



# Today's Health Technology Partnership: Innovations that Advance the Triple Aim

October 24, 2017  
2 pm – 3 pm ET

# Agenda

- Welcome and Introductions
  - Claudia Ellison, Program Director, eHealth Initiative
- Discussion & Comments
  - Dr. Anthony Nguyen, Senior Vice President - Population Health, UnitedHealthcare Clinical Services
  - Sagraan Moodley, Senior Vice President, UnitedHealthcare Clinical Data Services & Technology
  - Rich Panek, Chief Executive Officer, State of Franklin Healthcare Associates
- Questions & Answers

# Housekeeping Issues

- All participants are muted
  - To ask a question or make a comment, please submit via the Q&A feature and we will address as many as possible after the presentations.
- Technical difficulties:
  - Use the chat box and we will respond as soon as possible
- Today's slides will be available for download on eHI's Resource page [www.ehidc.org/resources](http://www.ehidc.org/resources)

# Our Mission

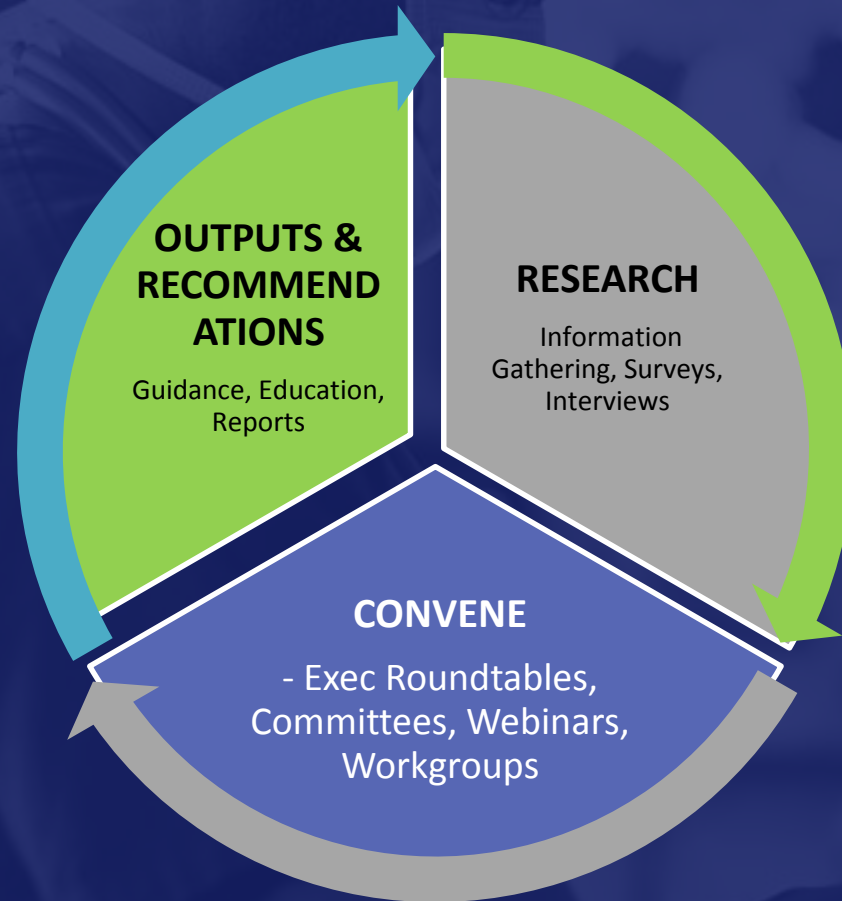
eHealth Initiative's mission is to serve as the industry leader convening executives from multi-stakeholder groups to identify best practices to transform healthcare through use of technology and innovation. eHI conducts, research, education and advocacy activities to support the transformation of healthcare.



