ACO Showdown

July 1, 2025

2:00 pm to 3:00 pm ET

Housekeeping Items

- We request that participants be on camera only when presenting or asking contestants questions regarding their presentations.
- Audience, please place you about the product and innovation in the chat and the moderator will ask the contestants after their presentation is completed.
- Questions are not only welcomed, but they are also imperative to enhance everyone's experience, so don’t be shy.
- When it is time to vote after all presentations are completed, a survey will be launched allowing ample time for everyone to cast their vote.

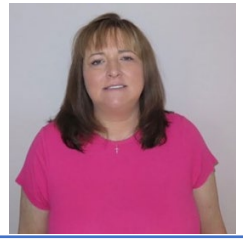
Thank you!

Scan to explore solutions built for value-based success.

Let's continue the conversation.

innovaccer.com

Speakers

	Jason Kemmer SVP, Commercialization Ventricle Health
	Jenny Gonnerman Director of Clinical Operations, Alternative Payment Models PSW & NW Momentum Health Partners ACO
	Joe Huang, MD MBA Medical Director Physicians of Southwest Washington (PSW) and MultiCare Connected Care
	Dawn Setting, BSN, RN CCM Manager of Care Management CareVio

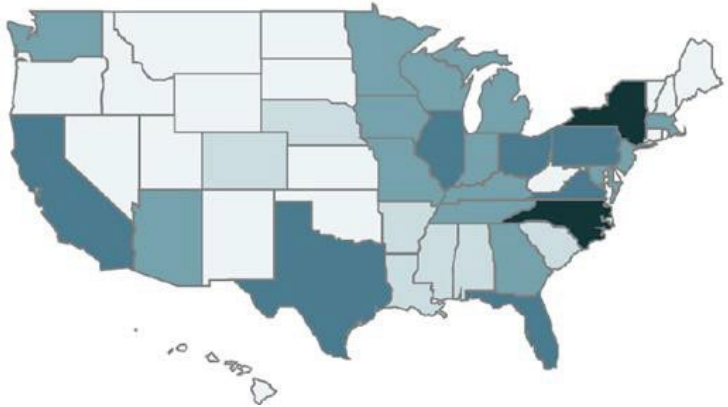
Ventricle health

NAACOs

July 1, 2025

Ventricle Overview

Virtual Heart Failure Clinic with 2000+ cardiologists at-the-ready nationwide



Cardiologists see patients every 2 weeks to titrate GDMT + diuretics

Weekly Nurse check-ins
24/7 call line / triage support
RPM monitoring

Pharmacy technicians provide grants and financial assistance

ventricle health

Aligning care with evidence-based medicine

Standard care	Ventricle Health
1% on medical guideline dosage	82% on medical guideline dosage
27% 30-day readmissions	7% 30-day readmissions

Bringing parity to underserved populations

1 cardiology visit over 4-months	**8** cardiology visits over 4-months
1-4 month wait time	**5-12** days

Real Cost Savings, Fast

$10,000-$20,000 savings in 4-months

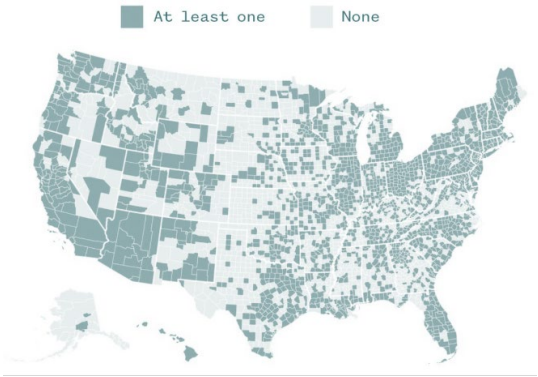
Case-rate guarantees minimum 1:1 ROI

Solving to Meet the Unmet Heart Failure Needs in the Market

Why Can't We Get Patients on GDMT?

Today's medical networks are **not optimized** for…

…cardiologists to provide equitable geographic coverage



86% of U.S. rural counties have no cardiologist.
Nearly half of **ALL** counties lack a cardiologist.

…rapid access that makes a difference

32+ day wait time for 1st visit

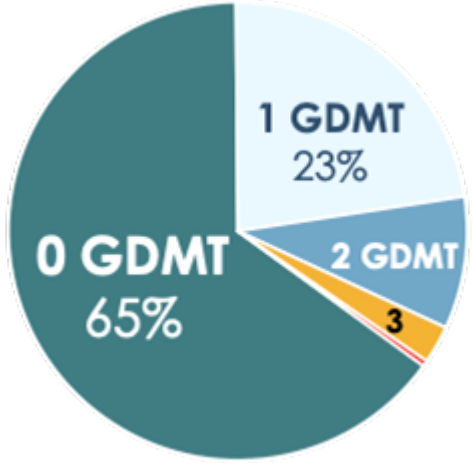
1 cardiologist visit per 4-months

30%+ 1-year mortality

For Cardiac Populations … Zip Codes Matter

An examination of Medicare FFS data in NC (2022-23)

% of New HF population on GDMT within 60 days

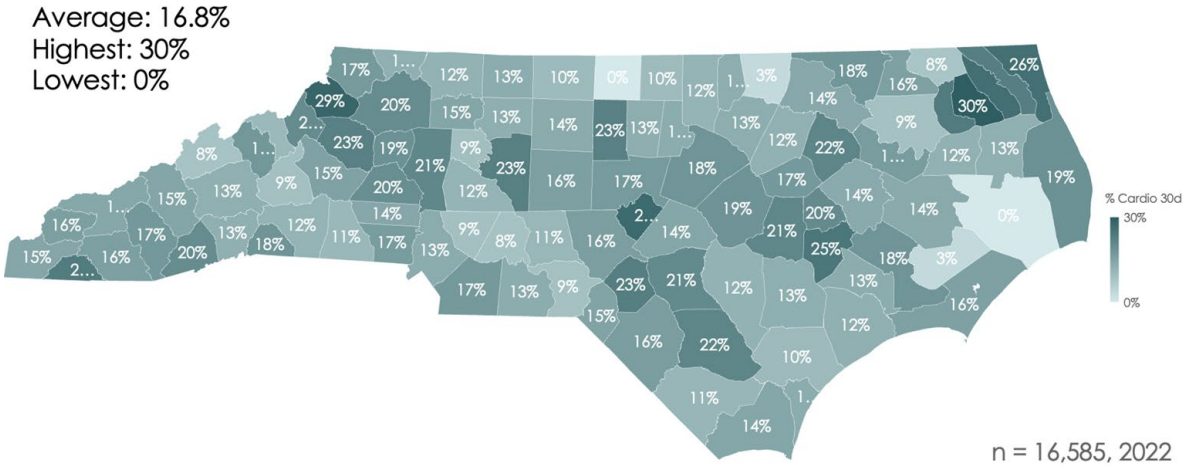


Out of 17,000+ :

