NAACOS Excellence Awards:

Learn from Leaders in Value-Based Care

October 9, 2025

2025 Excellence Awards

The NAACOS Excellence Awards recognize high-performing organizations who have demonstrated an outstanding commitment to and accomplishments in value-based care across three key areas:

Performance

- Improved quality and outcomes across multiple populations and areas of care; and
- Implemented value-based payment arrangements with reductions in total cost of care across lines of business.

Data and Technology

- Reduced provider burden or support practice-level care delivery improvements; and
- Fostered patient engagement or deploy patient-level care solutions.

Partnerships

- Engaged external providers and collaborated with other elements of the care delivery continuum; and
- Fostered engagement with the broader community, such as by partnering with community-based organizations.

2025 Winners

Speakers

	**Timothy L. Switaj, MD, MBA, MHA** **Vice President & Chief Population Health Officer** **Associate CMO – Primary Care Service Line** **WellSpan Health**
	**Lee J. Handke, PharmD, MBA** **Chief Executive Officer** **Nebraska Health Network**
	**Tina M. Sokolowski** **Vice President, Operations – Population Health** **Jefferson Health**

WellSpan Health ACO Success

Timothy L. Switaj, MD, MBA, MHA

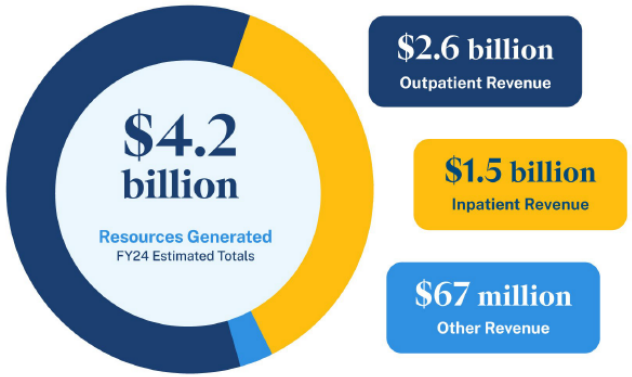
VP & Chief Population Health Officer

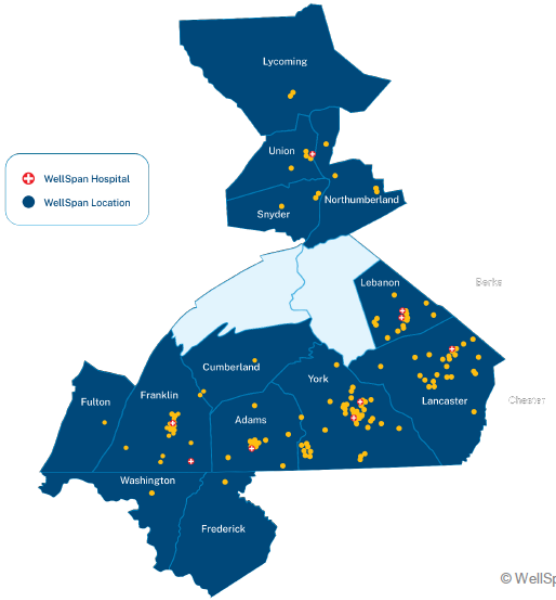
Associate Chief Medical Officer – Primary Care

10/9/2025

We Are Now One WellSpan

- 24,000 team members
- 3,250 providers
  - 2,500 employed providers
  - 750 aligned independent providers
- Accountable Care Organization (ACO), inclusive of Evangelical on Jan. 1
- 250+ patient care locations
- 7 Acute Care Hospitals
- 2 Specialty Hospitals
- 7 Ambulatory Surgery Centers
- Regional Behavioral Health Organization
- Regional Home Health Organization
- $400 million in community benefit
- Top 20% Credit Rating: AA- (stable)/Aa3 (stable)





Note: Per FY23 data

Leading in Value Based Care


BECKER'S
HOSPITAL REVIEW

44 ACOs to know | 2024

Anna Falvey - Updated Monday, September 16th, 202

Accountable care organizations, or ACOs, are physician- and health
ascertain and apply savings in healthcare delivery. These organizatic
with Medicare programs, while also providing care for private insurar

Each year, ACOs save patients and health systems alike millions of

67,205

Medicare patients receive primary care in our ACO, larger than most ACOs in the nation.

Documenting patient health risks

WellSpan physician s closed **92%** of patient health risk gaps

Industry leading pop health:

- Data analytics
- Care management
- Continuing care & home health
- Network administration
- Regulatory expertise

Higher quality score than 87% of ACOs nationally

- Better diabetes A1c control than 95% of reporters
- Improved admit rates for patients with multiple chronic conditions
- Low readmission rates

Providing the best care at the lowest cost

Over the last 3 years our ACO has saved our patients and the Medicare program over

$72,000,000

WellSpan Provider Network Snapshot

9 WellSpan Hospitals

Over 2,500 employed WellSpan providers

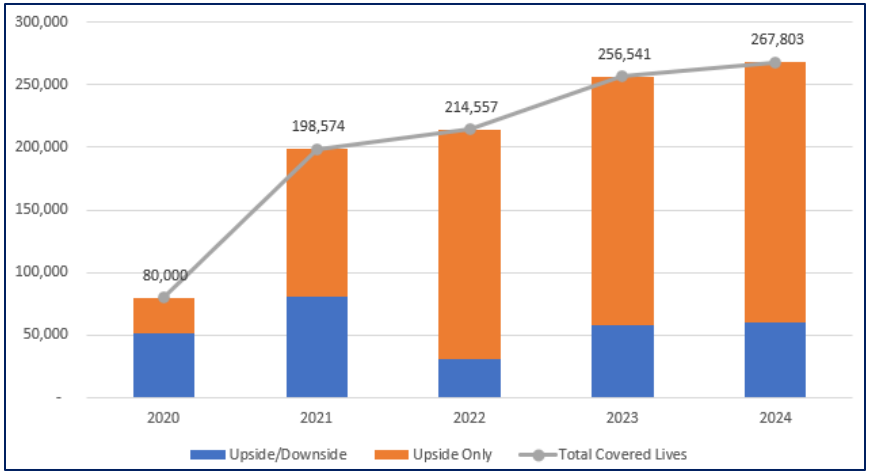
475+ independent providers

250+ WellSpan care locations

100+ Independent care locations

WELLSPAN HEALTH

Covered Lives



VBC Roster	# of Lives (as of 9/30/25)	% with WMG PCP	% with WPN WMG
MSSP (WellSpan Health Medicare Shared Savings Program)	56,547	71.7%	8.3%
WSHP (WellSpan Health Plan)	41,088	61.5%	5.8%
Aetna MA (WSH Aetna Medicare Advantage)	22,814	91.0%	1.2%
CBC Commercial (WSH Capital Blue Cross Commercial)	38,163	81.3%	3.2%
CBC Joint (WSH Capital Blue Cross Joint Product)	11,057	49.9%	4.5%
Highmark MA (WSH Highmark Medicare Advantage)	51,944	94.1%	2.3%
Highmark Commercial (WSH Highmark Commercial)	15,656	91.3%	1.5%
Highmark WholeCare (WSH Wholecare Medicaid Risk)	40,946	74.9%	5.8%

WellSpan's Medicare ACO in 2024: Leading in Value Based Care

Attribution

We successfully grew our Medicare ACO population.

Our ACO is **the 39th largest ACO nationally**.

