TRIBRIDGE

HEALTH360™

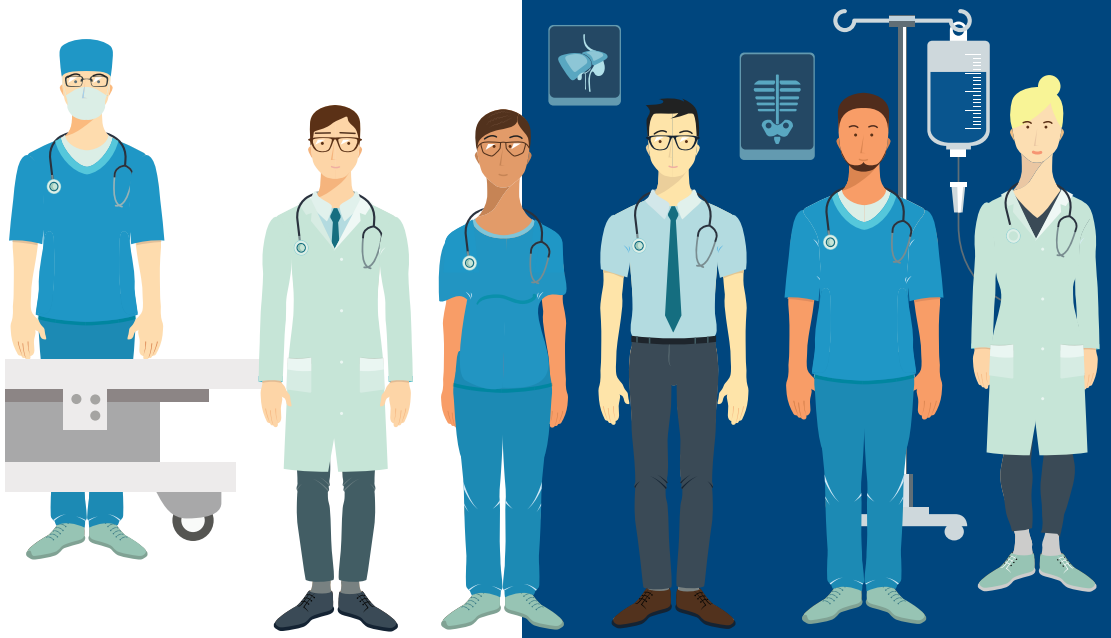
EMBRACING POPULATION HEALTH MANAGEMENT:

How Six Innovators Are Pioneering Value-Based Care

The march toward value-based healthcare and population health management is driving significant changes across the larger healthcare ecosystem. The urgency to affect lengths of stay, left-before-being-seen rates and other measures while simultaneously improving patient outcomes and satisfaction is forcing a wave of innovation.

Billions have been spent on electronic health records (EHRs) as a first wave of innovation, but it is commonly accepted that EHRs aren't by themselves the answer. Forward-thinking healthcare leaders now see a more fundamental need for customer-intimate, patient-centered solutions that make more effective use of data from patients and caregivers both inside and outside of healthcare facilities. They also understand that all their data must somehow be turned into meaningful actions to impact health one person at a time. Actions are what leads to change, after all, not just analysis.

As we move along the continuum from volume- to value-based care, not all providers face the same challenges, although there are critical areas of overlap. By looking more closely at acute care, post-acute care/rehabilitation management and chronic disease management providers, we hope to spotlight areas of innovation, in particular with Tribridge **Health360™**, that can spark innovation in similar organizations seeking to improve performance, outcomes and patient well-being in the age of value-based healthcare.



INNOVATORS IN ACUTE CARE

Acute providers are leading the value-based transformation of healthcare. They need new tools to provide personalized, coordinated care that results in better outcomes while also lowering costs. The key is the ability to mass-customize patients' care experiences. Following are three acute care organizations that are helping to define best practices.

Dartmouth-Hitchcock Medical Center Reimagines the U.S. Health System

Dartmouth-Hitchcock Medical Center is home to the fourth-oldest medical school in the U.S. and is respected around the world for its research and evidence-based clinical protocols. Like all U.S. healthcare providers, Dartmouth-Hitchcock is challenged to deliver high-quality, personalized care at a lower cost. Dr. Ethan Berke, Dartmouth-Hitchcock's medical director for clinical design and innovation, recently led a team of experts from a variety of different industries to reimagine healthcare from the ground up.

