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

May 4, 2022
Webinar Housekeeping

• Today’s presentation is being recorded - Links to the presentation and recording will be emailed to all participants and be available on AMGA’s web site.

• All lines have been placed on mute to prevent any background noise.

• At any time during the presentation, please enter questions or comments in the Q&A or Chat section of the system and our panelists will address them at the end.
Connecting Clinical Care to Social Needs

How Lightbeam Health Enables Augusta Health to Improve Healthcare in their Community
Agenda & Presenters

- Value Based Care
- Who We Are
- Why We Are Here
- Case Studies
- Tracking Results & ROI
- Future Commitment & Challenges
- Q & A
- AMGA High Performing Physician Enterprise

Clint Merritt, MD
Chief Clinical Officer for Population Health
Augusta

Christine DiNoia, BSN, RN
Director of Clinical Programs
Lightbeam
Value-Based Care is the Framework for Transformation

Challenges

- Complexity – the right care for the right patient
- Different EMRs
- Unaligned quality measures from many unique programs
- Limited understanding by providers & the public

We are committed to outstanding coordination of care-- the right services, at the right times and locations-- across our system and in our community.
Who We Are

• Non-profit Community Health System
• Central Shenandoah Valley
• 275 bed hospital
• Augusta Care Partners
  • ACO of Augusta Health
  • 290 providers in network
  • 17,000 full contract lives
Augusta Health will be a national model for community-based health care:

1. Unrivaled coordinated care of the highest quality
2. Improving the health of our community
3. A focus on community partnerships
4. Expanding value contracts as part of our financial strength
Six Tactics in Our Population Health Work

1. **SDoH**
   - Upstream focus on the social factors that determine much of our health status

2. **Health Equity**
   - Everyone has an equal opportunity to live the healthiest life possible

3. **Partnerships**
   - Strong partnerships between Augusta Health, clinical partners, community-based organizations and agencies

4. **Coordinated Care**
   - Matching the right services to the right patient, at the right time and location

5. **Enhancing Measurement**
   - Strengthening clinical and non-clinical data sets to provide direction and analyze program efficacy

6. **Value & Viability**
   - Better care outcomes at lower cost, finding ROI distinct from FFS
Choosing A PHM Platform

• Evaluated our needs for today and the future
• Researched vendors, narrowed to several
• Developed use cases
• Connected with other ACOs
• Considered the partnering professional team along with IT elements
The Lightbeam Solution

Technology and Data Drives Action
Our Services

Lightbeam's services provide the technology and resources to the people behind transformative population health efforts.

- Data Services
- Advisory Services
- Delivery Services
- Clinical Transformation Services
- Care Team Extension Services
Augusta Health Engagement

Identify

Prioritize

Refine

Design

Monitor

Deploy
SEGMENTING PATIENTS FOR PERSONALIZED CARE

Lightbeam’s Cohort Builder automates clinical workflows by serving as the conduit between the EDW, care management, and patient engagement. Benefits include:

• Ability to divide populations into subgroups by attributes, such as risk, cost, condition, and event (i.e., admission or discharge)
• Ability to initiate complex queries against patient information with just a few clicks
## ADT Insights

### Care Management

#### ADT Insights

**Hierarchy**
- Care Partner HealthCare Partners

**Provider**
- Type to find a provider

**Care Manager**
- Search... (0 of 73 selected)

**Patient Status**
- Active (NoClaims), Active (WithClaims)

#### Patient Events

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#### Active Daily Count

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### Patient Events

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The Structural Elements

- Population Health Professional Team
- Analytics & Care Management IT Platform
- An Engaged Physician Network
- Standard SDOH Screening Tool
- Community Referral Platform for Social Services
- Value Contracts
- Many Community Partnerships
Getting Started – Where Do We Focus This Year?

Lightbeam’s 12 Levers for Value-Based Care

✓ AWV Compliance
✓ HCC Recapture Rate
✓ High ED Utilizers
✓ Chronic Conditions + ACG 3
✓ Care Transition management
✓ ESRD Classification
✓ High Risk CHF
✓ High Risk COPD
✓ ACG High Risk Score 4
✓ Behavioral Health Management
✓ Diabetes management
✓ Focused quality initiative
Case 1

The High-Complexity ACO Patient Cohort
Selecting a Cohort
Hopkins ACG Score 3+ & High Care Coordination Risk

<table>
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<tr>
<th>2021 Baseline Finance &amp; Utilization (167 patients)</th>
<th>High Complexity Cohort</th>
<th>All MSSP Patients</th>
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<td>ACG Average Risk</td>
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<td>Hospital Admit Rate</td>
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<td>ED visit Rate</td>
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<td>572</td>
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<td>SNF Admit Rate</td>
<td>246</td>
<td>36</td>
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<td>30-d Readmit %</td>
<td>18%</td>
<td>9%</td>
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<tr>
<td>AWV in last 12 months</td>
<td>42%</td>
<td>57%</td>
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FULLY INTEGRATED CARE MANAGEMENT

Lightbeam’s integrated care management solution brings clarity that improves relationships and outcomes.

