Practice Transformation Strategies Panel Discussion

NAACOS
September 22, 2023

Practice Transformation Strategies: Unlocking Success in Value-Based Care

Panel Moderator
Jonathan Rubens,
MD, MHPE
Chief Medical Officer
CVS Accountable Care

Panelist
Janet Comrey,
RN, BSN, MHSA, CCSG, IA
Director of Payment Transformation
Geisinger

Panelist
Anthony Ardito,
MD
Chair and Vice President
Primary Care
Catholic Health

Panelist
Laura J. Zimmermann,
MD, DipABLM, MS, FACP
Medical Director of Value Based Care for Primary Care
RUSH

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“I AM IN FAVOR OF PROGRESS; IT’S CHANGE I DON’T LIKE.”—MARK TWAIN

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Serving the Quintuple Aim

- Cost
- Quality
- Health Equity
- Patient Satisfaction
- Provider Satisfaction

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Enabling the Shift from Volume to Value with Practice Transformation

System Challenges		Transformation Opportunities
Misaligned payment models	→	Financial programs
Provider strain / Workforce	→	Practice supports
Growing health disparities	→	Population analytics
Infrastructure	→	Scale, Skill and Cost

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CVS Health services are embedded in communities across the nation

~85%

of U.S. population lives within 10 miles of our CVS Health® community locations

~4.5

million consumers visit CVS Health locations daily

>9,000

local CVS Health touchpoints

>1,000

MinuteClinic® locations in our CVS ACO

~110

million PBM plan members

>23

million medical benefit members

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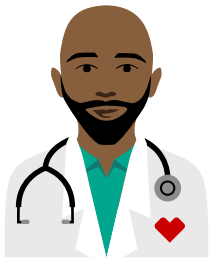
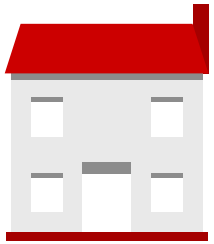
CVS Accountable Care™

CVS Health Value-Based Care Strategy

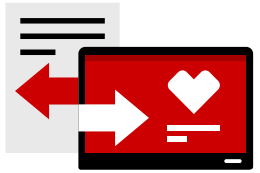
A focus on three key pillars:



Primary Care



Home Health



Provider Enablement

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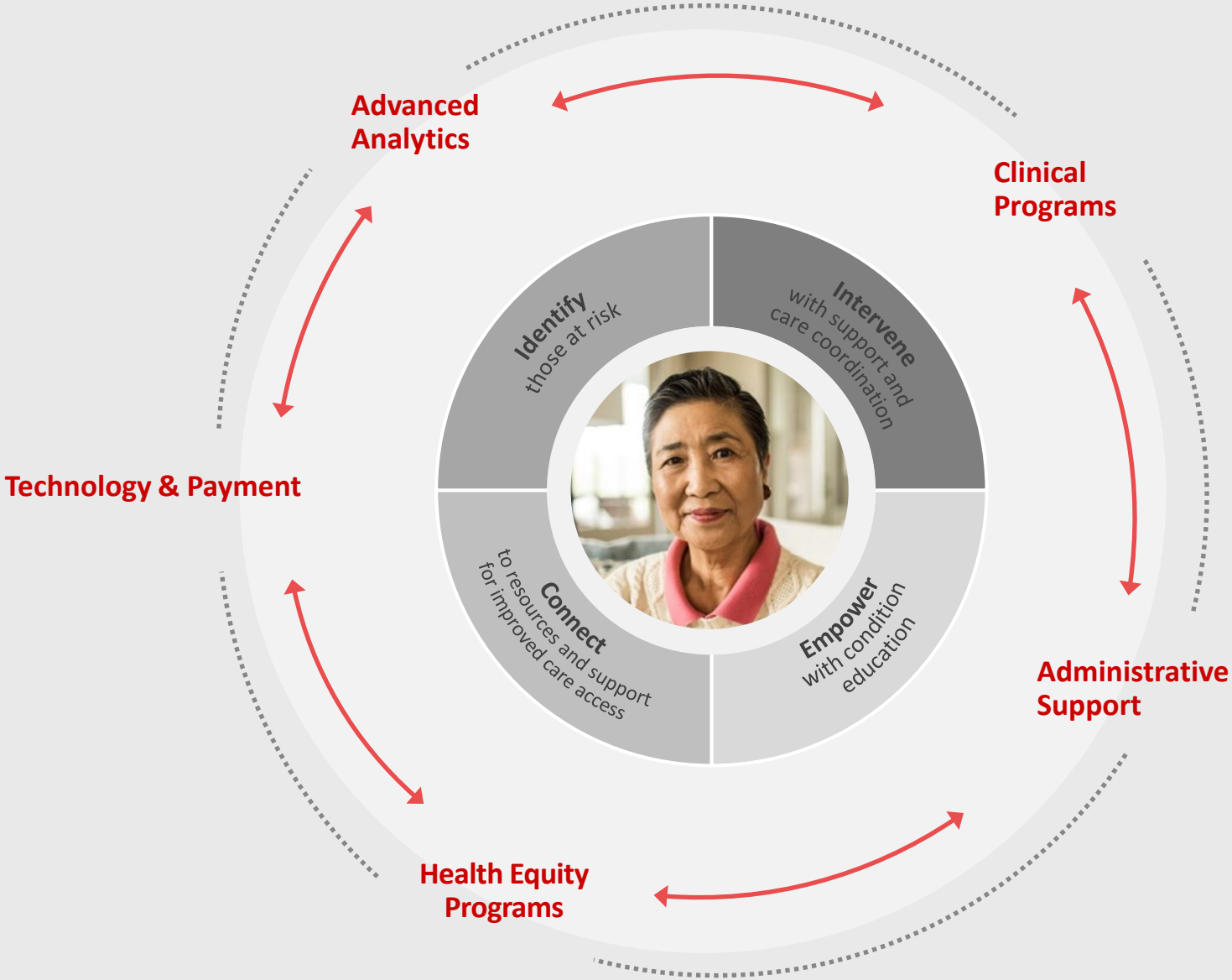
What is the CVS Accountable Care approach?



