DSRIP Program: Enabling Participation for Performing Provider Systems

Todd D. Ellis, Managing Director, Technology Enablement, KPMG
Vicki Harter, VP Product Management, Caradigm

March 25, 2015

Agenda

- The Need to Improve Populations: The New Paradigm
- Key questions for DSRIP
- Caradigm and DSRIP Overview
- Addressing the key DSRIP questions
- Caradigm DSRIP Package of Solutions
- Q&A

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Todd D. Ellis, Managing Director, KPMG

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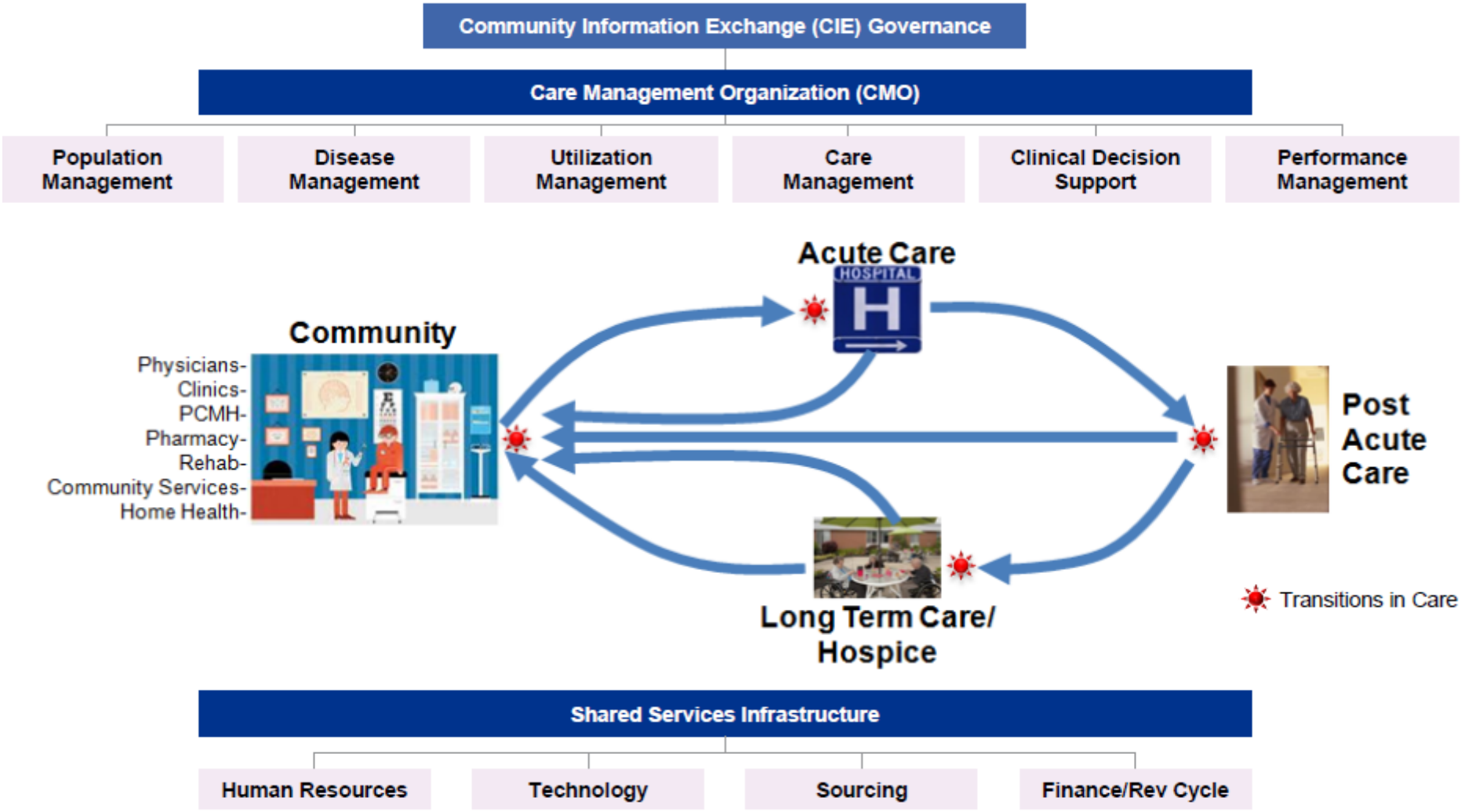
The Need to Improve Populations and Reduce Costs: The New Paradigm

DSRIP: More clinically integrated models



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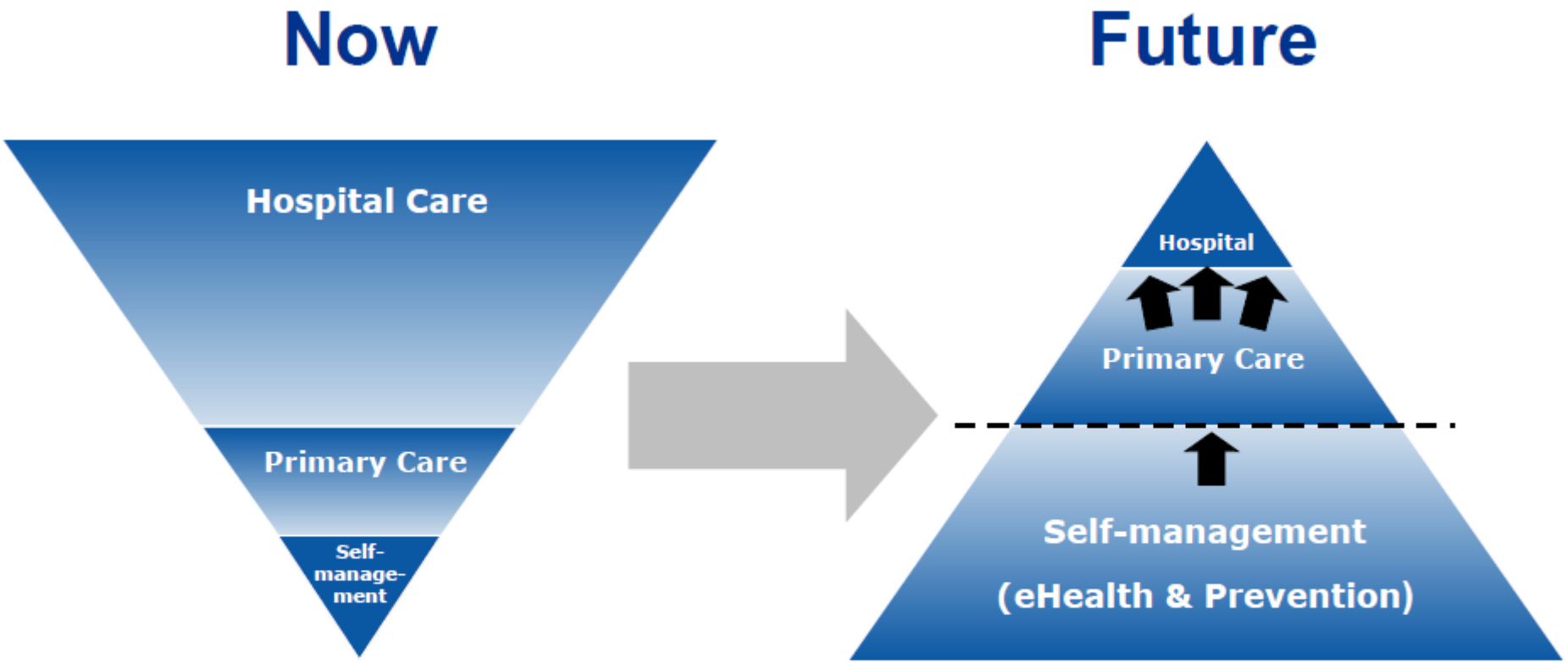
The Need to Improve Populations: The New Paradigm

Our system now does not put the responsibility on the patient and focuses too much on high cost services.



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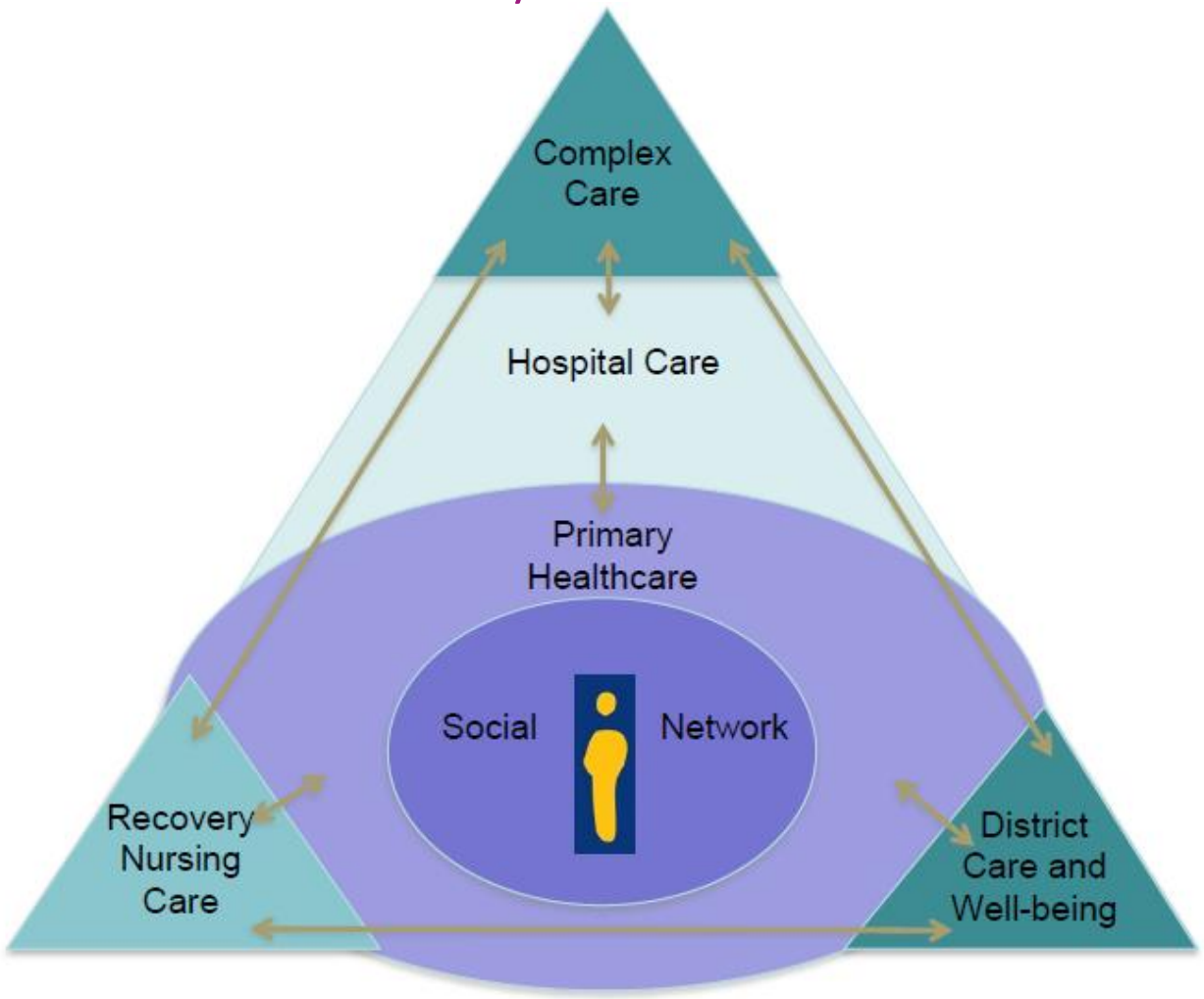
The Need to Improve Populations: The New Paradigm