The team's vision? A sustainable health system that puts patients and their families first. The focus is on mental and emotional health as well as physical, and its rewards are value- rather than volume-based. The idea is to provide ever-present, highest-quality, reasonably-priced, proactive care that individuals want and need, often within the comfort of their own homes. Care team members are armed with actionable data that enables personal, individualized care with an emphasis on illness prevention.

The result of this vision, ImagineCare, required a significant investment by Dartmouth-Hitchcock in infrastructure and new technologies, including remote health monitoring and telehealth. Also central to the success of ImagineCare is Tribridge **Health360**, a solution that enables a more personalized, coordinated care experience.

ImagineCare uses machine intelligence that enables providers to work within their Health360 platform to develop unique care plans for each patient. Nurses and health coaches can monitor each person's health status around the clock using data from sensors and devices and respond proactively in real time. Patients receive reminders, encouragement and dynamic updates to their care plans, interventions that can ultimately reduce unnecessary ER visits, disease reoccurrence and other costly factors.

Dartmouth-Hitchcock

Learn how Dartmouth-Hitchcock is revolutionizing healthcare with its ImagineCare solution.
Watch video now.

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PERSONALIZED CARE

"Dartmouth-Hitchcock's innovative solution, paired with the technological capabilities of solutions like Health360, are transforming the way healthcare is delivered today, improving patient outcomes, reducing costs and offering unprecedented levels of personalized care."

— Ethan Berke, MD, MPH, Medical Director, Clinical Design & Innovation, Dartmouth-Hitchcock

Improving Care Management and Care Services Coordination at an ACO

As one of the first accountable care organizations (ACO) operating under the guidelines outlined by the Centers for Medicare & Medicaid Services (CMS), this health system sought to deploy a new infrastructure that would allow its care managers to deliver higher-quality, better-coordinated care to meet the needs of all the people attributed to the ACO, primarily Medicare patients.

Although the four hospitals in its system specialized in acute care, its approach needed to extend beyond treating patients only when they were ill. This would include care teams both inside and outside the ACO, from office staff to physicians and nurses, who work closely together to create tailored care plans for each patient. These personalized, coordinated care plans would not just provide patients with the care needed during sickness, but instead would enable them to **"be well, get well and stay well."**

ACO leadership wanted a system that could "listen to the data to see what's happening" and create timely, targeted alerts. After a patient was admitted to the emergency room after a fall, for example, the system would alert the care manager, prompting her to engage the patient's primary care physician for the care required after a patient returned home. Leadership also wanted the system to be capable of triggering many other alerts, including preventative care requirements, prescribed follow-up care and annual wellness visits.

After searching extensively for an **"action"** system for interacting with its thousands of attributed lives to improve care quality, satisfaction and cost, the ACO chose Microsoft Dynamics CRM and Tribridge to tailor the solution to its precise requirements. These requirements included publication of alerts, tracking patient enrollment, creating patient assignments for care managers and customizing patient registries. Using an agile approach, the ACO worked with Tribridge to refine requirements for multiple population segments, disease states, data sources for integration and important functions for care coordinators.

The pioneering ACO now supports more than 50,000 patients, and the organization is on track for meeting its clinical goals, including metrics for certain chronic conditions and achieving higher patient engagement.

" We chose Tribridge because it has a vision for coordinating care that aligns with ours, as well as deep experience with Microsoft Dynamics CRM."

— Executive Vice President of Strategic Business Growth and Analytics

Enabling Customer-Intimate, Proactive Care Planning and Coordination at a Not-for-Profit Home Health Services Provider

One of the largest not-for-profit, faith-based health systems in the country with roots dating back to the early 20th century, operates approximately 90 hospitals and more than 120 continuing care locations. It provides nearly 2.5 million visits per year to people and communities in 21 states from coast to coast. Its home health and hospice program is one of the largest in the nation, and is also the largest not-for-profit provider of home health services in the U.S.

The system serves thousands of patients every year, providing services seven days a week by highly trained caregivers with on-call availability. It offers specialized programs such as palliative care, fall prevention and advanced wound care. The system is committed to the poor and underserved, including an aging population, and it strives to be the national leader in improving the health of the communities and individuals it serves—mostly Medicare patients.

To achieve its vision, the system arms thousands of field-based home and hospice caregivers with technology. This technology enables unprecedented customer intimacy and proactivity by coordinators in the field.

