

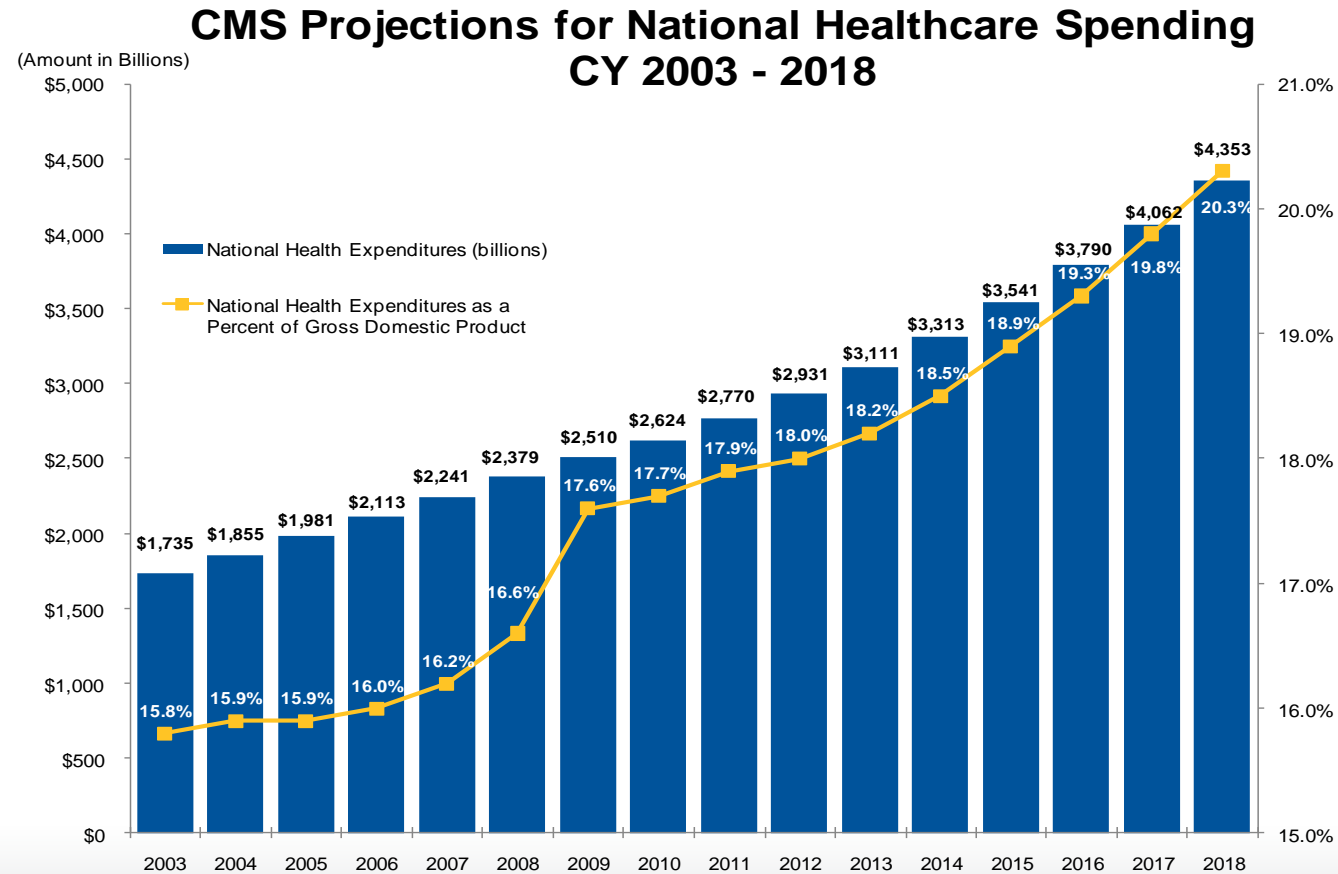
PRISMA HEALTHSM

Risk, Reward & Population Health: A Health System Response

Angelo Sinopoli, MD

Chief Clinical Officer, Prisma Health
President, Care Coordination Institute

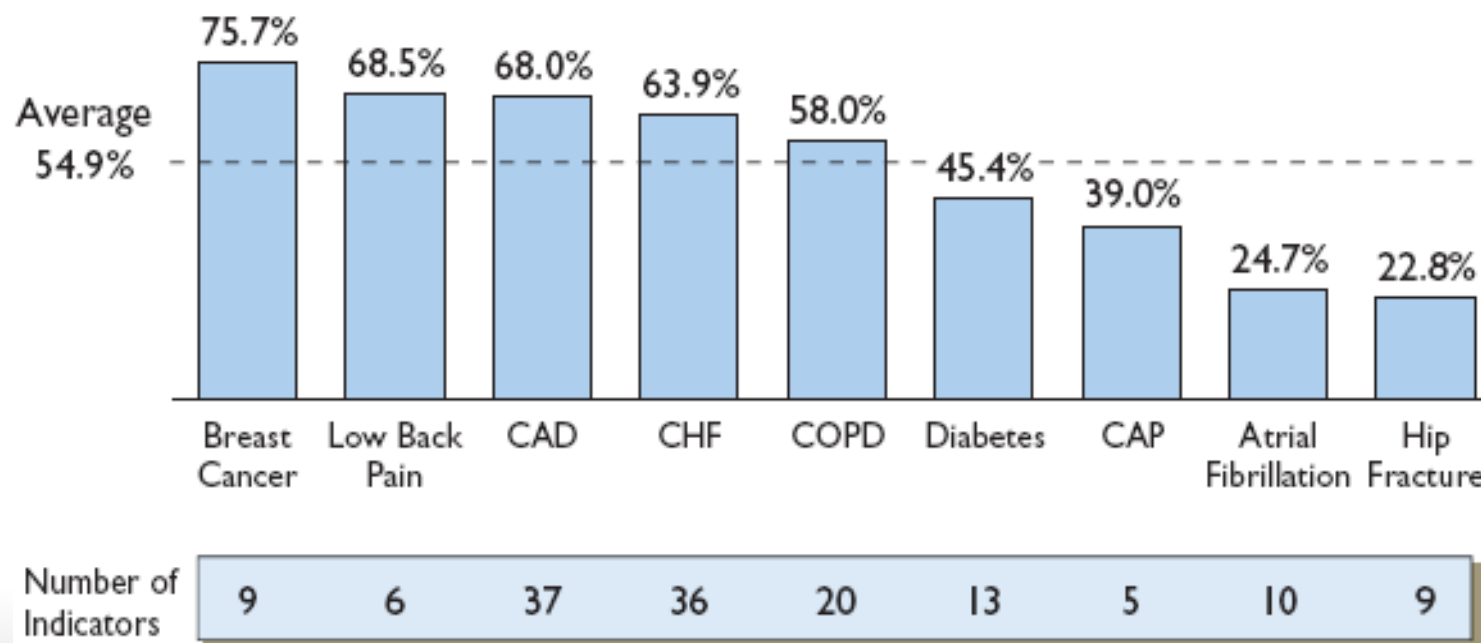
Health Care Spending Growing Out of Control



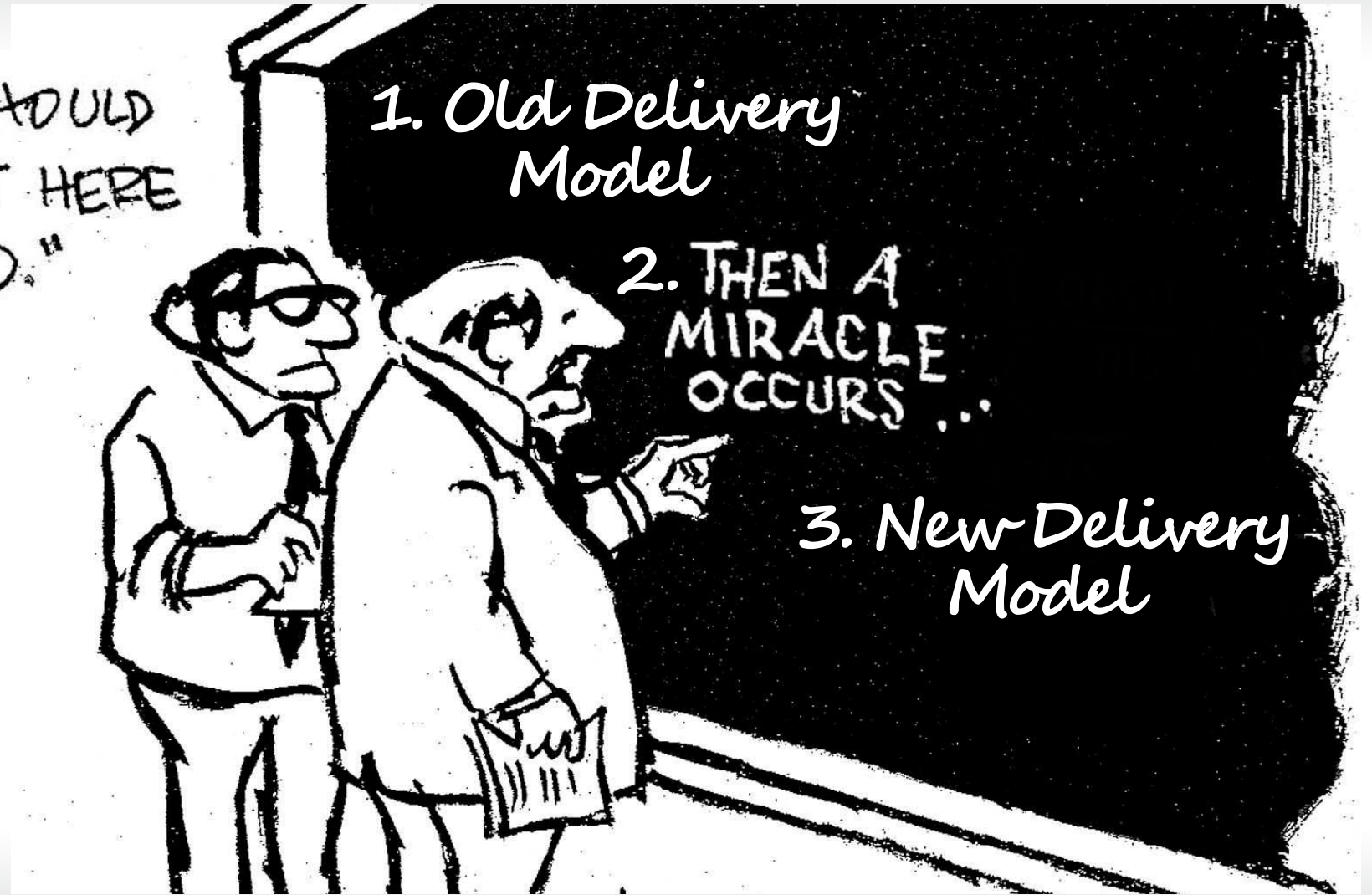
Source: Centers for Medicaid & Medicare Services - NHE Projections 2008-2018, Forecast Summary and Selected Tables

