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
  - Sagran Moodley, Senior Vice President, UnitedHealthcare Clinical Data Services & Technology
  - Rich Panek, Chief Executive Officer, State of Franklin Healthcare Associates
- Questions & Answers

Housekeeping Issues

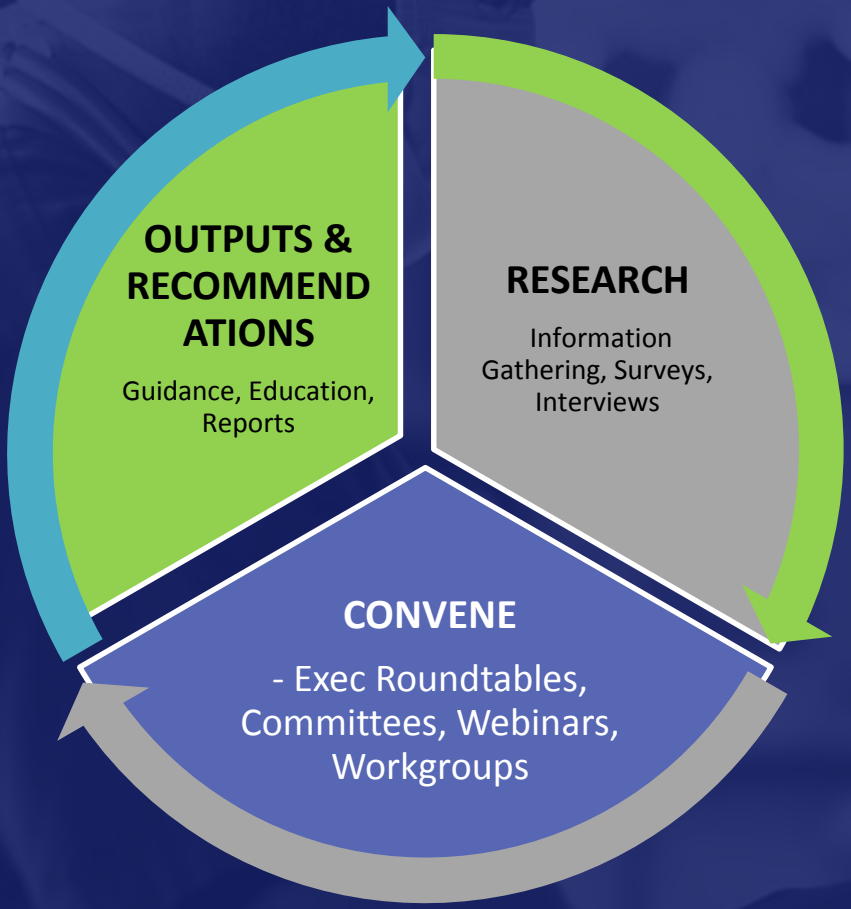
- All participants are muted
  - To ask a question or make a comment, please submit via the Q&A feature and we will address as many as possible after the presentations.
- Technical difficulties:
  - Use the chat box and we will respond as soon as possible
- Today's slides will be available for download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

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** 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**

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!

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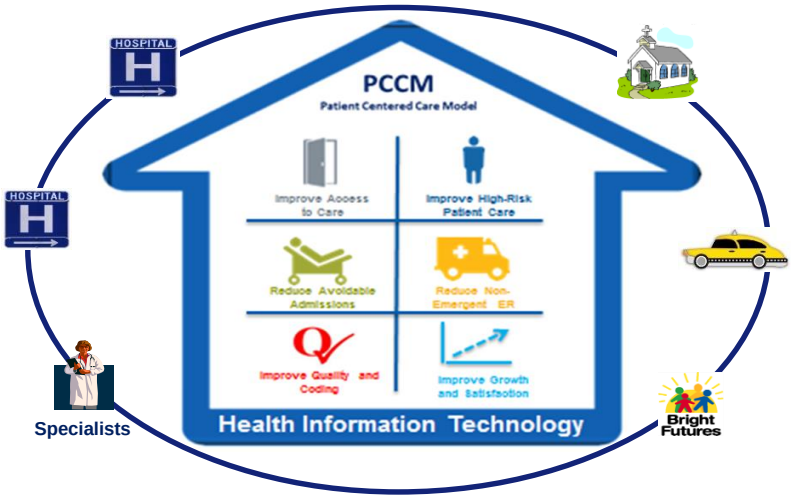
Our Operating Model: Provider-Based Population Health

- 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

Avoidable Inpatient	Non-Emergent ER	Site of Service	Pharmacy Management	Radiology Management
55%	20%	15%	5%	5%