65% are on ZERO GDMT

Less than 1% are on all 4

In North Carolina, less than 1 in 5 patients saw a cardiologist in 30 days after a new HF Dx



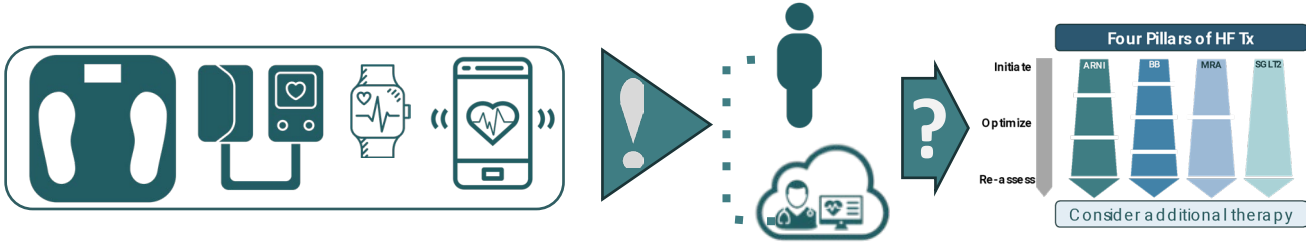
Patients on 4 GDMT have a 1-year mortality rate 78% lower than those on 0

Built to address challenges seen in other RPM HF models

RPM Alone

or

RPM-Enabled Decision Support Alerts



Studies have shown the limited impact of these approaches…

- Telemonitor + texting after hHF → no reduction in BNP, hHF or CVD (MESSAGE-HF)
- RPM+ Outpatient EMR nudges → increase in GDMT *but* no reduction in ER visits or hHF (PROMPT-HF)
- RPM + care (+ diuretics) vs RPM guidance only → Max GDMT 82% vs 54% -> 45%↓ hHF (MEDLY-TITRATE)

VH performs 60% better in All-cause and HF readmissions compared to usual care across all time frames

		Ventricle Health	Benchmark "Usual Care"	VH Improvement to Usual Care
30-day Readmission Rate (N = 173)	All-Cause	**6.9%**	**24.7%**	**72%**
	HF (Primary Dx)	**2.9%**	**8.7%**	**67%**
90-day Readmission Rate (N = 98)	All-Cause	**17.3%**	**31.6%**	**45%**
	HF (Primary Dx)	**6.1%**	**17.7%**	**66%**

All-cause: Readmissions while activated in VH program. Does not include ER/ED visits, observations, or planned admits. Patients with multiple admits are only counted once.
HF (Primary Dx): DRG 291 - 293 or any DRG where Heart Failure is the primary diagnosis
Benchmark: Medicare data on Primary HF Discharges that were readmitted for any reason (all-cause) or with Primary Dx HF. Blended across states for corresponding N

Innovating in Actuarial Analysis

Humbi enabled us to quickly and affordably deploy a full-stack actuarial and analytics platform

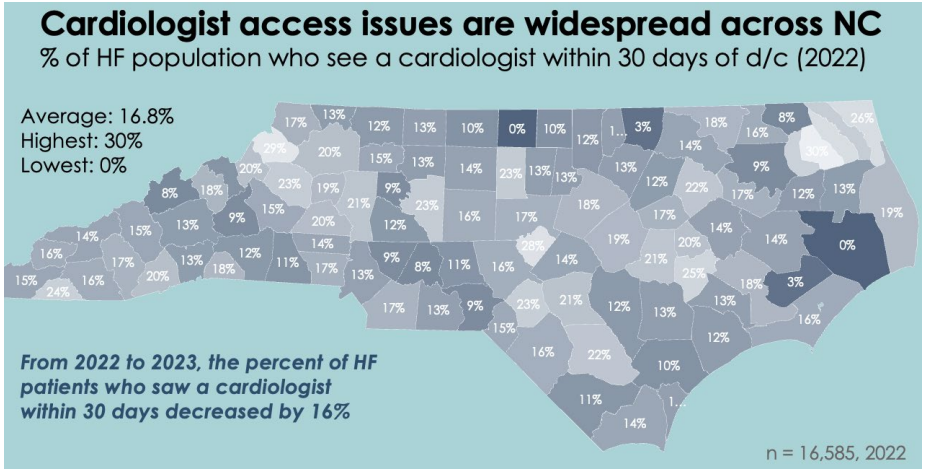
Ventricle's Actuarial Needs	Humbi's (Innovaccer) Innovation
Differentiate outcomes IP vs. OP place of service	Analysis focused on costs, timing, and outcomes related to place of diagnosis so we could **target populations**.
"Usual Care vs. EBM"	Identified the **quality and cost opportunities/gaps** in how heart failure care is delivered today vs. how Ventricle's **evidence-based treatment model.**
Geographic and Line of Business Targeting	Identified the highest **opportunity counties and LOBs** (ACO Reach, CKCC, MSSP, Commercial, etc) based on combinations of member engagement, quality and cost, population, Dx Rate, and other stratified factors.
Confidence to Develop a Unique Pricing Model	Innovative pricing **case rate** monthly on those patients we treat, with **1:1 guarantee**. Meaning if we don't save at least the case rate, we pay back the delta.

