Coordinating Communication across Community Organizations for Complex Patients

Case Studies using the Collaborative Medical Platform

Agenda

1:30 to 1:35 PM

Introductions

Lyman Dennis

1:35 to 1:40 PM

PHC Plan for Collective Medical Technology

Dr. Robert Moore, MD, MPH, MBA, Chief Medical Officer, Partnership Health Plan of California

1:40 to 1:55 PM

Collective Platform Overview: Enhancing Care Collaboration for High-Risk Patients

Suneel Ratan, General Manager, California, Collective Medical Technologies

1:55 to 2:00 PM

SacValley MedShare

Elizabeth Steffen, MBA/TM, PMP Executive Director, SacValley MedShare

2:00 to 2:12 PM

UCSF Collective EDie Program

Jeannine Ruggeiro. Clinical Social Worker at University of California San Francisco Medical Center in the ED

2:12 to 2:25 PM

Placer County Whole Person Care Expanding Treatment Coordination

Geoff Smith, Program Manager for the Placer County Whole Person Care program

2:25 to 2:30 PM

Q&A

2:30 PM

Adjourn

Lyman Dennis, MBA, PhD, Principal, El Dorado Health Consulting

- Webinar organizer with Suneel Ratan of CMT.
- Unusual program in that it focuses on an approach developed by a clear-thinking vendor, Collaborative Medical Technologies
- Introduce our speakers

Robert Moore, MD, MPH, MBA, Chief Medical Officer, Partnership HealthPlan of California

Suneel Ratan, General Manager, California, Collective Medical Technologies

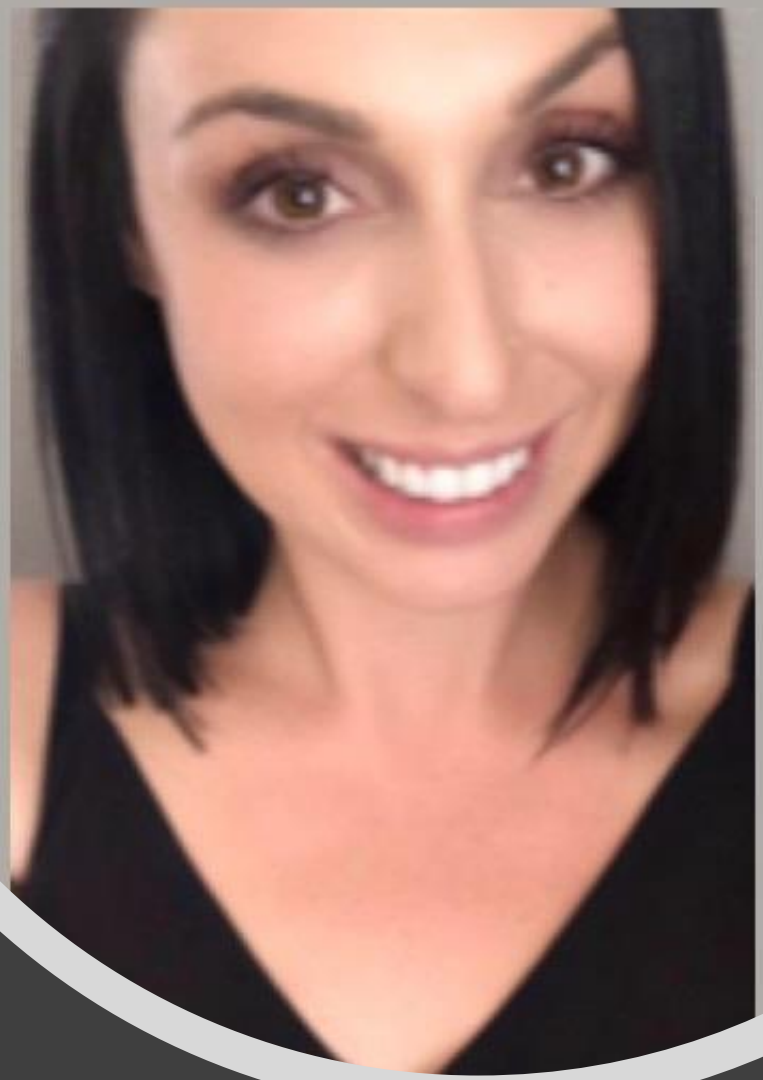
- Leads growth and sustainability of Collective Medical network in the state and transition to patients needing integrated approaches to clinical and non-medical needs.

Elizabeth Steffen, MBA/TM, PMP, Executive Director, SacValley MedShare

- SVMS is an HIO serving 16 counties in Northern California. The HIO and CMT provide a unique incentive to hospitals to participate in the ED, CURES and, services coordination.

Jeannine Ruggeiro. Clinical Social Worker at University of California San Francisco Medical Center in the ED

- Works with high-utilizing patients to provide programs and services that address psychosocial needs and reduce ED use.

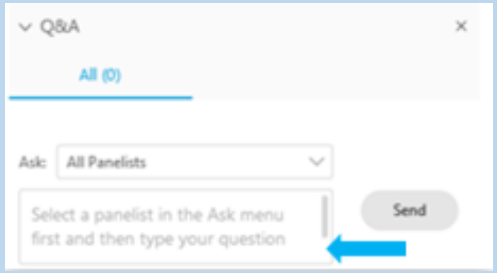


Geoff Smith, Program Manager for the Placer County Whole Person Care program.

- Also Licensed Marriage and Family Therapist.
- Placer County Whole Person Care program deals with some 200 homeless individuals coordinating physical care and social services.

