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An important step forward in managing the chronically complex populations

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CONFIDENTIAL

Background

The Chronically Complex population is the highest cost members who require specific resources, presenting a challenge for Independent Health. Today's operations do not provide a tailored care model to support their needs.

Background

Challenge

- Margin losses are primarily incurred through the **top decile of high-cost members** who are considered **Chronically Complex ("CC")**, specifically in the **Medicare Advantage LOB**
- Primary Care Physicians ("PCP") are generally **not equipped** to address the **needs of the CC population**, resulting in **inefficient use of resources and time**
- **Transportation and ability to meet providers** in the office is often **out of reach** for CC members
- **Caregivers** of CC members must be closely involved in the managed care process
- **SDoH factors** are critical considerations in the ability to manage care

Current State

- In order to manage today's CC members, **standard care management is utilized** without providing additional support to address CC-specific needs
- **Confusion commonly exists** among patients, caregivers and providers **without a single point of support**
- WNY contains some of the **lowest ranked counties** in New York state with **specific health issues** accounting for worse health outcomes including **chronic conditions** like hypertension.
- External market trends reveal the need and trend for **increased personalization of care models**

Who are these patients?

- Average of five different chronic conditions
- Significant use of time and resources to properly care for patients with these conditions
- Frequent physician visits
- Frequent hospital or ER visits
- Durability of medical spend over $30 K PMPY

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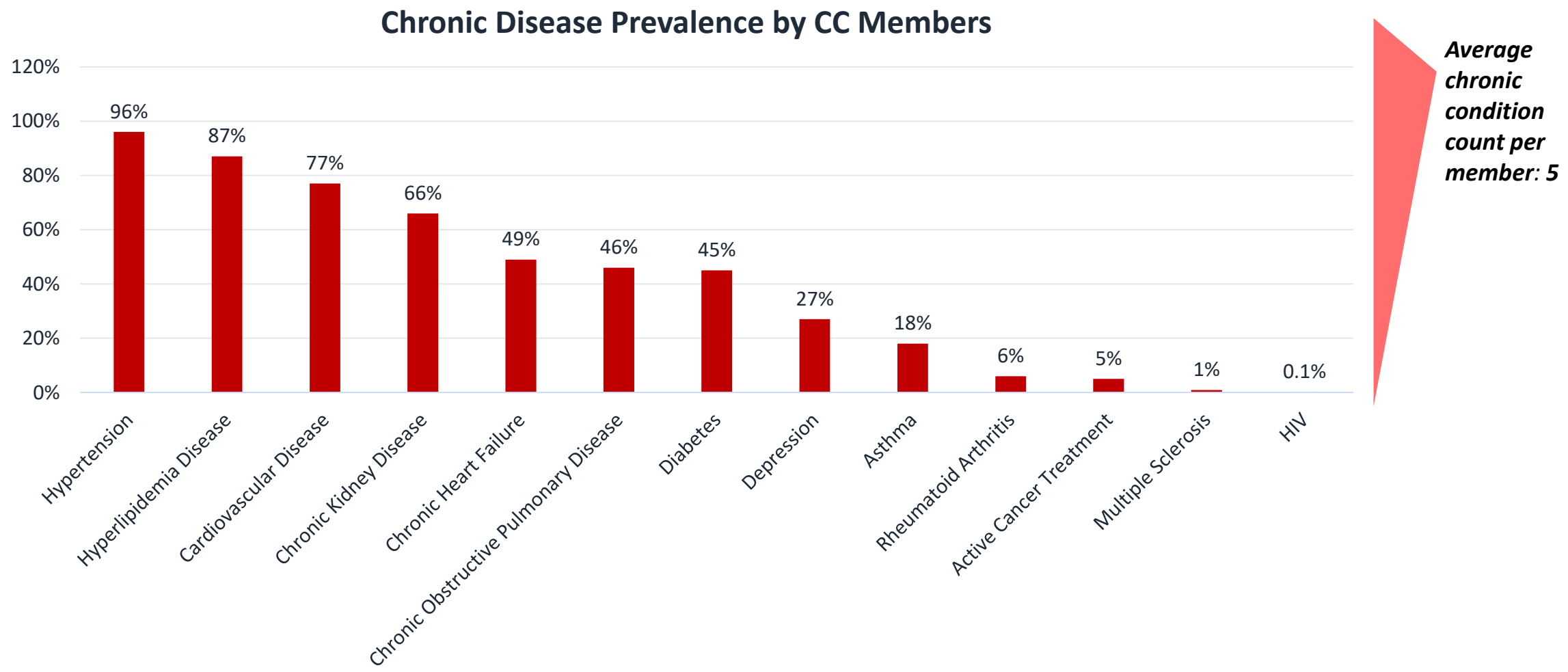
Chronic Disease Prevalence