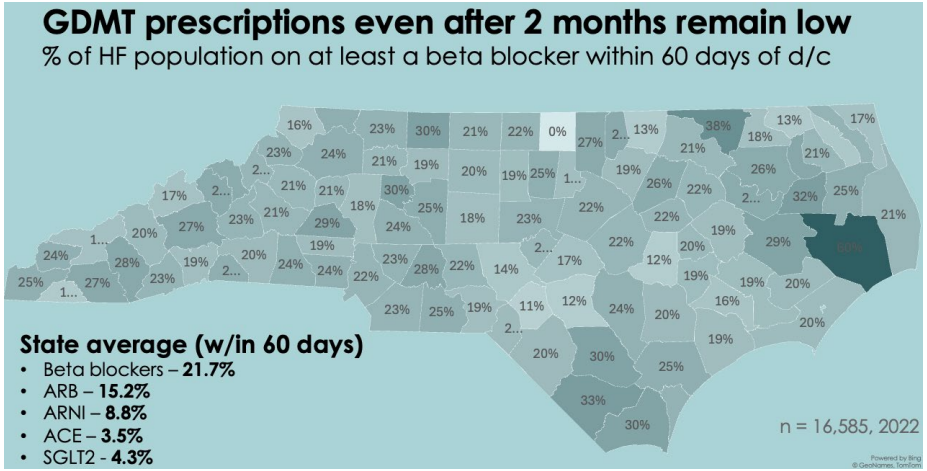
Differentiate outcomes IP vs. OP place of service

“Usual Care vs. EBM”

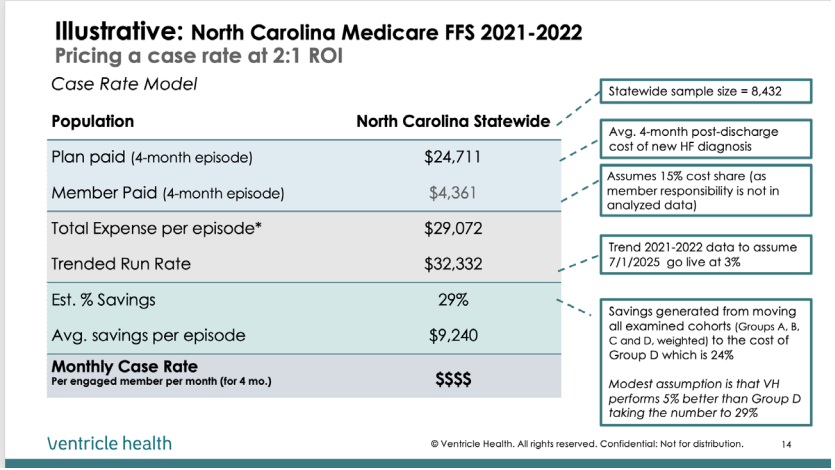
N = 16,437 new HF patients in NC 2023, Medicare FFS

Geographic Targeting





Confidence to Develop a Unique Pricing Model



Illustrative: North Carolina Medicare FFS 2021-2022
Pricing a case rate at 2:1 ROI

Case Rate Model

Population	North Carolina Statewide
Plan paid (4-month episode)	$24,711
Member Paid (4-month episode)	$4,361
Total Expense per episode*	$29,072
Trended Run Rate	$32,332
Est. % Savings	29%
Avg. savings per episode	$9,240
Monthly Case Rate Per engaged member per month (for 4 mo.)	$$$$

Statewide sample size = 8,432

Avg. 4-month post-discharge cost of new HF diagnosis

Assumes 15% cost share (as member responsibility is not in analyzed data)

Trend 2021-2022 data to assume 7/1/2025 go live at 3%

Savings generated from moving all examined cohorts (Groups A, B, C and D, weighted) to the cost of Group D which is 24%

Modest assumption is that VH performs 5% better than Group D taking the number to 29%

ventricle health

 14

2:1 Return on investment with a 1:1 Guarantee on our Monthly Case Rate

PSW
a population health company

Using Technology to Drive Outcomes Through Care Transitions

Joe Huang, MD, MBA
Medical Director

Jenny Gonnerman PT, DPT
Director of Clinical Operations

WHO WE ARE

PSW
a population health company

- An early adopter of value-based care, PSW was founded by independent physicians to ensure the patient-physician relationship remains central.
- Our 30 years of experience provides an integrative approach to value-based care.
- Delivering full-service solutions aligned with strategic and operational needs.

SOLUTIONS THAT FIT

PSW
a population health company

Delegated Services

Suite of capabilities to support risk and non-risk payor arrangements that will delegate all or a portion of operations required to manage a population