The need for integrated services with the focus on the patient and Populations. Information is key



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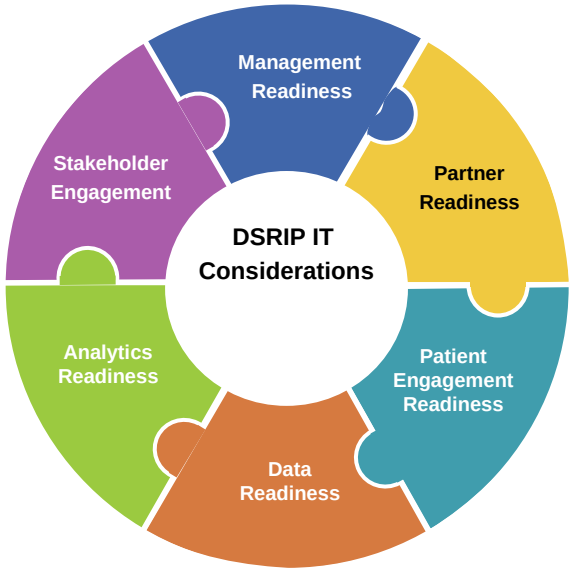
The Need to Improve Populations: The New Paradigm

Some common barriers that must be addressed…….

- Workflow Impact Analysis
- Policies and Procedures updates
- Business Continuity Planning
- Clinical and Data Governance
- Training and Education
- Helpdesk and Support
- Change Management

- IT Governance
- IT Strategy
- Architecture
- Future Roadmap
- IT Portfolio Management
- Vendor Management

- Physical Hardware, Network Connectivity
- Clinical Applications (EMR, Care Management, Referral tracking)
- Financial Application (Enrollment, Claims, Payment)
- Exchange Application (HIE/RHIOs)
- Add-ons (Interfaces)
- Business Intelligence Applications (Data Warehouse, Population Health)
- Engagement Application (Secure Messaging, Provider/Patient Portal, Online Directories, Remote Monitoring/ Telemedicine)



- Identification
- Segmentation
- Stratification
- Risk Scoring
- Performance Metrics
- Evidence Based Clinical Rules
- Alerts, Reports
- Care Gap Analytics
- Medical Cost Analytics
- Quality and Outcome Analytics
- Predictive Analytics

- Aggregation
- Normalization
- Exchange
- Data Mining
- Prediction
- Payer Data
- Semantic Interoperability
- Data Quality

- Master Patient Indexing
- Patient Consent
- Information Security
- Patient Attribution
- Patient Matching
- Patient Outreach and Communication
- Patient Engagement

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The Need to Improve Populations: The New Paradigm

Key questions to address……

- Understanding the goals of your organization in an environment of constant change (DSRIP and Non-DSRIP). What are the needs you are looking to address or improve in the community?

- How do you identify what high risks exist for a specific patient or patient population:
  - How do you assess them?
  - How is information provided to the care team?
  - How to engage the patient and encourage self management?
  - The transitions must be smooth and effective

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The Need to Improve Populations: The New Paradigm

Key questions to address…….

- Ensuring the technology you will use or purchase will actually meet the needs of the organization for DSRIP and future long term goals….intelligent technology spending
  - Many vendors in the field
  - A lot of options with mature functionality
  - Being able to see through the fog….understanding your needs
  - People, process, TECHNOLOGY and data

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Vicki Harter, VP Product Management, Caradigm

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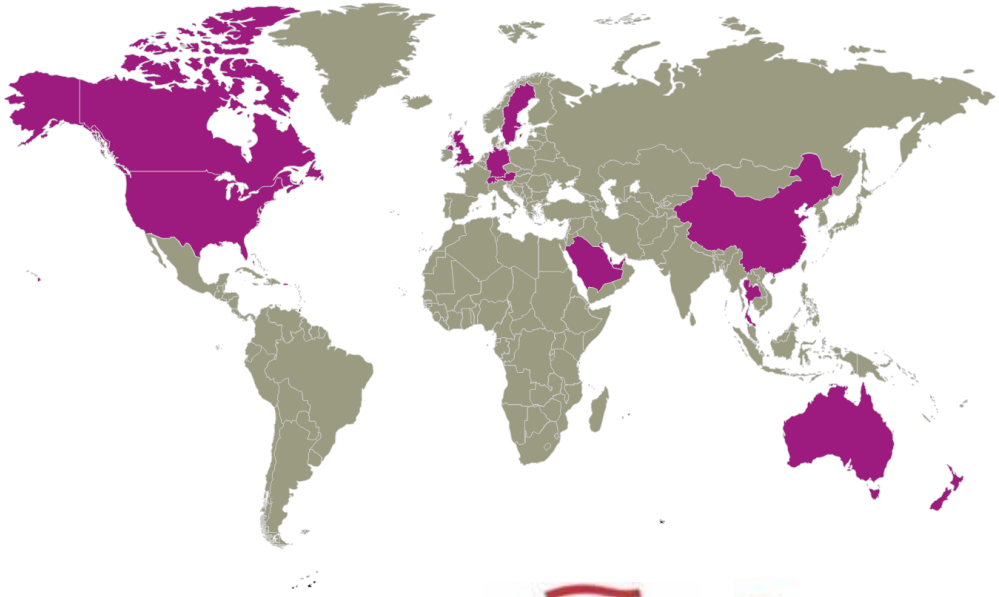
Unleashing innovation to solve healthcare's greatest challenges

caradigm™
a Microsoft | GE Healthcare company



650 person workforce
250 customers
1500 hospitals
1 M end users
175 M patients
500 source systems

GEISINGER HEALTH PLAN
Billings Clinic
OCHIN
PruittHealth
Committed to Caring
UW Medicine
RUSH HEALTH
HUNTSVILLE HOSPITAL

Customers | Promises | Simplicity | Teamwork


Photo courtesy of Naveed Zafar, part of the Caradigm team

Delivery System Reform Incentive Payment program

DSRIP States:

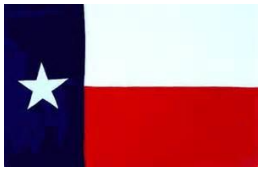
California

Kansas

Massachusetts

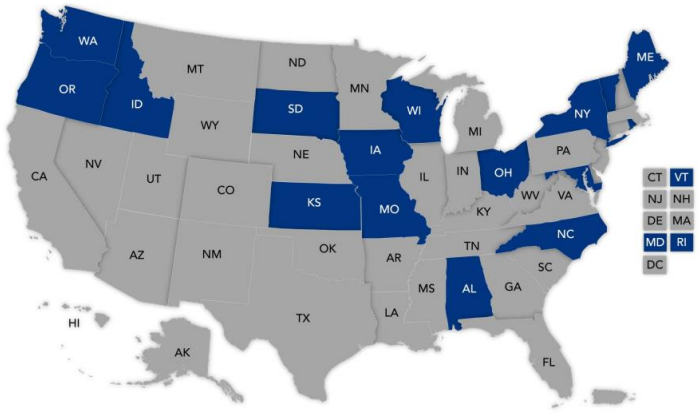
New Jersey

New York



Texas

Nationwide Importance:



As of November 2014, 16 states have a total of 20 approved Medicaid health home models.

DSRIP-similar states: Florida, New Mexico, and Oregon
DSRIP-applicant states: Alabama, Illinois, and New Hampshire

Goals:

- Reduce avoidable hospital use and improve other health and public health measures at both the system and state levels.
- Create a more cost efficient Medicaid program with improved outcomes.
- Assure access to quality care for Medicaid members and long-term delivery reform through managed care payment reform.

Source: Medicaid.gov. Health Home Information Resource Center. http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html

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The Key Questions

How do you assess high risks for a specific patient or patient population?

- Caradigm Risk Management – Identification and Stratification
- Caradigm Care Management – Assessment and Enrollment

How is information provided to the care team?

- Caradigm Care Management – Definition of the care team
- Caradigm Quality Improvement –Identify gaps in care

How do you engage the patient and encourage self management?

- Caradigm Care Management – Create Self Management Action Plan (SMAP)
- Caradigm Patient Engagement – Personal Health Record

Can the transitions be smooth and effective?

