LifeBridge Health ACO Population 2017 Strategy

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March 10, 2017

Agenda

ACO quality and value support across the continuum

Supporting participating providers with key infrastructure and services

Targeted care coordination efforts

In 2017 LifeBridge Health ACO will support quality and value across the continuum

Home | Primary Care | Specialists | Urgent Care | Hospital | Post-Acute

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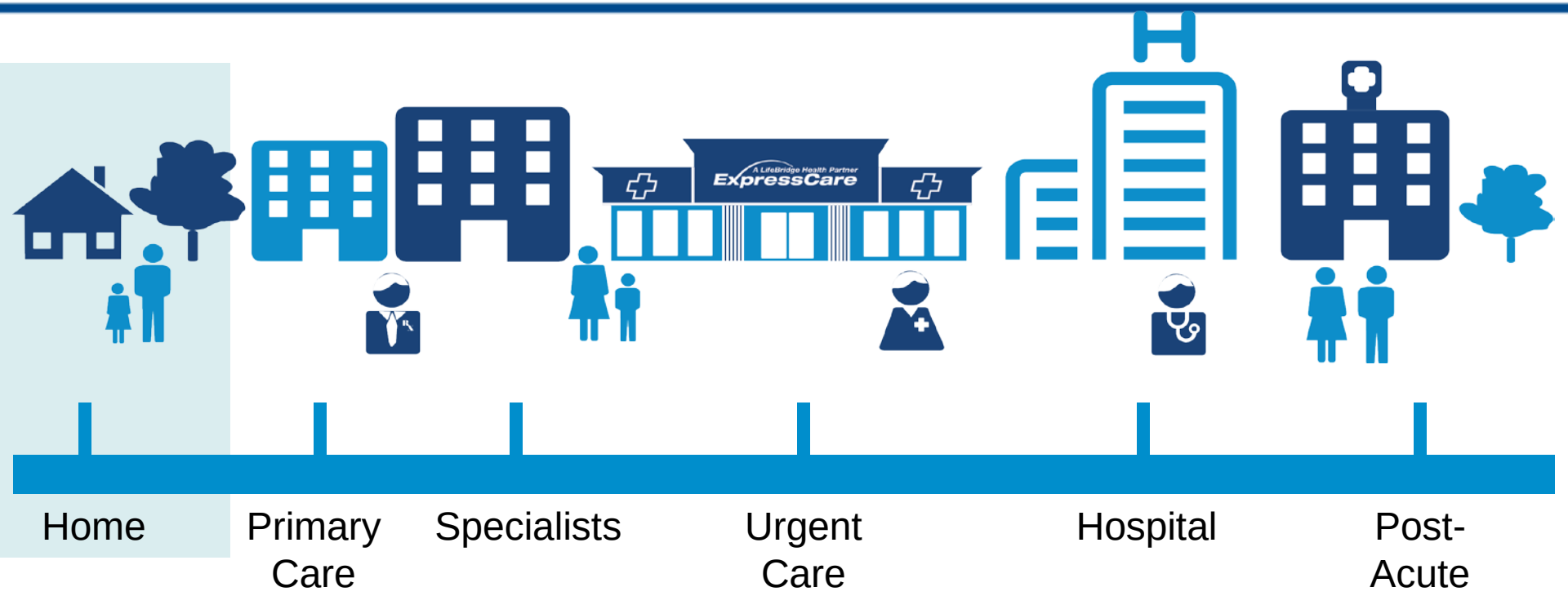

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- **Medicare ambulatory quality mailings**
- **Triage strategy**
- **Telehealth and home monitoring**