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Panel Discussion

Catholic Health

Anthony P. Ardito, MD
VP, Primary Care Service Line
Chief Medical Officer, Physician Partners IPA

Agenda Topice

Valued Based Goals/Opportunity

1. Catholic Health VBC

2. Practice Performance
   - ACO reach report card
   - One voice report card

3. Provider Engagement – What levers need to be pulled?

4. Alignment of Provider Compensation to System Goals

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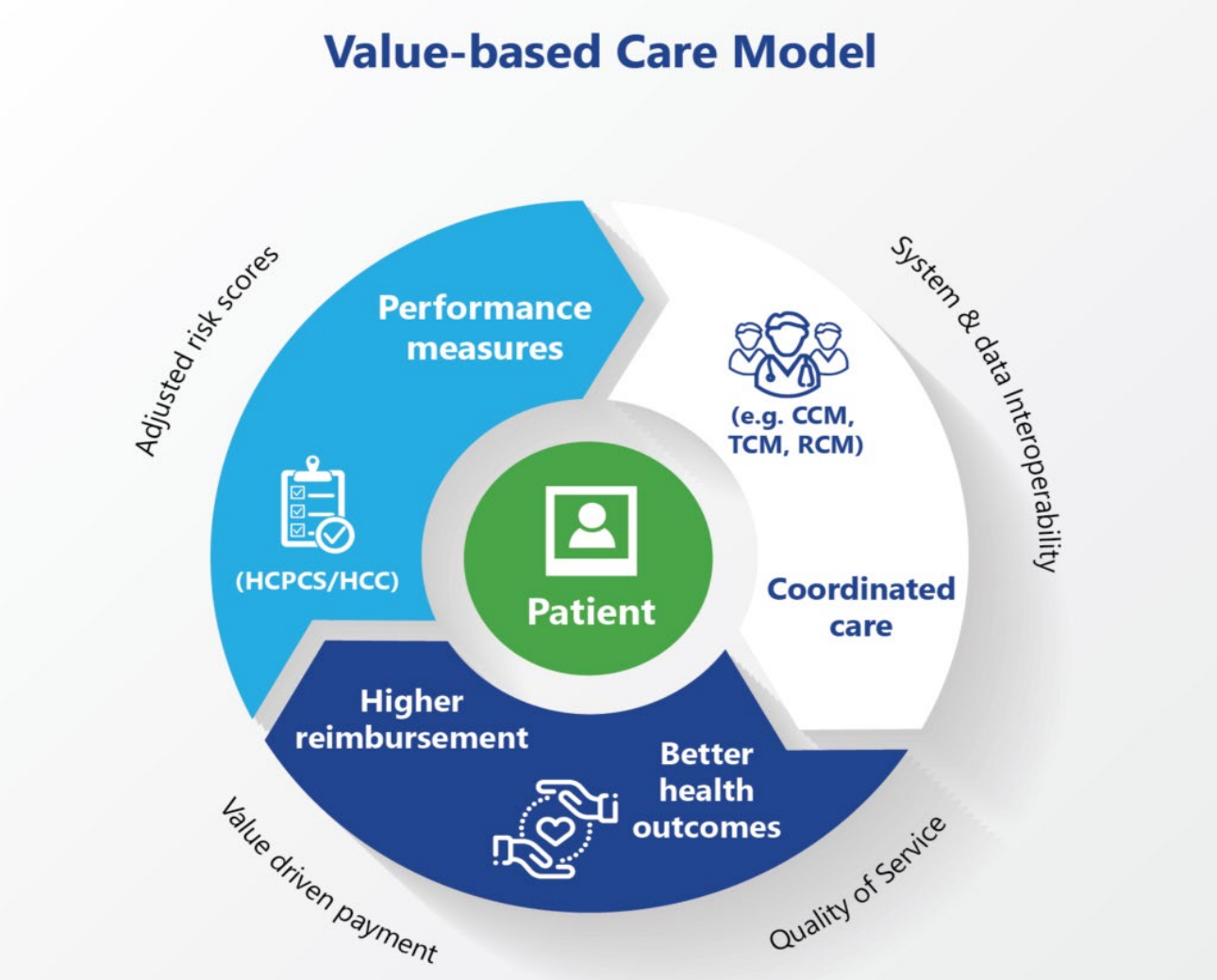
*Success in Value Based Care