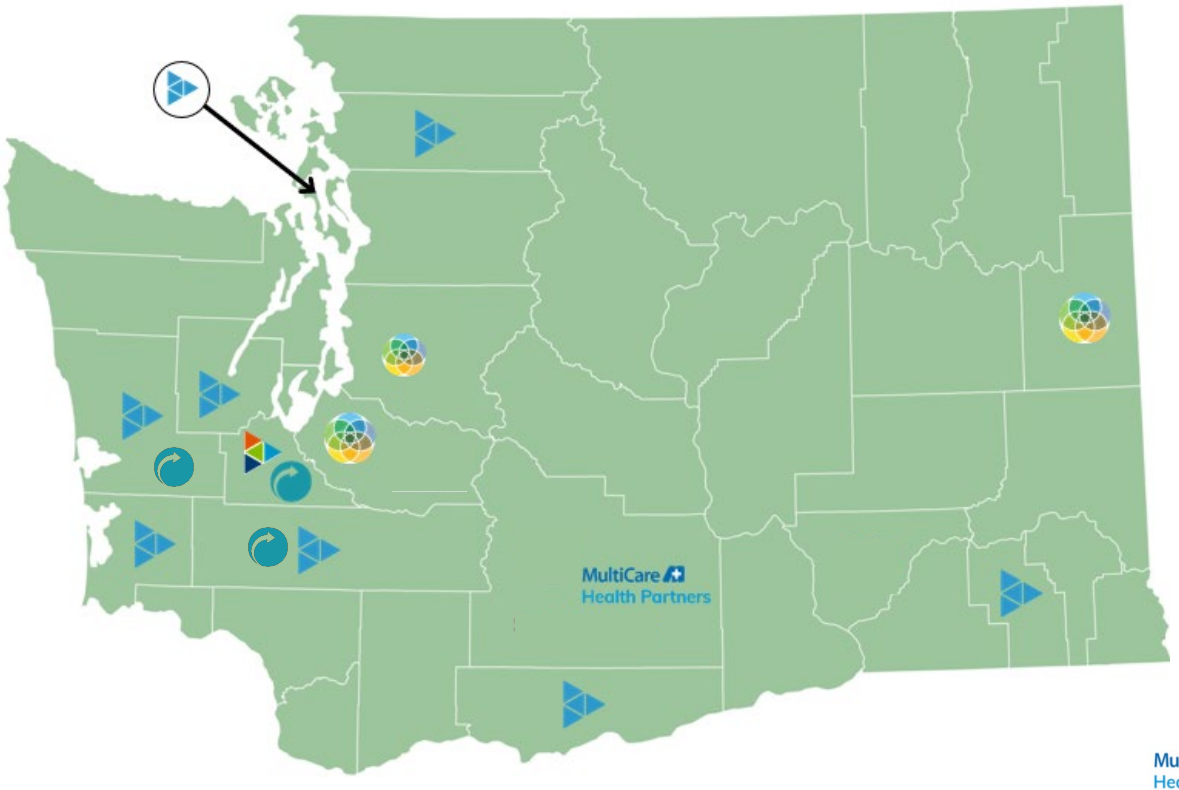
Population Health Analytics

Leveraging business intelligence insights with population health services to deliver actionable results

Innovative

- Full-risk Medicare Advantage Delegation
- High-performing ACO
- Population Health IT Infrastructure
- Advisory and Management Solutions
- Specialty Bundles
- Advanced Primary Care Clinics
- PACE Medicare

PSW ACO Portfolio



Over 72,000 covered lives

ACO established in 2017

First Next Generation ACO in WA

8,599 providers across the Pacific NW partnering for healing and a healthy future

Affiliated SNFs: 25

Savings Generated: Over $120M

Savings Earned: Over $73M

- PSW
- NW Momentum Health Partners ACO
- PSW Rural ACO
- MultiCare Connected Care
- MultiCare Health Partners ACO

The Power of Care Management

Engaged patients had a lower readmission rate of **11.1%** compared to **14.7%** for patients without transitional care management

Case Study – Inpatient Discharge Outreach

PSW's Care Management outreached to 60% of beneficiaries that discharged from the hospital in one of our 2023 Medicare ACO populations.

63% of those who were contacted agreed to talk with the Care Management team and 89% of them enrolled in Care Management services.

This population showed a **3.6% lower readmission rate** compared to beneficiaries not enrolled in our Care Management Services.

Data provided by Innovaccer

Best In Class

NCQA Accredited: Utilization Management

NCQA Accredited: Credentialing

NCQA Accredited: Population Health

SOC 2 Type 2 Certified

PSW
a population health company

Challenge

- How do we effectively follow a beneficiary throughout the continuum of care?
  - Innovaccer provided a platform for efficient notification of ADT events in an actionable user-friendly worklist to Care Managers to act

- Post-acute admissions (SNF, Swing Bed, IPR) challenges initially:
  - Visibility for location of admission
  - Feedback on network performance/utilization to guide decision making
    - Evaluating preferred SNF network
  - Consistent outreach to facility to reduce barriers & support timely discharge
  - Handoff to transitional nursing teams

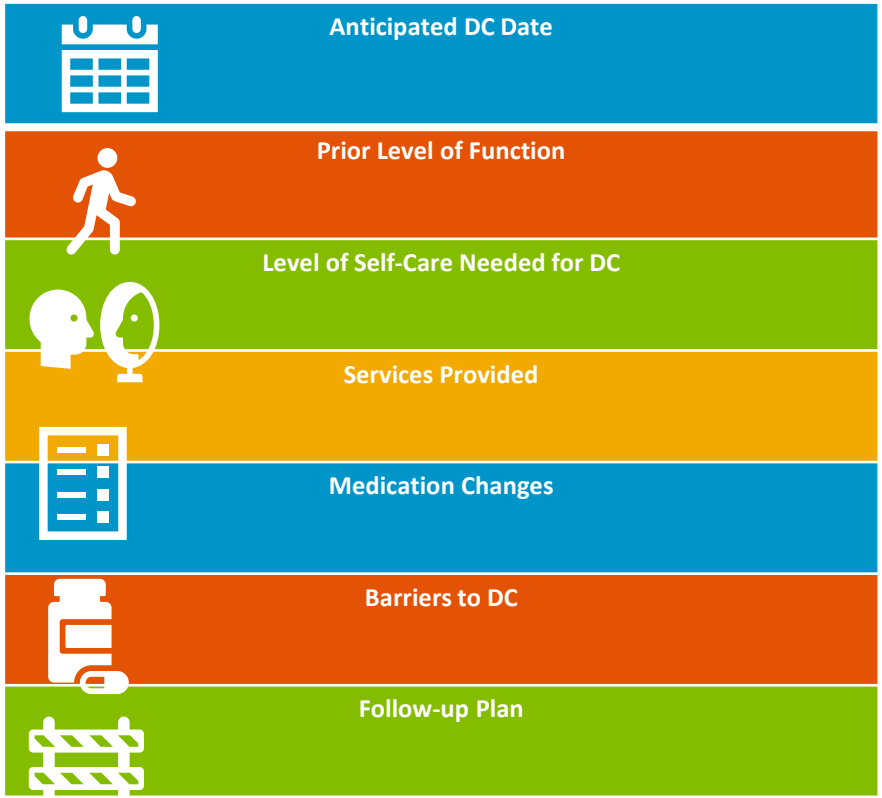
Highlight for ACO showdown: post-acute outreach & the Care Management impact

Our Solution? Partnering with Innovaccer

- ✓Early adopter of platform
- ✓Strategy for workflow developed to prompt Care Management protocols based on ADT data
  - Find out about admission to SNF within 24 hours of admission
- ✓Customized content in SNF protocol to guide best practice:
  - Functional status
  - Barriers to discharge
  - Recent changes
- ✓Post-acute care navigator's complete warm handoff to transitional care RN Care Management at discharge
  - Identification of at-risk beneficiaries for complex care management referral

Workflow

- Strategy to assign to specific post-acute team members
  - Geographic region, line of business, etc
- Worklist indicates CMSHCC Risk Score & Social Vulnerability Index (SVI) = identify who may at highest risk
- Platform provides some stay details automatically = saves staff time
  - Admit date, Location, Diagnosis
- Worklist allows user to schedule next outreach