Chronically Complex members have on average five different conditions. Hypertension and hypersensitivity lung disease are the most common conditions, attributing to ~90% or more of IH's CC members.



Footnote: 2019 Annual Data was leveraged for chronic disease prevalence by CC members.

Model Archetypes

Four model archetypes exist in the market as options for Independent Health, however, Captive PC models prove to be the optimal structure for IH.

		A New Captive	B Buy a PC *(make captive)*	C Partner with a PC	D Vendor
Costs	Start Up Cost	Medium	Medium	Low	Low
Costs	Start Up Effort	High	Medium	Medium	Medium
Costs	Network Abrasion	High	High	High	High
Results	Engagement	High	High	High	Medium
Results	Behavior Changes with NCM	High	High	Medium	Low
Results	Quality Results	High	High	High	High
Results	Coding Results	Medium	Medium	High	High
Results	Cost Savings	High	High	High	High
Results	Shared Savings	Low	Low	Medium	High
	Benefit to IH (Results-Costs)	High	High	Medium	Medium

Design FEMA

Design FEMA (Failure Mode and Effectiveness Analysis)

Item	Potential Failure Mode	Effects	Cause	Prevention	Recomended Action
Creation of a Captive PC	Failure to recruit staff	Not able to care for engaged patients to achieve results	Salary, Compensation, availability	Planning, hire core providers that attract others and management	Design RED SHIRT CARE to capitalize on IH Culture and assure we hire quality, motivated staff
Engagement Campaign	Failure to engage patients	Without engagement can not achieve cost reduction, quality improvement or code capture	Poorly designed outreach campaign (patients do not understand it)	Proper resources designated to the outreach, good contact information to start and strong script	Collaborate with communications, informatics, and sales/marketing for sharp, effective program design
Network Abrasion	Providerr Community is very upset	Providers discourage patients from engaging as well as cause tremendous disruption and noise	Failure to communicate early and often with the provider community what we are doing, why and listen to and address their concerns	Proactive meetings with key stackholders during design phase as well as meetings with key groups before and during implemantation	Identify who is most effected, set-up some key physician meetings and layout a coollaborative communication and implementation startegy
Continuity Program	Failure to develop Proactive Care Plans	Patients do not show improvement in cost, quality or satisfaction	Lack of design of how often cohorts of patients should be touched to achieve results	Tiered risk cohorts with systems to assure right amount of patient touches	Work with cross funtional team on creation of high, medium and low groups and correct amount of intervention and touches for each
	Failure to see patients urgently to	TCC is not effected at	There is no trust by the patient that you will solve their urgent need	Establish a 24/7 program that includes on-call providers that triage and	Establish an Urgentivist Program or

Program Overview

In alignment with IH's 5-year strategic plan, the Chronically Complex program aims to create provider partnerships and utilize technology to provide transformative care, thus achieving higher quality scores, better engagement with members and lower medical costs.

