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

May 4, 2022

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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.

IQL

Innovation, Quality & Leadership Conference

September 29-October 1, 2022
Grapevine, Texas
amga.org/IQL22

Connecting Clinical Care to Social Needs

How Lightbeam Health Enables Augusta Health to Improve Healthcare in their Community


AMGA
Advancing High Performance Health


Lightbeam
Health Solutions

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

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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.

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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

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Augusta Health Journey 2025

Population Health team supports four of the primary strategies for Augusta Health

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

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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

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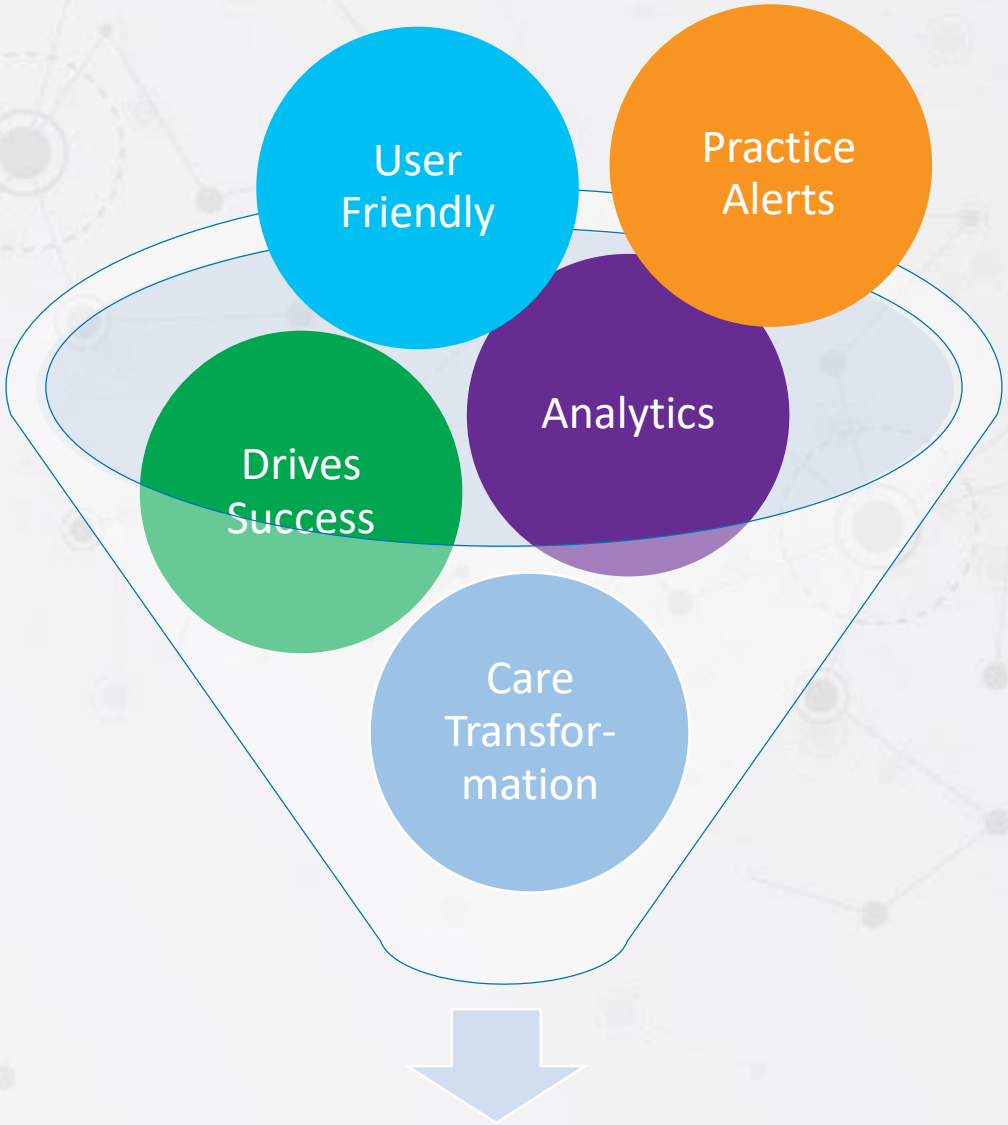
Choosing A PHM Platform

- 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



Population Health Platform

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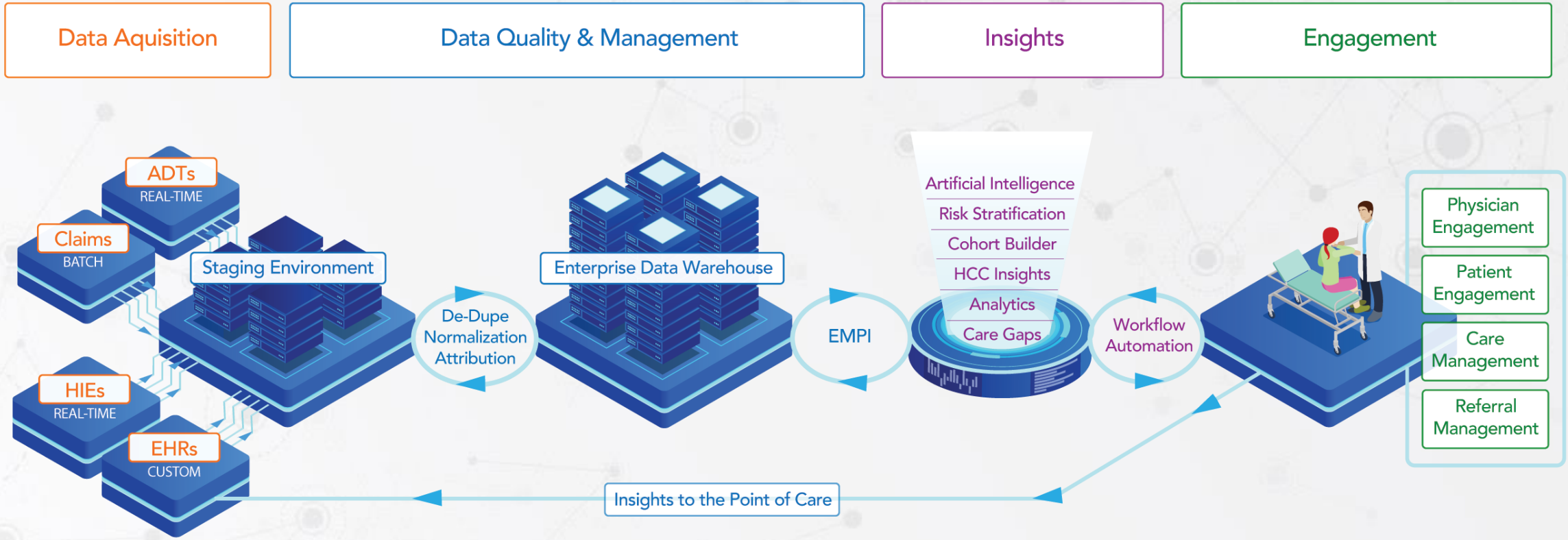
The Lightbeam Solution

