waymark

Enabling Providers to Expand Access for the Medicaid Insured

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Our Approach

Numerous studies have shown that community-based care can improve outcomes…yet it hasn't been scaled to serve the broader Medicaid population

24%

Average reduction in annual Medicaid spending among enrolled patients[1]

44%

Average reduction in 30-day readmit rates for patients in post-discharge care programs[2]

56%

Average reduction in no-shows for appointments within 30-days of discharge for patients[2]

1

Medicaid-focused CHW available for every 6,500 people with Medicaid benefits[3]

1. Felix, Holly C., et al. "Medicaid Savings Resulted When Community Health Workers Matched Those With Needs to Home and Community Care." Health Affairs, vol. 30, no. 7, Health Affairs (Project Hope), July 2011, pp. 1366–74. Crossref, https://doi.org/10.1377/hlthaff.2011.0150
2. Carter J, Hassan S, Walton A, Yu L, Donelan K, Thorndike AN. Effect of Community Health Workers on 30-Day Hospital Readmissions in an Accountable Care Organization Population: A Randomized Clinical Trial. JAMA Netw Open. 2021;4(5):e2110936. doi:10.1001/jamanetworkopen.2021.10936
3. 61,000 CHWs Nationally (https://www.bls.gov/oes/current/oes211094.htm) with ~20% serving Medicaid per NACHW CHW Survey data

We’re a Public Benefit company that seeks to **improve access**, **equity** and **quality of care** for people receiving Medicaid benefits

Our Approach

Waymark's Foundations

From Bench to Bedside to Curbside

1

CHW-only Care Model

Impact: Reduced **readmissions** (29% readmission reduction among enrolled, with 46% enrolled)

Pennsylvania Medicaid (UPenn)

2

Multidisciplinary Team and PCP Support

Impact: Reduced **new admissions** (44% total admissions reduction among enrolled, with 57% enrolled)

Tennessee Medicaid (CareMore)

3

Data Science and Workforce Building

Impact: Reduced **ER** and all admissions, and reduced **total cost of care** (11% cost reduction for enrolled, with 40% enrolled)

California Medicaid (Contra Costa)

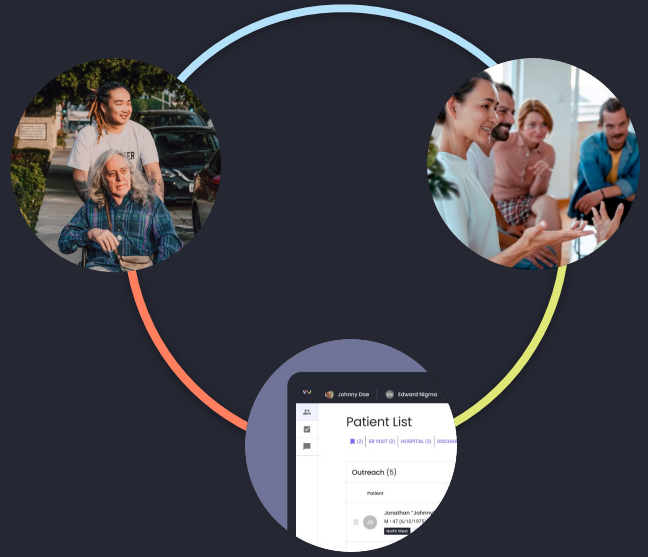
1. Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. Health Aff (Millwood). 2020 Feb;39(2):207-213. doi: 10.1377/hlthaff.2019.00981.
2. Powers BW, Modarai F, Palakodeti S, Sharma M, Mehta N, Jain SH, Garg V. Impact of complex care management on spending and utilization for high-need, high-cost Medicaid patients. Am J Manag Care. 2020 Feb 1;26(2):e57-e63. doi: 10.37765/ajmc.2020.42402.
3. Brown DM, Hernandez EA, Levin S, De Vaan M, Kim MO, Lynch C, Roth A, Brewster AL. Effect of Social Needs Case Management on Hospital Use Among Adult Medicaid Beneficiaries : A Randomized Study. Ann Intern Med. 2022 Aug;175(8):1109-1117. doi: 10.7326/M22-0074.

