Session 28

Partners’ Care Management Strategy: A 10-Year Journey

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Partners HealthCare

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MGPO Associate Medical Director, Primary Care
Medical Director for Primary Care, Population Health Management
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Learning Objectives

• Identify the essential elements of an effective care management program for chronically ill patients.

• Recognize how care management plays a key role in an effective population health management strategy.

• Determine how to use information to identify and effectively manage complex, chronically ill patients.
Poll Question #1

How effective is your organization’s care management strategy?

1) Not at all effective
2) Somewhat effective
3) Moderately effective
4) Very effective
5) Extremely effective
6) Unsure or not applicable
Partners HealthCare believes that chronically ill patients with multiple medical conditions often benefit the most from a coordinated care approach.
133 million Americans—45% of the population—have at least one chronic disease.

Chronic diseases are responsible for 7 of 10 deaths each year, killing more than 1.7 million Americans annually.

Treating people with chronic diseases accounts for 86% of our nation's healthcare costs.
Partners HealthCare is an integrated system consisting of the following:

- Two large academic medical centers (Massachusetts General Hospital and Brigham and Women’s Hospital).
- Six community hospitals.
- Five community health centers.
- Five major multispecialty ambulatory sites.
- Inpatient and outpatient psychiatric and rehabilitation specialty services.
- Homecare.
- More than 6,000 physicians.
500,000 Lives

Partners currently covers more than 500,000 lives in an accountable care contract.

1. **MEDICARE**
   - Example: Pioneer ACO
   - Covered lives: ~96k

2. **COMMERCIAL**
   - Example: Alternative Quality Contract
   - Covered lives: ~350k

3. **MEDICAID**
   - Example: NHP
   - Covered lives: ~30k

4. **SELF INSURED**
   - Example: Employees
   - Covered lives: ~100k
Brief Background

• High-risk patients—the sickest patients who often have chronic, complex conditions—require well-coordinated and often costly care.

• As healthcare moves toward payment for outcomes, Partners saw the need to more effectively manage the chronically ill.

• Partners’ integrated care management program (iCMP) was borne out of a highly successful and federally sponsored demonstration project conducted by Massachusetts General Hospital (MGH) beginning in 2006.
The Problem and Opportunity

- Chronically ill patients with multiple medical conditions find it very difficult to negotiate the complex health system.
  - Lacked care coordination, resulting in a less-than-ideal support relationship.
  - Holistic approach is needed, including greater focus on preventative care.
- Payment models are changing from fee-for-service to outcomes.
  - Healthcare providers will increasingly need to manage risks and costs.
- In the face of rising costs, healthcare providers will need to be better stewards of resources.
  - And prepare for pay-for-outcomes (value-based) reimbursement model.
Poll Question #2

What percentage of your organization’s primary care patients are under risk contracts (i.e. patients you have accountability for the total cost of care)?

1) Less than 5%
2) 5% to 25%
3) 25% to 50%
4) 50% to 100%
5) Unsure or not applicable
The Strategy
The Partners Path to Accountable Care

Pressure to reduce cost trend

Leadership and Delivery Innovations

New contracts with risk for trend

Changes to Partners organizational structure

Investment in Population Management Infrastructure
- Primary & Specialty Care Continuum
- Patient Engagement Infrastructure