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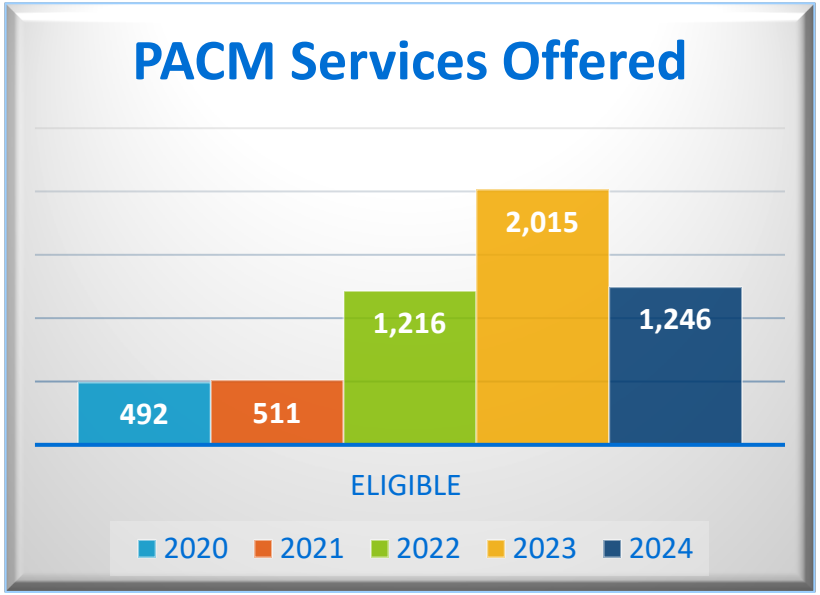
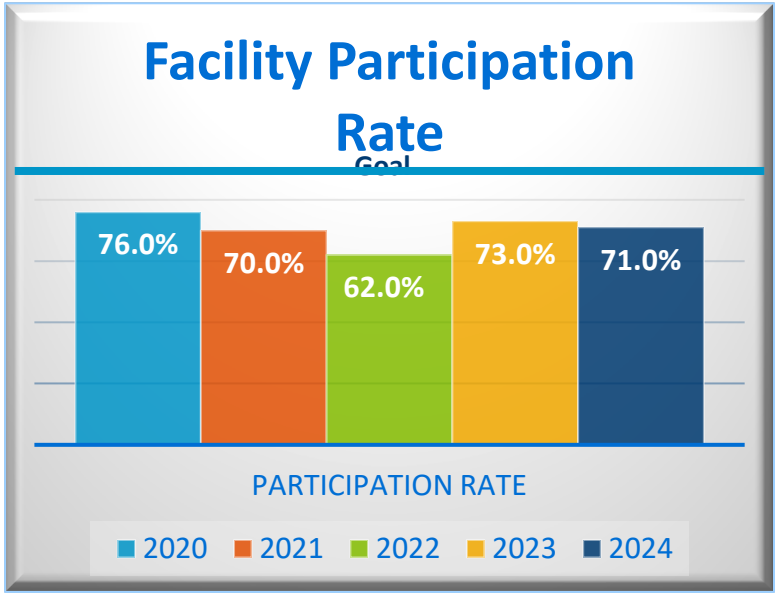
Customized Content

- SNF Care Protocols customized to prompt user based on best practices
  - Admission conversation different than subsequent engagements

PACM Performance Trends



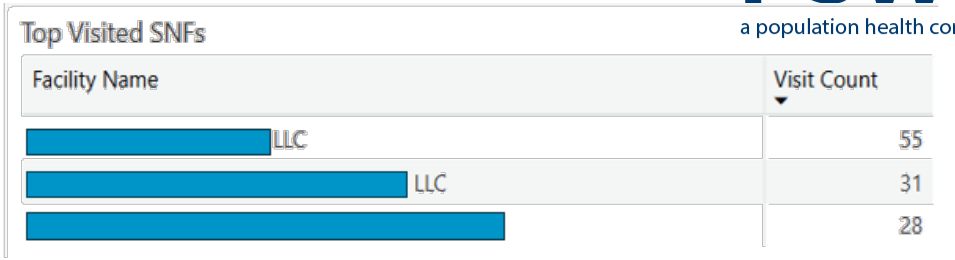
Use of SNF care protocols allows scalability for growth



Use of SNF care protocols allows tracking participation by facility, and guide collaboration efforts

Analytics

- Cost utilization information:
  - Inform providers for referral patterns
  - Useful when analyzing preferred network
    - Leakage
    - Volume, LOS, Readmit Rates
  - Provide feedback to facilities

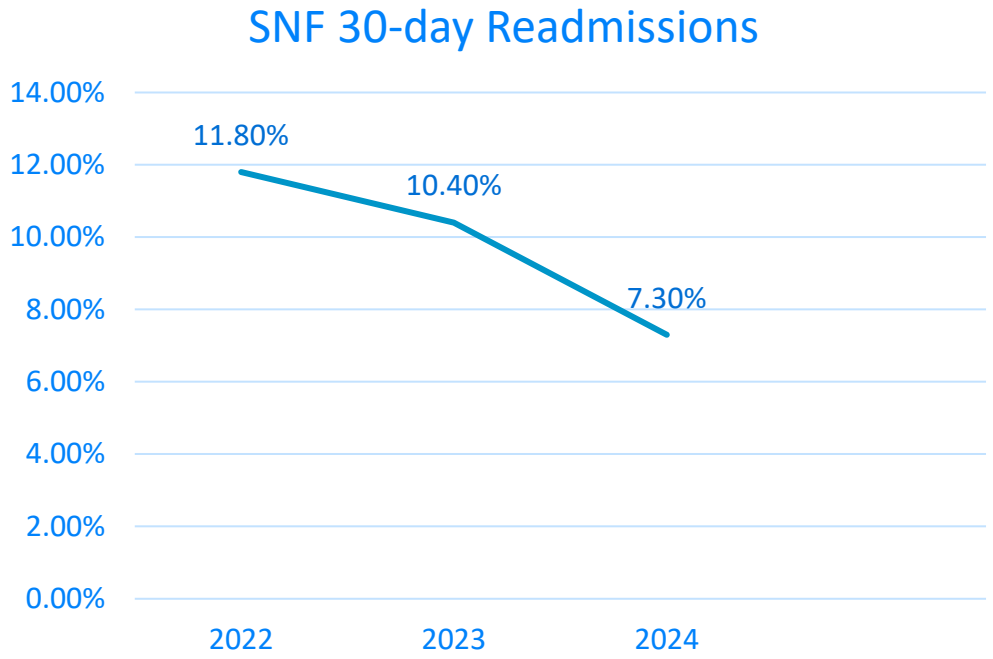


Facility City	# SNF Admits	Cost per Admit	Avg LOS	% Readmit to IP
LLC	10	$12,346.7	21.0	0.0 %
	22	$13,371.7	22.5	9.1 %
INC	24	$15,673.6	26.4	8.3 %
	13	$17,115.2	27.8	0.0 %
	27	$11,240.1	17.6	7.4 %
LLC	31	$12,999.6	21.1	6.5 %
LLC	23	$24,082.4	37.7	0.0 %