# Multi-stakeholder Leaders in Every Sector of Healthcare



# Roadmap to Transforming Care



Convening  
Executives  
To Research  
& Identify  
Best  
Practices

Best Practice  
Committees  
Identify &  
Disseminate  
Success Stories



**INTEROPERABILITY**



**DATA ACCESS & PRIVACY**



**PATIENT & PROVIDER  
TECHNOLOGY ADOPTION**



**DATA ANALYTICS**

# eHealth Resource Center Available With Best Practices & Findings

Best Practice Committees contribute to the eHealth Resource Center [www.ehidc.org/resources](http://www.ehidc.org/resources) which provides assistance, education and information to organizations transforming healthcare through the use of information, technology and innovation. The Resource Center is a compilation of reports, presentations, survey results, best practices and case studies from the last 16 years.





# Electronic Medication Adherence Collaborative (eMAC)

- Foundation for eHealth Initiative launched a multi-stakeholder Electronic Medication Adherence Collaborative (eMAC).
- Share best practice examples from different analytical and behavioral approaches, educate stakeholders on the insights available. Share information on the effectiveness of programs.
- **IN PERSON MEETING ON December 12 IN DC. INTERESTED? TELL [CLAUDIA.ELLISON@EHIDC.ORG](mailto:CLAUDIA.ELLISON@EHIDC.ORG)**



Save the Date: February 7 – 8, 2018  
Top of the Hill, Washington, DC

# eHealth Initiative Executive Summit: 2020 Roadmap Refresh



*Attendance is limited to eHealth Initiative members and  
invited C-Level Executives*

This webinar was made possible through the generosity and support of  
UnitedHealthcare!





# Today's Health Technology Partnership: Innovations that Advance the Triple Aim

**Dr. Anthony Nguyen**, Senior Vice President - Population Health,  
UnitedHealthcare Clinical Services

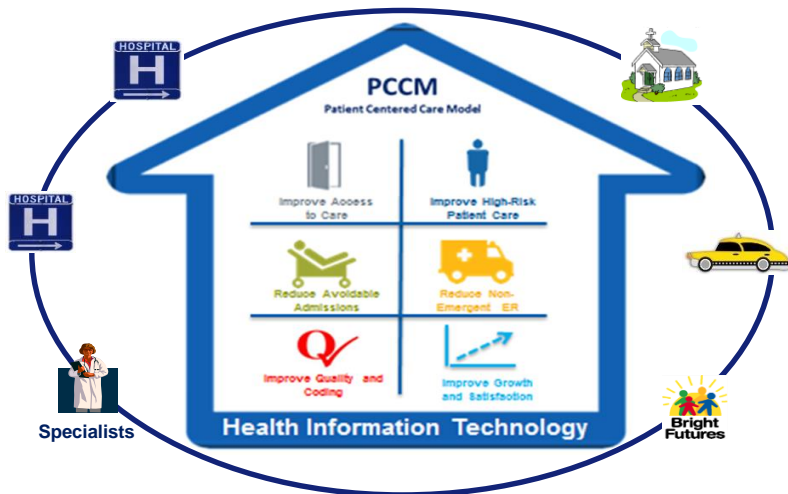
**Sagran Moodley**, Senior Vice President, UnitedHealthcare Clinical Data  
Services & Technology

**Rich Panek**, Chief Executive Officer, State of Franklin Healthcare  
Associates

# Our Operating Model: Provider-Based Population Health

- UnitedHealthcare provides clinical tools and helps support Accountable Care Entities / Community-Based Organizations to take action on achieving the Triple Aim through six pillars of population health.
- With our consultant's support, the expectation is that Accountable Care Entities will improve on each of the six pillars of population health. Each pillar has associated electronic data exchange and technology

## Six Essential Clinical Transformation Pillars & Technologies



### Integrating the Continuum of Care

#### 1. Improve High Risk Patient Care

Identify the practice's most fragile members and manage barriers to care, including social determinants of health

#### 2. Improve Access to Care

Utilize practice scheduling data to improve same-day access and reduce no-shows; determine best site of service & referrals

#### 3. Reduce Avoidable Admissions

Leverage daily discharge notifications to manage post-discharge care transitions and reduce readmissions

#### 4. Reduce Non-Emergent ER Visits

Leverage daily discharge notifications to manage care transitions and reduce avoidable emergency visits; assist in member triage and redirection.