Technology and Data Drives Action



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Our Services

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

Data Services

Delivery Services

Advisory Services

Clinical Transformation Services

Care Team Extension Services

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Augusta Health Engagement

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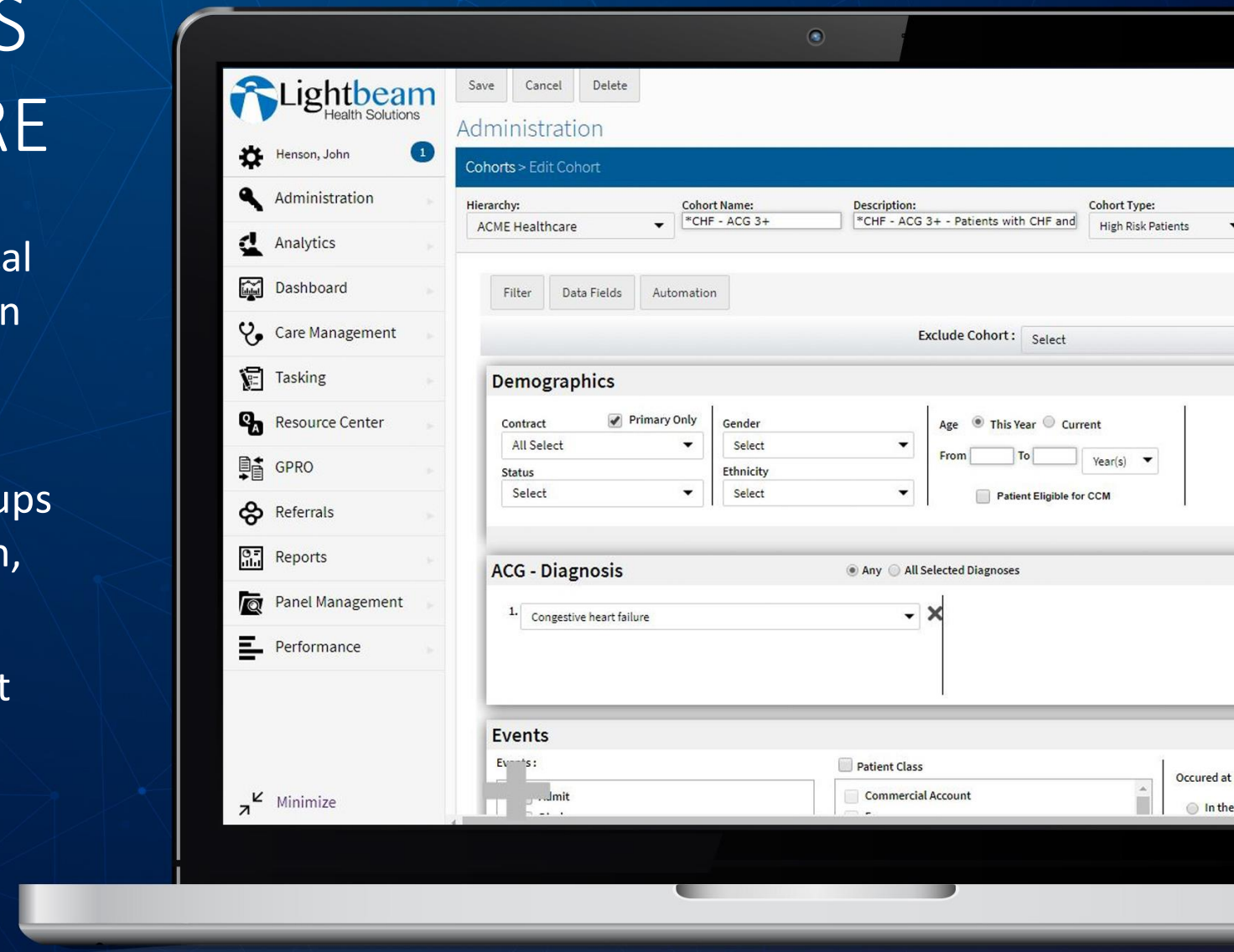
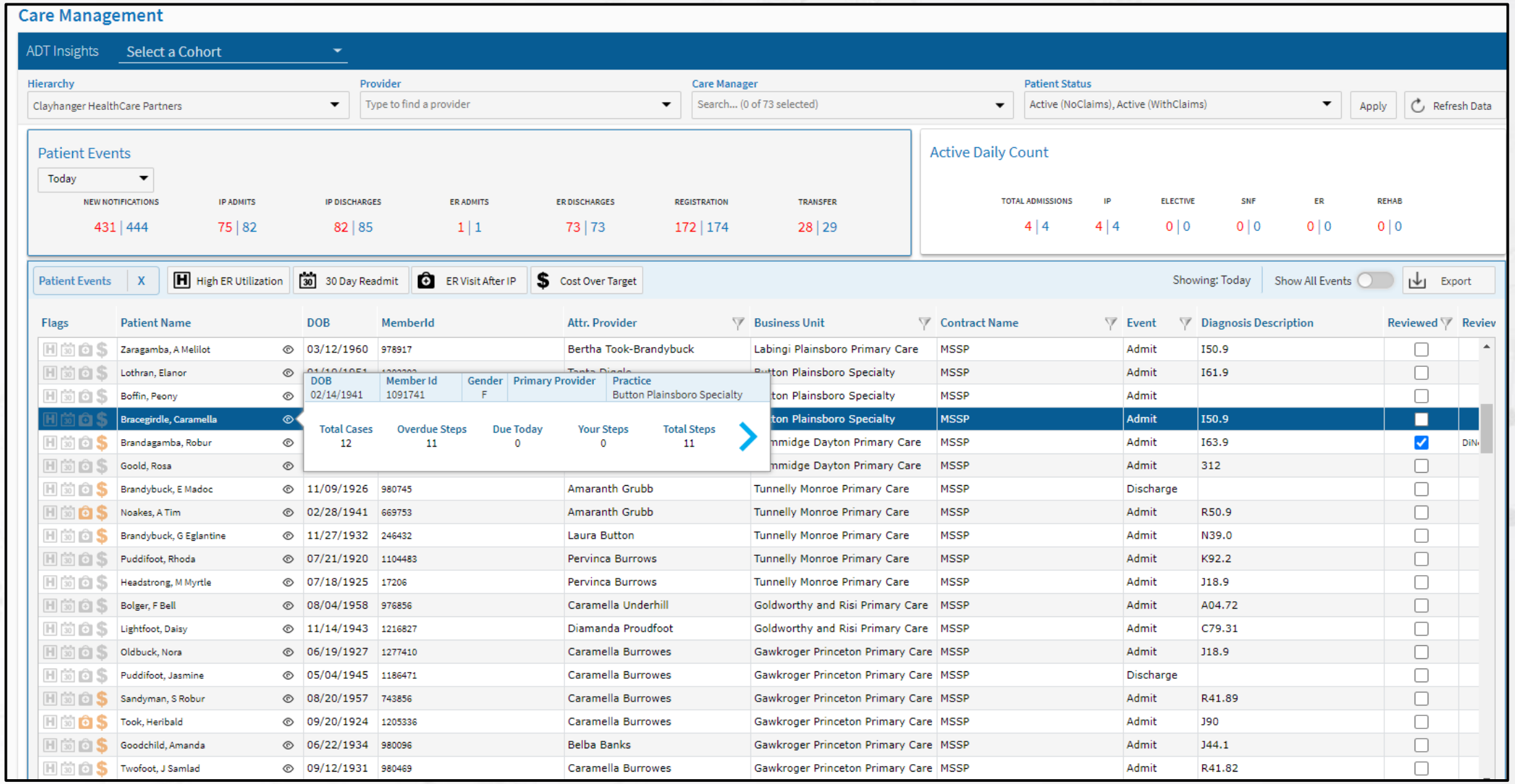
SEGMENTING PATIENTS FOR PERSONALIZED CARE