- Access to clinical data in real-time, simplifying the processes of retrieving patient records from varying locations
- Automatic distribution of qualified members to the appropriate care management resources with applicable clinical intervention prescribed
- Evidence-based, patient-specific care plans provide the rules, structure and content needed to drive results and improve the lives of patients
Use a Standard SDOH Screening Tool

<table>
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<th>SDoH Screening</th>
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<tr>
<td>Race &amp; Ethnicity</td>
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<tr>
<td>Employment</td>
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<td>Housing Status</td>
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<td>Transportation</td>
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<td>Personal Stress</td>
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<tr>
<td>Safety</td>
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<tr>
<td>Incarceration History</td>
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<tr>
<td>Veteran Status</td>
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Make Referrals for Social Services Through a Community-Wide Referral Platform

- Client
- Care Manager
- Additional Needs Identified
- Food Assistance Provider
- Transportation Provider
Engage the Physician Network

• 7 provider workgroups in 2022 working on value-based care
  • 1 is focused on the high complexity patient cohort:
    • How do we coordinate care better for this group of patients?
    • How can we support patients and families, so we lengthen the time living independently at home?

• Compensation for workgroup participation is tied to success of the ACO in the MSSP contract
• 35 providers have signed up for workgroups in 2022
Coordinate the Care in New Ways

- Inter-professional case conferences
- Virtual, 25 minutes
- Structured format
- Include key community agencies
- Goal: a shared understanding of a coordinated plan of care
Learn from the Individual Stories

60-year-old female with cancer who is receiving treatments every 3 weeks

Challenges:
- Had difficulty paying for gas to get to her cancer treatments
- Needed to see a dentist
- Had food insecurity
- On the verge of losing her electricity at home for non-payment
- Felt overwhelmed by her many tasks and needs
Learn from the Individual Stories

Case management, Unite Us, and local agencies achieved the following:

• Secured a gas allowance for the patient
• Found dental care that was affordable
• Secured utility assistance
• Coordinated help with getting an eye appointment
Clinical Transformation

Diagram:
- PCP
- PATIENT
- Centralized Care Manager
- Decentralized Care Teams
- Patient Goals
- Barriers (Patient Assessments)
- Interventions (Care Plans, Steps, Notifications)
- Visits (Discharge Planning)
- Outcomes (Analytics)
- Cohorts (Risk Stratification, ADT, TOC)
- Risk Adjustment (HCC Coding)
- Care Gaps (Measures)
- Chronic Conditions (Unaddressed Gaps)
Track Our Performance Quarterly

<table>
<thead>
<tr>
<th>Avg Total Cost</th>
<th>Avg Inp Admits*</th>
<th>Avg ER Visits*</th>
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<tr>
<td>Before Enrollment</td>
<td>$3,542</td>
<td>0.09</td>
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<tr>
<td>After Enrollment</td>
<td>$2,298</td>
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<tr>
<td>Eligible/Excluded Patients</td>
<td>$2,895</td>
<td>0.04</td>
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-35% ▼

-34% ▼

-27% ▼
Check the Work Against Our Key Tactics

6 Pop Health Tactics

- ✓ SDOH Work
- ✓ Health Equity
- ✓ Care Coordination
- ✓ Partnerships
- ✓ Enhancing Measurement
- ✓ Value & Viability
Case 2

The Mobile Clinic
Identify Health Disparities in Our Community

3 local groups have disparities tied to access barriers

Dual eligible population

Latino community members

Homeless persons
# Use Lightbeam to Understand Health Disparities

<table>
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<tr>
<th>Quality &amp; Utilization Metrics</th>
<th>Dual Eligible</th>
<th>All MSSP</th>
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<td>PMPM</td>
<td>$1,235</td>
<td>$757</td>
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<td>ED Visits/K</td>
<td>1,298</td>
<td>572</td>
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<td>Hospital admits/K</td>
<td>243</td>
<td>124</td>
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<td>IP Bed Days/K</td>
<td>2,294</td>
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<td>30-Day Readmit</td>
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<td>109</td>
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<td>AWV</td>
<td>37%</td>
<td>57%</td>
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<td>% Controlled Diabetes</td>
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<td>% Breast Ca Screen</td>
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<td>% Colon Ca Screen</td>
<td>54%</td>
<td>71%</td>
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Set Annual Goals Tied to Health Equity

2022 Operational Performance Goals

- SDOH Screenings Using PRAPARE: 5,000 patients
- Latino Community Members in primary service area receiving Primary Care: 598 patients

“We commit to improve the health of our community... by reaching deeper into the community to address the underlying reasons for health disparities.”