Internal Performance Framework
- Implement new local incentives/compensation

Network Affiliations
- New relationships with community hospitals and doctors

Improved quality and lower cost trend
# PHM Strategies

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Patient-Centered Medical Home (PCMH)</th>
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<tbody>
<tr>
<td></td>
<td><strong>High-risk care management</strong> (+ palliative care, telemonitoring)</td>
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<tr>
<td></td>
<td>Mental health integration</td>
</tr>
<tr>
<td></td>
<td>Virtual visits</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>Active referral management (e-consults)</td>
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<tr>
<td></td>
<td>Virtual visits</td>
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<tr>
<td></td>
<td>Procedural decision support (appropriateness)</td>
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<tr>
<td></td>
<td>Patient reported outcomes (PROMs)</td>
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<td></td>
<td>Bundles (episodes of care)</td>
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<tr>
<td>Care Continuum</td>
<td>Urgent care</td>
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<tr>
<td></td>
<td>SNF care improvement (network/waiver/SNFist)</td>
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<tr>
<td></td>
<td>Home care innovation (mobile observation)</td>
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<tr>
<td>Patient Engagement</td>
<td>Shared decision making</td>
</tr>
<tr>
<td></td>
<td>Customized decision aids and educational materials</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>Single EHR platform with advanced decision support</td>
</tr>
<tr>
<td></td>
<td>Data warehouse, analytics, performance metrics, including variation</td>
</tr>
</tbody>
</table>
Poll Question #3

Does your organization have a primary-care-based high-risk care management program?

a) Yes  
b) No  
c) Unsure or not applicable
Drivers of Trend…

Typical breakdown of health plan populations to cost

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<table>
<thead>
<tr>
<th>Plan Membership</th>
<th>Plan costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well</td>
<td>100%</td>
</tr>
<tr>
<td>At risk</td>
<td>15%</td>
</tr>
<tr>
<td>Chronically ill</td>
<td>20%</td>
</tr>
<tr>
<td>Acute ill</td>
<td>55%</td>
</tr>
</tbody>
</table>

SOURCE: Boston Consulting Group: "Realizing the Promise of Disease Management", Team analysis
…Translated into Populations

Population Volume

Intensity of Illness

Area of Greatest Opportunity

Intensity and Specificity of Intervention

Healthy

Chronic Illnesses

Medically Complex/ High Utilizers

HASUMMIT16
iCMP: Conceptual Strategy

SCHEMATIC: NOT DRAWN TO SCALE
Table Discussion

At your table, describe what patient populations you would place in a care management program. Describe the clinical (inpatient and outpatient), cost, and social characteristics of these patient populations.
Who Are iCMP Patients?

From Provider’s Viewpoint

From EMR
Understanding the iCMP Population

Distribution of Clinical Conditions for ACO iCMP Patients as of April 2014

Mental Health: 43%
Diabetes: 34%
Cancer: 23%
Malignant Hypertension: 20%
Respiratory: 19%
Renal Failure: 16%
Vulnerable Patients: 14%
Heart Disease: 12%
Dementia: 11%
Tobacco User: 8%
Transplants: 6%
Other Conditions: 18%

% of HR patients with the clinical condition

Clinical Conditions
Understanding the High-Risk Population

Clinical Conditions:
Commercial and ACO iCMP Patients

Date: July 2013

- Mental Health: 41%
- Diabetes: 25%
- Cancer: 24%
- Malignant Hypertension: 16%
- Renal Failure: 14%
- Tobacco: 12%
- Heart Disease: 12%
- Chronic Obstructive Pulmonary Disease (COPD): 11%
- Respiratory: 11%
- Embolism: 10%
- Substance Abuse: 9%
- Transplant: 8%
- Dementia: 7%
- Liver Disease: 6%
- Other Hematology: 5%
- Hemorrhagic Stroke: 5%
- Other: 5%
- Epilepsy: 4%
- CVA: 3%
- Other: 3%
- Diarrhea: 3%
- Influenza: 2%
- Aids: 1%
- COPD: 1%
- Asthma: 1%
- Osteomyelitis: 1%
- MS: 1%
- HIV: 1%

#HASUMMIT16
Patient Demographics

Payer Distribution
as of March 31, 2015

ACO
Commercial
NHP
Other

63%
20%
4%
13%

Patient Demographics

Median Age
Enrolled Patients

NHP
64
80
Commercial
52

Annual Mortality
-10%

Gender Mix

ACO
Female
Male

55%
45%

Commercial
Female
Male

51%
49%

Utilization Review
Monday, April 20, 2015 2:28pm

<table>
<thead>
<tr>
<th>Service</th>
<th>ACO</th>
<th>Commercial</th>
<th>NHP</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>MGH ED:</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MGH OBS:</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MGH Inpatient:</td>
<td>41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Partners EDs:</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other OBS:</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Partners Inpatient:</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*as of January 2014; Cohort 1; Enrolled and inclusive of CMHC/B patients
## Top 10 Admissions by Payment, Medicare

