HLTH AI PAVILION VIDEO 2

VIDEO TRANSCRIPT

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Well, hello and welcome.

Hi. All right.

So, we're just going to get started early because I think we're like the last panel.

Last save the best for the last, right?

Future of connected care.

I'm so delighted to have Melissa Stefan with me.

She's the president of, Evernorth Home Based Services.

Great, illustrious career.

She was at Propeller Health, DaVita, Presbyterian.

So, a long career in career care delivery and myself, Sonal Kathuria, Accenture Health Strategy.

So, Melissa, I'm just going to get into some questions, and, I know we talked about that, we're just going to chat. We're going to have conversations. Let's chat.

So, let's chat.

So, what does connected care mean to you.

I'm going to answer it in three ways, if that's okay.

I think connected care is a buzzword that we throw around in the industry a lot. And so, if I had to define it, I would take three lenses to it.

One, if you are a payer, connected care is going to mean something very different to you. It's going to be your care management teams. It's going to be your network. How they're communicating. Lots of interoperability issues.

If you are on the delivery side of care, if you're a provider, you're thinking about, you know, can I see all of the labs I need to see for my patient? Can I see test results? Can I be connected to specialists I'm working with?

But I think the definition that matters the most is that of the patient. And so, from a patient's perspective, connected care

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to them means they have a quarterback, and we haven't put the burden of our complicated system on them.

Connected to a patient means I want to know it's talking and I don't need to know how it's talking or who's making it talk in the background, but I need to know, my primary care doctor is talking to my cardiologist, and that the scan I just had is going to show up, and that if somebody is giving me advice at a specialist, it's not going to be counter to what I heard at my primary care doctor.

So, I think connected care can get lost in, I mean, look around us, right? We're sitting in the AI Pavilion surrounded by tech opportunities, which are great, and we need them. And all of all of this could be really misleading around connected care. And I think we have to route back to what does that mean to the patient? And if it's too fragmented, no matter how great the innovation is, we're not solving what that patient is still asking for, which is help. I need to navigate the system we've all created in a way that is meaningful to me.

Yeah, I love that because to me, the fragmentation or the lack of connection between payer, provider and member or patient, that triangle is the main issue, which I hope with future of connected care will solve for.

So, you run a home-based care business for Evernorth, which is owned by Cigna Group. And, what does value mean in home-based care.

And you said financial at the end, so obviously health care cost ultimately is a core principle to that.

Tell us a little bit about, Evernorth, home care model.

Yeah, I would love to. What's unique, what’s differentiated? Yeah. We're really proud of, the fact that we always have the patient at the, at the center of all that we do. We lead with our clinical care model first and foremost, because again, in the tension of a value-based arrangement, that's what's going to drive the results. We think of us as a primary care service, in the home. Everything from preventative care, which could be wellness, preventative screenings, maybe what I would call interventional. So, there's been an episode we need to step in for a certain amount of time, you've been hospitalized, you're coming back home, we're trying to stabilize you, to keep you from being readmitted. And then the far end of the spectrum would be a longitudinal primary care relationship.

We have several patients that cannot access healthcare in the way that we, as an industry have designed it.

And we know that because of their poor health outcomes.

They may live in a major metro city that has every nuance of healthcare out there, every technological advance that, you know, highest quality.

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But if they can't leave their home to get to the center of excellence, it doesn't matter, right?

So, when we look at certain segments of the population, the polychronic, the highly acute, there's a reason their conditions are not improving, and it's because they're not a match with the way we've designed the system.

So, bringing this lens of foundational care to them where they are is where we're starting to see this change, and meeting the patient where they are, whether it's by choice, they're still at home, or maybe they are homebound. And that's what we need to honor for them.

I can share an example of a story for a patient of ours that we love to talk about.

In the few months before we met, I'll call him Sam, just to make sure we're PHI compliant. Sam. Had COPD on oxygen 24 hours a day. He had 11 admissions in the four months prior to us meeting him - 11 hospital admissions.

We have a primary care team that is made up of an interdisciplinary function. So, we have everything from MDs, nurse practitioners, licensed social workers, behavioral health, clinical pharmacy, clinical educators, nurses.

So, when our team came in and met with Sam to figure out what was going on, he in those... in the time period where he had those admissions, he only had one primary care visit. So, 11 admissions and one primary care visit. Clearly the system's not working.

Sam had an oxygen tank that only had two hours, so, he couldn't leave his house. He was afraid to leave his house in the event that his oxygen tank ran out. So, he would wait till he was exacerbating to the point that he couldn't function and call the ambulance. And that would be his transportation, because there was safety for him, and knowing that there was oxygen on the ambulance.

And immediately all of our colleagues know we've got to get upstream. We've got to solve like there's so many things that could have been done to prevent this. But because it's an interdisciplinary model, our social worker jumped in and realized that Sam had a lot of SDOH challenges. His social determinants of health risk score was extremely high. Sam was illiterate, and so, Sam could not read the discharge instructions from those 11 admissions to understand next steps. Every time he came home with a new batch of medications, didn't know when to take some of his admissions were just based on the... the adverse effects of combining the wrong prescriptions at the wrong time and not understanding. So, our nurses did a color-coded system. You take the blue pills, you know, a blue sticker in the morning, you take a red bottle at night. You know, we were able to map it out for him. There was financial insecurity. We were able to work with him and figure out what benefits he had to help with financial copay assistance. Things like that.

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n the eight months post meeting Sam for the first time, he had four admissions and 19 in-home primary care visits. He's still chronically ill, you know his end stage COPD, but he doesn't want to be in the hospital. The expense of having him in the hospital, the quality of care, the continuity of care, it's really intervening. And when you go back to a value-based model, that financial structure allows us to wrap that team around him and, and truly do whole person care that you can't in that transactional system that I was talking about.

