Ten Easy Steps:
Better Care at Lower Cost

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I have no conflict of interest to disclose

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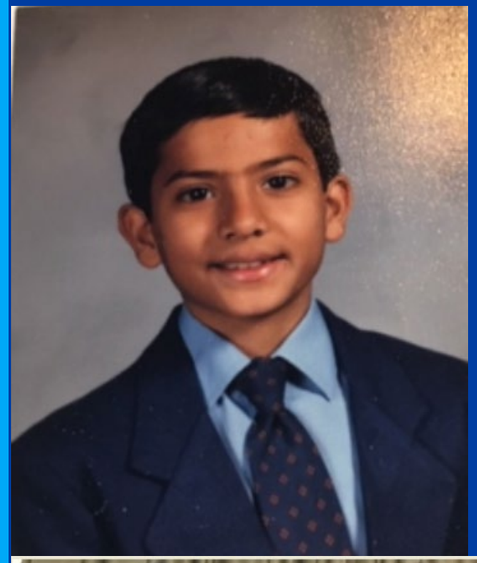
Step 1 – Align to Achieve Optimal Results

Collaboration is key to improved health results at lower costs

Focused efforts include:

- **Supporting** efforts to align with Evidence-Based Approaches
- **Accelerating** access to patient data, Holistically Supporting Most Complex
- **Aligning** disparate data sources, Create a Socio-Clinical Perspective
- **Advocating** for resources from government and corporate partnerships
- **Scaling** learnings based on positive outcomes



Cyrus' Personal Narrative: How Healthcare Came to Matter

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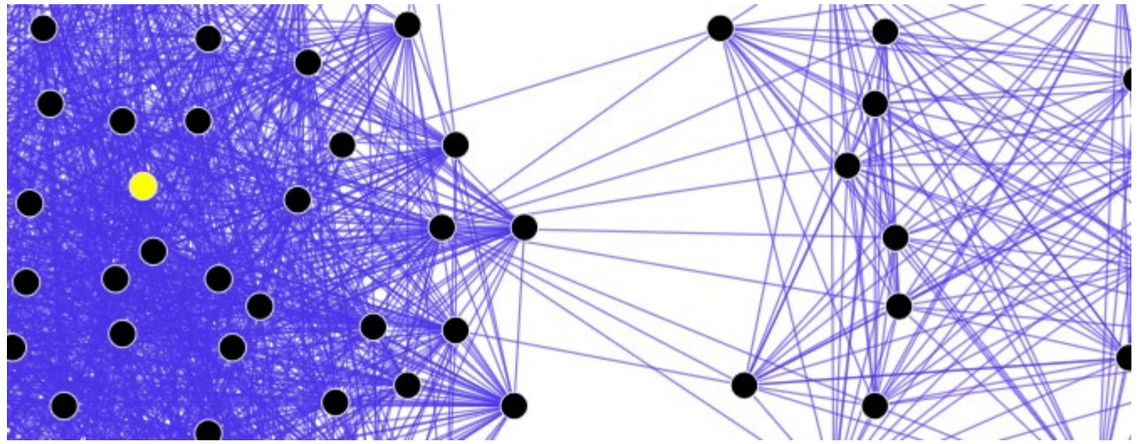
Step 2 – Divide and Support

Carefully Evaluate Your Target Population

The Art and Science of Segmentation, Stratification, Taxonomies, and Typologies: Population Analysis and Subgroups within Groups

