Marathon Health

NATIONAL ASSOCIATION OF MOBILE INTEGRATED HEALTHCARE PROVIDERS

Mobile Integrated Healthcare Summit

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Paradigm Shift:
Transitioning MIH from Specialty Program to Core Operating Model

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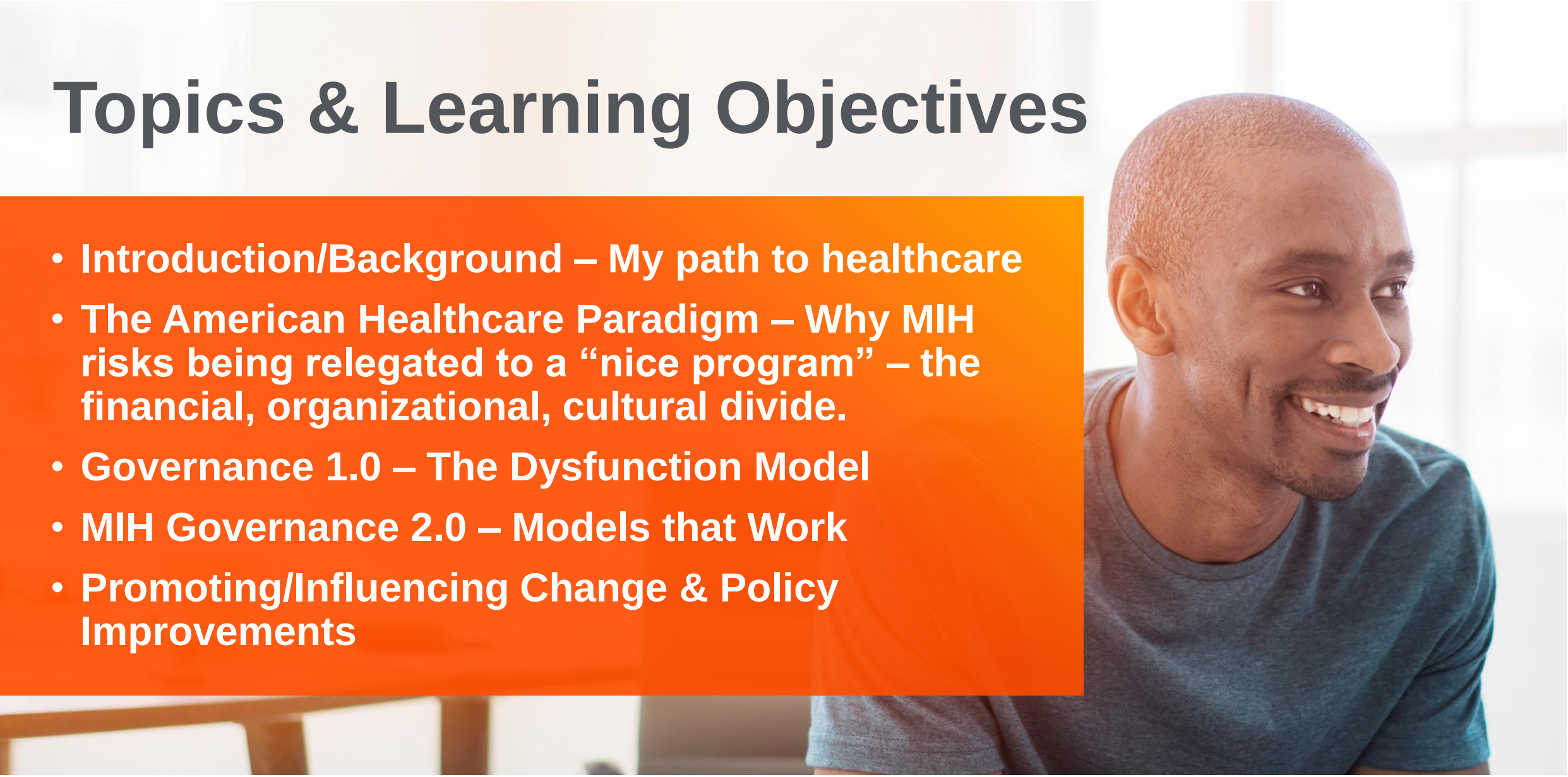
Topics & Learning Objectives