Uneven Adherence to the Evidence

Percentage of Recommended Care Received, by Condition¹



"I THINK YOU SHOULD
BE MORE EXPLICIT HERE
IN STEP TWO."



Strategic Positioning: Multi-Year Goals

Total Health Organization

- Right Care, Right Time, Right Place
- Clinical competencies to perform under Health Reform

Health Care Value Leader

- Business systems and structures to perform under health reform
- Partnerships with payers and industry
- Cost efficient, quality focused

Clinical Integration

- Systems, structures & processes to improve operating performance
- Network development for FFS business and for population coverage
- Building and linking the healthcare continuum

Innovation in Academics

- Leverage academics to improve clinical and financial performance
- Create a clinical workforce to lead in a reformed healthcare environment

Sustainable Financial Model

- Efficiently create and allocate resources to achieve mission
- Strong performance in today's environment while positioning for health reform

Duke Innovation Grant

- Initial pilot focused on Medicaid clinic population and subsequently the unfunded population
- Developed a stratification process based on ED and hospital utilization

James B. Dilke

THE DUKE ENDOWMENT

Duke Innovation Grant

Results:

- **55% decrease** in inpatient days
- **26% decrease** in Emergency Department visits
- **14% decrease** for Diabetes, number of patients with HgA1c High values (>9%)
- **15% decrease** in abnormal LDL-C values
- **13% improvement** for number of hypertensive, non-diabetic patients with readings within 140/80 parameters
- **11% improvement** for number of asthmatic patients appropriately receiving corticosteroid/acceptable alternative therapy

ED Care Management



- Active Case Management
- Connecting to a Medical Home
- Addressing Social Issues

Highest ED/EMS Utilization

Zip Codes: 29605 & 29611

36

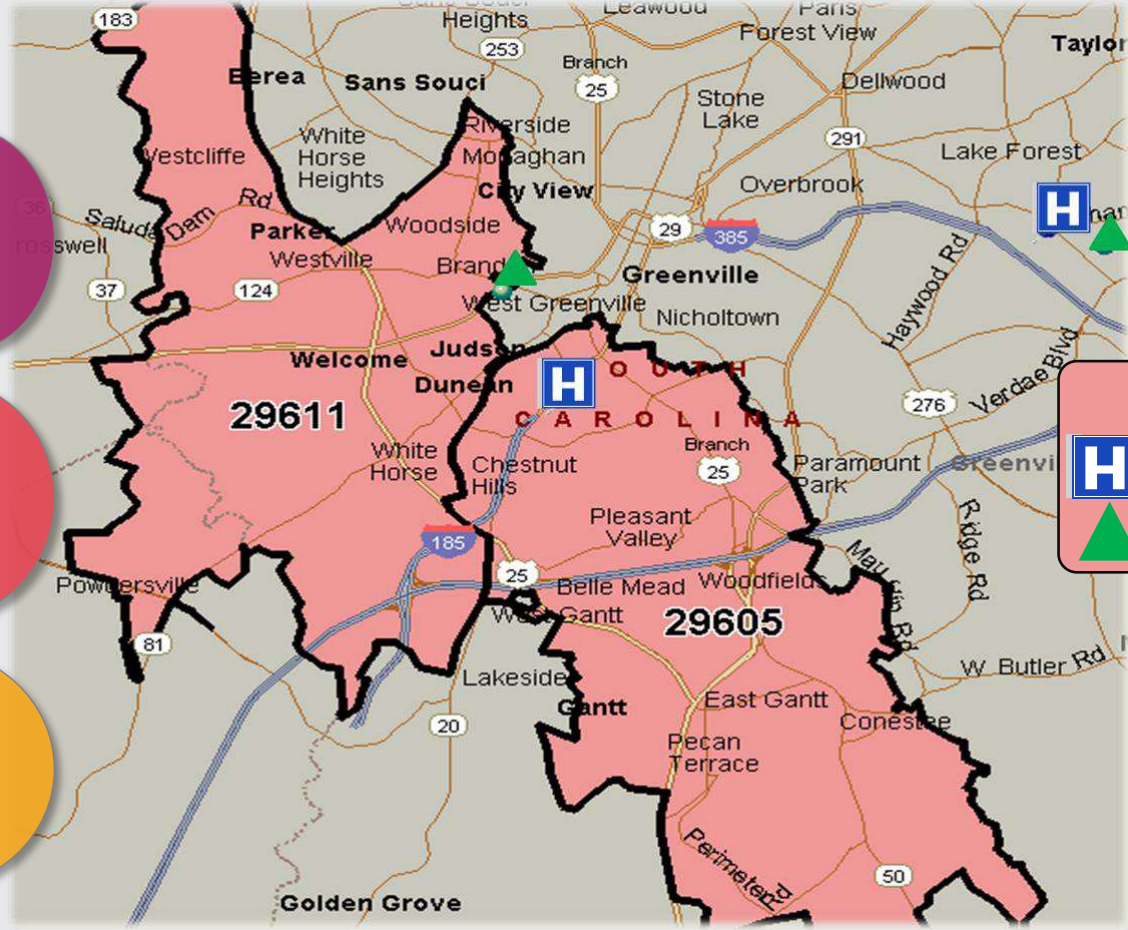
Average Patient Age

5.5

Average per Patient Visit

264

of 470 highest ED utilization patients reside in highlighted zip codes



Key

- GHS Hospitals
- St. Francis Hospitals

Alpha/Omega Calls

(Low Acuity)

Baseline Response Example		
All actual response assignments are decided by local Medical Control and EMS Administration		
Level	Response	Mode
ECHO	Closest Apparatus—Any (includes Truck Companies, HAZMAT, or on-air staff)	HOT
DELTA	Closest BLS Engine Paramedic Ambulance	HOT HOT
CHARLIE	Paramedic Ambulance	COLD
BRAVO	Closest BLS Engine BLS Ambulance (alone HOT if closest)	HOT COLD
ALPHA	BLS Ambulance	COLD
OMEGA	Referral or Alternate Care	

- 19% of all GCEMS calls
- Significant portion could be appropriately referred to the appropriate care setting:
 - Urgent care centers
 - Physician offices
 - Social services
 - Nurse advice lines
 - Follow-up service

GHS/EMS Partnership

Awarded a \$300,000 grant to reduce unnecessary ED and EMS utilization by:

- Creating an innovative nurse triage call center used in only two other locations in the US
- Providing care coordination to ED and EMS high utilizers so they receive the right care at the right time and place
- Developing patient-centered medical neighborhoods within the community



