Broken Health Care System
1. Organize into integrated practice units (IPUs)
2. Measure outcomes and costs for every patient
3. Move to bundled payments for care cycles
4. Integrate care delivery across separate facilities
5. Expand excellent services across geography
6. Build an enabling information technology platform
Broken Health System in America

Commonwealth Study

**Access to Care**
Ranks last on all cost related access

**Healthcare Quality**
Ranks near the top for effective care and patient centered care
Much lower for safe and coordinated care

**Efficiency**
Ranks last due to time and $ spent dealing with insurance, duplicate testing, lack of coordination

**Equity**
Ranks last  lower income adults delay care or receive care from ER

**Healthy Lives**
Infant Mortality
Potentially Avoidable Deaths
Obesity and Diabetes Crisis.
Diabetes and Obesity Trends

U.S. Leads Developed Nations in Diabetes Prevalence

DEC 2015

New and detailed data from the new International Diabetes Federation (IDF) Diabetes Atlas, released at this week’s World Diabetes Congress in Vancouver, Canada (Nov 30-Dec 4) reveals that, unsurprisingly, the United States has the highest prevalence (11% of the population aged 20-79 years) of diabetes among developed nations. This league table includes countries of the European Union plus Canada, Australia, New Zealand, Singapore, South Korea, Israel, Andorra, Norway, Switzerland, and the U.S. itself.
# Contributing Factors to the Broken System

| Lack of Transparency | • Patient steerage from entry point to profit centers  
| • Actual plan cost unclear to patient  
| • Inconsistent provider quality  
| • Prescription pricing models and rebates |
| --- | --- |
| Prescription Drugs | • Medication possession gaps  
| • Medication cost – both to patient and plan  
| • Patient understanding and compliance |
| Primary Care Access | • Provider availability  
| • Inadequate prevention and management of chronic disease  
| • Delayed diagnosis |
| Misaligned Incentives | • Fee for service compensation  
| • Malpractice risk  
| • ACA MLR targets |
| Inflated Billing | • “Optimized” medical coding  
| • Place of service variances |
| Varying Health Insurance | • HDHP, PPO, Indemnity  
| • Gap products  
<p>| • Provider and employer administrative overhead |</p>
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Average Revenue</th>
<th>Average Salary</th>
<th>Return</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>$1,830,200</td>
<td>$207,000</td>
<td>884%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>$1,493,518</td>
<td>$198,000</td>
<td>754%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>$2,169,673</td>
<td>$339,000</td>
<td>640%</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>$1,583,209</td>
<td>$276,000</td>
<td>574%</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>$2,746,605</td>
<td>$497,000</td>
<td>553%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>$1,210,586</td>
<td>$226,000</td>
<td>536%</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>$1,688,056</td>
<td>$350,000</td>
<td>482%</td>
</tr>
<tr>
<td>Cardiology (Invasive)</td>
<td>$2,448,130</td>
<td>$325,000</td>
<td>466%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>$2,445,810</td>
<td>$553,000</td>
<td>442%</td>
</tr>
<tr>
<td>Cardiology/Non-Inv.</td>
<td>$1,260,971</td>
<td>$291,000</td>
<td>433%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>$1,035,577</td>
<td>$249,000</td>
<td>416%</td>
</tr>
<tr>
<td>Neurology</td>
<td>$1,025,536</td>
<td>$277,000</td>
<td>370%</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>$1,190,870</td>
<td>$331,000</td>
<td>360%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$665,972</td>
<td>$195,000</td>
<td>342%</td>
</tr>
<tr>
<td>Urology</td>
<td>$1,405,659</td>
<td>$412,000</td>
<td>341%</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>$1,066,221</td>
<td>$334,000</td>
<td>319%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>$1,422,677</td>
<td>$455,000</td>
<td>313%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>$712,054</td>
<td>$275,000</td>
<td>259%</td>
</tr>
</tbody>
</table>

As of 2019 the average revenue generated for a Hospital by a Family Practice is $2,133,273

Merritt_Hawkings - 2016 Physician Inpatient/Outpatient Revenue Survey
“If you always do what you always did, you will always get what you always got.”