Presentations

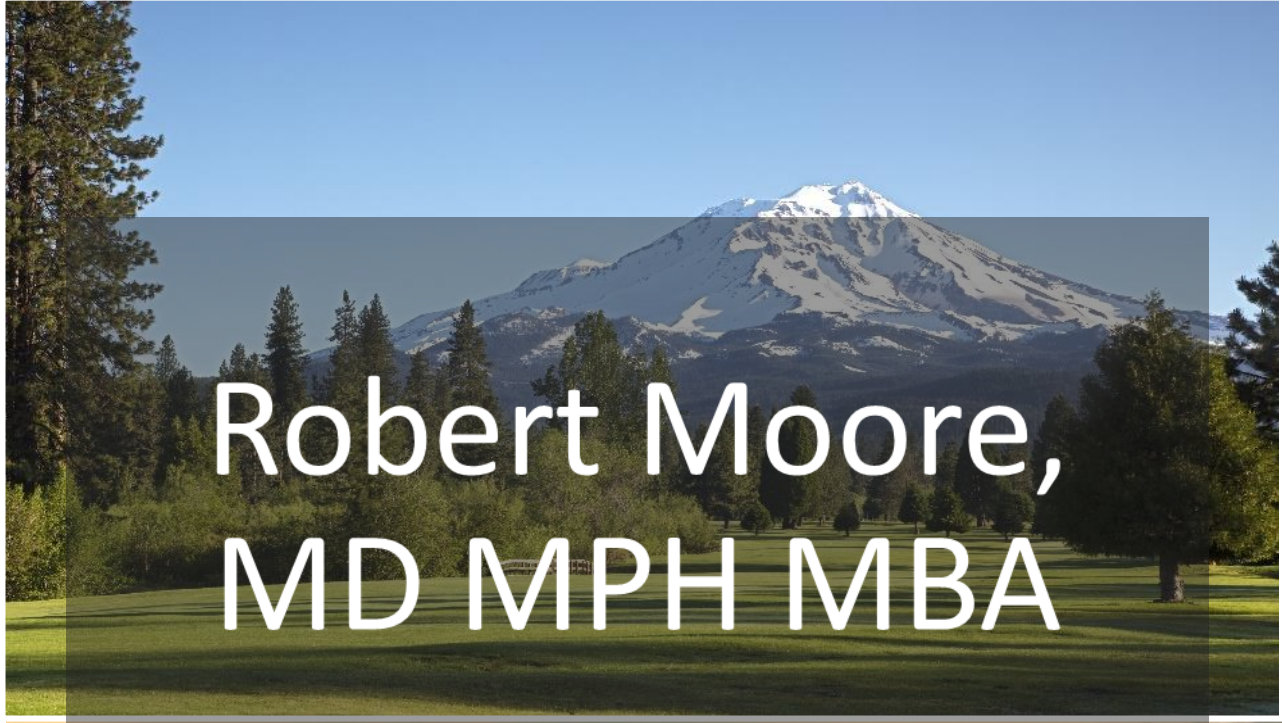
- Slides will be sent to all participants after the webinar.
- Webinar will be posted on Partnership website. We will send you the link.
- Questions will follow the presentations.
- Use Q&A box to submit your questions.



Robert Moore, MD, MPH, MBA, Partnership HealthPlan of California, Chief Medical Officer