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



Flags	Patient Name	DOB	MemberId	Attr. Provider	Business Unit	Contract Name	Event	Diagnosis Description	Reviewed	Review
	Zaragamba, A Melilot	03/12/1960	978917	Bertha Took-Brandybuck	Labingi Plainsboro Primary Care	MSSP	Admit	I50.9		
	Lothran, Elanor				tton Plainsboro Specialty	MSSP	Admit	I61.9		
	Boffin, Peony				ton Plainsboro Specialty	MSSP	Admit			
	Bracegirdle, Caramella				ton Plainsboro Specialty	MSSP	Admit	I50.9		
	Brandagamba, Robur				mmidge Dayton Primary Care	MSSP	Admit	I63.9		DiN
	Goold, Rosa				mmidge Dayton Primary Care	MSSP	Admit	312		
	Brandybuck, E Madoc	11/09/1926	980745	Amaranth Grubb	Tunnelly Monroe Primary Care	MSSP	Discharge			
	Noakes, A Tim	02/28/1941	669753	Amaranth Grubb	Tunnelly Monroe Primary Care	MSSP	Admit	R50.9		
	Brandybuck, G Eglantine	11/27/1932	246432	Laura Button	Tunnelly Monroe Primary Care	MSSP	Admit	N39.0		
	Puddifoot, Rhoda	07/21/1920	1104483	Pervinca Burrows	Tunnelly Monroe Primary Care	MSSP	Admit	K92.2		
	Headstrong, M Myrtle	07/18/1925	17206	Pervinca Burrows	Tunnelly Monroe Primary Care	MSSP	Admit	J18.9		
	Bolger, F Bell	08/04/1958	976856	Caramella Underhill	Goldworthy and Risi Primary Care	MSSP	Admit	A04.72		
	Lightfoot, Daisy	11/14/1943	1216827	Diamanda Proudfoot	Goldworthy and Risi Primary Care	MSSP	Admit	C79.31		
	Oldbuck, Nora	06/19/1927	1277410	Caramella Burrowes	Gawkroger Princeton Primary Care	MSSP	Admit	J18.9		
	Puddifoot, Jasmine	05/04/1945	1186471	Caramella Burrowes	Gawkroger Princeton Primary Care	MSSP	Discharge			
	Sandyman, S Robur	08/20/1957	743856	Caramella Burrowes	Gawkroger Princeton Primary Care	MSSP	Admit	R41.89		
	Took, Heribald	09/20/1924	1205336	Caramella Burrowes	Gawkroger Princeton Primary Care	MSSP	Admit	J90		
	Goodchild, Amanda	06/22/1934	980096	Belba Banks	Gawkroger Princeton Primary Care	MSSP	Admit	J44.1		
	Twofoot, J Samlad	09/12/1931	980469	Caramella Burrowes	Gawkroger Princeton Primary Care	MSSP	Admit	R41.82		