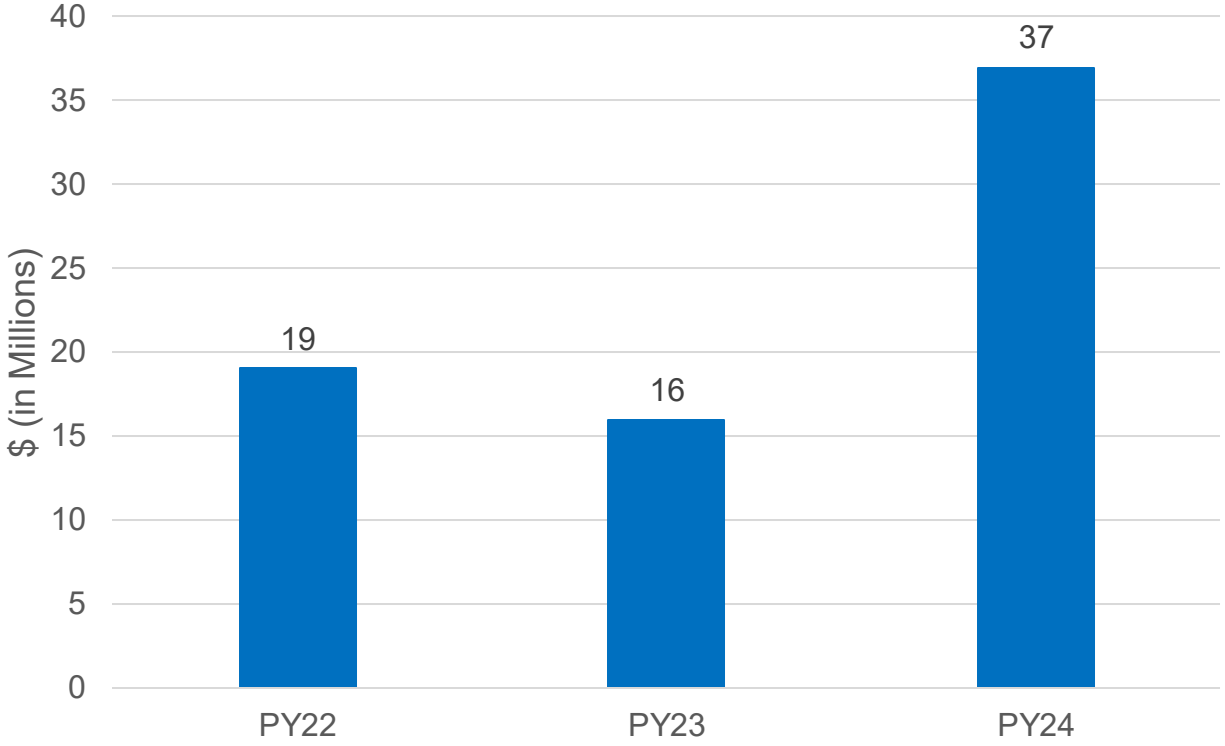
Quality

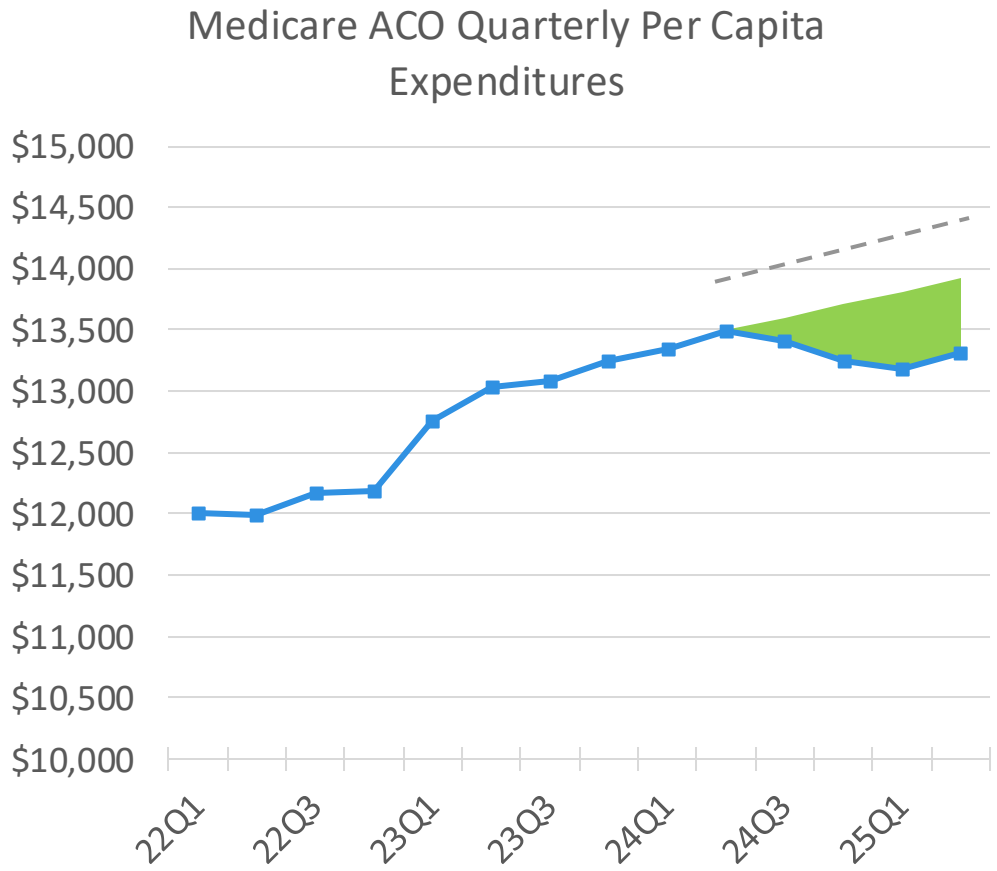
WellSpan's Medicare ACO quality score of **82.17%**.

Cost & Utilization

Our ACO produced **$36,839,858 total savings**.

Total ACO Savings





*source: CMS quarterly Expenditure & Utilization reports

Bending the Cost Curve

- WellSpan's Medicare ACO total costs of care remain less than the 2nd quarter of CY 2024.
- These are pure, non-risk adjusted costs
- This is remarkable progress in WellSpan's leadership in value-based care.
- We achieved this through:
  - Partnership of service lines with Population Health to identify wasteful spending through development of evidence-based care pathways for common conditions
  - Improved ambulatory triaging protocols by the nurse triage call center
  - Robust partnerships with internal service lines and external independent partners

The Quadruple Aim

Value Imperative

Improve health by delivering the highest quality care with an exceptional experience at an affordable cost with savings passed on to our patients.

WellSpan Mission

Working as One to improve health through exceptional care for all, lifelong wellness, and healthy communities.

WellSpan Total Costs of Care Work is Paying Off

Post Acute Inpatient Rehab

Although we still lead our region in post acute inpatient rehab spending, we continue to make notable reductions. Whereas prior to COVID we spent 3 times the national average here, we are now at 1.77 times the national average.

When Rehab and skilled nursing facility costs are combined, we now perform slightly better than the ACO national average.

Emergency Department Visits

Our recent TCOC emergency department work has led to significant improvement in reducing avoidable ED utilization.

Through the last 3 years our emergency department utilization has improved relative to the national average by 2.5%.

Keys to our Success

Robust partnerships internally and externally

- Service line integration
- Practice engagement

Data democratization

Culture of “Working As One”

Innovation

- Genomics
- AI

Physician leadership

Support for cost of care reduction at all levels of Executive leadership

- Systemwide annual goal
- Current focus areas
  - ED Utilization
  - CHF / COPD / Dementia
  - Appropriate Inpatient Rehab Referrals
  - Enhancing Palliative and Hospice Care
  - Evidence-based disease pathways

WellSpan HEALTH

Questions?

Timothy L. Switaj, MD, MBA, MHA

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WellSpan HEALTH


WELLSPAN®
HEALTH

NAACOS Fall Meeting: Oct. 9, 2025

Nebraska Health Network

METHODIST

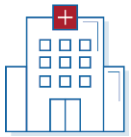
Nebraska Medicine

2010

Partnered to create an

ACCOUNTABLE CARE ORGANIZATION

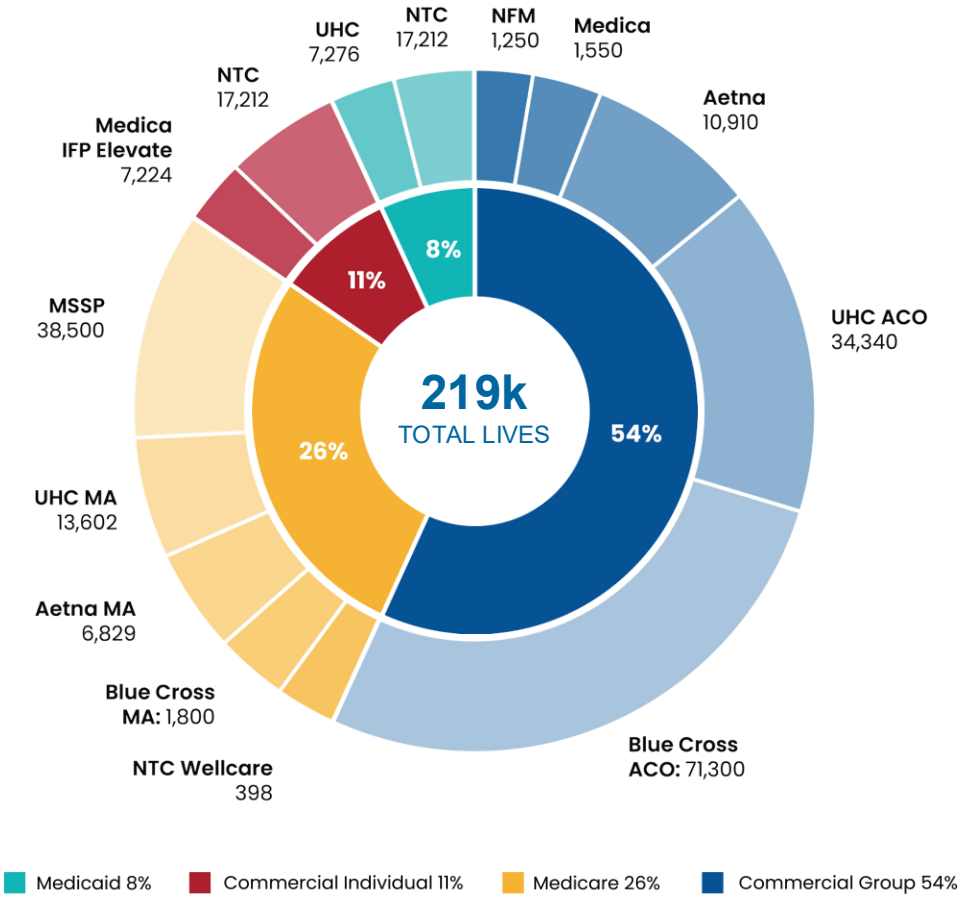
The Nebraska Health Network includes:



8 Hospitals
181 Clinics

More than 3,200 physicians and advanced practice providers

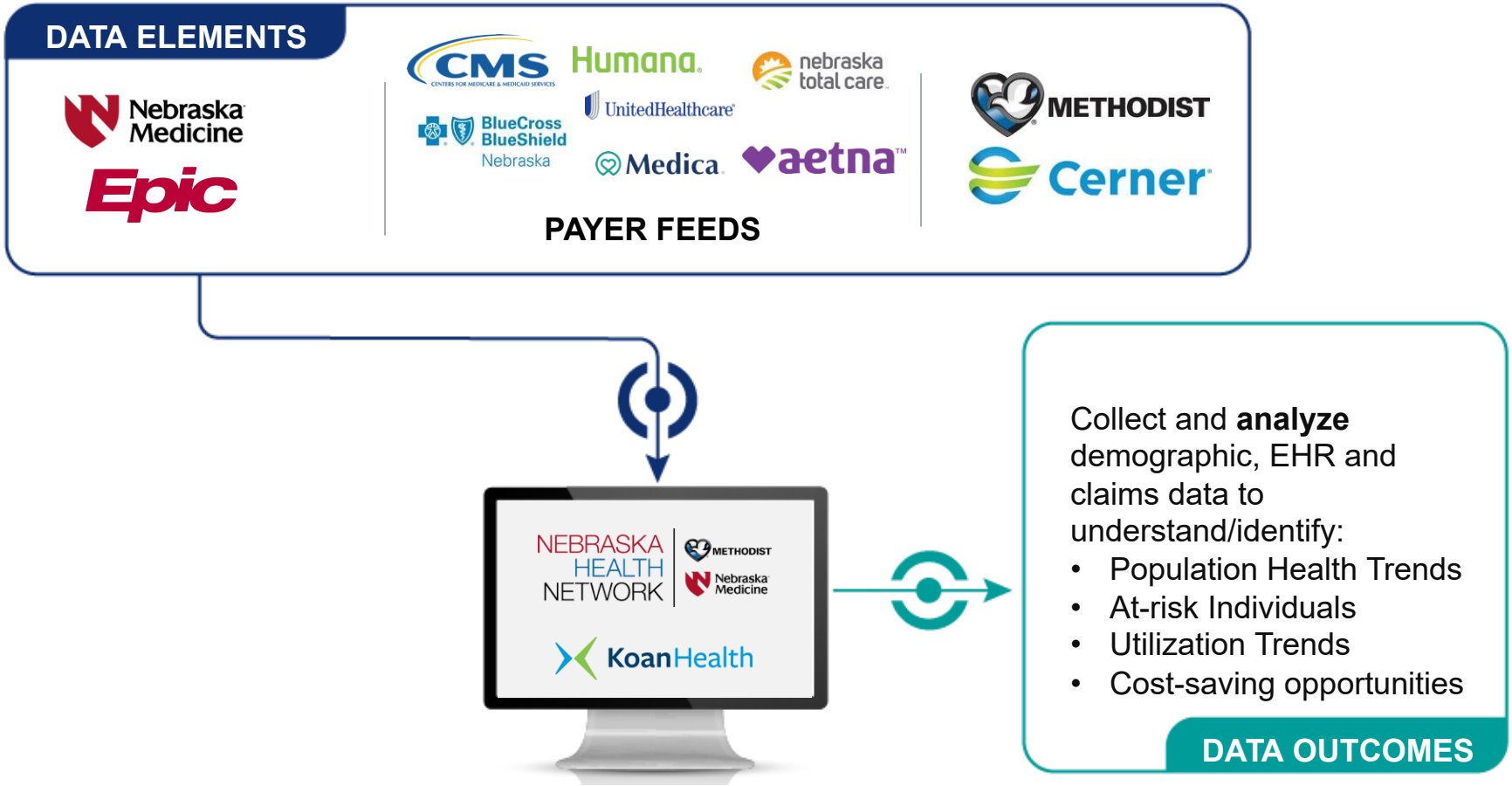
2025 Value-Based Contracts



Commercial Group 54%	Blue Cross Blue Shield ACO UHC ACO Aetna Medica
Medicare 26%	MSSP UHC MA Aetna MA Blue Cross MA
Commercial Individual 11%	NTC Wellcare Medica IFP Elevate
Medicaid 8%	Nebraska Total Care UHC