- Caradigm Care Management – Real-time alerts and rules based work flows
- Caradigm Knowledge Hub – Surface information to the point of care

Caradigm DSRIP Package of Solutions

Care Coordination and Management Solution

- Risk Management (RM)
- Care Management (CM)
- Quality Improvement (QI)
- Patient Engagement

Caradigm Intelligence Platform (CIP)

Outreach → Enrollment → Care Planning → Care Management and Coordination → Billing Data

Track, Monitor and Report on Metrics

Caradigm Population Analytics

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Integrating and sharing data within the PPS: Caradigm Intelligence Platform

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Enabling a Strategic Approach

Leveraging the Investments in the Caradigm Intelligence Platform

Rich Data Asset
Robust, smart interfaces to simplify and accelerate data aggregation
Data from the community, made available within work flows in real time

Analytics and Big Data
Analytics tools and third-party connections to easily generate insight and drive improvements

Cohort Management
Tools to rapidly address common surveillance and cohort management needs

Solution Ecosystem
Embedded applications that scale to meet changing business needs
Full development environment to accelerate solution creation

Cloud Hosting
Flexibility with subscription pricing and simplified deployment

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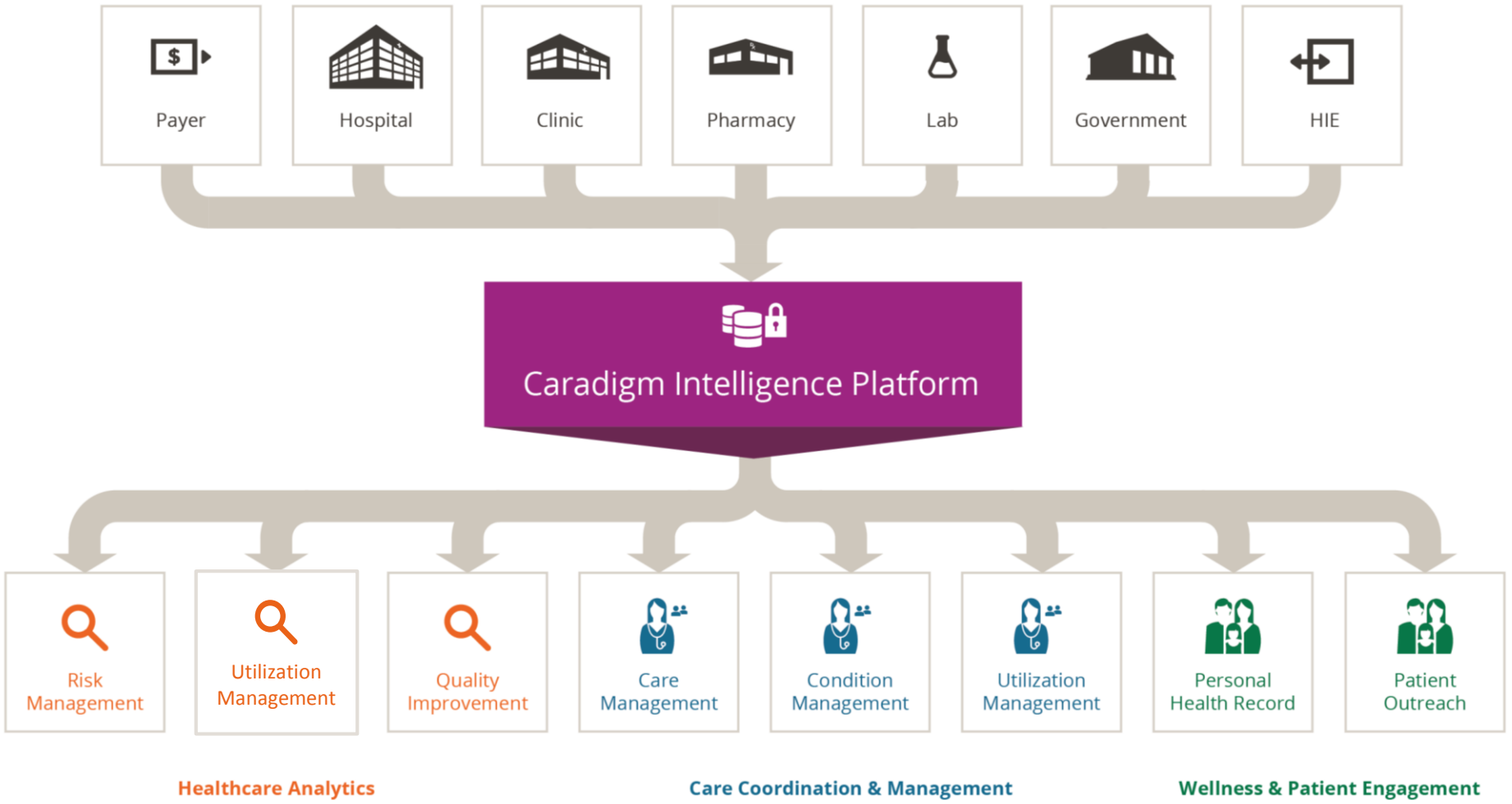
Future-proof your data investment



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Identifying and Stratifying the Population: Caradigm Risk Management, Quality Improvement

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Accurate and meaningful prediction

A more complete picture

The Science

- Blended artificial Intelligence
- Highest accuracy, sensitivity, specificity

The Differentiators for DSRIP

- Most accurate science in the industry
- Models calibrated to the customer's Medicaid population
- Identification of most actionable patients
- Patient-level drivers of current and future risk

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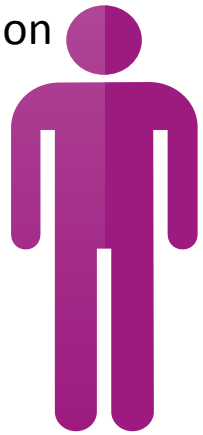
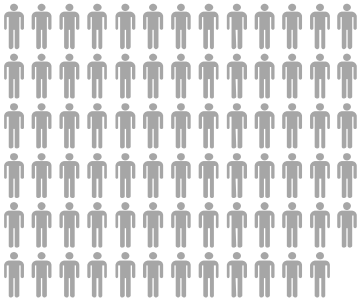
Maximizing Return on Intervention

Focus on the right interventions with the most actionable patients

1.6 M
population



77,000 Diabetics



Common Approach:

High Cost patients

High Cost Population

54,552 patients

Savings potential $425 PM/PY

Caradigm Risk Management

Acute Impact
Quality Compliance
Motivation
Movers

High Impact Population

925 patients

Savings Potential
$6,403,775

Savings potential $7000 PM/PY

Risk Management, powered LexisNexis® with by MEDai science

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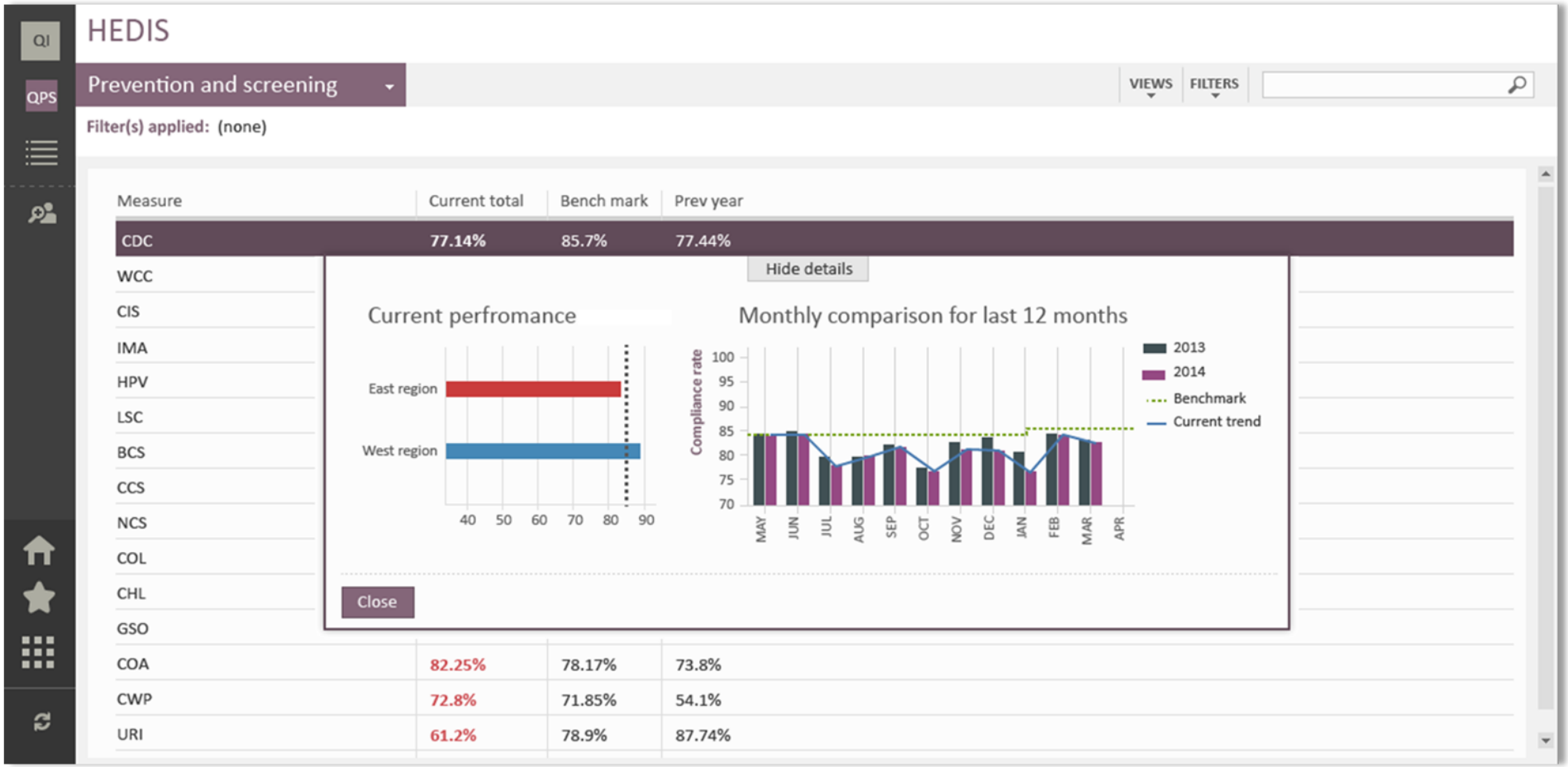
Quality Improvement

Screen Shot – Performance Benchmarking

Measure Calculation | **Performance Benchmarking** | Quality Gaps Analysis | Quality Management | Workflow Integration



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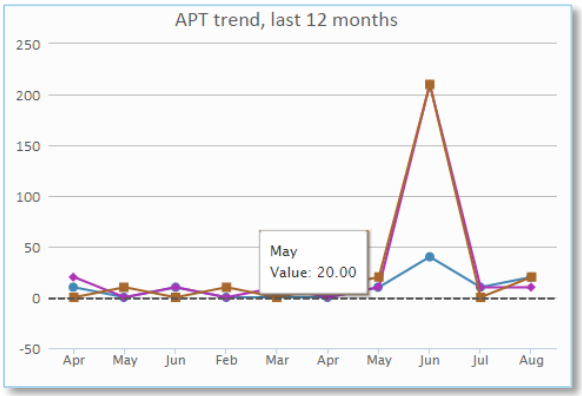
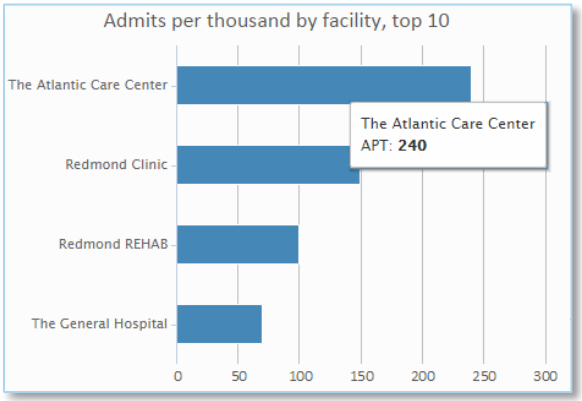
Admissions per 1000 Analysis

Following admission trends





Features & benefits

- Industry-standard metric determines the number of admissions over time by many factors, including region, facility, provider specialty, provider, major diagnostic category (MDC), diagnosis related group (DRG) and age grouping.
- Cross facility/provider/specialty comparative analytics
- Navigation to the individual patient/member longitudinal care record.