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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

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Getting Started – Where Do We Focus This Year?

Lightbeam's 12 Levers for ValueBased 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

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Case 1

The High-Complexity ACO Patient Cohort

Selecting a Cohort

Hopkins ACG Score 3+ & High Care Coordination Risk

2021 Baseline Finance & Utilization (167 patients)	High Complexity Cohort	All MSSP Patients
ACG Average Risk	4.618	1.0
PMPM	$6,250	$837
Hospital Admit Rate	1,055	124
ED visit Rate	6,856	572
SNF Admit Rate	246	36
30-d Readmit %	18%	9%
AWV in last 12 months	42%	57%

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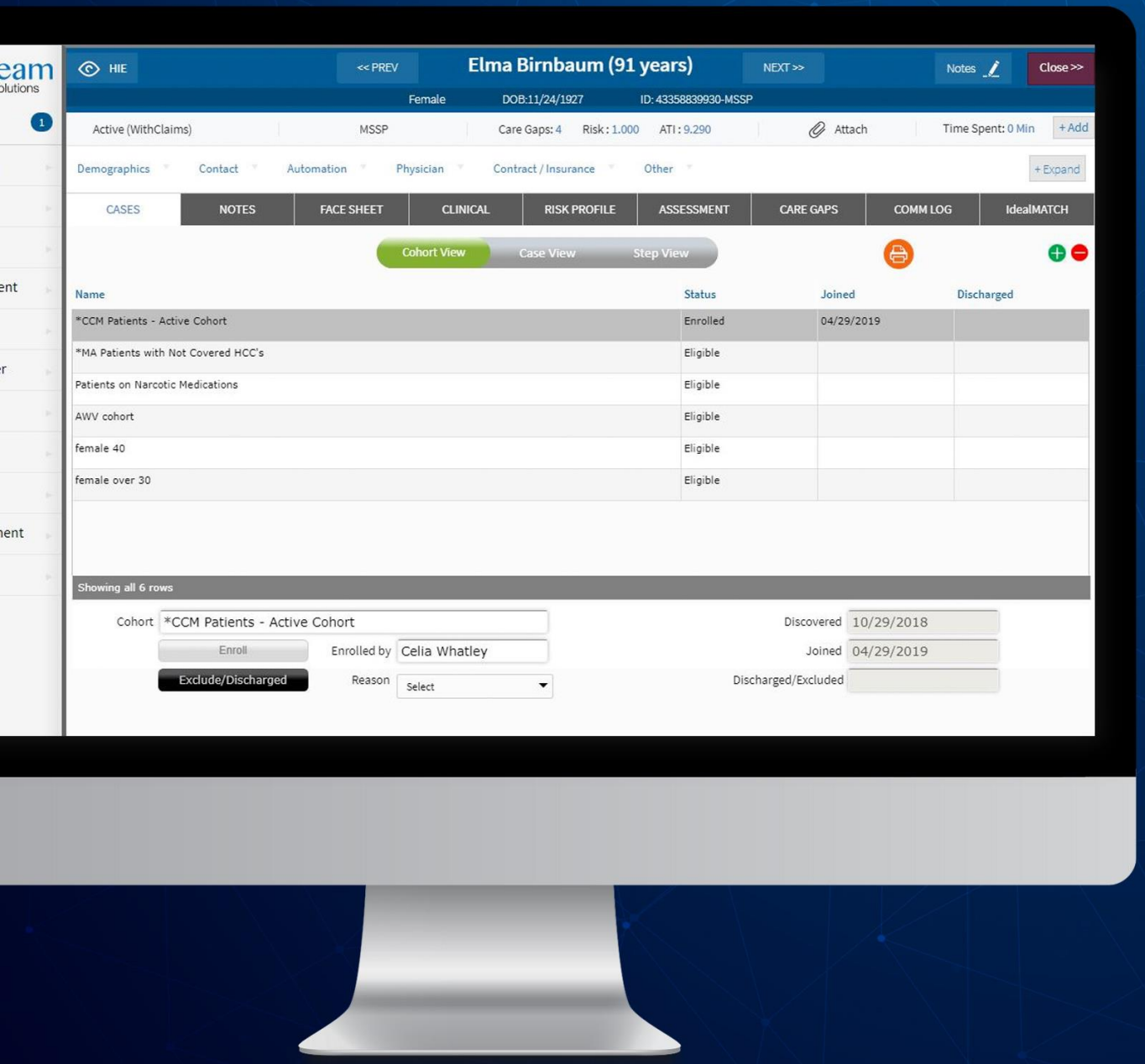