Data Supporting Performance

Data Workflow



2025 VALUE-BASED CARE QUALITY MEASURES

NEBRASKA HEALTH NETWORK | Methodist | Nebraska Medicine

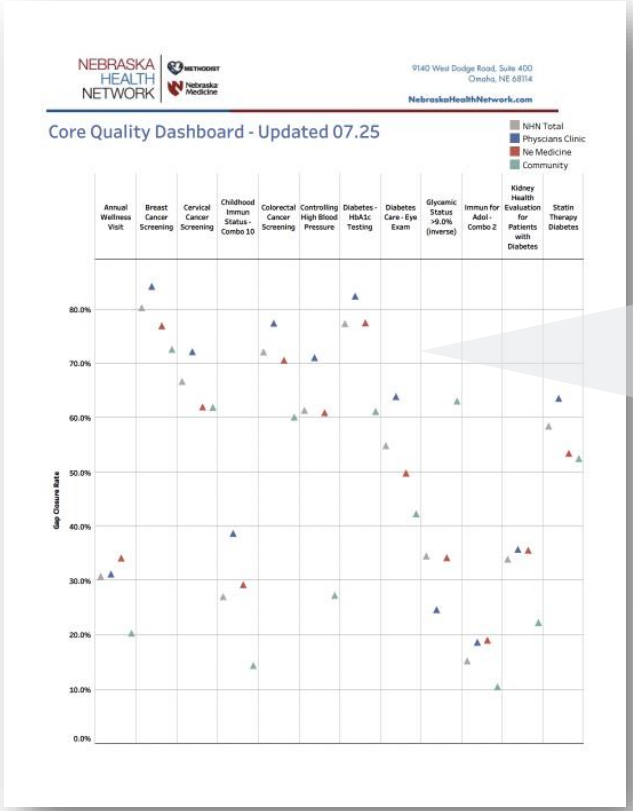
QUALITY MEASURE, Core Quality Measures noted in blue ■

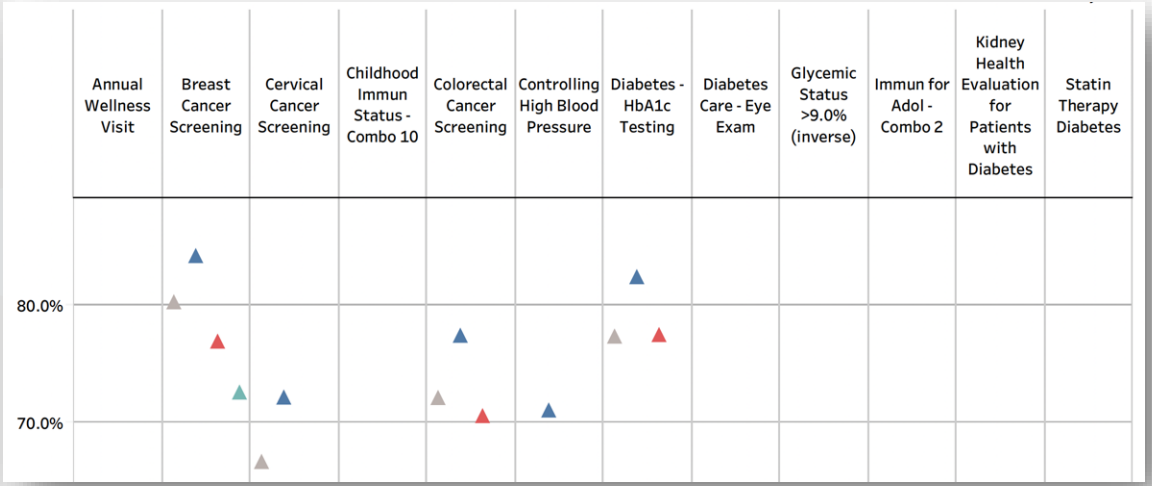
		MEDICARE	NON-MEDICARE COMMERCIAL						MEDICARE ADVANTAGE				MEDICAID	
		CMS	BlueCross BlueShield Nebraska	aetna	UnitedHealthcare	Medica	Medica	nebraska total care	aetna	BlueCross BlueShield Nebraska	nebraska total care	UnitedHealthcare	nebraska total care	UnitedHealthcare
		MSSP[1]	BCBS	Aetna[2]	UHC/UHC Nexus	Medica Commercial	Medica IFP	NE Total Care IFP	Aetna MA	BCBS MA	NE Total Care MA	UHC MA	NE Total Care	UHC
SCREENINGS	Breast Cancer Screening (BCS-E)	X	X	X	X	X	X	X	X	X	X	X	X	X
	Colorectal Cancer Screening (COL-E)		X	X	X	X	X	X	X	X	X	X	X	
	Cervical Cancer Screening (CCS-E)		X	X	X			X					X	X
	Chlamydia Screening (CHL)				X			X					X	X
	Screening for Depression and Follow-up Plan (DSF-E)	X												
IMMUNI-ZATIONS	Childhood Immunization Status - COMBO 10 (CIS-E)				X									X
	Immunizations for Adolescents - COMBO 2 (IMA-E)		X										X	X
DISEASE MANAGEMENT	A1c Testing Completion													
	Glycemic Status Assessment for Patients with Diabetes - Poor Control >9% (GSD)	X		X				X	X	X	X	X	X	X
	Glycemic Status Assessment for Patients with Diabetes - Poor Control <8% (GSD)		X		X	X	X							
	Eye Exam for Patients with Diabetes (EED)		X	X	X			X	X	X	X	X		
	Kidney Health Evaluation for Patients with Diabetes (KED)		X		X			X	X	X	X	X	X	
	Controlling High Blood Pressure (CBP)	X	X			X	X	X	X	X	X			X
	Use of Imaging Studies for Low Back Pain (LBP)				X									
	Osteoporosis Management in Women Who Had a Fracture (OMW)								X	X	X			
	Appropriate Treatment for Upper Respiratory Infection (URI)				X									
	Appropriate Testing for Pharyngitis (CWP)				X									
MEDICATIONS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)		X		X									
	Medication Adherence Diabetes Medications (PDC-DR)								X		X	X		
	Medication Adherence Hypertension (RAS antagonists) (PDC-RASA)								X		X	X		
	Medication Adherence Cholesterol (Statins) (PDC-STA)								X		X	X		
	Statin Therapy for Patients with Diabetes (SPD/SUPD)[3]								X	X	X	X		
	Statin Therapy for Patients with Cardiovascular Disease (SPC)								X	X	X	X		
	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)				X									
	Asthma Medication Ratio (Total: 5-85 yrs) (AMR)				X									
	Concurrent use of Opioids and Benzodiazepines (COB)								X					
	Use of Opioids at High Dosage (HDO)				X									
	Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH)								X					
UTILIZATION	Well Child Visits in the first 15 months of Life (0-15 months) (W30)												X	
	Well Child Visits in the first 30 months of Life (15-30 months) (W30)				X								X	
	Child and Adolescent Well-Care Visits (WCV)				X			X					X	
	Prenatal and Postpartum Care (PPC)												X	
	Avoidable ER per 1,000			X										
	Follow-up after ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)								X	X	X	X		
	Impactable Admits per 1,000			X										
	Plan All-Cause Readmissions (PCR)	X		X				X	X			X		
	Transition of Care- Medication Reconciliation (TRC)										X			
	Annual Preventative Visit						X			X				
	Annual Wellness Visit (AWV)	NC							NC	X	NC	NC		
CARE FOR OLDER ADULTS	Care for Older Adults - Functional Status Assessment (COA)								X		X			
PATIENT EXPERIENCE	Getting Needed Care											X		
	Care Coordination											X		

NHN Core Quality Measures

- Common measures shared across all value-based contracts approved by VBPAC
- Selected based on clinical relevance, network-wide priorities and frequency of measures in value-based contracts
- Goal: Increase visibility of patient health across populations enabling us to proactively identify opportunities to enhance the care we provide.

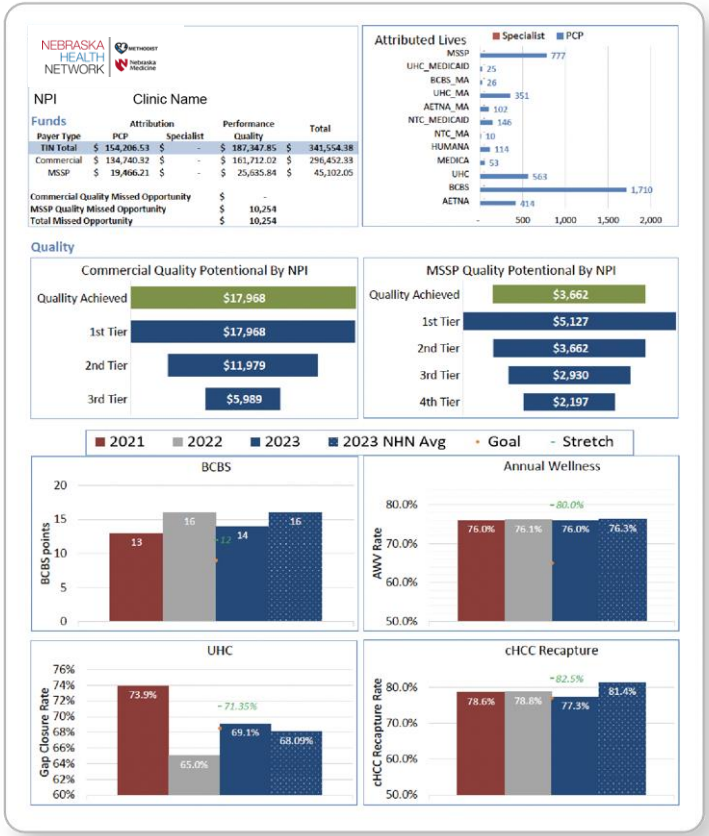
Sample Reporting: Core Quality Dashboard