Costs Saved

Total Program Costs Saved

**\$3.3
Million**

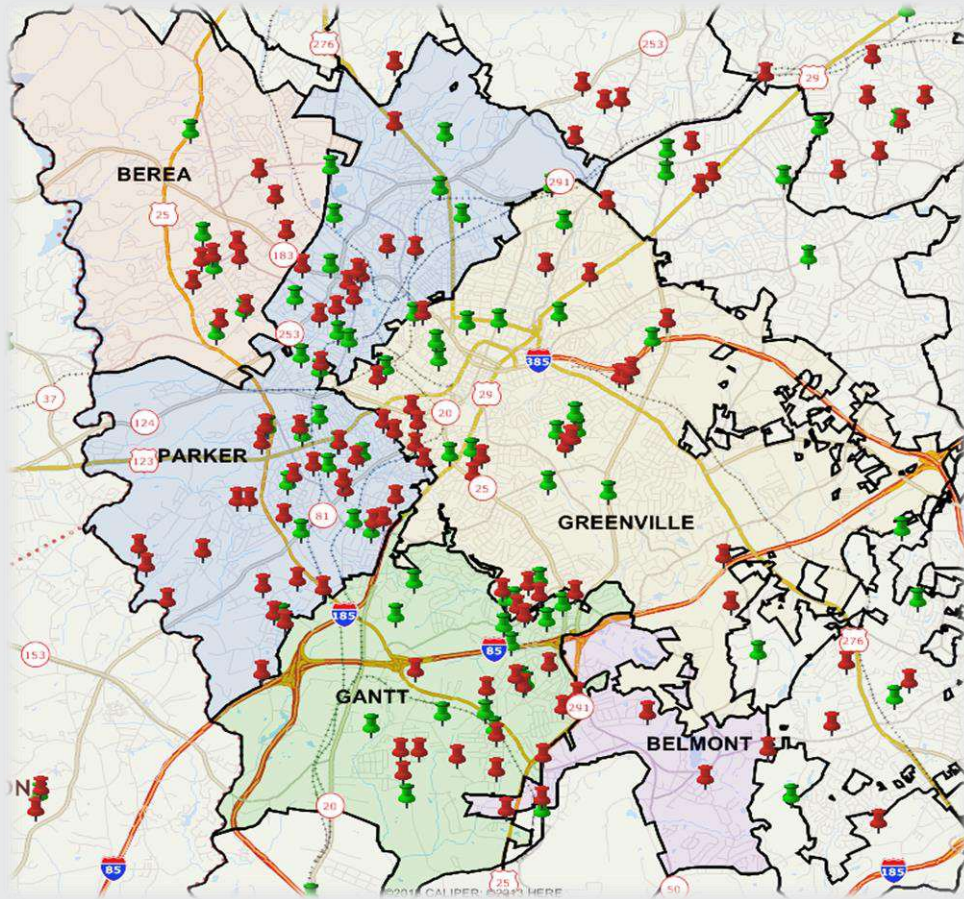
Total EMS Responses Avoided – 4,475

- \$1,872,801

Total ED Visits Avoided – 1,536

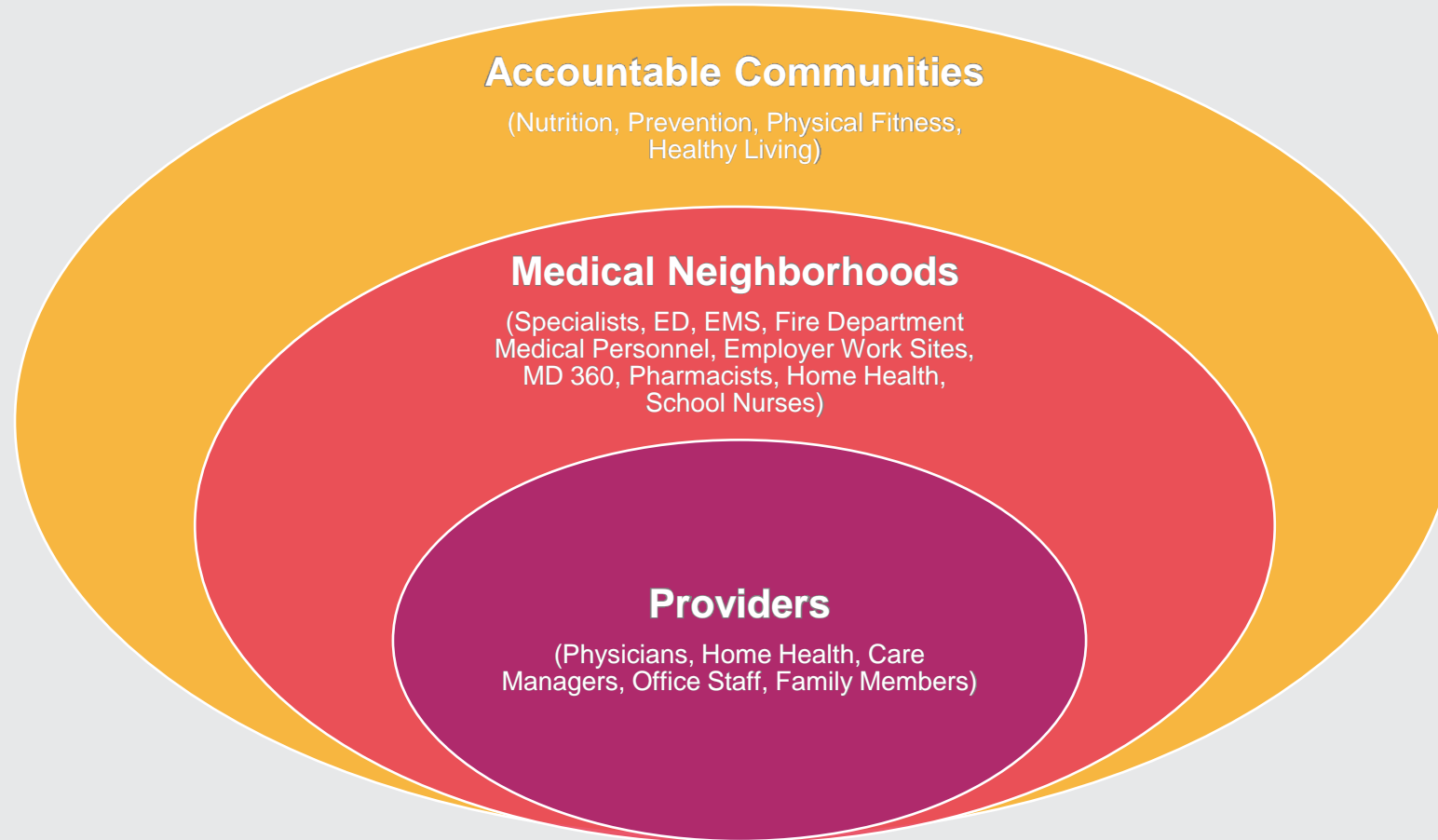
- \$1,496,199

Neighborhood Health Partners Care Team



- BCBSSC Grant Year Three
- ED/EMS High Utilizers
- Pilot Neighborhoods:
 - Parker
 - Bera
 - Gantt
 - Belmont
 - Greenville City
 - Added Laurens, Pickens, Oconee
- Healthy Outcomes Plan

Beyond the Medical Home



Medical Neighborhoods

- Health system and safety-net collaboration
- Providing access to care within communities
- Community Paramedic and Health Worker Models
- Home Health
- Mobile Health Clinic
- Care Management
- Care Coordination



Neighborhood Health Partners

Community Health Worker



GHS Utilization:

- Overall cases increased by 6.4% (increase in PCP visits)
- Hospital admissions decreased by 44.4%
- Emergency room visits decreased by 15.4%
- Primary Care visits increased by 49.7%

Of 493 patients, 252 patients had data and included in this analysis

Neighborhood Health Partners Community Paramedic

GHS Utilization (aggregated numbers for CPP for patients enrolled through May 2018):

- Total cases decreased by 5.9%
- Total cost decreased \$754,170
- Hospital Admissions decreased by 33.7%
- ALOS decreased by 3.8 days
- ER Visits decreased by 19.5%
- Primary Care Visits increased by 70.6%

EMS Utilization:

- EMS responses decreased by 53%
- Total costs decreased by \$149,160

Total Program Costs Saved

\$903,330
(\$9,610 per patient)

Neighborhood Health Partners Mobile Health Clinic

- Go-live Feb. 17, 2016
- 2673 patients encounters to-date
- 475 community clinic days at 9 sites
- 2138 uninsured patients referred to AccessHealth
- Payor:
 - 80% Uninsured
 - 10% Medicaid
 - 5% Medicare
 - 5% private

HEALTH | FEB 25, 2016 | BY MELINDA YOUNG

'Healthy and at home'

Local health systems offer solutions to treating chronically ill and uninsured



10 4 < PREVIOUS | NEXT >

f t in e

SHARE LINES

ACA has pushed health care industry toward keeping people healthy and out of hospitals

Bon Secours St. Francis and Greenville Health System focus on prevention, neighborhood health

Home visits and hands-on case management keep patients out of the ER

Gone are the days when health systems competed for patients and championed new technology to fill hospital beds. The Affordable Care Act (ACA) has pushed the nation's health care industry into a new direction: keeping people healthy and **out** of the hospital.

According to the [Congressional Budget Office](#), health care costs tripled in real terms between 1985 and 2005. Since the ACA became law, health care spending slowed to the lowest average rate of growth on record since 1965, according to a 2013 [presidential report](#).

Since most health care organizations accept government-funded Medicare and Medicaid patients, the [ACA](#) can influence change by setting financial mandates and incentives within those two systems. One such

RELATED

HEALTH | FEB 25, 2016
Who gives poor, uninsured patients primary care services?