Objective: The Chronically Complex program serves to become a **transformative care delivery model** to manage **highest-cost and most complex members**. The objective of the program is to provide **higher quality, accessible and tailored care** for the Chronically Complex member needs by utilizing **partnerships with providers and innovative technology.**

Business Rationale: In alignment with Independent Health's **5-Year Strategic Plan**, the design and implementation of **Advanced Care Models** has been identified as one of the strategic pillars. Within this pillar, **high-priority and impactful programs**, such as **Chronically Complex**, are a focus given its level of opportunity to **better engage members, achieve higher quality scores and lower medical costs**. Independent Health recognizes the Chronically Complex population requires **greater attention and care customization** through a transformative care delivery model to accomplish these goals.

Guiding Principles

A successful Chronically Complex program will leverage integration with PCPs, deliver whole person care in the home, integrate technology in services, and partner with a provider system to provide the level of care required.

01 **Integrate with Provider Network PCPs**

*Solution will require a high degree of **communication and collaboration with the provider network** to maximize patient outcomes, achieve quality, reduce costs and minimize provider abrasion.*

02 **Deliver Whole Person Care in the Home**

*Solution will **deliver care to the patient** by providing a hybrid of home visits and in-office visits, varying in frequency and type of interaction (e.g., telephonic, telemedicine, and in-person) as determined by individualized care plans.*

03 **Integrate Technology for Ongoing Monitoring & Support**

*Solution will rely on **remote patient monitoring tools and support for ongoing surveillance and early care team interventions** as required by Chronically Complex members.*

04 **Partner with Provider System to Support IP & Care Transitions**

*Solution will identify **preferred care partners to provide multi-disciplinary inpatient and transition support** for the Chronically Complex population in focus.*

Benefit to patients

Through the Care for You program, patients receive personalized support, greater accessibility, alignment among providers and care personnel, and efficient and effective service.

PERSONALIZED CARE

Care management and **provider support tailored** to patient needs

- *Customized care plan*
- *Identification & resolving Social Determinants of Health*

ACCESSIBILITY

24/7 access to care within the **home or assisted living setting**

- *Nurse Triage call center*
- *Remote Patient Monitoring*

SINGLE POINT OF SUPPORT

Aligned support among **providers, care coordinators and caregivers** through centralized services

COLLABORATION & SUPPORT for PCPs

Patient updates communicated through EMR

EFFICIENCY & EFFECTIVENESS

Result: fewer **unnecessary treatments or admissions**

- In-home urgent care visits

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Value Proposition to IH

Creating a Chronically Complex program that focuses on the highest cost members will drive short and long-term value for IH.

Addressing Highest Cost Members	The highest cost and most complex members will receive personalized and accessible care, leading to better health and satisfaction with services.
Greater Control of Care Plans	IH obtains greater control in care plans for its most complex patients by sharing responsibility with PCPs to manage and provide care for its patients.
Greater Visibility of Patients	Providing 24/7 in-home medical service not only benefits members but promotes greater visibility for IH to assess and manage patient needs on a 24/7/365 basis.
Provider and Member Nudge	Potential behavior changes across providers and members who are “nudged” by initiatives to adopt a more efficient and effective approach to care.
Increased Cost Savings	Managing the highest cost members to achieve greater health will result in increased medical cost savings.
Market Presence	Partnerships in the program can help IH achieve a greater presence in the market by creating the capabilities to provide care in new geographic areas or capacities.

Benefit to primary care physician

ALLEVIATE TIME & RESOURCES needed to properly care for chronically complex patients

TIMELY UPDATES of patients' conditions and care plans

CARE RESOURCES for the patient not currently available to PCPs

REDUCTION OF SERVICES:

- Emergency Room Visits
- Hospitalizations
- Re-admissions

MEDICATION ADHERENCE and appropriateness

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Objectives:

- Support primary care providers through communication, coordination and collaboration
- Improve quality of care delivery
- Provide personalized, technologically advanced, multi-disciplinary approach
- Engage patients and caregivers
- Reduce overall costs

Vertical Integration

Insurer → Affiliates → Affiliated Practices

- Large Group
- Small Group
- Self Funded
- Individual
- Exchange
- Medicare
- I-SNP
- C- SNP
- Medicaid
- D-SNP (pending)

Pharmacy Benefit Dimensions — An Independent Health company

reliance rx

nova — An Independent Health company

WNY Collaborative Management Services LLC

Management Service Organization

WNY Coordinated Medical Care PC

Medical Group

- **Care for You-** Medicare- Complex Care Management and In-home Wrap Around Visits/ Services

What Does the Care For You Program Include?

