Right Data, Right Time:

A 360-degree View on Health & Wellness

Presented by: Barb Stinnett

The Problem:

Source: Bipartisanpolicy.org

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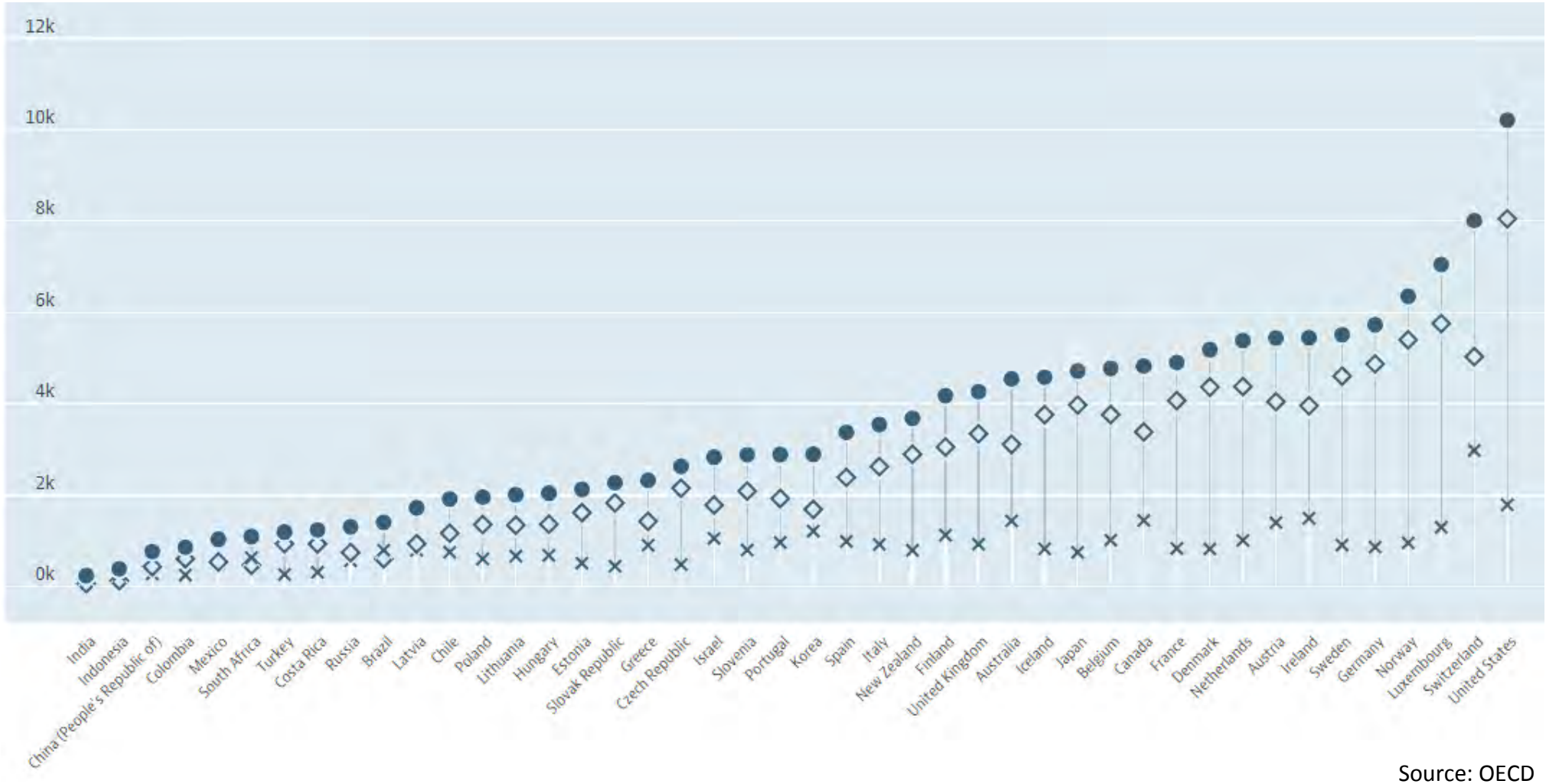
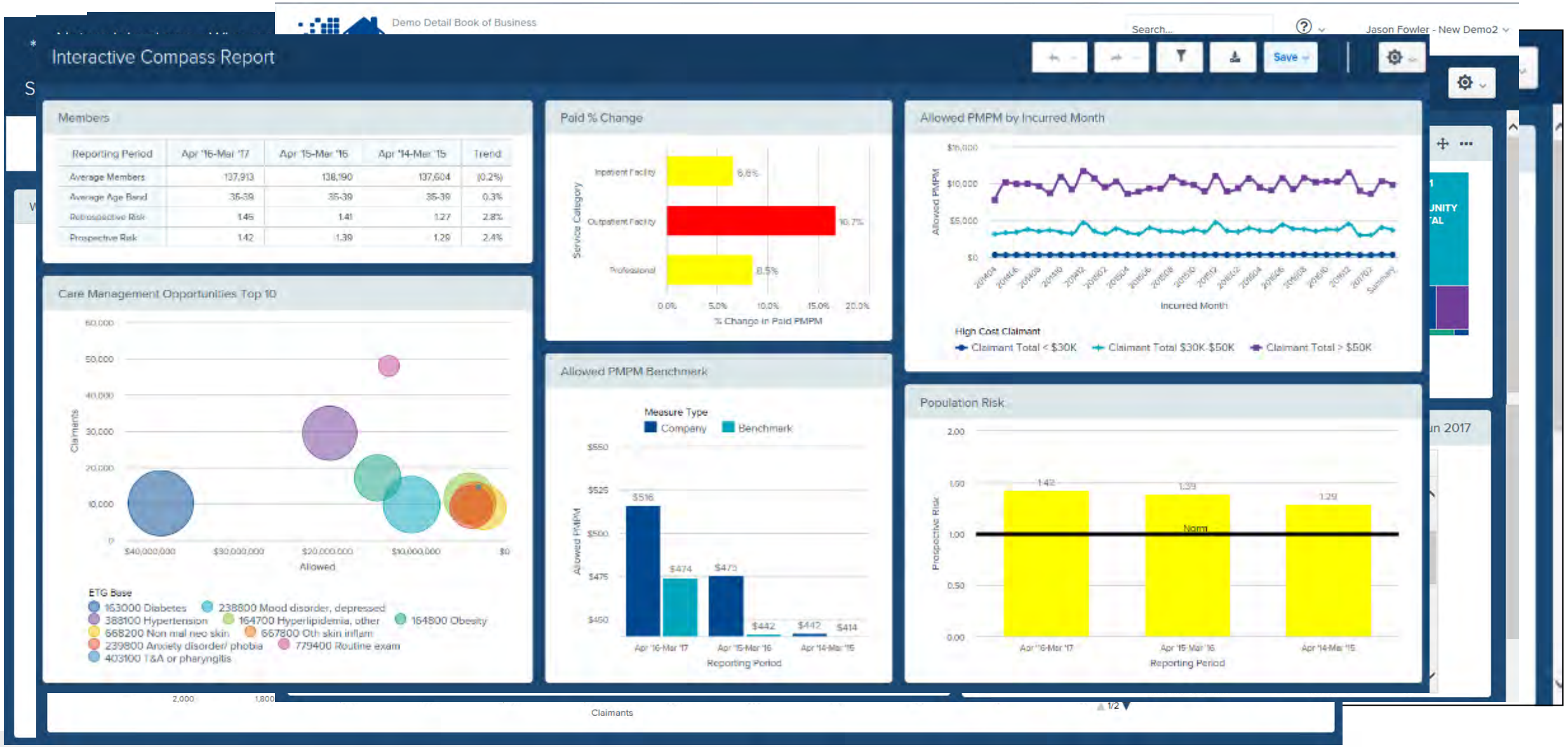
Health Expenditure per Capita, 2018