- Care Management performance data allows analysis of engagement by facility to determine relationship needs

(Example Only) – demonstrates review process	SNF A	SNF B	SNF C
# of Admits	55	24	31
SNF Participation Rate	95%	15%	90%
ACO Preferred Provider?	Yes	No	Yes
Relationship Status	Strong	Poor Engagement	Strong

What is the Impact? Readmission Reduction



30% reduction in SNF readmissions from 2023 to 2024 for population in Thurston County, WA

CAREVio
Linking Care. Improving Health.

CareVio's Sara Experience

Advancing Health Outcomes with AI

ChristianaCare & CareVio

ChristianaCare

ChristianaCare is a private, non-profit healthcare system serving patients in Delaware, Pennsylvania, New Jersey, & Maryland.

It offers a variety of outpatient & satellite services, including a freestanding emergency room in Middletown

ChristianaCare operates 2 hospitals in Delaware, 1 in Maryland and manages the Helen F. Graham Cancer Center, Center for Heart & Vascular Health, the Center for Women & Children's Health & ChristianaCare Home Health

CareVio

CareVio, a subsidiary of ChristianaCare, serves as the case management solution for both the healthcare system and the clinically integrated network.

What problems we were trying to solve?

- Putting patient care 1st– every minute spent on documentation is a minute taken away from patient care
- Reducing burnout and improving retention by reducing inefficient processes
- Reducing redundancy and improving accuracy in documentation
- Improving timely documentation thus preventing communication breakdowns and gaps
- Improving cost-inefficient workflows drive up indirect costs. Streamlining documentation improves operational efficiency

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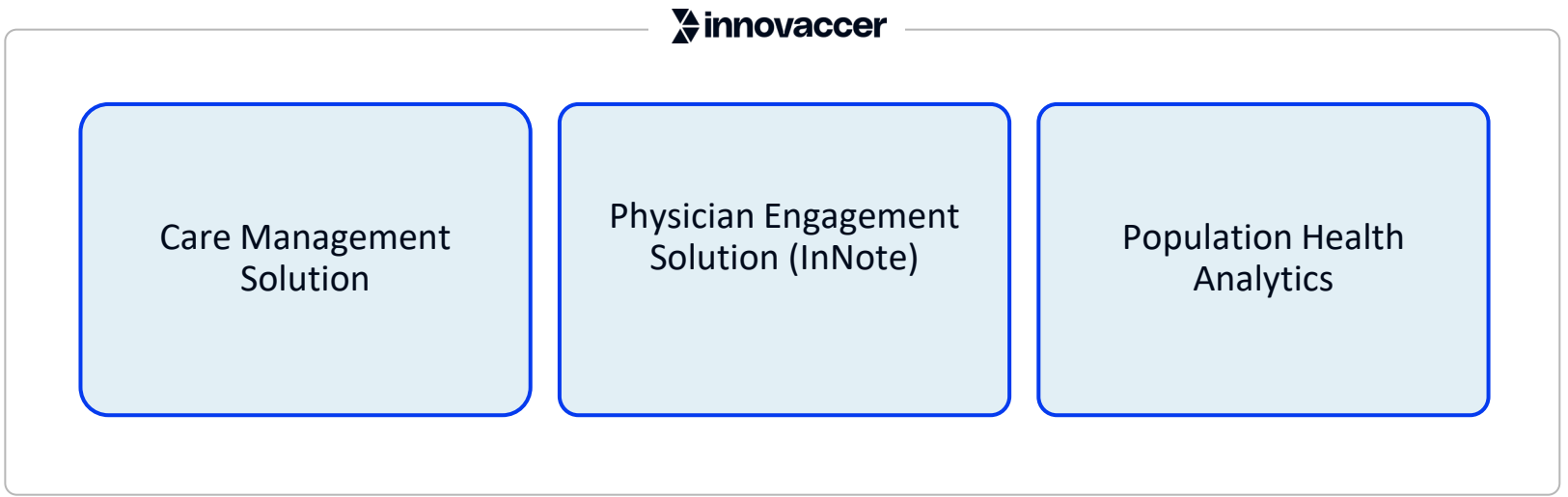
Linking Care. Improving Health.

CareVio & Innovaccer

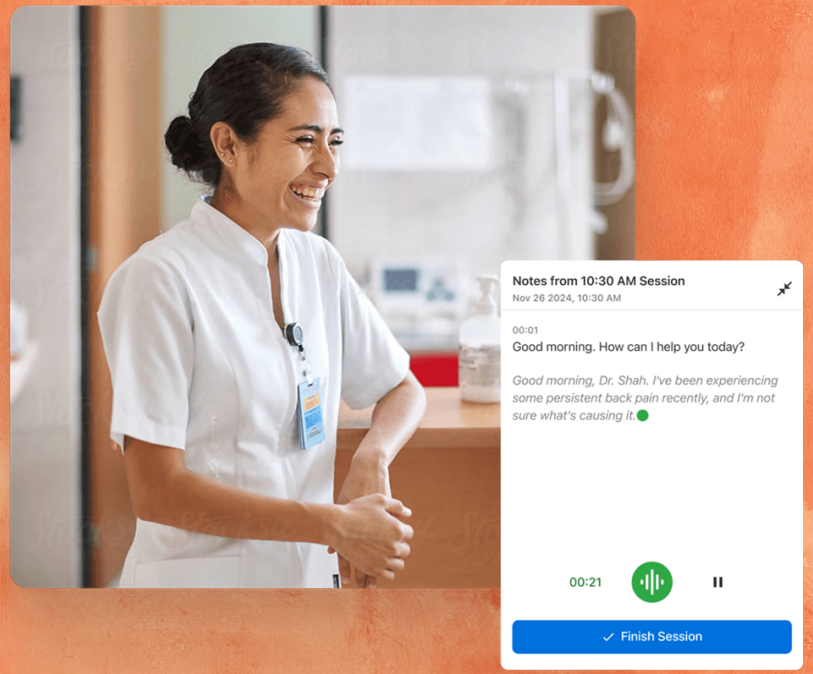
Leveraging the Innovaccer suite
of services which include:



Sara AI Engine

What is Sara?

