

NWX-HHS-AOA-1

Moderator: Lauren Solkowski
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Operator: Welcome and thank you for standing by. All participants will be on a listen only mode until the question and answer session of today's call. At that time, you can press *1 to ask a question from the phone line. I would also like to inform all parties that the call is being recorded. If you have any objections, you may disconnect at this time. I would now like to your call over to your host Lauren Solkowski. Thank you mam you may begin.

Lauren Solkowski: Great, thank you so much and good afternoon everyone. Thank you for joining us today for our - there's the Administration for Community Livings Business Acumen Webinar, entitled using data to tell your story. Again, this is Lauren Solkowski with ACL and, I will be facilitating our webinar today.

So for today we've invited (Paul Watkins) He's with the Aging & In-Home Services of Northeast Indiana, as well as (Sarah Lovegreen) and (Juliet Simone) Both with the OASIS Institute and also part of the Gateway Wellness Network in Missouri. And we have invited them to talk with us today in terms of how they've been able to use data to tell their story and helping to build their value proposition.

So before we start with their presentations I have a few housekeeping announcements. So to start, if you have not done so, please use the link that was included in the calendar appointment to get on to the WebEx. So that you can follow along with the sites but also, so that you can ask your questions and you have them through the chat function.

If you don't have the link that was emailed to you. You can also go to WebEx.com. Click on the, attend a meeting button that is located at the top of the page and then enter the meeting number, which is 667026529. Again, that meeting number is 667026529.

If you have any other problems getting on to WebEx, please call the technical support number and that number is 1-866-569-3239. Again, that number is 1-866-569-3239. As our operator mentioned all of our participants are on a listen only mode. However, we do welcome your questions through the course of the webinar and there are two ways that you can ask your questions.

The first is which using the chat function. So you can enter your questions and we will sort through them and then answer once all of the speakers have presented. And you can see the chat boxes located there on the right hand side of your screen.

And then also, so you can ask your questions through chat but also through the phone line. So when that time comes, the operator will give us instructions as to how to queue up to ask your questions through the audio line. If there are any questions that we don't get to during the course of the webinar, please feel free to email them to me (Lauren) I have entered my email address there on the right hand side of the screen in the chat box.

And also as the operator had mentioned, we are recording today's webinar and we will be posting the recording, the slides and a transcript of the webinar on the ACL website. As well as on the MLTSS network website and I've also posted both of those websites in the chat box.

Okay, so with that I would like to introduce our speakers. So first, as I mentioned, we have (Sarah Lovegreen) and (Juliet Simone) with the OASIS Institute. (Sarah) is the National Health Director at the OASIS Institute. Where she leads the implementation and evaluation of health related programs and grants across the OASIS Network, of 50 cities and 25 states, including evidence based programs for chronic disease management and fall prevention.

Sarah is an active master trainer in the Stanford Chronic Disease and Diabetes Self-Management Programs and a lead trainer for A Matter of Balance. She also leads the Gateway Wellness Network, which is a network of community providers, improving quality of life, health outcomes and hospitalization rates for older adults.

Joining (Sarah) today is (Juliet Simone) (Juliet) is the Community Health Manager for the regional St. Louis OASIS Evidence Based Health Programs for older adults. (Juliet) has led community health projects as a Peace Corp volunteer and with the Minnesota Aids Project and shared their board of directors for interface legal services for immigrants.

With OASIS (Juliet) manages a statewide fall prevention grant and staff that recruits and trains volunteers to lead evidence based health programs at a variety of locations across the state. She is also a statewide coordinator of the Show Me Falls Free Missouri State Coalition and is a master trainer in Stanford University's Diabetes and Chronic Disease Self-Management Program and A Matter of Balance.

And finally we have - we also have (Paul Watkins) (Paul) is a Senior Vice President of Business Development and Health IT with Aging & In-Home Services of Northeast Indiana and (Paul) also worked closely with the Preferred Population Health Management Team as their Business Development Officer for the Social Services Market. (Paul) uses his experience with the Social Services Industry to identify, design and implement software solutions for community based organizations. (Paul) also co-develops and assists with establishing contracts to improve outcomes for high-risk populations within health systems, manage care and physician groups.

So thank you, so much for joining us today and with that, I will turn it over to (Sarah) and (Juliet) You may begin.

(Sarah Lovegreen): Hey, thanks (Lauren) This is (Sarah) and so I thought- we're going to try to make data real fun and interesting. Because sometimes, you know, it can be a little bit of a dry topic of a dry topic. So, the good news is data - data's everywhere and so we want to talk to you a little bit today about some of the existing data that you may already have.