And you can't do it if if he's still ill? Right. Like so, he's better, it creates the equation. And so, you're never competing from a financial perspective of how to make that equation work.

So, I don't think I ever shared this with you, but my mom is a homebound patient. And we get home based primary care at home. It comes from the hospital, UPMC, which I think is terrific. But, I truly see the value in it. And yeah... Our patients... we still have hospitalizations, but we gotta try to mitigate it. Our patients have over a 90% satisfaction rate. Once we're there, and we have an established relationship.... Yeah. ...that's what they want. Yeah.

As you look forward, what are some of the other things that need to innovate or advance when it comes to care?

I think we have to continue to push... there are so many companies out there. I know, it's been three days of trying to answer that question. Yeah. And 12,000 people offering solutions. Yes.

I think we have to continue to advance the innovation in being able to do higher acuity care in the home. Right. We know that... Like hospital at home, yeah, hospital at home, SNF at home. I think, you know, we know in the next 10 to 15 years, probably up to 50% of Medicare dollars will be for care that's delivered in the home. So, we have to understand how to do that safely. We can't just call it that and then assume that we're ready. So it's got to be very intentional.

I've loved all the dialog around AI and thinking about how does this change the way we deliver care. We have physician and nurse shortages, clinician shortages. We need to make our, physicians more accessible, that the practice of care, increase the access that in a way that is safe. But allow, allow that access to grow so that we can reach more of our patients. And even if it's as simple as, you know, provider productivity and efficiency, if it's the way we work with incoming clinicians as they're coming out of training and how they are able to ramp up faster and take on differently... there's so much in that space that can change the way we're doing it, but we just need to be intentional about where are we going and not get distracted by the several fragmented solutions and chasing down different paths.

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Because then to your very first question, we're going to get back to the whole is it connected? Is it not connected? Are we making it more cumbersome? Is it two steps forward, three steps back? So, I really hope that there's an intentionality in how we design all of this, in a way, with a North Star that we're aiming for.

Any questions from the audience? Because I... Hi. You made it to0, I was trying to make sure people show up too, you know. Yeah.

Well, it's okay if there's not, but we just thank you for taking a couple minutes to listen to our passion for home care and hopefully plant some seeds about what we need to be thinking about going forward in the next 5 to 10 years. And the intentionality around stepping back and thinking from a patient perspective. Is this connected? Does it move the needle? Will it advance the way we practice medicine? Yeah. And yeah.

Thank you both for being here. You mentioned a couple of things that... So. the question is about, what could be the distractions from AI that would take us off course. I think anything that's a fragmented solution that solves one piece of the care continuum, I think, the division of the value is also a distraction. There's only so much value in a dollar. And if you point, you know, 100 solutions at it, nobody's actually moving the needle forward.

And then I think if we're not focused on the outcomes that the innovation drives, the clinical outcome, in a scenario specifically for us where we're talking about polychronic patients, where we're not managing diabetes in a silo or COPD in a silo, or managing the amplification of the two disease states together. And so there may be wonderful innovations in each one of those clinical conditions. But we need to be thinking about when connected to other clinical conditions. Do the two solutions work? Does the innovation still drive an outcome? Because if not, we're going to find ourselves exactly where we are today. Which is best-in-class solution A, best-in-class solution B, C, D, etc., but the sum of the parts is not actually moving anything forward. So, I think the distraction is getting caught up in the individual pieces, which I mean, let's be real, like that's easy to get done. It's harder to do something that is broader. And so, we tend to look for the quick win and they're not bad, but we just can't stop there. It needs to be, you know, tier one and then tier two and then tier three. And there's a longer roadmap to it. Yeah, of course.

Hi Melissa. Hi. Tom.... I track health. How do you see this shift going into the home being compensated? Who's going to be paying for that movement to go in that direction? And the systems that are set up now are really to be hospital based rather than home based.

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Absolutely. I came... my initial part of my career was in the hospital-based side. And so I have that in the back of my head, like, this is going to be awesome if I do this. And then there's a hospital CEO who's like, we need that bed filled. And how does this work in the referral system? Because at discharge and all, all of the moving pieces.

So, I think there's needs to continue to be reform and advocacy in the reimbursement side. Right. Like we saw a huge movement in telehealth because the pandemic pushed us to make some decisions. And we hope those continue to expand. But I think that, the understanding of the value piece of it and the health outcome in the quality that we're paying for will help drive that equation. Because, again, in the transactional system, especially with things like SDOHs today, that we know, you can't separate from the clinical outcome, it's going to continue to push the needle on the conversation, but it's going to take a lot of focussed advocacy and continual innovation. And here's how we think we can do it and demonstration. These are the results we get when we do it this way, you know, the system is still a foot in two canoes, you got your fee for service and you've got your value. And everyone's wondering when do you jump into the other. Value-based care hasn't reached the commercial sector yet, so how do you think through that?

So, we're at the beginning of the journey, but I think it's continual results. Like I talked about our patient Sam, to say, here's what happened and here's the improvement. Yeah. And I know where you're coming from, Tom. Like having lived through that situation with my mother, it's a lot of private pay right now. And at some point you are going to get to a tipping point and policy, politics, reimbursement, and of course, you know, where Medicare and Medicaid takes it, because that's where a majority of the patients fit in this profile, is going to really matter a lot because a lot of this is unaccounted for right now. And I think there needs to be better policy decisions and reimbursement decisions to go drive that.

Thanks for the question. Yeah. Great question. Anybody else? Thank you for the time. Thank you, Sonal, for inviting me. It was great. Thank you for doing this with me. Enjoy the rest of the conference.

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