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The Most Powerful Name in Corporate News

Web-Based Care Coordination Software for Clinical Outcome Improvement

About Equicare Health Inc.
Equicare Health is the industry's leading provider of care coordination software that improves clinical outcomes for patients, and enables care providers to operate more effectively. Equicare's solution, EQUICARE CS™, includes functionality for patient navigation, long-term follow-up and patient engagement. EQUICARE CS™ is a web-based healthcare solution that supports patients throughout the care continuum, and is used in hospitals and care centers throughout the world**.**

Interview conducted by: Lynn Fosse, Senior Editor, CEOCFO Magazine

CEOCFO: *Mr. Grenier, what is the concept for Equicare Health?*
Mr. Grenier: The underlying idea behind Equicare was taking an approach or methodology, called case management, which is mostly used in North America in the hospital industry to manage length of stay and keep it as short as possible. We take that basic methodology and apply it to managing patients with one or more chronic diseases; specifically chronic diseases in which you can improve both clinical and financial outcomes by managing the patient effectively, rather than just treating them and turning them loose into the wild.

CEOCFO: *Is that still where you are today?*
Mr. Grenier: Yes. As a small, growing company, we decided to identify an initial vertical to work in, build some success in that vertical and then move into other chronic diseases. Therefore, we decided that we would apply our methodology, initially, in dealing with cancer patients. The very first incarnation of the product was targeted purely at the survivorship phase; managing surveillance, inaudible and education for patients once they were at or very near the end of treatment and then managing them through the subsequent multiyear surveillance process. We later extended that to start at the beginning of the process and we now have a tool set that supports patient navigation, providing education and follow up from the point where a patient presents with a positive screen result, whether that is a positive screen on a screening mammogram or perhaps a colorectal screen, or now lung screening. We provide facilities with the tool set to manage the patient through this very complex and confusing time. We begin helping when someone says "You may have a problem," and then manage them through the process of getting the initial diagnostic work up and then finding out if indeed there is something they need to be concerned about. If there is, then we manage them through the process of understanding what their treatment options are, making a treatment decision and them continue to provide them with appropriate educational material and support through treatment and then into long term surveillance.

CEOCFO: *Have similar programs been tried?*
Mr. Grenier: Interestingly, not in oncology. In Europe, a couple of years ago, there was a special edition of the European Journal of Heart Failure and they looked at a very similar thing, using nurse lead clinics to manage patients with congestive heart failure post treatment. They did a multi site trial. The control group of patients was treated as they would normally be and then turned loose. The trial group of patients was treated and then they were followed on a routine basis by a nurse. They were able to reduce the rate of readmissions, depending on the site, by between thirty and forty five percent. Therefore, one of the things that we are currently working to do is identify customers in our installed base that are willing to do some of the long term academic work with us to see if we can actually validate this for oncology in North America. The consensus is clinically, this is absolutely the right thing to do. However, we still need a great deal of really good research on demonstrating the overall clinical and financial impact over a multiyear period.

CEOCFO: *I would think it is intuitive that it would work. Do most people understand?*
Mr. Grenier: Yes. People look at it and say, "Yes, that makes sense." It is intuitively obvious that it is a good thing to do. The other thing that somewhat preempts that discussion is that the Commission on Cancer, in their 2015 audit cycle, is mandating that all of their accredited facilities provide a navigation program, the ability to do psycho social distress assessments and the ability to create survivorship care plans with follow up and education for all of their new analytic cases. So not only is it intuitive, but it will soon be mandatory for certain accreditation standards.

CEOCFO: *Would you tell us how the process works?*
Mr. Grenier: Let us look at a couple of different entry points. If a facility has a screening program, what would happen is, typically a nurse would end up with an item and work list that says, "Mr. Jones has a positive screen and needs to be followed up with." That would be coming out of an appropriate reporting system; whether it was a radiology information