That you're able to incorporate in to your conversations with potential providers or contracting agencies that you may be working with and those commune within your network as well as other secondary data sources that are available. And then some of our go to published studies, in areas that we go to as well as when we go looking for data to help support and tell our story. Next slide.

So it's in our network we have, you know, we definitely want to use our network data to show our impact and effectiveness and, you know, as we've

come together. And I think for my Gateway Wellness Network perspective is to kind of reiterate that we're really focused on the implementation of evidence health based programs. So A Matter of Balance and other evidence based programs around. Chronic Disease and Diabetes Self-Management and working with our network partners on delivery of those programs.

As well as complimentary services such as medication reviews, in-home assessments and things like that. That would complement those evidence based health programs and so, you know, as we've gotten started and we're getting off the ground, you know, we haven't run, you know, a group of patients through our full package of services. But all of our network partners have been offering these programs and doing these services for some time and we're coming together as a network to streamline that implementation process.

So we all have our program evaluation data, you know, and we're using. For those of us who are implementing those evidence based health programs. We are utilizing those standardized program evaluation metrics across all of our locations so that we all have that same data. Which not only allow us to track fidelity of the program but also to track our program outcomes on a, you know, certainly not necessarily the long-term ones but those kind of short mid-term outcomes. I mean and also for those who are doing our in-home assessments.

Our group of network partners have really come together to say here are the assessments that we're doing and here, you know, we all agree to do this depression measurement. We all agree to do the ten foot up and go versus the eight foot up and go and really making sure we're all using those assessments, you know. And using the same measurement tools and taking that data that we've used independently before we all came together to prove that, you

know, individually our programs are working and we're streamlining a process.

So while ripe with data as we've needed that, you now, in our funding requests and as part of our evaluation reports to those funders and so it's just packaging that data we already have to use to help tell our story. Then also we're expecting new data through our programs pilots within our network and so (Juliet)'s been leading for us some pilots. We have one with another physician and getting ready to kick off one with a federally qualified health center and I think one that is quickly coming to the table with another private practice.

A multi-physician practice that should come up relatively close and so this is when we really have our chance to collect our data on our service package that we have. Specifically for us, we're focused right now on our fall prevention package and so we're able to sort of collect that data from the beginning and watch those consumers through the process and collect that data. What we know is that so we think that that our - depending on the audience there's going to be differences in the types of data that they want and (Juliet), I'll let you speak to that a little bit in terms of what we think a contracting agency might want versus our referral source.

(Juliet Simone): Absolutely, so in our original conversations with our first pilot participant, which is one single family physician and a nurse practitioner working together. And, you know, coming from a community health standpoint, you know, with a public health degree and that epi kind of mind - epidemiology mind. I thought - I assumed they would want all the data, all the time and as I - as we started talking through the process a little in more detail.

They didn't want any of that. They didn't particularly need the tense it up and go score. They didn't really care if the person had reduced the fear of falling

over A Matter of Balance Program. They didn't really care if their sit to stand improved over the Tai-Chi Program. All they really wanted to know was that this person was seen, check. This person was invited to an exercise class, check. This person attended and exercise class, check and alike.

So I, you know, had heard from that, you know, we get a ream of paper faxed to us as a referral source a) and a ream of paper from source b). So we really don't have time to digest all that material, so the more concise the better and I said okay. So we're working with this independent physician to meet that offices needs and make sure that their getting the appropriate amount of information that will work for them.

And the way that they wanted to receive that then was to see wherever those checkmarks are. Whether it's kind of in the told them about it or informed them column. Into participating column or refuse to participate column, so that they can reinforce whatever they need to reinforce and move that arrow in to a new category during the in-person visit.

So that was what was important to them and with the federally qualified health center we're going to start from that same place, because we understand that they also have a lot of information. However, their case managers are going to be a little more I think directly involved by doing some personal touches and phone calls to those patients. So they might have slightly different needs about what data comes in to their chart and the same with the other healthcare groups.

So we're really trying to at least in these pilot stages, be really nimble and flexible and listen to what the client needs. Now once we actually get, you know, contracts with insurance companies they might want a totally different

data set. So we're just trying to collect everything we can and make it as digestible as our partner wishes.

(Sarah Lovegreen): Yes, and I think based on some - we participated in a research study around the Diabetes Self-Management Program with a health insurance company. Who is an active player in that research project and they were as part of that wanting some more specific information about not only did their consumers that were part of their plan participate but then in sort of long-term what was the health outcome and how did that track potentially in utilization. So I think certainly for those who might be paying the bill there's probably a little bit more interest in the health improvement in change and utilization but we're still learning that as we continue conversations with potential contractors.