Provider Specialty	Tot Pop	% Pop	# Admit	% Admit	Newborn	> 65	Male	Female	Other
Cardiovascular	100	16.00	16	16.00	0	0	1	1	1
InternalMed	100	12.00	12	12.00	0	0	1	1	1
Oncology	100	12.00	12	12.00	0	0	1	1	1
Orthopedics	100	11.00	11	11.00	0	0	1	1	1
Surgery	100	12.00	12	12.00	0	0	1	1	1

The admission analysis:

- Uncovers trends in admissions that will lead to better transitions coordination
- Enables better understanding of utilization patterns of current at-risk populations.
- Enables better understanding of utilization patterns of populations to reduce unnecessary admissions

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Integrate the Care Team:
Caradigm Care Management

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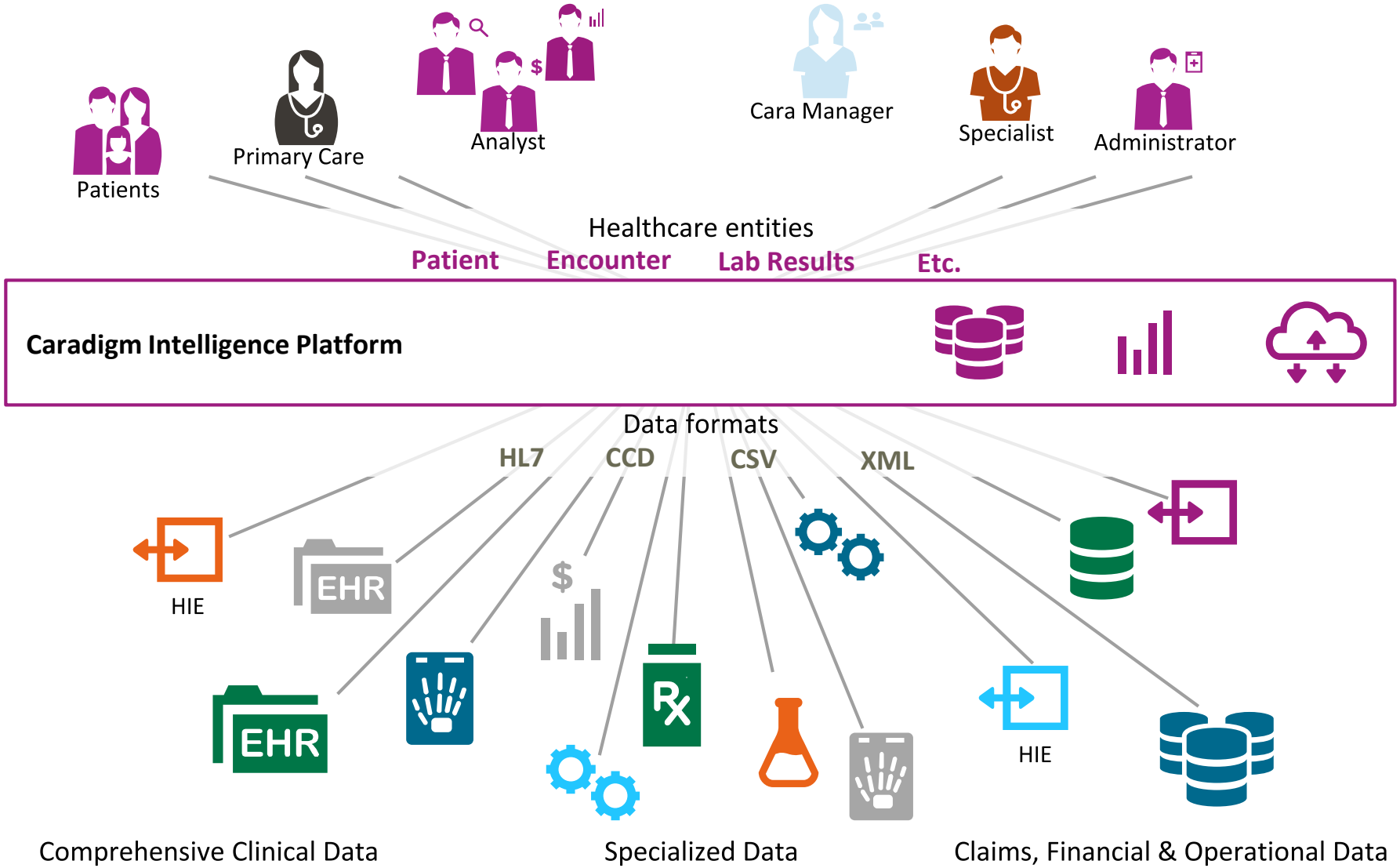
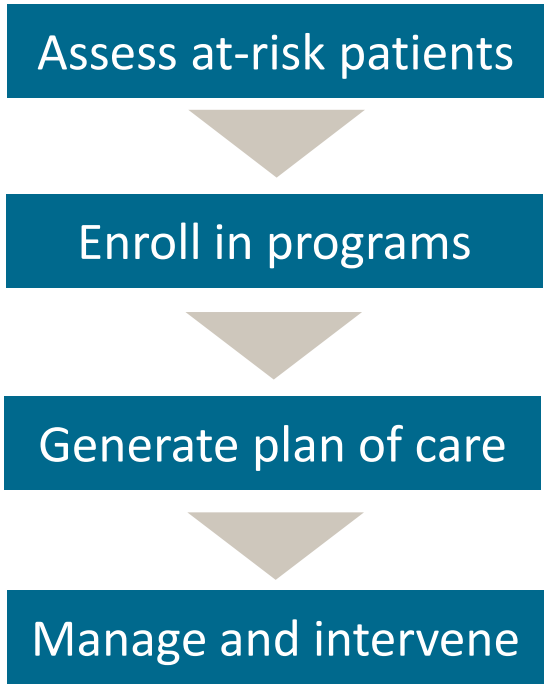
Technology for Integrating the Community- Wide Care Team



Care Management

Integrates evidence-based clinical guidelines into patient-centric care plans to promote quality and efficiency in the delivery of healthcare across the continuum.

- Individual assessments of Medicaid patients
- Defined care teams
- Communication of care plans
- 360° view of the patient and care team



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Caradigm Care Management Personas