A. Einstein

Using data to identify costly healthcare benefit problems is not new. Employers have always studied spending trends and cost-share balances and we’ve all learned that cost-shifting and adjusting premiums are always short-term and short-sighted solutions to long-term problems.

What would Albert do?

Look at things with a fresh set of eyes.
When you look at data differently, you can reduce your healthcare spend, lower your risk and improve the health of your population.
What is an onsite/near site health clinic?

An On-Site clinic is an area physically located in a company which is designated as a medical clinic. The provider then operates out of that site caring for employees for acute care situations. ...

These comprehensive health and wellness centers are located directly on the employer’s worksite to offer maximum convenience for on-site employees.

Near-site health services are a great way for a company looking to control health care costs and is positioned near multiple sites of the employer. These facilities are positioned near the employer’s location, often in an area that’s convenient for distributed workforces as well as spouses and dependents.

Shared-Site is health centers to share the cost of a clinic by partnering with a group of companies. Facilities located in proximity of employees homes and employer location.
How does the health clinic control costs?

Directing main street health encounters into a more controlled environment

Clinic Encounters

Lead to savings

<table>
<thead>
<tr>
<th>Medical Costs</th>
<th>RX</th>
<th>Wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Compliance</td>
<td>Utilization Reduction</td>
<td>Chronic Condition Management</td>
</tr>
</tbody>
</table>
Overall claims trend with clinic option
CareATC’s Primary Care
Remarkably Different Healthcare

We’re changing the way healthcare is delivered.

Since 2000, we’ve been recreating the healthcare experience to drive more engagement, better outcome, and lower plan costs. Our unique approach to workforce health is more than a model. It’s a movement to better outcomes.
Our mission is to promote health, prevent disease, and provide a shorter path to care.
86% of healthcare costs are attributable to preventable, treatable, chronic disease.

High-risk employees are 3x more likely to file workers’ comp claims. **

Chronic disease is the primary contributor to death and illness in the U.S.

17% of adult Louisiana residents report not being able to see a doctor when needed in the past 12 months due to costs. ***

Louisiana Number of Adults with Diabetes: 400,984***

* Source: Center for Disease Control 2016
**Georgetown University McCourt School of Public Policy, Health Policy Institute, “Disease Management Programs: Improving health while reducing costs?”
*** Louisiana State Health Assessment and Improvement Plan, 2019
Methodology

Data Driven Population Health Management

CLINICS

ANALYTICS

TECHNOLOGY

PCMH

OPERATIONS
The Model

Current model relies on patients to know...

- What is available
- How to access
- When they need each service

New model gives patients an ambassador to...

- Identify patients in need
- Serve as their advocate and cheerleader
- Proactively reach out, educate, and engage
- Connect patients to resources
Primary Care

**Personal Physician**
Primary Care will be performed and managed by a personal physician at the center that will collaborate with other health professionals and utilize consultation or referrals as appropriate.

**Cost-Effective**
Primary care at the center will provide patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services.

**Continuous Communication**
Primary care at the center will promote effective communication with patients and serve as the patient's first point of entry into the health care system and as the continuing focal point for all needed health care services, not limited by problem origin, organ system, or diagnosis.
Primary Care

Promote Health
Primary care at the center will provide health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.).