1. Quality
2. Risk Adjustment
3. Spend
4. Network Utilization
5. Provider/Staff Engagement
6. Patient Experience
7. Patient Engagement



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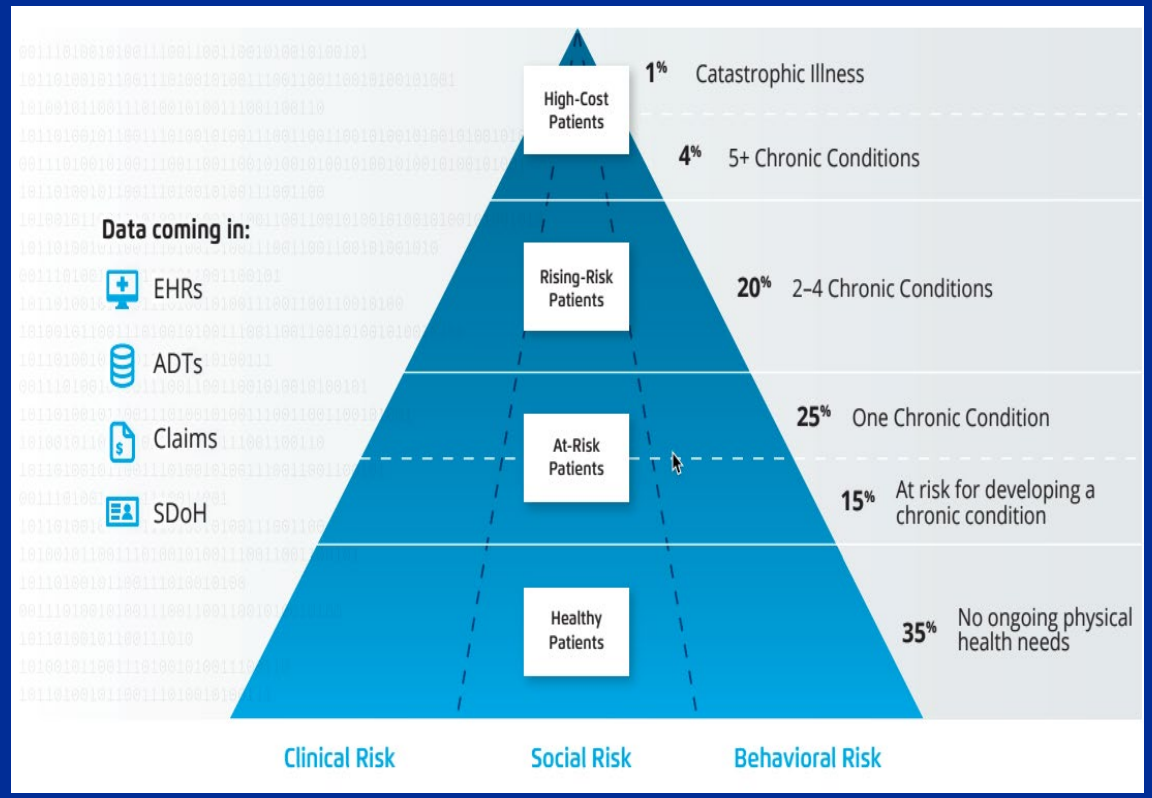
Prioritizing Efforts



