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.

<table>
<thead>
<tr>
<th>Segment and Target</th>
<th>Reach and Engage</th>
<th>Coordinate Care and Apply Interventions</th>
<th>Evaluate and Improve</th>
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</thead>
<tbody>
<tr>
<td><strong>Segment population with stratification, predictive and consumer analytics</strong></td>
<td><strong>Health Outreach</strong></td>
<td><strong>Intervention Support</strong></td>
<td><strong>Outcomes Measurement</strong></td>
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<td><strong>Lines of Business</strong></td>
<td><strong>Patient Navigators</strong></td>
<td><strong>Non-Clinical Intervention Support</strong></td>
<td><strong>Measure and Report</strong></td>
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<tr>
<td>Commercial</td>
<td>Barriers to Care Removal</td>
<td>Clinical Intervention Support</td>
<td>Performance Quality <strong>Outcomes</strong></td>
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<td>Medicare</td>
<td><strong>Care Coordinators</strong></td>
<td><strong>Program Enrollment &amp; Referral</strong></td>
<td><strong>Measure and Report Clinical Quality Outcomes</strong></td>
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<td>Medicaid</td>
<td>Health Risk Assessment</td>
<td>Unscripted Case &amp; Chronic Condition Management</td>
<td><strong>Well / Healthy</strong></td>
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<td>Dual Eligible</td>
<td>Scheduling with Care Team</td>
<td>Discharge Planning &amp; Post Discharge Outreach</td>
<td><strong>At-Risk</strong></td>
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<td><strong>Predictive Samples</strong></td>
<td>Program/Product Education</td>
<td>Utilization Management</td>
<td><strong>Episodic</strong></td>
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<td>Hospitalization Consumption</td>
<td>Stars/ACO Quality Measure Outreach</td>
<td>Remote Monitoring</td>
<td><strong>Chronic</strong></td>
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<td>Diabetes Risk</td>
<td><strong>Multi-Channel Patient Engagement</strong></td>
<td>Quality Monitoring</td>
<td><strong>Complex</strong></td>
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<td>COPD Risk</td>
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<td><strong>Elderly/ Aging</strong></td>
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<td>Cancer Risk</td>
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<td><strong>Outcomes Reports</strong></td>
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<td>Asthma Risk</td>
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<td><strong>Workflow and Virtual/ Home Enablement</strong></td>
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<td>CHF Risk</td>
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<td><strong>Health Risk Assessment</strong></td>
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<td>Depression Risk</td>
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<td>Program/Product Education</td>
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<td><strong>Consumer Orientation</strong></td>
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<td><strong>Care Coordinators</strong></td>
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<td>Behavior Segments</td>
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<td>Program Enrollment &amp; Referral</td>
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<td>Customer Needs</td>
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<td>Unscripted Case &amp; Chronic Condition Management</td>
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<td>ThirdParty Insights</td>
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<td>Discharge Planning &amp; Post Discharge Outreach</td>
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<td><strong>Health Continuum</strong></td>
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<td>Utilization Management</td>
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<td>Well/Healthy</td>
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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

Hospital
- Physician/Nurse
  • Hospitalization
  • Emergency Dept.
  • Specialists
- Primary Care Center
- Physician/Nurse
  • Office Visits
- Nurse
  • Deliver Care

New Models

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
- Social Childcare

Logistical Transportation

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

Enabling:
- Patient-centric approach through higher collaboration amongst clinicians and other care givers
- Empowerment through education, training and coaching

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

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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

**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.)

**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
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.

<table>
<thead>
<tr>
<th>Barriers to Accessing Care</th>
<th>FINANCIAL</th>
<th>LOGISTICAL</th>
<th>COORDINATION AND EDUCATION</th>
<th>CULTURAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Coverage for care</td>
<td>• Appointment scheduling</td>
<td>• Coordination of care plans</td>
<td>• Awareness and understanding</td>
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<td></td>
<td>• Out-of-pocket expense</td>
<td>• Transportation assistance</td>
<td>• Education services</td>
<td>• Emotional</td>
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<tr>
<td></td>
<td>• Rx set-up / refill</td>
<td>• Child care coordination</td>
<td>• Community services</td>
<td>• Language / Ethnic preferences</td>
</tr>
<tr>
<td></td>
<td>• Authorization requirements</td>
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</tbody>
</table>

**Lay Patient Navigators**
- Identify & remove barriers
- Determine required services
- Outreach
- Support & monitor care plan
Case #2: Basque Country (Spain) Population Health

Some characteristics of the region

- 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%

Context

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 health
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

Enabling Tools
- Risk stratification
- Unified clinical record
- e-Prescription
- Multichannel center
- Patient Net 2.0
- Financing & contracting

Core Interventions
- Prevention & promotion
- Clinical integration
- Expert patient
- Advanced nursing
- Subacute hospitals
- Community cooperation

Innovation
- Telehealth
- I&R&D
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

Solution

- 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

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%
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.

### La Fe Study Population

<table>
<thead>
<tr>
<th>% of Total Health Expenditure</th>
<th>% of Population</th>
<th>Representative Spend by Category</th>
<th>Le Fe Healthcare Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>35%</td>
<td>Multi-Chronic / Intense</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>25%</td>
<td>High Risk</td>
<td>13%</td>
<td>4%</td>
</tr>
<tr>
<td>20%</td>
<td>Medium Risk</td>
<td>43%</td>
<td>4%</td>
</tr>
<tr>
<td>20%</td>
<td>Healthy</td>
<td>40%</td>
<td>4%</td>
</tr>
</tbody>
</table>

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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