Patient Advocacy
Primary care at the center will be organized to meet the needs of patients with undifferentiated problems, with the vast majority of patient concerns and needs being cared for in the primary care practice itself. The primary care physician will advocate for the patient in coordinating the use of the entire health care system to benefit the patient.

eConsults
We are able to offer an innovative eConsult service that connects clinic providers to same-day insights from top specialists. It removes barriers to timely and convenient specialist feedback, improves quality of care and overall experience for patients, helps eliminate unnecessary patient visits to specialists, and engages in clinical knowledge sharing with other providers. The platform is HIPAA compliant and specialist feedback is comprehensive, getting 5 stars from providers in 80% of reported cases. 40% of reported eConsults help avoid referrals, resulting in improved outcomes.
Acute and Chronic Healthcare

CareATC is fully capable of providing care, symptom treatment, and management and have been providing these services since our inception.

CareATC's complete adult primary care services will be provided by a licensed board-certified physician that is a specialist in Family or Internal Medicine who provides definitive care to the patient at the point of first contact and takes continuing responsibility for providing the patient's comprehensive care. Care may include chronic, preventive and acute care in both inpatient and outpatient settings.
Program Components

Patient Care Team
• Patient Ambassador/Advocate
• Primary Care Provider
• Out of Area Primary Care Network
• Enhanced Virtual Telehealth Services
• Behavioral Health Specialist
• Physical Therapy (Onsite and Virtual)
• Dietitian
• Community-Based Programs
• Referral Specialist
• In-Network Specialists
• In-Network Facilities

Best Practices & Resources
• Medical Record/Claim-Based Risk Analysis
• Population Health Management Software
• Registry Compilation
• Patient Outreach
• Staff Huddles
• Face-to-Face Care
• Closed-Loop Referral Process
The Science Behind our Version of Artificial Intelligence

**Cognitive Clinical Success Machine**
An Eigen-based engine delivering a comprehensive patient view that predicts not just risk of an event but also the clinical actions that will improve outcomes and drive engagement.

**Going Beyond the EHR**
EHRs amass large amounts of patient data but don’t actually drive more effective care. Cognitive learning machine can consume diverse data and deliver customized outputs.

**Beyond Predictive to Prescriptive Analytics**
Just predicting what is likely to happen is no longer enough and the cognitive clinical machine provides a list of interventions that are most likely to change a patient’s trajectory.

**Identifying Avoidable Admits and ER Visits**
Using a hyperdimensional platform we can see who in the population is heading toward an avoidable healthcare event and provides insights to the most effective actions to lower risk and improve the outcome.
True Population Health Management

The primary users of healthcare AI are hospital systems. We are bringing this technology to primary care to limit an employer’s need for hospital systems.

What’s the fastest way to lower health plan spend?
The best way to lower the cost of care is drive prevention and provide interventions early in a way that ensures workforce engagement. By knowing who is at risk, who is likely to participate in their own health and the best way to reduce their risk, we have the critical pieces of information necessary to ensure success of our clients’ health plans and the health of their populations.

How can we provide early interventions?
By knowing who is at risk, who is likely to participate in their own health and the best way to reduce those risks, we have the critical pieces of information necessary to ensure success.

Inappropriate use of ER and hospital resources is the major source of waste in the healthcare system.
Many studies indicate that early ambulatory-based interventions, coordinated care and targeted treatments effectively avoid admissions, reduce ER visits and improve quality of life.

In the primary care setting, we can provide these ambulatory-based interventions.
Using the risk predictions and the intervention prescriptions provided by the ‘machine,’ we can build client-specific programs to target very specific risks in a given population.

Coordinating care between PCP visits and educational programs
Engagement is the key to success and meeting patients where they are comfortable is the key to engagement. Because the ‘machine’ tells us whether patients are comfortable with digital programs and technology, we can be sure to get each patient to the type of program guaranteed to offer them the greatest chance of success.