And one I think that we've really tapped in to particularly to help identify the need and whether that's a statewide need. Whether that's a need that we can drill down to a County level. Even potentially in St. Louis, Missouri we do quite a bit by zip code level. Because there's large disparity based on the region of the city where folks live and, you know, we're really able to tap in to some wonderful secondary data sources that are available to us.

You know, two that we have here on the slide are St. Louis County recently went through a very large and in depth multi-sectorial assessment on, you know, sort of what aging is currently looking like in St. Louis. What does that look like in our different regions? How is that drilling down by zip code? Where are we seeing poverty? Where are we seeing falls? Where are we seeing gaps in transportation?

And so by having that wealth of data that was done across the county we can very much sort of have a very informed conversation as we talk about our service package and some of those social service items such as transportation.

That, you know, really or nutrition and meals that may need to be added as part of a well implemented service package for a certain set of our older adult audience. Our health conversion foundation recently in late October or in late 2014 had published a report on health disparities among older adults in our state and, so that was - confirmed a lot of what we know and really made the data local here in Missouri, we're the show me state.

So while there's a lot of wonderful national data sources, you know, there's definitely always that question that says well what about Missouri or what about my patient population? And so we're able to tap in to some of these sources and really drill down pretty well to a very regional or local level within our state. We also use quite frequently are some academic reports.

So there's been a wonderful series of reports called for the sake of all that have looked at disparities across age spans and now they've identified some of these primary issues across the region. Then the next step is, what are we going to do about and so that's the spot where a Gateway Wellness Network can come in as a resource to say here's how we can impact some of these readmission concerns among older adults.

Lauren Solkowski: And some social determinants of health were addressed in that report as well?

(Juliet Simone): Absolutely.

(Sarah Lovegreen): A huge favorite spot for us in our public health world and in mine set here is our state and county health department data sets. Missouri is very fortunate to have a very robust state health department website where we can really run some, again very localized, you know, down to a county level where our state was I believe about 118 counties across the state of Missouri.

So our counties are relatively small compared to some other states but we can really drill down and get some very wonderful data over, you know, we can see trend data over years. We can look at just the most recent year's data. We can export full data sets or email our county or state and get - very quickly get data sets back that we can then manipulate ourselves to look at what's happening across the state of Missouri. How do we identify needs? How do, you know, can we see some changes in trends over time? And more recently they have actually added a mapping function, which has been hugely powerful for a lot of our conversations we've been having and that's on the next slide (Lauren).

There we go, so this is an example, I've heard those of you who saw our value proposition conversation. This probably looks a little bit familiar as it's nearly the same slide and so these are just some of the maps that we're able to pull and we can pull that by. So this is death rates among unintentional falls for older adults over a looks like six to seven year period and we can divide that up in to quintiles and so very quickly at a glance.

When we're working in St. Louis for example, which is on the right side of your Screen there we're able to see in that dark blue section. This is a huge concern for our St. Louis region, you know, as we're talking to potential payers in other parts of the state it may be harder to sell, because they may be in that light yellow category. So, you know, it definitely helps us one, target our efforts in terms of obtaining a contract as well as have very educated conversations about how many people we might be able to put through a service package given, sort of, the need in a particular service area.

And so we can do this for chronic conditions, we can do it for physical activity, we can do it for falls. This is (deaths), but I believe we can also do it for hospitalizations, and just even prevalence of falls, injury, yes.

So, here, like, and I know Missouri is a little bit fortunate in having, I think, some of this direct access where we can do some manipulation on our own. But, you know from our experience in working in the broader Oasis network, you know, by just getting in touch with your state. You know, find your epidemiologist in your state chronic disease division or your aging services division and they may be able to help you get your fingers on some of this data as well. And I'm sure they'd be thrilled to share too. People get excited and love to share their information about their data sets.

Yes, and I will say and sort of knowing that we're all a bit resource-strapped, you know, this has been a great opportunity for interns for us. You know, we've got intern who want to come in and do data analysis and evaluation and this a wonderful opportunity for them to get in and really provide us with some meaningful data analysis that will help to move our program forward versus just looking at program evaluation data which is helpful, but we can do that pretty well on our own because we do that on a day-to-day basis.

But having interns, you know, we've had GIS interns who are really coming in to enhance the map. We've got (Barrett), our fall prevention intern, is looking more at, you know, sort of various data sources and making sure we're telling our story in a very complete way.