Hot and Cold Spotting: Evidence-based models to improving healthcare

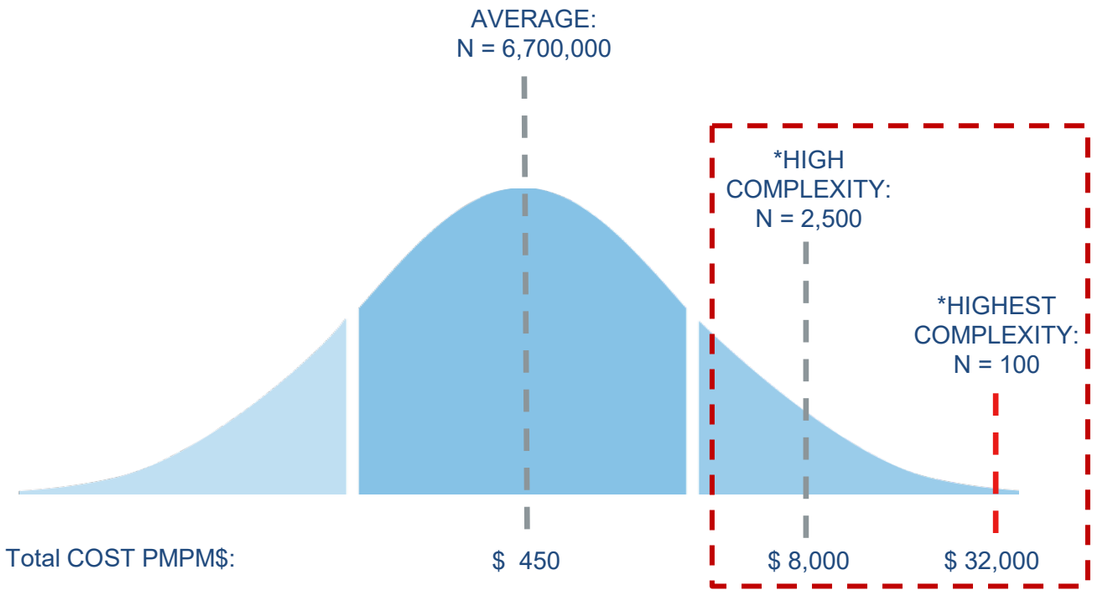
- Focused Member Segmentation and Selection
- Structured - Network Processes
- Partnered Staffing Model
- Engaged Legal and Compliance Infrastructures
- Measurement-Oriented Financing Models



Housing + Health: “Housing First” Strategy

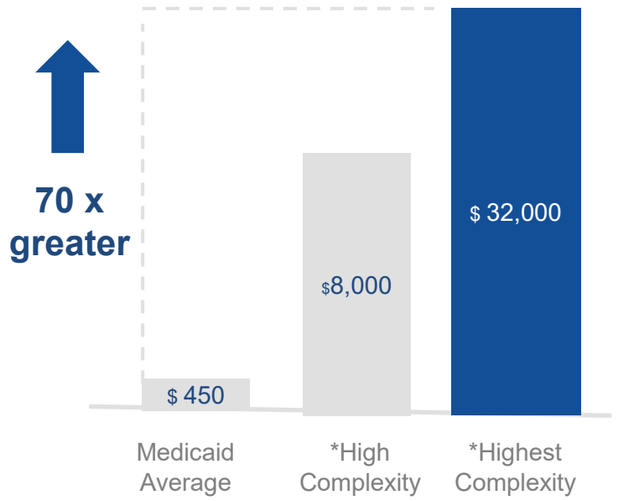
Focus on housing most complex patients experiencing homelessness

Medicaid Membership | Total Claims Costs by Subgroup



Medicaid Total Claims Costs by Subgroup

PMPM, $



Medicaid highest complexity members experiencing homelessness have costs that are 70 times greater than avg. Medicaid members.

*Subgroup focused on patients experiencing homeless identified by ICD-10 codes

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Step 3 – Know Your Patient Population

Mixed Methods Research as a Foundation

Quantitative research, such as clinical trials or observational studies, generates numerical data.

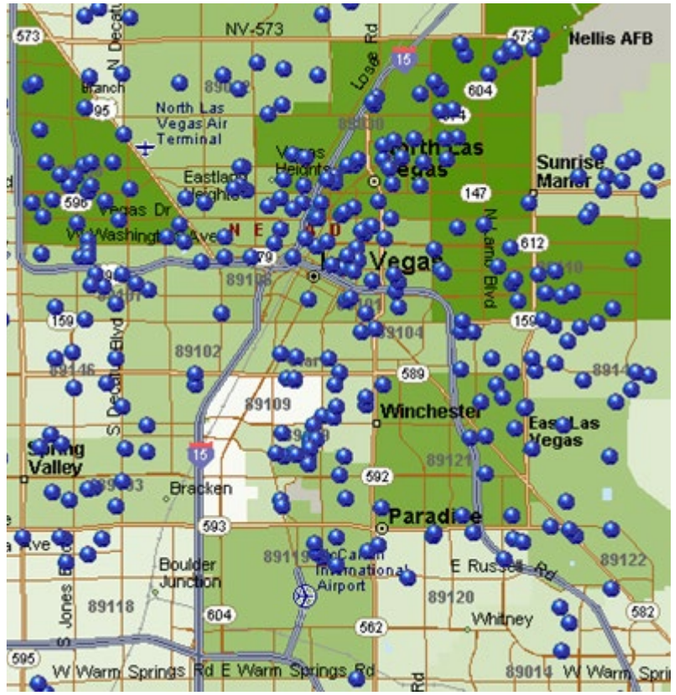
Qualitative approaches tend to generate non-numerical data, using methods such as semi-structured interviews, focus group discussions and participant observation.