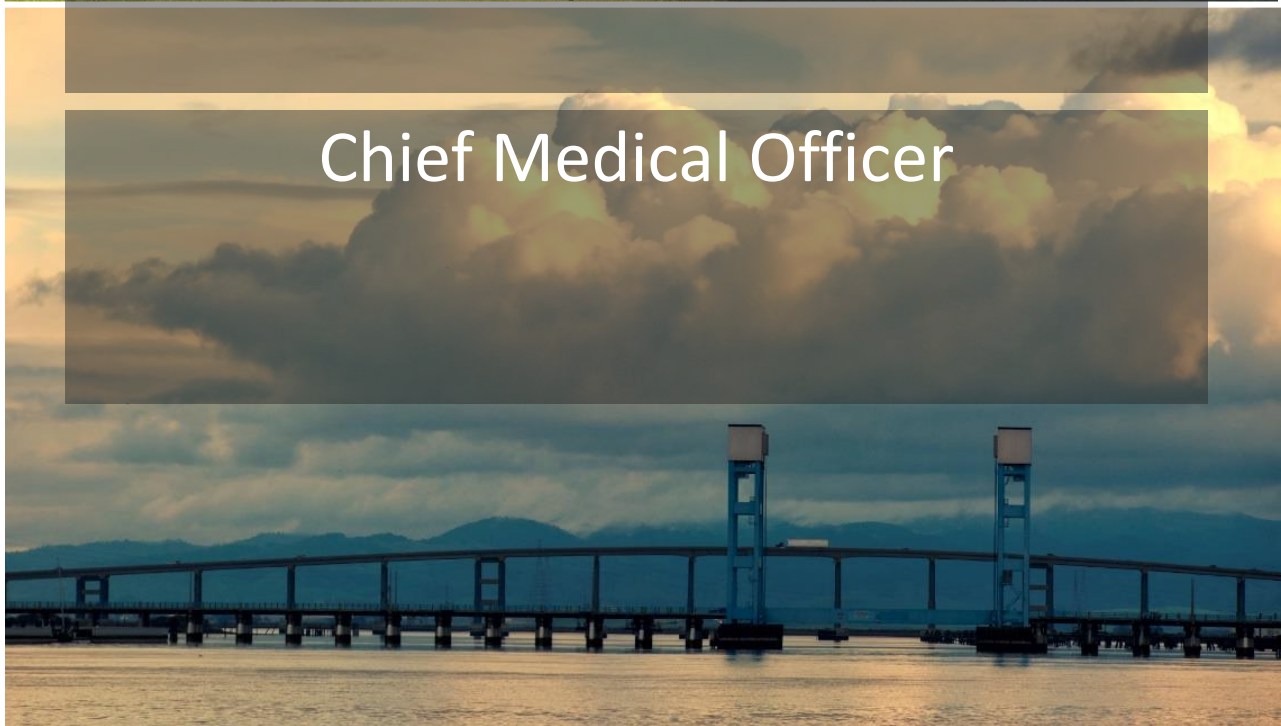
PARTNERSHIP HEALTHPLAN of CALIFORNIA

A Public Agency



Robert Moore, MD MPH MBA

Chief Medical Officer



About Us

Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

PHC Plan for Collective Medical Technology

- Signed agreement in September 2019
- Plan to implement in late 2020
- Components
  - EDIE for Inpatient and ED census tracking
  - CollectivePlan for cross-organizational case management
- PHC agreement includes covering interfaces with Care Management Partners

Why PHC Selected Collective Medical Technology

- Mission alignment with leadership
- Broad hospital coverage: More timely ED visit and inpatient admission information
- Experience providing care management communication platform with similar health plans and community partners.

Communication Across Organizations

- Needed by Community Partners
  - Whole Person Care (WPC) pilots
  - PHC's Intensive Outpatient Care Management Program (IOPCM)
  - DHCS Planned Enhanced Care Management (ECM)
- Efficiency
  - Case Management
  - Prediction of Risk
- Effectiveness
  - Targeted interventions
  - Avoiding duplication
  - Analysis of ROI

Goal for Webinar

Learn from those who have gone before us to help PHC and our community partners to prepare for optimal future implementation

Suneel Ratan, General Manager, California, Collective Medical Technologies

Collective Platform Overview:

Enhancing Care Collaboration for High-Risk Patients

October 30, 2019

collectivemedical®

Collective Medical is the national leader in supporting collaborative care management efforts with a demonstrated track record

- Started by an ED social worker
- 9+ years since first go-live
- Nationwide network spanning 36+ states
- 3500+ ACOs, plans, hospitals, UCs, and clinics
- Tens of Thousands of providers
- More than 225 million unique visits

100% customer retention since inception

Endorsed by:

American College of Emergency Physicians® ADVANCING EMERGENCY CARE

California Health Care Foundation

Hospital Council of Northern & Central California

HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA®

Providence St. Joseph Health

Sutter Health We Plus You

L.A. Care HEALTH PLAN®

MOLINA HEALTHCARE

Amerigroup RealSolutions in healthcare

CENTENE® Corporation

KAISER PERMANENTE®

Regal Medical Group, INC.

PREMERA BLUE CROSS

Dignity Health

Humana®

Adventist Health

Health Care LA™

KAISER PERMANENTE®

PRIME HEALTHCARE SERVICES Charting a new course in hospital management…

UnitedHealthcare A UnitedHealth Group Company

SAN FRANCISCO HEALTH PLAN Here for you

UCSF

UCLA Health

Anthem BlueCross

PacificSource HEALTH PLANS

JOHN GEORGE PSYCHIATRIC HOSPITAL A member of Alameda Health System

Regence

DATA SOURCING

Collective gathers data from across the network, sourcing from every point of care: hospitals, post-acute, ambulatory, community services, risk-bearing, and governmental

DATA AGGREGATION

Information from these sources is normalized, then aggregated on the Collective Platform where it can be accessed by everyone on the patient's care team

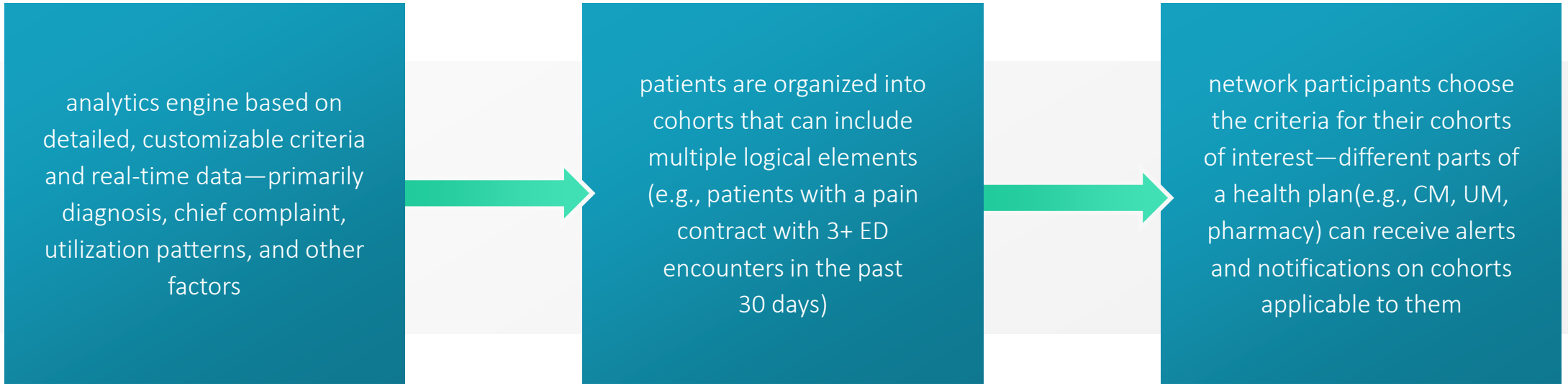
MATCHING AND ANALYTICS

Collective's data normalization and master patient index generates an incredibly accurate database of patients—both regionally and across the nation—that can be quickly and easily analyzed and queried