FULLY INTEGRATED CARE MANAGEMENT

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

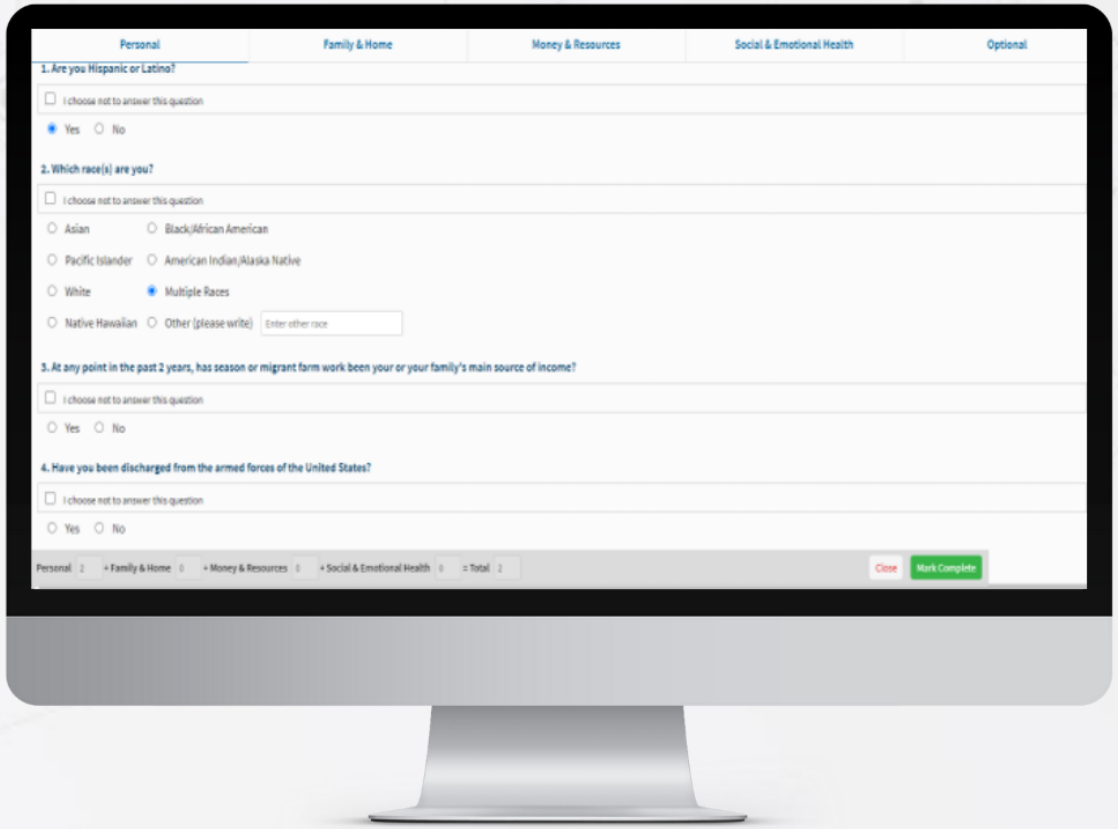
- Access to clinical data in real-time, simplifying the processes of retrieving patient records from varying locations
- Automatic distribution of qualified members to the appropriate care management resources with applicable clinical intervention prescribed
- Evidence-based, patient-specific care plans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

Use a Standard SDOH Screening Tool

SDoH Screening	
Race & Ethnicity	Education
Employment	Insurance
Housing Status	Income
Transportation	Social Support
Personal Stress	Primary Language
Safety	Domestic Violence
Incarceration History	Refugee Status
Veteran Status	Migrant Labor

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences



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Make Referrals for Social Services Through a Community-Wide Referral Platform

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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

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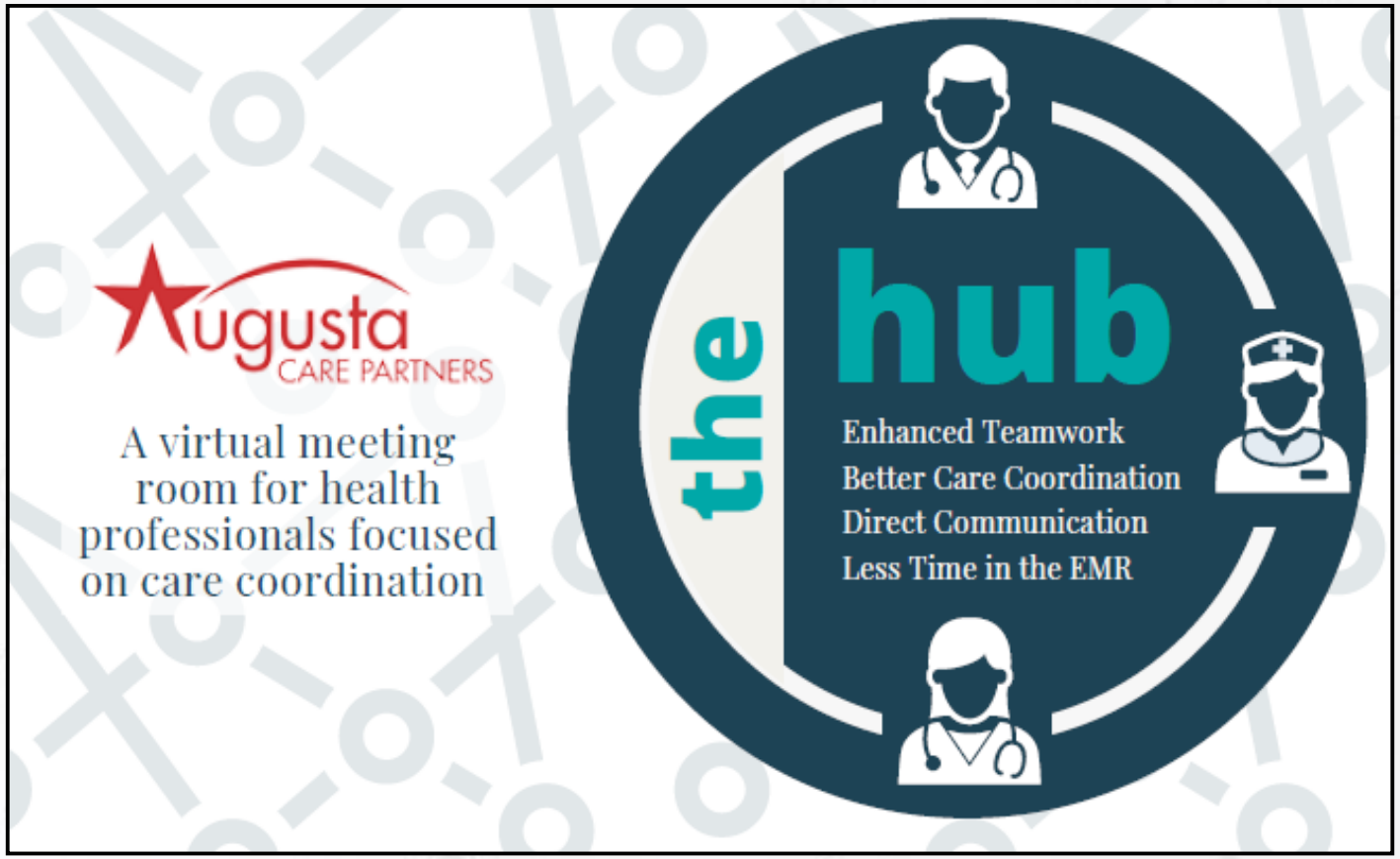
Coordinate the Care in New Ways