Quantitative methods have dominated health research; however, there is a developing movement in combining qualitative and quantitative methods.

Step 4 – Build & Expand Strategic Partnerships

Partner to Align Patient Data Across Anchor Institutions

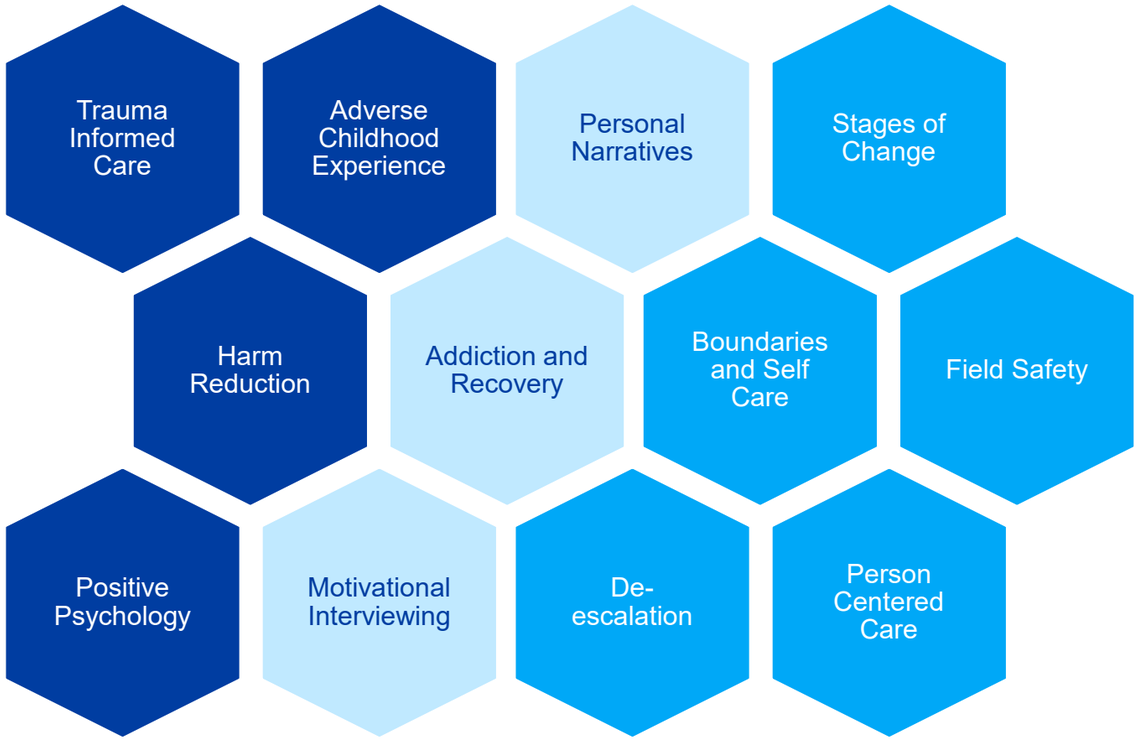
- School and Universities
- Jails and Prisons
- Healthcare Organizations
- Social Service Agencies
- Financial Institutes
- Transportation Controllers



By collaborating with entities that control vast economic, human, intellectual, and institutional resources, anchor institutions have the potential to bring crucial, and measurable, benefits to local patients, their families, and communities.