#### 5. Improve Quality & Coding

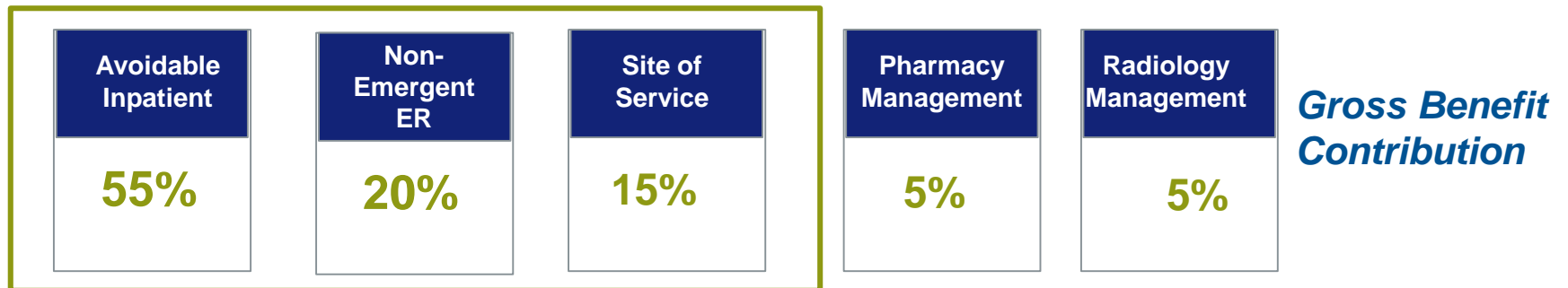
Use bi-directional data exchange to identify and document risk prevalence; close gaps in care, optimize medication adherence,

#### 6. Improve Growth & Satisfaction

Create competitive products, benefits and services to attract and retain patients. Track and report CAHPS drivers.