NHN Total
Physicians Clinic
Ne Medicine
Community

Clinic Level Performance



- Shared savings and quality payments earned YTD
- Attribution by value-based care contract
- Quality performance at NPI level
- Gap closure rate by strategic priority

Partnerships and Collaboration

NHN Patients with Documented Social Determinants of Health

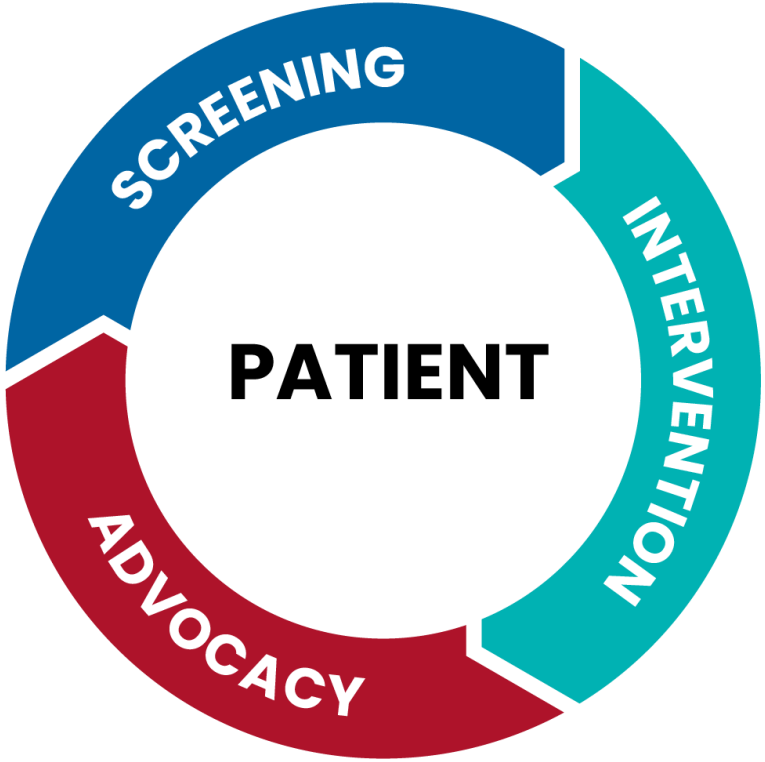
FOUR TIMES THE
COST OF CARE

FIVE TIMES THE
HOSPITAL ADMISSIONS

SIX TIMES THE
ED UTILIZATION

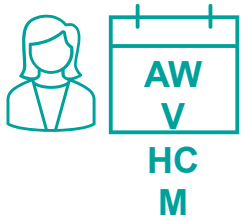
Based on an analysis of 200,000 patients in NHN value-based contracts including commercial, Medicare and Medicaid from Nov. 2021 to Oct. 2022.

Addressing Health Equity



Primary Care Proactive Social Drivers of Health Screening Workflow

Prior to an Annual appointment, all patients 18 years+ are screened for Social Drivers of Health



If the patient screens positive for Interpersonal Safety, the provider partners with the patient to develop care plan, referral to PCMH Social Work or Forensic Nurse Team

If the patient screens positive and wants assistance (excluding IPS), there is an automatic referral to a Community Service Navigator

The Community Service Navigator receives referrals to address barriers and prevent admissions, helping reduce the administrative burden on the primary care team

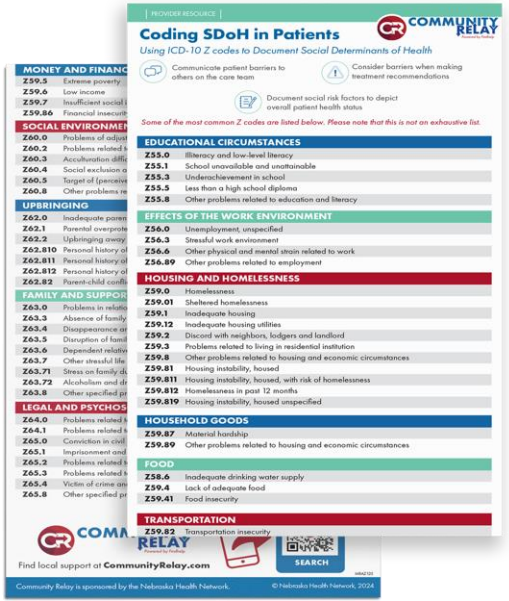
Community Relay

- Free, online platform that connects users with free, or reduced-cost local programs and services
- Powered by the national Findhelp directory
- Used internally by clinicians and CHWs to manage patients' SDoH and health equity needs
- Promoted in the community as a free resource and way to connect with individuals in need who are not utilizing our health care services

Sample Community Outreach Campaign

Encouraging Providers to Utilize Z codes

- Z codes are ICD-10 Codes Z55 to Z65 that give details for Social Determinants of Health (SDoH)
- Including Z codes in patient record helps holistically address patient's needs

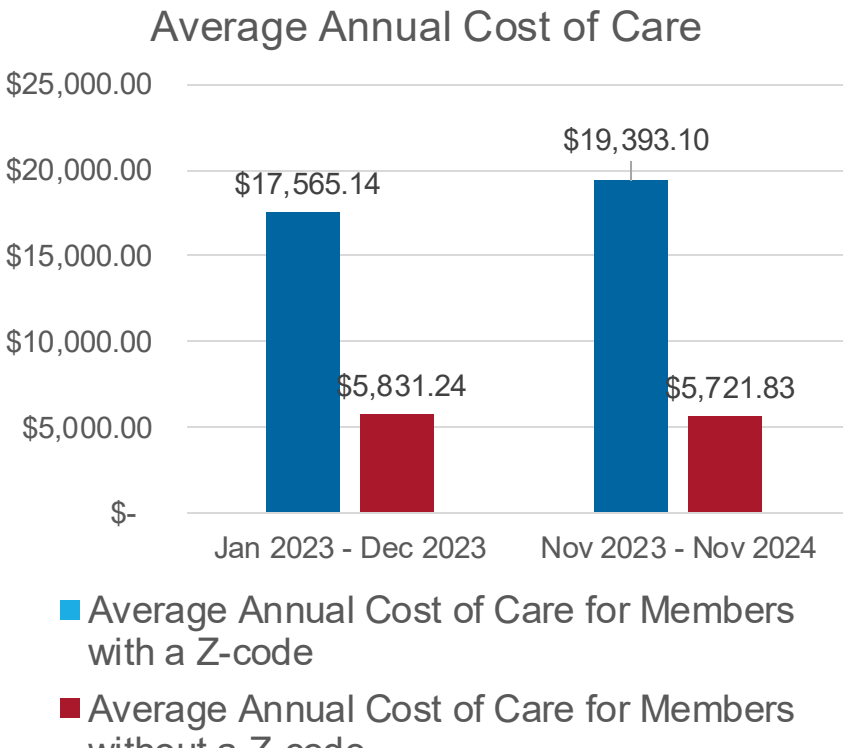


Laminated pocket cards help providers quickly identify and document common Z codes.

DEMOGRAPHIC ONLY	DEMOGRAPHIC & DISEASE BURDEN RISK SCORE
Lives at home	Lives at home
Age 28	Age 28
Second year on Medicaid	Second year on Medicaid
	Type 2 diabetes mellitus without complications (E11.9)
	Morbid Obesity (E66.01)
PROJECTED COST OF CARE	**PROJECTED COST OF CARE**
$	$$

Nebraska Sample Medicaid Partner Data

DHHS Template Refreshed Data Jan 2023-Nov 2024



Summary:

The average annual cost of care for Medicaid Partner A patients ***with* a documented Z-code** is typically **more than twice the cost of care** compared to patients *without* a documented Z-code

Performance Outcomes

Strategic Priorities

NHN Core Quality Measures

Focused on 13 quality measures to ensure clinical performance in screenings, immunizations, disease management, medications and utilization.

Medicare Annual Wellness Visits

Focused on increasing the quality completion of AWVs with Medicare beneficiaries.
Target: 80% completion rate

Medical Risk Adjustment

Our MRA strategy encourages accurate coding and documentation to reflect patient complexity and optimize reimbursement.
Target: 82.5% cHCC recapture rate

Post-Acute Care

Our PAC strategy optimizes patient outcomes by providing oversight throughout the care continuum including post-acute, SNF and home health.

Health Equity

We help advance the vision that all people can attain the highest level of health and wellness.

Key Highlights

Medicare Annual Wellness Visits

Increased completion rate from 20% in 2016 to 83% in 2024

Medical Risk Adjustment

Increased chronic HCC recapture rate from 74% in 2017 to 84.85% in 2024.

Post-Acute Care

Developed a preferred SNF network helping to achieve 9% per capita SNF cost reduction from 2022 to 2024

National Benchmarking Cohort

Cohort Selection Criteria

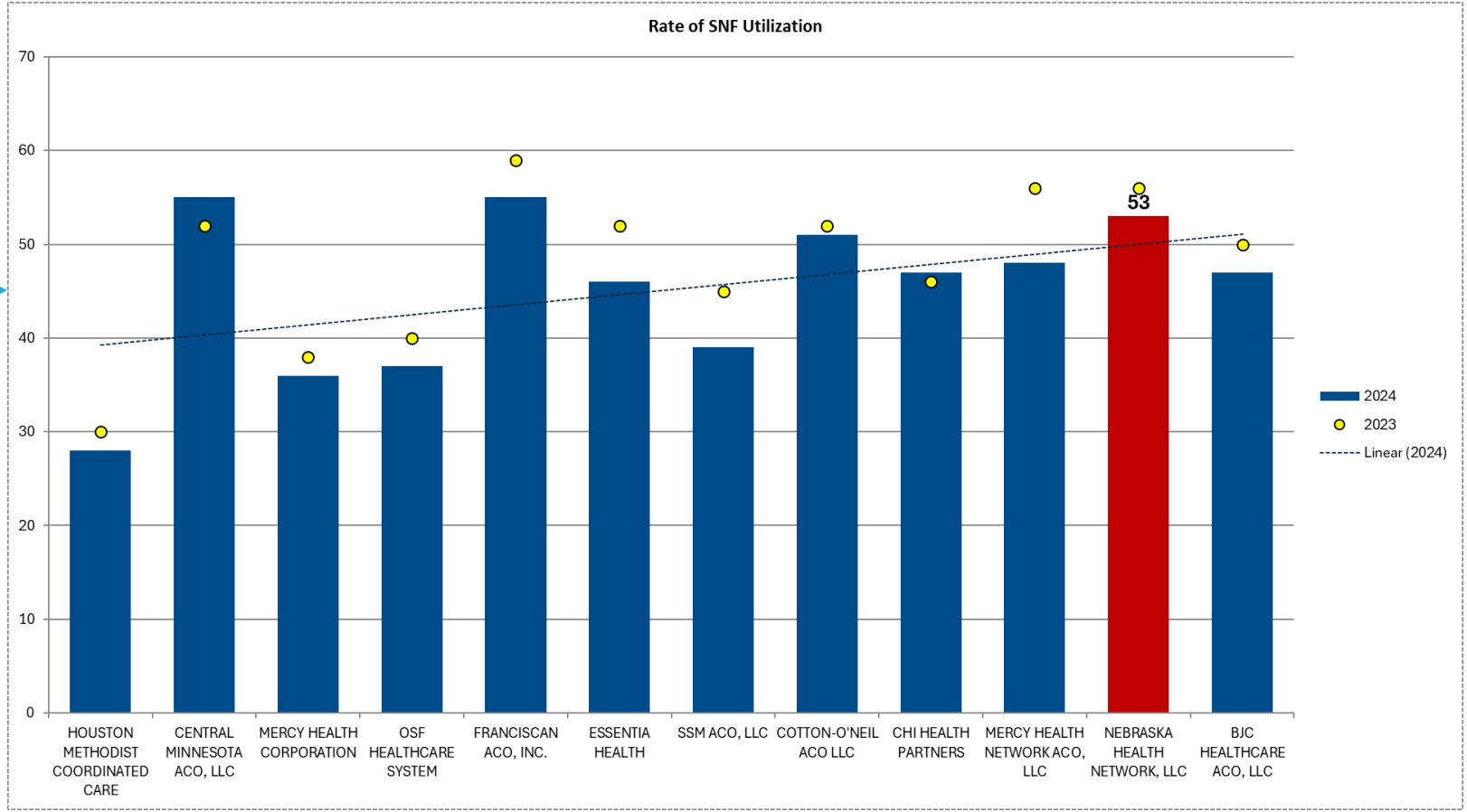
- Risk-Bearing Contract
- Experience/level in MSSP
- Number of beneficiaries
- PCP-to-Specialist Ratio
- Regional ACOs