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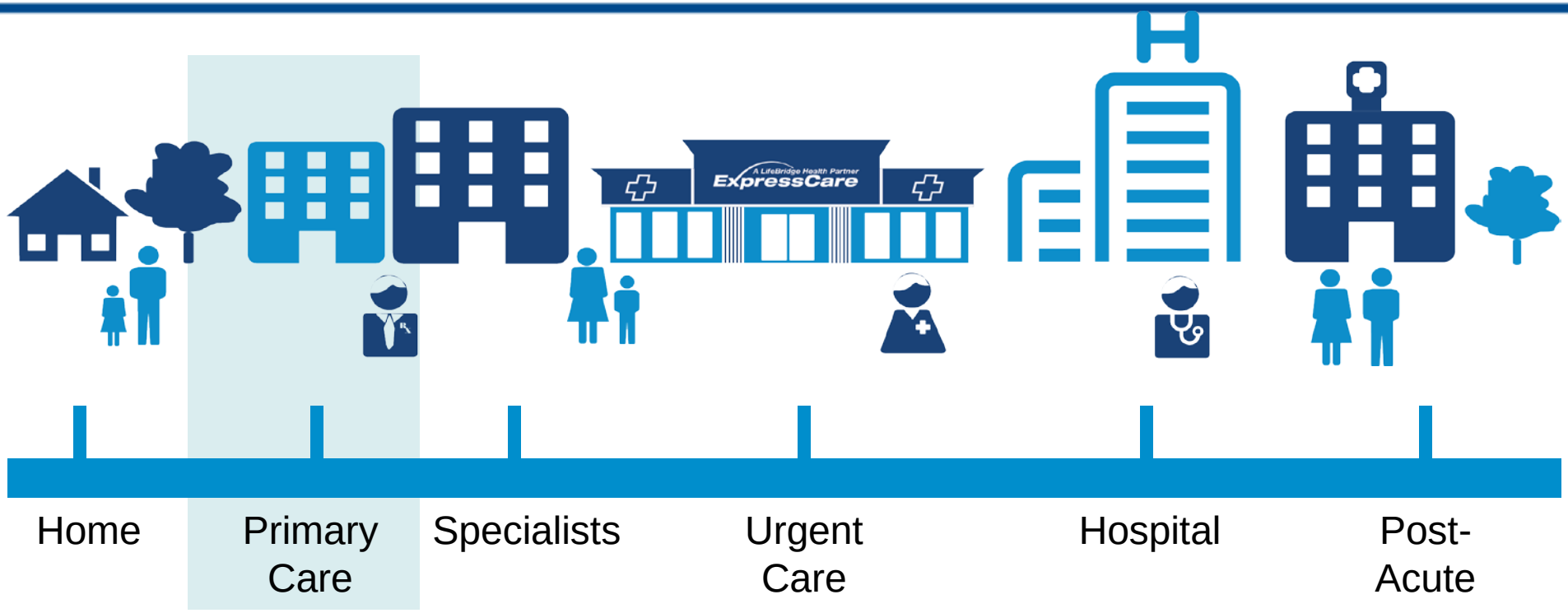

- **ENS notifications**
- **Integration with ACO inpatient case managers**
- **Help incorporating ACO quality metrics into daily huddle and workflow**
- **Timely feedback on cost and quality metrics to practices and physicians**
- **Embedded care coordinators?**

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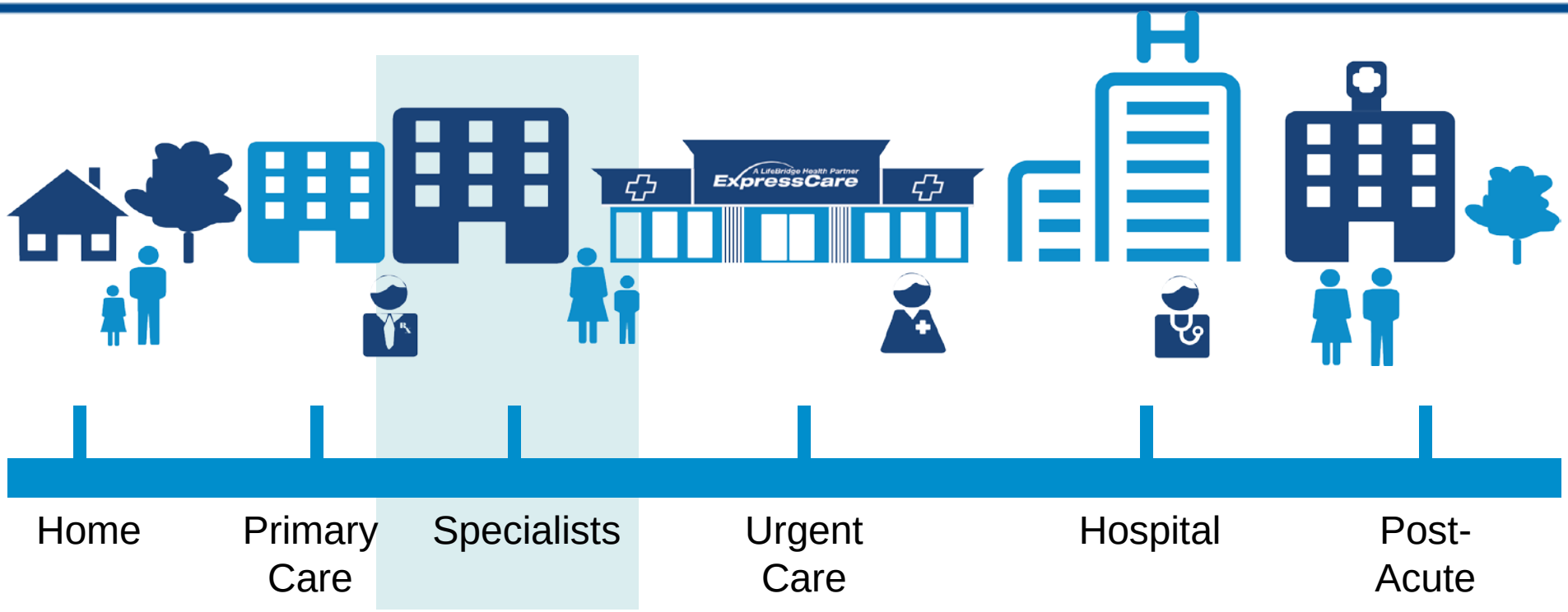