## Focused on Largest Gross Benefit Contribution

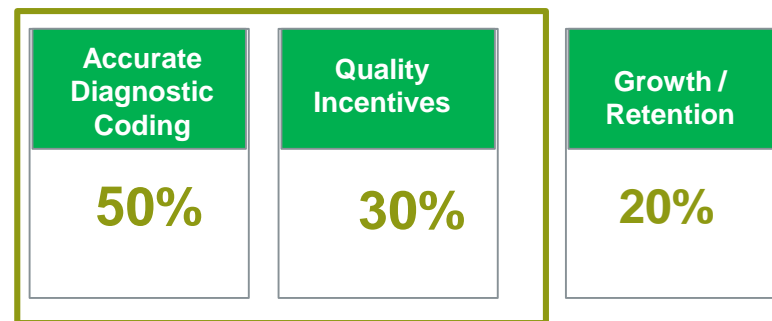
### Core savings categories



*Focus Area*

### Core revenue levers

*Gross Benefit Contribution*



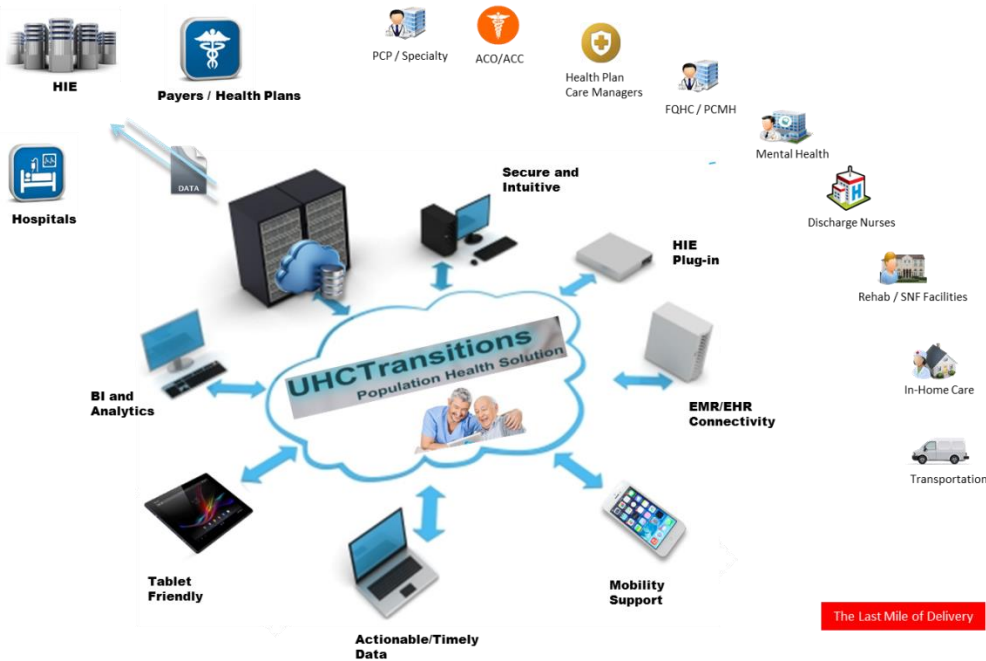
*Focus Area*

# Engaging through the Continuum of Care

## Technology & Data

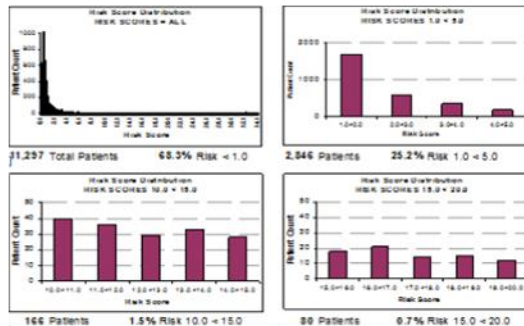
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## Practice-Based Resources



# Actionable Data to Support Six Critical Pillars

Process begins with our Provider-based “attributed” population risk profile



Care Transitions link Hospitals to Practices using ER & IP Notifications

Census Dashboard Messaging(4) Quality Scheduling

Patient Search Patient List Admitted Patients Discharged Patients Inactive Patients

Export All Patients Filter Reset

ID	NAME	DOB	DISCHARGE	CHIEF COMPLAINT	PROVIDER	HEALTH SYSTEM	COORDINATOR
1	Doc, Jane Risk Score 33 Event Type: RP Admit Discharge Disposition	01/05/1941 Age: 75		ABD PAIN, BLACK STOOL, RESOLVING PNEUMONIA	Crowdfly-jackson, Zeebat El Rio Health Center 860280557		Moreno, Martha
2	Wihly, Gabby Risk Score 4 Event Type: ER Discharge Discharge Disposition: HSA	06/12/1940 Age: 76	2016-07-05 17:39:00 376 days	PAIN ON L SIDE OF HEAD DIZZY?			Moreno, Martha
3	GUWCM, AFYKHU Risk Score 18 Event Type: ER Discharge Discharge Disposition: Home	01/09/1933 Age: 83	2016-06-27 15:20:00 384 days	WEAKNESS X4 DAYS	Ryn, Amy Yonkers County Community Health Services 860000561		Foster, Pamela

Our Registry Provides Patient Profiles with Actionable Care Opportunities

Census Dashboard Messaging(1) Quality Scheduling

Export Filter Reset

ID	EVENT	DOB	CARE OPPORTUNITY	PROVIDER	SPECIALIST	COUNT	...
1	Med_P	06/25/1952 Age: 67	OMV Med/On unable to complete osteoporosis screening. Critical Due Date: 07/14/2017	DELANI, SHAI		1	...
2	Elstak, Cuba	10/28/1958 Age: 57	OMV	HEALTHCARE PROFESSIONAL PC RHA_BK0302		1	...
3	Jyoti, Gita	07/18/1940 Age: 75	OMV	CHANGA, ANISH HEALTHCARE PROFESSIONAL PC RHA_BK0302		1	...
4	Legall, Ph	10/27/1938 Age: 78	ASA	SMAS, ELIZABETH ASSOCIATES IN FAMILY MEDICINE PC 84273175		1	...