	IA	IL	IN	KS	MI	MN	MO	ND	NE	TX	WI
BJC HealthCare ACO, LLC		◉					◉				
Central Minnesota ACO, LLC						◉					
CHI Health Partners	◉								◉		
Cotton-O'Neil ACO LLC				◉							
Essentia Health						◉		◉			◉
Franciscan ACO Inc		◉	◉								
Houston Methodist Coordinated Care										◉	
Mercyhealth Corporation		◉									◉
MercyOne ACO III	◉	◉									◉
Nebraska Health Network LLC	◉								◉		
OSF HealthCare System		◉			◉						
SSM ACO, LLC		◉									

Markets Served

Example: SNF Utilization Rate/K 2024

45
Average Rate



ACOs Ordered by Total Savings Per Beneficiary.

NEBRASKA HEALTH NETWORK

METHODIST

Nebraska Medicine

NebraskaHealthNetwork.com

Follow Us

Jefferson Health

Jefferson Health: Advancing Excellence in Value-Based Care

Innovative approaches improving patient outcomes and efficiency

Who Are We

Thomas Jefferson University

200+ Graduate and undergraduate programs

77,000+ Alumni

17 NCAA Division II teams

8,300+ Students (full/part time)

Over **$200 million** In applied, basic, clinical and scholarly research

1,000+ Patents for new drugs, software innovations, medical devices and diagnostic tools

Data is FY24 - updated January 2025

Jefferson Health

4,350 Employed physicians

32 Hospital campuses

700+ Sites of care

13,600+ Nurses (full/part time)

4 Magnet® designated locations

4 Pathway to Excellence® designations

2,500+ Advanced Practice Clinicians

8.8+ million Outpatient visits (hospital and physician)

Data is FY24 - updated April 2025

Jefferson Health Plans

362,000+ Total members

40+ Years of service

316,000+ Medicaid members

750 Employees

13,000+ Medicare members

20,000+ CHIP members

13,000+ Individual and family plans

Data is 12/24 - updated January 2025

Who Are We

Celebrating 30+ years of nationally ranked care

By U.S. News & World Report

Thomas Jefferson University Hospitals
- 2nd in the Philadelphia metro area
- 3rd in Pennsylvania (tied)
- 2nd in the nation for Ophthalmology (Wills Eye Hospital)

Lehigh Valley Hospital—Cedar Crest
- 1st in the Allentown metro area
- 3rd in Pennsylvania (tied)

Jefferson Abington Hospital
- 8th in the Philadelphia metro area
- 17th in Pennsylvania

Jefferson Moss-Magee Rehabilitation
- MossRehab 10th in the nation for Rehabilitation

THOMAS JEFFERSON UNIVERSITY HOSPITALS

Nationally Ranked in 6 Specialties

- #2 Ophthalmology — WILLS EYE HOSPITAL
- #19 Orthopedics — ROTHMAN ORTHOPAEDICS AT JEFFERSON HEALTH; THE PHILADELPHIA HAND TO SHOULDER CENTER AT JEFFERSON HEALTH
- #22 Ear, Nose & Throat
- #25 Neurology & Neurosurgery
- #35 Pulmonology & Lung Surgery
- #39 Gastroenterology & GI Surgery

HIGH PERFORMING

- Cancer — JEFFERSON HEALTH – SIDNEY KIMMEL COMPREHENSIVE CANCER CENTER
- Geriatrics
- Urology

LEHIGH VALLEY HOSPITAL—CEDAR CREST

Nationally Ranked in 2 Specialties

- #25 Orthopedics
- #42 Pulmonology

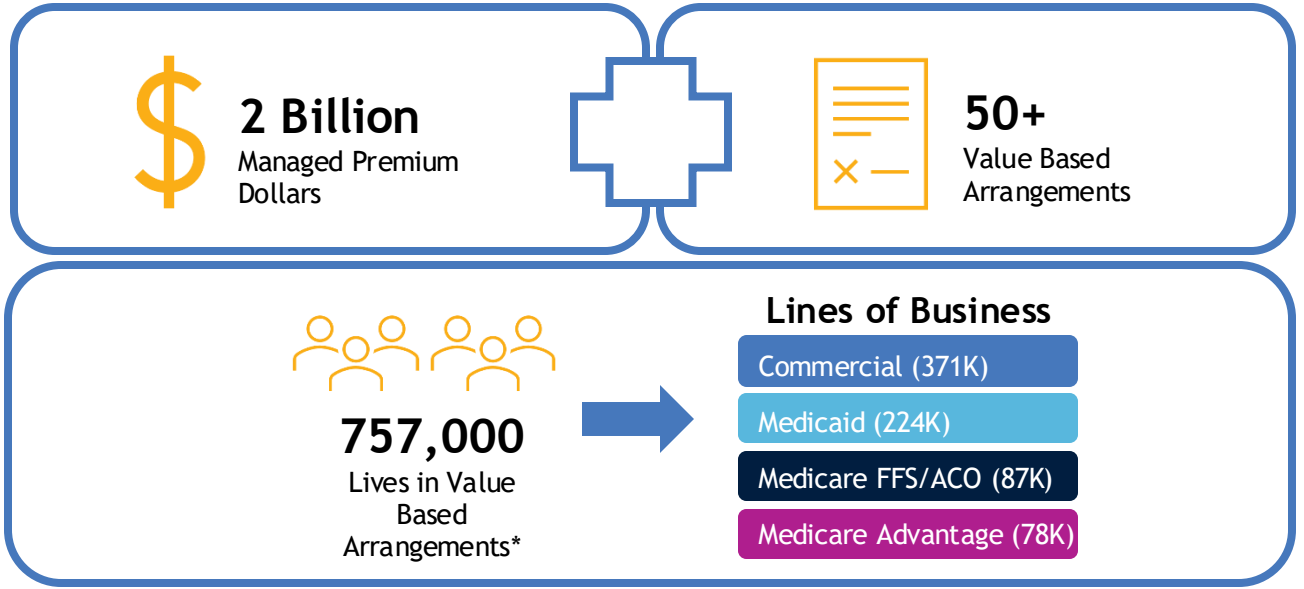
HIGH PERFORMING

- Cardiology, Heart & Vascular Surgery
- Diabetes & Endocrinology
- Gastroenterology & GI Surgery
- Geriatrics
- Neurology & Neurosurgery
- Urology

Jefferson Health Footprint

- Serving rural and urban populations across Pennsylvania and New Jersey
- 700+ Total sites of care
- 150+ Primary care sites
- NCI-designated Sidney Kimmel Comprehensive Cancer Center is one of 57 comprehensive cancer centers nationwide
- Level 1 trauma centers

Jefferson- Value-Based Care Landscape



Jefferson's Value-Based Commitment

Scale and Diversity

Jefferson manages nearly 750,000 lives across Medicare, Medicaid, and commercial lines, showcasing broad reach and capability.

Value-Based Revenue Growth

Post-COVID-19, Jefferson achieved $180 million in value-based revenue, demonstrating resilience and strategic growth.

Risk-Based Care Models

Jefferson operates three MSSP ACOs and participates in full or downside risk arrangements in commercial, Medicare, and Medicaid lines of business.

Enterprise-Wide Commitment

The organization's enterprise-wide approach highlights dedication to value creation and innovation in health and education.

Jefferson's Einstein Care Partners MSSP ACO Performance

Overview

Associated with Jefferson's safety net hospitals serving a 25% Black, Indigenous, and People of Color (BIPOC) population.

Covers approximately 30,000 beneficiaries.

Performance Highlights

Had not achieved shared savings since 2020; now expecting over $4 million in shared savings for CY 2024.

Primary care visits per 1000 increased from 9,106 to 10,580 (2021–2023).

ED visits per 1000 reduced from 717 to 680 (2021–2023).

Inpatient visits per 1000 reduced from 300 to 257 (2022–2025).

Quality Improvements

Hemoglobin A1c (HbA1c) Poor Control (>9%) improved from 19.60% to 14.70% (2021–2023).

Colorectal Cancer Screening improved from 68.70% to 75.10% (2021–2023).

Breast Cancer Screening improved from 76.50% to 78.70% (2021–2023).

Controlling High Blood Pressure improved from 65.10% to 76.60% (2021–2023).

Screening for Depression and Follow-Up Plan improved from 79.40% to 91.20% (2021–2023).