HEALTH | FEB 25, 2016
Case study: How home visits

Accountable Communities

Community-led innovation

- Community asset maps
- Community resources (faith-based organizations, schools, EMS, police and fire districts)
- Safety-net providers (free clinics and FQHCs)
- Community volunteer programs
- Food deserts and community gardens

Partnerships to improve health

- AccessHealth
- Clemson Health Extension Pilot
- PASOs
- Swamp Rabbit Trail
- YMCA

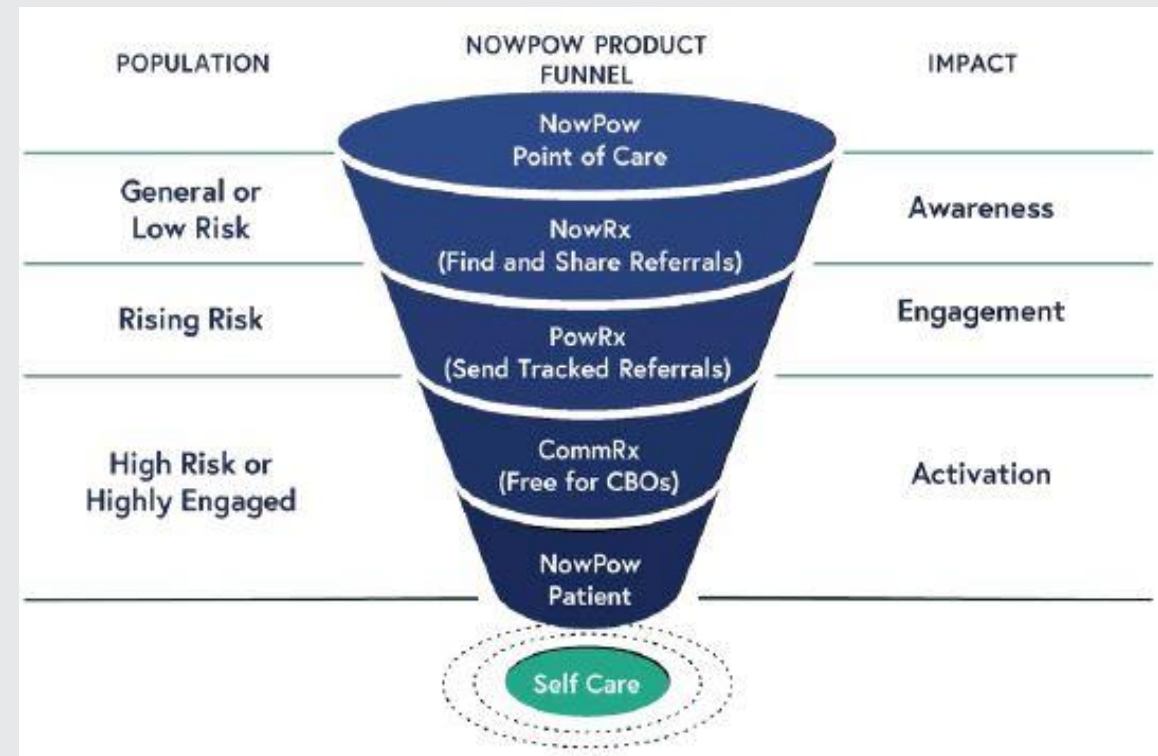


Better Connection to Community Based Organizations

NOWPOW

Overview

NowPow is multi-level technology platform that drives community level collaborations across the entire continuum of care. It empowers providers to promote quality community resources, make data-driven referrals, and track patient engagement and activation. The tool supports patients across the risk spectrum and supports many use cases while driving toward the goal of patient self care and fosters collaboration between health providers and community organizations.

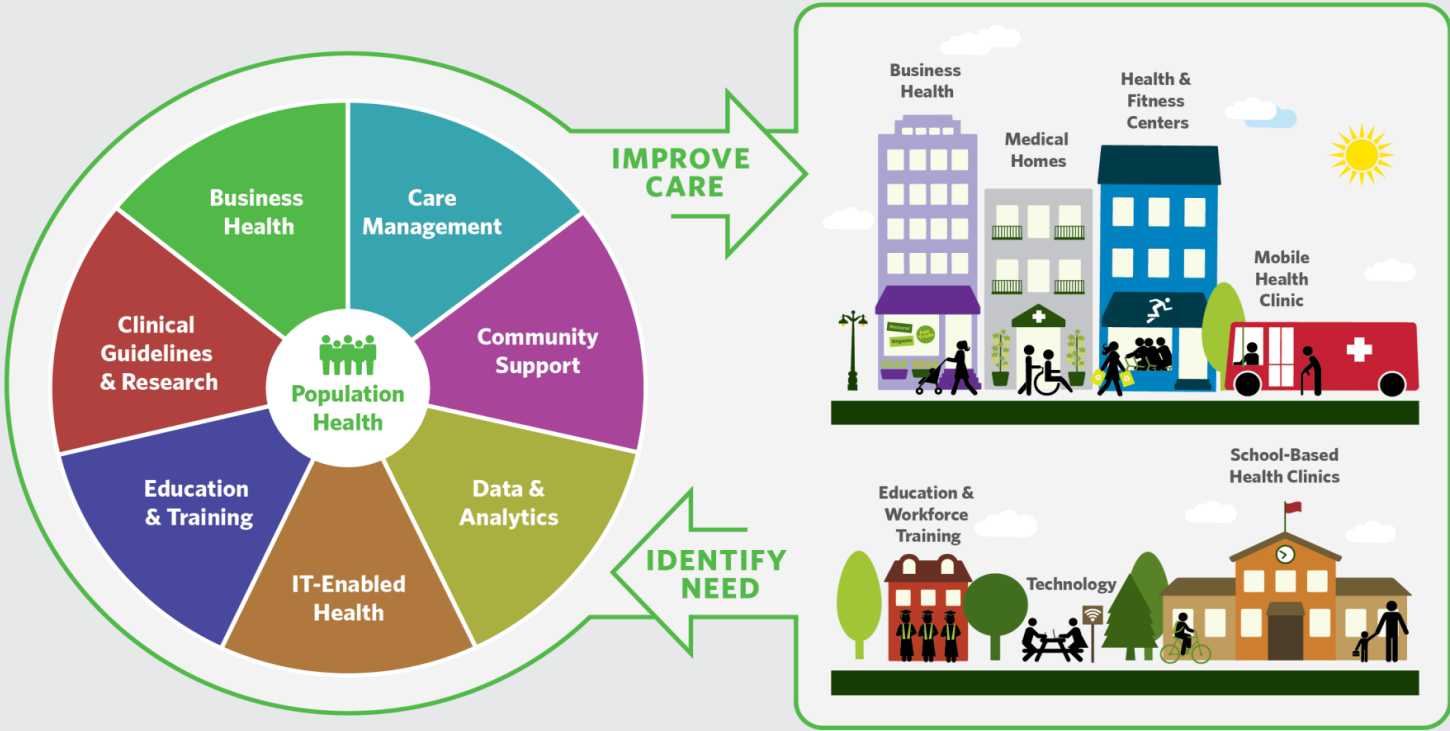


New Models of Primary Care Intervention



- Traditional physician office visits
- Advance practice providers
- Team care
- Care management
- Diabetes educators
- Community Health Workers
- Community Paramedics
- SmartExam
- Mobile clinics
- Retail clinics