Medication Adherence notifications alert the need to refill member prescriptions

Patient Care Opportunities Patient Rx Scorecard Patient Refill History Support Condition Report

Prokpl, Ofense  
Subscriber ID: 11111112  
Member Card ID: 999999999  
Male, 71  
Phone: (123)111-1111  
DOB: 12/12/1945

Drug Name	Fill Date	Qty	DS	Prescribing Provider	Pharmacy	Adherence Category	Refill Status	HIM	Action
METFORMIN TAB 500MG ER	05/14/2016	180	45	PAUL, MIKAN	WALGREENS 9612 9612 (203)221-0296	Diabetes	Refill Past Due (383 days late)		MANAGE
NITROFURANTIN CAP 100MG	05/06/2016	14	7	CLARICE GREENS	WALGREENS 9612 9612 (203)221-0296	HRM		HRM	MANAGE
LISINAPRIL TAB 2.5MG	05/11/2016	90	90	PAUL, MIKAN	WALGREENS 9612 9612 (203)221-0296	Hypertension	Refill Past Due (310 days late)		MANAGE
SIMVASTATIN TAB 40MG	05/13/2016	90	90	PAUL, MIKAN	WALGREENS 9612 9612 (203)221-0296	Cholesterol	Refill Past Due (308 days late)		MANAGE



# Actionable Data to Support Six Critical Pillars

The **Member Assessment** tool provides **Suspect Lists for Correct Coding**

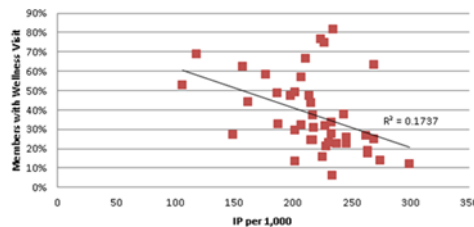
NOTE: The attached tool allows the Physician Practice to report instances where a licensed clinical professional assessed the patient for the conditions listed below. If the professional was able to diagnose the patient's condition, the appropriate diagnoses should be documented in the medical record and reported on the claim. If the professional assessed the patient for a condition indicated below but is unable to render a complete diagnosis at this time, the practice can include below. All information on this form should be entered by a practice employee with authority to provide such information.

Condition	HCC	Provider	Suspect Detail	Other Suspect Information	Assessed not diagnosed at the time	DOB
Delirium with Complications Added: 10/25/2019	018	RuACEMB, ALPHA-BETA BLOCKERS	<input type="checkbox"/>		<input type="checkbox"/>	09/01/2017
Chronic Obstructive Pulmonary Disease Added: 10/25/2019	111	RuACEMB, ALPHA-BETA BLOCKERS	<input type="checkbox"/>		<input type="checkbox"/>	09/01/2017
Vascular Disease Added: 10/25/2019	138	Previously Coded: ER GABAPENTIN ORAL NEURONTIN, Insulin DK 707.8	<input type="checkbox"/>		<input type="checkbox"/>	06/26/2017
Chronic Hepatitis Added: 10/25/2019	029	Previously Coded	<input type="checkbox"/>		<input type="checkbox"/>	09/06/2017
Seizure Disorders and Convulsions Added: 10/25/2019	079	Ru-RANOLAZINE ORAL ER RONEZA, Insulin DK 412	<input type="checkbox"/>		<input type="checkbox"/>	06/10/2017

**Performance Tracking** results shared monthly with **Partnering Organizations**

Improve High Risk Patient Care

Medicare ACOs: As Rate of Wellness Visits for High Risk Members Increases, We See Corresponding Reduction in Inpatient Utilization