- **Quarterly feedback on utilization data**
  - **Total cost of care by episode and risk**
- **Timely feedback on applicable quality metrics**
- **(Bidirectional) engagement on access strategy**

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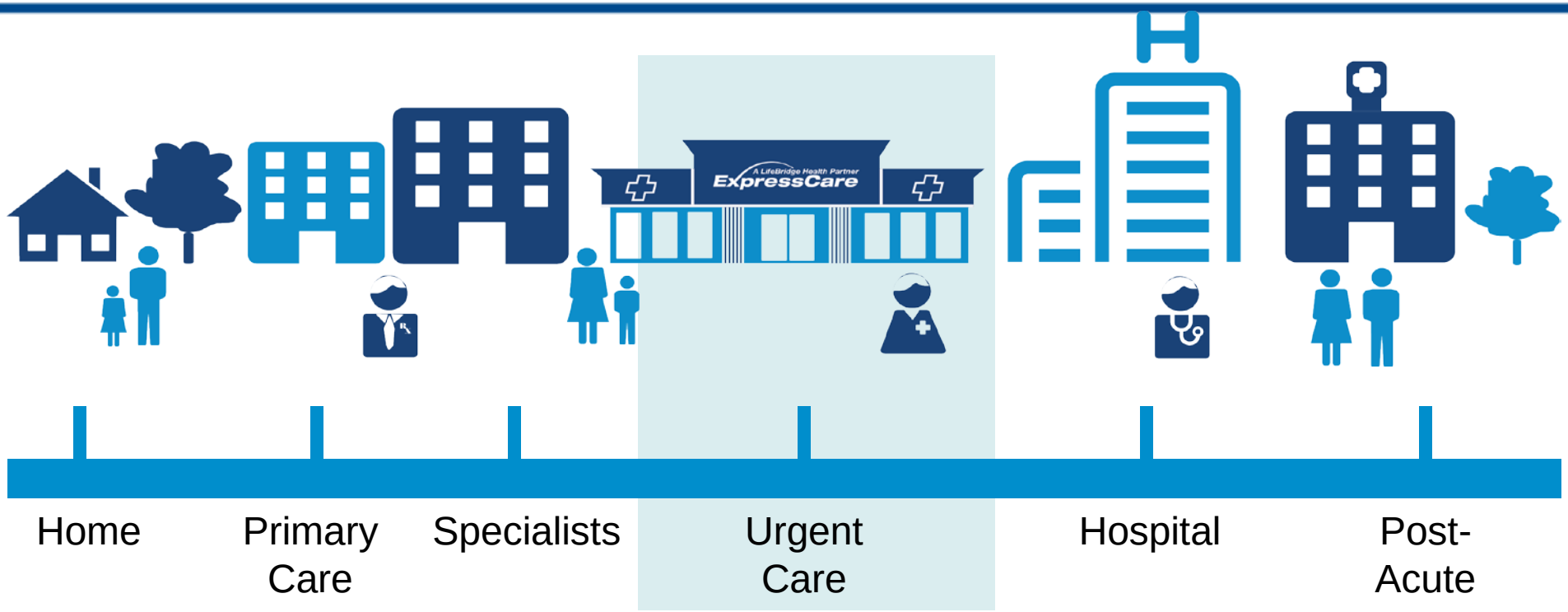

