

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.

A blue rectangular banner with a white rounded rectangle in the center. The URL 'innovaccer.com' is written in blue text within the white box. Several small, yellow, rectangular confetti-like shapes are scattered around the white box.

innovaccer.com

Speakers



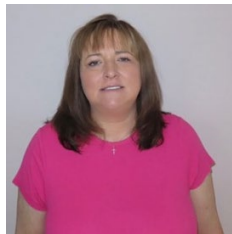
Jason Kemmer
SVP, Commercialization
Ventricle Health



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

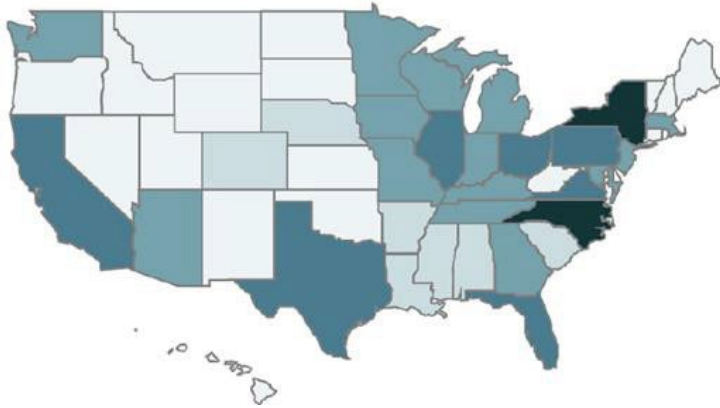
NAACOs

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



1% on medical guideline dosage



Ventricle Health



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