Source: OECD

Power of Analytics



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TG Community Care Model

Source: The Timmaron Group

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TG Analytics Journey Map

Age old problem – new insight & action

Situation:

- High rate of ED visits
- ED conducts tests to eliminate physical issues
- Discharged with no resolution
- Financial strain on the community hospital and the patient experience

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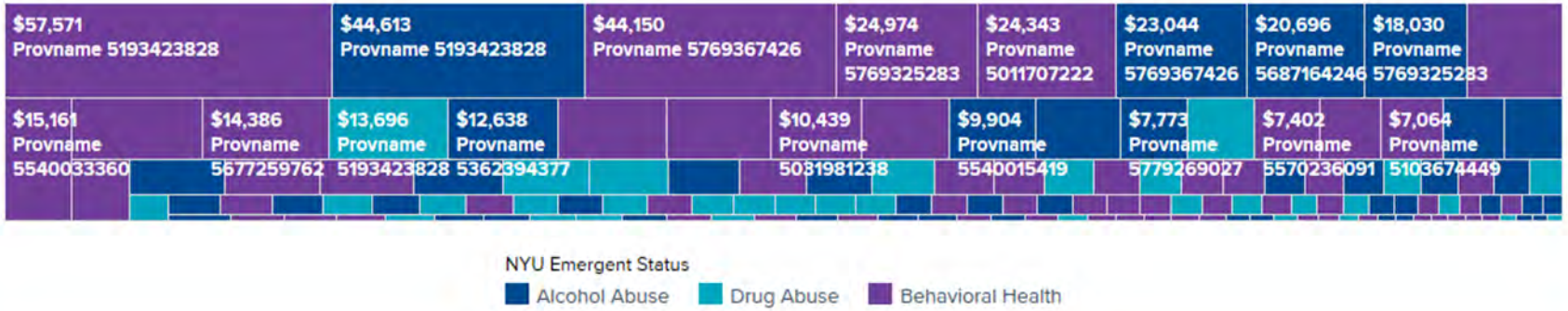
*Behavioral Health and Substance Abuse ER Claims Analysis

Save

Which providers have the highest behavioral health and substance abuse ER claims?

Reporting Period: Jul '17-Jun '18 ICD-10 Diagnostic Category: F01-F99 Mental, Behaviora...



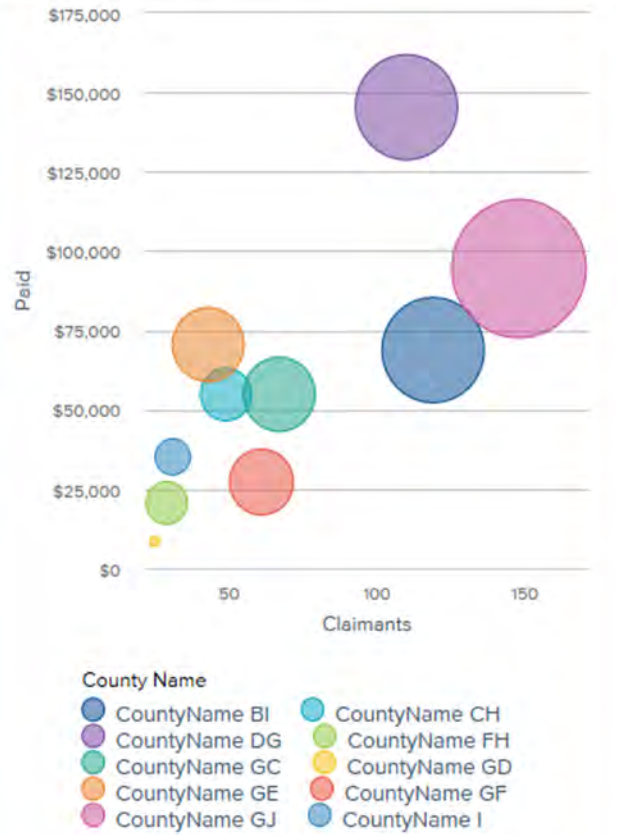
How are providers performing YOY for behavioral health and substance abuse ER use?

Reporting Period: Jul '17-Jun '18,Jul '16-J... ICD-10 Diagnostic Category: F01-F99 Mental, Behaviora... Services: > 3 (agg)

Provider Name	County Name	NYU Emergent Status	Reporting Period	Claimants	Services	Paid	Services/1000	Claimants/1
Provname 5769367426	CountyName GJ	Behavioral Health	Jul '17-Jun '18	75	91	$38,361	18.1	
			Jul '16-Jun '17	67	81	$34,933	19.8	
			Trend	11.9%	12.3%	9.8%	(9.0%)	
		Alcohol Abuse	Jul '17-Jun '18	22	40	$19,021	7.9	
			Jul '16-Jun '17	18	33	$15,421	8.1	

Which Counties?