- Introduction/Background – My path to healthcare
- The American Healthcare Paradigm – Why MIH risks being relegated to a “nice program” – the financial, organizational, cultural divide.
- Governance 1.0 – The Dysfunction Model
- MIH Governance 2.0 – Models that Work
- Promoting/Influencing Change & Policy Improvements



My Path to Healthcare

"I realized that we were in the healthcare business…

Literally."

- Financial Imperative
- Population Health Operations Focus

  Mobile Integrated Care – Fire/EMS

  Veteran/Chronic Homelessness
- Social Determinants of Health

  Local Governments are best positioned to support governance changes needed to improve outcomes
- Healthy Employees Cost Less

  Health Fund, Workers Comp., Third-Party Liability
- Healthy Employees Serve Best
- *Local Leader Imperative*

MIH – department program or organizational approach?

Brutal Facts
The American Healthcare System

- The U.S. has the world's most expensive healthcare system – spending approximately twice as much, on average, as 11 other large, wealthy countries, including Canada, the United Kingdom and Japan.

- The U.S. has the world's highest spending on pharmaceuticals — $1,443 per person. Switzerland is next-highest, at $939.

- Despite spending the most on healthcare, the U.S. ranks last in health outcomes.

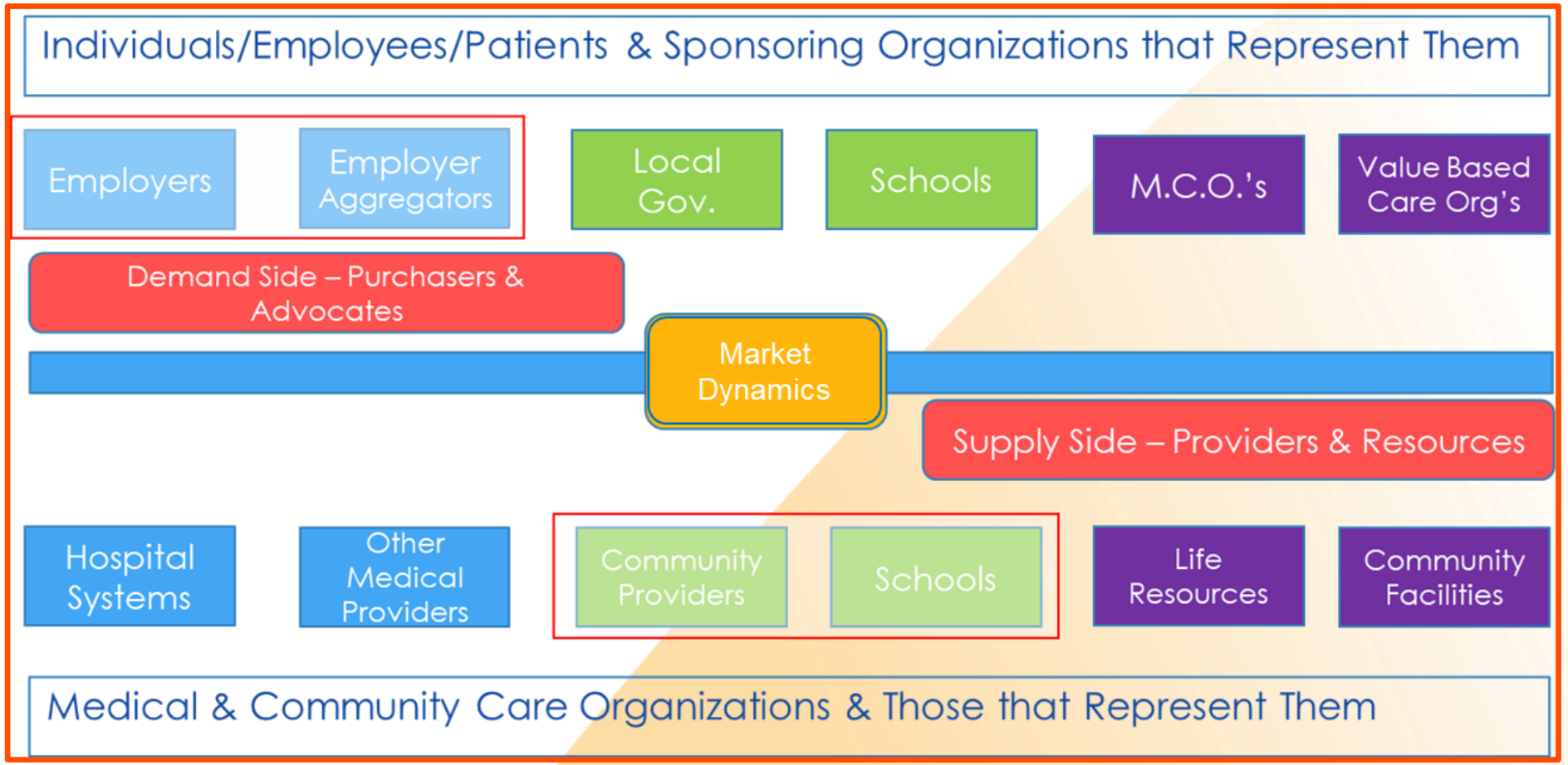
Source: Health Care Spending in the United States and Other High-Income Countries, March 13, 2018 JAMA
https://jamanetwork.com/journals/jama/article-abstract/2674671
Source: Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care, Commonwealth Fund,
https://interactives.commonwealthfund.org/2017/july/mirror-mirror/