<table>
<thead>
<tr>
<th>DRG Grouping</th>
<th>% of Total HR ACO Pymts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure &amp; Shock</td>
<td>6.2%</td>
</tr>
<tr>
<td>Septicemia or Severe Sepsis with Mechanical Vent 96+ Hours</td>
<td>5.8%</td>
</tr>
<tr>
<td>Simple Pneumonia &amp; Pleurisy</td>
<td>3.0%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>2.9%</td>
</tr>
<tr>
<td>Cardiac Valve &amp; Other Major Cardiothoracic Procedure</td>
<td>2.9%</td>
</tr>
<tr>
<td>Respiratory Infections &amp; Inflammations</td>
<td>2.8%</td>
</tr>
<tr>
<td>Major Joint replacement or Reattachment of Lower Extremity</td>
<td>2.1%</td>
</tr>
<tr>
<td>Kidney &amp; Urinary Tract Infections</td>
<td>2.1%</td>
</tr>
<tr>
<td>Major Small &amp; Large Bower Procedures</td>
<td>1.8%</td>
</tr>
<tr>
<td>Circulatory Disorders Except AMI, with Card Catheter</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

**Total Cost = $17,907,263**
## Top 10 Admissions by Frequency, Medicare

<table>
<thead>
<tr>
<th>DRG Grouping</th>
<th>% of Total iCMP ACO Admits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure &amp; Shock</td>
<td>8.8%</td>
</tr>
<tr>
<td>Simple Pneumonia &amp; Pleurisy</td>
<td>4.7%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>4.6%</td>
</tr>
<tr>
<td>Kidney &amp; Urinary Tract Infections</td>
<td>3.9%</td>
</tr>
<tr>
<td>Septicemia or Severe Sepsis with Mechanical Vent 96+ Hours</td>
<td>3.8%</td>
</tr>
<tr>
<td>Cardia Arrhythmia &amp; Conduction Disorders</td>
<td>3.1%</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>2.7%</td>
</tr>
<tr>
<td>Respiratory Infections &amp; Inflammations</td>
<td>2.7%</td>
</tr>
<tr>
<td>Esophagitis, Gastroent, &amp; Misc Digest Disorders</td>
<td>2.4%</td>
</tr>
<tr>
<td>G.I. Hemorrhage</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

**Total Admits = 1,394**

Note: DRG Grouping takes like DRGs and aggregates them regardless of complications or comorbidities. For example, the Renal Failure group includes three DRGs, Renal Failure w/Major Complications and Comorbidities, Renal Fail with Complications and Comorbidities and Renal Failure without Complications and Comorbidities.
How do you (or would you) go about identifying these patients in your organization?
But Who Are They Really?

Focus on subset who are **chronically ill, medically complex**, and would benefit from a care management intervention.

Characteristics of these patients include:

- Multiple medical conditions.
- One chronic, severe medical condition.
- Mental health, behavioral health, or substance abuse complicating medical condition.
- Lack of socioeconomic resources to manage illnesses.

For example, this group may include more acute episodes such as complicated OB, trauma.
Partners iCMP developed a methodology using a risk predictive modeling software, and financial and clinical data to prospectively identify medically complex, chronically ill patients.

- Identifies those patients who are likely to be higher risk for high costs in the next 12 months.
- **Key Feature**: PCPs and care managers validate the list and remove patients as needed.