So those are handy guys if, when you're feeling a little - and also, like they've made, from my perspective, I don't work with data everyday anymore and you know I know (Paul) probably, (Paul) works very deeply in data every day. So, sometimes it's nice for us to have one of those interns on hand who have that faculty link as well to be sure that we're looking at the data in the right way.

And so another spot that we go to quite a bit are just the wealth of published studies that exist on the programs that we're implementing. You know, we have program developer web pages list those peer-review studies. Stanford has it, Tai Chi for Arthritis has it, Matter of Balance has it. And so all of those program developers keep a running list of what data are being shown for the effectiveness of their program.

We use that because it helps, those that are looking at more long-term outcomes and, you know, today we're not equipped for a six-month followup, we're not funded to do a six-month followup on a chronic disease or diabetes self-management program. So we need to rely on that research that was, you know, very well done by well-paid universities for a very large grant. You know, the CDC has these wonderful references and, again, linking to sort of the evidence around the programs that they're promoting. I know particularly around Tai Chi for Arthritis, we spend a lot of time on CDC's web page and some of their compendiums and things like that.

From a cost standpoint, this is also where the published studies can really come in. You know, there may be some independent peer-review articles that are out there. We lean quite a bit on the Report to Congress that was published, well it's been a couple years now, 2014 I think, late 2014, maybe early 2014.

Woman 2: Maybe 2013.

Woman 1: Maybe 2013, it might be 2013. But it looked at all the evidence-based programs' participants and, you know, sort of what is CMS seeing through their data and their claims data in terms of the effectiveness of those programs and the potential cost savings. And around falls with the Matter of Balance and Tai Chi, those numbers are pretty compelling.

Woman 2: Yes.

Woman 1: We also know with the help of the National Council on Aging Cost Calculator, that's available to help you factor in all of the costs to implementing an evidence-based program that was specifically designed originally for the Stanford Self-Management Program. But it can be applied to others. You know, we know what our cost is for those programs, so we're able to, you know, at least estimate what we would expect to see as a cost benefit to a contracting agency based on those peer-review studies, what we know are our costs and then what our evaluation is actually showing.

Woman 2: (Unintelligible) there.

Woman 1: I would just say to just, anyone out there can cite the CMS study because it is not specific by state or region. So there might be, you know, some slight variations in cost-of-living, you know, but that is one that we do cite often and the numbers that we even have in other slides coming up here in a second could be used for anybody across the country.

Woman 2: Yes. So I think that the next slide shows kind of our example of what we shared based on sort of our data, as well as those published studies. Sort of how we started talking about within our value proposition the financial benefit to an agency that we're talking to. Not only, yes our contracting organization certainly, but also our referral sources and these physician groups where we're looking to funnel patients through.

And so, we were able to share with them sort of based on actual costs, what we expect to be our completer rate, you know, what would the cost savings be for a Matter of Balance participant, a Tai Chi for Fall Prevention participant,

you know what that looks like in total and then estimate a return on investment.

And so, this gets people's attention. Like, you know, I really think even if you're close, these numbers are still pretty compelling if you talk about a thousand clients. And that's a lot of clients and, you know, I don't think that, you know for an evidence-based program that's a lot of clients in a single year. But, you know, certainly where do we want to tell a story and sort of use numbers in these examples that demonstrate our ability to scale and reach a wide audience.

Woman 1: And that \$2,000 cost savings in the first bullet-point there is just a sum from that CMS report of Matter of Balance and Tai Chi.

((Crosstalk))

Woman 1: And the Matter of Balance was 938. That number has been, I think, tattooed into our brains, and the Tai Chi was about 1,100. So we just kind of rounded it out and put it together to make a nice even number. So again, anyone can use that. That number is national, yes.

Woman 2: Here's your map, so. Okay and our next slide. Some of the questions that I think we got, I think early on to, you know, for folks who submitted questions prior to our webinar help us get ready and prepare for what we're sharing with you today, you know, there were some questions around like, how do you know what data you can collect? How nimble are you being in terms of what data you collect? And, you know, what if someone wants to do something you can't do, right?

And so this is how we're approaching it today. I mean, we haven't really been faced with some of these, but this is sort of where our thinking is on it at this point. So, you know, the first things that we looked at were what are our network members already collecting. What is already part of their standard procedures? And for us, we were really fortunate and there was great overlap. You know, everybody was using Geriatric Depression Scale already. I think everybody but Oasis was using the ten-foot (Up-and-Go), whereas we were using an eight-foot (Up-and-Go). And so that was something that we needed at Oasis to alter as part of our data collection process.