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Catholic Health Provider Scorecard – Employed Practices

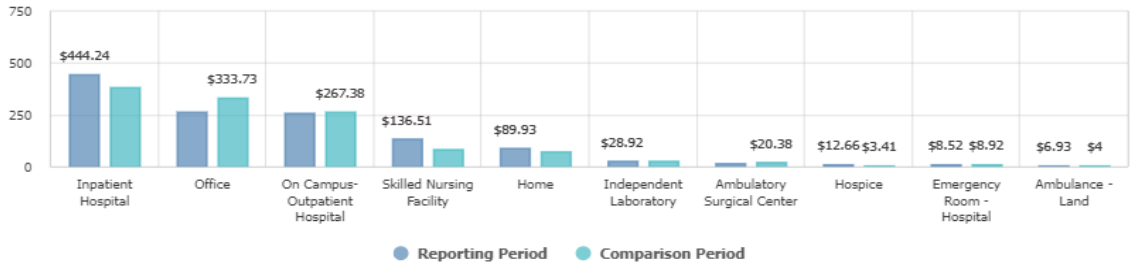
 # Attributed Beneficiaries
18,489
18,489 (+0.00%)

Total PBPM vs. BoB Average
$1,294.55 -6.07%
$1,215.95

21.33
Readmits/K vs. BoB Average

IP Admits/K vs. BoB Average
200.78 -2.62%
195.53

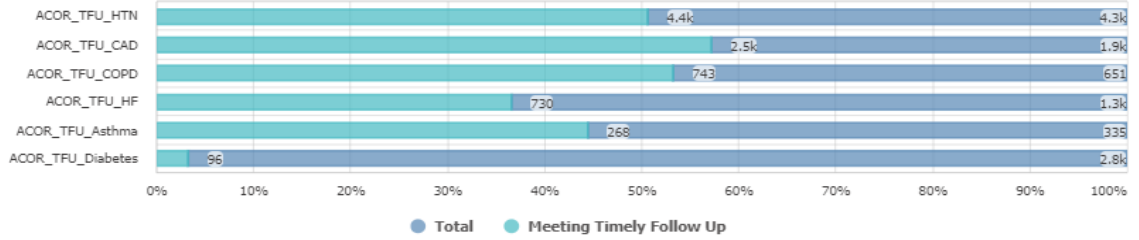
Medical PBPM Spend by Place of Service



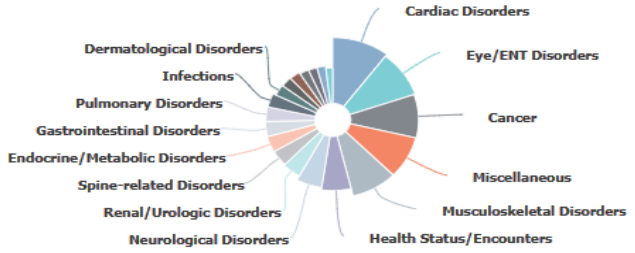
ED Visit/K vs. BoB Average
258.3 +12.72%
291.15

SNF Days/K vs. BoB Average
1,229.47 -4.72%
1,171.42

Timely Follow Up
After Acute Exacerbations of Chronic Conditions



PBPM Spend by Condition and Percent of Total



8.07%
Annual Wellness Visit %

15,270
Beneficiaries w Office Visit

HCC Score vs. Comparison Period
0.51
0.51 (+0.33%)

3.48%
HCC Recapture % (Chronic)

3.48%
HCC Recapture % (Total)

New HCC Suspect Capture %
0.00%
0.00% (+0.00%)

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One Voice Goals

Aligning our Voluntary and Employed Providers to common metrics

Goal: A single source of truth that aligns both voluntary and employed providers into a single platform of quality, utilization, and cost metrics thereby holding all accountable for metrics surrounding our valued based programs that is easily deliverable to the doctors and is actionable

- Consistent and recognizable metrics that deliver a clear message to providers
- Validated and referenced data with intuitive meaning
- Decommissioning confusing dashboards that no longer align with organizational goals
- This report card can be used to align our PIIP payments on both the employed and voluntary side.
- Our goal is to manage our own quality and utilization data through a handful of meaningful, actionable dash boards

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One Voice Scorecard and the One Voice Dashboard

Aligning Metrics with System Goals

The One Voice Scorecard

- Provides a retrospective view of performance on key value-based clinical quality, utilization and cost metrics
- Updated monthly and calculations reflect year-to-date
- Scorecard results are subject to claims lag
- Static tool on gaps in care, utilization, and spend