Claims data \(\rightarrow\) Risk predictive modeling software \(\rightarrow\) Preliminary iCMP List \(\rightarrow\) PCP and CM review list and selects pts. appropriate for the program
Version 2.0 Patient Identification Algorithm

**Conditions**
- **High Acuity**
  - Renal Failure
  - Transplant
  - Osteomyelitis
  - Respiratory
  - HR CHF/Pulmonary
  - HR Liver Disease
  - Malignant Hypertension
  - Vulnerable Patients
  - Metastatic Cancer
- **Moderate Acuity**
  - CVA/Hemorrhagic Stroke
  - Moderate COPD
  - Moderate MH
  - Moderate Diabetes
  - Hematology
  - Embolism and Thrombosis
- **Low Acuity**
  - LR diabetes
  - Colitis
  - Nephritis
  - Localized Cancer
  - LR MH or SA
  - LR Liver Disease
  - Dementia
  - LR COPD/Obstructive Asthma
  - Tobacco use
  - HIV/AIDS
  - MS

**Patient Complexity**
- 1 or more high acuity
- 1 + Moderate acuity
- And 2+ Low acuity
- 2 + Low Acuity
- 3+ Low Acuity

**Trigger Intensity**
- **Level 1 Trigger**
  - 1 Medical Admit
  - 2 or 3 ER visits

- **Level 2 Trigger**
  - 3+ New Patient consults
  - 2 +medical admits
  - 7+ High risk medications
  - 15+ Office visits
  - ICU /CCU
  - SNF stay
  - 4+ ER visits
  - Complications of Care

**Output**
- Patients with risk score of > 10
- Patients 90 years or older (commercial only)

PCP and CM reviews list and selects Patients candidates iCMP program
Poll Question #4

What mechanism does your (or would your) organization use to identify high-risk patients?

a) Claims  
b) Clinical  
c) Clinical opt-in  
d) We guess  
e) A combination of the above  
f) Unsure or not applicable
Poll Question #5

If your organization has a high-risk care management program, how effective are your methods for identifying high-risk patients?

1) Not at all effective
2) Somewhat effective
3) Moderately effective
4) Very effective
5) Extremely effective
6) Unsure or not applicable
Design of the iCMP
Table Discussion

List the components of managing a high-risk care management program (people, process, technology, resources, etc.).

Three buckets to consider:
1. Must-haves
2. Should-haves
3. Things that would be nice, but we could live without them
What is iCMP?

Key elements:

• **Access to specialized resources** including mental health, community resources expertise, pharmacy, and palliative care.

• **Involvement through continuum of care** with home visits, telemonitoring, integration with post-acute and specialty services.

• **Patient self-management** with health coaching and shared decision making.

• **IT-enabled systems** to improve care coordination leveraging real-time, automatic notification of admissions/discharges and EMR flags identifying iCMP patients.

• **Data-driven analytics** to support strategic decision making and operations.

• Intensive, ongoing **support and training** for teams and staff.

• **A payer-blind approach**, with initial attention to Medicare, commercial, and NHP.
## iCMP Design

### Care Managers are Integrated into All Primary Care Practices

- ~200 patients/care manager.
- Follows patients longitudinally.
- Assess patients—identifying gaps: risks for poor outcome.
- Develops proactive plan.
- Coordinates care between providers, services.
- Facilitates better communication/transitions.
- Specialized training and ongoing team-based learning.

### Foundation

- Embedded in primary care practices.
- Modifies classic care team.
- Uses mass customization: configuring defined and available services to fit patient needs.
- Iterative: allowed to ‘evolve’ based upon experience.
- Knows and uses available community and institutional resources.
- Heavy reliance on IT and real-time data.
Delivery Model Incorporates Other Specialized Services to Manage Specific Needs

Key Tenet: Each team member must be working at the top of their license.
Defining the Broader Team

- Hospice VNAs
- Non-Acute Care Agencies
- Elder Service Network
- Transport Providers
- Civic Orgs
- Community Agencies
- Care Agencies
- PCP
- Specialist
- Pharmacist
- Financial Service Specialist
- Mental Health Team
- Substance Abuse Specialist
- Community Resource Specialist
- Palliative Care and Hospice
Identifying an iCMP Patient

ENROLLED Member, MassGeneral Care Management Program
Practice Case Manager: Luongo, Bonnie  
Pager: 14029

Please page for assistance with any care related issues
8AM - 4:30PM, M-F

For more information: http://www.massgeneral.org/caremanagement/
Table Discussion