Today, these care teams are piloting the cloud-based Tribridge **Health360** population health management solution, which runs on Microsoft Dynamics CRM. The flexible solution is ideal for this mobile field workforce because it doesn't force-fit patients to care plans. Instead, it enables caregivers to truly personalize care for each individual. The pilot lets caregivers fine tune the platform to achieve many local use cases, providing ample proof that Health360 serves their needs better than the Salesforce.com healthcare CRM solution they originally considered.

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Learn how you can achieve more personalized care with Health360. **Watch video now.**

INNOVATORS IN POST-ACUTE CARE

Post-acute providers have the opportunity to serve their patients over the long term, not just during an acute episode of care. A proven, cloud-based population health solution lets them establish meaningful, proactive, personalized relationships, not only with patients but also with their support network of family and loved ones.

Proactively Managing All Relevant Patient Relationships for More Personalized, Coordinated Care and Support

Assistance in Recovery (AiR), a leading provider of behavioral health intervention and recovery assistance, has set the standard of intervention practice and strives to be the leader in the continuum of behavioral healthcare, education and advocacy around the world. It understands that addiction is a family disease and treats it as such. Its proven program provides supplemental guidance and support to clients and their families, helping them navigate the traditional treatment model, move through each stage of recovery successfully and avoid relapse.

Because their services are extremely customer-intimate and client relationships with their families and other support structures are core to the process, they wanted a cloud-based care management solution, built on the Microsoft Dynamics CRM platform, to manage all interactions with, and between, involved parties. A master set of customer data already in the system gave them the foundation for building individual intervention and support plans that can be managed efficiently within the **Health360** solution. Every touch point is captured and managed proactively within the platform.

The solution is already having significant results. Care members now have a 360-degree view of friends, family and others who are collectively invested in a patient's recovery. Care team members also have the tools to manage all those relationships and the personalized care plans for each person they're helping to coach through recovery. This has led to greater care team efficiency that is manifested in higher member-to-client ratios and improved client satisfaction scores.

AiR Healthcare Solutions™

Flexible Deployment Options

AiR specifically sought a private cloud solution. Fortunately, Tribridge Health360 can be deployed in a variety of ways to suit an organization's need, including on-premise, public, private or hybrid cloud models.

Reinventing Physician Relationship Management at One of the Nation's Largest Rehab Organizations

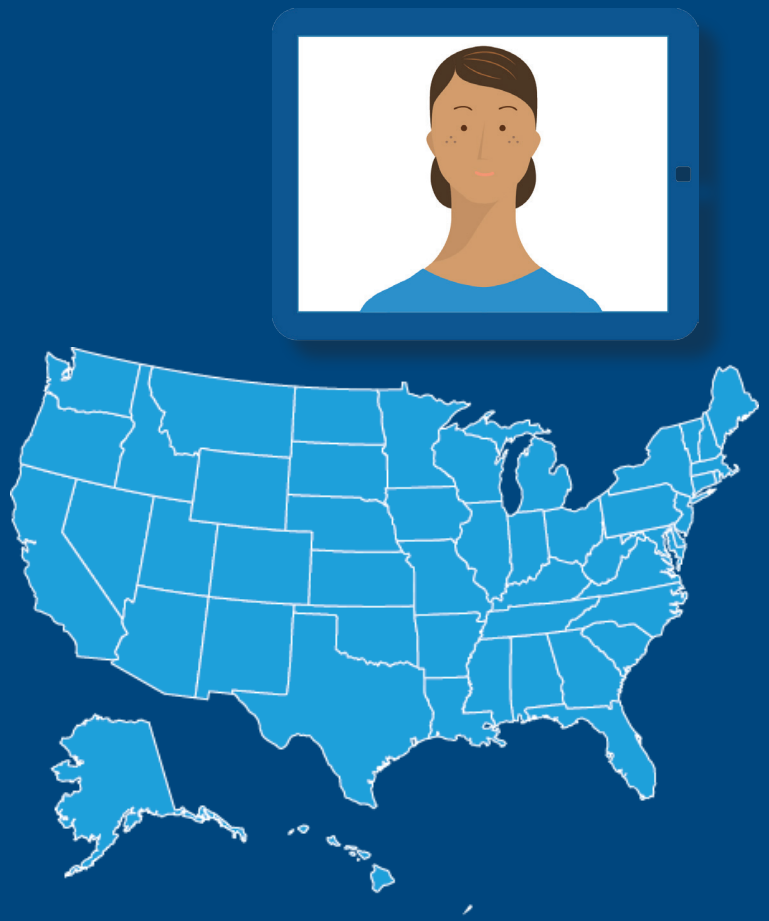
One of the largest post-acute care organizations in the U.S. operates rehabilitation hospitals, clinics and home care services in more than 30 states. Its rehabilitation liaisons nationwide cultivate referrals by building stronger relationships with physicians, social workers, case workers and patients at 95 inpatient rehabilitation hospitals and six long-term acute care hospitals across five regions. Liaisons are out in the field every day, relying heavily on their mobile devices to exchange referral information with the corporate office.