Gross Benefit Contribution

Focus Area

Core revenue levers

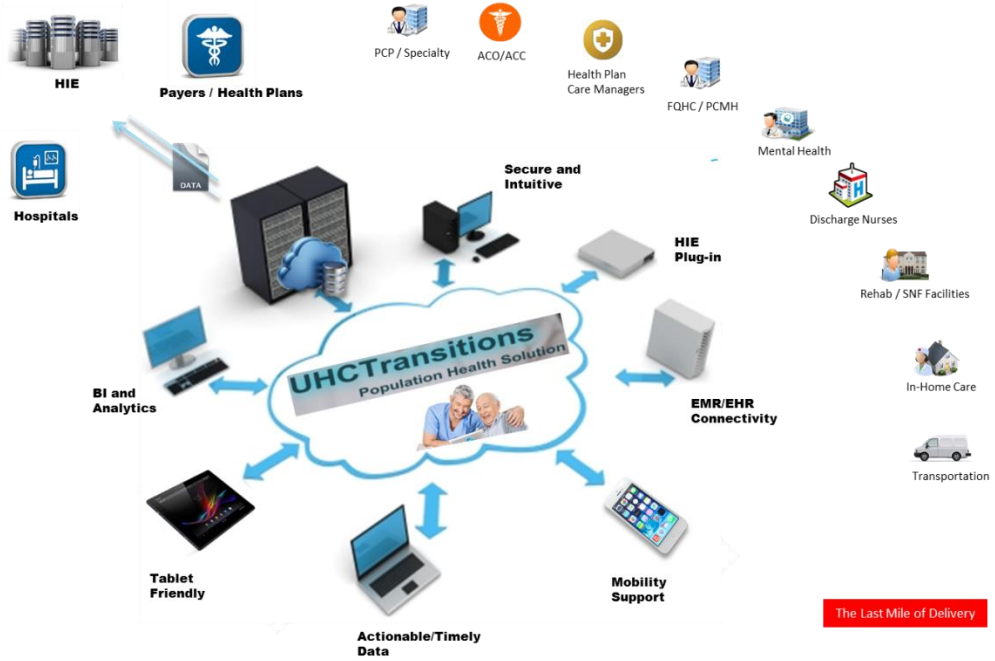
Accurate Diagnostic Coding	Quality Incentives	Growth / Retention
50%	30%	20%

Gross Benefit Contribution

Focus Area

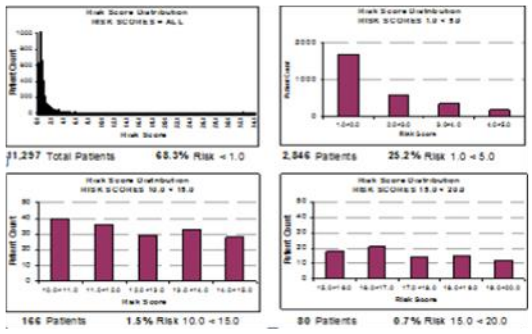
Engaging through the Continuum of Care

Technology & Data + Practice-Based Resources

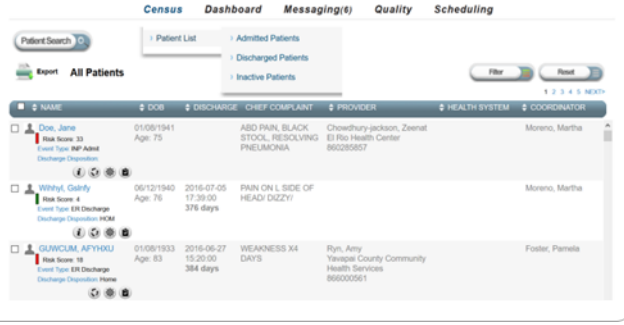


Actionable Data to Support Six Critical Pillars

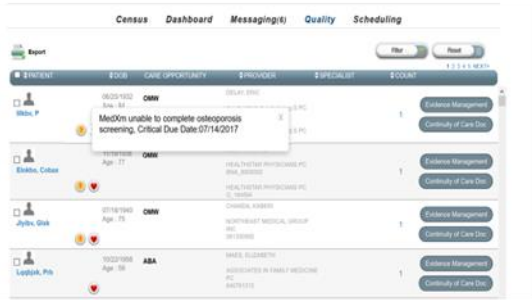
Process begins with our Provider-based "attributed" population risk profile



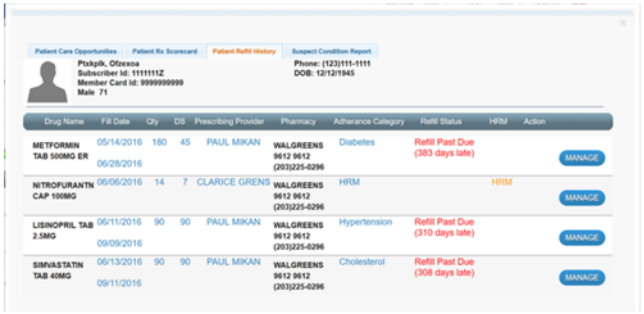
Care Transitions link Hospitals to Practices using ER & IP Notifications



