Deon Health

William Penn Human Services

Partnering for Better Health Outcomes

Integrated Care Management for Individuals with Intellectual Disabilities & Autism

4×

Higher risk of costly health events

30%

Preventable hospitalizations

16%

ID/A adults with diabetes vs 7% general

Today's Discussion

01

About Deon Health

Who we are, our mission, and what makes our model different for the ID/A population

02

The Health Outcome Challenge

Why individuals with ID/A face disproportionate health risks and how the current system fails them

03

How We Partner with Providers

Our provider-first approach, shared savings model, and how WPHS fits into our care ecosystem

04

Our Integrated Care Model

Clinical care management, service navigation, and the multidisciplinary team driving better outcomes

05

Health Outcomes Focus

The metrics that matter: hospital avoidance, preventive care, chronic disease management, quality of life

ABOUT

Deon Health

Deon Health is a Community Supported Care Organization: a provider-aligned managed care model purpose-built for individuals with intellectual and developmental disabilities (ID/A).

We sit at the intersection of managed care and community-based care, holding financial accountability for outcomes while preserving the relationships and providers that individuals trust.

Our Mission

Better health outcomes for individuals with ID/A through integrated, community-centered care.

Provider-Aligned Model

We are built with and for ID/A providers, not imposed on them. WPHS and organizations like them are core partners, not just vendors in our network.

Managed Care Accountability

We hold total cost of care accountability across Medicaid (HCBS & ICF), physical health, behavioral health, and Medicare while delivering coordinated value across systems.

Community-Based First

Our care management model extends the reach of existing community supports, such as DSPs, service navigators, and families, rather than replacing them.

Outcome-Driven Incentives

Shared savings flow back to providers who deliver quality care. We align financial incentives with what actually improves people's lives.

The Health Outcome Challenge

Individuals with ID/A face disproportionate health risks — and the current system is not equipped to address them.

4×

More likely to incur high annual health costs

16%

ID/A adults with diabetes diagnosis vs 7.2% of general population

3×

More likely to have a UTI vs. those without ID/A

30%

Of hospital admissions for ID/A are preventable

Why the Current System Falls Short

Fragmented Across Systems

Care spans Medicaid, Medicare, education, and ID/A systems, each with different rules and funding streams, creating coordination gaps.

Reactive, Not Preventive

The current system responds to crises rather than preventing them. Individuals with ID/A consistently experience avoidable acute events.

Insufficient Provider Support

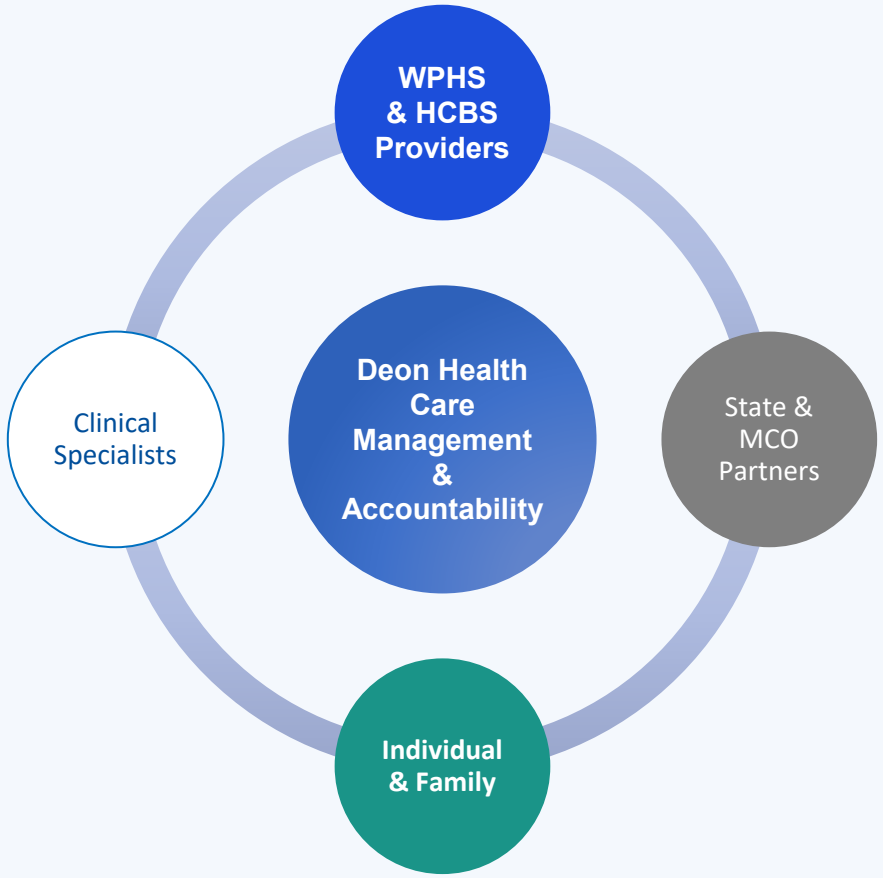
ID/A providers are poorly reimbursed, under-resourced, and excluded from integrated care decisions.