Generating referrals requires a strong sales and marketing structure and discipline. Tightly coordinated field and corporate marketing enables timely and consistent communications, anticipation of future needs and the ability to deliver relevant information to prospective clients when and how it's needed. For this large rehab organization, goals also included automating the capture of patient referral source information and improving the timeliness of patient transfer between facilities and specialists.

The organization needed to arm its liaisons with tools to more efficiently and effectively serve and communicate with providers who refer patients for care. The answer came from Tribridge, which implemented Microsoft Dynamics CRM including functionality from the Care Network module of Health360. With this new functionality, physician liaisons now have mobile tools to help achieve aggressive goals for physician referrals and reduce patient transfer time.

In the field, liaisons access the central database remotely via a mobile device or tablet. This improves visibility into physician and patient relationships and streamlines the flow of referral data between hospitals. It's now much easier to identify patients and other referral sources, including the ability to connect with them by using highly relevant, personalized messaging.

Health360 is reinventing physician relationship management by uniting the power of a highly mobile field force. The **Health360**-driven platform offers valuable interconnectivity and flexibility which extends into the future, too. Future plans call for implementation of Microsoft Azure Cloud and Cortana Analytics as the organization continues to push the boundaries of what's possible in the increasingly competitive healthcare marketplace.



Health360 is reinventing physician relationship management by uniting the power of a highly mobile field force.

INNOVATORS IN CHRONIC DISEASE MANAGEMENT

The life expectancy of an average person has more than doubled in the last 150 years, thanks to medical advances and more accessible primary care. The result is an increasingly aging population that is prone to more long-term, chronic conditions. Treating chronic illnesses is one of the most daunting challenges facing the U.S. healthcare system, which needs to focus on the unique needs of chronically ill people as much as it does on peoples' acute and primary care needs.

Scaling Personalized Chronic Kidney Disease Management

One in 10 American adults, or more than 20 million, is said to have some form of chronic kidney disease (CKD), according to the U.S. Centers for Disease Control and Prevention. Underlying complications from CKD and often multiple co-morbidities lead to high rates of hospital admission and readmission and contribute to staggering costs system wide. This puts CKD squarely in the crosshairs of the Centers for Medicare & Medicaid Services (CMS). CMS strongly advocates for enhanced care coordination that provides a more patient-centered care experience and improved outcomes.

One of the largest providers of dialysis and CKD management services in the world operates hundreds of dialysis centers and vascular clinics in the U.S. It serves a large part of the CKD population, including those who suffer from end-stage renal disease (ESRD), which is characterized by total and permanent kidney failure. In fact, it is one of 13 ESRD Seamless Care Organizations (ESCOs) participating in the Comprehensive ESRD Care Model.

The ESRD Care Model is designed to identify, test and evaluate new ways to improve care for Medicare beneficiaries with ESRD. CMS now partners with healthcare providers and suppliers to **"test the effectiveness of new payment service delivery models in providing beneficiaries with patient-centered, high-quality care."** The program encourages systems to provide coordinated healthcare that goes beyond their traditional roles in treating ESRD, both in and outside the dialysis clinic.

With more than 200 dialysis facilities, this provider is considered a large dialysis organization (LDO), making it eligible to receive shared savings payments as well as exposing it to shared losses. This risk/reward paradigm creates strong incentive to deliver highly efficient, effective and personalized care. There's potential for significant financial upside and downside.

To better manage its risk and maximize its upside, the organization recently partnered with Tribridge on a **Health360** pilot implementation. It's demonstrating that, when fully deployed, the **Health360** solution can indeed provide more personalized care with fewer staff. Equally important is that the solution can help manage an entire continuum of care, not just dialysis and CKD management, by delivering a highly personalized experience that measurably improves health and well-being at a lower cost.