How would you need to modify your care management strategies to manage different patient populations (Medicare, Medicaid, commercial)?
Current State of the iCMP
Program Evolution

Decision to scale the program:

- Hospitalization rate/1000 was 20% lower than in comparison group.
- 12.1% in gross savings among enrolled patients.
- Improved physician and patient satisfaction.
Current State of iCMP

iCMP Care Teams
(as of November 2015)

- 88.7 FTE care managers (includes adult and pedi).
- 22.3 FTE social workers (includes adult and pedi).
- 5.1 FTE pharmacists.
- 10.1 FTE community resource specialists.
- 2.9 FTE medical director (includes adult and pedi).
- 1.5 FTE psychiatrist (includes adult and pedi).

Patient Engagement
(as of November 2015)

- 50,002 patients identified by algorithm (adult and pedi).
- 11,304 patients managed in the adult program.
- 213 patients managed in the pedi program.

Training
(as of November 2015)

- 532 individuals have filled 1716 seats in 46 sessions.
- Sessions have included motivational interviewing, managing substance abuse, and team sustainability.
Growing into a Systems-Wide Initiative: Working Principles

Goal: Develop strategy for the Partners System to support practices in improving value for high-risk patients.

- Develop system tools to support care providers in offering better care management/care coordination for medically complex patients.

- Provide resources required centrally to support implementation, make recommendations regarding necessary local resources—“Centrally Guided Locally Led.”

- Evolve towards a payer-blind approach, with initial attention to Medicare and commercial patients.

- Integrate approaches with primary care strategy and align with other key Partners initiatives, such as readmissions and palliative care.

- Develop value dashboard, including quality and cost, as well as implementation metrics.

- Create a transparent, inclusive process across the system to develop, implement, and continually improve key service offerings.
Organizational/Governance Structure

- **Primary Care Council**
- **Partners PHM**
- **Pediatric Oversight Committee**
- **Management Team**
- **Algorithm and Evaluation**

**Operations Management Team (HR Leadership from Entities/Community)**

**IT**
- Integrate with overall PHM IT process.
- Care management software support.

**Care Team**
- Care model development.
- Protocols.

**Mental Health**
- Conceptual and strategic design.
- Protocols.
- Internal and external linkages.

**Data Analytics and Measurement**
- Patient lists.
- Outcomes (quality and trend).
- Process.
- Implementation.

**Training**
- Reference guide.
- Learning collaboratives.
- Systemwide team trainings.

**Pediatrics**
- Pediatric protocols and workflow.
- Support practice integration.

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**Communication among teams and within entities**

Ad hoc groups formed on an as-needed basis.
## Centralized Support System

### Analytics

- Systemwide patient identification with practice level refinement.
- Measurement: implementation, process, and performance metrics.
- Trend impact analyses.
- Generate standard, timely reports for this population.
- Develop and manage measures for the Internal Performance Framework (IPF).

### Curriculum Development and Training

- Develop and maintain PHS high risk reference guide/toolbox for practices.
  - E.g. templates, job descriptions.
  - Practices use as needed.
- Create PHS-wide learning collaborative meetings (online and in person) for practices and care team members.

### Enabling Tools

- Patient care management system (IT solutions).
  - Real-time, automatic notification of admissions/discharges/ED.
  - EMR high risk icon.
  - Pt enrollment/disenrollment capability.
- Maintain PHS community resource database.

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**Multidisciplinary collaboration and guidance from convening forums**

- Convened representative workgroups to inform the above system supports.
- Developed system standards where appropriate.
Outcomes
Table Discussion

What measures would you want to have in order to monitor and manage your care management program (structure, process, and outcome measures)?
# Financial Incentives: Internal Performance Framework

### Outcome

**Impact of the High Risk Program**
- Decrease in medical admits per 1000 rate.

### Workflow and Process

**Post Discharge Bundle of Care**
- Care manager contact.
- Post discharge assessment completion.
- Patient touch within 14 days discharge.

**Patient Survey**
- Determine if the iCMP patients are aware of their iCMP care team and have a general understanding of how to work with their iCMP care team.