The One Voice Dashboard

- Provides patient-level information to help providers and practices manage their valued-based patients
- Identification of members who the provider is accountable for but do not frequent the practice
- Supports clinicians with pre-visit planning at the point of care
- Focus on patients with increased risk for recurrent hospitalization, overutilization of medical services, and poor coordination of services by segmenting patients into high, medium (rising) and low risk via the Johns Hopkins ACG® risk score
- Allows access to outside patient encounters so providers can see where the patient went, when, with whom, and what were they seen for

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ONE VOICE

Catholic Health Physician Partners

Provider Performance Scorecard

Measurement Timeframe: Year To Date Jan- Feb 2023

Practice: Great Place

Provider Name: Dr Who

Total Member Months 700 **Attribution** #

Performance Category	Category Weight	Current YTDa	Prior YTD	Peers YTD	Target	Performance to Target	Points Earned
1. Preventive Care Compliance	30.0%	34.97%	40.5%	40%	55.0%		66.6
2. Primary Quality Score	40.0%	30.00%		30.0%	50.0%		33.3
3. Spend	30.0%	Value					59.96
Admits per 1,000 (Score / Percentile) b		4.5	8.58	11.00	11		33.3
Readmissions (Percent)		0%	15%	13%	12%		33.3
ED Visits per 1,000 b		15	17.60	16.00	13	Met	100
Generic Prescribing Rate		79%	39%	0.67	75%		66.6
Total spend PMPM b		272.00	833.25	792.00	740		66.6
4. In Network	N/A	45%	15%	50%	60%		
							Percent Earned
	100.0%						51.288

a. YTD Year to Date
b. Target is a Percentile

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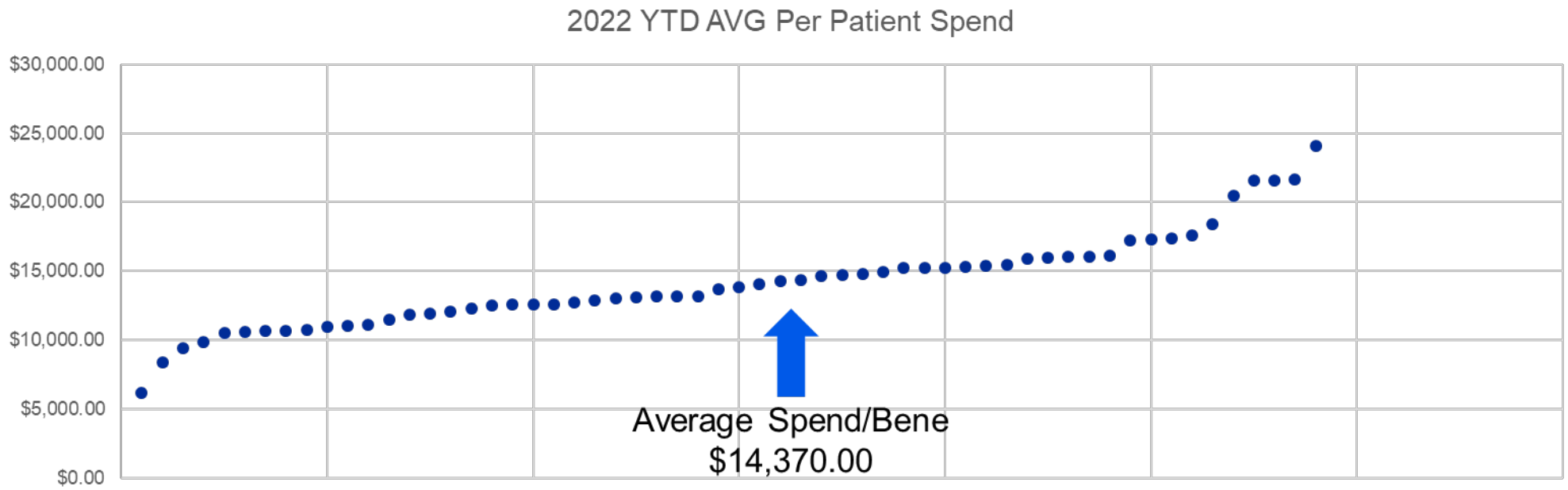
What effects outcomes?