Market Dynamics/Governance 1.0

The American Healthcare System

The fee-for-service model dominates the American Healthcare System

Financial, organizational, and cultural differences leads to care fragmentation, high costs, poor results.



Market Description:

Key Terms/Definitions

The Healthcare – Community Care Continuum

Healthcare Organization. Primary care, specialty care and other providers serving patients through medical doctors, nurses and related personnel and services with fees and services typically covered by health insurance.

Community Care Organization. Fire/EMS personnel, social workers, case managers, human service providers, law enforcement, and related organizations serving a wide range of needs such as housing, food, emergency response, mental health, education and job training.

Market Description:

Key Terms/Definitions

The Healthcare – Community Care Continuum

Public Health. Policies and communications that support healthy lifestyles; research related to disease and injury prevention; detecting, preventing and responding to infectious diseases.

Population Health. The process of monitoring and managing the health outcomes of a specific group of individuals, including the distribution of such outcomes within the group.

Clinical Care. Access to and provision of quality medical care including competent clinicians and adequate facilities.

Community Care. The provision of and access to social, human and supportive services to meet needs like housing, food security, transportation, childcare, job training and education.

Market Description:

Governance 1.0 Challenges

The Clinical vs Community Care Divide

Financial

- Most Clinical Providers Bill Insurance or Medicaid/Medicare – traditional fee for service care
- Community Provides Operate primarily through Grants & Public Operating Budgets
- Few examples of value-based payment models cutting across the clinical / community care divide.

Organizational

- Multiple Medical Providers & Hospital Systems
- Multiple Social Service Agencies & Government Entities
- Different Terms/ Definitions/Language
- Distributed governance
  - No natural shared ownership of process or results
  - No natural, neutral convening Agency