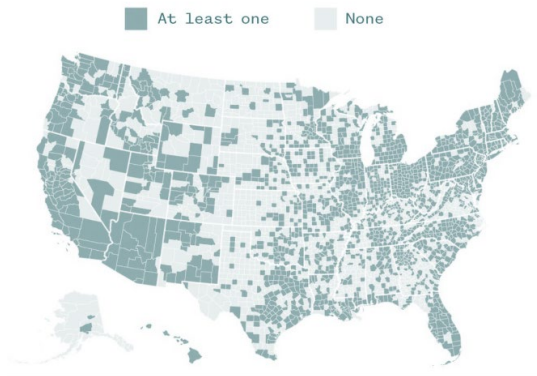
Case-rate guarantees minimum 1:1 ROI

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

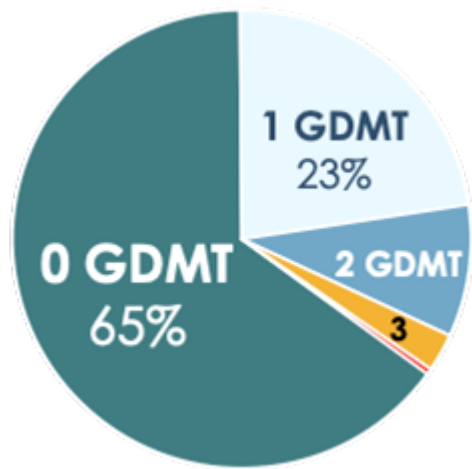


30%+ 1-year
mortality

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

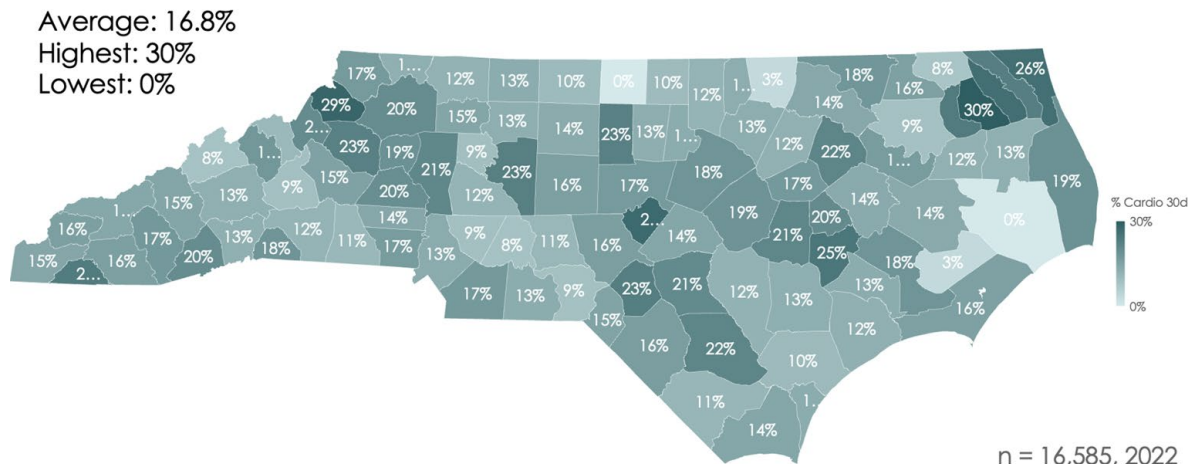


Out of 17,000+ :

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**

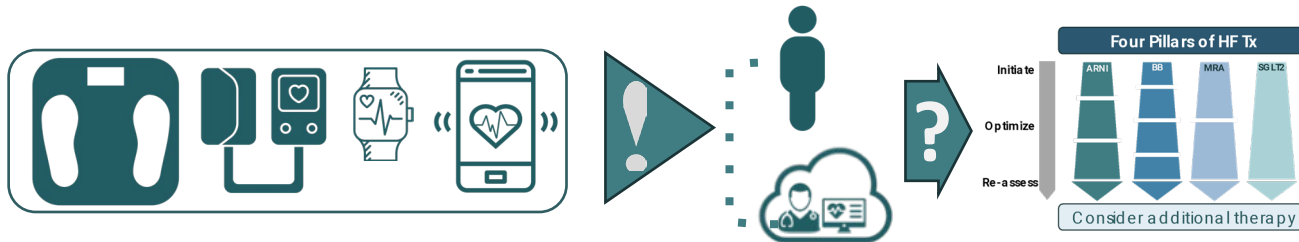
Built to address challenges seen in other RPM HF models

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

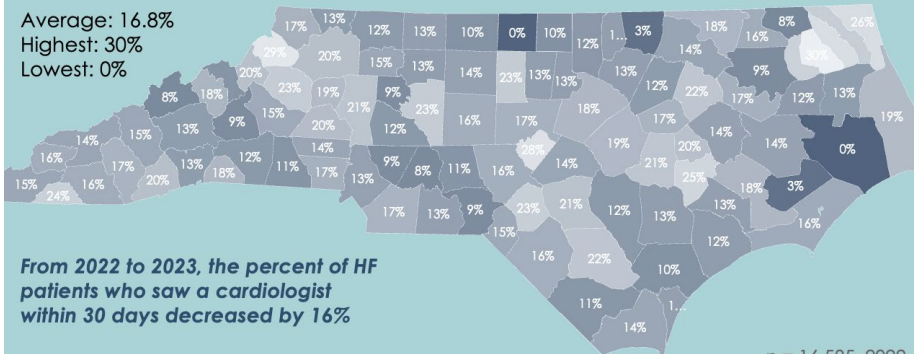
Cardiologist access issues are widespread across NC

% of HF population who see a cardiologist within 30 days of d/c (2022)