Sources: American Journal of Public Health; National Institutes of Health; Commonwealth Fund — ID/A Health Outcomes Research

How We Partner with Providers

A provider-first model designed to amplify what WPHS and community organizations already do well.

The Partnership Structure



Savings flow back to ID/A Providers

You Stay Central

WPHS and HCBS providers remain the primary relationship with individuals. Deon adds clinical care management and financial infrastructure — not bureaucratic oversight.

Shared Savings, Shared Upside

When better care management reduces avoidable costs, savings are shared back with providers who deliver quality services. Your excellence is financially recognized.

DSPs as Care Extenders

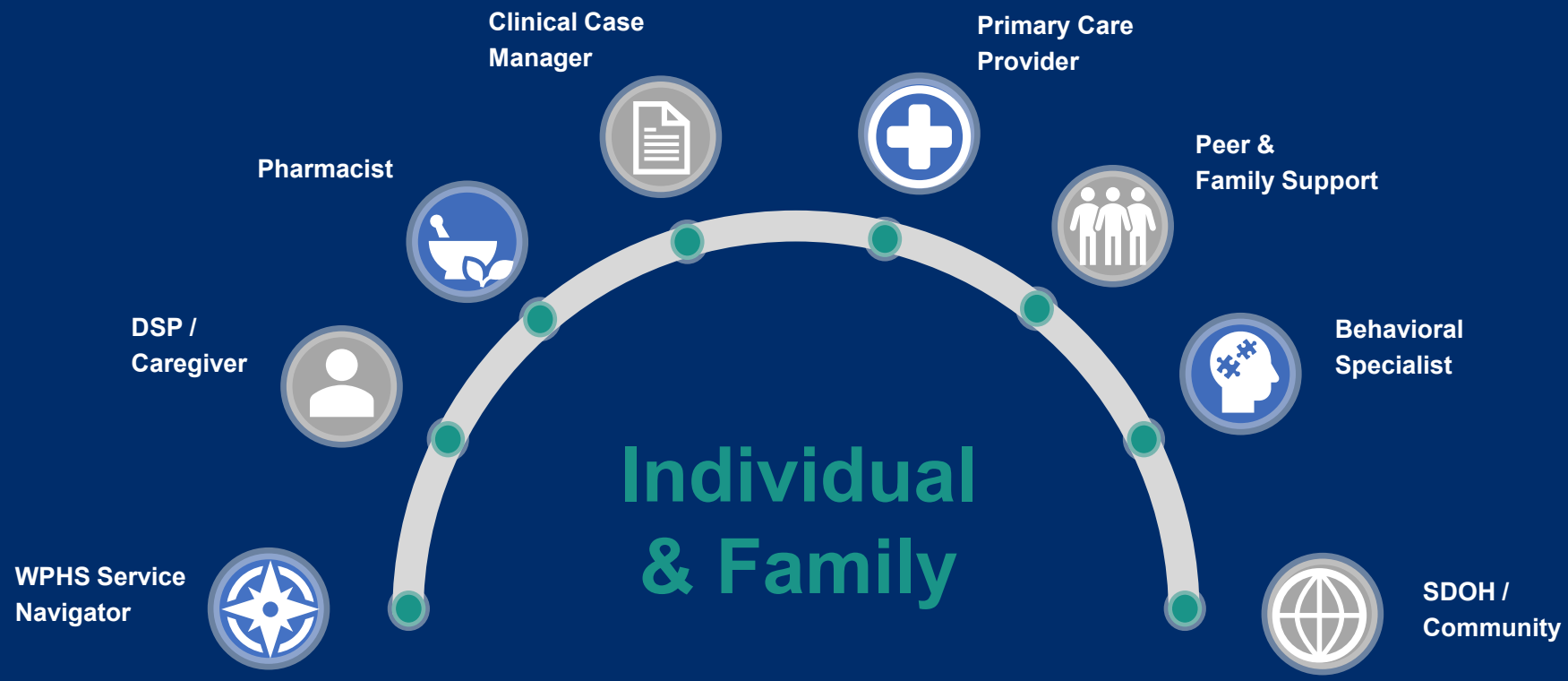
Direct support professionals — your workforce — are integrated into the care model as clinical extenders. They are supported, trained, and valued as health team members.