**Innovation**
- Allow local iCMP teams to develop, plan, test, and report a measure in one of the following areas: post acute, specialty care, hospital, transitions, mental health, and palliative care.

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**Building the foundation for a robust iCMP**
Measurement Strategy

Three-phase plan for measurement.

Total program measurement as well as measuring variation across the entities within the system.

**Cohort grouping is key to measuring program outcomes (tool developed).**

- Patients enrolled and engaged during the same time periods grouped for measurement.

Entity-level management reports **important** for local program management.
## Program Metrics to Consider

### Implementation
- # Patients identified
- # Patients enrolled
- # of staff by discipline
- # of staff hired
- Additional capacity

### Process
- % Eligible
- % Enrolled
- % Removed
- % Assessed/care plans
- % Discharged
- # of care team activities per month
- Priority stratification
- % of total risk contracts
- % Post discharge assessments
- # of contacts between Inpt and iCMP care managers for acute admits

### Outcome
- Medical admits per 1000
- Cost and utilization by patient enrollment cohort
- ED | Total medical expense | SNF | Inpatient | Office visit | Leakage | End of life
- Performance overtime
- Identification | Validation/enrollment | Intervention
- Comparison to patients who refuse program
- Patient survey

Quality/HEDIS metrics are well established as a Partners strategy, and measurement occurs as part of population health management for all patients.
Early Outcomes

Qualitative
- Physician Satisfaction
- Patient Care | Work-life | Time
- Staff Satisfaction
- Patient Quality of Life
- Communication

Clinical
- Hospitalization rate/1000 was 20% lower than in comparison group.
- Emergency department visit rates were 13% lower for enrolled patients.
- Annual mortality 16% among enrolled versus 20% among comparison group.

Cost/Savings
- 12.1% in gross savings among enrolled patients.
- 7% in annual net savings among enrolled patients after management fee paid by CMS to MGH.
- Return on investment—for every $1 spent, the program saved at least $2.65.
Percent of patients with a completed assessment and completed care plan as of 11/30/2015.

Average activities per reached and receptive and/or eligible patients: 3.4 per patient
Poll Question #6

Once a care management program is in place, how long does it take before you begin to see changes in clinical and cost outcomes?

1) 6 months
2) 1 year
3) 18 months
4) 2 years
5) Greater than 2 years
6) Unsure or not applicable
Annualized Trend 2012-2014

Source: Claims with 90 day lag (23 months of claims) dates of service 1/1/2012-11/30/2014

Need at least 18 months of patient engagement to show outcomes.
Medical Admits per 1000

TOTAL medical admits trend CY13 to YTD14

PHS Network

-18.6% -12.0% -5.5% -4.7% -2.4% 2.0% 2.8% 4.4% 14.7% 0.8%
Scheduled and attended visits within 7 days of medical and 14 days of surgical discharges

*Readmissions

% with a scheduled visit or home health services

% who attended and actual visit

*\textit{n<15 discharges}
Lessons Learned

1. Program success and adoption locally can be attributed to being “centrally guided, locally led.”
2. Define foundational requirements.
3. Support change management.
4. Adapt to local needs and recognize local variation.
5. Necessary central supports include the following:
   1. Patient identification.
   2. Reporting and analytics.
   3. Training.
   4. IT solutions.
   5. Establishing and facilitating workgroups of local leaders.
6. Measure early and report often.
7. Control/comparison groups are key to measuring success.
8. Financial Incentives have merit if they don’t subsume the clinical mission.
9. Communicate, communicate, communicate.
Future Plans

1. Continue to refine, improve, and expand the iCMP model.

2. Focus on increasing adoption, implementing more improvements, and tracking efficacy and outcomes.

3. Continue the Partners’ journey to a data-driven culture, supported by an advanced analytics infrastructure across the entire organization.

4. Maximize the efficacy of the program for different populations of patients.
Analytic Insights

Questions & Answers
What You Learned…

Write down the key things you’ve learned related to each of the learning objectives after attending this session
Thank You