Average: 16.8%

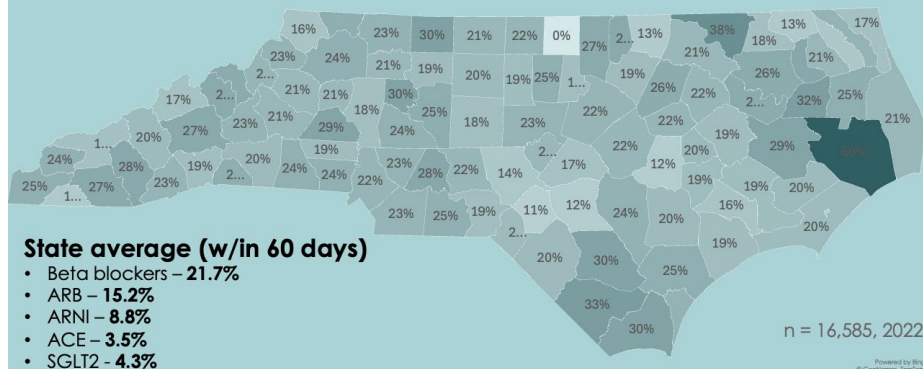
Highest: 30%

Lowest: 0%



GDMT prescriptions even after 2 months remain low

% of HF population on at least a beta blocker within 60 days of d/c



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

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14

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

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

- 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

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

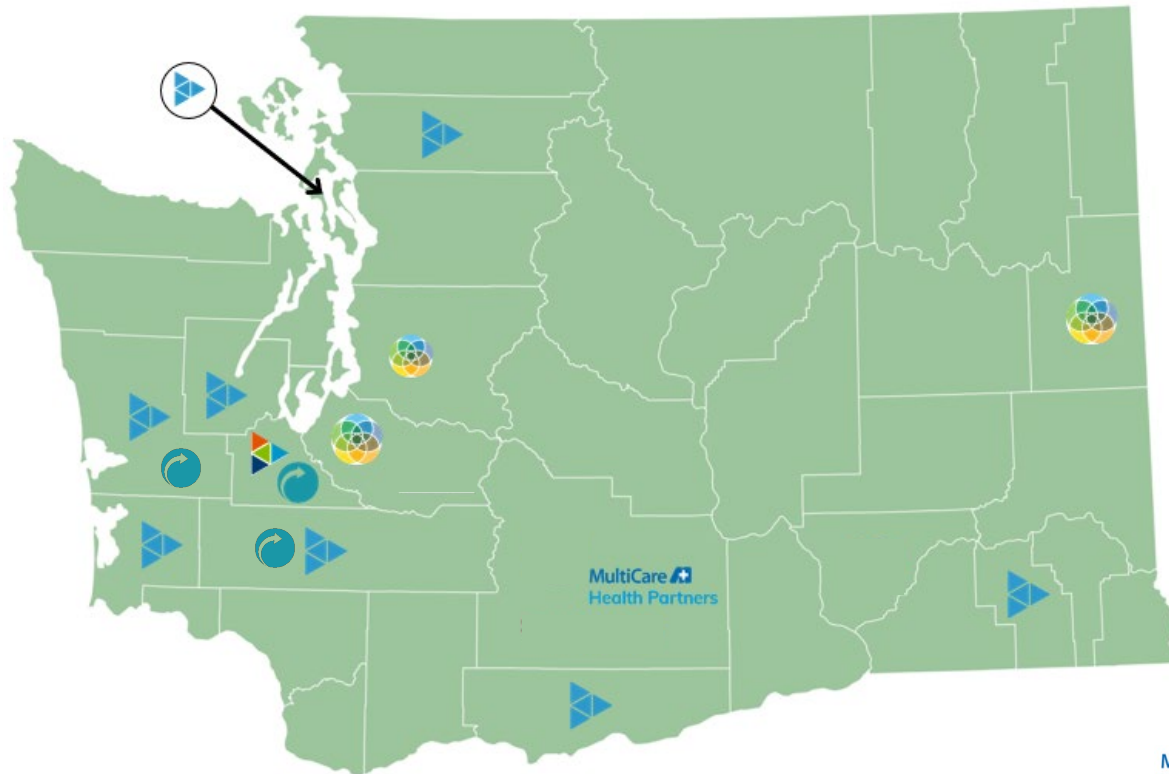
Advisory and Management Solutions

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.