Data to Drive Better Care

We provide WPHS with real-time population health data, helping you identify at-risk individuals earlier and intervene before costly acute events occur.

Integrated Care Management Model

A multidisciplinary team approach placing the individual and family at the center, with health outcomes as the measure of success.



Outcome: Fewer hospitalizations · Better chronic disease management · Higher quality of life · Lower total cost of care

Health Outcomes: What We Measure and Why It Matters

For individuals with ID/A, the right care coordination produces measurable, meaningful health improvements.

Preventive Care

78% → 89%

Primary care completion rate

Proactive primary care, dental visits, and preventive screenings, which are the foundation of keeping individuals healthy and out of the ER.

Chronic Disease Management

30%↓

Reduction in avoidable hospitalizations

Coordinated management of diabetes, hypertension, epilepsy, and behavioral health conditions that disproportionately affect the ID/A population.

Hospital Avoidance

4×

Higher baseline risk vs. general population

Crisis prevention through early identification, care escalation protocols, and DSP-integrated monitoring stops emergencies before they happen.

Behavioral Health Integration

61% → 72%

Dental visit completion

Integrated behavioral health support reduces psychiatric crises and out-of-home placements, keeping individuals in their communities.

Quality of Life

91.9%

BMI monitoring compliance

Employment, community participation, housing stability, and social connection are outcomes that matter to individuals and families, not just actuaries.

Total Cost Reduction

~10%

When health outcomes improve, total cost of care decreases. Savings are reinvested in better provider rates, workforce support, and expanded services.

Data from Easterseals pilot evaluated by HMA (March 2025) and American Journal of Public Health

William Penn Human Services

WPHS' Quality-First Data-Informed Strategy

01

Community Supported Care Model

A team-based, person-centered approach to simplify access to services and resolve barriers for individuals with intellectual disabilities and autism.

02

Comprehensive Provider Network

Ensure a comprehensive and effective network by expanding provider options, enhancing relationships, and using performance metrics.

03

Person-Centered Outcomes

Our commitment to prioritize individual needs and preferences, tailoring care to enhance personal satisfaction. WPHS aligns initiatives to boost overall quality of life and care effectiveness.

04

Data-Informed Decision Making

Uses comprehensive data and WPHS-developed quality indicators to guide decisions, measure effectiveness, and drive improvements, ensuring interventions are evidence-based and meaningful for the I/DD population.

05

Outcome-Based Payment Structure

A payment model that ties provider compensation to the achievement of quality outcomes, ensuring alignment with performance goals.

Service Navigation Overview

Service navigation is an individual and family centered, team-based approach that facilitates access to needed services, resolves barriers and helps people with intellectual disabilities/autism and families navigate effectively and efficiently through multiple and complicated systems such as Medicaid home and community waiver services and health care services, including in-patient and out-patient hospital care, primary and specialized care, dental and behavioral health care, and social services.

Support Coordination

Basic Functions: [2]

- Locating needed services and providers
- Coordinating, development and on-going
- Monitoring and assessing a person's health, safety, and well-being

Duties: [2]

- Facilitate meetings to ensure the ISP is working and person's desired outcomes occur
- Discuss needs and update ISPs as needs change
- Explain waiver services and budget caps
- Conduct face to face and/or virtual monitoring determined by waiver enrollment
- Assist with identifying services provided by waiver and base funding
- Informing/education families on activities to participate in, such as IM4Q

Footnote 2: From the PA Office of Developmental Programs

Service Navigation

Core Functions: [3]