Cultural

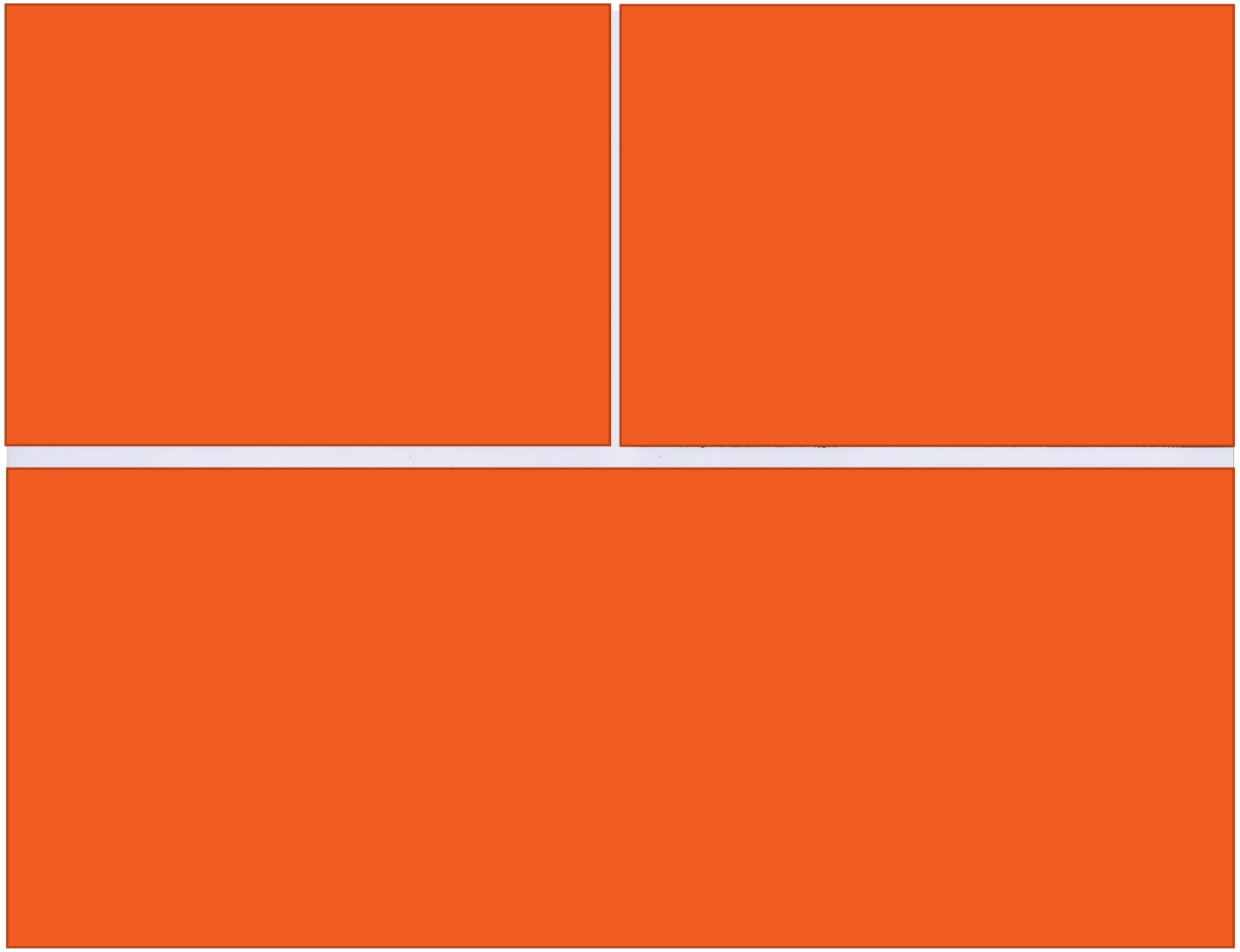
- Cultural Hierarchy Prioritizing Hospital/Clinical Care over Community Care
- Failure to jointly own patient & community health outcomes
- Fear of “central governance” goes back to cold war capitalism vs communism.
- The political “blame game” works!

Market Description:

Governance 1.0 Challenges

The Political Blame Game

– An Illustration



Market Description:

Governance 1.0 Challenges

An unexpected global leader

– Learning from Cuba

Cuban PolyClinic Model

- Integrated Primary Care/Urgent Care
- 24/7 Emergency & Specialist Care
- 15-30,000 Patients Per Clinic
- Coordinated Community Care
- National Initiatives linked to local Community
- Clinical Data Rolls Up to Natoinal Population Health Data
- They make house calls

"In America, doctors wait for our patients to come see us. In Cuba, I am increasingly convinced that doctors do indeed go to people in their homes, building relationships and intervening before health issues become serious."