IMPROVING THE HEALTH OF POPULATIONS







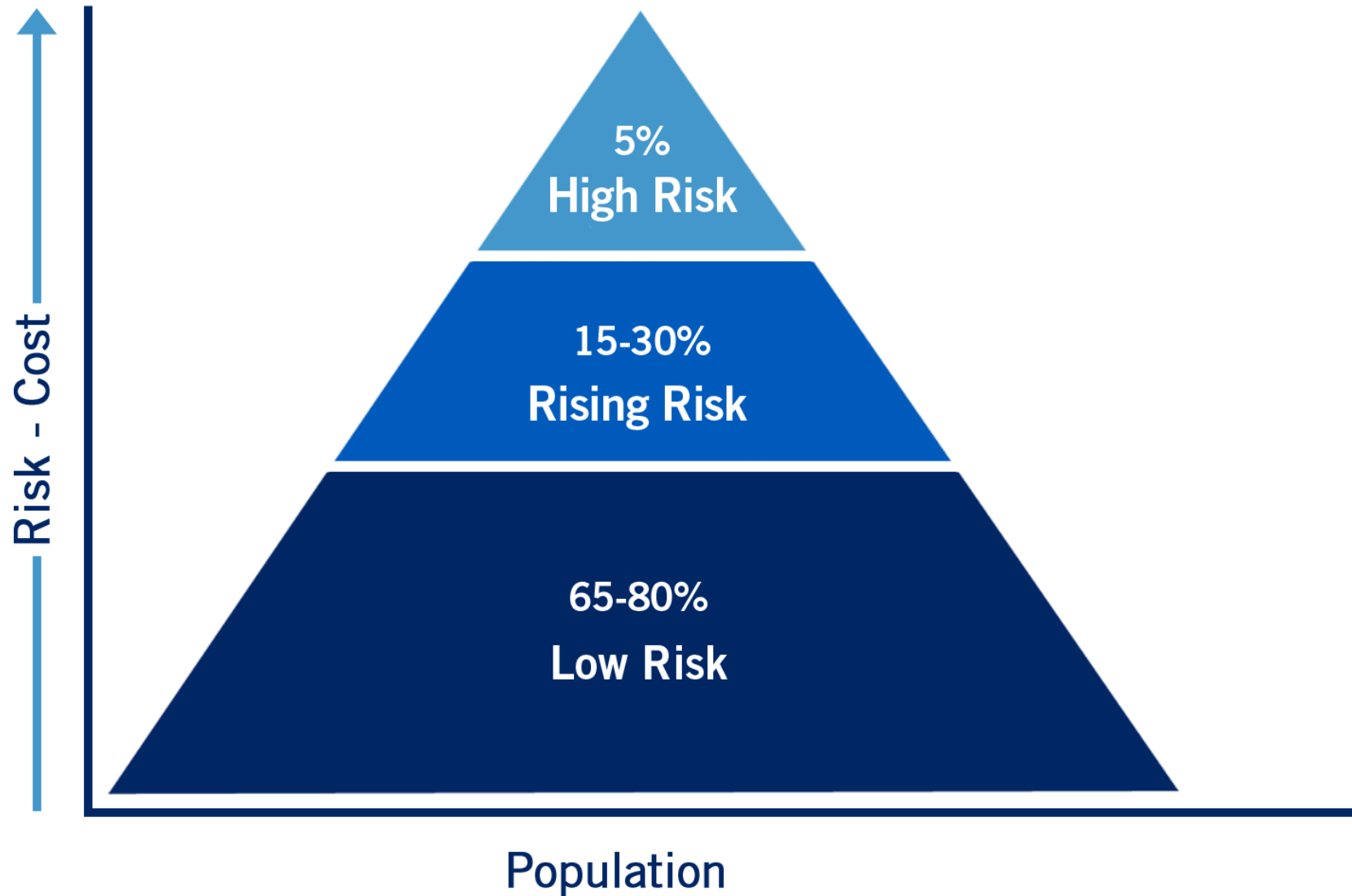
Population Health Approach

- Care Model Processes
- Evidence-Based Clinical Guidelines
- Care Pathways
- Practice Transformation
- Quality Improvement Programs
- Education and Training

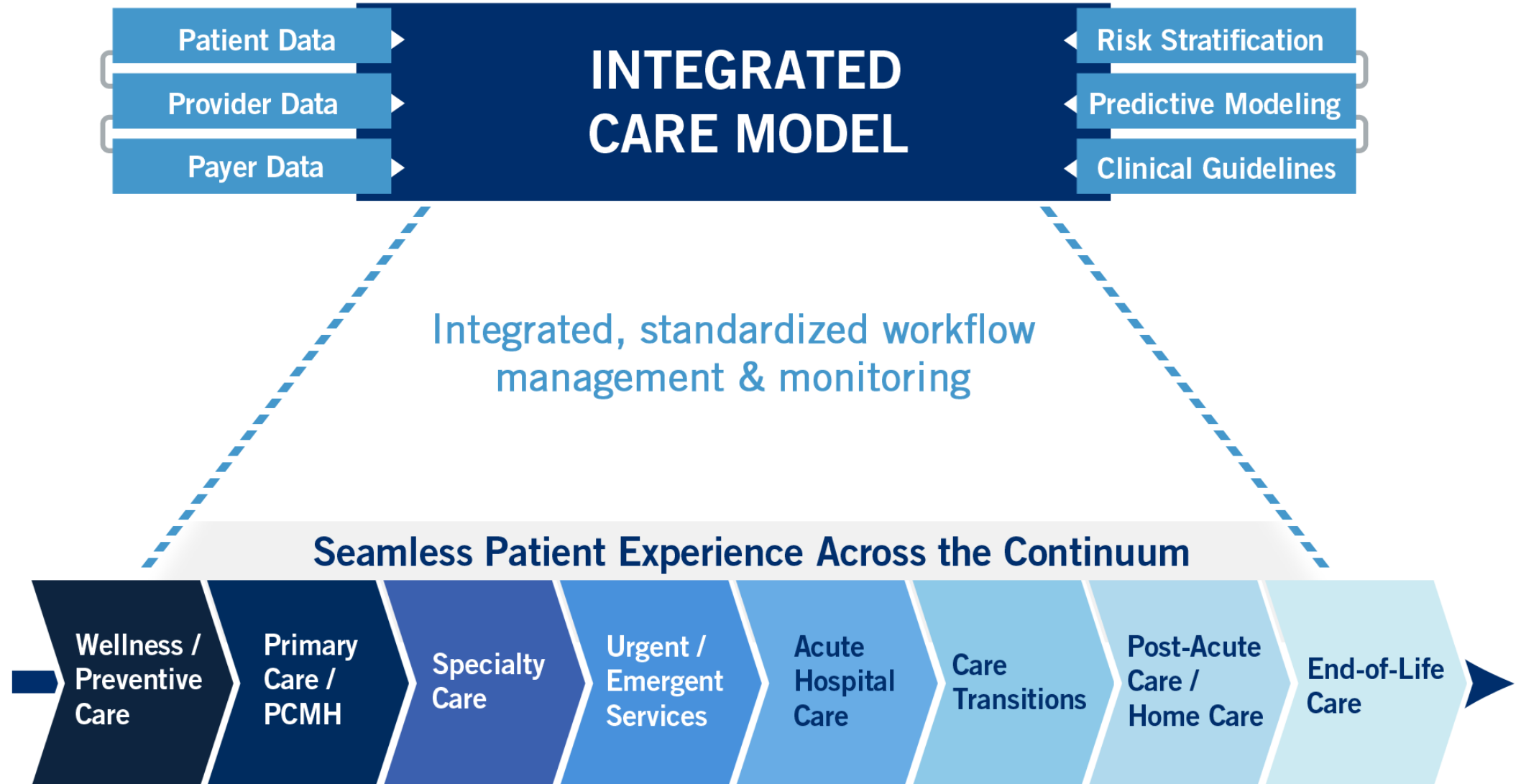
Analytics & Performance Improvement

- Data Acquisition
- Risk Stratification
- Quality, Cost, Experience & Process Reporting
- Population Health Analytics
- Performance Improvement Support