NOTIFICATIONS AND REPORTS

Notifications are automatically delivered in real-time to the point of care and to other members of the patient's care team, enabling visibility into movements; reports are generated and distributed to care managers, risk-bearing entities, state health organizations, and policy makers

Collective Alerting and Notifications – Key Principles



Automated Risk Identification, Notification, and Care Team Member Engagement

Care Team and Risk Criteria Identification

- care team members establish risk criteria for their patients
- the Collective platform automatically listens for these key risk criteria

Patient Event

- an event occurs at a facility participating on the Collective network (i.e., ED encounter, inpatient admission, etc.)
- data is ingested by numerous sources and analyzed in real time

Risk Analyzed

- If risk is found relating to any facility's previously established criteria, any number of events occur—including notifications sent, workflows triggered, or additional data analyzed

Workflow

- if risk is identified, providers are engaged in their native workflows
- providers are given insights relative to their relationship with the patient and the care setting
- alerts, notifications, and insights are automatically pushed into the EHR—within provider workflows

Collaboration

- risk-based insights are provided before seeing the patient so providers can make more informed decisions
- providers can collaborate and see one another's care recommendations
- treatment and follow-up care occur through real-time collaboration and communication

The Collective Platform seamlessly connects each member of a patient's care team together for effective collaboration on even the most complex patients.

Collective's California Value Proposition

Building Local Networks to Uniquely Support Continua of Care and Key Archetypes of Complex Patients

Complex Chronic – Medi-Cal SPDs, Medicare, Duals

Establish meaningful continuum of acute and post-acute care for older adults, some with cognitive decline, and younger patients with complications springing from catastrophic illness, disabilities, and complex life conditions.

Network components: Hospital ED and inpatient, SNFs, health system / ACO / heath plan care managers, primary care

Persistently High-Cost Chronically Homeless (SB 1152)

Enable continuum of care and care plan portability – moving to a real, living care plan – to reduce administrative burden with repeat visits / admissions and to reduce readmissions.

Network components: Hospital ED and inpatient, SNFs, homeless services providers that can sign a BAA, primary care

Opioid-use Disorder

Enable accurate reporting around individuals from whom buprenorphine treatment is initiated in the hospital and support community-based continuum of care and care transitions.

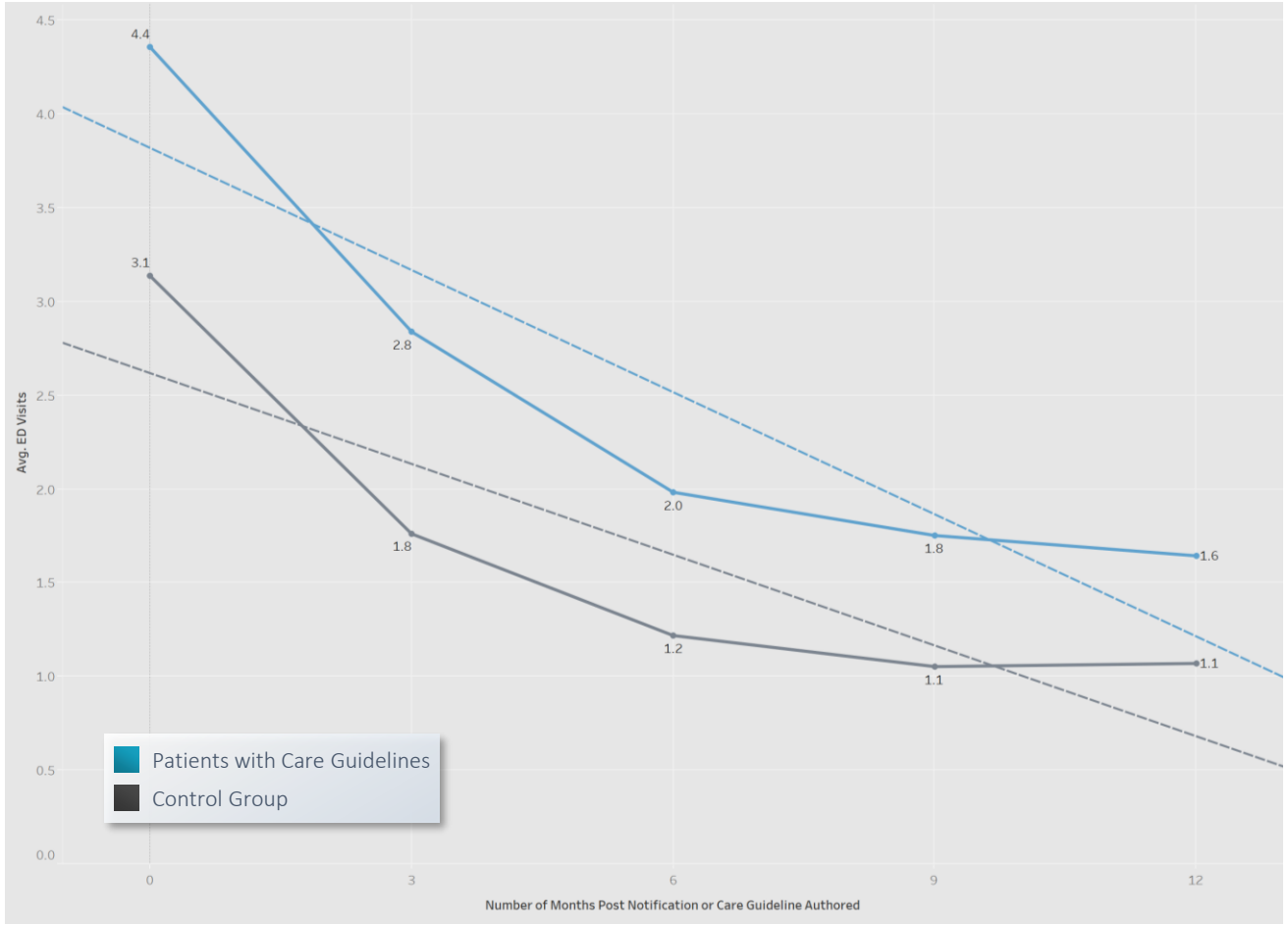
Network components: Hospital ED and inpatient, outpatient MAT providers, primary care