- **Triage strategy integrated with urgent care partners**
  - **Providing transportation directly to urgent care centers**
  - **After-hours support initiatives through an integrated triage strategy**

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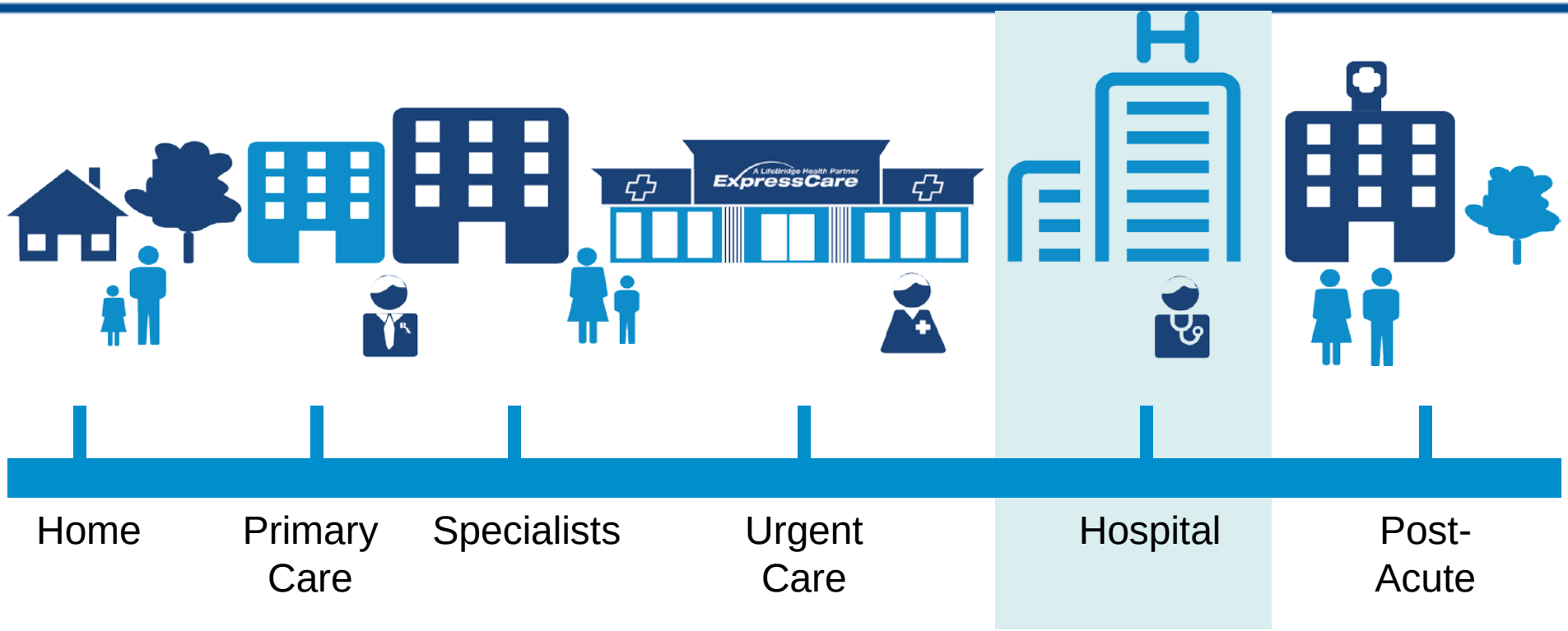

- **Inpatient Care Coordinators**
  - **Documentation of applicable quality metrics**
  - **Close coordination with PCP and/or specialists on details of stay**
  - **Triggering of “high utilizer” ambulatory care coordination**
  - **Cost effective planning of post-acute needs**