And so really looking to say, like, these are going to be that consistent tools and protocols that we use for our data collection, so it's very easy for us to pool that data together and analyze it and look at it so that we can include that as part of our value propositions.

You know, again, what are the established methodologies for obtaining this data? And this is really more around our evidence-based health promotion programs. Is it a pre- and a post- or is it a pre- and a three-month follow-up? Like, you know, what questions if we are doing a pre- and a post- are the ones that we would expect to see movement on in that, you know, several-week period, versus something that you wouldn't see unless you were 90 or 120 days out, for example?

And so with that we kind of identified and are beginning to really define the data that's going to be collected for all of our consumers. And (Juliette), I think, you know said, right now we're kind of erring on too much, right? Because we're definitely still in a learning curve, you know, and so we ourselves are learning what works and what doesn't and we're also still learning what is of most value to our organizations.

But by kind of going through those first two steps of, like what data are we collecting and what is the best methodology for that, we're able to define what we can collect. And there are always going to be things that we can't collect. You know, we are not going to be collecting A1C. We're going to leave that to the physician. That's something that should be done in an office visit. We are not designed to do A1C as part of a diabetes self-management program.

We are happy to be in partnership, you know, with our referral source so that we can monitor A1Cs for people who participated in our program in case we need to do any course-correction to be sure we're providing a very effective program as part of that model. You know, I think as we get to more, right now, I mean, (Juliette) shared this, we're working more from a provider side and they're wanting just, you know, sort of like, did the patient do it? If yes, great, I can check that off from my quality measure standpoint. But we know that's going to look a little bit different when it comes to what the insurance companies or other payors might be looking for.

But again, I think we have clearly defined what we can do, and I think if we can't do it, it's a conversation about, like, how can we get that data or get close to that data in collaboration and in partnership together. You know, we don't want to do this in a vendor/vendee relationship.

I think, was that our last slide? No, okay. This is our last slide. And so I think, you know, all of these pieces and kind of pieces from the seven preceding slides that we've had and that we've been able to share with you, we've put into our value proposition.

And again, I know some folks on the call saw that as part of the business acumen meeting earlier in May, and we took those slides and actually adapted that to a two-page flier. Because a lot of those meetings are small-group

meetings, there was three to four people, and so that way we're able to provide, you know, a document for us to talk through as part of that meeting.

They're able to ask some great questions with that document and then, you know, for example, as we talked about some of the cost-savings pieces, you know, the questions that were asked were, hey can I see those studies? Absolutely. That's a wonderful way for us to follow up and have a continued conversation after that initial meeting with a potential payor.

So it gives us, we found so far as we've only used it a couple times, that this has been, you know, a nice addition to the PowerPoint slide when the PowerPoint deck doesn't really make sense for us to do that. But, we really blended the data that we've collected to date, our secondary data sources and those published sources to really pool that together into a comprehensive story of what's happening in Missouri around falls.

Woman 1: I think that wraps it up for us.

Lauren Solkowski: Great, well thank you both so much. Let's see, I think before we go into questions, we're going to hear from (Paul Walkins) who is also going to share with us some of his insights and he's also going to walk through some of the questions that (Sarah) had mentioned that were sent in to us prior to the webinar. So I've pulled those up on the screen, and so with that, (Paul), I'll turn it over to you.

(Paul Walkins): Thank you. So yes, actually, I would just be highlighting some of those things that they are just kind of emphasized. We actually co-developed our data measurement items with our contractor. So we had a series of meetings that probably occurred over a six-month period of time, and then we spent probably a solid month coming up with similar data metrics that they wanted

to have measured. And then we actually implemented those criteria into our population health logistics tool so that their staff could actually have direct access to the work that we were completing.

So transparency has always been a real big one for the work that we've been doing. And right on-point to, they only want very specific information. Not only that, but we found that our individual staff wanted very specific information. They didn't necessarily pay attention to lab results or a physician order that a nurse might need to fill. So we actually developed a very specific abstract on the information we collect and then each of those entities get a nice summary of the activities that we're completing.

From there, we actually have a dashboard that kind of shows everybody where we're at in the program. The contractors can only see their clients, however, we can look at our programs across the agency or across multiple agencies, or we can even compare staff or compare agencies to see who's developing the best practices and having the most impact on the services we're delivering.