Reporting Period: Jul '17-Jun '18 ICD-10 Diagnostic Category:



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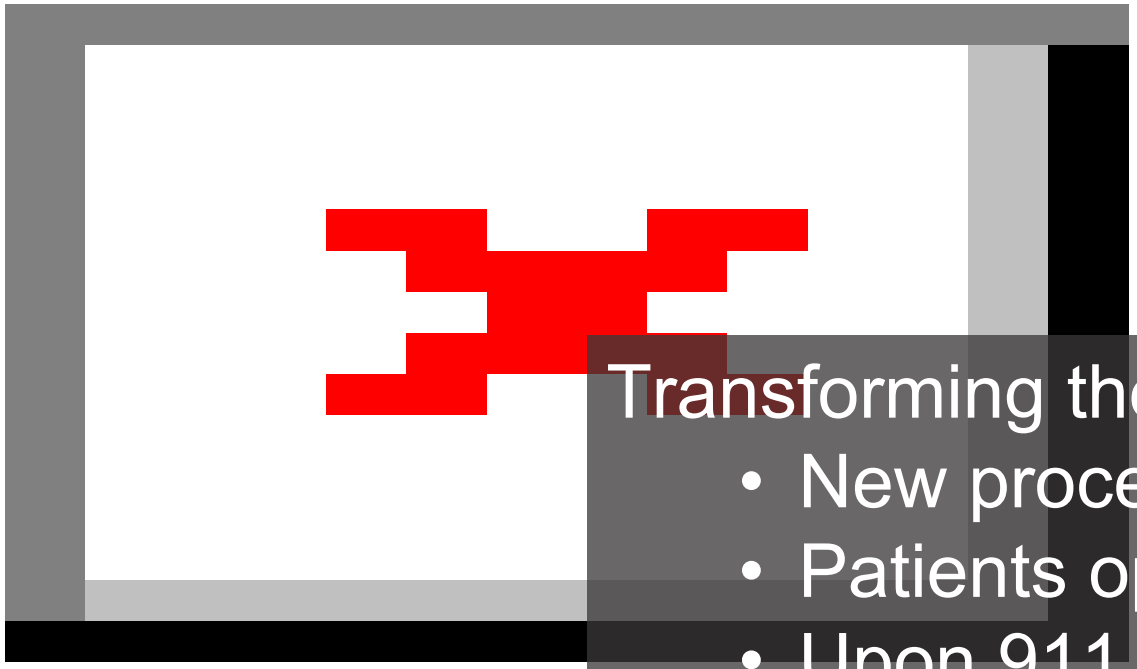


Transforming the community

- New process implemented
- Patients opt-in to the program
- Upon 911 call both paramedic and case worker/psychiatrist assess patient at home

Incorporating Behavioral into Mobile Crisis Process

Observe	Take Action	Transform
• ED visits too high • Tests run to eliminate, but not resolve • No behavioral or case management involved in this workflow	• Community effort • Brought in multiple ancillary stakeholders, including EMR	• Changed workflow process at 911 • Community working together • Lowered ED visits by 40% • Reduced suicide rate

Disease Management – New Approach

Situation

- High rates of diabetes for years/post surgery readmits
- Disparate groups of age, demographics, ethnicity
- PCPs, clinics, county health have implemented programs with no results

Diabetes Compliance Dashboard

Save

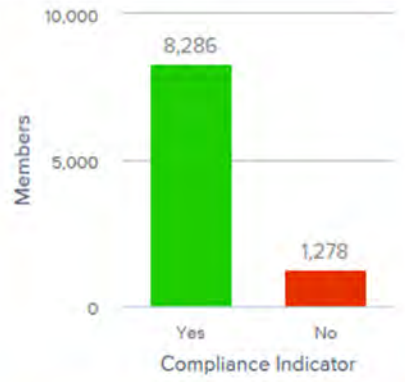
1+ HbA1c in last 6 mos?

HbA1c in last 12 mos?

Annual diabetic retinopathy scree...

Annual nephropathy screening?