ECP MSSP ACO Performance Highlights

Measure	2024 FINAL SCORE		2023 FINAL SCORE		2022 FINAL SCORE		2021 FINAL SCORE	
	ECP Rate	2023 Measure Score	ECP Rate	2023 Measure Score	2022 Rate	2022 Measure Score	2021 Rate	2021 Measure Score
CARE-2: Screening for Future Fall Risk	95.97%	10	94.00%	10	88.10%	9.8	89.70%	9.96
DM-2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	12.10%	9.79	14.70%	9.52	16.20%	9.38	19.60%	9.04
HTN-2: Controlling High Blood Pressure	82.40%	9.24	76.60%	8.66	69.00%	7.89	65.10%	7.5
MH-1: Depression Remission at Twelve Months	24.18%	NA	23.60%	NA	19.50%	NA	15.30%	NA
PREV-5: Breast Cancer Screening	80.65%	9.06	78.70%	8.87	76.70%	8.66	76.50%	8.64
PREV-6: Colorectal Cancer Screening	75.10%	8.51	75.10%	8.51	65.80%	7.57	68.70%	7.87
PREV-7: Influenza Immunization	73.11%	8.31	72.90%	8.28	70.10%	8	66.00%	7.59
PREV-10: Tobacco Use: Screening and Cessation Intervention	78.57%	8.85	76.50%	8.64	65.20%	7.52	54.30%	6.42
PREV-12: Screening for Depression and Follow-Up Plan	92.80%	10	91.20%	10	78.90%	8.89	79.40%	NA
PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	94.94%	NA	94.00%	NA	88.00%	NA	85.70%	NA
Total Quality Measure Points		**73.76**		**72.48**		**67.71**		**57.02**
Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate	0.17%	1.68	0.17%	1.46	0.20%	3	0.20%	3
Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC)	NA	NA	NA	NA	39.20%	3	41.30%	3
CAHPS Score	6.62	6.62	5.36	5.36	NA	6.19	NA	7.66
Total Cost and CAHPS Points		**8.30**		**6.82**		**12.19**		**13.66**
Final Quality Score (for comparison against benchmark)		**82.06**		**79.32**		**72.64**		**70.68**
40th Percentile Quality Benchmark		77.05		* 2022 40th 77.73		77.73		77.83
Quality Points (Out of 50)		**41.47**		**40.11**		**36.62**		**35.36**

Einstein Care Partners MSSP ACO Performance Highlights

Metric	2021	2023
Primary Care Visits/1000	9106	10580
ED Visits/1000	717	680
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	19.56%	14.74%
Colorectal Cancer Screening	68.74%	75.10%
Breast Cancer Screening	76.50%	78.70%
Controlling High Blood Pressure	65.10%	76.60%
Screening for Depression and Follow-Up Plan	79.40%	91.20%

Team Based Care- Responsibilities

Care Coordination

TOC
LCM
CCM
RPM
Chronic Condition

Quality/ Engagement

Quality Care Gaps
- HEDIS
- STARS
- eCQM
- Pediatric Measures
- VB contracts

Campaigns
Retinal Eye Program
Practice Transformation
- Workflow Optimization
- PDSA

Ambulatory Pharmacist

Medication Adherence
Medication Management
- Refill Conversion

Chronic Condition Mgt
Collaborative Care
Opioid Stewardship

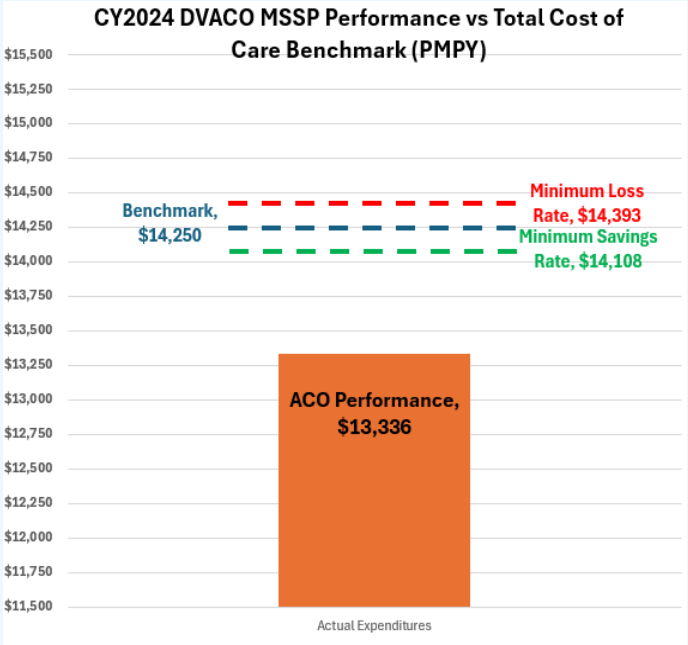
Social Services

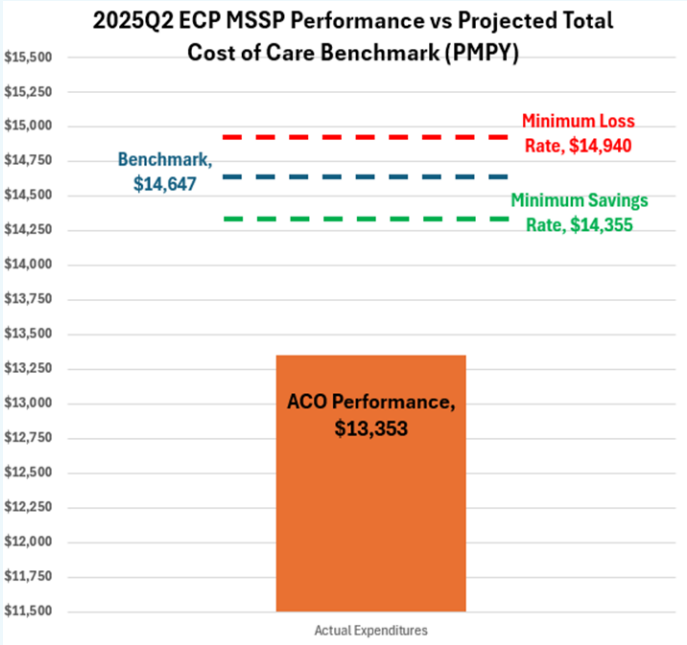
HRSN Screening
Referrals SW
Insurance Navigation
Community Based Programs
CHW buddies

Accountability Tracking- Payer Program View

Highmark -Quality Improvement Program - Commercial & Medicare Advantage									
Component	Component Weighting	Metrics	Targets	Measures Weighting	Earned Target	Earned Points	Potential Points	Earned Dollars*	Potential Dollars *
Commercial Quality	37.5%	**55%**							
		Self Reported Metrics - ACE (15)	≥ 75th Percentile	20.6%		0.0	55		
		45%							
		All Cause Readmissions	≥ 75th Percentile	4.5%	< 50th percentile	0.0	12.0		
		Potentially Avoidable ED Utilization	≥ 80th Percentile	3.0%	≤ 30th percentile	0.4	9.0		
		CG-CAHPS	≥ 90th Percentile	9.4%		6.0	25.0		
Medicare Advantage Quality	36.5%	**45%**							
		STARS (18 Measures)	≥ 4.35 Stars	16.4%	3.60	9.0	45.0		
		STARS Bonus Opportunity	Tiered	n/a	3.60	n/a	n/a		
		55%							
		Annual Wellness Visit	≥ 75th Percentile	7.3%		0.0	20.0		
		All Cause Readmissions	≥ 75th Percentile	4.4%	≥ 50th - ≤ 59th	4.0	12.0		
		Potentially Avoidable ED Utilization	≥ 80th Percentile	2.9%	≤ 30th percentile	0.4	8.0		
		CG-CAHPS	≥ 90th Percentile	5.5%		3.0	15.0		
Inpatient Quality	26.0%	**IP Component Score**	≥ 66%	26%	45.9%	45.9	100.0		
		20%							
		STARS Bundle	≥3.85 Stars	5.2%	Varies by Hospital	0.0	20.0		
		80%							
		7-Day Readmissions (Commercial)	≥ 70th Percentile	1.3%	Varies by Hospital	0.9	5.0		
		7-Day Readmissions (Medicare Advantage)	≥ 70th Percentile	1.3%		4.5	5.0		
		3-Day Return (Commercial)	≥ 70th Percentile	1.3%		4.5	5.0		
		3-Day Return (Medicare Advantage)	≥ 70th Percentile	1.3%		4.6	5.0		
		Palliative Care (Commercial)	≥ 70th Percentile	0.8%		0.0	3.0		
		Palliative Care (Medicare Advantage)	≥ 70th Percentile	1.3%		3.7	5.0		
		7-Day Post Discharge Follow-Up Visits	≥ 70th Percentile	2.6%		0.8	10.0		
		C-Section Rate	≤ 40th Percentile	2.6%		0.0	10.0		
		Complications Rate Following THA/THK	Same as/Better Than	2.1%		0.0	8.0		
		PSI-09 Hemorrhage/Hematoma Rate	Same as/Better Than	2.1%		0.0	8.0		
		PSI-11 Post Op Respiratory Rate	Same as/Better Than	2.1%		0.0	8.0		
		PSI-13 Post Op Sepsis Rate	Same as/Better Than	2.1%		0.0	8.0		

Accountability Tracking – ACO TCOC Performance





Accountability Tracking – Team Report Out

2025 Population Health Value Base Care Operations Workgroup Team: Quality and Outreach

Past 30 Days Accomplishments & Deliverables
• Developed monthly KPI template to report on centralized and local population health outreach.
• Trained CHW team to assist with outreach to JHP and KF in-active/never seen patients.
• Finished IBC lab outreach.
• Text reminder to KF patients who are due for an annual dental exam. Health Equity population sent on 8/26.
• Telephonic outreach to Alaskan Native/American Indian patients with dental gap completed.
• PTC practice plans developed and shared with practices for VBC for Q3
• PTC discussing CHBP metric - reassessing elevated BP along with appropriate documentation
• All North staff trained on Cerner to assist with coverage of EPM eye days, as well as Cerner outreach
• Realign DM days to maximize success in VBC; 26 DM days scheduled for EPM (160 IBC pts)
• PH hosted 2 Mammo events; 32 women screened - 4 with findings and need additional screening

Decision/Issue Escalation

What (Decision/Issue Description)	What you need	By When
Horizon Medicaid VB Program	Medicaid Roster data in Epic and Qlik Scorecard data.	Will be important if Horizon rises to Tier 1.