system or in the case of mammography, one of the mammography reporting systems. At that point, what you would know about the patient is basic demographics, plus the amount of positive screening. Best practices would say that once it turns up in this work list, then the nurse would, contact the patient, ideally within twenty four hours of that result being available, and then say, "We are concerned about your results and in order to resolve this you need the following." Then the nurse would have a series of diagnostic procedures scheduled, which are appropriate to the disease type. They would then work with the patient to get those schedules, make sure the appropriate referrals were in place and then provide the patient with all of the typically relevant educational information. For example, if the procedure happened to be a diagnostic mammogram, as opposed to a screening, they would give them some educational material on what that is. If it is a biopsy, then they would be giving them information on what type of biopsy it is, exactly what is involved, what the aftermath is like and how quickly they could expect results. The person doing this in the background is being supported by a sophisticated electronic tool set, to be sure that they do not miss any steps and that no patients fall through the cracks. Once the patient has been through the diagnostic process, typically best practices would say that their case would be discussed at a multi disciplinary committee (also known as Tumor Board). That would occur if the patient had a positive diagnosis. Then they would be deciding on the optimal treatment for that patient and presenting the patient with a decision that has to be made between the different alternatives. At that point the navigator would be making sure that the patient has relevant information on what they have got, as well as information on the different treatment alternatives and what the side effects and light effects are, that are associated with each, as well as the probabilities and success. As you can see, there is a theme emerging, which is providing patients with the information and support they need for the specific spot that they are in. Once they are in treatment, typically the treatment part is being managed either by their oncologist, the therapist. However, the navigator will be dealing with all of the other non-clinical issues; things like transportation, financial issues, or distress that they might be encountering. The focus is on trying to keep the patient as healthy as possible as they go through the process. As they get near the end of treatment a survivorship nurse, could be a practitioner or a PA, would sit with them and review their treatment summary to that point and would give them some education on what they can expect for both short term effects and then late effects. They would work with them to put together a follow up surveillance plan based on the NCCN guidelines. That would be based on the disease type, site and the kinds of treatment the patient has had. That would lay out the road map for surveillance for the next four or five years.

"We take that basic methodology and apply it to managing patients with one or more chronic diseases; specifically chronic diseases in which you can improve both clinical and financial outcomes by managing the patient effectively, rather than just treating them and turning them loose into the wild." - Len Grenier

CEOCFO: ***Typically, would an organization use this for all of their patients who fit into a category such as their oncology patients or might they pick and choose? What are the implementations like?***
Mr. Grenier: Prior to the COC publishing their most recent set of guidelines there was a wide range of behavior. We would see people that were implementing it for everyone and people that were saying, "We are just going to follow our high risk breast patients," Now, the guidance from the Commission on Cancer is to follow all of the new analytic cases. Therefore, I think we are going to start to see more consistency in what clinical practice is.

CEOCFO: ***As your system has been in use, what are some of the changes or tweaks that you have made? What have you learned from the concept to utilization?***
Mr. Grenier: One of the big things was that if you are only dealing with the survivorship end of the spectrum you are missing out on a whole bunch of people on the front end. Therefore, one of the biggest changes that we made was implementing the whole navigation tool set, which enables us to follow patients right from screening. We also decided to enter into a licensing agreement with the NCCN, so we are providing their industry best follow up guidelines to our customers. Probably the most recent change is much more sophistication on questionnaire component.

CEOCFO: ***Would you give us an example?***
Mr. Grenier: A great example of questionnaire is a stress or toxicity assessment. There is a great deal of research that shows that if a physician asks a patient questions that are designed to elicit information about their toxicity level, the information that they get and the conclusions about the level of toxicity are quite different if it is a physician face to face asking a patient questions or of the patient is sitting at a computer screen in private answering the questions. In the patient reported circumstance, they get much better quality data. Therefore, "patient reported outcomes" is one of the current hot areas that people are working on. We support collecting that information and pushing it back into the oncology information system, whether for example inaudible, to help the treating physician make the appropriate decisions about that. Another big one would be distress assessments or quality of life questionnaires. When a patient fills in one of these questionnaires, they are scored in real time. Depending on their score the patient gets immediate feedback in a message. If the score is very benign they get a message that is the facilities choice, but it is typically something like, "Thank you for doing this. This is an important part of keeping your health record up to date." If, on the other hand, the score shows that the patient is in acute distress, then the patient will get a message that says, "You should contact your care provider

immediately and book an appointment." However, on the back end, the care coordinator that is responsible for that patient gets an alert in their work list, that not only indicates that the patient has completed the questionnaire, but it is red flagged to indicate that some intervention is needed immediately. Our tool sets provide a dashboard that may show, for example "Yesterday forty two patients did questionnaires and there are three that you absolutely must deal with right now."