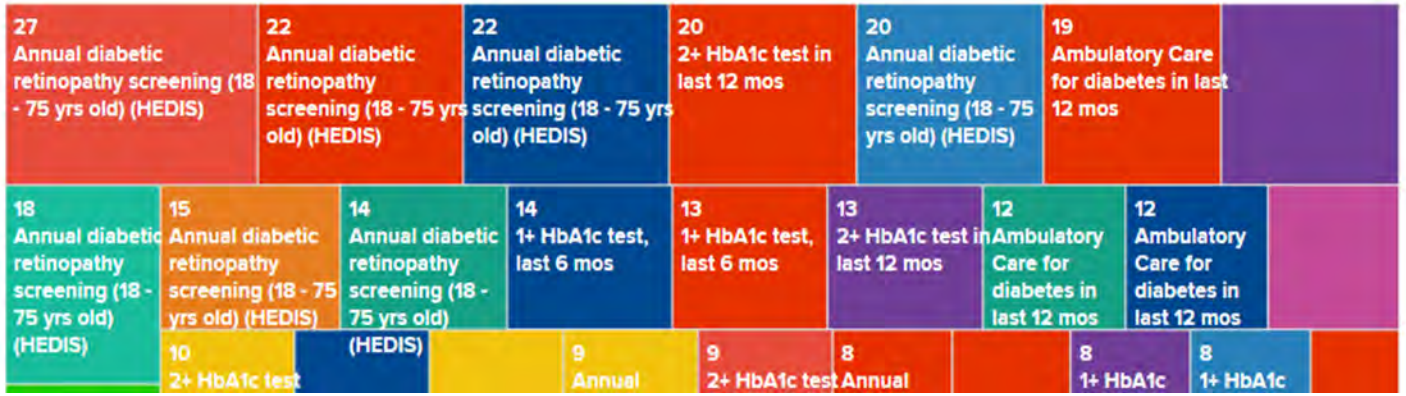
Adult: HDL test in last 24 mos?



Member compliance by guideline.

Compliance Indicator	Yes	No
Guideline	Members	Members
1+ HbA1c test, last 6 mos	6,314	3,466
2+ HbA1c test in last 12 mos	5,349	4,420
Adult: HDL test in last 24 mos	8,286	1,278
Adult: LDL test in last 24 mos	8,294	1,270
Adult: serum creatinine test in last 12 mos	7,993	1,335
Adult: triglyceride test in last 24 mos	8,261	1,300
Ambulatory Care for diabetes in last 12 mos	8,654	1,123

PCPs with most Non-Compliant diabetic patients



TG Community Care Model

Food Prescriptions

Available in Doctor's Offices

Ongoing Chronic Needs

- 25 meals provided
- Specific diets based on chronic condition, i.e., diabetes & cardiovascular disease
- Culturally specific versions available (Hispanic, Thai, Somali)

Acute Needs

- Fulfills 72 hours worth of need
- Pre-packed with nutritious food items and balanced levels of sodium and sugar

Prevention Services

- Addressing broader social determinants of health through care coordination
- In-clinic staff connect patients to food and other community resources, they need to be healthy

Food is Medicine

Observe	Take Action	Transform
• High A1C • No improvement over years • Traditional clinical data ADTs, labs, etc.	• Community effort • Food banks and grocery stores • County & HHS for education, parks and programs	• Worked with PCPs to deliver food as medicine • Community to improve access to parks, bike paths • A1C finally reducing 11.3 to 8.7)

Transitions of Care

Situation:

- Discharge notifications delayed and inconsistent
- Follow up with patients late and impacting care – no care coordination plans communicated to ancillary providers
- Behavioral, county health workers, pharmacy and LTC out of the loop for up to 60 days

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Transitions of Care

Solution:

- Community population health and analytics solution
- Automated alerts to community partners including Long Term Care and Public Health nurses
- Alerts in advance of discharge to help plan and reduce costs
- Social services engaged for more effective home care

Transitions of Care

Observe

- Follow up after discharge late, non compliant, impacting care
- Follow up on Rx out of hospital lacking to none
- Ancillary out of loop for up to 60 days

Take Action

- All hands on deck – hospital: home to hospice
- Community effort including public health nurses, long term care facilities, and social services engaged

Transform

- Better pregnancy and infant care
- MTM– improved compliance for discharged patients
- 360-degree patient view for all community care managers
- Development of care pathways for all transitions

In Summary

- Thinking differently pays off
- Right people - It is all about the community and their willingness to work together
- Right partners – to support the effort of the people
- Right data – knowing what to ask, how you ask, and who can take action and transform


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Thank you