**CCD & HL7 Interchange** allows for **bi-directional data sharing** with providers

**Complete Member Profiles** provide a view of each member's care team & history

# Navigating Data Exchange Capabilities



**Daily admit and discharge alerts**



**Configurable, workflow-based transitional care**



**Enhanced Part D (Rx) Measures and Suspect Conditions**



**Interactive HEDIS & Open gap Mgt, + clinical doc upload**

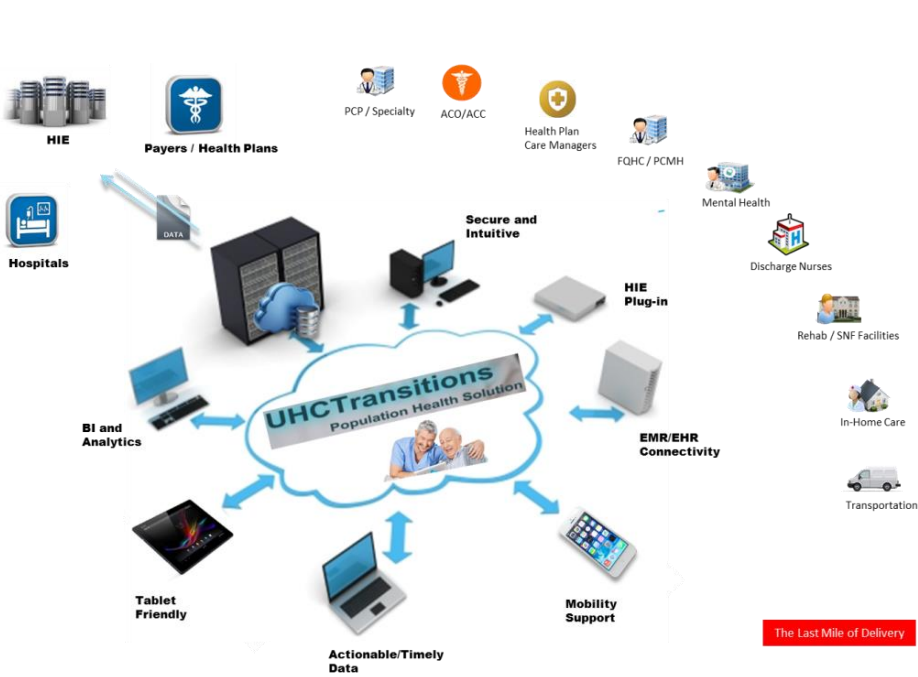


**Suspect Conditions and Provider Incentive Program**



**Bi-directional data sharing with care teams (Rx, BH, etc.)**

# Navigating Data Exchange Capabilities



# About SoFHA: Patients First, in All We Do



- Founded in 1998, Physician owned and operated
- Serve 112,000 patients in the Tri-Cities Tennessee-Virginia region
- Staff includes 80 physicians and 49 advanced practice nurses,
- Recognized by NCQA as a Level 3 Patient Centered Medical Home
- Driven by long-term relationships: “We grow old with our patients”



# UHC-SoFHA Partnership: Closing Gaps in Care



- Monthly **clinical data exchange** (CDE) supplements claims information to create a more accurate and complete patient
  - Data includes BMI, Breast Cancer Screening, HA1C & BP values, nephropathy testing and other data not clearly identifiable from claims.
  - UHC sends SoFHA a **Physician Clinical Opportunities Report** that contains the full set of Medicare Advantage Star Ratings quality measures
  - These reports allow SoFHA to identify gaps in care at the patient level and take action – for example, patients with a recent fracture (osteoporosis measure) who were not treated at SoFHA, or medication adherence for patients who don't get their prescriptions filled



# UHC-SoFHA Partnership: Care Transitions and Coordination



- Daily census report identifies SoFHA patients who have been admitted to an inpatient facility (acute, SNF, Rehab) & disposition of D/C.
  - Data sharing among facilities is often fragmented and incomplete
  - Often, physicians are not alerted when their patients are admitted to a hospital, skilled nursing facility or rehab center
  - Report allows SoFHA to track the patient course of care and deploy resources for care transitions
  - Once discharged we deploy after care which includes home visit and/or 2 day phone call, and a 7 day follow-up at the clinic
  - Ongoing monitoring of results, continued improvement in admissions and readmissions