Best In Class

NCQA Accredited:
Utilization Management

NCQA Accredited:
Credentialing

NCQA Accredited:
Population Health

SOC 2 Type 2 Certified



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

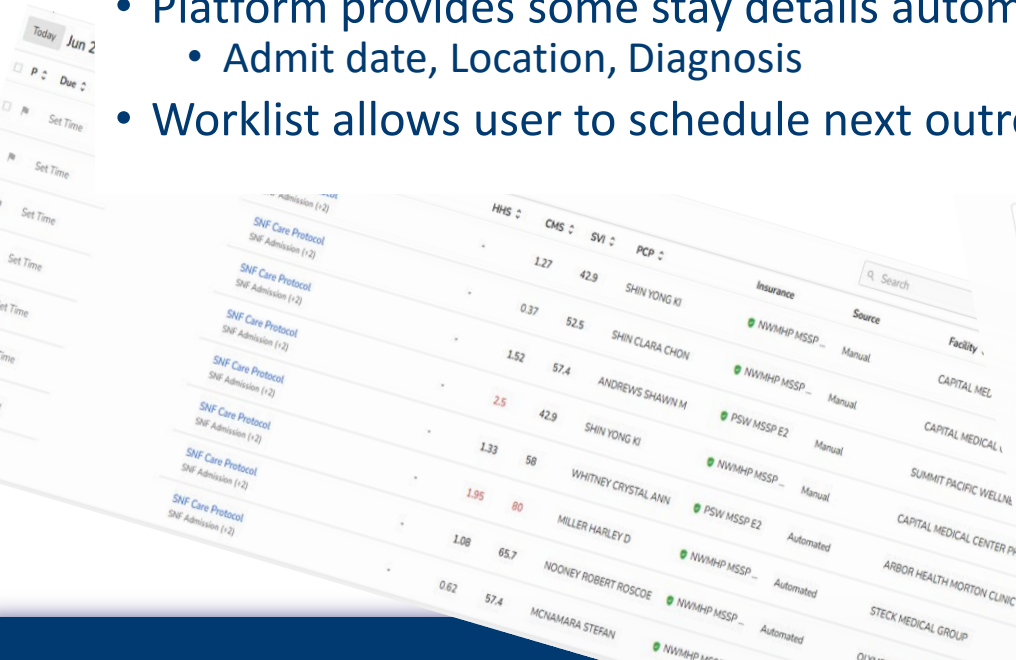
Our Solution? Partnering with Innovaccer

- ✓ 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 CSMHCC Risk Score & Social Vulnerability Index (SVI) = identify who may be at highest risk
- Platform provides some stay details automatically = saves staff time
 - Admit date, Location, Diagnosis
- Worklist allows user to schedule next outreach



HHS	CMS	SVI	PCP	Insurance	Source	Facility
1.27	42.9		SHIN YONG KI	NWHP MSP...	Manual	CAPITAL MEDICAL
0.37	52.5		SHIN CLARA CHON	NWHP MSP...	Manual	CAPITAL MEDICAL
1.52	57.4		ANDREWS SHAWN M	PSW MSP E2	Manual	SUMMIT PACIFIC WELLN
2.5	42.9		SHIN YONG KI	NWHP MSP...	Manual	CAPITAL MEDICAL
1.33	58		WHITNEY CRYSTAL ANN	PSW MSP E2	Automated	ARBOR HEALTH MORTON CLINIC
1.95	80		MILLER HARLEY D	NWHP MSP...	Automated	STEEK MEDICAL GROUP
1.08	65.7		NOONEY ROBERT ROSCOE	NWHP MSP...	Automated	
0.62	57.4		MCNAMARA STEFAN	NWHP MSP...	Automated	

DETAILS
Date of Admission:
05/06/2025
Facility Type:
Discharged/transferred to skilled nursing facility (SNF)
Admitting Facility:
CornerStone - Puget Sound Healthcare Center
Admitting Diagnosis:
S72142:Displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing; H3530:Unspecified hypertension, unspecified; I2720:Pulmonary hypertension, unspecified; K580:Irritable bowel syndrome with diarrhea; M2041:Other hammer toe(s) (acquired), right foot; N179:Acute kidney failure, unspecified; E785:Hyperlipidemia, unspecified; K219:Gastro-esophageal reflux disease without esophagitis; M7741:Metatarsalgia, right foot; W19XXXD:Unspecified fall, subsequent encounter; R2243:Localized swelling, mass and lump, lower limb, bilateral; Z95818:Presence of cardiac implants and grafts; I4820:Chronic atrial fibrillation, unspecified; E039:Hypothyroidism, unspecified; I10:Essential (primary) hypertension; I50812:Chronic right heart failure; E871:Hypo-osmolality and hyponatremia; M4716:Other spondylosis with myelopathy, lumbar; J449:Chronic obstructive pulmonary disease, unspecified; Z4789:Encounter for other orthopedic aftercare