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

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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

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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

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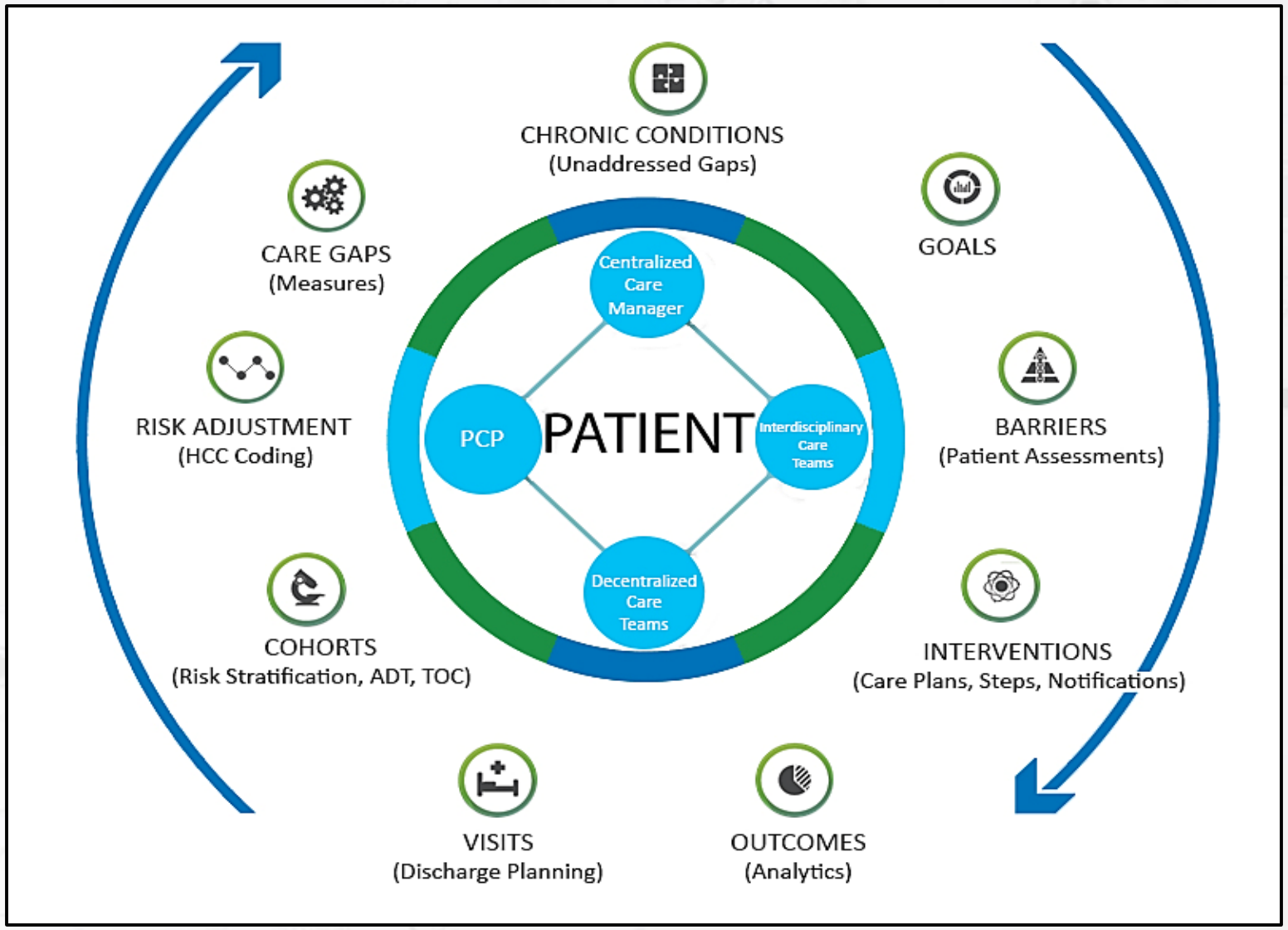
Clinical Transformation