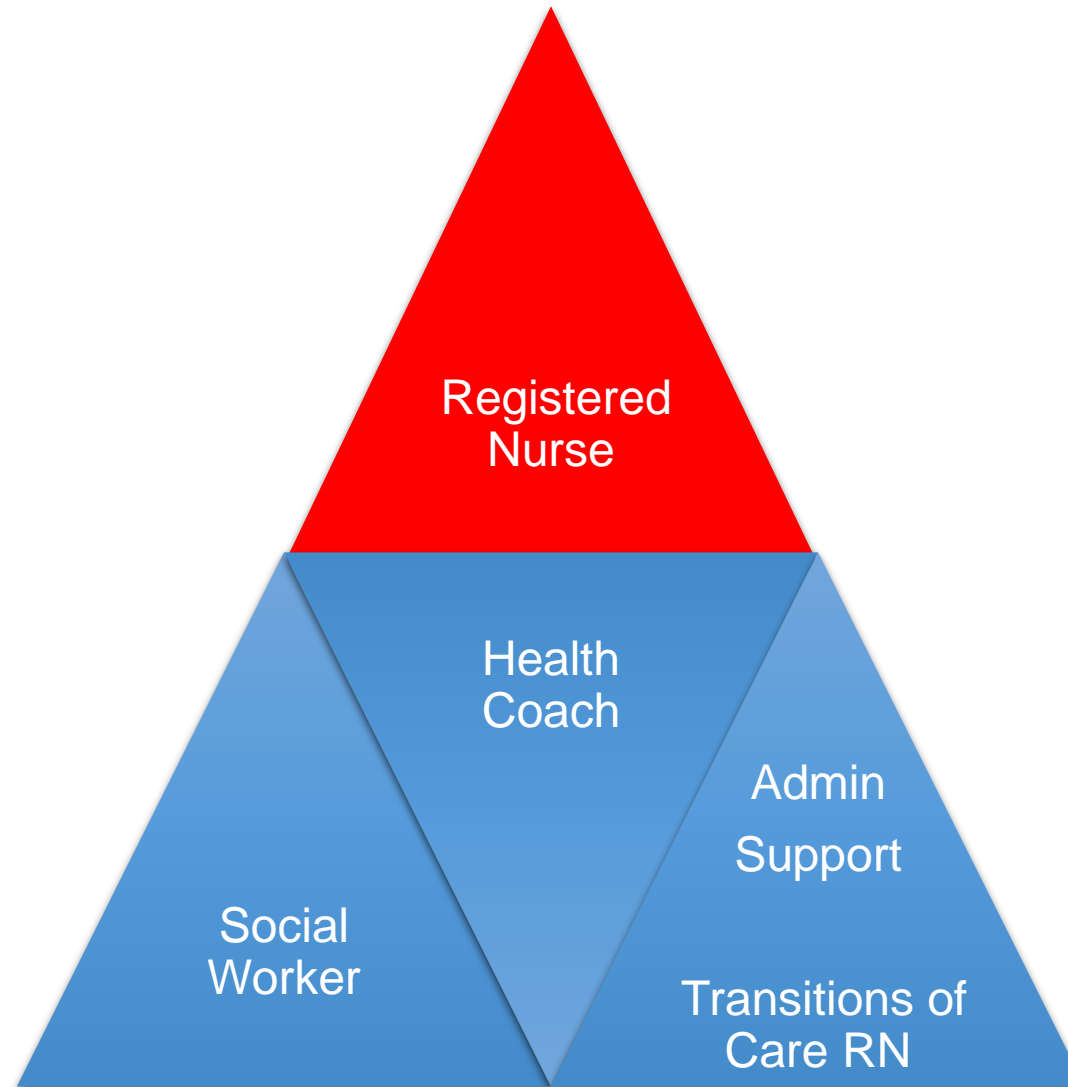
Population Categorization



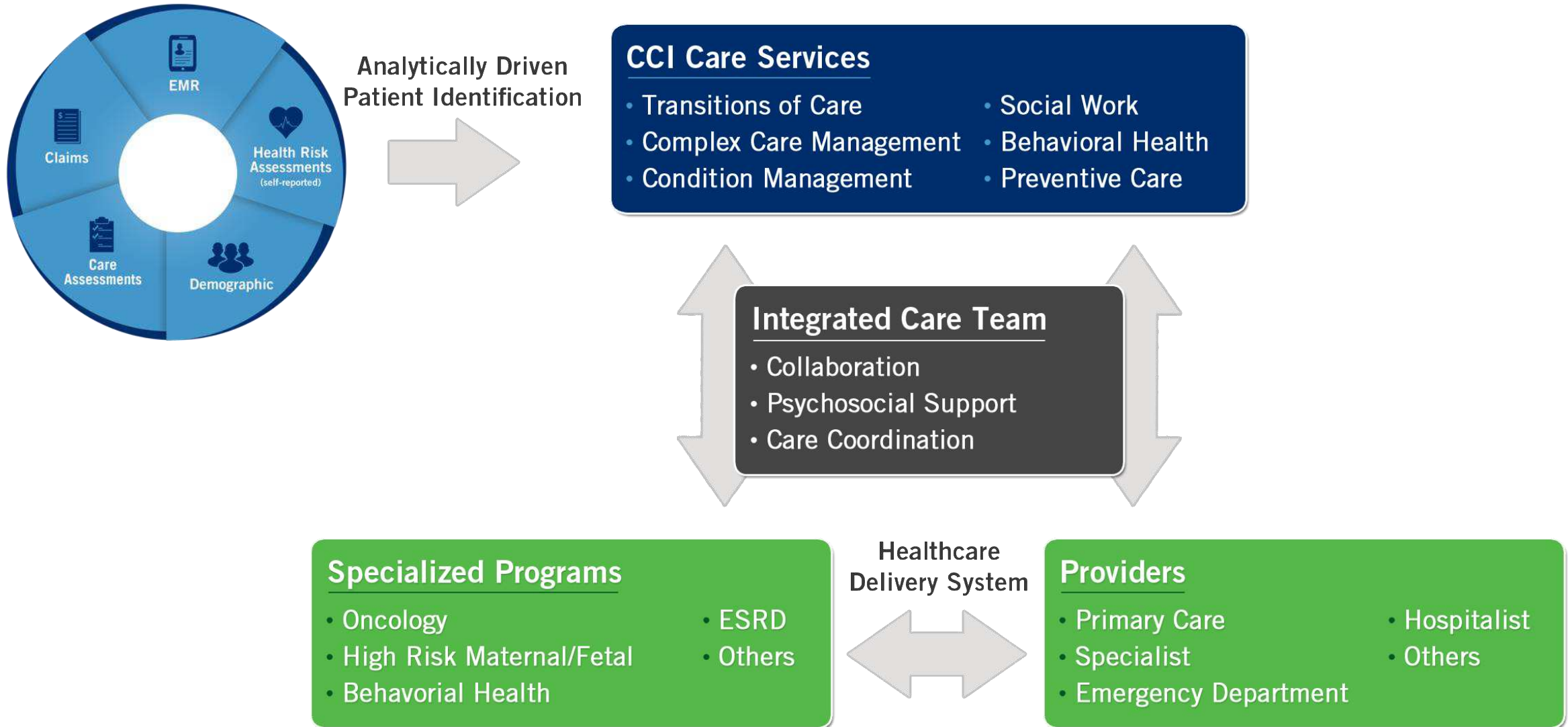
Continuum Based Care Model



Team-Based Model



Robust Collaborative Care Coordination



- **Integrated Care Teams**

- RN Care Managers (Complex Care Management)
- Health Coaches (Condition Management)
- Social Workers
- Support Specialists

- **Medical and Behavioral Health Physician Advisors**

- **Connected to Delivery Systems**

- Hospital Case Management
- Specialized Clinical Programs
- Community Health Programs (non-traditional)

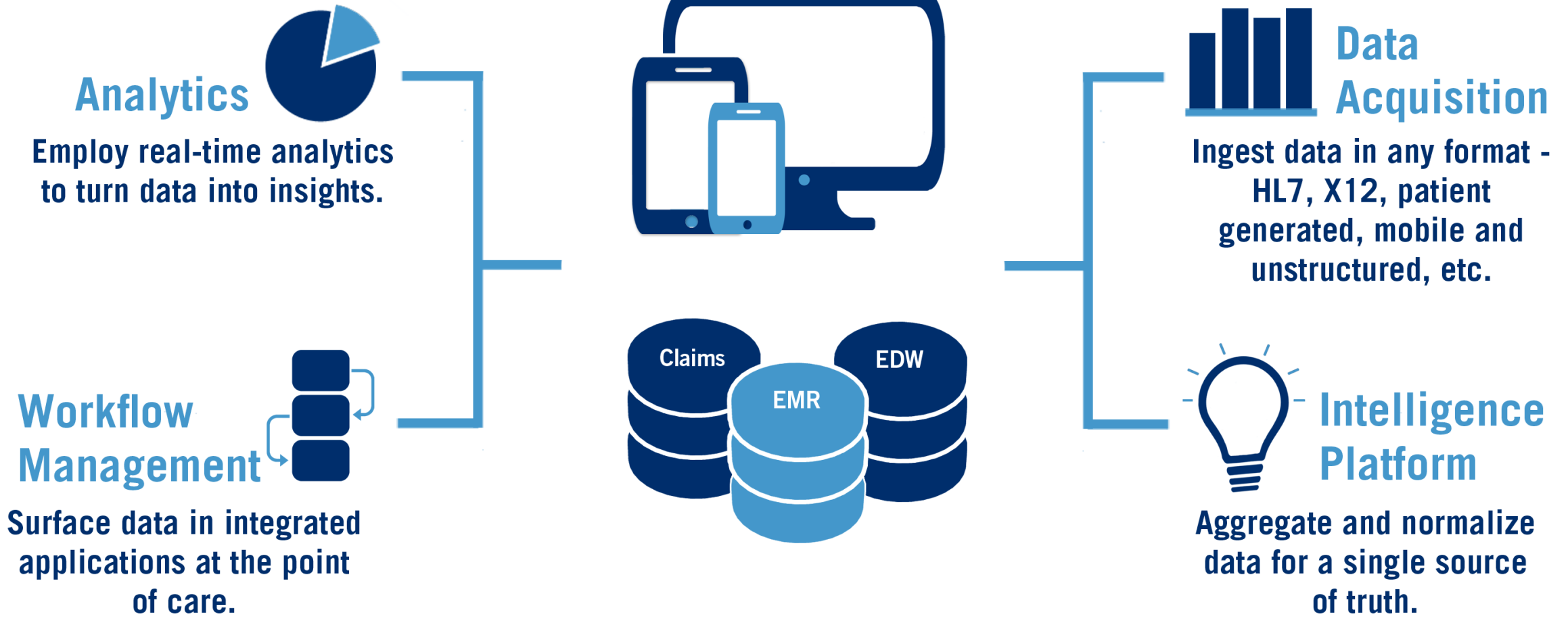
- **Subject Matter Expertise**

- Care Model Design
- Post Acute
- Value-based Care
- Evidence-based Guidelines

Care Model Outreach into Community



Population Health Infrastructure



Operations, Performance & Analytics

Data Operations

Activities

- Data Acquisition
- Data Wrangling (cleanse/normalize)
- Data Management

Job Family

- Database Admin
- Data Modeler
- Data Engineer
- Data Miner

Reporting & Analytics

Activities

- Reports, Dashboards, Visualizations
- Statistical Analysis
- Predictive Modeling
- Machine Learning

Job Family

- Report Writers
- Business Analyst
- BI Intelligence
- Statistician/Biostat
- Data Scientist

Application Development

Activities

- Custom application (web/mobile focus)
- Application integration and configuration
- API development/use

Job Family

- Software Engineer or Application Developer
- Mobile App Developer
- Front-end Designer
- API Specialist

