



Advancing High Performance Health

AMGA Member Best Practices

***Connecting Clinical Care to
Social Needs: How Lightbeam
Health Solutions Enables
Augusta Health to Improve
Health Care in Their Community***

webinar

Connecting Clinical Care to Social Needs: How Lightbeam Health Solutions Enables Augusta Health to Improve Health Care in Their Community

Clint Merritt, M.D., Chief Clinical Officer for Population Health, Augusta Health

Christine DiNoia, B.S.N., R.N., Director of Clinical Transformation, Lightbeam Health Solutions

Webinar Summary, May 4, 2022

With the shift from traditional fee-for-service health care to the value-based model, healthcare systems need to focus on improving patient outcomes, improving the patient experience, and reducing unnecessary costs. Lightbeam Health Solutions eases this transition by providing innovative technology solutions, experienced advisors, and marketplace partners for Accountable Care Organizations (ACOs), payers, provider groups, health systems and other healthcare organizations. Dr. Clint Merritt of Augusta Health and Lightbeam's Christine DiNoia discussed how Augusta has been implementing Lightbeam technologies and services to reduce costs, improve quality, and engage clinicians as they navigate the sometimes very complex value-based care model.

Finding New Ways to Reach Value-Based Care Goals

Augusta Health is a nonprofit community health system in Fishersville, Virginia, located in the central Shenandoah Valley. It comprises a hospital with 275 beds and an ACO, Augusta Care Partners. Augusta Health's ACO is a clinically integrated network of 290 providers managing care for 17,000 lives through various value-based contracts.

Merritt, an internal medicine physician, is the Chief Clinical Officer for Population Health at Augusta Health, leading the system's efforts to improve access to care for underserved community members, reduce local health disparities, and lead coordination and clinical programming for Augusta Health's ACO. Merritt said Augusta's mission "is to be a national model for community-based health care," and the population health team that he leads supports four strategies that are key to fulfilling that mission:

1. Coordinating unrivaled care that advances Augusta's ability to manage complex patients across clinical sites and with community partners
2. Improving the health of the entire community

"We know we have a disparity. We are setting organizational priorities tied to health equity and reducing health disparities. Part of the process of doing health disparities work well is engaging your community partners."

— **Clint Merritt, M.D., Chief Clinical Officer for Population Health, Augusta Health**



Merritt



DiNoia

Figure 1: Six Tactics in Augusta Health's Population Health Work



- 3. Focusing on community partnerships
- 4. Expanding value contracts as part of Augusta's financial strength

Each year, the population health team looks at six specific tactics and asks, "What's going to be our focus area? What are our projects? What are we going to grow and improve on?" The six tactics (see Figure 1), Dr. Merritt explained, include value-based work, social determinants of health work, health equity work, developing community partnerships, coordinating care, and enhancing measurement and the quality of data to support this work. The purpose of these six tactics is "to know that there's a good return on the work, and to know that we're improving the community's health in ways that we intended."

"It was clear two years ago," said Merritt, "that in our journey in value-based care, we needed an IT infrastructure, a population health management platform to be able to bring these pieces together." His team looked at all the various population health management platforms available and picked three to bring to

Augusta's campus to connect with frontline teams, go through use cases, and meet with data analytics personnel.

"And through that process, we felt really strongly that Lightbeam had a few things that were special and why we selected them for the population platform. Among them is this integration that's really tight ... where we have our data analytics, but we also have care management programming tied to cohorts of patients and to chronic disease management. And that was a really strong selling point. The other is the professional team that Lightbeam brings with their platform to collaborate on programming and on focus areas and learning analytics."