Step 5 – Meaningfully Engage Your Patients

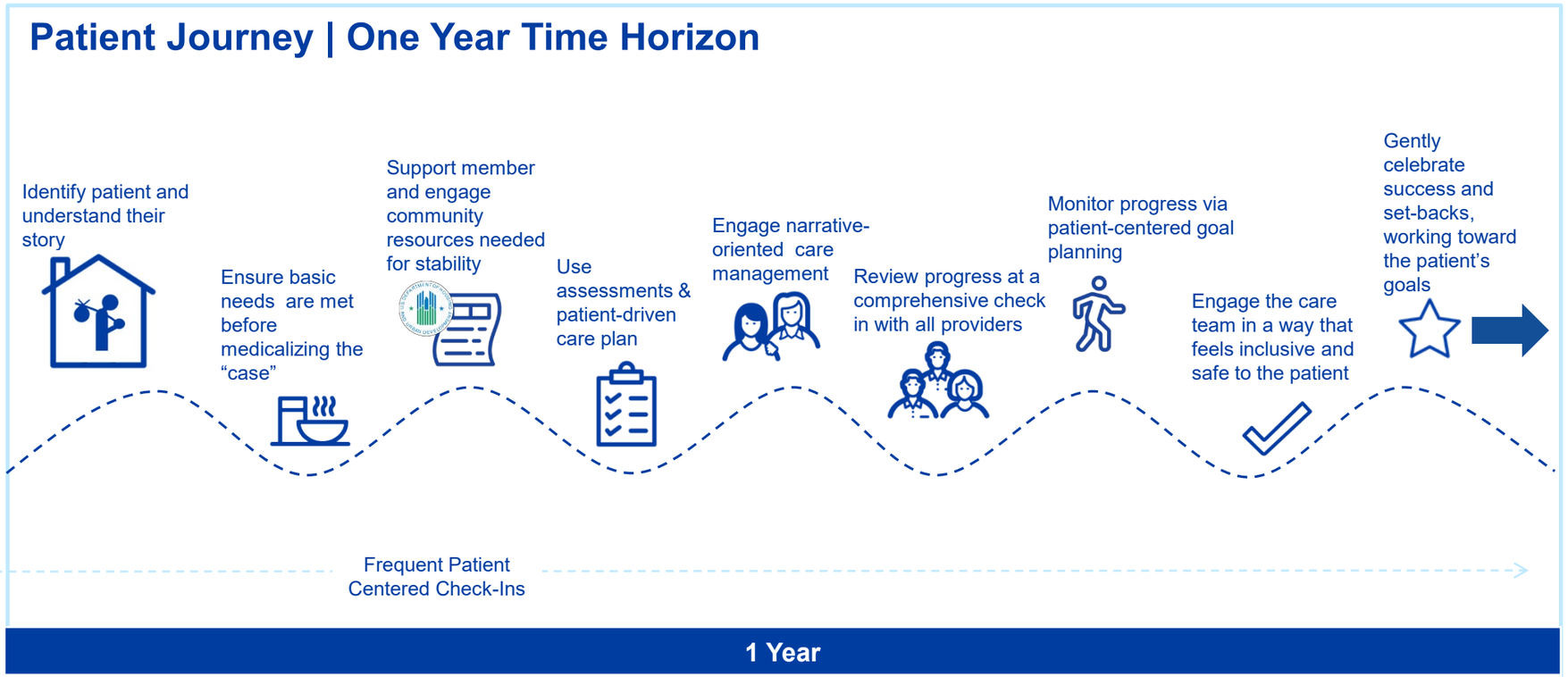
Care Philosophy for Complex Care



- Personalized, Therapeutic Approach
- Integrated Medical, Social and Behavioral
- Relational vs Transactional Care
- Member-Driven Care Planning

Person-Centered Well-Being

Examining a Patient Journey



Step 6 – Use Evidence-Based Methods

“Housing First” Medicaid Strategy: <u>Stabilize Highest Utilizing and Most Costly Homeless</u>

- Evidence-Based Model
- Focused Member Segmentation and Selection
- Structured Process and Measurement

- **Evidence-Based Approach:** “Housing First” used and has demonstrated positive results
- **Expected Outcomes at Scale:** Improved care and health outcomes, reduced cost, increased member and provider satisfaction
- **Member Selection Process:** Based on utilization, cost, clinical indicators of success (multidisciplinary board review)
- **Partner Selection Process:** Specialized in “Housing First” – Specialized in mental health, addiction, and social