- Provider variability in care often result in increased readmission rates and poorer outcomes
- Provider Access
- TOC - Improved coordination in the immediate post hospitalization period when the risk for readmission is highest Driving factors:
  1. Patient access to immediate care
  2. Medication errors
  3. Falls risk
  4. Patient engagement
- SNF over-utilization and readmission to acute care facilities are often avoidable with improved coordination with high value SNF facilities
- Levers of Success (Quality, Spend, HCC, Utilization)

Un-blinding Data – Supports heathy competition



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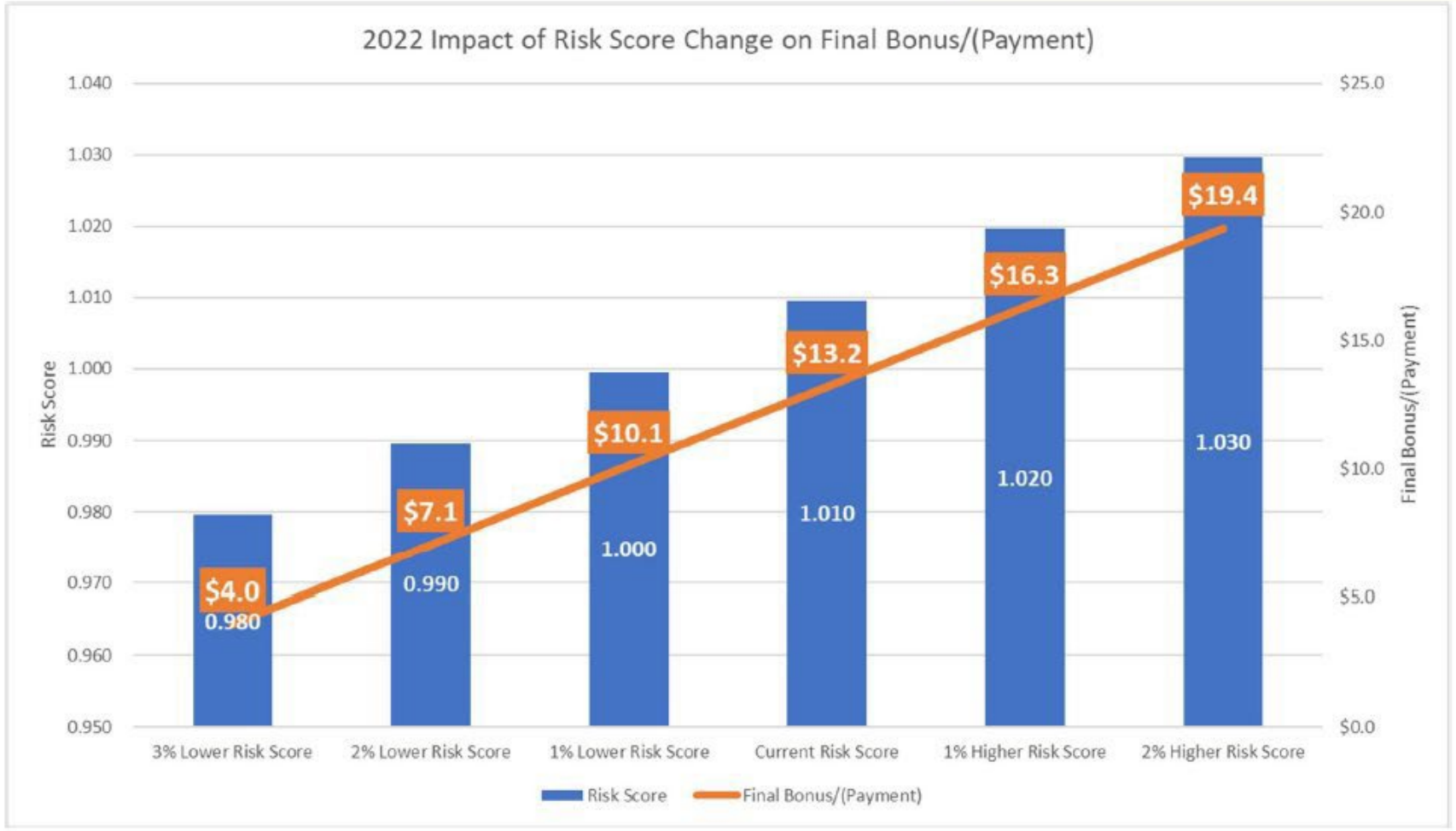
2022 Risk Score

1% change in risk score is ~$3.1M



- Current Assumption is 1.4% aggregate decrease from 2021 risk score levels (0.4% lower than 2022Q3 forecast)
- Uncertainty due to possible rebound of CMS National Average Renormalization factor
- Value of 1% Change in Risk Score is ~$3.1MM