- Be the link between Medicaid home and community-based waiver, health care and social service providers
- Locate, coordinate and monitor services and remove barriers that prevent access to services
- Support individuals to ensure their desires are discovered and reflected in their Person-Centered Plan and integrated into their supports
- Advocate with individuals and families for needed services
- Promote self-determination of individuals with ID/A

Responsibilities: [3]

- Is knowledgeable about and supportive of each individual on their caseload
- Provides information and educates individuals and families about services
- Works with individuals to create person centered support teams
- Assists individuals to lead person centered planning meetings and ensures the person/family is at the center of decision making
- Arranges/schedules assessments as needed
- Ensures that authorizations for services are completed
- Continuously meets with the individual/ family/ providers (in person and/or virtual) and monitors waiver, physical health, behavioral health and social services provided to a person to ensure they are meeting the person's needs and the person//family are satisfied with the outcome of the services
- Advocates with the person/family when services are not provided/denied/terminated to remove barriers to accessing the services

Footnote 3: From William Penn Human Services

Elements of WPHS Quality Framework

Our framework integrates diverse quality standards, while meeting ODP Performance Contracting standards and incorporates Centers for Medicare and Medicaid Services Home and Community Based Services Quality Measures and Final Rule Standards, ensuring a comprehensive and integrated approach to service delivery.

Prioritization of Quality

01

Unlike many organizations that may adopt a more traditional, compliance-focused approach, WPHS places quality at the core of its strategy. This commitment ensures that quality is not just a metric but a guiding principle in all decision-making processes.

Person-Centered Orientation

02

The strategy emphasizes person-centered planning and satisfaction, ensuring that care and services are tailored to individual needs and preferences. This focus on personalization enhances the overall participant experience and outcomes.

Performance Metrics

03

WPHS goes beyond basic performance metrics by incorporating both Performance Based Contracting criteria and the Centers for Medicare and Medicaid Services Home and Community Based Services Quality Measures Set. This dual focus not only meets regulatory requirements but also aligns with best practices and emerging standards in quality care.

Data-Driven Decisions

04

WPHS integrates comprehensive data analysis into its quality management practices. By leveraging detailed data insights, WPHS can proactively identify areas for improvement, tailor interventions, and make informed decisions that enhance care and operational efficiency.

Continuous Improvement Focus

05

WPHS's approach fosters a culture of continuous improvement by regularly reviewing and adapting strategies based on data-driven insights. This dynamic process allows WPHS to stay ahead of industry trends and maintain high standards of care and service delivery.

Quality as a Differentiator

WPHS differentiates itself in quality through:

1. **Quality-First Approach:** Prioritizes quality in every decision, ensuring that all initiatives focus on enhancing participant outcomes and satisfaction.
2. **Innovative Quality Indicators:** Develops I/DD-specific quality indicators that address unique needs, driving targeted improvements in care and service delivery.
3. **Comprehensive Data Utilization:** Employs robust data analysis and quality indicators to inform decisions, identify trends, and ensure that interventions are evidence-based and relevant.
4. **Outcome-Based Payment Structure:** Aligns provider compensation with achieving quality outcomes, reinforcing a commitment to high standards of care.
5. **Holistic Service Model:** Integrates person-centered care with a comprehensive provider network and service navigation to ensure all aspects of care are tailored to individual needs and preferences.
6. **Community Supported Care Model:** Fosters community involvement and support, enhancing the overall effectiveness and reach of services.

Why This Partnership Works

What Deon Health Brings

- Managed care infrastructure and financial accountability
- Total cost of care management across Medicaid + Medicare
- Clinical care management team and protocols
- Population health data analytics and reporting
- Shared savings financial model rewarding quality
- Regulatory navigation and MCO partnership relationships

What WPHS Brings

- Decades of trusted relationships with individuals & families
- Comprehensive HCBS service delivery infrastructure
- Service navigation expertise and community knowledge
- Trained direct support professional (DSP) workforce
- Quality-first organizational culture and accountability
- Network of provider relationships across the region

Deon brings managed care infrastructure. WPHS brings community trust and service expertise. Together, we close the gap.

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Building the Future of ID/A Care Together

The vision is straightforward: individuals with ID/A deserve the same quality of integrated, proactive healthcare that everyone else receives. With WPHS as a partner, we have the community trust, service expertise, and shared commitment to outcomes to make that vision real.