Step 7 – Develop Collective Language

- Words matter, division or unification?
- Develop communication patterns that cut across traditional barriers of patient care
- Complexity should be recognized and simplified
- Organize based on learnings and work together
- Achieve a common objective

2019 Social Determinants of Health ICD-10 Codes

As a care provider, you play an important role in helping identify members who may have a social determinant of health (SDOH), which often creates a barrier to health and wellness. SDOH are the conditions in which people are born, grow, live, work and age. They include factors like:

- Access to health care and healthy food
- Education circumstances
- Employment and socioeconomic status
- Physical environment
- Social support networks
- Foster care

If you're providing services to a UnitedHealthcare member and are capturing a SDOH that has an existing ICD-10 code, please use the following list of ICD-10 codes to include the appropriate codes on claims you submit.*

We know these codes do not address all social factors that impact health and wellness. To strengthen our ability to work together with you to help more people, UnitedHealthcare has made a recommendation to expand the ICD-10 codes to be more comprehensive. For now please use the established codes, which provide an opportunity for us to collect, understand and address some of your patients' SDOH.

ICD-10 Codes to Identify SDOH

Description	ICD-10 Codes
Contact with and suspected exposure to arsenic, lead or asbestos	Z77.010 Contact with and suspected exposure to arsenic Z77.011 Contact with and suspected exposure to lead Z77.090 Contact with and suspected exposure to asbestos
Educational circumstances	Z55.0 Illiteracy and low level literacy Z55.1 Schooling unavailable and unattainable Z55.2 Failed school examinations Z55.3 Underachievement in school Z55.4 Education maladjustment and discord with teachers and classmates Z55.8 Other problems related to education and literacy Z55.9 Problems related to education and literacy, unspecified
Effects of work environment	Z56.0 Unemployment, unspecified Z56.1 Change of job Z56.2 Threat of job loss Z56.4 Discord with boss and workmates Z56.89 Other problems related to employment Z56.9 Unspecified problems related to employment
Foster Care	Z62.822 Parent-foster child conflict Z62.21 Child in welfare custody
Homelessness/other housing concerns	Z59.0 Homelessness Z59.1 Inadequate housing Z59.2 Discord with neighbors, lodgers and landlord Z59.8 Other problems related to housing and economic circumstances Z60.2 Problems related to living alone

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UnitedHealthcare Community Plan

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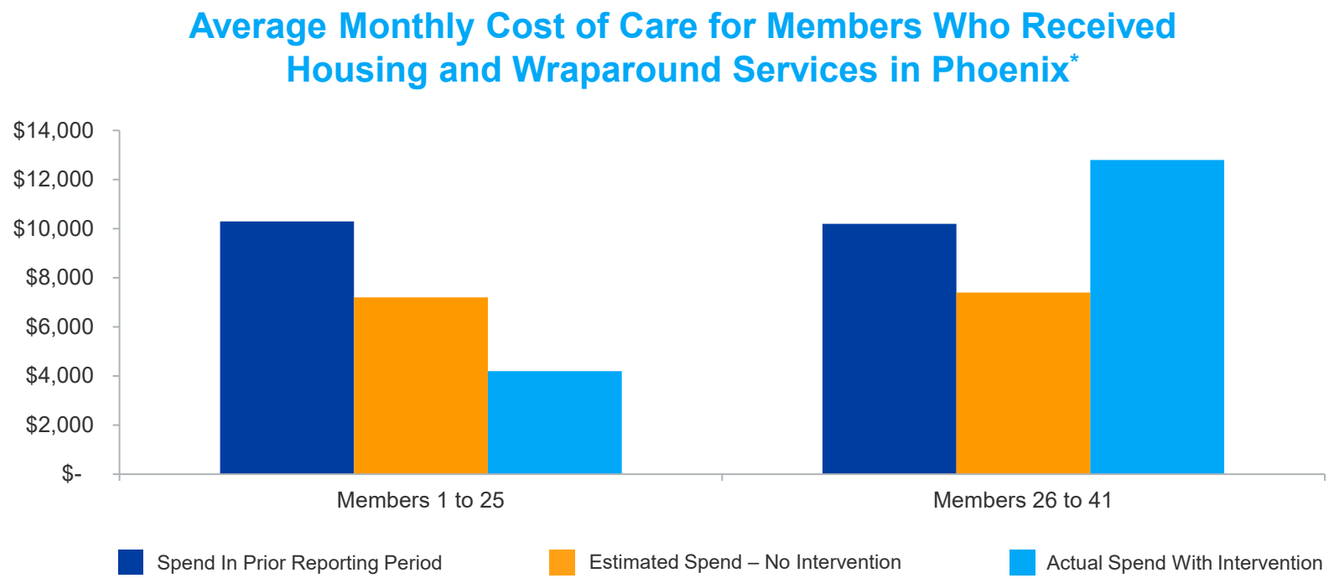
Step 8 – Innovative, but Fail Fast