Former U.S. Senator and Medical Doctor, Bill Frist
"A look inside Cuba's Family Clinics"
Forbes, Oct. 2015

Governance 2.0:

Understanding Collective Impact

"Collective Impact is unlike most collaborations, collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants."
Stanford Social Innovation Review, 2011

cc: Steve Selwood - http://www.flickr.com/photos/8507625@N02

Governance 2.0

MIH Opportunities

Connecting the Divide

– The Role of Backbone Agencies

LEVERAGE

FISCAL ROLE TO DRIVE VALUE & ALIGN OPERATIONS

FACILITATE

INFORMATION EXCHANGE

REPORT

OUTCOMES

COMMUNITY DRIVEN HEALTH & WELLNESS BACKBONE OPERATIONS

Governance 2.0

Backbone Agency Example

The City's Human Services organization serves as the backbone agency for Continuum of Care partners.

Paul Paddock hugs Patty Quinn of Carpenter's Place while friends David Didier and Mark Gaines unload a van of furniture and household items Thursday, Dec. 17, 2015, at the Skyrise Apartments in Rockford. rrstar.com.

Governance 2.0 Example

City of Rockford Veteran/Chronic Homelessness

THE CITY OF ROCKFORD REACHED FUNCTIONAL ZERO THROUGH A POPULATION HEALTH MANAGEMENT APPROACH

- **Backbone Organization = City of Rockford/Fiscal Agent**
  - Coordinate Federally Funded Continuum of Care Partners
  - Invite/Coordinate Non-Funded Partners
  - Funding alignment supports management alignment
- **Housing 1st/Single Point of Entry Strategy**
- **By-Name List Adopted**
- **Intervention/Outreach**
- **Ongoing Operations & Policy Level Reviews**

Governance 2.0 Example

City of Rockford Veteran/Chronic Homelessness

THE CITY OF ROCKFORD REACHED FUNCTIONAL ZERO THROUGH A POPULATION HEALTH MANAGEMENT APPROACH

Driving Total Population Health at Marathon Health

Our clinical teams leverage our award-winning data and analytics capabilities to identify and engage patients that have, or are at-risk for having, one or more chronic conditions.

Then we empower them with new health behaviors and smarter health decisions.

Risk stratification

We leverage the Johns Hopkins Adjusted Clinical Group (ACG) risk model to identify patients at risk of hypertension, depression and mental health.

Drive Engagement

We use a multi-channel engagement strategy to meet patients where they are and drive them into our health centers.

Care Coordination

Our providers will coordinate with the integrated care team, which includes health coaches and behavioral health specialists.

Care Navigation

Our referral team will assist members without sacrificing quality or cost.

Marathon Health Model
Driving Value One Patient at a Time

Population Health	**Identify Risk**	**Mitigate Risk**	**Change Utilization**	**Capture Savings**
Patient Health	**Empower Patient**	**New Health Behaviors**	**Smart Health Decision**	**Improved Health**
	• Claims Data • HRA • Biometric Screen • Population Stratification	• Comprehensive Health Review • Health Coaching • Disease Management	• Alter Risk Profile • Discover/Treat Undiagnosed Conditions • Reduce ER/UC/ Specialist & Hospital Stays	• Lower Claims • Fewer Lost Work Days • Higher Productivity

Electronic Medical Record / Patient Portal / Analytics / Virtual Care / Population Health

Patient Lists
Driving Engagement One Patient at a Time

Population Health Engine

- List generated through Claims, Biometric, HRA & EMR Data
- Clinicians Identify, Engage & Manage Contacts with Members
- Chronic Conditions & Care Gaps/SOC Highlighted (Red/Green)
- Highest Risk Prioritized

View: Active Life Style Risks/Chronic Conditions New Location: MHP: Condition:
Last Name: First Name: Clear