AH Board of Directors Commitment on Health Disparities
Engage our Community Partners

Helping to provide access to care was #1 priority. We did this by:

- Surveying the local community on health needs
- Guiding our model for enhancing connection to primary care services
- Providing education, promotion of events & volunteer

Latino Community Health Council

<table>
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<th>Promotores de Salud</th>
<th>Office of New Americans</th>
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<td>Molina Healthcare</td>
<td>Augusta Health</td>
<td>Engaged community volunteers</td>
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Pilot a Care Delivery Model that Lowers Access Barriers

The Augusta Health Mobile Clinic

Where

- Local Latino Community Center
- 3 Homeless Shelters
- 2 Subsidized Housing Neighborhoods

Timing

- Recurring schedule – same days of week and times of day

Address barriers tied to:

- Language
- Transportation
- Mobility
- Poverty
- Immigration status
# Build the Professional Team

**Social Care**
- Case Manager
- Social work
- Community Health Worker
- Medicaid Enrollment Services
- Financial Aid Services

**Clinical Care**
- 8 providers forming the mobile clinic provider team
- 2 Nurses
- Health Educators
- Pharmacy Support

**Program Support**
- IT
- Finance
- Marketing
- Compliance
- Interpreter Services
- Practice Management
Measurement Framework Focused on Health Equity

The 3 cohorts served by The Mobile Clinic will reduce measurable disparities tied to:

• Primary care access
• Diabetes control
• HTN control
• Breast cancer screening
• Avoidable ED visits
Tie the Work to Cost Savings & Value Contracts

- Lower uncompensated care
- Lower catastrophic care through better disease management
- Increase overall clinic visits, screenings and referrals
- Increase primary care connection to Augusta Health
- Increase Medicaid enrollment
- For patients in value contracts, we will have detailed cost, utilization and care quality outcomes
Check the Work Against our Key Tactics

The Mobile Clinic

6 Pop Health Tactics

✓ SDOH Work
✓ Health Equity
✓ Care Coordination
✓ Partnerships
✓ Enhancing Measurement
✓ Value & Viability
What Are We Learning?

Our Commitment & Challenges
For every decision being made, we’re asking ourselves, “How is this action advancing health equity?”

Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services
Health Equity is Changing How We Understand Success

Challenges:
- Measurement
- Community Listening
- Community Partners
- Education

Health disparities are fundamental to knowing if we are improving the health of our community.
Next Levels of Success in Community Health Tied to Health-Related Social Needs

Challenges:
- Standard Measurement
- Clinical Workflows
- Lots of Education
- The Community Network
- Incentives

We cannot achieve our community health mission without understanding and addressing health-related social needs.
Questions?
High Performing Physician Enterprise (HPPE)

Governance/Leadership
Clinical Outcomes
Operations
Value
Provider
Financial
Patient

In partnership with

23 Focus Areas – 130+ Indicators
A Collaborative Framework

Ongoing Support
Webinars / Community list-serve / Quarterly Benchmarking / White papers & articles

Shared Learning
In person meetings, paired with AMGA’s Annual Conference and IQL, dedicated to only HPPE participants

Insight into High Performance
A roadmap to galvanize your organization’s key leaders, providing focus and clarity on strategic initiatives
WEBINAR: The Seven Domains That Lead to High Performance

Wednesday, May 11 | 2:00 p.m. (ET)
Special Encore: Thursday, May 26 | 2:00 p.m. (ET)

Details on Measures of Each Domain
Financial and operational alignment in key performance areas, Identifying issues related to physician burnout and satisfaction, etc.

Early Findings / Lessons
Pilot groups from diverse organizations, including independent private practices, large integrated systems, and in-between

Clinical Care Indicators for High-Performance
Powered by Lightbeam Health Solutions, AMGA’s exclusive partner for analytics and population health management solutions

Register at AMGA.org
Thank you for joining us!