Anticipated DC Date



Prior Level of Function



Level of Self-Care Needed for DC

Services Provided



Medication Changes



Barriers to DC

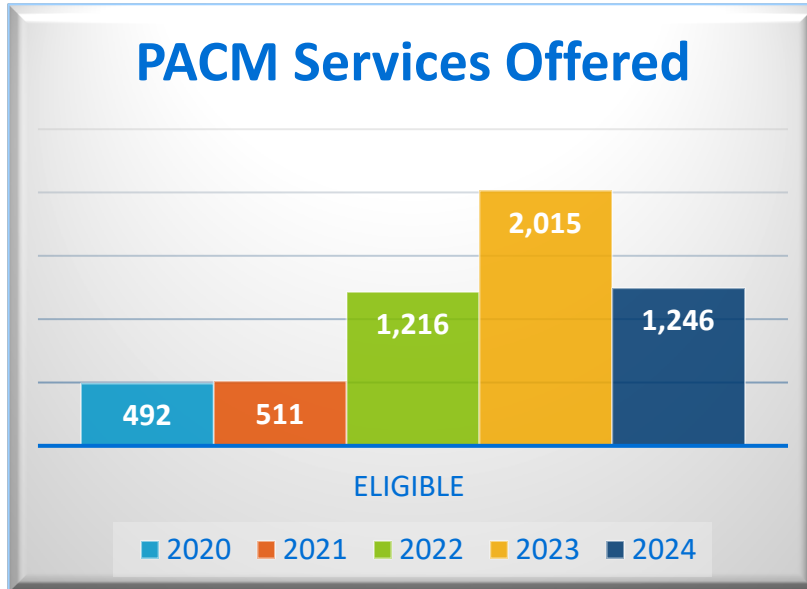


Follow-up Plan

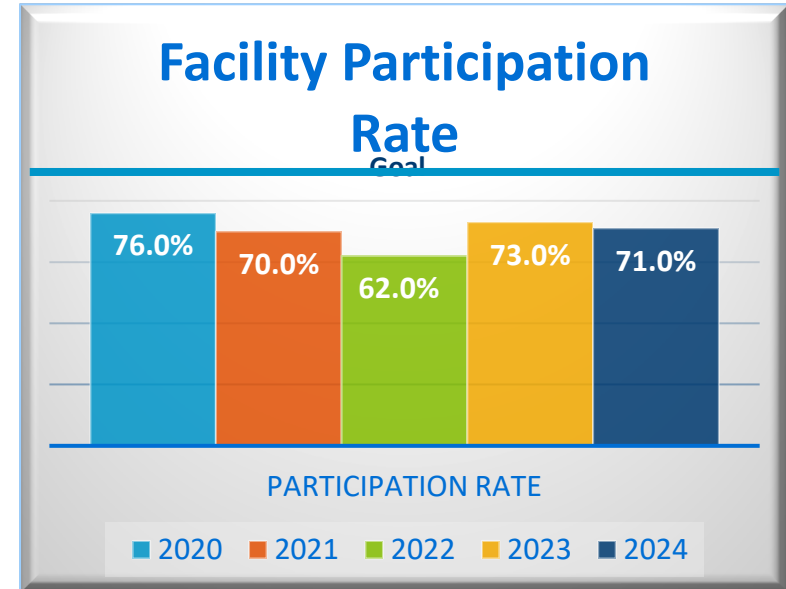
Customized Content

- 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

Top Visited SNFs

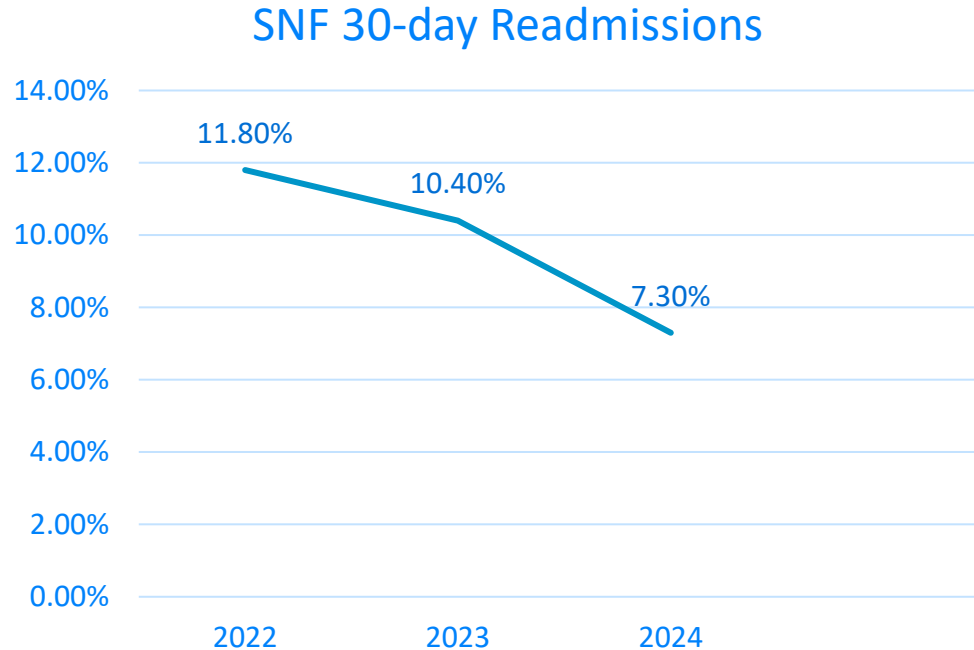
Facility Name	Visit Count
 LLC	55
 LLC	31
	28