Our Approach

Our model includes three core elements that **wrap-around PCPs and their Medicaid patients**

Community-Based Care Teams

Local Waymark care teams that partner with PCPs to increase their capacity and build relationships with hard-to-engage patients



Evidence-Based Care Pathways

Clinical and community interventions that improve HEDIS scores and close gaps in patient care

Proprietary Technology

Novel patient management platform and machine learning models to identify rising risk patients and the right interventions

Our Approach

Local, multidisciplinary teams combined with **evidence-based interventions** to improve outcomes

Community-Based Care Teams

Community Health Workers	Frontline public health workers from the communities they serve
Care Coordinators	Serve as dedicated Waymark point-of-contact for primary care practices
Licensed Therapists	Providing trauma-informed cognitive behavioral therapy and related modalities
Advanced Practice Pharmacy Team	Work directly with PCPs and patients to assist med access, adherence, and between-visit monitoring

Evidence-Based Care Pathways

Accompaniment & Navigation	Gaps in care closure, visit adherence
Chronic Condition Support	Help patients achieve goals and prevent complications and associated ED and hospital visits
Behavioral Health Therapy	Directly providing therapy and coordinating substance use and mental health treatments
Social Services Coordination	Transportation, food, housing, and other social services

Our clinical pathways address: Rising-risk, behavioral health, maternity care, and pediatrics (incl. adolescents) populations

Our Approach

Grounded in multiple published studies that show lower ED, IP utilization and Rx spending

Accompaniment & Navigation

CHW-led care navigation
- 89% engagement
- 92% satisfaction
- 62% HEDIS gap closure

Data science-led proactive CHW outreach
- Reduced ED visits by 4% and IP admissions by 11%

Chronic Condition Support

CHW/peer support programs
- 36% inpatient cost reduction from reduced acuity and LOS

ACSC Programs
- 16% decrease in risk of ED visits/hospitalization

Monroe program for maternity
- 47% lower NICU admissions

Behavioral Health Therapy

Tele-therapy to shore-up gaps in psych network
- 7 studies with access to care improvements

NavSTAR management for comorbid substance use
- 26% reduction in admissions, 34% reduction in ED visits

Substance use treatment access coordination
- 21%-31% reduction in overdoses and associated ED visits/hospitalizations

Social Services Coordination

Closed-loop coordination for social determinants
- 12%+ reduction in hospitalizations from nutrition, housing, transport interventions

Referral assistance for PCPs and their practice
- Faster service, from 4-31% based on condition

Our Approach

Proprietary Technology

A tech stack to enable community-based care in partnership with PCPs

Waymark Signal

Rising-risk algorithm and prioritization tool

- Incorporates SDOH into risk prediction
- Based on data from 30.6 million Medicaid patients across the country
- Prioritizes outreach based on critical window of opportunity to redirect ED use to PCP
- 90% accuracy for predicting non-emergent ED or hospital visit in independent national validation (3X higher sensitivity that the next-best published model)

Waymark Lighthouse

In-house patient management system

- Integrates claims, ADT, and internal data
- Enables rapid SMS, phone, chat, travel optimization for CHWs (HIPAA-secure)
- Steers CHWs, care coordinators, pharmacists and therapists to the most effective outreaches & interventions
- Enables rapid action and synchronous coordination among care team members and patients

Additional innovations for care teams to optimize proactive targeting and care including pharmacy analytics for proactive outreach and automated systems for patients “falling between the crack”