VB Wellness & Engagement KPI Report

KPI Report

Actions in next 30-90 days

What (Activity Description)	Who (Owner)	Support Needed to Achieve Success	Due Date
• Outreach plan includes KF WCV, Commercial IBC RAF opportunity, and PCP visits.	Toni		9/30/25
• Preparing for IBC cervical cancer outreach. Will focus on practices who are not meeting targe and who do PAPs in their offices due to lack of GYN appointments.	Toni	Assistance to convey to OBGYN service line the importance of the new patient appointments for PAPs.	9/30/25
• Collaborating with Healthy Planet Team to develop Epic campaigns for WCV, Attributed Inactive/Never Seen Patients, and diabetic eye exams.	Toni		TBD
• Collaboration with Pediatrics and FM to transition outreach for KF & IBC WCV	Kim	PH working with operation to maximize access	Ongoing
• Formulate a plan for POC A1C testing for the Medicare population	Kim		9/12/2025
• Quarterly Quality Meeting - Quarter 3	Kim/PTCs		9/30/2025

Quality Scorecard- Trend to Goal

CURRENT	Performance thru Dec-24	Performance thru Jun-24	Performance thru May-25	Performance thru Jun-25	Band 2 Target	Gaps to Band 2 Target	Denominator	Numerator	Supplemental Rate	Gaps for Supplemental Rate	Weighted Rate	Focus
Breast Cancer Screening	83.09%	79.25%	79.70%	80.44%	82.00%	322	20,593	16,565	81.75%	52	80.34%	Tertiary
Cervical Cancer Screening	77.36%	72.37%	73.51%	74.30%	77.00%	948	35,102	26,081	75.02%	694	74.30%	Tertiary
Colorectal Cancer Screening	72.10%	63.61%	69.83%	70.74%	69.00%	0	50,257	35,551	72.16%	0	72.47%	Secondary
Controlling Blood Pressure	71.71%	65.00%	63.83%	68.56%	79.00%	2,687	25,739	17,647	77.58%	366	69.70%	Primary
HbA1c Control < 8	69.54%	55.09%	51.80%	55.10%	68.00%	1,159	8,977	4,946	65.14%	257	55.10%	Primary
HbA1c Control < 9	77.63%	64.91%	58.68%	62.15%	89.00%	754	2,806	1,744	78.40%	298	62.15%	Primary
Kidney Health Evaluation	70.79%	44.89%	40.60%	46.31%	62.00%	2,081	13,261	6,141	54.72%	965	47.59%	Tertiary
Retinal Exam	65.60%	53.96%	56.80%	59.24%	67.00%	914	11,782	6,980	63.08%	462	63.40%	Secondary
Child And Adolescent Well-Care Visits	57.76%	24.62%	21.17%	27.24%	66.00%	1,158	2,985	813	38.36%	826	27.24%	Tertiary

June 30th	Performance thru Dec-24	Performance thru May-24	Performance thru Apr-25	Performance thru May-25	Band 2 Target	Gaps to Band 2 Target	Denominator	Numerator	Supplemental Rate	Gaps for Supplemental Rate	Weighted Rate	Focus
Breast Cancer Screening	83.09%	78.03%	78.56%	79.70%	82.00%	485	21,079	16,800	80.71%	272	79.67%	Tertiary
Cervical Cancer Screening	77.36%	70.99%	72.24%	73.51%	77.00%	1,256	35,934	26,414	74.13%	1,031	73.50%	Tertiary
Colorectal Cancer Screening	72.10%	61.69%	68.96%	69.83%	69.00%	0	51,371	35,872	70.90%	0	71.59%	Secondary
Controlling Blood Pressure	71.71%	59.51%	57.38%	63.83%	79.00%	3,843	25,323	16,163	68.19%	2,739	65.29%	Primary
HbA1c Control < 8	69.54%	49.39%	45.79%	51.80%	68.00%	1,478	9,123	4,726	59.52%	774	51.80%	Primary
HbA1c Control < 9	77.63%	58.15%	51.41%	58.68%	89.00%	836	2,754	1,616	74.69%	395	58.71%	Primary
Kidney Health Evaluation	70.79%	38.42%	34.27%	40.60%	62.00%	2,858	13,354	5,422	47.88%	1,886	41.77%	Tertiary
Retinal Exam	65.60%	50.52%	53.04%	56.80%	67.00%	1,211	11,876	6,746	59.93%	840	60.89%	Secondary
Child And Adolescent Well-Care Visits	57.76%	19.89%	14.99%	21.17%	66.00%	1,415	3,155	668	27.61%	1,212	21.17%	Tertiary

Multi Payer Portfolio – ACOs/ CINs

ACO Payer Arrangements

MSSP

United

Aetna

Humana

Cigna

CIN/PHO Contracted Payer Arrangements

Independence Blue Cross

Keystone First

UPMC

Cigna

Aetna

Humana

Jefferson Health Plan

Highmark

Capital

United Medicare

Commercial & Medicare Advantage Success

Risk Arrangement Management

Jefferson Health successfully manages over 100,000 lives through its commercial and Medicare Advantage risk arrangements.

Financial Performance

The organization earned more than $50 million in cumulative payouts for 2023 and 2024 performance years.

Quality Improvements

Improvements include a 4% rise in colorectal cancer screening and an 11% betterment in blood pressure control.

Patient Therapy Advances

Improved statin therapy for patients with diabetes by 2% points, exemplifying enhanced patient care outcomes.

Medicaid Population Strategies

Risk Arrangement Management

Jefferson has risk agreements for over 100,000 Medicaid members.

Collaborative Care Approach

Jefferson population health in collaboration with primary care and our Jefferson Collaborative for Health Equity implemented specific strategies utilizing pharmacy, on site wellness days and community health worker support to improve quality for this population.

Improved Health Metrics

Key health indicators improved including asthma medication ratio by 3%, A1c control by 5% and controlling high blood pressure 9% points.

Focus on Developmental Screening

Developmental screening rates increased by 20%, highlighting focus on early health assessments.

Commitment to Equity

Initiatives reflect Jefferson Health's dedication to equity and innovation for vulnerable Medicaid populations.

Annual Wellness Visits & Social Needs Screening

Annual Wellness Visit Program

Jefferson Primary Care has improved overall care for older adults through its commitment to Annual Wellness Visits.

The Jefferson Medical Group implemented a nurse-driven AWV program to increase access and engagement.

Improved AWV visits by 5 percentage points, adding 8,800 visits in FY25.

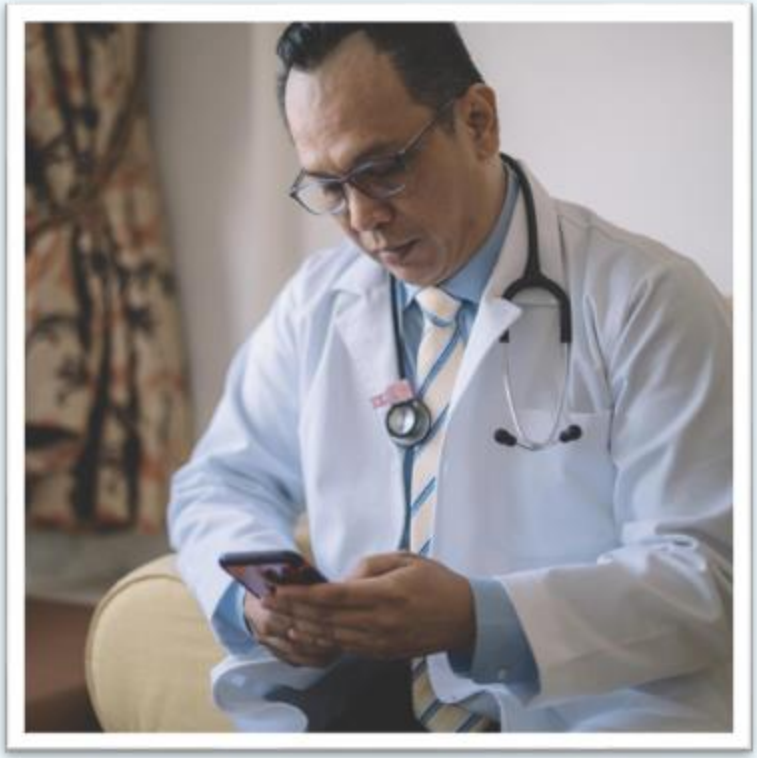
Social Needs Screening & Support

Jefferson Health implemented universal Health-Related Social Needs screening in 2023

Improved screening rates by 10 percentage points and reaching over 1 million patients by 2025.

Comprehensive care teams including social workers and community health workers support Jefferson Primary Care in addressing identified needs.

Rx Health Texting Platform



Patient Engagement via Texting

Rx Health platform is utilized to engage patients in preventative care and annual wellness visits, sending over 47,000 messages annually to enhance patient communication and engagement.

Behavioral Science Application

Nudge style texting is a more effective way to engage patients with tailored language.

Jefferson has formed a “Nudge Steering Group” to utilize the most effective techniques and language for campaigns like influenza vaccination.

Improved Wellness Visits

The platform has driven a 5% increase in Annual Wellness Visits within the medical group.

Technology-Driven Practice Improvements

Jefferson Health’s innovative use of technology supports better patient engagement and practice enhancements.

Portal Messaging

Happy Birthday, (Patient First Name)!

Happy birthday from your primary care team at Jefferson Health. Your birthday is a great time to remember important healthcare milestones and schedule health screenings. Regular visits with your provider, vaccinations and preventive screenings are important for maintaining your health and wellbeing. See the suggested screenings below, and make your health a priority this year.

Questions about the information below? Please contact your primary care provider at (phone number) or via a MyJeffersonHealth message.

PREVENTIVE SCREENINGS	IMPORTANT DATES	WHY THIS IS IMPORTANT
Colorectal Cancer Screening To schedule a colonoscopy, call 800-JEFF-NOW. For an at-home test, contact your PCP.	Colorectal cancer screening not currently indicated **Colorectal cancer screening not currently indicated** **If you had an abnormal colonoscopy or have certain risk factors, you may need to be screened more frequently. In this case, please follow the screening schedule that your PCP or GI provider recommended.*	Screening is recommended for patients ages 45-75 via colonoscopy at least once every 10 years (depending on risk factors). Colonoscopies are safe and help detect problems such as polyps and cancer. Another option is an at-home stool test, which is completed every one or three years, depending on the type of test. At-home tests should not be used if you have certain risk factors or a previous abnormal colonoscopy.
Cervical Cancer Screening To schedule a Pap test, call 800-JEFF-NOW.	No pap test screenings are on file **You are currently overdue for cervical cancer screening**	Recommended once every three to five years for average risk patients ages 21 through 65. You can be screened through a Pap test. During a Pap smear, cells are collected and tested for cervical cancer. This test is quick and should not be painful. **If you have a history of abnormal PAP smears or positive HPV, have a history of cervical or other gynecological cancer or pre-cancer, have HIV or take certain immunosuppressant medications, you may need cervical cancer screening more frequently.*
Breast Cancer Screening To schedule a mammogram call 800-JEFF-NOW or Epichttp://Scheduling[click here].	No mammograms are on file **You are currently overdue for breast cancer screening**	Recommended screening every one to two years beginning at age 40. A mammogram is an X-ray of the breast used to look for early signs of breast cancer. Regular mammograms are the best way to find breast cancer early. . Individuals with heterogeneously dense or extremely dense breast tissue may be recommended for ultrasound screening in addition to screening mammogram.

According to our records, you are due for your annual visit with your primary care provider!

Pts. not seen in last 12 months

PRIMARY CARE PROVIDER (PCP) VISIT	IMPORTANT DATES	WHY IS THIS IMPORTANT
You can schedule an annual visit via MyJeffersonHealth by Epichttp://Scheduling[clicking here] or you can call 215-997-0890.	Last PCP visit:	When you see your provider regularly, they are able to detect health conditions or diseases early. Identifying problems early gives you the best chance for getting the right treatment quickly and avoiding complications.

Have you already completed any of these screenings? Great! Please forward test results to your provider to update your health record.