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'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

CareVio & Innovaccer

Leveraging the Innovaccer suite
of services which include:



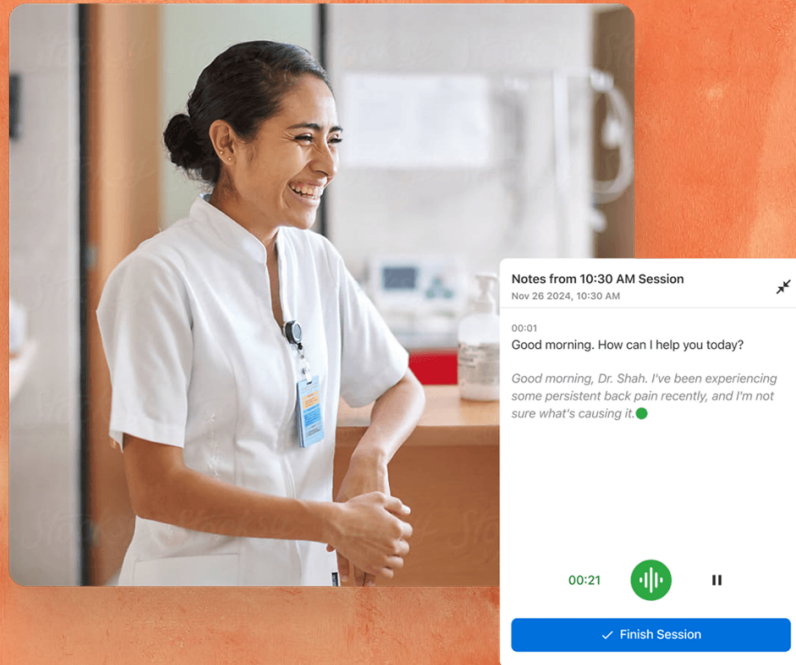
Care Management
Solution

Physician Engagement
Solution (InNote)

Population Health
Analytics

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.



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

The screenshot displays the innovaccer software interface for a patient named Joy Lawson. The top navigation bar includes tabs for InCare, Worklist, Patients, Care Admin, and Groups. The patient's header shows their name, date of birth (09/12/1992, 27y), sex (Female), and gender identity (Female (She/Her)). It also lists contact information and various clinical flags such as High Readmission Risk, EMP, P392847, PCP, Sharon Fuller, Risk, SVI, M, +3, Functional Limita..., and Hearing. A left sidebar menu lists various care management tools like Patient 360, Care management, Timeline, Care protocols, Assessments, Tasks, Goals, Care plans, Medication review, Community resources, Episodes, Risk, Claims, Profile, Manual entry, and Documents. The main content area is titled 'Chronic Care Management' and shows a list of 'Care Protocol so far' with two entries dated 05/29/2024 and 04/30/2024. Each entry includes a list of bullet points detailing the care protocol completion and patient engagement. Below the protocols, there are two task completion sections: 'Chart Review/Eligibility' (1 of 1 task completed) and 'Patient Contact Attempts' (2 of 4 tasks completed), both marked as completed on 04/30/2024.

Sara

Preparing for the patient call

Review Previous engagements with the Patient

Talking to the patient

Autofill Care Protocols

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Additional Enhanced Documentation

Follow up activities

Conversation Summary

Barriers to Care and Next Steps

Connected Protocols and Assessments

The screenshot displays the innovaccer InCare interface. At the top, the patient's name is Geller, Monica, with a birth date of 02/01/1982 (42y). The interface includes a sidebar with navigation options like Patient 360, Care management, Timeline, Care protocols, Assessments, Tasks, Goals, Care plans, Medication review, Community resources, Episodes, Risk, Claims, Profile, Manual entry, and Documents. The main content area shows a 'Health Risk Assessment' form with four questions. A 'Record conversation' modal is open, asking for consent to record the conversation. The modal shows the patient's name, birth date, and gender, and provides buttons for 'Consent provided, start recording' and 'Patient denied consent'. A notification in the bottom right corner indicates that 6/11 unanswered questions were autofilled.