Lean startup is a methodology for developing businesses and products, which aims to shorten product development cycles and rapidly discover if a proposed business model is viable.

Lean Process - Housing Scenarios

	Scenario	Plan
1	Member changes insurance plans	Member can stay in the unit until a thoughtful transition plan is identified.
2	Member's eligibility for insurance changes	Member can stay in the unit until a thoughtful transition plan is identified.
3	Member becomes critically ill	Care planning team will evaluate what is in the best interest of the patient.
4	Member is evicted	Care planning team will evaluate what is in the best interest of the patient and support Member through transition to other housing
5	Member death occurs	National team convenes a critical incident/review board that will review all scenarios
6	Housing + Health program terminates	Member can stay in the unit until a thoughtful transition plan is identified.
7	Property Management scenarios	Care planning provides support through relationships with the housing provider (heat, AC, electrical, etc.)
8	Property Management crisis (major disaster)	Member receives housing support until a thoughtful transition plan is identified (i.e. hotel voucher, transition to alternate housing solution)

Step 9 – Measure Outcomes and Leverage Learnings



- Interventions don't necessarily have the same impact on all members, as proven by the dramatic decrease in overall health care spend for the Top 25 Medicaid members.
- Even for high-utilizing members, spend can potentially decrease over time independent of interventions. This phenomenon is *regression to the mean*.
- Truly effective interventions require vigilant member selection using *both* stratification and qualitative insights.

*Reflects average monthly health care costs up to 12 months before and after for members housed since October 2017. Results may increase as additional paid claims become available.

Housing + Health Delivers Lower Spend and Improved Wellbeing

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Since October 2017, 248 high-risk, high-cost Medicaid members have been housed in Arizona, Nevada and Wisconsin.*

44-51%
Average monthly cost of care

33-43%
ER visits

55%
Inpatient admits

67%
Inpatient days

*Results are based on members who met the eligibility requirements for the analysis. Utilization based on per 1000 members. Paid claims data is limited and improvements for members may lessen as additional paid claims become available. These results do not consider regression to the mean, which is expected to be higher as total claim costs increase.

Step 10 – Better Together

Healthcare Imperatives

1. Develop **Socio-Clinical Networks** across the patient populations you serve
2. Create new pathways to **Stabilize Complex and Costly** members
3. Cultivate innovations to **Impact Patient Care and Policy**
4. Collectively **Represent Learnings in Population Health Forums**

Achieve the “Triple Aim”

Reduce Utilization and Cost

Enhance Health Outcomes and Wellbeing

Increase Transitions Out of Institutions

Activate Vulnerable Patients Using Story

Improve Behavioral Health and Primary Care Access

Thank YOU – Advance the Common Good, One Person at a Time!

Better care.

Lower cost.

Better outcomes.

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Next Steps: Discussion of Impact and Implications

Better care.

Lower cost.

Better outcomes.

- **What types of community or regional collaborations could improve health results for the patients you serve?**
- **Does your organization recognize trauma and practice trauma informed care? If yes, how? If no, can you describe the benefits to your patients?**
- **Is there an opportunity to use hotspotting or cold spotting to find areas of opportunity?**
- **Using a qualitative lens, how can your organization measure outcomes beyond dollars?**
- **How can we measure population health through the stories of the patients you serve?**