Performance Improvement

Activities

- Time/process studies
- Data analysis and process analysis
- Connect with front-line practice

Job Family

- Performance Analyst
- Quality Engineer
- Lean Engineers
- Statisticians

Analytics & Reporting



- Ability to aggregate disparate clinical sources
- Automation of reporting
- Drive quality and performance improvement
- Produce risk categorization, quality and cost analysis, and develop predictive modeling

Population Management Experience

2.4M

Patient Lives

85

Practice
Groups

8,600

Providers

40M

Encounters

200,000

At-Risk Lives

3,600

Network Providers

Upstate SC Network



MyHFN Coverage & Providers

13 Counties

11 Hospitals

2,319 Providers

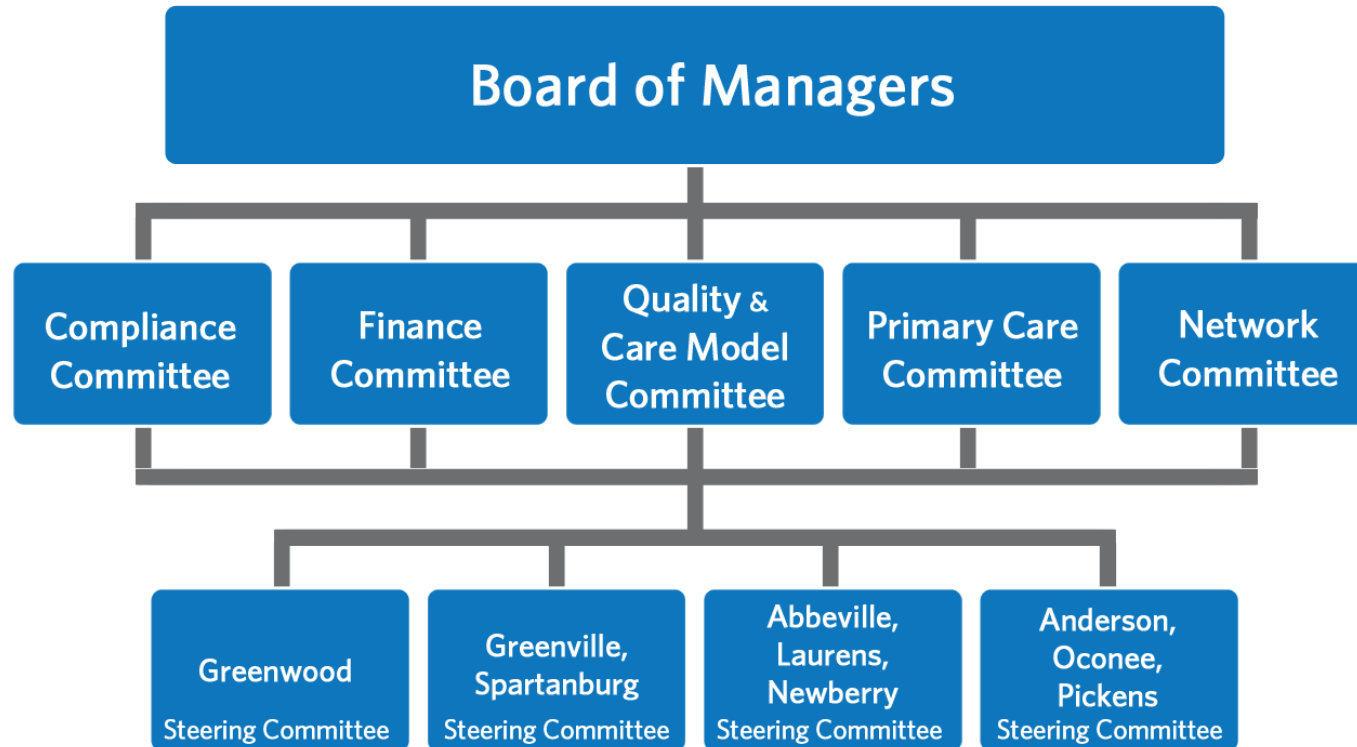
583 Primary Care

1,736 Specialists

1,917 Employed

402 Independent

Network Governance

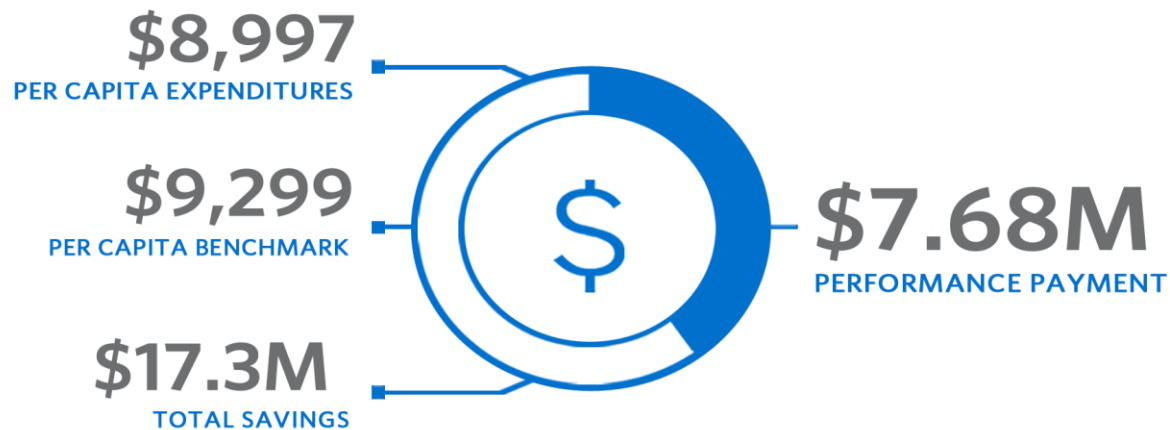


2015 MyHFN MSSP Performance



59,996

ASSIGNED BENEFICIARIES



\$17.3M

TOTAL SAVINGS

2016 MyHFN MSSP Performance



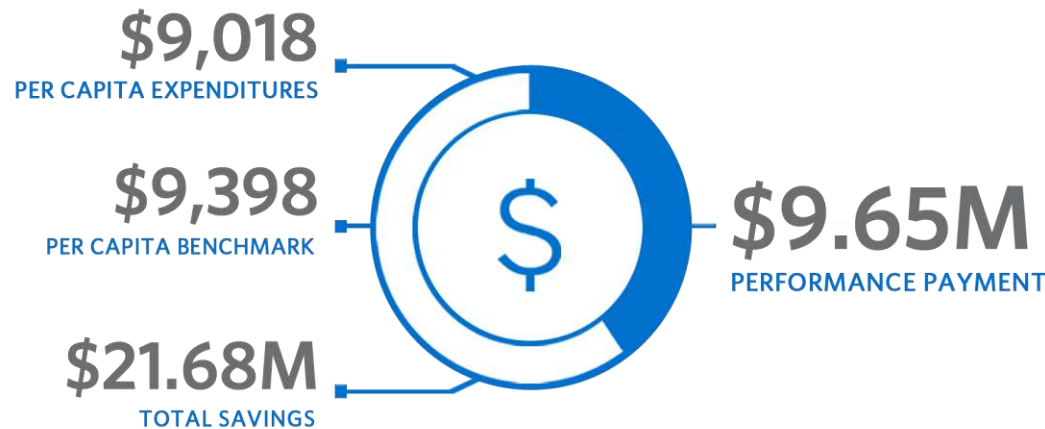
58,690

ASSIGNED BENEFICIARIES



90.9%

QUALITY SCORE



\$21.68M
TOTAL SAVINGS

2017 MyHFN MSSP Performance



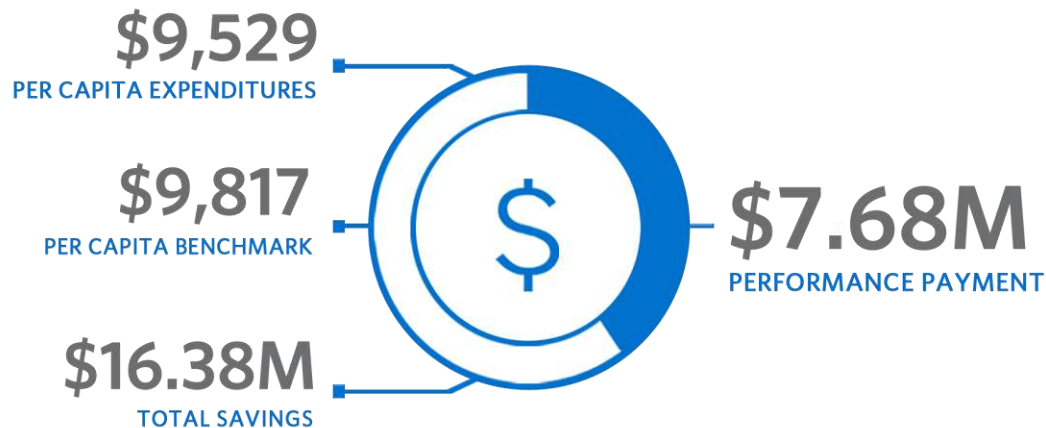
58,472