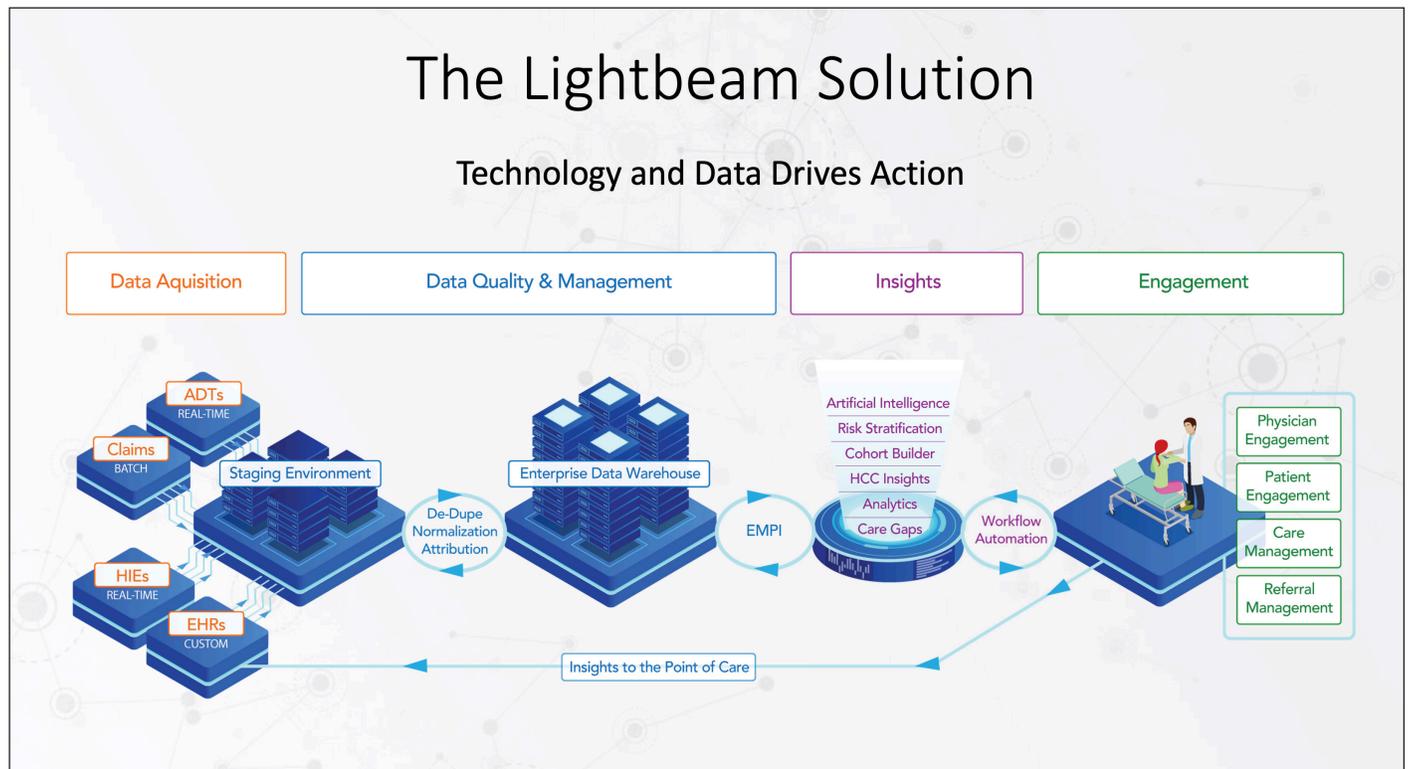
DiNoia is a nurse with 30 years of experience who is now Director of Clinical Transformation and a Clinical Transformation Advisor at Lightbeam Health Solutions. She explained that Lightbeam offers "a complete and comprehensive approach to population health management for physicians, payers, employers, care managers, and others. The technology helps providers

deliver the right care at the right time.” (See Figure 2.) The platform aggregates data from multiple different sources, such as clinical, claims, lab data, and ADT feeds. From there, powerful analytic tools identify target cohorts, which includes high-risk patients, care gaps, and potential HCC coding opportunities. Lightbeam’s population health advisors provide deep insights into cost savings opportunities. They monitor adopted initiatives and relay data insights, while the clinical transformation advisors consult with clients, make recommendations, streamline implementation, and automate care management workflows to address the population’s immediate and long-term needs. “And that combination of the development, coordination, and monitoring of the cohort,” says DiNoia, “simplifies all the efforts for Augusta Health to achieve the Triple Aim. Lightbeam can also provide additional care management staff, CareSignal (Deviceless Remote Patient Monitoring®), and access to marketplace vendor partners who provide additional services.”

“When the clinical transformation and population health advisors met with Augusta,” said DiNoia, “we started with the discovery session, which helped us to identify the current initiatives. Our population health advisors identified insights and opportunities, and from there we prioritized the programs that they wanted to adopt. Through collaboration, we designed efficient clinical programs that incorporated their current workflows. We trained Augusta’s team and deployed the programs to their care managers. We are currently in the ‘monitor and refine’ phase, where we are monitoring for progress, reviewing the workflows for any additional efficiencies, and adding additional care team members. Most notably, Augusta recently added community health workers and social workers. So, we built out workflows for those team members.”

DiNoia noted two Lightbeam tools were particularly helpful to Augusta. The Cohort Builder can apply any number of filters to identify subsets of the population that may have higher needs and/or higher cost.