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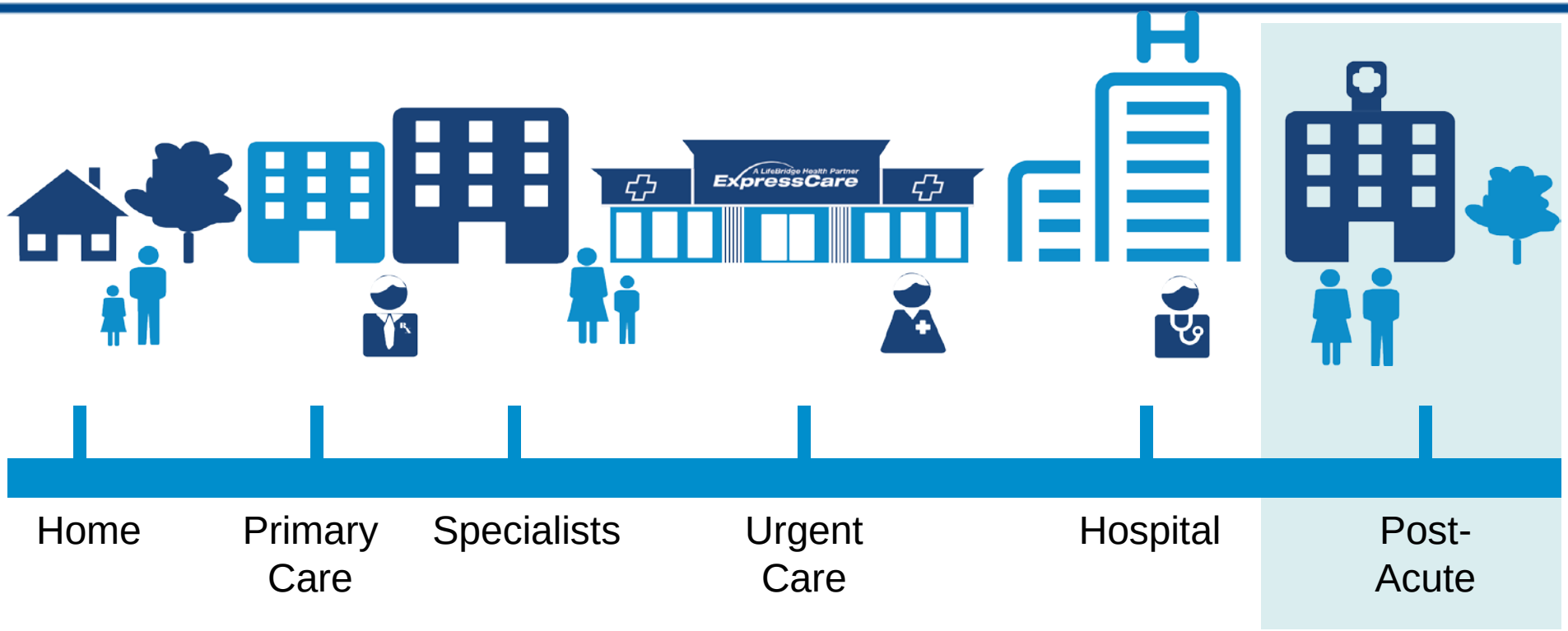

- **Population specific post-acute strategy executed by IP case coordinators**
- **Impact of system-wide skilled nursing facility (SNF) collaborative**

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LifeBridge ACO supports our primary care practices with key infrastructure and services

The LifeBridge ACO offers Quality Support that is essential in the post-MACRA era

- ✓ **GPRO submission**
- ✓ **Beneficiary outreach**
  - ➢ Reminders for vaccines, etc.
  - ➢ “Checklists” to bring to visit
- ✓ **Annual wellness visits**
  - ➢ Scheduling support
  - ➢ Work-flow support
- ✓ **Diagnostic testing and vaccines**

Our inpatient case managers provide a key resource in managing ACO patients

- ✓ **Quality support**
  - ➢ Documentation of key metrics
  - ➢ Identification of key gaps in care
  - ➢ Close communication with PCPs
- ✓ **“Hot spotter” program**
  - ➢ Identification of ER overutilization
  - ➢ Triggering of target interventions
- ✓ **Post-acute utilization control**
  - ➢ Cost-effective discharge planning helps optimize post-acute facility (e.g. SNF) and specialist spend

LifeBridge ACO infrastructure can extend your reach and enhance patient engagement

- ✓ **Beneficiary outreach program**
  - ➢ Reminders for vaccines, etc.
  - ➢ “Checklists” to bring to visit
- ✓ **Website and online media promoting Medicare resources**
- ✓ **In-office patient engagement materials and media**

Our ACO data infrastructure will be consolidated and simplified within the CIN

- **Regular reports in key areas**
  - Cost
  - Quality (including CAHPS)