- **Personalized Care Plan** – You're unique. An experienced nurse will visit with you at your home to learn about your health and develop a personalized care plan that can be shared with everyone involved in your care, including your doctors.

- **24/7 Access to Care** – When you need care, you can call us anytime. We'll help you make the right choices when it comes to getting care that is specific to your personal health needs.

- **In-Home Care Team** – Our in-home care team is here to support you in all matters related to your health, not just when a need for care arises. Team members include:

  - » Nurse Care Manager
  - » Nurse Practitioner
  - » Physician
  - » Pharmacist
  - » Licensed Social Worker
  - » Registered Dietitian
  - » Community Health Worker
  - » Mental Health Support Specialist
  - » Physical Therapist

- **In-Home Urgent Care Visits** – When you don't feel well, our team can provide in-home urgent care visits 7 days a week, including evenings and weekends – to help avoid urgent care or emergency room visits and help you stay healthy at home as long as possible.

- **Aligned Support** – The Care For You team will communicate with you, your doctors and caregivers to ensure that the needs of your personalized care plan are met. We help you schedule appointments, coordinate transportation and more, to assure you receive the care you need, when and where you need it.

Partnering with Providers

01 | **Care support for PCPs**

Communication and close collaboration with the patient's PCP *to maximize patient outcomes, achieve quality, foster provider partnerships and reduce costs.*

02 | **Deliver Whole Person Care in the Home**

Deliver care to the patient *through a hybrid of home and in-office visits, varying in frequency and type of interaction (e.g., telephonic, telemedicine, and in-person) as determined by individualized care plans.*

03 | **Integrate Technology for Ongoing Monitoring & Support**

Remote patient monitoring tools and support for ongoing surveillance and early care team interventions

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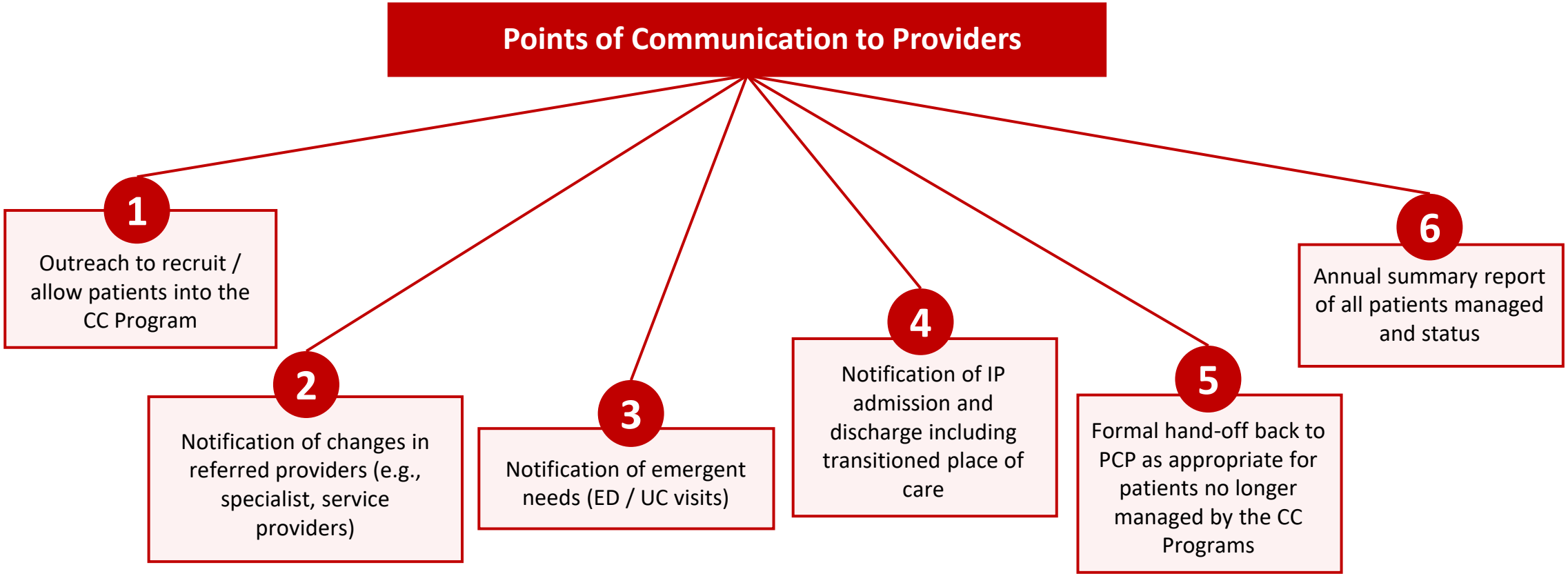
Network Strategy