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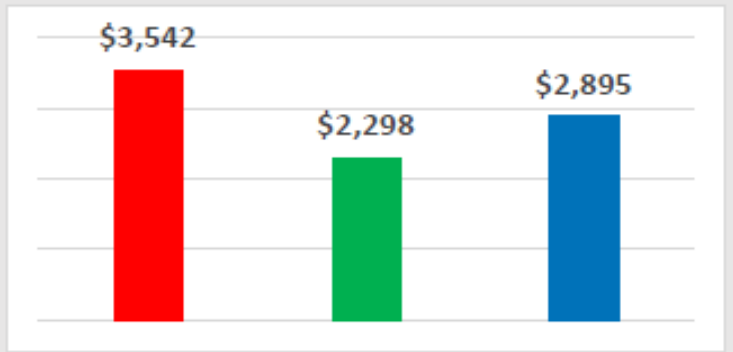
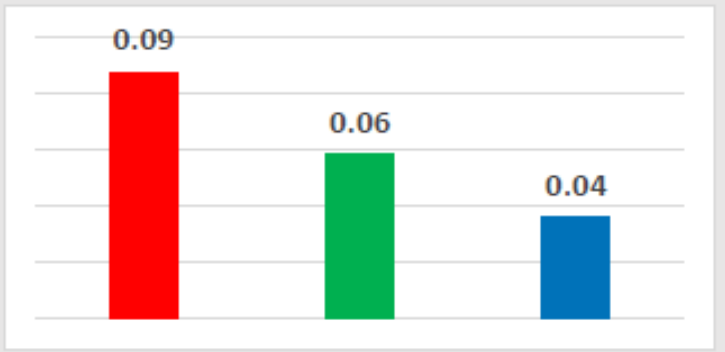
Track Our Performance Quarterly



Avg Total Cost

Before Enrollment	After Enrollment	Eligible/ Excluded Patients
$3,542	$2,298	$2,895

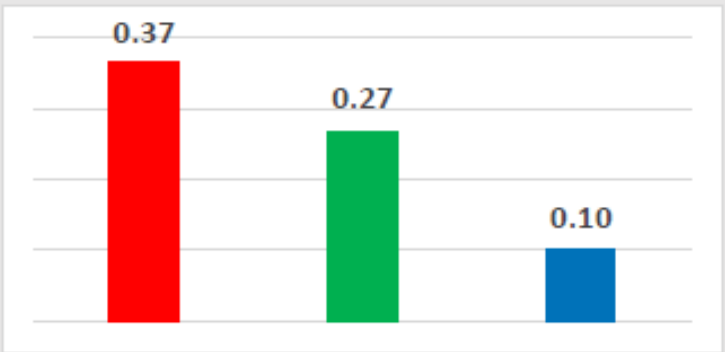
▼ -35%



Avg Inp Admits*

Before Enrollment	After Enrollment	Eligible/ Excluded Patients
0.09	0.06	0.04

▼ -34%



Avg ER Visits*

Before Enrollment	After Enrollment	Eligible/ Excluded Patients
0.37	0.27	0.10

▼ -27%

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Check the Work Against Our Key Tactics

6 Pop Health Tactics

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

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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

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Use Lightbeam to Understand Health Disparities

Quality & Utilization Metrics	Dual Eligible	All MSSP
PMPM	$1,235	$757
ED Visits/K	1,298	572
Hospital admits/K	243	124
IP Bed Days/K	2,294	690
30-Day Readmit	17%	9%
SNF Admits/K	109	36
AWV	37%	57%
% Controlled Diabetes	69%	78%
% Breast Ca Screen	63%	82%
% Colon Ca Screen	54%	71%

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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

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Engage our Community Partners

Latino Community Health Council

Sin Barreras	Promotores de Salud	Office of New Americans
Central Shenandoah Health District	Futuro Latino	Embrace Community Center
Molina Healthcare	Augusta Health	Engaged community volunteers

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

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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

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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

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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

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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

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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

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What Are We Learning?

Our Commitment & Challenges

Broad View: CMS, Health Equity & Value-Based Care

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

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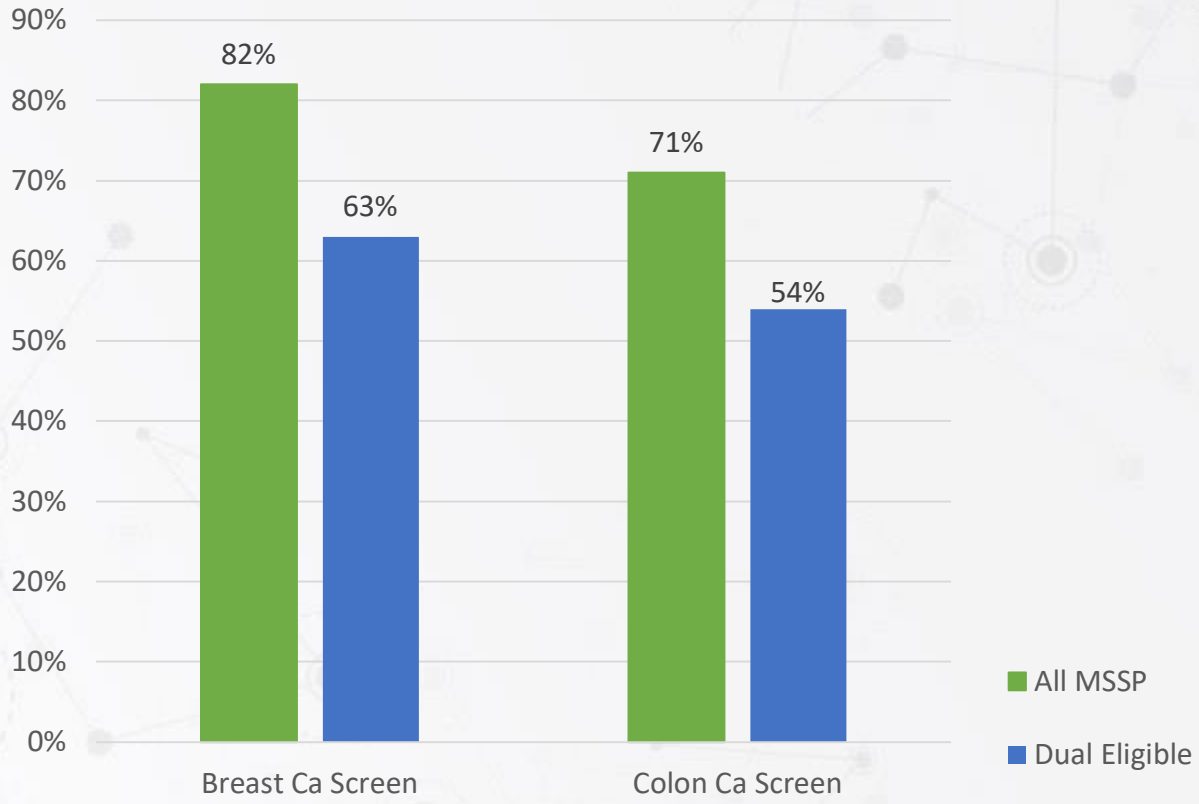
Health Equity is Changing How We Understand Success