Our Registry Provides Patient Profiles with Actionable Care Opportunities

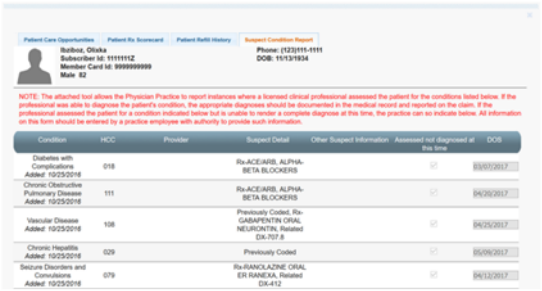


Medication Adherence notifications alert the need to refill member prescriptions

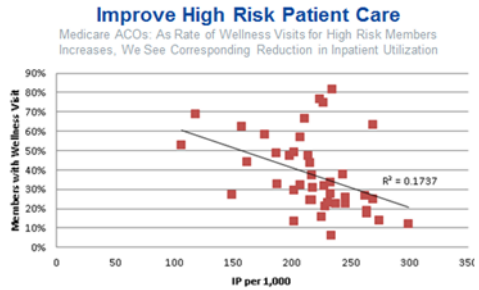


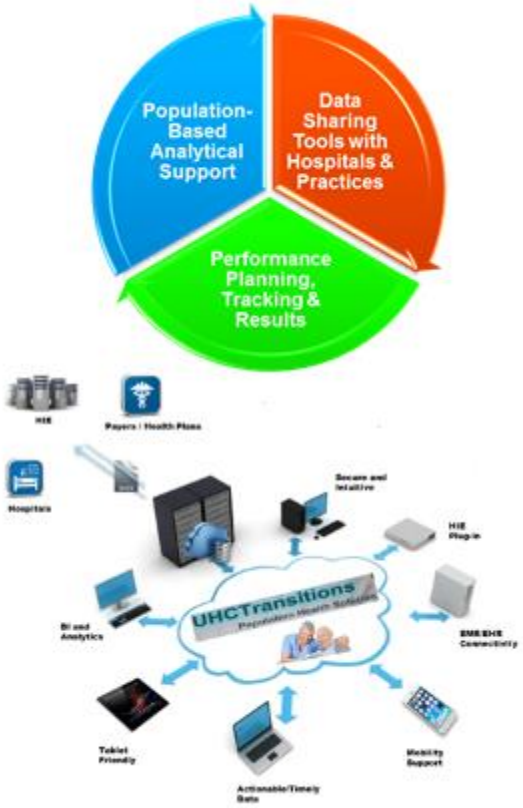
Actionable Data to Support Six Critical Pillars