- A customizable AI tool to help produce results relevant to your specific institutional needs.
- Assists with the automation of repetitive tasks.
- Uncovers insights from large volumes of medical data to help support clinicians at the point of care.



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Sara

Preparing for the patient call

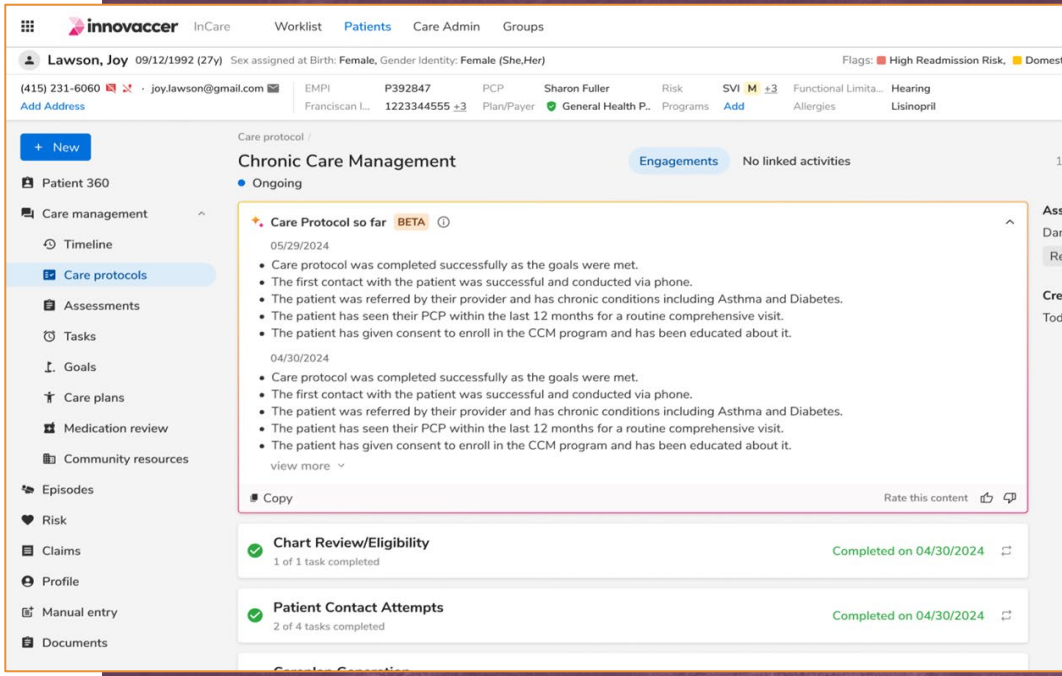
Review Previous Engagements
with the Patient

Talking to the patient

Autofill Care Protocols
Autofill Assessments
Additional Enhanced Documentation

Follow up activities

Conversation Summary
Barriers to Care and Next Steps
Connected Protocols and Assessments



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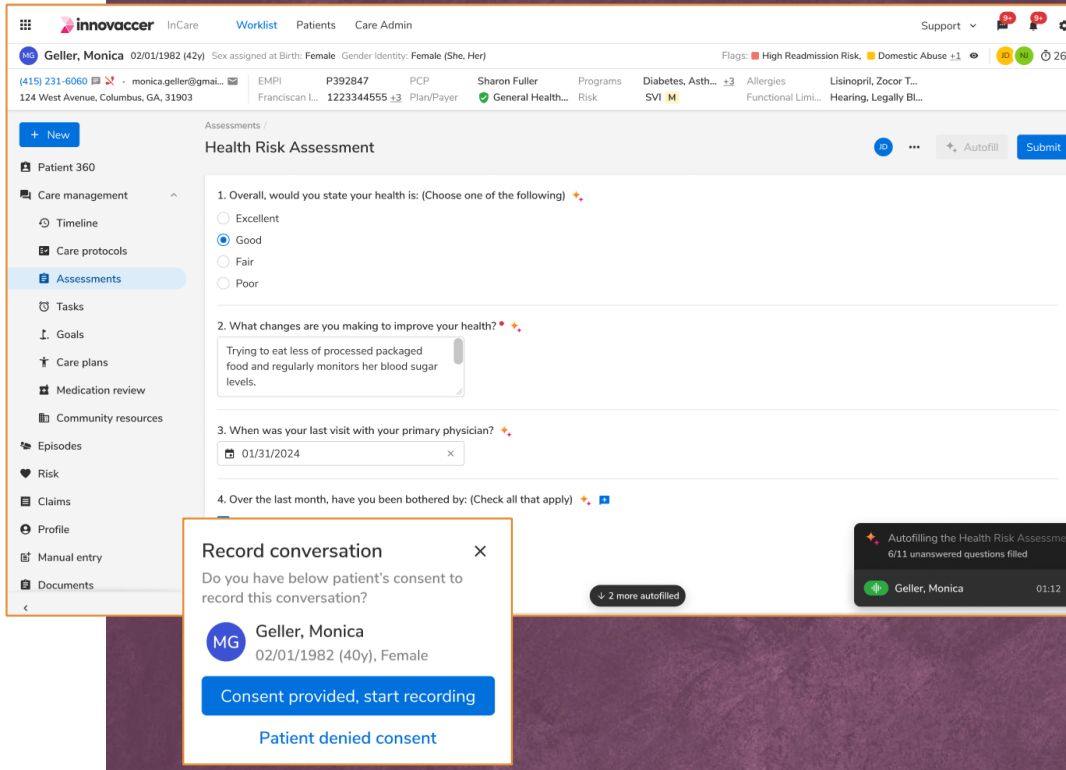