So we actually have monthly phone calls where we'll jump on and say, hey we noticed your conversion rate to face-to-face assessments dropped by 30%. What's going on there? And then have our best practices kind of explain, you know, this is how we're introducing ourselves on the phone, this is how often and what time of day that we're stopping by a person's home or in the hospital, and we're able to kind of turn that Titanic on-the-dime.

And there's been several cases where you can tell exactly the month where we had the conversation and then every month after that you see a very sharp improvement on whatever metric that we're measuring.

So that's kind of a real brief outline of how we kind of came to our data measurement. We always customize our data. I don't know that we've come across two contractors who are looking for the exact same data. There are similar types of information that people are looking for. So we have an actual risk stratification tool in there now that's real similar to the (Culmanish) type of model if you're familiar with that.

So there's a risk stratification that occurs based on diagnosis, health care utilization both inpatient and outpatient, medication review to say, hey these medications may trigger a re-admission or if the person even picked up those medications. Then we do a root-cause analysis for those as well to kind of identify what those high-risk members are dealing with.

So as we collect the information, we actually get a re-admit risk (score) from the hospitals or the insurance companies based off the claims data, and then we compare it with our risk stratification tool to say, actually, this percentage of the population that you're referring to is probably at a high or moderate risk category, whereas the rest of the referrals may be at more of a moderate to low risk category.

And we're actually going to use that to expand on our number of referrals because we can say, you know, these are the metrics we agreed on that would cause somebody to be a high risk, we admit back into the hospital. And what allows us to do that is the population health logistics information that we're collecting.

So we're really close to actually just entering a contract to just monitor through our health information exchange, as well as feedback from our clients, to say, hey you're an Anthem member, you were recently hospitalized, which will trigger a point for us to communicate with our contractor to say,

hey would you mind us working with this client for the next 30 days? Then he approves that process, they can see where they're at in that approval process, and then we start our service delivery.

So the data, as long as it's presently simply and very straightforward, it seems like people really grasp onto it. So I wouldn't try to get into, like, the weeds of the data. Kind of what (Sarah) was saying earlier, you know, maybe they don't necessarily care about a very specific score on that assessment tool, but maybe a series of assessment tools. Meaning that they're at a higher risk of falling, and they just want to know if all their clients who are at a high risk of falling versus moderate or low risk of falling.

So as long as you can kind of condense the data to where you really can paint that simple picture of the complex clients that we are used to working with, it usually translates very well. Especially if you can come from kind of the standpoint of a Medicaid population, I think we can all agree that there are common issues that they're going to face, right? Transportation, financial concerns, home modifications might be an issue.

So really trying to kind of paint the picture of not only re-admission risk but what's their home-and-community-based services risk? And how long have you been working with that population? And then really kind of emphasizing, this is the number of resources we secure for people, and this is the impact we have on the population that you're struggling with.

From there, we actually have an RY calculator, a return-on-investment calculator, that's been approved by CMS that allows us to kind of simulate a population so that an insurance company can say, oh okay, this is the population we serve, this is how much it costs us to do it. How much would it

cost for you to deliver the same services? And let's say you had a 10% reduction on our re-admission rates, what would our ROI be?

And since it's been validated by CMS, they typically will take those questions very seriously and allow us to be more transparent on the dollars that they have to spend. We've learned a lot about the different buckets of money that they have access to. There is a lot of power to kind of blending departments, so not necessarily just the Medicaid department or a commercial or Medicare, but maybe trying to blend all three of those populations so that they get more of an economy-of-scale and we get a larger referral rate on a state-wide basis. So there's a lot of ways you can kind of play with the data on a micro and macro level, right?

So, I'm just going to dive into the Q&A. How did we come to the measures? Were they negotiated or simply stated in contract language? We did both. So we kind of presented to them, hey here's what we measured today, number of phone calls, how many people we see face-to-face, how many assessments we complete, the type of assessment that we complete. And then we negotiated what we thought was successful on those measurements. And then we left the door wide open for adjustment.

I don't think anybody really has a solid list of data points that they want to measure, but as long they're open to adjusting when you see adjustments necessary, I think that's our strongest collaborative effort, especially with our contractor and the staff that are working with us.

So we actually measure the number of referrals that we get, the number of face-to-face assessments we complete, how many visits we complete, how many resources we identify and if people actually secured those resources or no, how often we actually problem-solved with their staff, the re-admission

rates obviously, number of follow-up visits to client's primary care physician, and then percentage of high-risk members that we're surveying as well.