It's demonstrating that, when fully deployed, the **Health360** solution can indeed provide more personalized care with fewer staff.

WHAT'S YOUR VISION?

The preceding pages highlight some examples of healthcare organizations that are leading the industry's transformation to value-based care. The challenges faced by acute care, post-acute/rehab and chronic disease management providers may be different in some ways, but their commonality is the need to deliver efficient, effective care to entire populations while also providing proactive, personalized care to individuals.

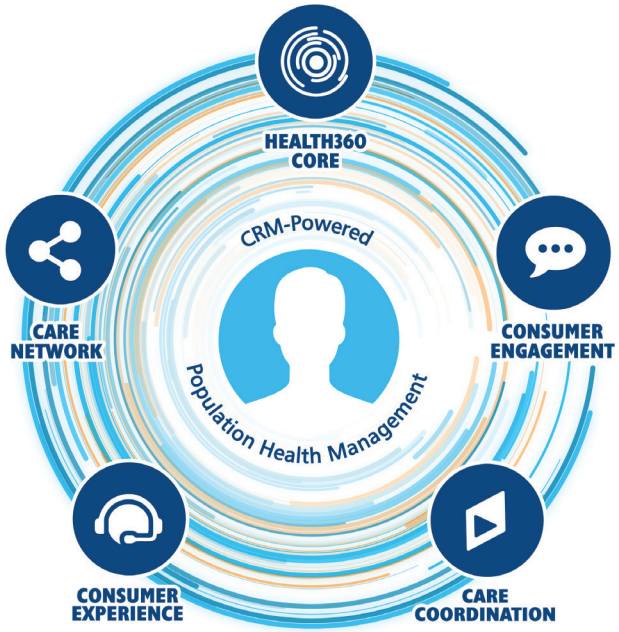
The organizations featured are at different stages along the value-based care continuum, but they are all innovating using the same population health management solution: Tribridge **Health360**. Whether value-based payments represent only a small portion of today's revenue or are a major profit and loss driver, this solution is equal to the task.

From **consolidating and integrating your physician and care network relationships to personalizing care experiences that improve outcomes and HCAHPS scores to proactive patient engagement and care coordination outside of care facilities**, **Health360** is a solution that is designed match your vision. More important, however, is that Tribridge developed it for action, not just analysis. To achieve success at the scale necessary, a population health management solution must enable action instead of passive analysis. Tribridge built **Health360** with care coordination at its foundation, so it's designed to drive meaningful actions in all aspects of a patient's life, from point of care to home and among an extended network of professional care-givers, family and friends.

Whether you have contracted for multiple value-based populations with different agreements and payment protocols or are already engaged with a large value-based population, **Health360** can help now. What's your vision?

About Tribridge Health360

Tribridge **Health360** is cloud-based CRM-powered, Population Health Management solution from Tribridge and enables providers and payers to personalize care experiences, ensure quality, lower costs and increase satisfaction and customer loyalty. Health 360 is built on Microsoft Dynamics CRM and integrates machine learning, wearable technology, telehealth, Microsoft Azure, Office365 and Cortana Analytics to provide a complete technology solution. Health360 is a new way to tackle Population Health - one person at a time. For more details, visit **www.tribridgehealth360.com** to learn more or contact us directly at **877-744-1360.**



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HEALTH360 CORE

Person-centered data model for Microsoft Dynamics CRM Online and Azure, pre-configured for healthcare requirements.

CARE COORDINATION

Proactively plan and coordinate care for each person and enable perpetual patient relationships. Improve outcomes and patient satisfaction, while reducing costs. Option to leverage embedded clinical protocols and best practices from **Dartmouth-Hitchcock.**

CONSUMER ENGAGEMENT

Campaign for attention and engage consumers and patients in their own, personalized care experience. Monitor patient-sponsored and IoT health data in real-time. Give patients easy-to-use mobile apps for enabling ongoing dialog and perpetual feedback.

CONSUMER EXPERIENCE

Personalize every interaction with the health system with powerful Next Best Action guidance from Health360 based on what we know about a consumer (clinical, behavioral, situational and preferential intelligence). Enable marketing and contact center automation and efficiency and consumer intimacy. Leverage embedded **Telehealth Guidelines from Schmitt-Thompson Clinical Content**.

CARE NETWORK

Optimize your Provider network with Physician Relationship Management, M&A pipeline management, onboarding, training and referral management. Leverage embedded Provider Intelligence and Claims Data from **Evariant**.