Thank you for choosing Jefferson Health as your health care partner. We look forward to seeing you soon.

Mailer Campaign- *Never been Seen Patients*

Jefferson Health

Welcome to Jefferson Health

Thank you for selecting a Jefferson Health doctor or advanced practice clinician for your healthcare. Whether you're in the suburbs or the city, we have multiple state-of-the-art facilities across the region—so you can always find the care you need nearby.

At Jefferson Health, we are reimagining health care through our service-minded and diverse community of providers and specialists. We strive to be bold and innovative, while putting your health and safety first. Each day, we are focused on you.

From complex conditions to daily aches and pains, our world-renowned multidisciplinary providers work together to help you live life, better. With hundreds of primary care physicians and specialists to choose from, we have a care team that is right for you.

We look forward to providing you with uncompromising care.

Schedule an Appointment with a Primary Care Provider (PCP)

Primary care providers help manage your day-to-day health needs:

- They teach you how to stay healthy
- Monitor health screenings for conditions like cancer, high cholesterol or diabetes
- Treat you when you are sick
- Manage chronic conditions like diabetes, high blood pressure or arthritis

Build a relationship with your PCP before you need them. Even if you don't currently have any medical issues, make sure your health is on the right track.

Make an appointment today!

1-800-JEFF-NOW
JeffersonHealth.org/Schedule

JEFFERSON 200

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Need Care Before Your Appointment?

If you need care prior before your appointment, don't worry! We've got you covered with our 5 urgent care locations and JeffConnect virtual visits.

Urgent Care and JeffConnect Virtual Visits should be used when your condition requires immediate attention but isn't life threatening:

- Infections or allergies
- Cough, cold, flu
- Burns
- Prescription refills

Other Reasons to Use Urgent Care

- You doctor isn't available or it's after hours
- You might have a sprain or broken bone or need stitches

Walk-ins welcome or call to make an appointment.

Other Reasons to Use JeffConnect Virtual Visits

- You prefer to see a provider virtual using your smartphone, tablet or computer with a webcam
- Your doctor or urgent care locations are not available or it's after hours.

Download the App and Enroll

- Download the JeffConnect app from the App Store or Google Play. You can also visit JeffConnect.org
- Create an account
- Once you are enrolled, log into JeffConnect for an on-demand visit with a Jefferson provider.

Urgent Care Locations

Jefferson Health
Urgent Care Flourtown
1820 Bethlehem Pike
Flourtown, PA 19031
215-836-1354

Jefferson Health
Urgent Care Grant Avenue
2451 Grant Avenue
Philadelphia, PA 19114

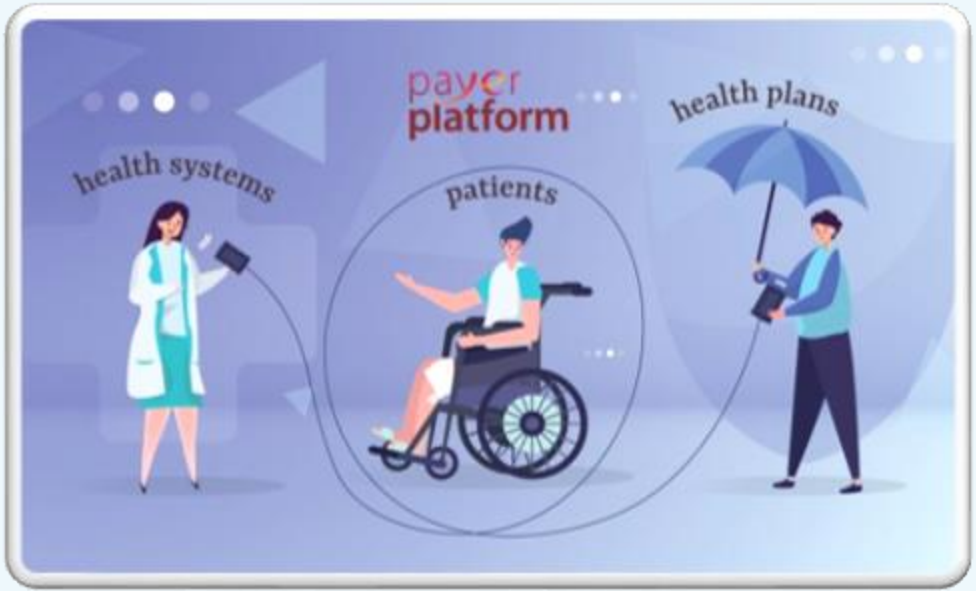
Jefferson Health
Urgent Care Rittenhouse
2021 Chestnut Street
Philadelphia, PA 19103
267-443-2020

Jefferson Health
Urgent Care Smylie Times
2607 Rhawn Street, Suite 403
Philadelphia, PA 19152
215-333-0304

Jefferson Health
Urgent Care Washington Square
700 Walnut Street
Philadelphia, PA 19106
215-503-7300

Jefferson Health

Epic Payer Platform & Data Efficiency



Overview

Jefferson utilizes Epic as its EMR and care management solution.

Epic Payer Platform

Implemented Epic's newest offering to reduce manual data submissions and improve value based contract metrics.

Improves interoperability with Payors and allows for more efficient sharing of EMR data, reducing reliance on claims information and manual data feeds.

Efficiency Gains

Reduces lag time and allows reallocation of resources to patients with true gaps in care.

Post-Acute Care Network & Bamboo Technology

YEAR	SNF ADMISSIONS/1000
Jan 2023	58
Dec 2024	46

Overview

Jefferson formed a high-performing network of post-acute facilities in 2023.

Technology Integration

Includes monitoring, site visits, data exchange, and collaborative care coordination.

Results

Reduced SNF admissions from 58/1000 to 46/1000 over two years.

Bamboo Technology

Post acute facility connections can often be limited for care coordinators.
Jefferson has implemented Bamboo technology to get real time alerts to post acute care managers facilitating improved transitions of care and patient engagement when patients need post acute care
Nearly 100 preferred and participating facilities participate with Jefferson via an “ACO Flag” that makes it easy for them to see when ACO patients are onsite.

Community Health Collaborative and CHW Academy

Community Health Collaborative

Partnering with community to solve the most pressing challenges across Pennsylvania, Delaware, and New Jersey.
Through its Community Health Collaborative, Jefferson coordinates efforts with local organizations, public health agencies, non-profits, and faith communities.
Leverages resources from Jefferson Health, Jefferson Health Plans, and Thomas Jefferson University, and Sidney Kimmel Medical College, to address social determinants of health.
The initiative begins with community needs assessments and develops tailored solutions. Impact is measured through improved patient outcomes and healthier communities.

CHW Academy Training

Jefferson Population Health collaborates with the Community Health Collaborative to operate the CHW Academy.
The academy provides trainees with exposure to population health strategies and prepares them to serve Jefferson's diverse patient populations.
The Academy functions as a workforce development pipeline, equipping CHWs with the skills needed to support care coordination and community-based interventions.

Impactful Health Programs

Programs like Blood Pressure Buddy utilizes CHWs to engage patients in hypertension control.
The program has been successful in enrolling over 150+ patients who RN care managers have previously not been able to engage in monitoring and primary care visits.

Health Mentors Program and Mobile Health Initiatives

Health Mentors Program

A 20-year partnership where 230 community members participate annually as Health Mentors to help educate health professions students—including all Sidney Kimmel Medical College students. The program promotes sharing their experiences with chronic health conditions, impairments, or disabilities to educate interprofessional groups of students on the value of team based, person-centered care through home visits and meetings.

JeffHOPE Mobile Health Initiative

Founded in 1991, JeffHOPE engages 200+ medical students and 50 residents annually to provide over 5,000 patient visits at four homeless shelters and one needle exchange site. The initiative exemplifies culturally responsive care and community-guided wellness.

Cancer Screening Mobile Unit

Jefferson's mobile health initiatives partner with trusted nonprofits and businesses to address community-identified barriers. The Sidney Kimmel Cancer Center Mobile Screening Unit has delivered cancer screenings to over 3,000 underserved patients.

In Summary

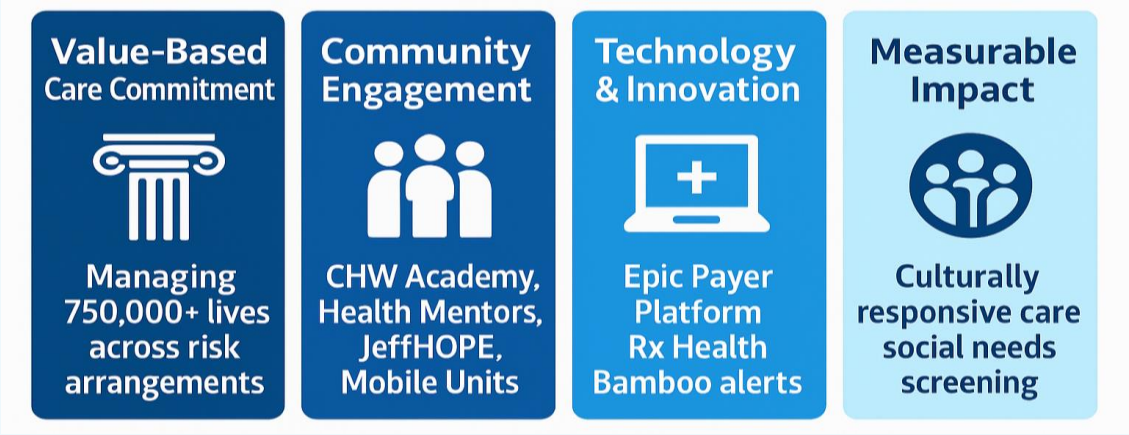
Jefferson Health remains steadfast in its commitment to value-based care across Medicare, Medicaid, and commercial populations.

Innovative programs like the CHW Academy, Blood Pressure Buddy, and JeffHOPE demonstrate measurable impact and community engagement.

Technology-driven solutions, including Epic Payer Platform and Rx Health, enhance care coordination and patient outreach.

Strong partnerships with community organizations, public health agencies, and educational institutions drive equity and culturally responsive care.

Jefferson's integrated approach continues to improve outcomes, reduce costs, and build sustainable pathways to wellness.



Jefferson's Commitment to Excellence

Commitment to Equity

Jefferson Health prioritizes equity to ensure fair and inclusive healthcare for all populations.

Innovation in Technology

Investment in advanced technology and data analytics drives improved healthcare outcomes.

Collaborative Partnerships

Strong community and ACO partnerships enhance value-based care and cost reduction.

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Panel Discussion

- Describe your early challenges and how you overcame them.
- What's one thing you'd definitely do again and one thing you'd definitely do differently?
- What advice would you give to organizations just starting their VBC journey?
- What are the current challenges you're grappling with today?
- How has your organization's VBC strategy shifted through the years?

Audience Q&A

Virtual participants – use the Whova app to submit questions!