



# Partnering for Health: Enhancing Outcomes through Managed Care and PERS Provider Collaboration

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# Payor Challenges

- Claims Data is Insufficient
- Lack Real-Time Visibility into Home Care Needs
- Periodic Visits Miss Emerging Health Challenges
- Need for Real-Time Monitoring to Prevent Crises

# Where it Began



**Robert H.**  
Case Study

- 29 Dispatches (Mostly Related to ADLs & Falls)
- Only 1 Resulted in a Hospitalization
- Service Coordination Dispatched to Assess

# PA Health & Wellness Partnership

- PHW Launches Coordinated PERS-facilitated Care Model (PCM) in 2018
- PERS Devices Provide 24 / 7 Safety Net
- Real Time PERS Data Capture (Including call Reasons and Outcomes)



# Case Study: PERS-Facilitated Care Model (PCM)

## Challenge

Limited real-time visibility into members' changing in-home needs delays interventions, increasing safety risks, hospital use, and costs.

## Objective & Purpose

Use real-time PERS data to spot risks early, coordinate care, and reduce avoidable ED visits while supporting independent living.

- Centralize multi-source data for timely insights
- Enhance care coordination & proactive outreach

## Data & Method

- **Population:** 1,710 LTSS members with PERS (Jan 2023 – Jun 2024)
- **Groups:** 1,269 with PERS + PCM; 441 with PERS only
- **Risk Stratification:** Low, Medium, High



# Service Coordinator Insights

- ✓ PERS Reports Enable Timely Awareness In Between Check-Ins
- ✓ Succinct Reports Improve Efficiency and Response
- ✓ Program Supports Proactive Care and Member Safety

## Sample Reporting

| Event Date | Name   | ID    | Last Year | Last 90 days | Last 30 days | Reason | EMS Dispatch | Outcome          | Details                               |
|------------|--------|-------|-----------|--------------|--------------|--------|--------------|------------------|---------------------------------------|
| 9/1/24     | Doe, J | 11011 | 7 calls   | 2 calls      | 5 calls      | Fall   | Yes          | Assisted on site | Fell out of wheelchair, needs help up |
| 9/1/24     | Doe, L | 12341 | 4 calls   | 2 calls      | 2 calls      | Pain   | Yes          | Transported      | Severe head pain, vomiting            |



# Todd Levin

Chief Revenue Officer

**Connect America**

# Connect America Footprint

## The Four Pillars of Our Strategy

- 1** Partnership for faster, more efficient intervention to shorten time from detection to response
- 2** Standardization—one common language for data across systems
- 3** PCM—Strategic integration of PERS into the care model that drives better outcomes
- 4** Measuring impact to determine value

# Perspectives from Service Coordinators

## PERS: Critical Support When It Mattered Most

- Delivered rapid, life-saving help and uncovered urgent needs between visits
- Kept teams instantly aware of caseload priorities
- Turned key facts into clear, actionable reports

**“Without this program, critical needs in the home would remain invisible to us.”**

**“It keeps you up to date, so you know what’s happening and who needs extra support.”**

**“Every moment spent sifting is a moment lost for our members. Now we have actionable information.”**

# The PCM Model Results

**Population:** 1,710 LTSS members stratified into low, moderate, & high risk  
**Intervention Group:** PERS + PCM  
**Comparison Group:** PERS only

## Low-Risk Group

**PCM:** ↓ 15% ED visits  
↓ \$515 savings / person

**PERS-only:** ↑ 9% ED visits  
↑ \$212 cost increase / person

**PCM Net Difference: \$728 Savings**

## High-Risk Group

**PCM:** ↓ 4% ED visits  
↓ \$176 savings / person

**PERS-only:** ↑ 6% ED visits  
↑ \$248 cost increase / person

**Net difference: \$424 savings**

# Key Takeaways of Partnership

- ✓ Early Intervention Benefits **Everyone**
- ✓ Standardized PERS Data Enables Predictive Analytics & Proactive Care
- ✓ Payor-PERS Partnership Drives Scalable Person-Centered LTSS Care



# Thank You