# UHC-SoFHA Partnership: At-Risk Patients



- Quarterly report identifies high utilizers/at-risk patients who have not yet been admitted to an in-patient facility
  - These patients are at increasing risk and need further clinical surveillance, intervention and treatment to avoid disease progression
  - Report is supplemented by additional data provided by UHC to SoFHA in an access file, which documents claims paid on behalf of attributed members
  - Helps SoFHA identify specialist utilization, which can assist with holistic care coordination and communication

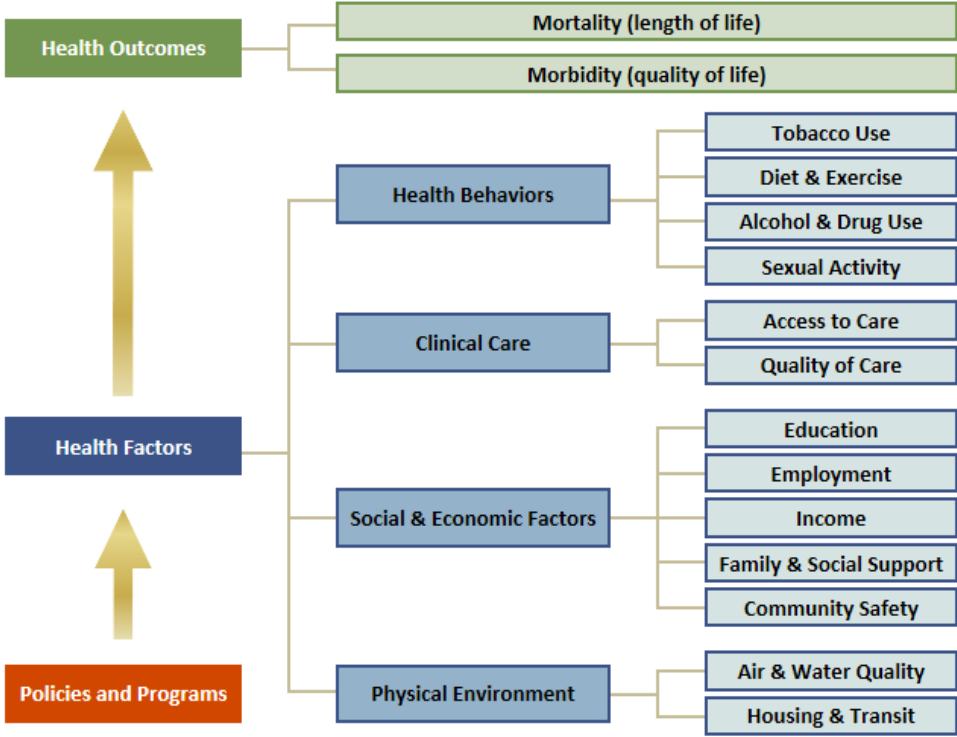


# Opportunities for Collaboration: Social Determinants of Health



The efficacy of healthcare treatment is influenced and often limited by social determinants of health

Successful ACOs need information on a patient's social determinants to provide effective and personally meaningful treatment



County Health Rankings model © 2014 UWPHI



# Opportunities for Collaboration: Interactive, Real Time Data



- **Interactive PCOR report:** Provider-level data on quality metrics increases transparency for each practitioner's alignment with evidence-based medicine and promotes clinical best practices
- **Real-time data:** Patient information can lag by 2 to 6 months, creating barriers and blind spots. Providers need real-time, actionable data to provide the right care at the right time, tailored to a patient's individual needs

# Questions and Answers

- Dr. Anthony Nguyen, Senior Vice President - Population Health, UnitedHealthcare Clinical Services
- SAGRAN Moodley, Senior Vice President, UnitedHealthcare Clinical Data Services & Technology
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