Figure 2: The Lightbeam Solution



The Cohort Builder can also automate tasks, such as enrolling or discharging patients from the cohort, assigning a care manager or a care team, and assigning a care plan and the activities required to successfully complete the program. The ADT Insights Dashboard provides near real-time ADT information, updating about every 15 minutes. This helps with managing admission, discharge, and transfer transitions. “Patient care plans can be put into motion immediately. Providers can work right from this dashboard to access care plans, and they can even mark off the patient if they have acknowledged the information,” which eases workload and provides visibility to the other teams that may be working with this patient.

When Merritt’s team started looking toward goals for 2022 in the Fall of 2021, Lightbeam highlighted what they call 12 levers for value-based care, which are 12 focus areas geared toward specific chronic diseases or high-complexity patients. They looked at Augusta’s patient population in 2021 and showed how many patients were in each of the 12 groups. In working with ACOs and seeing successful initiatives, Lightbeam was able to show Augusta the financial gain that could result from a 10% improvement in certain metrics. Augusta picked five of the “levers” to be the focus for 2022:

1. Connection through annual wellness visits to primary care
2. Complexity capture for HCC coding
3. A focus on high emergency department (ED) utilizers
4. A chronic condition/high complexity group
5. Care transitions management work

To both clarify the collaboration process and to show how successful it’s been, Merritt shared two programs: one that has been in place and another that is currently in development.

The High Complexity Cohort

Augusta’s high-complexity ACO patient cohort is defined by two factors: a Johns Hopkins ACG score of three or higher and a care coordination risk measure. The Hopkins ACG scoring system has a long clinical and research history as a validated scoring tool for patient complexity to predict hospitalizations. Lightbeam’s care coordination risk measure relates to patients who are seeing many specialists but have very few primary care visits. As Merritt noted, the likelihood of coordinating across multiple clinical sites and clinical teams in that situation could be at risk. Putting those two measures together, 167 patients were identified for the high-complexity cohort at the end of 2021.

“The per-member-per-month (PMPM) spend for this cohort is eight times higher than the average Medicare patient in our ACO,” said Merritt. “Their hospital admission rate is eight times higher. Their ED visit rate also comparably eight times higher. Admission/readmission percentage is double our Medicare cohort. Their annual wellness visits were significantly lower than average at 42%.” Augusta decided to create some programming tied to improving care for this cohort of patients. Using the Cohort Builder and care management program, Lightbeam created a series of assessments so that patients in this cohort are assigned to one of Augusta’s care management teams. The teams assess patient needs, such as medications and follow-up plans, personal goal setting, and social determinants of health screening. Then, the care management program has a sequence of follow-ups and check-ins to meet targets and goals.

Regarding assessing patient needs, Merritt noted, “We need to be much better at screening for social determinants of health in a structured way and building our connections in the community to meet those needs well.” A state group in Virginia has

recommended the PRAPARE instruments, which Augusta has adopted, and which is embedded in Lightbeam. The PRAPARE tool addresses education, employment status, food insecurity, housing insecurity, and incarceration history. Augusta's care management team works with patients to complete the PRAPARE assessment. As a result, said Merritt, "we have a lot more analytics on where the social needs are in patients in our community."

Connected to the social determinants screening is the ability to make referrals to community agencies when needs are identified. In 2021, Virginia provided funding support for health systems that adopted Unite Virginia, a version of the Unite U.S. platform, which is a platform shared by health systems and community agencies. It allows either partner to enroll patients and make referrals for specific social needs and be able to see that those referrals are completed.

How it works: A patient connects with a care manager, who conducts the social determinants of health assessment. If a need is identified—for example, food insecurity—the care manager gets consent from the patient to use Lightbeam as the community referral platform. The care manager logs in and makes a referral to one of Augusta's partner food banks, which then provides the necessary services. If the food bank team later finds the patient has a need for transportation services, they can continue to make referrals through the Unite Virginia platform.

Augusta went live with Unite Virginia in July of 2021 and brought 18 community partners onto Lightbeam at the same time, creating a starter network.

Another valuable care coordination tool for this high-complexity cohort is what Augusta calls "The Hub," which is an interprofessional case conference. Merritt compared it to a tumor board. Basically, any professional member of a care team can request a

Hub call to address a patient issue—for example, when the patient is having a hard time staying out of the hospital or has a lot of ED visits. Merritt explained, "We'll invite providers connected to the patient. So, their primary care might be the psychiatrist, the cardiologist, etc. We'll invite the social worker or case manager that's helping the patient. If there's a home health nurse, if there's a member from a community organization that's having a meaningful role in their health, we invite them and we have a structured 25-minute case conference where we hear from the team about what's going on. The goal is to walk away from the Hub with two or three new steps to coordinate and enhance the care for the patient. And then we have a structured documentation that goes in our EMR: 'Patient had a care coordination conference through the Hub. Here's the plan, here's who attended.' This is one of the tools that we started right at the beginning of the pandemic, and we're enhancing this year as a care coordination method."