Challenges:

- Measurement
- Community Listening
- Community Partners
- Education

Health disparities are fundamental to knowing if we are improving the health of our community.

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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.

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Questions?

AMGA High Performing Physician Enterprise

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High Performing Physician Enterprise (HPPE)

Governance/Leadership

Provider

Clinical Outcomes

Financial

Operations

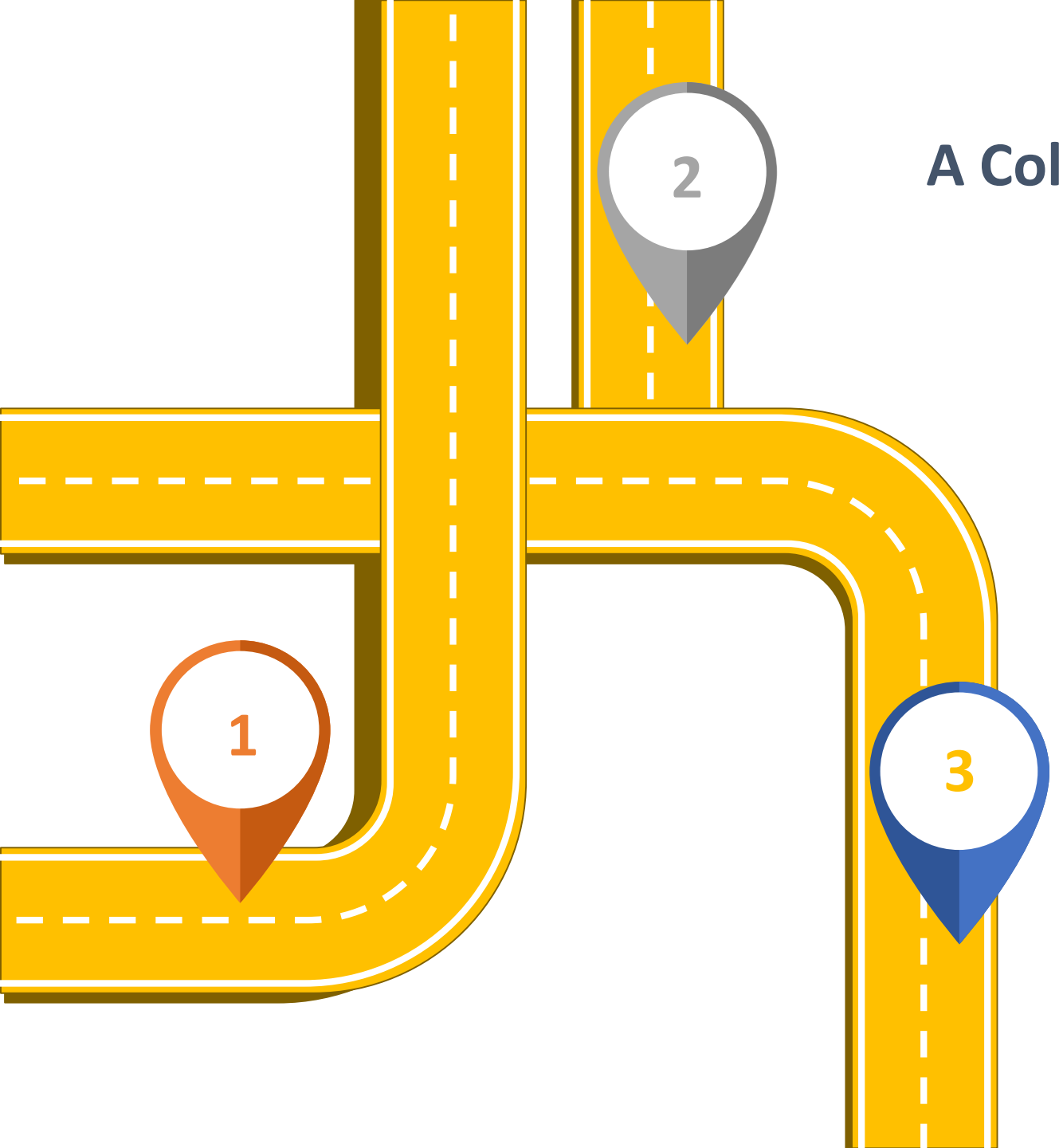
Patient

Value

23 Focus Areas – 130+ Indicators

In partnership with

Lightbeam Health Solutions



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!