Care Insights Outcomes

Average Number of ED Encounters after a Care Insight is Written

- For patients in California with between 10 – 19 ED encounters over a twelve-month period, there is a significant ($p < 0.01$) decrease in ED encounters when compared to the control group
- If the control group had the same decrease in ED encounters as the group with Care Guidelines, then on average, each patient would have 1.5 fewer ED encounters over one year
- Care Guidelines can help reduce ED visits by 8% in one year

Number of ED Encounters Every Three Months



762 patients with Care Guidelines x 1.5 fewer ED encounters per patient per year = 1,295 ED encounters saved from high-utilizing patients in one year

Patient Success Story: Health Plan / PCP Collaboration

- 88-year-old female with history of COPD and heart disease
- Seen in the ER 8 times in the past 12 months with 5 IP visits in the last 12 months

Scenario

- *Patient was identified for her frequent ED and IP stays*
- *Health plan case manager identified that patient was not getting key prescriptions filled for pulmonary diagnosis and ER visits were primarily for COPD flare-ups*
- *Health plan case manager and primary care case manager reviewed the case together*

Intervention/Collaboration

- *Through collaboration, it was determined that patient would benefit from a medication reconciliation*
- *Pharmacist at PCP contacted the patient, conducted a medication reconciliation and provided education*
- *Patient was enrolled in case management with primary care*

Outcome

- *Patient continues to be supported by primary care case manager*
- *Prescriptions have been filled*
- *No ED or IP stay visits since collaboration meeting*

Patient Success Story - Health Plan / PCP Collaboration

- 58-year-old female with frequent ED visits
- History of chronic pain and transportation barriers

Scenario

- *Patient was identified due to 10 ED visits*
- *Patient seeing a pain specialist but not utilizing her PCP*
- *Transportation barriers prevented patient from visiting PCP office*
- *Patient previously declined case management*

Intervention/Collaboration

- *Through collaboration, it was determined that a home visit would be beneficial to assess for safety and barriers*
- *Health plan arranged for a contracted provider to do a home visit*
- *MD visited home and did a thorough review of medications and encouraged the patient to follow her provider's plan of care*

Outcome

- *The records from the home visit were sent to the patient's PCP*
- *Patient enrolled in case management*
- *No ED visits since collaboration has begun*

THANK YOU

Deep local hospital network and California experience and presence

Shared care planning tools based upon a world-class analytics platform to go far beyond simple encounter-based notifications

