chronic illnesses**
3. **Responsibility & Autonomy for patients**
4. **Continuous care for the chronic patient**
5. **Efficient interventions adapted to the patients needs**

Delivered Through 14 Projects



Case #3: La Fe (Valencia, Spain) Population Health

Context

- Valencia Spain – Population of 210,000
- 10% of the population has chronic condition
- Care center locations
  - University Hospital La Fe
  - 6 Primary care centers

Benefits Achieved

- Reduced high-risk patient costs by 65%
  - Equates to 9% total healthcare cost reduction (applied against full population)
  - Reduced hospital stays by 80% for this high risk group
- Increased inpatient bed capacity by 16%
- Reduced unplanned hospital visits by 38%

Solution Summary

- Developed predictive analytic model to identify high risk patients (nearly 2x more accurately than CARS)
- Established innovative operating model with new organization, technology, population management and care center for patient follow-up
- Implemented low cost interventions to prevent acute high cost episodes

Case #3: La Fe Population Health – Targeting the Right Patients

The La Fe team targeted high-risk patients to intervene before they incurred multi-chronic "intense" costs.

% of Total Health Expenditure	% of Population	Representative Spend by Category				Le Fe Healthcare Cost
		Pharma	Outpatient	ER	Inpatient	
 35%	Multi-Chronic / Intense 4% 	4%	7%	2%	22%	$214M
 25%	High Risk 13% 	4%	8%	1%	12%	$153M
 20%	Medium Risk 43% 	4%	8%	2%	6%	$122M
 20%	Healthy 40% 	4%	11%	3%	2%	$122M

 Primary Target – Early Stage Chronicity ← **La Fe Study Population**

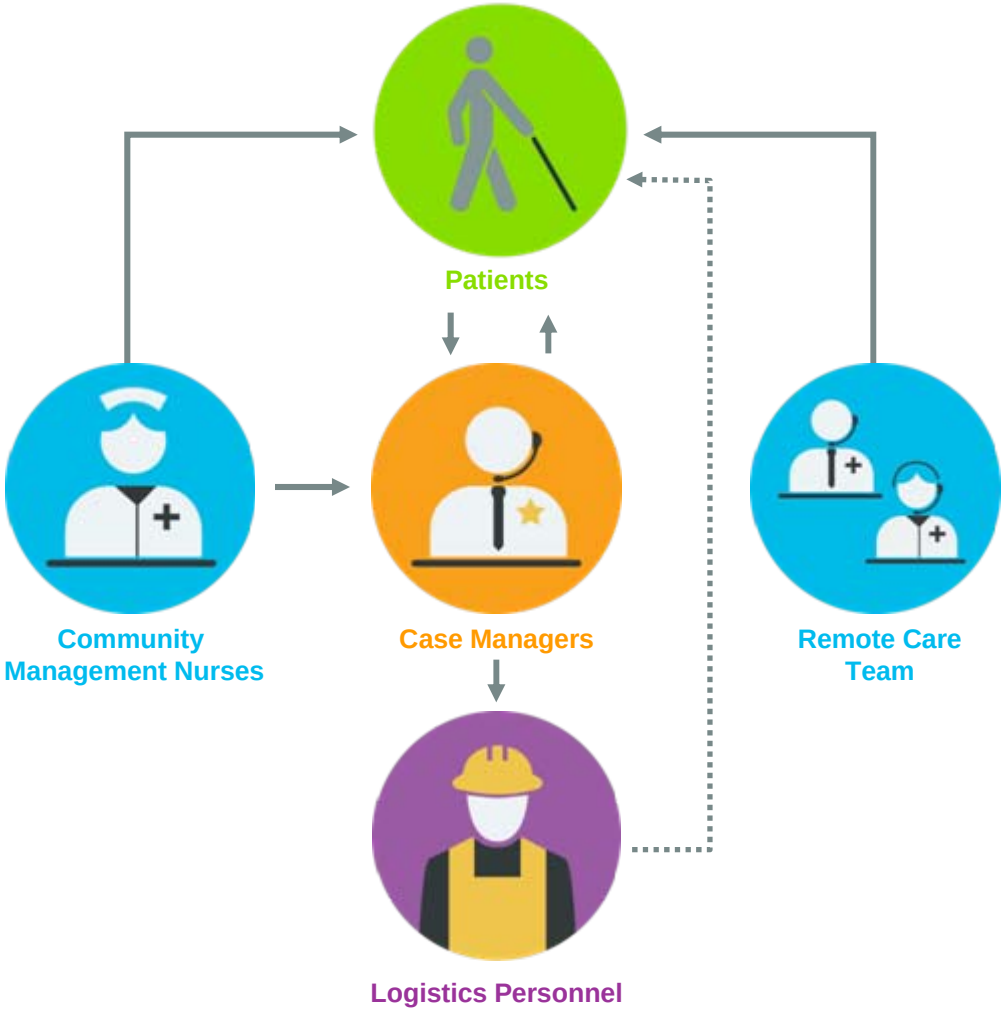
 Secondary Impact – Late Stage Chronicity

 Not Targeted

Total - $611M

Case #3: La Fe (Spain) Population Health – New Care Delivery Model

Patients identified by the predictive model received low cost interventions enabled by a new non-acute based care delivery model.



Engagement Primary Care Centers and General Practitioners

- New organization model ensures clear communication between all involved parties
- General Practitioners play a key role in patient enrollment

New roles for nurses created

- New Case Management role that defines specific actions plans and coordinates care levels (primary care, specialists, home care)
- New Community Management Nurse role in Primary Care Centers as liaison between care levels and to ensure continuous momentum

New Remote Care Team

- Client doctors and nurses to visit identified patients at home

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