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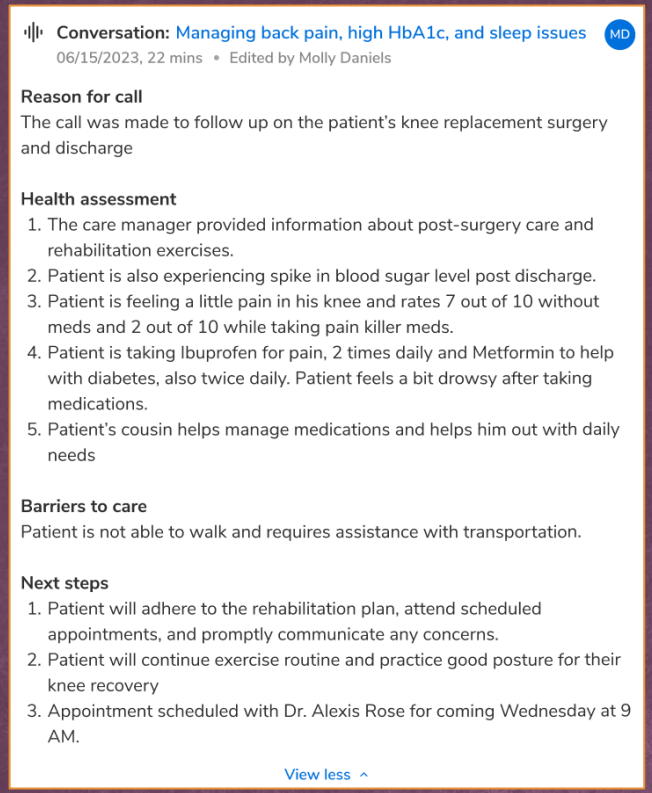

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SARA

Brings the joy back into healthcare

As a trusted AI partner for the healthcare teams, Sara boosts productivity time through automation and provides front-facing clinical decision support tools, thus allowing clinicians to spend more time on the things that matter the most.

Quality Human Connection

Pilot Details

Target Population	High Risk Maternity
Initial Scope	6 months
Install Process	4 weeks
Pilot Length	8 weeks*

*Due to unforeseen issues causing pilot disruption secondary to new Hitrust/AI Security Steer Implementation Process

Goals envisioned for the pilot

- Reduce the amount of time users spend on documentation
- Increase the number of patients each care manager can cater to
- Improve quality of documentation and fill rates

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Estimated Savings at the Pilot Start

	7 patients per user per day	Documentation Daily Gains	Documentation Weekly/Monthly/Yearly Gains	ROI
3 users	21 patients	1 hour saved per day	5 hours saved per week 20 hrs per month 240 hrs per year	**2080 average FTE hrs per year** **CM Average Hourly Rate=$45** **$45x4200=189,000 or >2 FTE's saved**
50 users	350 patients	17.5 hrs saved per day	87.5 hours saved per wk 350 hrs per month **4,200 hrs per year**	

Reported saving **3-5 minutes** of documentation per patient

Users complete an average of **7-9 patient** calls per day

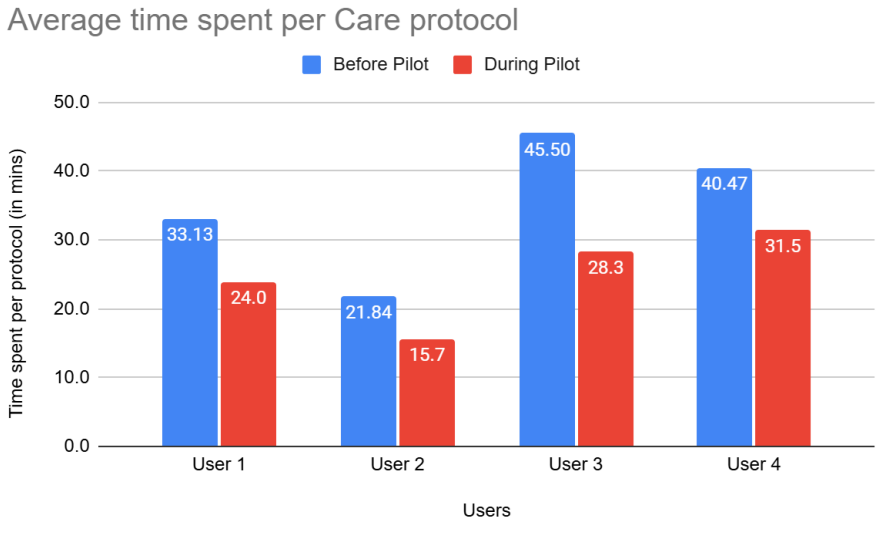
Assuming an average RN CM receives $45/hour

October 2024 - December 2024

Change in average time spent per protocol (in mins)

The Pilot was pursued and workflows were tested on four care managers who have used the platform

Users were spending ~30-50% lesser time per protocol because of the increased efficiency in documentation



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Actual Post Pilot Results

	10 patients per user per day	Documentation Daily Gains	Documentation Weekly/Monthly/Yearly Gains	ROI
3 users	30 patients	3 hour saved per day	15 hours saved per week 60 hrs per month 720 hrs per year	2080 average FTE hrs per year CM Average Hourly Rate=$45 $45x13920= $626,400 or > 6 FTE's saved
50 users	500 patients	58 hrs saved per day	290 hours saved per wk 1150 hrs per month **13920 hrs per year**	

Users saved **7-15 minutes** of documentation per patient

Users completed an average of **10-12** patient calls per day

Assuming an average RN CM receives $45/hour

Pilot Expansion Proposal

Expand the pilot to all patient populations, and developing specific KPIs for transitional vs longitudinal case management

Extended pilot will include the following features:

- Automated Call Summary
- Automated Care Protocol Summary
- Care Protocol Autofill NEW
- Assessment Autofill NEW
- Other features released in this category in future - Post call recommendations.

TARGETED SAVINGS FROM THE EXTENDED PILOT

25% Increase in the number of patients addressed per care manager

25-30% Reduction in documentation time

Less than 20% edits in AI-generated documentation

Questions?

Voting

NAACOS
Advancing Value in Health Care

ACO SHOWDOWN

AND THE WINNER IS...

Ventricle Health!

Congratulations on your first place innovation!

Contact Information

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