The results are healthier patients and lower costs
Up to ¾ of ER visits do not require immediate attention or are preventable through ambulatory care and as many as 28% of those are ‘frequent fliers’. Because the majority of unplanned hospital admissions are a direct result of ER visits, identifying the patients at risk for both ER and Admission events can provide as much as a 25% savings in health plan costs.
Engagement Strategies
Patient Activation
- Digital Patient Registration
- PHA Events
- Digital Education Programs
- Population Health Management
- Preventative Care Outreach
- Clinical Screening Tools

Patient Communication
- Program Announcements
- Seasonal Education
- Service Promotion
- Convert to Digital High Touch

Patient Experience
- Interactive Messaging
- Patient Satisfaction Survey
- Improved Refill Process
- Avoided Specialty Referrals
- High Quality Primary Care
Enhanced Patient Experience

• Focus on an exceptional patient experience
• Personalized service
• Shorter wait times
• Expanded appointment times
• More options to receive care
• Concierge-like care
Digital Results and Education

Take Personalized Care to the next level – Visually

- The brain processes video 60,000 times faster than text
- Viewers retain 95% of a video message vs 10% when reading text
- Patient engagement with online video is 600% more effective than print or direct mail
- Approximately 15 quadrillion permutations possible
NETWORK Optimization

• **Narrow Networks**
  - Preferred imaging services
  - Preferred network specialists
  - Referral management

• **Partnering - primary/specialty care**

• **Onsite/Near-site Specialty Services**
  - Specialist eConsult Service
  - Behavioral Health
  - Physical Therapy | Massage Therapy etc.
  - Alternative Medicine | Local Solutions
Creates and Applies Technology:

- Enabling Providers
- Optimizing Service
- Engaging Members
Data Integration as a Core Competency

• Dedicated data integration and management team
• Sophisticated member/patient matching algorithms
• Real time via APIs
• All major file types and data structures
• Average 2,400 data points per patient
• Architecture for optimal transparency and security
Provider Enablement – CareHub

Comprehensive Medical Record (CMR) with trended health data in one click:

- Risk Conditions
- Health Assessment Results
- Chronic Condition Management
- Allergies
- Medications
- Visits
- Procedures
- Labs
Clinical Analytics and Reporting

**LIKELIHOOD OF HOSPITALIZATION**

Based on factors such as medication gaps in care and diagnosis acuity, the ACG system assigns a group of probability factors to each patient which indicate that patients risk for hospitalization in the coming 12 months.

- **2.9%** GROUP AVERAGE – 12 MONTHS
- **102** MEMBERS RISK ≥ 25%
- **87%** HIGHEST PROBABILITY
- **27** MEMBERS WITH HIGH ICU RISK

**MEMBERS AT RISK FOR HIGH COST**

High Cost Claimant (HCC) defined as having total costs, including pharmacy, in the 5% of studied population. Persistent High Cost Claimant (PHCC) defined as having total costs, including pharmacy, in the top 20% of the studied population every quarter for the next four quarters.

- **440** AT HIGH RISK OF UNEXPECTEDLY HIGH PHARMACY COSTS
- **228** HAVE 50% OR GREATER CHANCE OF BEING A HIGH COST CLAIMANT
- **88** HAVE 50% OR GREATER CHANCE OF BEING A PHCC FOR 24 MONTHS

**PREDICTED RISK SCORE**

Estimated total costs (including pharmacy) for the year following the observation period represented as a relative weight in which 1 represents the mean.

- **67% LOW RISK** – Predicted Risk Score less than 1
- **24% MODERATE RISK** – Predicted Risk Score between 1 and 3
- **9% HIGH RISK** – Predicted Risk Score greater than 3
Operational Analytics and Reporting
Continuous Improvement Through Client and Patient Feedback

Net Promoter Score

86

Detractors: 3%
Passives: 8%
Promoters: 89%

Net Promoter Score = % Promoters - % Detractors
Patient Communication – Multi-modal

Push Notification

Text Message

Email

Paper Mail

Outreach and Inbound Call Centers
CareATC Market Presence
On-site and Shared-Site Clinics – From Coast to Coast!

101 open clinics
(As of Sep. 6, 2019)

9 clinics in process

111 providers

393 associates

146 clients
Question?
Open Discussion