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Source: CedarGate

Transitional Case Management

Identify and prioritize opportunities to reduce readmissions and utilizes resources onsite and post discharge:

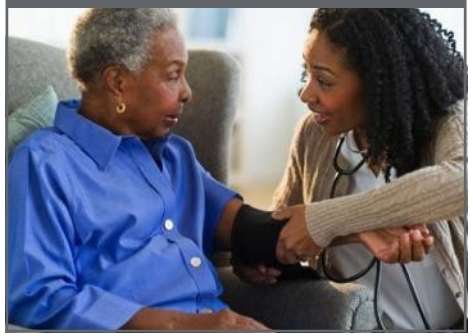
Onsite

Onsite resources at each facility establish communication with patient as a “trusted advisor” within 24 hours of admission

An identification and stratification process analyzes each admission, including:

- Age and gender
- Current and prior admission diagnoses
- Behavioral health, cardiology, GI, ID and respiratory diagnoses confounders for current and prior admissions
- Prior out-patient, ER, home health and durable medical equipment services
- Current and prior prescription drug patterns; therapeutic class, compliance and mix

Post Discharge



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Telephonic

Case managers establish communication within 24 hours of discharge, prepare for follow-up appointments and facilitate post-discharge services.

Home Visit

Available to highly complex, at-risk populations, nurses provide an initial in-home comprehensive assessment and follow-ups.

TeleHealth

Can be leveraged in addition to primary methods to address disability, mobility, locality, complexity, acuity and adherence issues.

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Redesigned Primary Care Physician Compensation Model

Seek alignment with system goal and provider compensation

Developed a new primary care compensation model ("PCP Comp Model"), designed to move the system towards a value-based care centered compensation model instead of the traditional RVU-based compensation model

Goals of the New Comp Plan:

1. Increase patient access (including new patient and panel size growth)
2. Improve overall panel management with enhanced clinical outcomes at reduced costs
3. Improved coordination of services with a narrow network of In-Network Utilization (INU)
4. Improved patient experience/satisfaction
5. Development of a team based approached where mid-levels support all system goals

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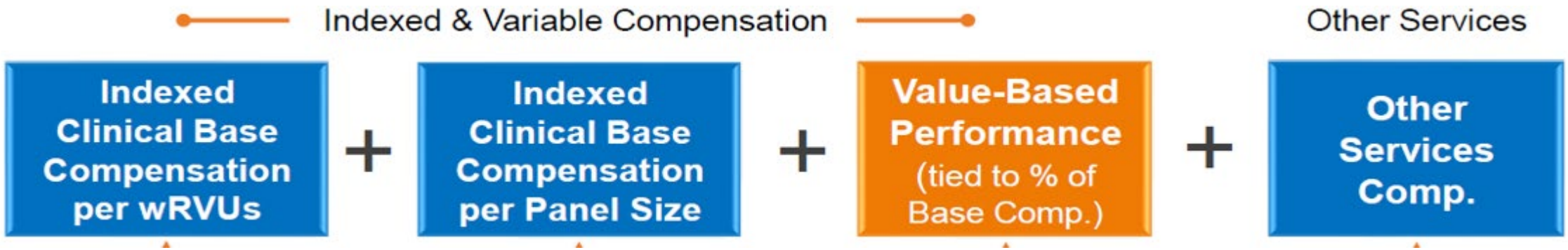
Primary Care Physician Compensation