1. Irvin, J.A., Kondrich, A.A., Ko, M. Basu S. Incorporating machine learning and social determinants of health indicators into prospective risk adjustment for health plan payments. BMC Public Health 20, 608 (2020). https://doi.org/10.1186/s12889-020-08735-0
2. Basu S, Sussman JB, Rigdon J, Steimle L, Denton BT, Hayward RA (2017) Benefit and harm of intensive blood pressure treatment: Derivation and validation of risk models using data from the SPRINT and ACCORD trials. PLoS Med 14(10): e1002410
3. Basu S, Sussman JB, Hayward RA. Black-White Cardiovascular Disease Disparities After Target-Based Versus Personalized Benefit-Based Lipid and Blood Pressure Treatment. MDM Policy Pract. 2017 Aug 17;2(2):2381468317725741.
4. Yadlowsky S, Hayward RA, Sussman JB, McClelland RL, Min YI, Basu S. Clinical Implications of Revised Pooled Cohort Equations for Estimating Atherosclerotic Cardiovascular Disease Risk. Ann Intern Med. 2018 Jul 3;169(1):20-29.
5. Scarpa J, Bruzelius E, Doupe P, Le M, Faghmous J, Baum A. Assessment of Risk of Harm Associated With Intensive Blood Pressure Management Among Patients With Hypertension Who Smoke. Trial. JAMA Netw Open. 2019 Mar 1;2(3):e190005.
6. Basu S, Narayanaswamy R. A Prediction Model for Uncontrolled Type 2 Diabetes Mellitus Incorporating Area-level Social Determinants of Health. Med Care. 2019 Aug;57(8):592-600.
7. Basu S, Sussman JB, Berkowitz SA, Hayward RA, Bertoni AG, Correa A, Mwasongwe S, Yudkin JS. Validation of Risk Equations for Complications of Type 2 Diabetes (RECODe) Using Individual Participant Data From Diverse Longitudinal Cohorts in the U.S. Diabetes Care. 2018 Mar;41(3):586-595.
8. Basu S, Sussman JB, Berkowitz SA, Hayward RA, Yudkin JS. Development and validation of Risk Equations for Complications Of type 2 Diabetes (RECODe) using individual participant data from randomised trials. Lancet Diabetes Endocrinol. 2017 Oct;5(10):788-798

Our Impact

Peer-reviewed results showing **high performance** for Waymark Signal algorithms

Predicting non-emergent ED and hospital visits to enable rapid action by our team

AUC/C-statistic (95% CI)	Accuracy (95% CI)	Positive Predictive Value (PPV) (95% CI)	Negative Predictive Value (NPV) (95% CI)
79.5% (78.1, 79.5)	90.4% (90.2, 90.7)	81.1% (77.5, 83.6)	90.5% (90.2, 90.8)

- **3x higher probability of predicting a non-emergent visit** ahead of time, compared to the next-best algorithm
- **90% accuracy** for predicting non-emergent ED and hospital visits for patients in Medicaid
- **Validated on data from 30.6 million patients** on Medicaid, nationwide, the largest such Medicaid-specific risk algorithm
- **Neutralized the Black-White prediction bias** (under-predicting Black health needs) in common cost-based risk models

Patel, S. et al. Predicting non-emergent acute care utilization among patients receiving Medicaid: a comparison of risk modeling approaches. Nature Scientific Reports' under review
Obermeyer, Z. et al. Dissecting racial bias in an algorithm used to manage the health of populations. Science; 366,447-453 (2019).

Our Impact

Provider activation and provider satisfaction in **WA** and **VA**

Practices representing >90% of patients identified by MCOs agree to partner with Waymark*

**ACO/CIN arrangements where agreement is needed, including providers with at least 1,000 eligible patients at the tax ID number level*

- Supporting ~50,000 patients in 2023
- Requires no technology integration for the practice
- Rapid onboarding to learn communication preferences

- **Provider Satisfaction Score = 100%**

"First time an external/3rd party care management vendor has been a clear value add for some of our patients."

“Very convenient, helpful, quick to respond. A great resource for our patients who need some extra help.”

“Has been great. The working relationship we have with each other has been a wonderful benefit for our patients, especially those who have trouble engaging in care.”