I would say we really focused heavily on our service delivery data points, and we continue to negotiate those, especially on an annual basis and make sure we're on the same page about what we consider to be successful. So that's been real powerful, especially since there have been some staff changes, we've been able to kind of pull up our historical data and we can run those data points even the day of the meeting to make sure it's accurate. And then we can also set even higher standards for our service delivery network which is our statewide network here.

I wouldn't necessarily sell short the value ads that your agencies probably provide the clients, so we will include client stories when they come across. And we found that our contractors will actually include those stories in their proposals to the state or kind of report it at the chain of command to their fiscal departments. So not only do they get to see the dollar value that's added, but you actually get to see the perception from the client's end as well.

The second question, how consistent are the measures from one contract to another? Like I said earlier, we have not come across where all of the standards are completely the same from one contract to another, so our software actually allows us to tailor those measuring points from one contract to another even down to very specific forms that a healthcare system may be wanting to use for one reason or another. So we just wanted to make sure that we can kind of live in their world as much as possible, as well as communicate back to why the information we're feeding is also important.

Reporting outcomes to payors through EHR or other means, definitely electronic health record, especially the transparency that allows them to log-in

so that they can see exactly what we're doing with their clients and have those abstracts at the end, has been very powerful for us. Not to mention, they get a perception that we're actually doing what we say we're going to do and they can kind of see that as we work with clients.

Have payors had requests that you were unable to meet? Yes. Some payors want you to go into a risk-shared model. Obviously, most agencies don't have the capital to do that, but what we have been able to say is, we'll do a performance risk-shared. So maybe we'll negotiate to say, you know, here's our base fee which we know covers our costs and the margin, but then on top of that if we hit certain metrics, we have an additional bonus structure after that.

So either way, we make sure we have our costs that are covered and that we are able to accurately measure. And to make sure that we can directly impact the data that they're requesting. So if somebody said, we want you to improve, you know, 50% of our clients enjoy seeing their primary care physician, that's something we probably can't impact so we wouldn't necessarily agree to that term.

So whatever you do agree to, make sure you can measure it and make sure you can measure it accurately so that if somebody on their actuarial side wants to press you on the issue, you can talk in-depth about how you came to that number, how you're measuring it, and what tool sets are making that a consistent measure across your service delivery.

The last question here is, how do we demonstrate the value of something that doesn't happen? How do we use data to have (NCOs) that are particularly service can reduce Medicaid costs by keeping people out of the nursing

homes. This one is real big for like the bundled payment initiatives that are out there.

We actually can track the length-of-stay in a facility through our care-utilization tab, and so if we can even reduce a nursing home stay by, let's say two days, that's a significant amount of money especially if you go across a few hundred clients from one particular program especially with bundled payments. That cost may be in theory, but you should be able to see what the Medicaid costs are on a nursing facility stay, what their daily rate is, as well as hospitalization.

So, it doesn't necessarily have to be data you own, but similar to what (Sarah) was saying, if you can find evidence-based data or data that's similar to the population and geographical area that you serve, then it goes a long way. For us, we just use our ROI calculator and that tells us exactly how much money an agency is going to use to spend on their high-risk patients right out of the gate versus long-term and kind of reduction of those costs as well.

So I wouldn't stay still with the data that you're collecting. Try to be creative and look at what the data actually means. Try to stay away from collecting numbers just to be collecting numbers. One issue that we ran into was, we take 10,000 phone calls a month. Well, that doesn't necessarily tell the payor anything. It's like, great, you have a wonderful call center, but what's the result of those calls?

So if you're collecting data, look at what that data is actually impacting. Make sure it's consistent and if it's not, start collecting it and make sure it's consistently delivered and consistently analyzed for your presentation. I'm going to stop there.

Lauren Solkowski: Okay, thank you so much, (Paul). So at this point, we will open it up for further Q&A. So operator, if you could please again provide instructions for asking a question on the phone, that would be great.

Operator: Yes, thank you. This portion of the call we are going to begin our question-and-answer session. If you'd like to ask a question from the phone lines, please press star 1, unmute your phone, and record your name when prompted. If you would like to withdraw your question, please press star 2. One moment please for the first question.

Lauren Solkowski: Great, thank you. So in the meantime, so (Sarah) and (Juliette), we did get a question from someone asking if you would be able to share that value proposition flier that you had showed on the last slide, or maybe a version of it so that it could be used as a template.

(Sarah): Sure.

Lauren Solkowski: Great, awesome.

(Sarah): That was easy. I like those questions.