innovaccer InCare Worklist Patients Care Admin Support

Geller, Monica 02/01/1982 (42y) Sex assigned at Birth: Female Gender Identity: Female (She, Her)

(415) 231-6060 monica.geller@gmail.com EMPI P392847 PCP Sharon Fuller Programs Diabetes, Asth... Allergies Lisinopril, Zocor T... 124 West Avenue, Columbus, GA, 31903 Franciscan L... 1223344555 ±3 Plan/Payer General Health... Risk SVI M Functional Limi... Hearing, Legally BL...

Assessments / Health Risk Assessment

1. Overall, would you state your health is: (Choose one of the following)

☐ Excellent

☒ Good

☐ Fair

☐ Poor

2. What changes are you making to improve your health?

Trying to eat less of processed packaged food and regularly monitors her blood sugar levels.

3. When was your last visit with your primary physician?

01/31/2024

4. Over the last month, have you been bothered by: (Check all that apply)

Record conversation

Do you have below patient's consent to record this conversation?

MG Geller, Monica 02/01/1982 (40y), Female

Consent provided, start recording

Patient denied consent

Autofilling the Health Risk Assessment 6/11 unanswered questions filled

Geller, Monica 01:12

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



Linking Care. Improving Health.

Powered by Christiana Care

 Conversation: [Managing back pain, high HbA1c, and sleep issues](#) MD

06/15/2023, 22 mins • Edited by Molly Daniels

Reason for call

The call was made to follow up on the patient's knee replacement surgery and discharge

Health assessment

1. The care manager provided information about post-surgery care and rehabilitation exercises.
2. Patient is also experiencing spike in blood sugar level post discharge.
3. Patient is feeling a little pain in his knee and rates 7 out of 10 without meds and 2 out of 10 while taking pain killer meds.
4. Patient is taking Ibuprofen for pain, 2 times daily and Metformin to help with diabetes, also twice daily. Patient feels a bit drowsy after taking medications.
5. Patient's cousin helps manage medications and helps him out with daily needs

Barriers to care

Patient is not able to walk and requires assistance with transportation.

Next steps

1. Patient will adhere to the rehabilitation plan, attend scheduled appointments, and promptly communicate any concerns.
2. Patient will continue exercise routine and practice good posture for their knee recovery
3. Appointment scheduled with Dr. Alexis Rose for coming Wednesday at 9 AM.

[View less](#) ^

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



Powered by Christiana Care



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

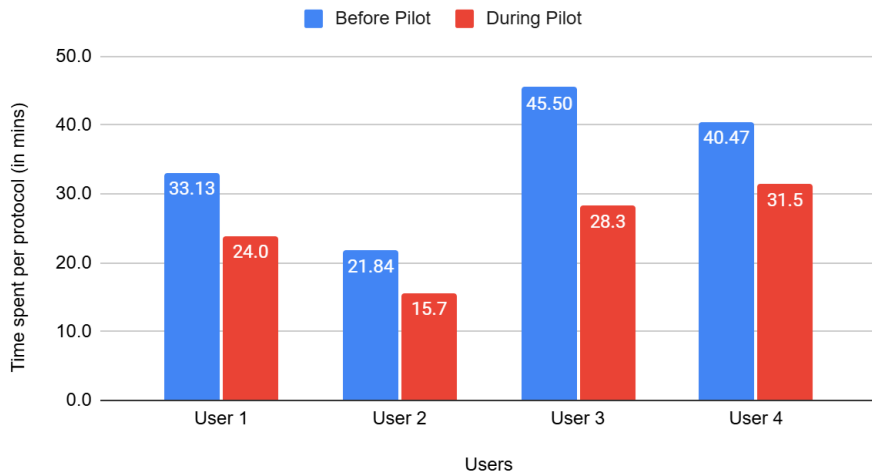
Assuming an average RN CM receives \$45/hour

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

Average time spent per Care protocol



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





AC
SHOWDOWN



AND THE WINNER IS...

Ventricle Health!

Congratulations on your first place innovation!

Contact Information



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