- Three Cs
  - Control
    - The PCP is still in control. They approve the patients and can make referrals to the program
  - Coordination
    - We are the eyes and ears in the home helping to coordinate both medical and social determinants of health for the delivery system.
    - We chose Medent for our EMR which is in 60% of WNY practices and we can direct message between Medent and all other major EMRs
    - We post all our provider notes on HEATHeLink
  - Collaboration
    - We consult with PCP on all chronic disease management changes (ex. We will not change blood pressure regimen without communicating with PCP first)

Coordination with PCP's

Maintaining an open line of communication with PCP's is critical to the success of the Chronically Complex program to minimize network abrasion and promote connectivity between patient support.



Program Approach

Four objectives of the program outline the approach for care in the Episodic and Transitions program.

Before ED or Admission

Prevent Initial ED Visit
Provider / Member Nudge

+ **Target:** All patients at high-risk of utilizing preventable ED and admissions
+ **Strategy:** Educate members and providers of Nurse Triage Call Center to act as a point of navigation to provide immediate in-home care

After ED or Admission

Decrease Repeat ED
Predict and Prevent

+ **Target:** High-risk patients released from ED or discharged
+ **Strategy:** Set patient up with the following: 1) discharge/ED release plan, 2) transition of care plan and 3) care in home capabilities

Decrease Admissions
Engage and Intercept

+ **Target:** Patients in ED with low acuity and preventable admissions and ED revisits
+ **Strategy:** Divert patient from admissions by sending them to ED Treat and Release or to lower level of care facilities

Decrease Readmissions
Standardize & Support

+ **Target:** Patients discharged
+ **Strategy:** Set patient up with the following: 1) discharge plan, 2) transition of care plan and 3) care in home capabilities

Point of Intervention Processes

Different tactics for intervention exist depending on where the patient falls in the care process when issues are triggered.

When Patient is at Home…

Provider / Member Nudge

Decrease ED

*Work with PCPs to **educate and enable all members** to utilize the **24/7 Nurse Triage Call Center and in home urgent visits** to provide first line of defense in care services at home*

If Identified High-Risk Patient is in ED…

Inpatient Diversion or **ED Treat and Release**

Decrease Admissions*

*Following ED intake, the **Nurse CM and UM on the Transitions Care Team** will coordinate with the hospital and the rest of the remote Transitions Care Team to divert patient from admission to **lower levels of care or to ED treat and release***

If Identified High-Risk Patient is Admitted or in Sub-Acute Care…

Hospital / Facility Discharge

Decrease ED, Admissions and Readmissions*

*1. During discharge or ED release, the **Nurse CM on the Transitions Care Team** will coordinate with the hospital and the rest of the remote Transitions Care Team a **transition of care plan inclusive of SDoH support** and **monitor patients for 30 days post-discharge**. A follow-up appointment with the **Nurse CM** on the Transitions Care team will be **scheduled for 48 hours after discharge***