The Member Assessment tool provides Suspect Lists for Correct Coding

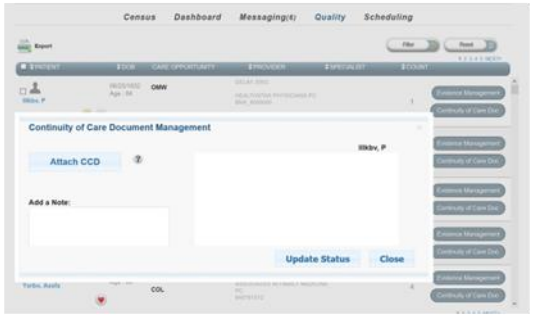


Performance Tracking results shared monthly with Partnering Organizations

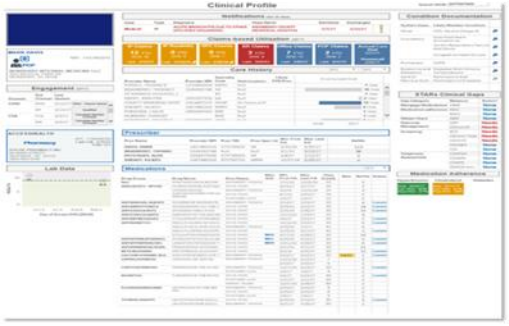




CCD & HL/7 Interchange allows for bi-directional data sharing with providers



Complete Member Profiles provide a view of each members care team & history



Navigating Data Exchange Capabilities

Daily admit and discharge alerts

Configurable, workflow-based transitional care

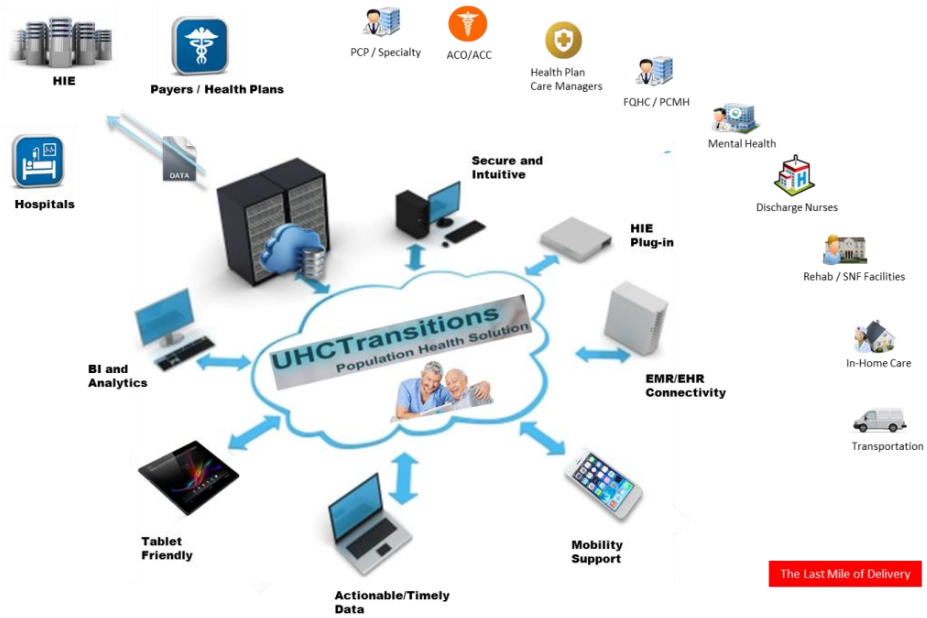
Enhanced Part D (Rx) Measures and Suspect Conditions

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



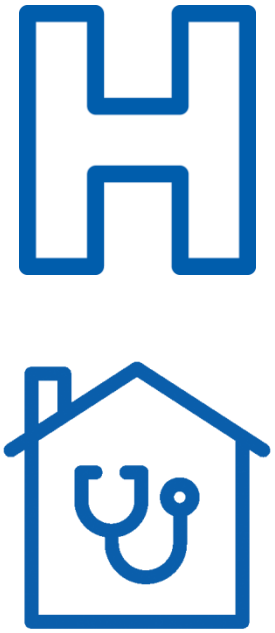
About SoFHA: Patients First, in All We Do

- 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

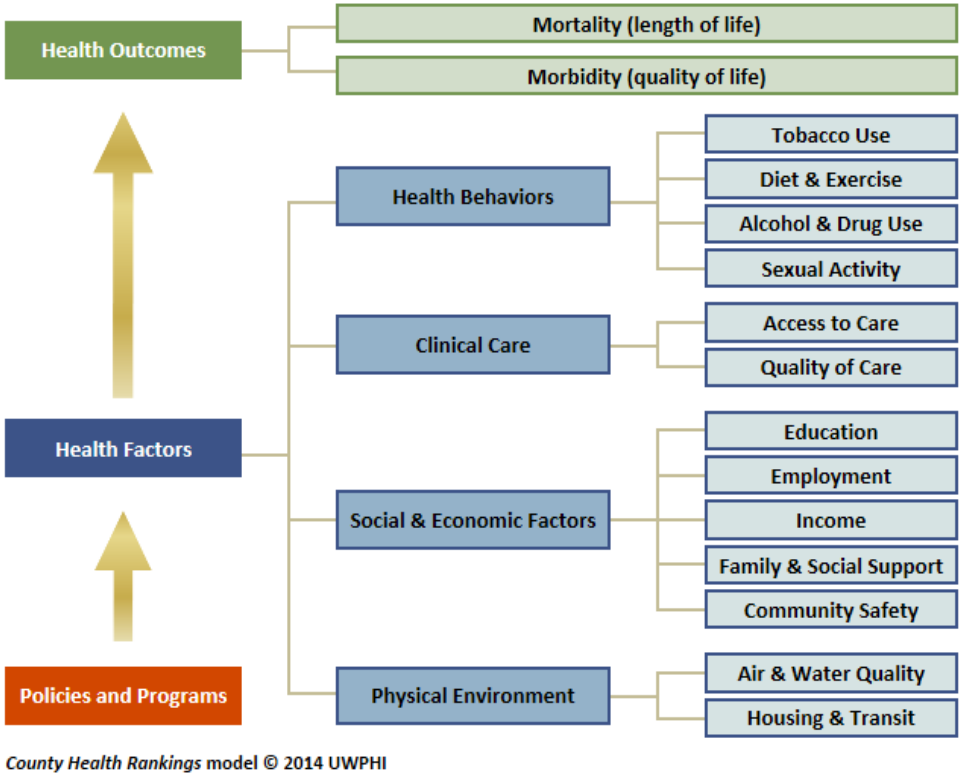
UHC-SoFHA Partnership: At-Risk Patients

- 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

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