In addition to all the above, the high-complexity cohort also has a dedicated work group of physicians, physician's assistants, medical professionals, and other professional team members, as well as representatives from community-based organizations. The work group looks at how to better coordinate care for this group of patients and how to better support patients and their families. To encourage engagement from physicians in the network, Augusta ties success of the network in a shared savings program to work group compensation. "So, if we succeed in 2022 with shared savings, which we anticipate we will, work group members can receive compensation for their participation. And we set up the work groups intentionally to lead toward our success in the shared savings contract. We currently have 35 providers signed up in our various work groups along with a lot of the other professional team working on this."

Figure 3: Quarterly Performance Tracking



“What we always want to be doing,” Merritt said, “is checking back. Are we actually helping people with all this programing?” Individual stories relayed by case managers suggest that is the case. For example, one Augusta patient, a 60-year-old female, was receiving chemotherapy treatments for cancer every few weeks. “And in our connection with her,” Merritt said, “she shared a lot of challenges.... She was going regularly to lots of appointments at her infusion centers and couldn’t pay for the gas to make it to those cancer treatments. She was having trouble with food insecurity and was getting notices from the utility company that because she couldn’t pay for her power bills, she was at risk of having her electricity cut off. And then she needed some help getting to a dentist and worried about the cost of that.” The patient was overwhelmed. Using the screening, the VA Unite platform, and collaborating with the local agencies, the care team was able to secure the patient a gas allowance to make it to her treatments; found local, affordable dental services for her; secured assistance for her utility bills; and coordinated getting the patient to a needed eye appointment. “So, our sense from the individual

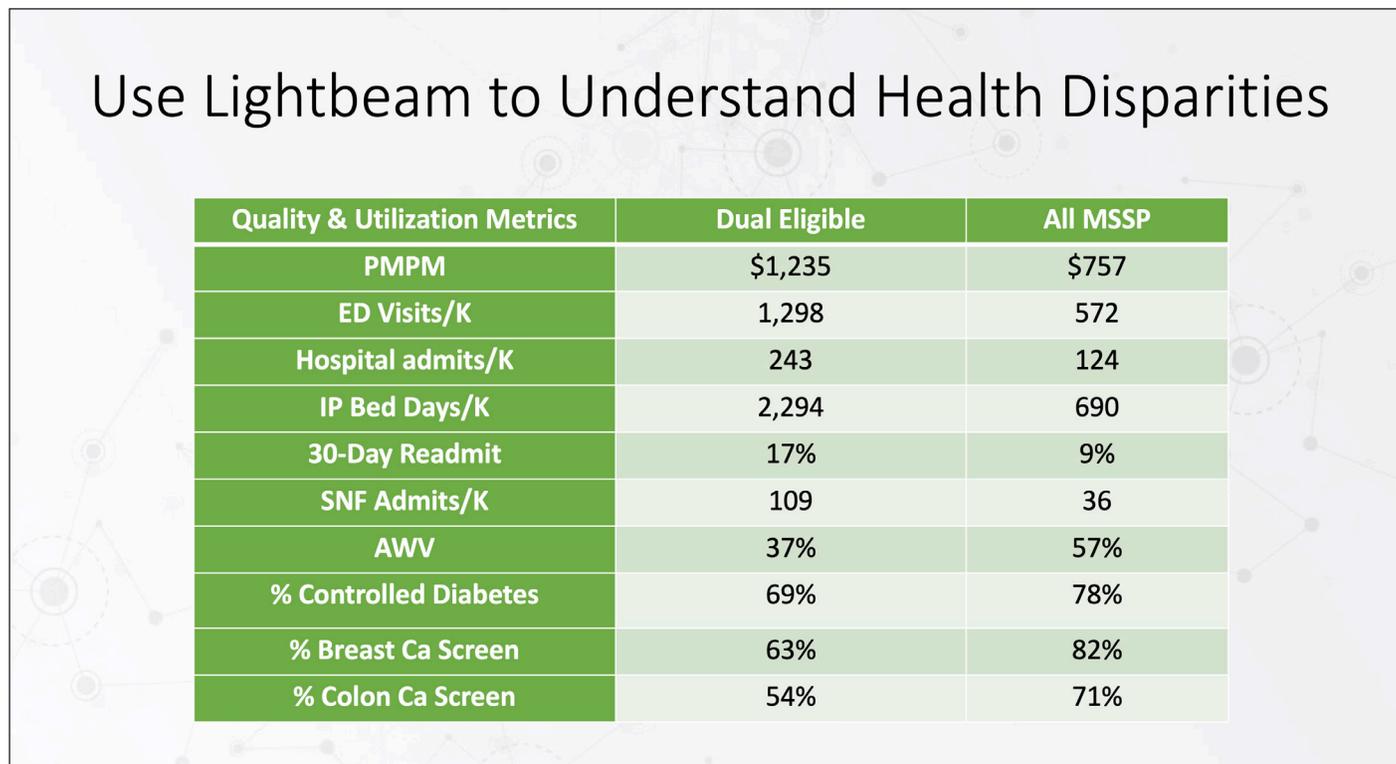
stories,” said Merritt, “is that the programing that we’re putting in place, the structure we have is meaningful.”