- **Simplified data infrastructure**
  - Combine multiple programs (ACO, PCMH, MA) into one “data stream”
  - Data will be geared towards potential actions and interventions

- **Data you can trust**
  - Enhanced transparency compared to CareFirst

“Big Data” analytics will be used to help target specific patient populations

- **Risk stratification will trigger key processes**
  - “Opt in” lists for care coordination
  - “Hot spotter” and other population-specific data driven interventions
  - Palliative consults for patients in need

We will invest heavily in scalable home monitoring solutions to empower PCPs

- **Specific condition sets and clinical pathways will be piloted in 2017:**
  - e.g. CHF home monitoring “opt in”
- **Call center technology and physician extenders will filter data intelligently**
  - Algorithms will prevent “false positives”
  - Integration will preserve PCP workflow
- **Escalated home-based interventions can be piloted:**
  - e.g. Dispatch medics to home to give lasix trial before ER

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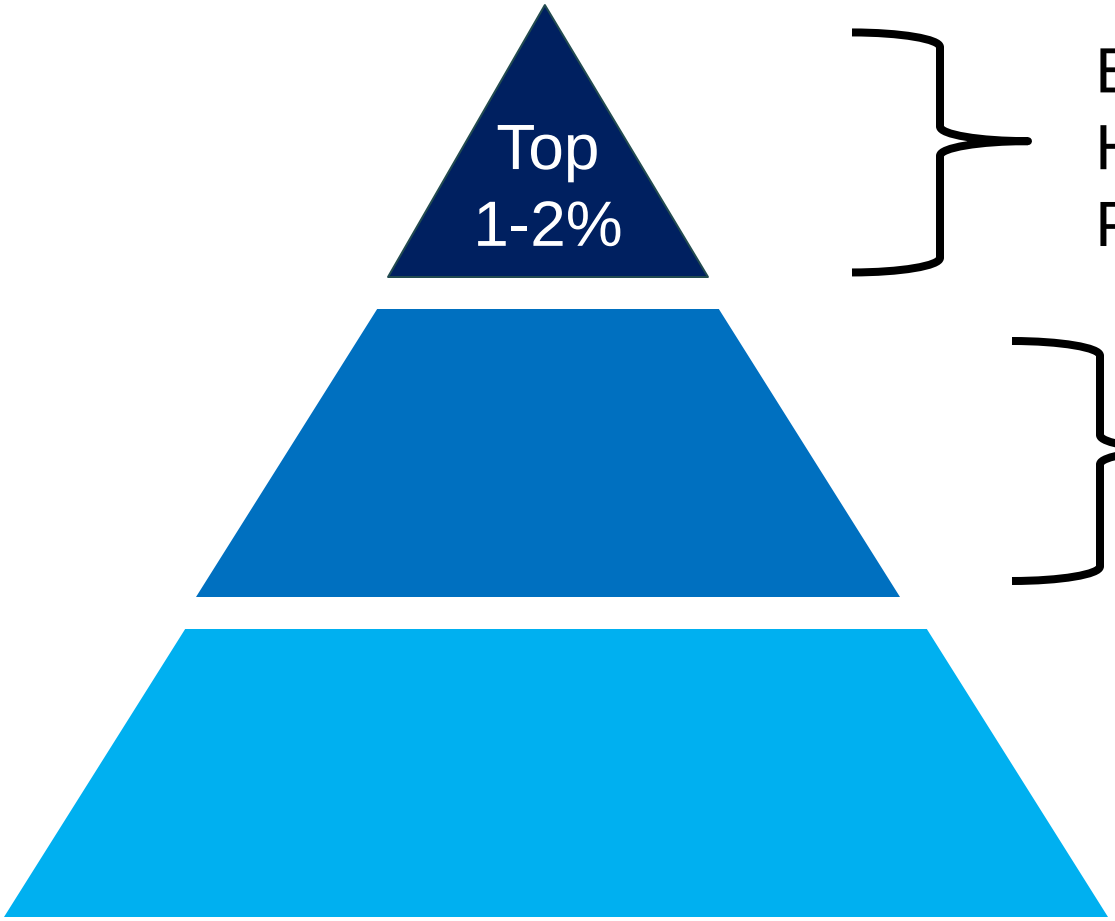
In addition we will deploy some forms of TARGETED care coordination in 2017



ESRD (external partners)
High utilizers (2-LINK)
Palliative candidates

Rising risk and chronically ill (e.g. CKD managed by external partner)

All others