Building to support today's healthcare organizations

Healthcare Professionals

Entering, consuming, analyzing, acting upon information

Ann
Care Manager

Dr. Catherine
PCMH Physician

Bill
Behavioral Health

Rosa
Medical Assistant

Sara
Social Worker

IT and Development

Installing, maintaining, supporting, building value

Chester
Sr. app dev

Iris
IT admin

Amita
Clinical and Business app analyst

Singh
Data integr. specialist

Delilah
Database admin

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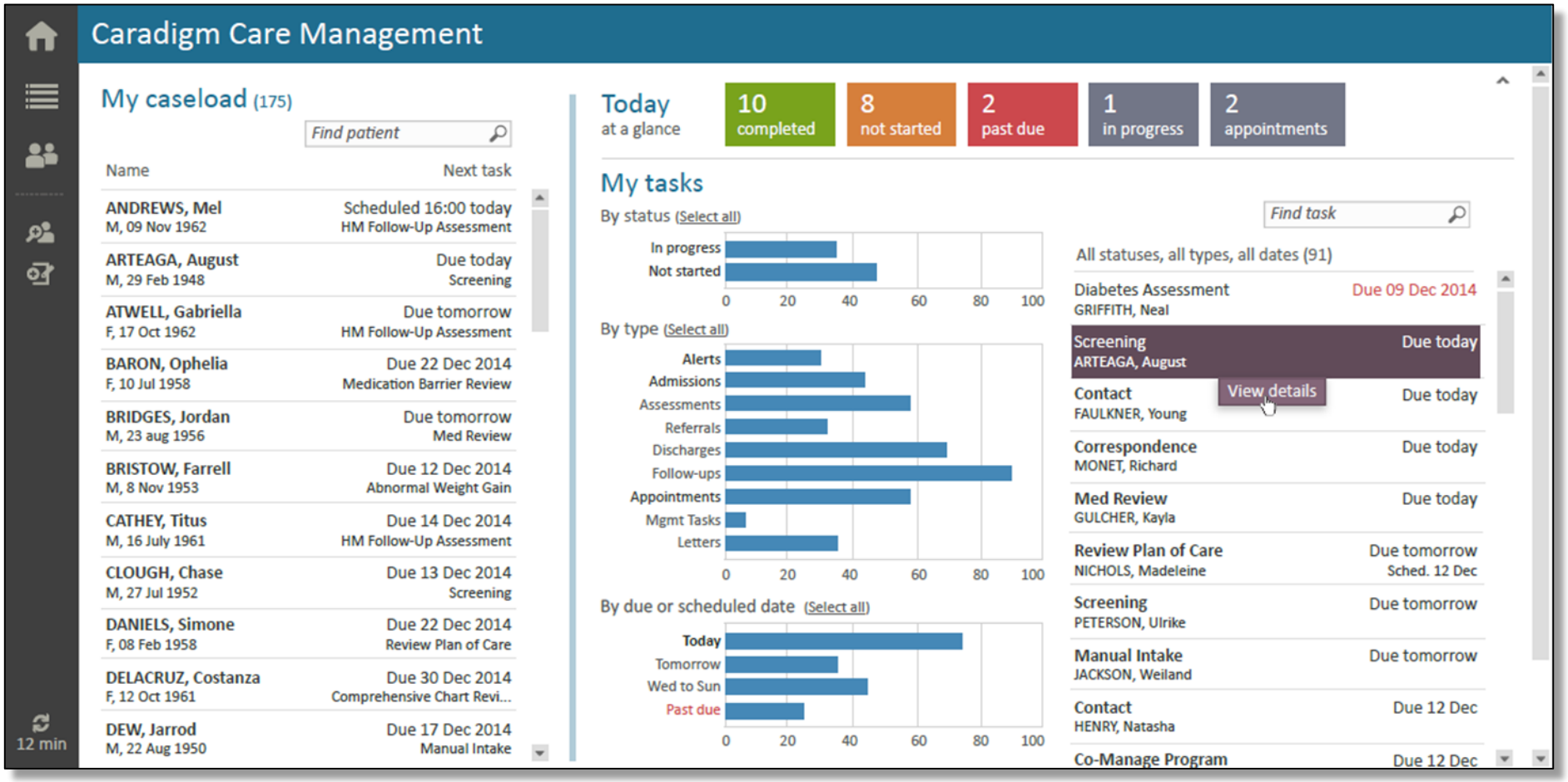
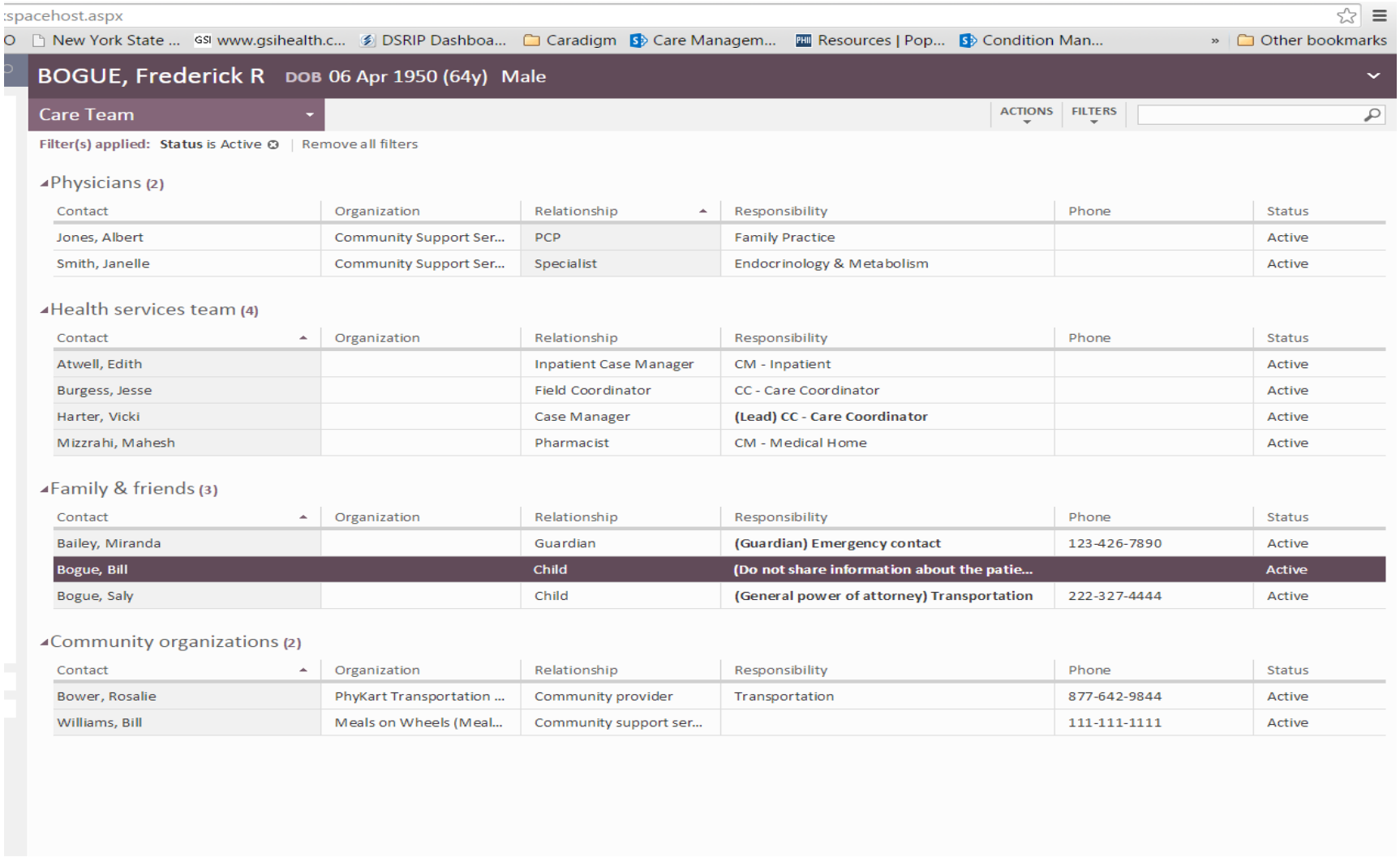
Care Management

User home screen allows for easy prioritization of a complex workload



Robust Care Team Approach

Establish clear roles and responsibilities to coordinate care



spacehost.aspx

New York State ... | www.gsihealth.c... | DSRIP Dashboa... | Caradigm | Care Managem... | Resources | Pop... | Condition Man... | Other bookmarks

BOGUE, Frederick R DOB 06 Apr 1950 (64y) Male

Care Team | ACTIONS | FILTERS

Filter(s) applied: **Status** is Active | Remove all filters

Physicians (2)

Contact	Organization	Relationship	Responsibility	Phone	Status
Jones, Albert	Community Support Ser...	PCP	Family Practice		Active
Smith, Janelle	Community Support Ser...	Specialist	Endocrinology & Metabolism		Active

Health services team (4)

Contact	Organization	Relationship	Responsibility	Phone	Status
Atwell, Edith		Inpatient Case Manager	CM - Inpatient		Active
Burgess, Jesse		Field Coordinator	CC - Care Coordinator		Active
Harter, Vicki		Case Manager	**(Lead) CC - Care Coordinator**		Active
Mizzrahi, Mahesh		Pharmacist	CM - Medical Home		Active

Family & friends (3)

Contact	Organization	Relationship	Responsibility	Phone	Status
Bailey, Miranda		Guardian	**(Guardian) Emergency contact**	123-426-7890	Active
Bogue, Bill		**Child**	**(Do not share information about the patie...**		**Active**
Bogue, Saly		Child	**(General power of attorney) Transportation**	222-327-4444	Active

Community organizations (2)

Contact	Organization	Relationship	Responsibility	Phone	Status
Bower, Rosalie	PhyKart Transportation ...	Community provider	Transportation	877-642-9844	Active
Williams, Bill	Meals on Wheels (Meal...	Community support ser...		111-111-1111	Active

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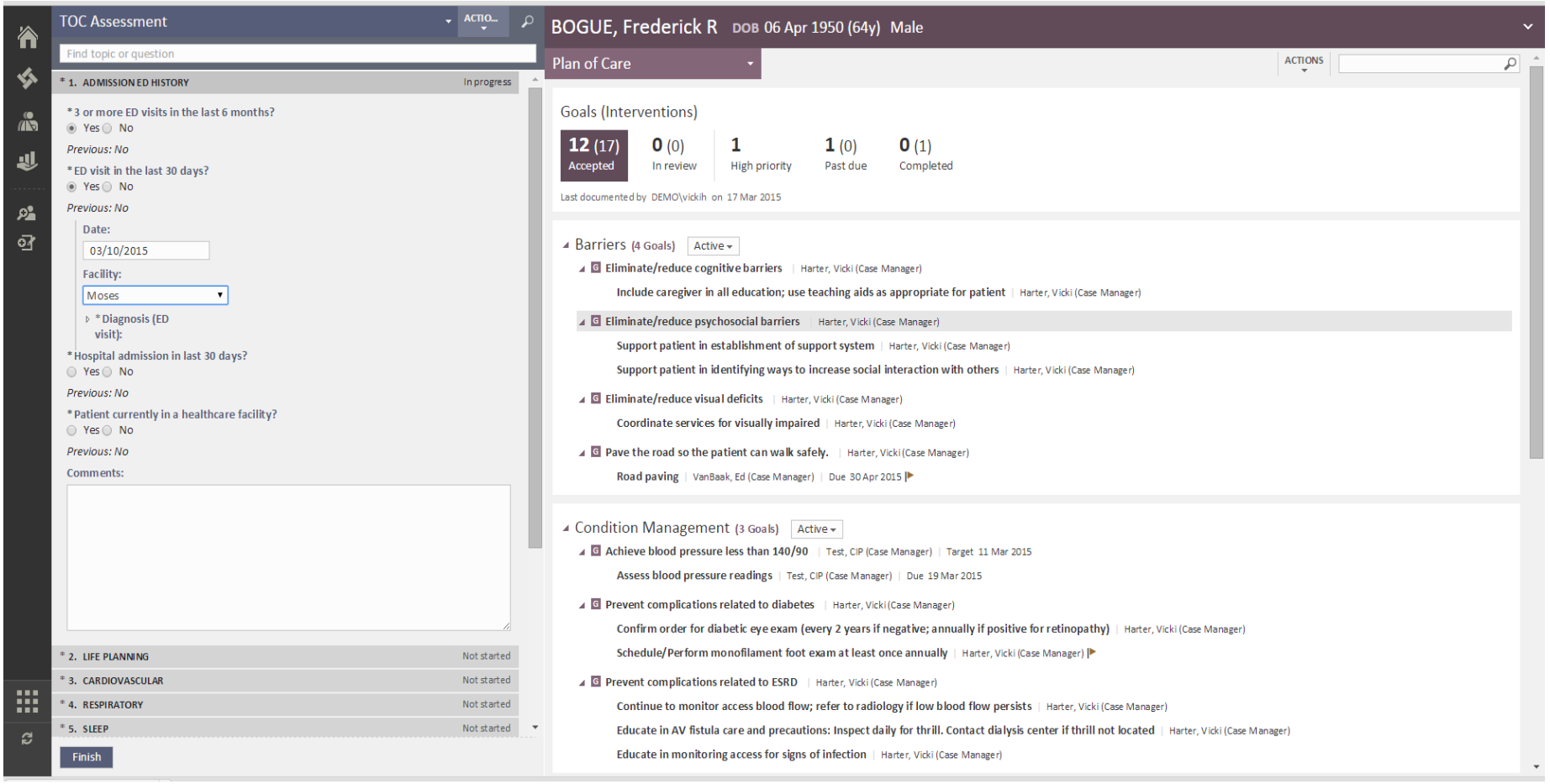
Assessments Drive an "Intelligent Plan of care"