CEOCFO: ***Is there a common thread among the organizations that have implemented your service, such as size, geography or mindset?***
Mr. Grenier: Comprehensive cancer centers would tend to be in the majority of our customers. That is because much of the value we bring is in helping manage the patient through complex healthcare processes, and comprehensive centers have the most to gain from process management. Typically COC or the NCI has a couple of community programs that they are working with. There is an NCI designation for Community Cancer Center that does that special certification in breast cancer treatment, for example. COC accredited sites tend to be the most frequent users of our products; we're not as prominent yet with academic medical centers, but we are starting to work with a couple of them now. That is because they tend to be under less staff pressure than the community cancer centers. The community cancer centers tend to be more dependent on trying to use automation to reduce some of that staff pressure and still do everything that they need to.

CEOCFO: ***A couple of months back you announced an agreement with Iron Medical Systems. Would you tell us about that? Would that be typical for you or an area that you would like to do more of going forward?***
Mr. Grenier: We are seeing customers get more and more comfortable with not having everything bolted to the floor in their data center. Therefore, today we offer three deployment options. If a customer chooses, they can buy hardware from us, in which case we will install VMware and a couple of virtual machines and ship it to them and they can bolt it in their data center. Alternatively, if they already have a VM farm, we can just send them those same VMs. They can install them in their own VM farm and proceed that way. Thirdly, we can take those same VMs and we can park them out at Iron Medical and let them have a hosted solution. Where the hosted option is getting more and more popular is with facilities that have made an intentional decision to move away from having new in house IT systems and smaller practices where they do not have the depth of IT resource. You might see a small community practice where the IT guy is the doctor's brother, Bob. It does span the gamut from larger multi site facilities that have decided that the economics favor hosting and smaller sites where you either do not have or do not wish to commit additional resources to being able to manage all of that IT infrastructure themselves.

CEOCFO: ***How is business these days?***
Mr. Grenier: Good! It is actually, definitely improving! While meaningful use has absolutely helped drive the sales of a subset of our product, what we call the Active Patient Portal, which is being used by one of the major OIS vendors for Phase I to Phase II compliance; it in some sense has muddied the waters. That is because hospital administrators are typically under such pressure that they tend to be focused on what the problem is today and tomorrow, as opposed to the one next week. Now that some of the dust is settling around MU2 and the beginnings of the CoC 2015 audits cycle are looming, it is driving much more interest in the core product, EQUICARE CS, which includes all of the navigation and survivorship functionality we discussed.

CEOCFO: ***What might Equicare Health be like a year or two from now?***
Mr. Grenier: I think you will see us in many more locations. Varian Medical Systems has been a pretty good partner for us. They have sold about one hundred and sixty to one hundred and seventy systems and we have implemented about ninety so far. Probably the biggest difference is that we have been developing our own direct sales organization that is working in parallel with our channel partner. We started that process last September with the recruitment of Margaret Nash, a well known senior sales executive with many years of experience of oncology. Margaret has grown her team to the point where we now have, as of July 1st, five direct sales folks covering North America. I think that because that allows us to have a much more direct relationship with the customer, what we are going to see are certainly many more sites, but also what we are also seeing is sites that interested in actively engaging with us and doing research into survivorship and navigation, bringing a lot more visibility to the clinical and financial benefits to these tools. One of the things that we are now starting to browse for is an existing or potential site that is going to work with us on starting to move into other adjacent verticals, with other chronic conditions.

BIO: A long time entrepreneur, Len Grenier was a co-founder of ALI in 1986 and a Director for the early development of the company. He held the senior technical role from inception of the company through its acquisition in July 2002 by McKesson Inc. Len's most recent role at ALI was Senior Vice President of Engineering and Chief Technology Officer. As well, his responsibilities included Inbound Product Management and Regulatory Affairs. Mr. Grenier brings a wealth of experience in the development of medical software companies providing multi-facility integrated solutions in a regulated environment. Len assumed the role of President and CEO of Equicare Health in April 2006.

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