*2. Appropriate patients will be set up with **Remote Patient Monitoring** at home **monitored 24/7 by a Nurse Triage Call Center**. Nurse Triage can assess level of care required for patient when an issue is flagged or if the patient calls*

*3. Nurse Triage can call upon **advanced team** to perform at-home services, urgent visits or treatments*

*4. Nurse Triage can call upon a **physician** to complete a **telehealth or virtual visit***

Risk stratification data analytics will be conducted to **identify high-risk patients at the hospital who require a Transition of Care plan.*

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as of June 1st, 2023

Funnel

Meet Criteria
9,600
Identified as eligible by Actuarial

PCP Reviewed
9,168
Eligibility reviewed by PCP. On Provider Engagement files or referred

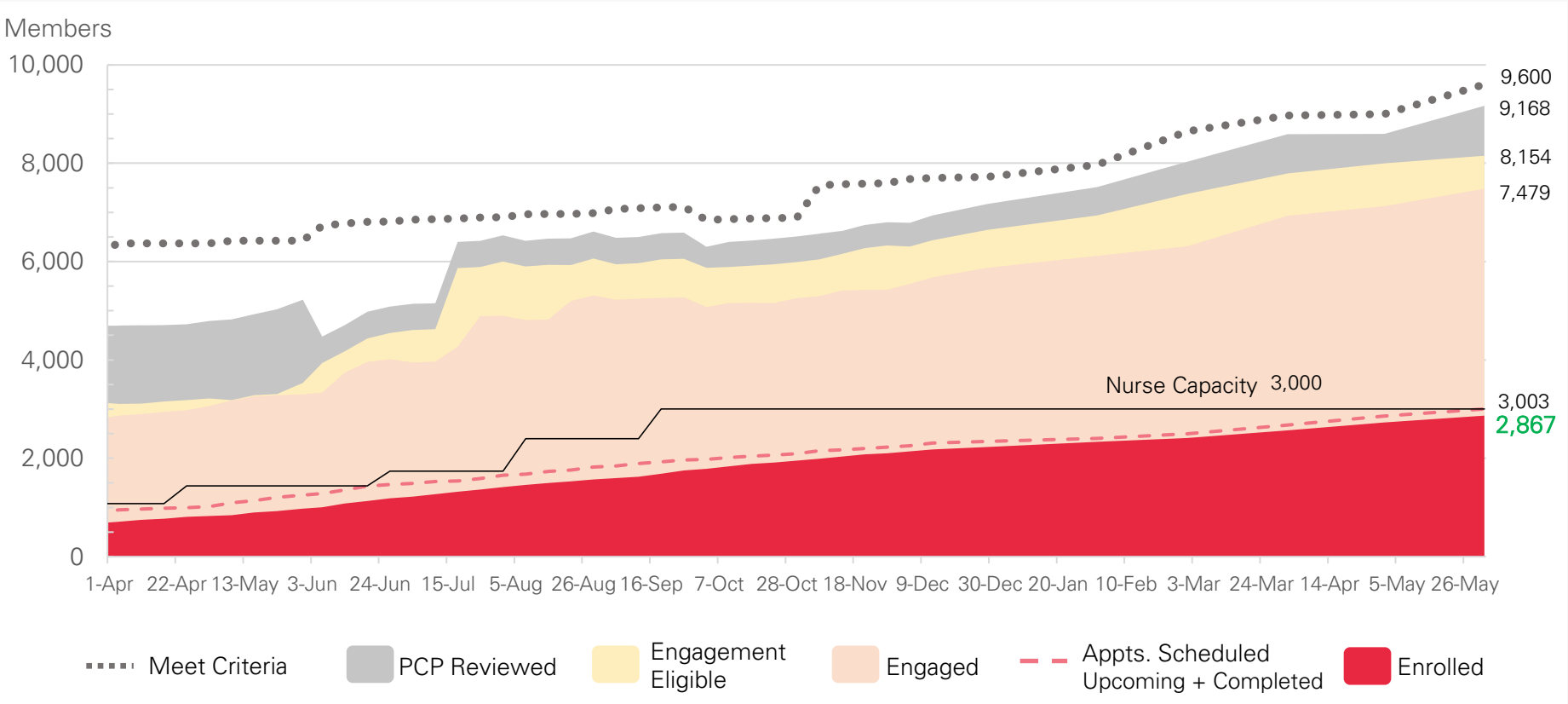
Engagement Eligible
8,154
In Area, PCP approved, ready for or already engaged