Based on any relevant piece of available clinical data

Focus on user automation

Patients benefit from Collective's rapid innovation and nationwide reach

Dynamically-curated notifications and synthesized insights from a broad data set

Deep experience with HIEs and statewide initiatives

Unmatched, documented outcomes

collectivemedical®

Elizabeth Steffen, MBA/TM, PMP
Executive Director, SacValley MedShare

SacValley MedShare

About SacValley MedShare

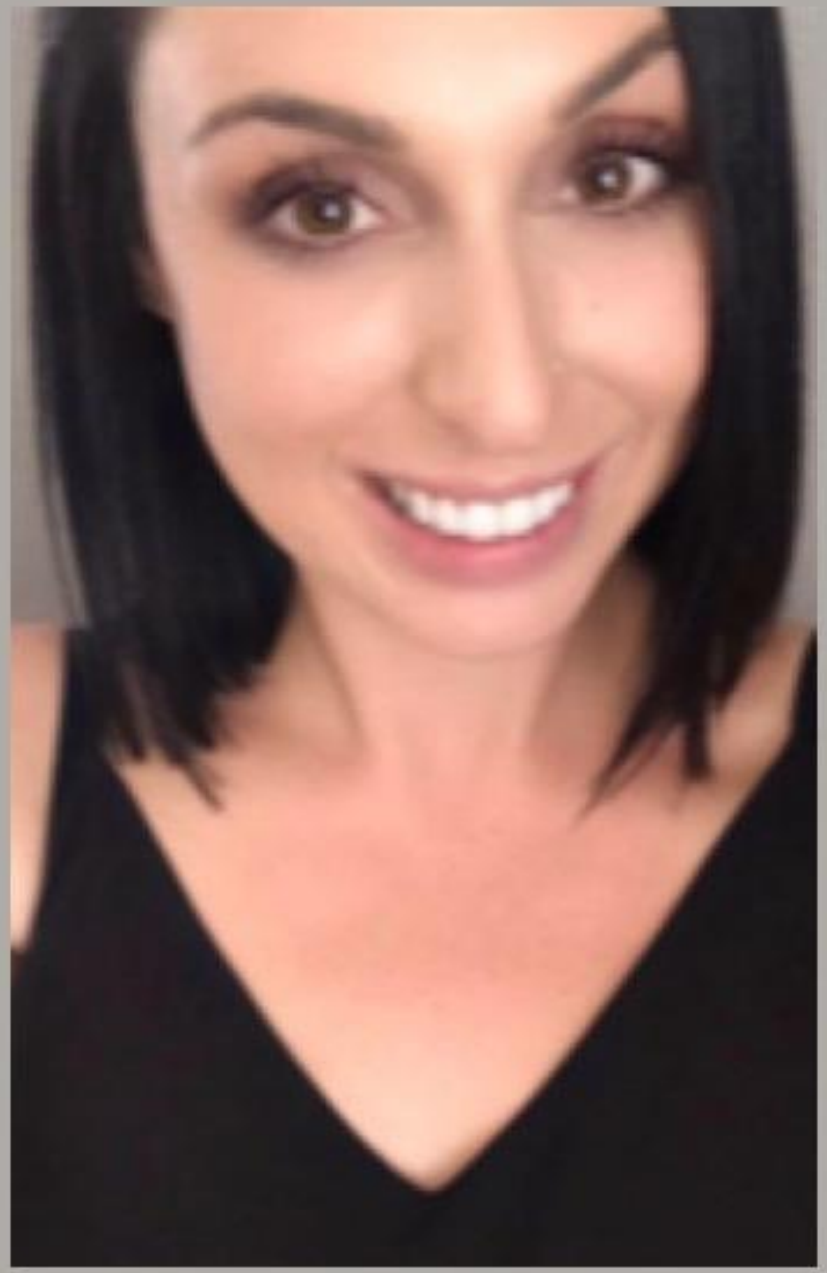
- Began in 2012 with 8 founding members covering 7 counties
- Expanded in 2015 to add 5 additional counties (merged with North State Health Connect)
- Expanded in 2018 to add 4 additional counties (merged with Connect HealthCare)
- California not-for-profit corporation, 501(c)(3)
- Governed by local community Board of Directors
- Board is comprised of member organization senior leadership to provide geographic and institutional diversity. 16 seats, all occupied.
- SacValley is made up of Individual Acute-Care Hospitals, Hospital Systems, Critical Access Hospitals, Tribal Healthcare, Federally-Qualified Healthcare Clinics, Private Medical Clinics, Imaging Centers, Laboratories, and a payer.

Current Service Area

- 17 Counties – 40,000 square miles
  - Butte, Colusa, Glenn, Lake, Lassen, Modoc, Napa, Plumas, Shasta, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba

CMT-EDie

- Partnered to offer EDie product to hospitals
- Hospitals find it a valuable addition to HIE
- Reports are:
  - Concise
  - Complete
  - Informative



Jeannine Ruggeiro. Clinical Social Worker at University of California San Francisco Medical Center in the ED