Reducing variations in care through evidence-based content mapping



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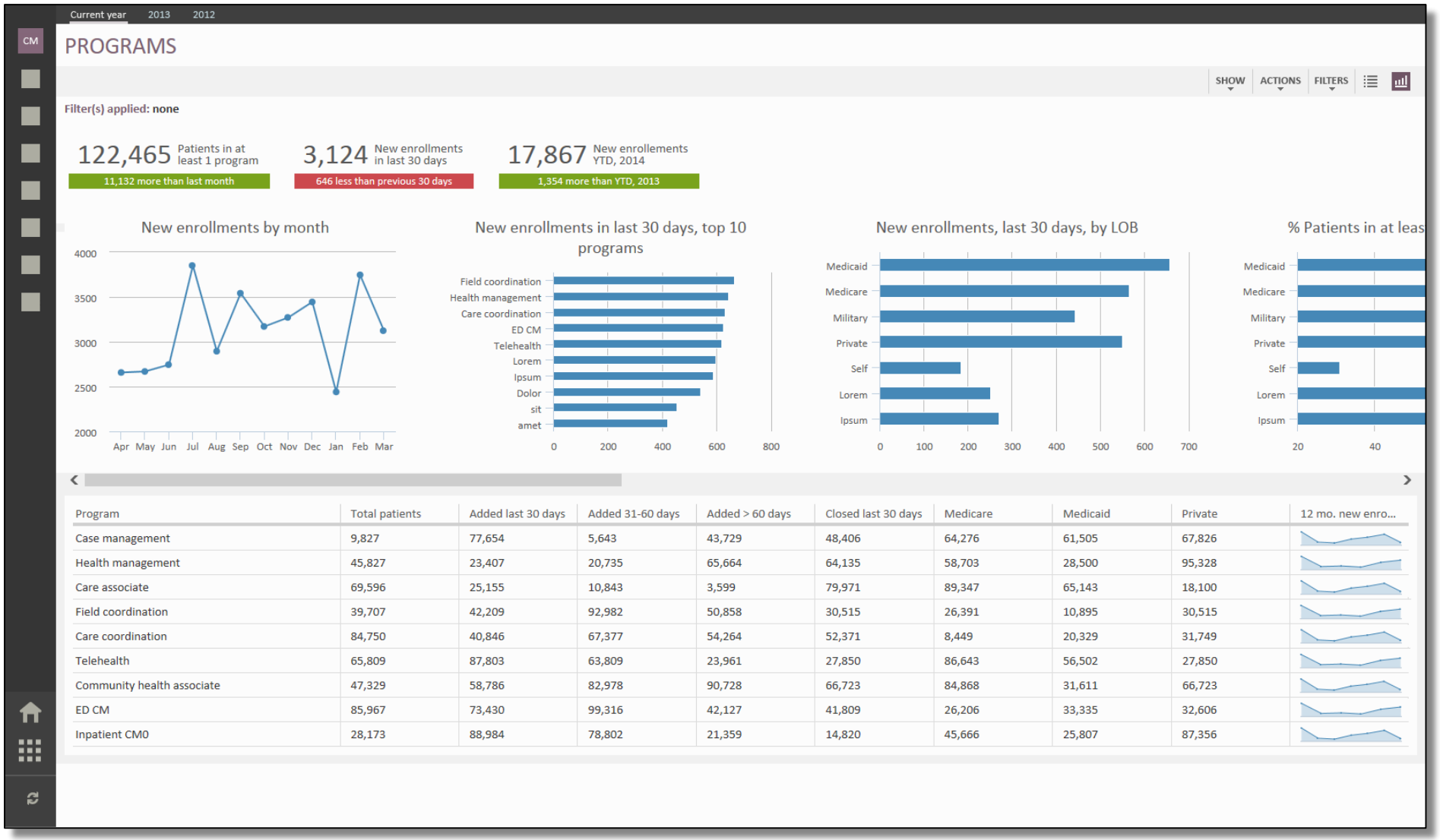
Program analytics



Program	Total patients	Added last 30 days	Added 31-60 days	Added > 60 days	Closed last 30 days	Medicare	Medicaid	Private	12 mo. new enro...
Case management	9,827	77,654	5,643	43,729	48,406	64,276	61,505	67,826	
Health management	45,827	23,407	20,735	65,664	64,135	58,703	28,500	95,328	
Care associate	69,596	25,155	10,843	3,599	79,971	89,347	65,143	18,100	
Field coordination	39,707	42,209	92,982	50,858	30,515	26,391	10,895	30,515	
Care coordination	84,750	40,846	67,377	54,264	52,371	8,449	20,329	31,749	
Telehealth	65,809	87,803	63,809	23,961	27,850	86,643	56,502	27,850	
Community health associate	47,329	58,786	82,978	90,728	66,723	84,868	31,611	66,723	
ED CM	85,967	73,430	99,316	42,127	41,809	26,206	33,335	32,606	
Inpatient CM0	28,173	88,984	78,802	21,359	14,820	45,666	25,807	87,356	

Effective Transitions at the Point of Care:

Caradigm Knowledge Hub, Patient Engagement

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Point of Care integration capabilities

Desktop Integration

- Knowledge Hub

Desktop Integration

- Single Sign On (SSO)
- Context Management

Document Sharing

- Pass Care Plans between systems
- Enabled by HIE infrastructure

Discrete Data Sharing

- Decompose discrete data from a Care Plan and include that in the EMR
- HL7 messages (lab results for example)

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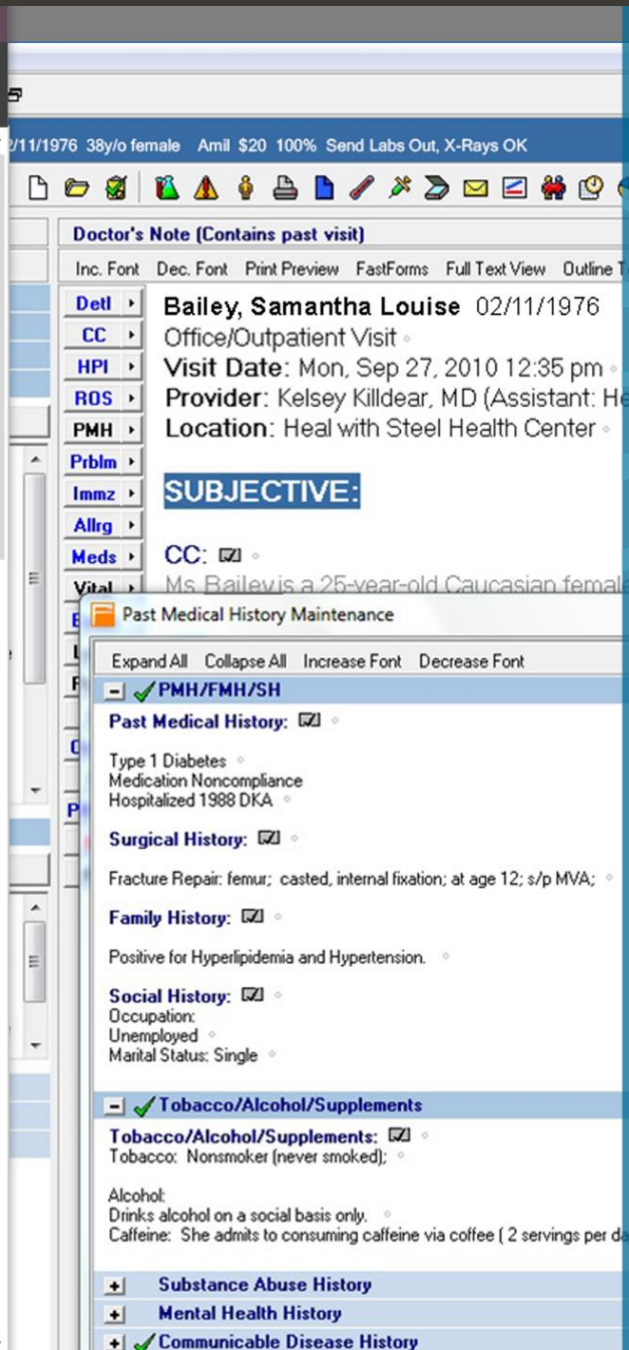
Knowledge Hub – Bringing additional patient data into the EMR



Knowledge Hub surfaces additional patient information within the clinical workflow.

Features

- EHR integration
- Context management
- Configurable scorecard
- Computed risk scores
- Application integration
- Notes or data capture