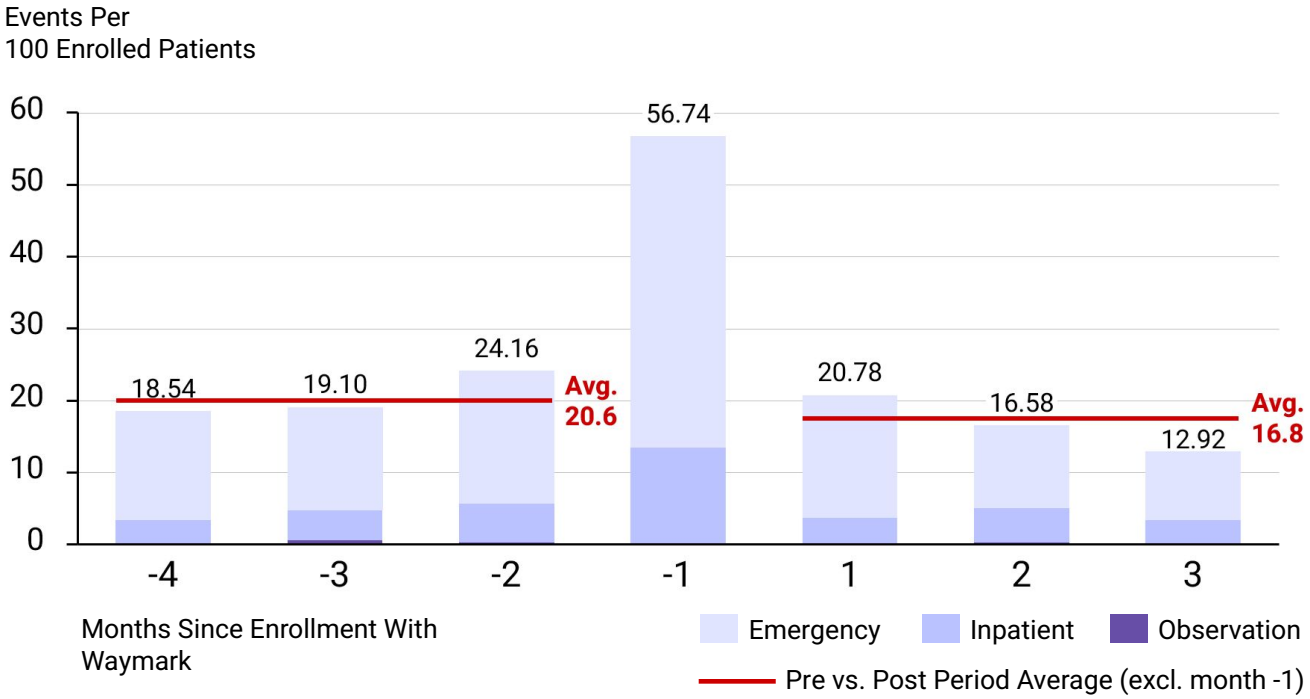
“I give Waymark a 5 [star] rating.”

“Seeing real support with addressing social determinant challenges as well as directly addressing healthcare maintenance opportunities.”

“Our patients appreciate the assistance they get from Waymark. They know people besides themselves care about their health just as much if not more than.”

Our Impact

Early results show ED visit and IP admission reductions for enrolled patients



8.8% reduction in inpatient admission rate

20.5% reduction in ED visit rate

22.1% reduction in avoidable acute event rate

Notes: Data through 10/4/2023. Number of avoidable ED visits or IP stays (including observation stays) is based on ADT feed data. Population includes 356 Waymark patients. Month -1 is excluded from pre vs post enrollment analysis as this month includes ED visits or IP stays (including observation stays) that were detected via CMT and triggered Waymark patient outreach and subsequent enrollment, meaning month -1 is higher in events but not due to patient or Waymark actions.

Maternity

Helping providers achieve reductions in maternal mortality

Claims-based outreach often stifled because claims can be bundled after delivery, delaying benefits of prenatal outreach

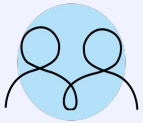
Very high rates of distrust in maternal care system, with doula support helpful but scattered in terms of training, staffing, and availability

The evidence-based program we deploy was found to reduce intensive care unit admission rates from 107.6 to 56.7 per 1000 births*

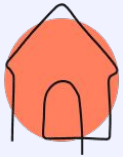
Stankaitis JA, Brill HR, Walker DM. Reduction in neonatal intensive care unit admission rates in a Medicaid managed care program. Am J Manag Care. 2005 Mar;11(3):166-72. PMID: 15786855.

Our approach:

We use Rx claims and community-level data to facilitate early prenatal period engagement



We incorporate components of the DONA international-level doula training into our CHW trainings, and support pediatric WCV and CIS gap closure



Our therapists deploy prenatal and postnatal depression, psychosis and substance use therapy including the Maternal Opioid Misuse (MOM) Model

Thank You

Please email me at rb@waymarkcare.com with any questions.