University of California San Francisco

UCSF Collective EDie Program

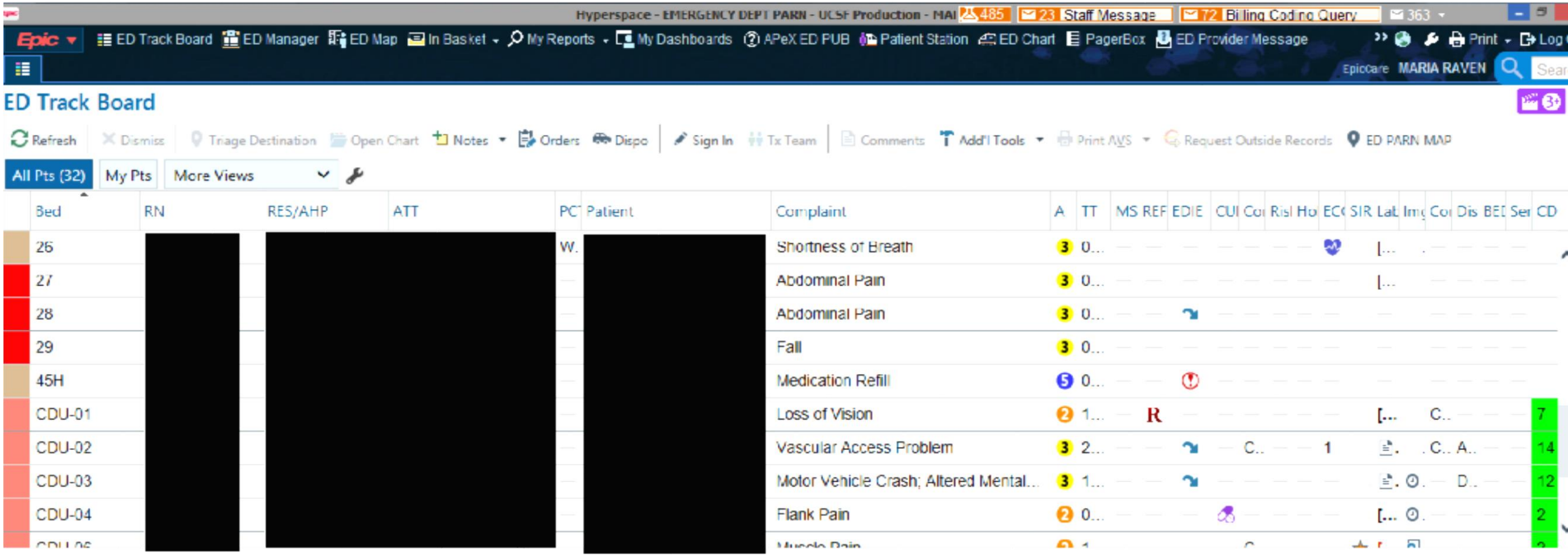
Jeannine Ruggeiro

Presentation to Partnership Webinar

November 7, 2019

UCSF Collective EDIE Program

Emergency Department Information Exchange (EDIE) Program



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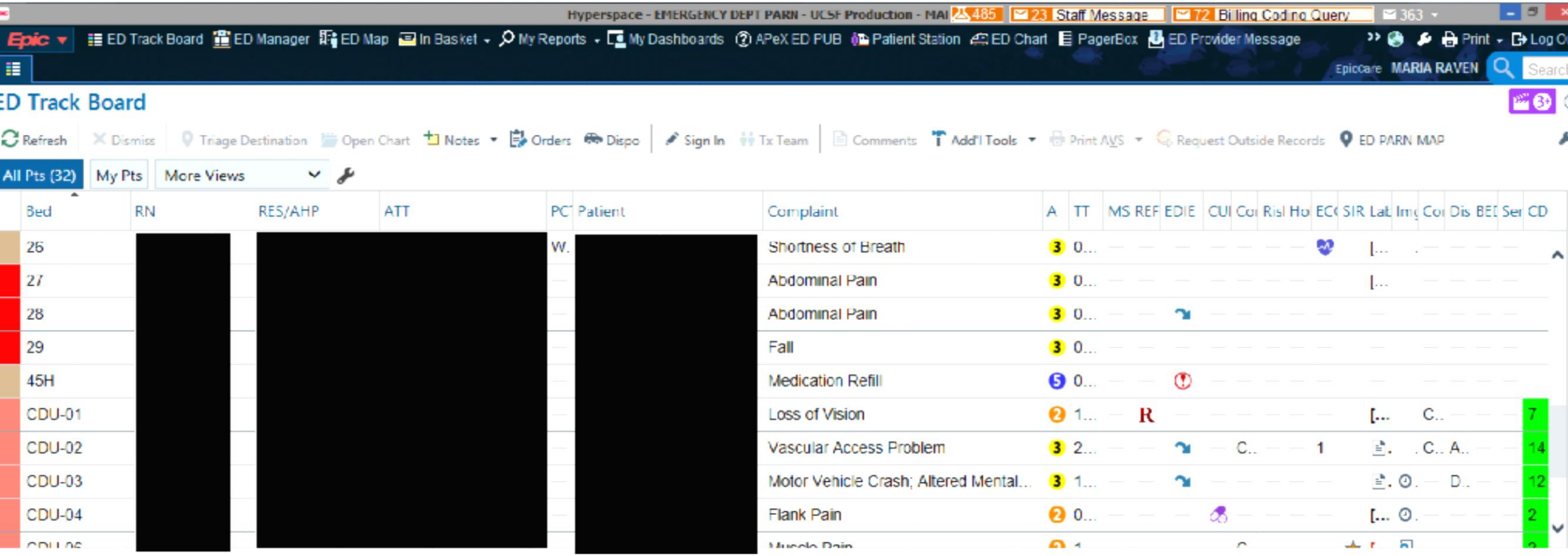

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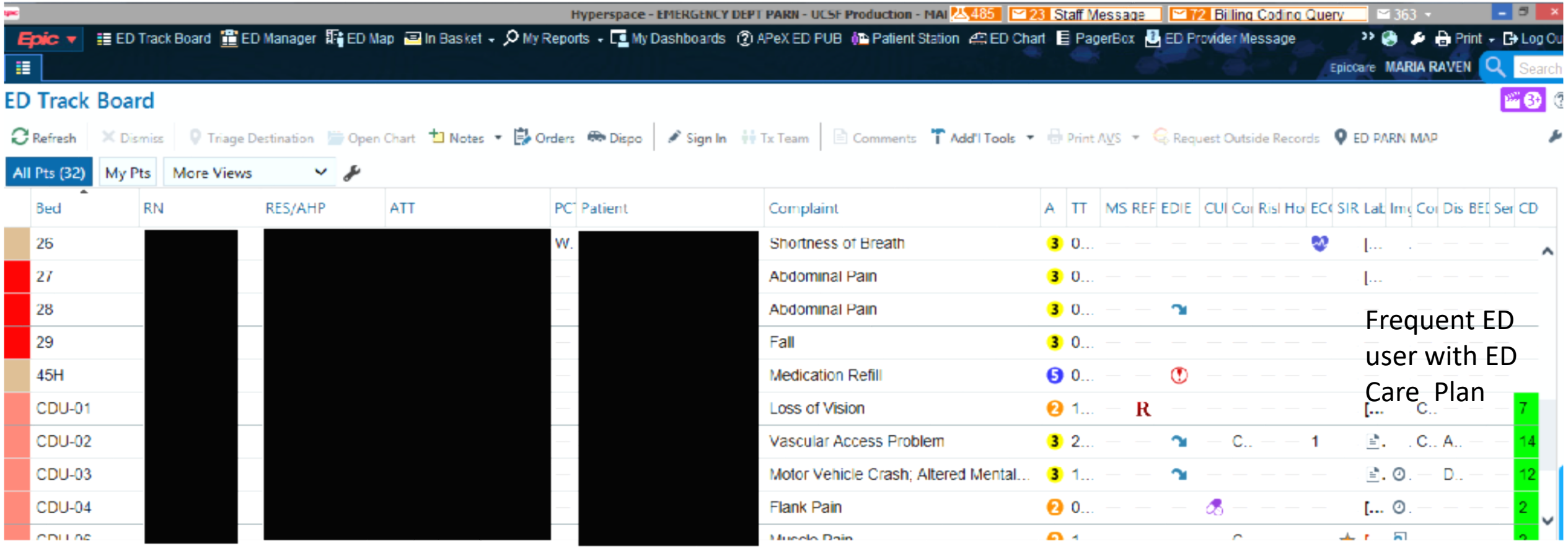