?	P	Patient	T	HR	LSR	ChrCon	CHR	HRA	MHQ	Bios	Due	Last Activity	Outreach	E
	H	Masters, Norman	E	8	3	3	8/9/2016		5/3/2016	5/3/2016		5/3/2017	2	Y
	H	Corkan, Veronica	E	7	1	3		1/19/2011			7/17/2017	9/4/2012	7	
	H	Benoit, Glen	E	7	2	1		7/2/2010			11/8/2012	11/8/2012	2	Y
	H	Ryan, Barbara	E	7	1	1		7/14/2010		7/14/2010	5/3/2017	12/5/2012	4	Y
	H	Boutell, Peter	E	6	1	3	8/27/2014	7/19/2010		7/19/2010	6/7/2017	12/3/2016	26	N
	H	Test, Blaise	E	6	1	3	4/28/2017	9/30/2015	5/11/2016				0	Y
	H	McMahon, Timothy Ryan	E	6		2		11/4/2010		11/4/2010	6/1/2017		5	Y
	H	Swanson, Rachel S	E	6		1		8/10/2010		8/10/2010	5/22/2017	11/28/2012	3	N
	H	Zak, Maureen	E	6		1	5/12/2010	11/24/2008		11/24/2008	6/25/2015	12/28/2016	11	
	H	Hall, Marie	E	5	2	4	6/25/2010	1/3/2007	1/19/2011	1/3/2007	2/24/2016	2/3/2016	9	
	H	Fuente, Hector	E	5	1	4		4/26/2017	11/10/2014	12/21/2016	6/8/2015	5/22/2015	9	Y
Highest Priority Risks		DBP: 94; HR: 5;												
Chronic Conditions		CAD (E) DM (E) HTN (E) MS (E)												
	H	Blakely, Maurice	E	5	2	3	7/16/2015	12/5/2013	9/23/2010	9/23/2010			0	Y
	H	Miller, Frank	E	5	2	3			7/26/2011		10/30/2015	10/6/2015	4	N
	H	Swann, Paul	E	5	2	3	3/26/2015	4/2/2008	1/8/2008	10/17/2007			0	
	H	Cochran, Linda	E	5	1	3			12/3/2016				0	Y

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Governance 2.0

MIH Opportunities

Value Focused Organizations & Efforts

– Organizations positioned to drive collective impact operations & leverage MIH initiatives

Common Connection. Four types of organizations that share the goal of improving health outcomes – striving for value over volume.

Employers & Employer Aggregators. Public and private self-insured employers – and health and wellness organizations that provide services to them such as Marathon Health – represent the demand side of the healthcare market.

Hospital Systems & Other Care Providers. Hospital systems and other medical care and community care providers commonly lead initiatives to drive community health improvement despite simultaneous incentives towards fee-for-service care.

Value-Based Care Organizations. Accountable Care Organizations (ACO's) and other types of Managed Care Organizations (MCO's) in programs like Medicaid and Medicare reward providers financially for improved outcomes and lower costs.

Cities and Other Local Governments. Cities, counties and other local governments such as school districts frequently lead community-based health improvement initiatives across the nation. They can represent both provider and participant roles.

Governance 2.0

MIH Advocacy

Leveraging your first-responder role as influencers

– Associations and partnerships that can lead change

EMS Organizations. As you are doing today, encourage your colleagues and affiliated organizations to join groups like the National Association of Mobile Integrated Healthcare Providers. These organizations are helping to lead advocacy and education.

Local Governments/Elected Officials. A great place to start is by educating your local elected leaders and asking for their support in helping to elevate MIH beyond a program to an overall population health approach.

Find, Educate, and Partner with Allied Political Organizations. There are numerous city and county advocacy organizations that represent your local elected leaders such as the US Conference of Mayors, the National League of Cities, National Association of Counties and their State level affiliate organizations.

Find, Educate, and Partner with Allied Employer Organizations. There are numerous business groups on health across the nation that actively lobby federal and state governments on healthcare policy. These organizations can help advocate and inform on the value of MIH and support creative MIH value-based care models.

Questions

Thank you

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