Lauren Solkowski: All right. So that was the only question that we had come in over the chat, so we'll give it another minute or two just to see if others have questions. I know that, you know, we did give the participants an opportunity to ask specifically their questions and you both did a wonderful job sort of responding to those directly, so thank you for that. But I did want to give it another minute just to see if there were others.

(Juliette): Sure, and (Lauren), in the meantime, this is (Juliette). I thought of another example of a way to collect data on what doesn't happen.

Lauren Solkowski: Okay.

(Juliette): We haven't done that through Gateway Wellness Network yet, but one of our community partners is working on a specific project for the high emergency room utilizers by doing some preventive visits at their homes. And essentially kind of doing social work/EMT visits.

And in a pilot that they worked on, one way that they calculated their return on investment was just by simply asking that patient when they went to their home, "If you didn't call us today, would you have called the emergency room?" And if they said yes, then they used whatever the average cost of an emergency room visit was for the hospital as part of their savings. So, again by taking that model and extrapolating it to a relevant, you know, example might be something that would be helpful to folks out there.

Lauren Solkowski: That's wonderful. Thank you for sharing that.

(Paul Walkins): Yes, actually one thing that I'd keep in mind is, so sometimes the cost savings that people are calculating are what was billed to CMS, not actually what the hospitals or health systems collected from that bill's amount. So just make sure when you're talking to your contractors, that you say, you know, this is what we think your cost savings are. Does this reflect what you're seeing? And most of the time, they end up being more transparent about what they actually collect from CMS on the available activity which will usually open up some doors for the Medicare Advantage or Medicare side as well.

Lauren Solkowski: Okay, great. So we did get another question asking what are the typical costs for data collection systems per month, if that's something that you all have.

(Paul Walkins): Yes, I don't know about...

((Crosstalk))

(Paul Walkins): Yes, go ahead, (Sarah), sorry.

(Sarah): Okay, (Paul). I was going to say that your system is I think at this juncture more sophisticated than what we're using, but we are looking into - I mean, right now we're using a physical lockbox and a secure fax line. You know, it like actually collects some of this data that's part of the project, not what we're all collecting as individuals.

But, you know, we are looking into some other better communication tools to communicate that data and, you know, having a big data system created is quite spendy, but we're trying to (unintelligible) for other options. Like, not just a secure email, but a secure - like we have a company that we're getting pitched to by next week for a, you know, a data-secure app where you can add users and delete users even for temporary reasons, so we're trying to be a little flexible and creative in how we collect too in a cost-effective way.

(Paul Walkins): So what we pay is \$10 per member per month for all the clients that we manage, and then we actually just pass those costs through to our contractors, so we just include that in there. And then we actually generate income off of our data management tool because what we've found is, the amount of information we gather, some of our legal services or assisted living facilities who are used to calling us and waiting on the phone, they would rather just pay us a fee to look at the information about their clients.

So we actually make money off of our data management system, but it was an upfront initial investment that probably took a little bit of time to recoup the

cost on, but we're now in the black and it's been additional revenue for the agency.

Lauren Solkowski: Wonderful. Okay, so - oh operator, has questions come in on the phone line?

Operator: Once again, if you'd like to ask a question from the phone lines, please press star 1 and record your name when prompted. We are currently showing no questions at this time.

Lauren Solkowski: Okay, thank you.

Operator: You're welcome.

Lauren Solkowski: And also I wanted to mention, so if, I will get those fliers from (Sarah) or (Juliette) and I will share will all the webinar participants. So, yes, we will definitely do that. And I'm just checking one more time on my screen to see if there's other questions. I'm not showing any other questions, but we'll give it another minute.

I just, you know, wanted to thank you, (Sarah), (Juliette) and (Paul), again for your presentations, and also sort of, you know, you both - as I said, you know, we're able to respond to the questions that were sent in, which was great. And I think, you know, it's just been extremely helpful in terms of, you know, helping, you know, how folks can go about, you know, translating data into information that, you know, can really peak the interests of and be useful to potential payors. So this has been awesome.

So I guess we'll check one more time to see if we have questions.

Operator: There are still no questions from the phone lines.

Lauren Solkowski: Okay, well at this point I think I will wrap up the webinar, and like I said, just thank you all again for joining us and to our presenters for the wonderful presentations. I will be sure to follow up with everyone with those fliers, and I think that'll do it. Thank you again and everyone, please enjoy the rest of your day.

(Group): Thanks, (Lauren).

Lauren Solkowski: Yes, thanks everyone.

(Paul Walkins): Okay, bye.

Lauren Solkowski: Okay, bye-bye.

Operator: That concludes today's conference. Thank you for participating. You may disconnect at this time.

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