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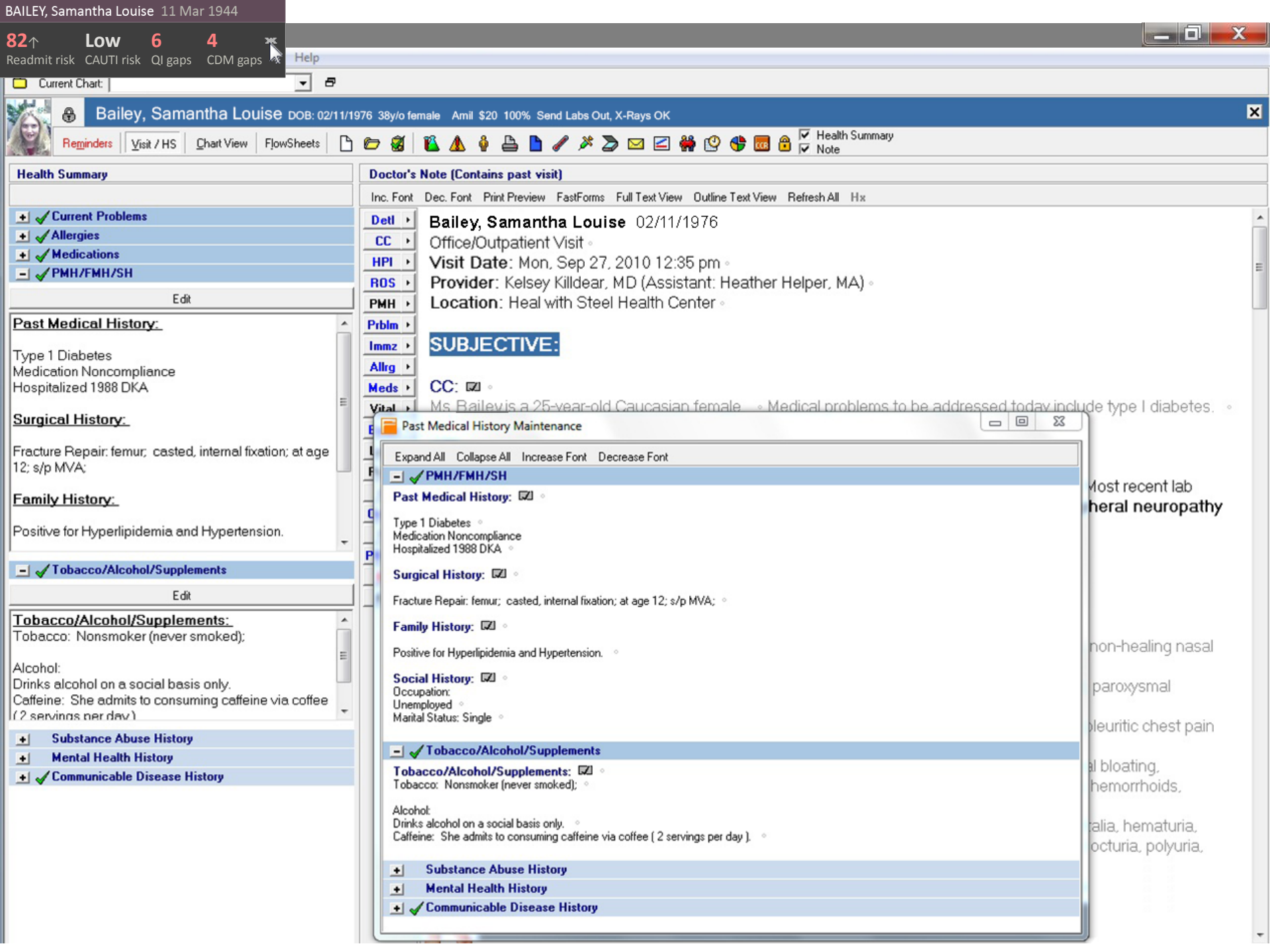
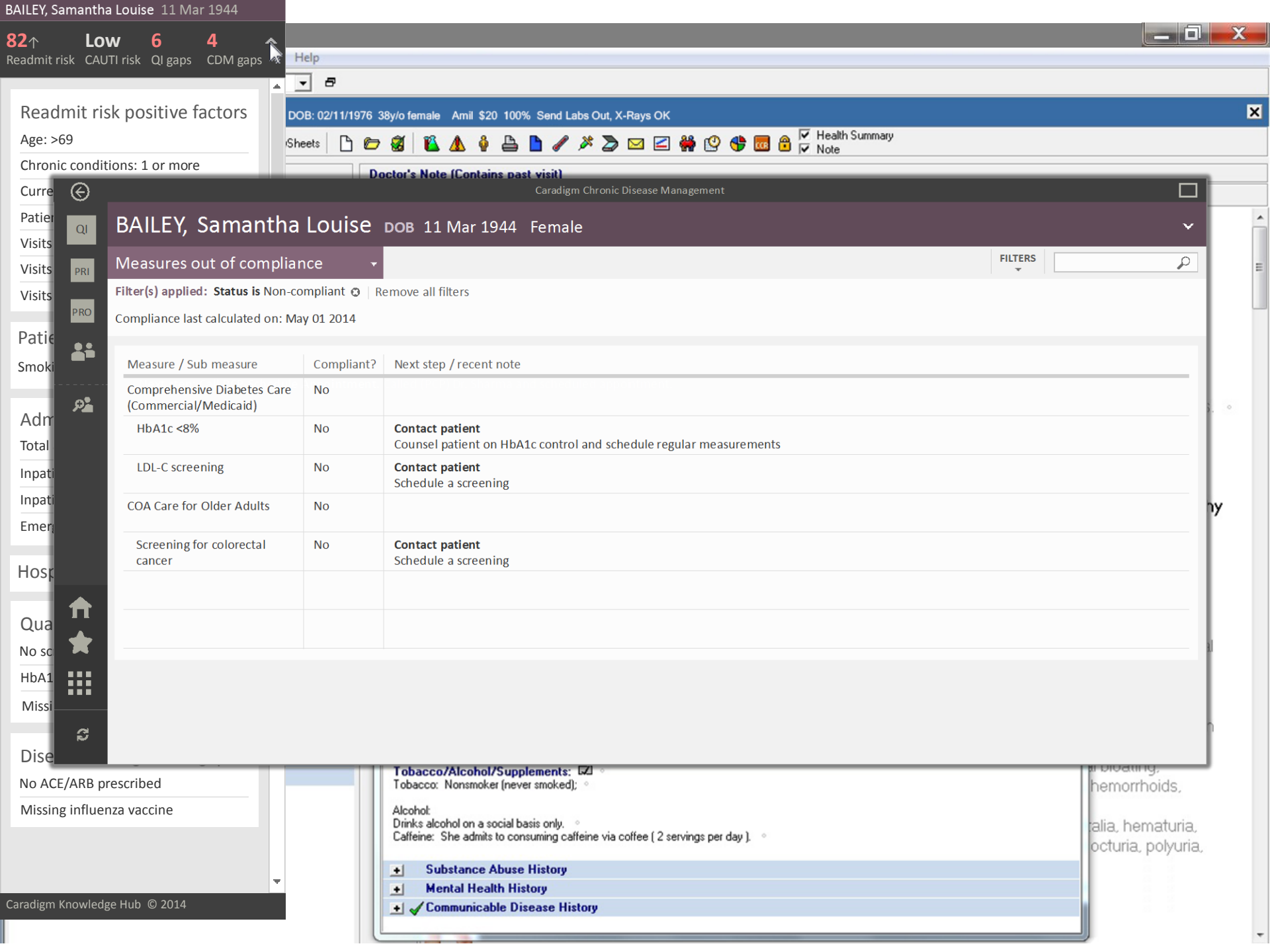
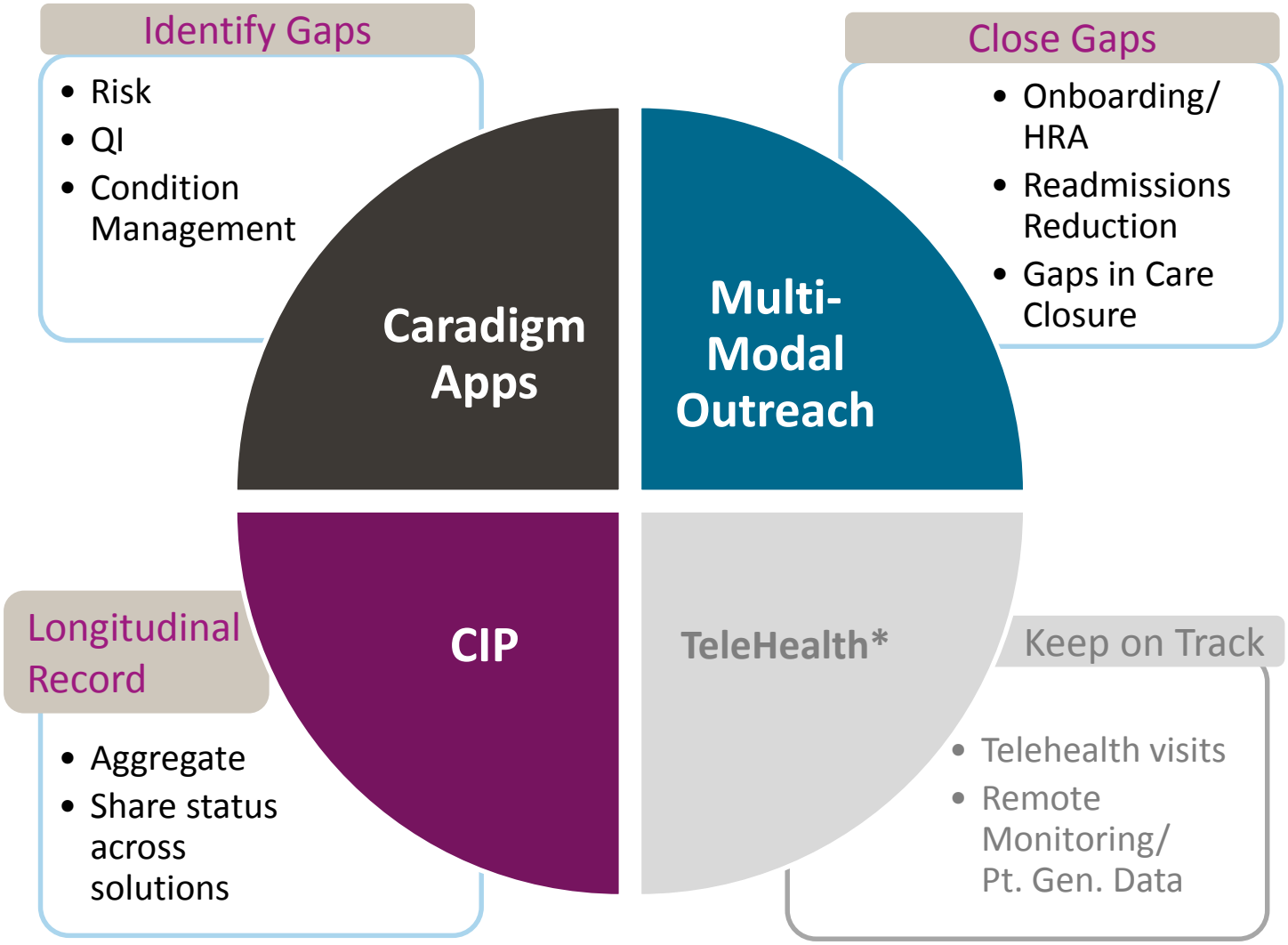