ASSIGNED BENEFICIARIES



97.9%

QUALITY SCORE

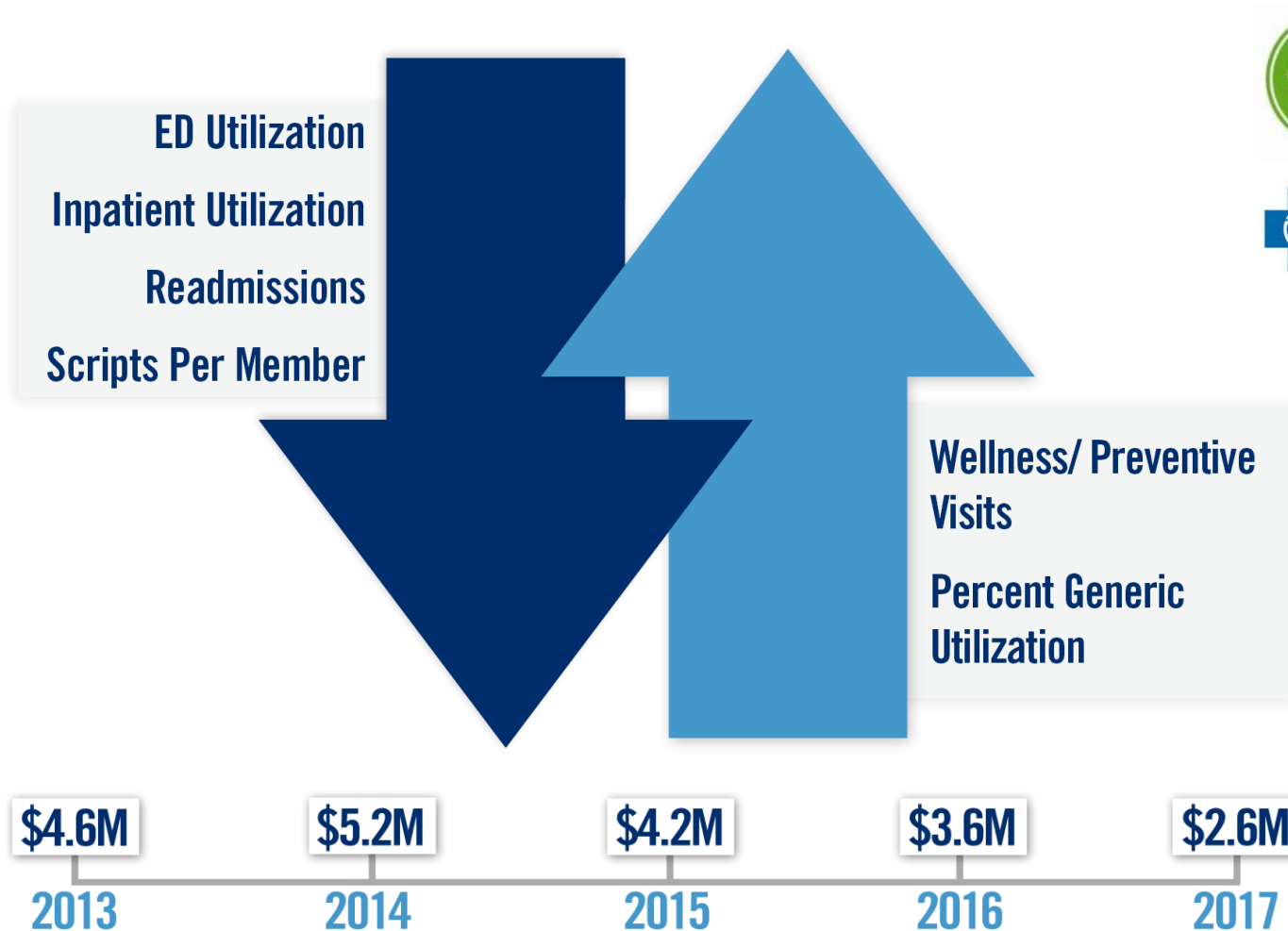


\$16.38M

TOTAL SAVINGS

Medicaid: Healthy Blue Successes

\$20 Million shared savings from 2013-2017



Employee Health Plan Successes

Improved A1C and LDL; Reduced PMPM

- Bent cost curve and improved employee outcomes through case management and population health initiatives
- Decrease in average A1C and LDL
- From 2013-2017, 6.1% increase bent to 2.7% increase in medical spend and 11.9% increase bent to 5.0% increase in pharmacy spend



	Per Member Per Month Spend					% Increase/(Decrease)			
	2013	2014	2015	2016	2017	2014	2015	2016	2017
Medical Claims ¹	\$362	\$385	\$367	\$364	\$374	6.1%	(4.5%)	(0.9%)	2.7%
Pharmacy Claims	100	112	128	126	133	11.9%	14.2%	(1.7%)	5.0%
Total Net Claims	\$463	\$497	\$495	\$490	\$506	7.4%	(0.3%)	(1.1%)	3.3%

¹ Medical Claims are net of stop loss
Calculated by FY (Oct-Sept)



RANKED

44th

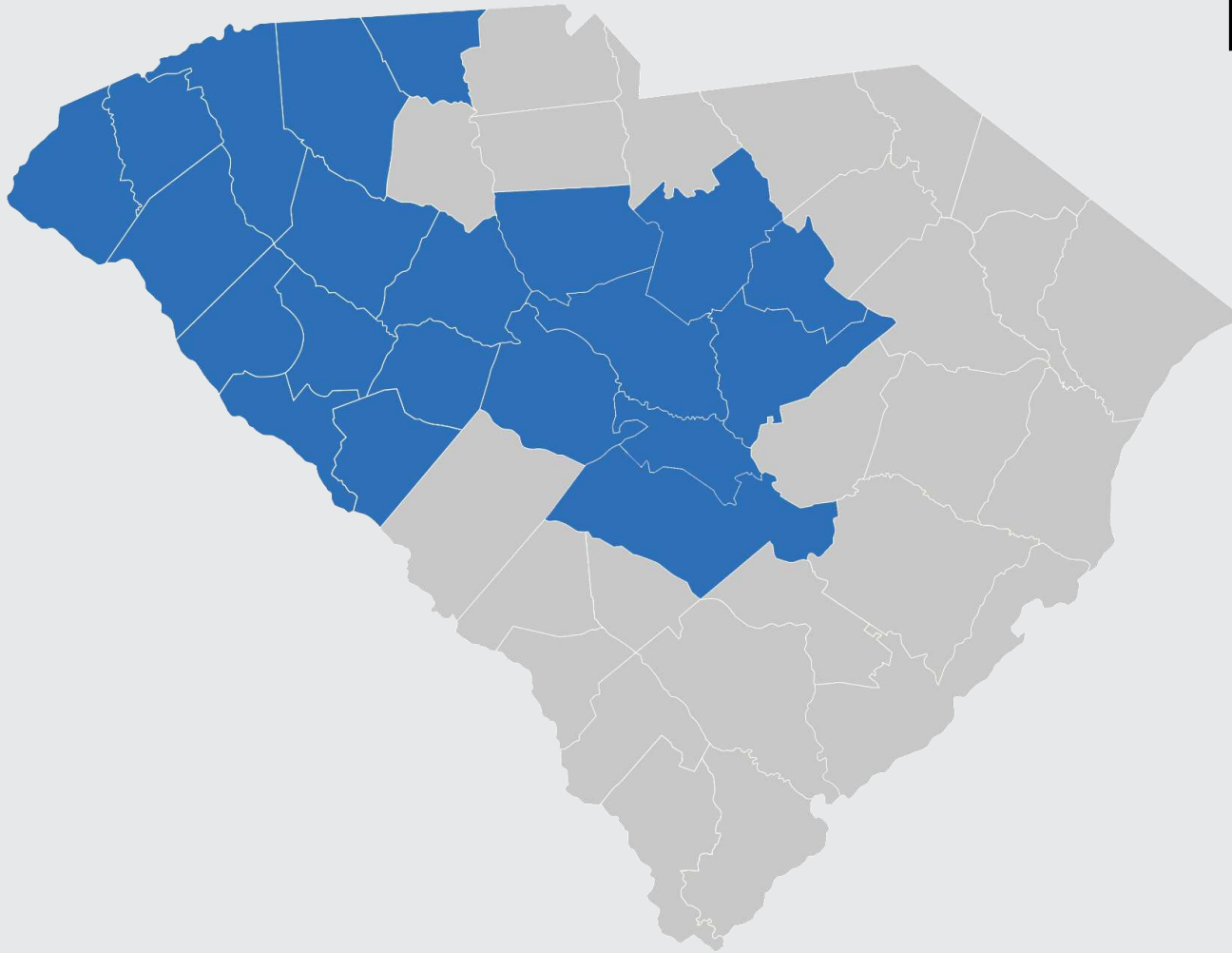
NATIONALLY

**Health care
needs a
new
approach...**

**Creating a better
health care future
for South Carolina**



PRISMA
HEALTH SM



Together we serve nearly half of South Carolina

Together, we serve
21 counties
with over
3,700 providers

Questions?