Lightbeam’s data analytics back up that conclusion. To help Augusta track whether the high-risk cohort programs and care management efforts are producing cost savings, Lightbeam provides a Cohort Trending Report (see Figure 3). This example shows that for the first 90 patients enrolled in this high-risk cohort, the program is averaging approximately a 35% decrease in overall spend, a 34% decrease in inpatient admissions, and 27% decrease in ED visits.

Addressing Healthcare Inequalities

In 2021, Augusta and Lightbeam identified three groups in the community with significant barriers to accessing medical care: dual eligible (Medicaid and Medicare) community members (see Figure 4), Latino community members, and homeless persons. With the intention to set annual operational goals tied to health equity, Merritt’s team set two goals. First, to have 500 patients receive a PRAPARE

Figure 4: Health Disparities in Dual Eligible Community Members



screening for social determinants of health needs in 2022. Second, to double the number of Latino community members in Augusta’s primary service area who are receiving primary care, for a new total of 598 patients.

To help meet these goals, Augusta decided to launch a mobile clinic that will provide care at a community center serving the local Latino community, three homeless shelters, and two of the subsidized housing neighborhoods in the area. Merritt noted that the mobile clinic model has shown much success at reducing barriers tied to language, transportation, mobility, poverty, and immigration status. Augusta has built a broad professional team ready to provide screening for social determinants, make referrals to services through Unite Virginia, get financial aid, and assist with Medicaid enrollment. The provider team includes primary care doctors, hospitalists, and urgent care doctors. Community support is also key. “We know we have a disparity,”

said Merritt. “We are setting organizational priorities tied to health equity and reducing health disparities. Part of the process of doing health disparities work well is engaging your community partners.” One example of this is Augusta’s Latino Health Council. It includes a lot of engaged participants from the community, meeting every couple of months to discuss how Augusta can meaningfully improve the health status of Spanish-speaking community members. “That group is helping us survey the local community, guiding the model for how we develop primary care, and they’re also at a lot of our events promoting health care for the Latino community.”

Because measuring the value of any program requires metrics, Augusta expects a measurement framework with a strong health equity component that will look for measurable reductions in disparities tied to primary care access, control of diabetes and hypertension, breast cancer screening, and avoidable ED visits. Merritt said they are also “working to tie

the program to cost savings, to success in value contracts, and to prove a return on investment for the work.” They believe the mobile clinic model “has several streams to it that lower uncompensated care. This model is to shift catastrophic care toward disease management and prevention. We will increase clinic visits, screenings and referrals, primary care connection, and Medicaid enrollment. And many of the patients who we will be helping will be in value contracts, where we’ll have more detailed analytics on their utilization, quality outcomes, and detailed costs.”

Learning and Growing

Both DiNoia and Merritt noted that the Centers for Medicare & Medicaid Services (CMS) is placing health equity as a key element in value-based work. CMS’ strategic plan includes having all Medicare beneficiaries under some sort of value contract by 2030. “We believe that this will continue to grow as a body of work,” said Merritt, “and we also think it’s

at the heart of meaningfully improving the care of our communities. Health equity is really changing how we understand success.” He noted that Augusta seemed to be doing “really well” on breast and colon cancer screening, but the data showed that dual eligible patients were 15 to 20 points lower in participating in cancer screening than other patients in the ACO. Merritt said, “We really can’t know how well we’re doing to improve the health of our community without understanding who isn’t doing well. So, it is meaningfully changing how we understand success.”

Merritt described the process as a journey, and he can see the evolution. “There are more providers in our network asking questions about the work we are doing and are interested in the programing we’re trying. When we reach out and say, hey, can we talk about, for example, avoidable ED visits for urinary tract infections or something like that, there is more interest in understanding and seeing a growing role for that.”



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One Prince Street
Alexandria, VA 22314-3318

amga.org