BAILEY, Samantha Louise 11 Mar 1944
82↑ Readmit risk
Low CAUTI risk
6 QI gaps
4 CDM gaps
Help
Current Chart:
Bailey, Samantha Louise DOB: 02/11/1976 38y/o female Amil $20 100% Send Labs Out, X-Rays OK
Reminders
Visit / HS
Chart View
FlowSheets
Health Summary
Note
Health Summary
Current Problems
Allergies
Medications
PMH/FMH/SH
Edit
Past Medical History:
Type 1 Diabetes
Medication Noncompliance
Hospitalized 1988 DKA
Surgical History:
Fracture Repair: femur; casted, internal fixation; at age 12; s/p MVA;
Family History:
Positive for Hyperlipidemia and Hypertension.
Tobacco/Alcohol/Supplements
Edit
Tobacco/Alcohol/Supplements:
Tobacco: Nonsmoker (never smoked);
Alcohol:
Drinks alcohol on a social basis only.
Caffeine: She admits to consuming caffeine via coffee (2 servings per day)
Substance Abuse History
Mental Health History
Communicable Disease History
Doctor's Note (Contains past visit)
Inc. Font
Dec. Font
Print Preview
FastForms
Full Text View
Outline Text View
Refresh All
Hx
Detl
CC
HPI
ROS
PMH
Prblm
Immz
Allrg
Meds
Vital
Bailey, Samantha Louise 02/11/1976
Office/Outpatient Visit
Visit Date: Mon, Sep 27, 2010 12:35 pm
Provider: Kelsey Killdear, MD (Assistant: Heather Helper, MA)
Location: Heal with Steel Health Center
SUBJECTIVE:
CC:
Ms Bailey is a 25-year-old Caucasian female. Medical problems to be addressed today include type I diabetes.
Past Medical History Maintenance
Expand All
Collapse All
Increase Font
Decrease Font
PMH/FMH/SH
Past Medical History:
Type 1 Diabetes
Medication Noncompliance
Hospitalized 1988 DKA
Surgical History:
Fracture Repair: femur; casted, internal fixation; at age 12; s/p MVA;
Family History:
Positive for Hyperlipidemia and Hypertension.
Social History:
Occupation:
Unemployed
Marital Status: Single
Tobacco/Alcohol/Supplements
Tobacco/Alcohol/Supplements:
Tobacco: Nonsmoker (never smoked);
Alcohol:
Drinks alcohol on a social basis only.
Caffeine: She admits to consuming caffeine via coffee (2 servings per day).
Substance Abuse History
Mental Health History
Communicable Disease History
Most recent lab
heral neuropathy
non-healing nasal
paroxysmal
pleuritic chest pain
l bloating,
hemorrhoids,
talia, hematuria,
octuria, polyuria,


BAILEY, Samantha Louise 11 Mar 1944
82↑ Readmit risk
Low CAUTI risk
6 QI gaps
4 CDM gaps
Readmit risk positive factors
Age: >69
Chronic conditions: 1 or more
No ACE/ARB prescribed
Missing influenza vaccine
Caradigm Knowledge Hub © 2014
Help
DOB: 02/11/1976 38y/o female Amil $20 100% Send Labs Out, X-Rays OK
Sheets
Health Summary
Note
Doctor's Note (Contains past visit)
Caradigm Chronic Disease Management
QI
PRI
PRO
BAILEY, Samantha Louise DOB 11 Mar 1944 Female
Measures out of compliance
FILTERS
Filter(s) applied: Status is Non-compliant
Remove all filters
Compliance last calculated on: May 01 2014
Measure / Sub measure
Compliant?
Next step / recent note
Comprehensive Diabetes Care (Commercial/Medicaid)
No
HbA1c <8%
No
Contact patient
Counsel patient on HbA1c control and schedule regular measurements
LDL-C screening
No
Contact patient
Schedule a screening
COA Care for Older Adults
No
Screening for colorectal cancer
No
Contact patient
Schedule a screening
Tobacco/Alcohol/Supplements:
Tobacco: Nonsmoker (never smoked);
Alcohol:
Drinks alcohol on a social basis only.
Caffeine: She admits to consuming caffeine via coffee (2 servings per day).
Substance Abuse History
Mental Health History
Communicable Disease History
hemorrhoids,
hematuria,
polyuria,

Caradigm PHMS – Integrating the Patient



* Target partnership timing 2H'15-1H'16

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Establish Engagement as a Core Element of PHMS

GOAL: Activate patients to drive health-related behavior change

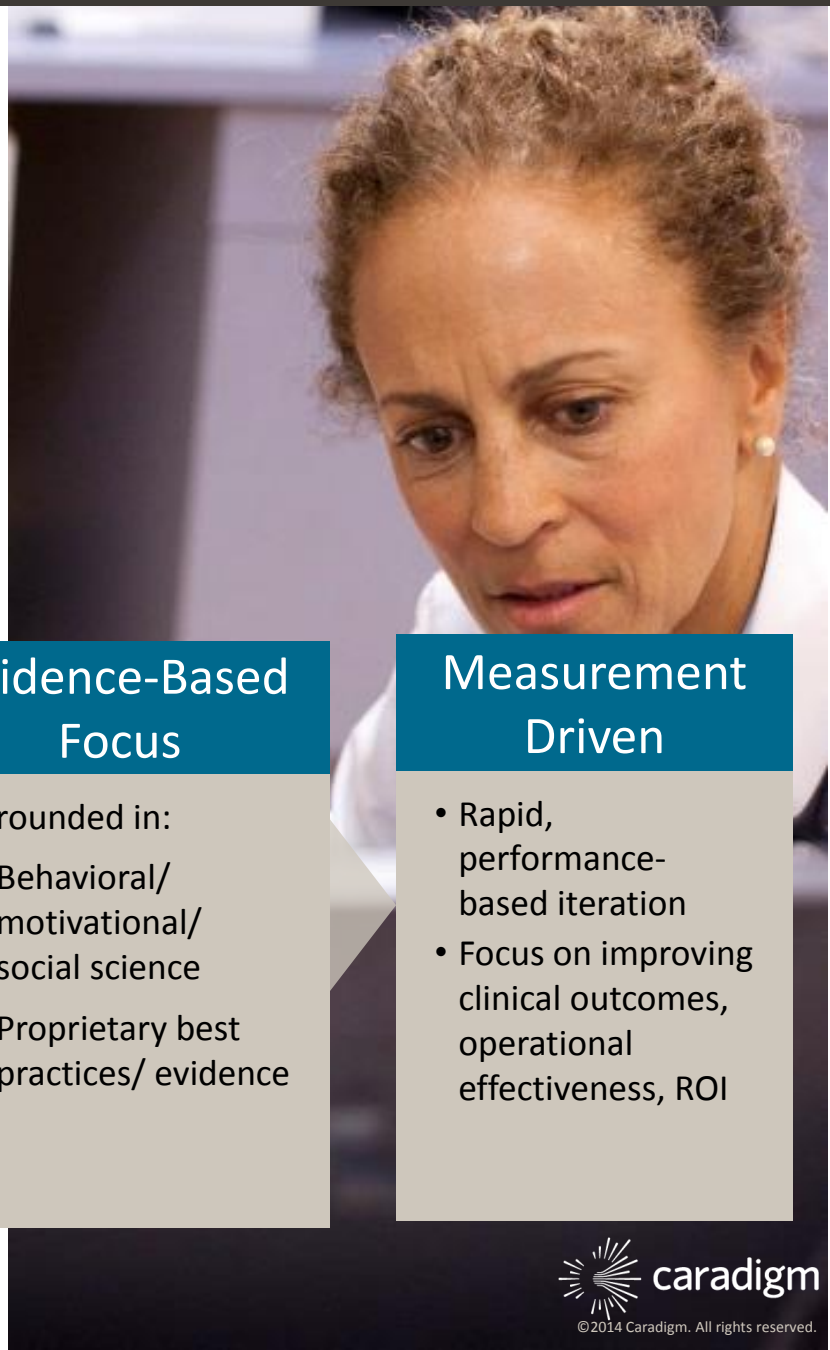
Meet patients **where they are** with the **right message** at the **right time**

Behavior = Ability------X-----Motivation-----X-----Trigger

(ease of action) (why I should care) (prompt to act)

Engage Outreach partner with proven expertise/solutions:

- Best practice/evidence-based messaging, targeting and interaction design
- Comprehensive campaign tools for patient relationship management
- Robust monitoring system to enable rapid, performance-based iteration
- Actionable analytic reports with metrics at the outreach, program and LOB level



Outreach

- Full range of contact modalities
- Incorporating patient contact preferences
- Targeted messaging
- Proven, effective interactions

Telehealth

- Virtual visits
- Remote patient monitoring
- Bi-directional data flow with CIP

Evidence-Based Focus

- Grounded in:
  - Behavioral/ motivational/ social science
  - Proprietary best practices/ evidence

Measurement Driven

- Rapid, performance-based iteration
- Focus on improving clinical outcomes, operational effectiveness, ROI

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Caradigm DSRIP Package of Solutions

Care Coordination and Management Solution

- Risk Management (RM)
- Care Management (CM)
- Quality Improvement (QI)
- Patient Engagement

Caradigm Intelligence Platform (CIP)

Outreach → Enrollment → Care Planning → Care Management and Coordination → Billing Data

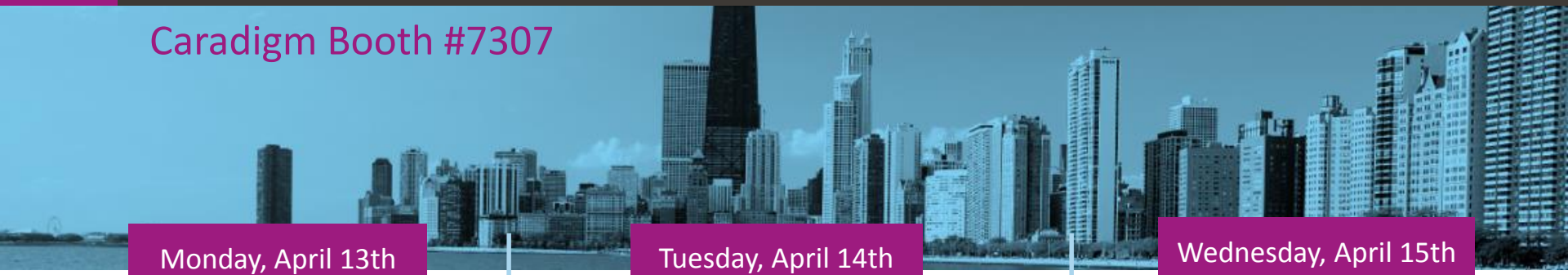
Track, Monitor and Report on Metrics

Caradigm Population Analytics

KPMG caradigm

Join us at HIMSS15

Caradigm Booth #7307



Monday, April 13th

1:00pm
Panel: Population Health Trends and Insights

3:00pm
Panel: Accountable Care Organizations

Tuesday, April 14th

11:00am
Panel: Accountable Care Organizations

1:00pm
Panel: Population Health Trends and Insights

3:00pm
Panel: DSRIP Program – Enabling Participation for Performing Provider Systems

Wednesday, April 15th

12:00pm
Panel: The State of Healthcare Data Privacy and Security

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Questions?

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