Engaged
7,479
Via outbound or inbound call

Appts. Scheduled
3,003
Upcoming + Completed

Enrolled
2,867
Successfully enrolled in careforyou

Over Time



Conversion Rates (Program to Date)

Meet Criteria > PCP Reviewed	% identified members reviewed by PCP for eligibility	96% (9,168 of 9,600)
PCP Reviewed > Engagement Eligible	% of PCP reviewed members who are engagement eligible	89% (8,154 of 9,168)
Engagement Eligible > Engaged	% of eligible members the MST has engaged	92% (7,479 of 8,154)
Engaged > Enrolled	% of engaged members that ultimately enrolled	38% (2,867 of 7,479)

Firm Decline Rates (Program to Date)

Declined Program	Member declines, does not include PCP decline	24% (1,808 of 7,479)

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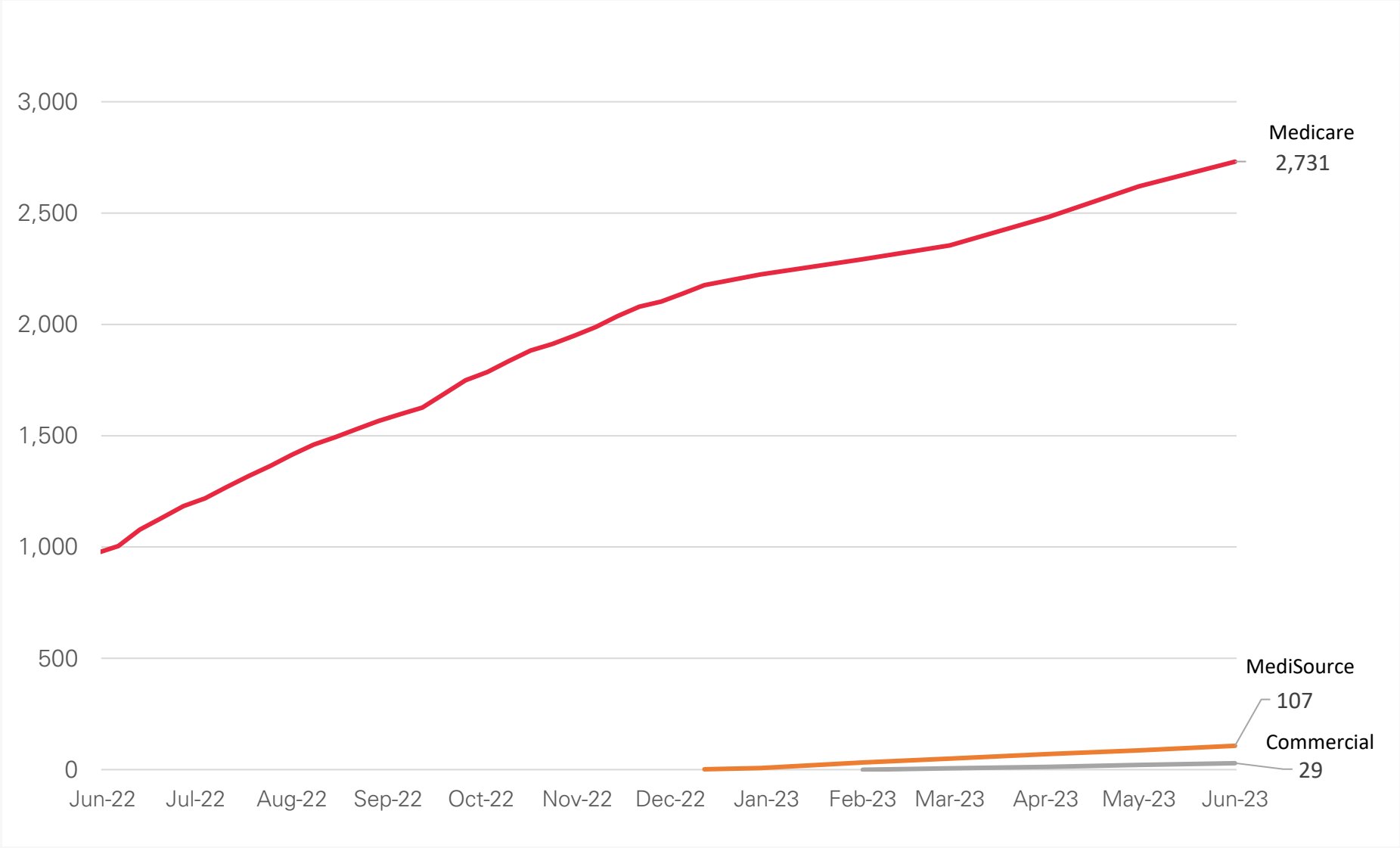
as of June 1st, 2023