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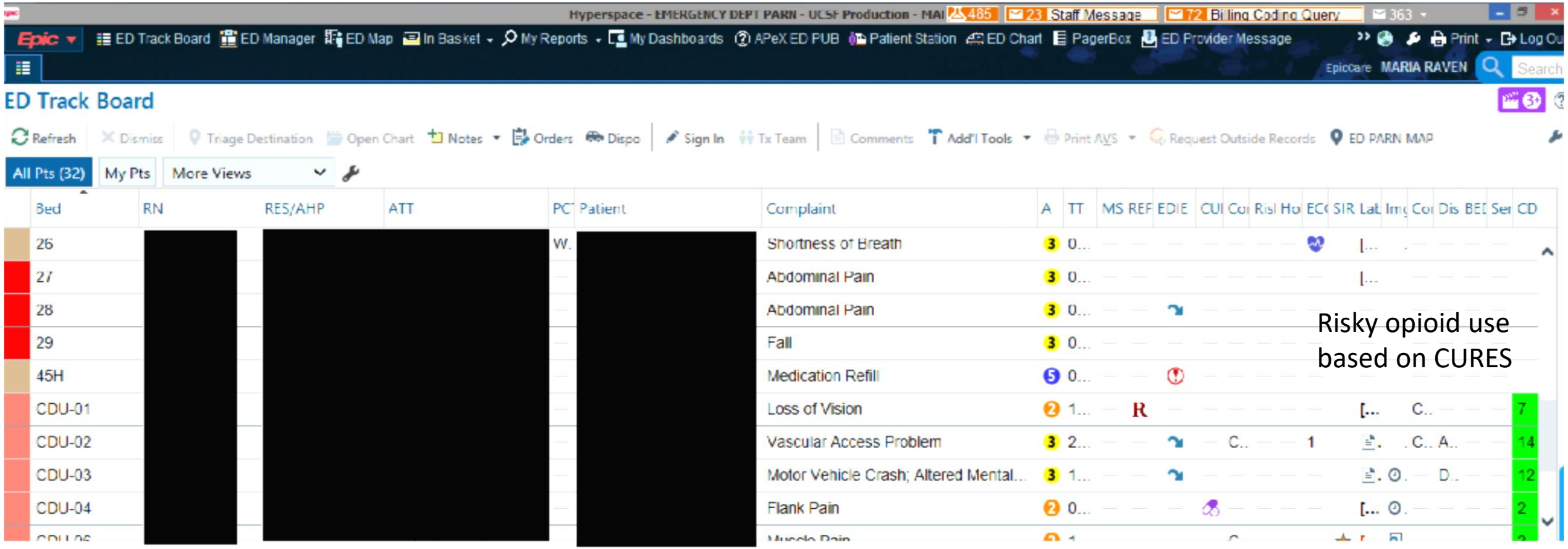


UCSF EDIE Care Coordination Team

- EDIE Health Care Navigator + Social Worker
- Hours: Mon to Fri, 8am to 8pm
- EDIE team meets directly with patient when criteria are met

  - 3 ED visits, 3 different EDs, 3 months
  - 5 ED visits, any EDs, 12 months

UCSF Care Coordination Team

- Broad screening for social needs by EDIE team
- Work with ED clinicians to incorporate medically significant info
- Meet and collaborate with:
  - SF Dept of Public Health
  - SF Street Medicine
  - other SF hospitals
  - community social services, treatment programs

Geoff Smith, Program Manager for the Placer County Whole Person Care program

Placer County Whole Person Care

Expanding Treatment Coordination

COUNTY OF Placer®

Placer County Whole Person Care

- Seven day-hospital follow-up visits
- PreManage notifications
- Treatment Plan sharing capabilities
- Information for coordinating with Primary Care

County of Placer

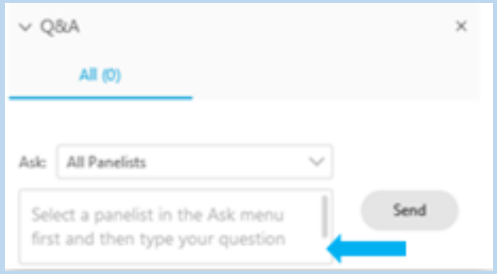
Expanding Treatment Coordination in Placer County

- Adding Full Service Partnerships
- Adding Adult Outpatient notifications
- Reviewing data to improve level of service decisions

COUNTY OF Placer®

Questions…

- Use Q&A box to submit your questions.



- Unanswered questions during the webinar will be answered via email.