Enrolled by Line of Business



1 Month Change

ALL	+139
Medicare	+111
MediSource	+20
Commercial	+8

IH2025
Destination Excellence

Enrollment Metrics

- **Eligible** Cohort- **9,566**
  - Medicare- 8,242
  - Medicaid- 807
  - Commercial- 507
- Appointments Scheduled- 2,983
- **Enrolled** Patients- **2,848**
  - Medicare- 2,717
  - Medicaid- 103
  - Commercial- 28

Current- 30%

Goal 2023- 42% (4,000)
Goal 2024- 52% (5,000)

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Target Metrics of Success

Independent Health has established target metrics for Member Engagement, Medical Costs, Revenue and Quality to determine success within the program.

PROVIDER ENGAGEMENT

93% ☑ **60-80% of cohort Approved by PCP** for the program in **2 years**

81% ☑ Provider satisfaction scores in the **80s**

QUALITY IMPROVEMENT

☑ **4.5-5** STARs on all measure for chronically complex

- ☑ Improvement in all HEDIS measures with higher intensity management
- ☑ GAP closures for those at home by bringing services to them (i.e., A1C, eye exams, etc.)

REVENUE INCREASE & MEDICAL COST REDUCTION

- **RAF improvement** (~$1-2 M)

11.3% ☑ **10%** reduction in TCC (~$24 M)

- ☑ Reduction in Hospitalization
- ☑ Reduction in Readmissions
- ☑ Reduction in ED utilization
- Reduction in Medication costs

MEMBER ENGAGEMENT

☑ **50-60%** Enrollment of total cohort in **2 years**

2022 Goal - 1800
2022 Actual - 2231

☑ Patient satisfaction scores in the **90s**

97%

Care For You – Inpatient/ER Impacts

	Care for You Enrolled Population	Targeted Population
READMISSIONS	↓ 45%	↑ 0.9%
PREVENTABLE ADMISSIONS	↓ 54%	↓ 10%
ER VISITS	↓ 23%	↑ 12%
ACUTE INPATIENT STAYS	↓ 42%	↓ 14%
ALL INPATIENT STAYS	↓ 33%	↓ 8%
PM/PM SAVINGS		

Across all aspects of care, our Care for You members are showing savings between **$350** to **$450** per month when compared to their expected expense.

Input, Feedback, Questions?

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