New Standard Panel Growth Focused Model



= Total Cash Compensation

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About Keystone ACO

Janet L Comrey, RN, BSN, MHSA

Director

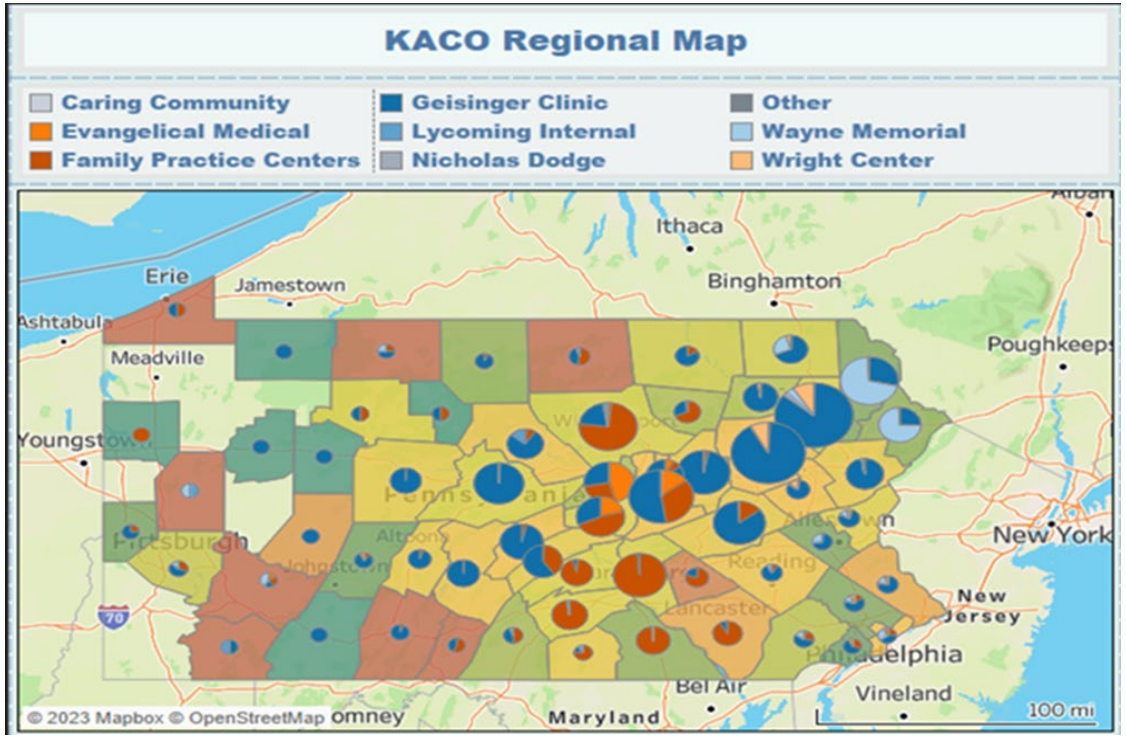
Geisinger serves as **Convener** and **Participant**

- **MSSP Level E** Risk Track
- **AVG 70,000** Beneficiaries
- 19 TIN Participants
- 4,100 Providers
- 5 Disparate EMRs; 1 Paper chart
    - Epic, Athena, Medent, DigiDMS, Meditech

Keystone ACO, LLC formed in 2012

- $201M Total Savings
- $92M Shared Savings

2023 Beneficiary Assignment by Partner	Unique Members	Percent of Members
Geisinger Clinic	34,491	51.35%
Prime Med	6,577	9.79%
Family Practice Centers	15,167	22.58%
Wayne Memorial	5,481	8.16%
Evangelical Medical	2,930	4.36%
Wright Center	1,118	1.66%
Caring Community	562	0.84%
Lycoming Internal Medicine	241	0.36%
Dr. Nicholas Dodge	204	0.30%
Other/null	400	0.60%



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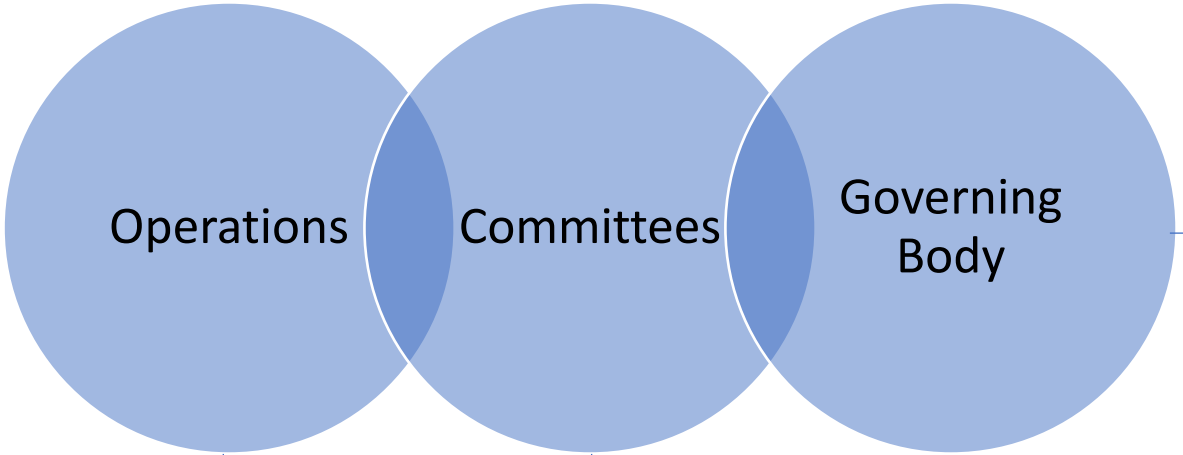
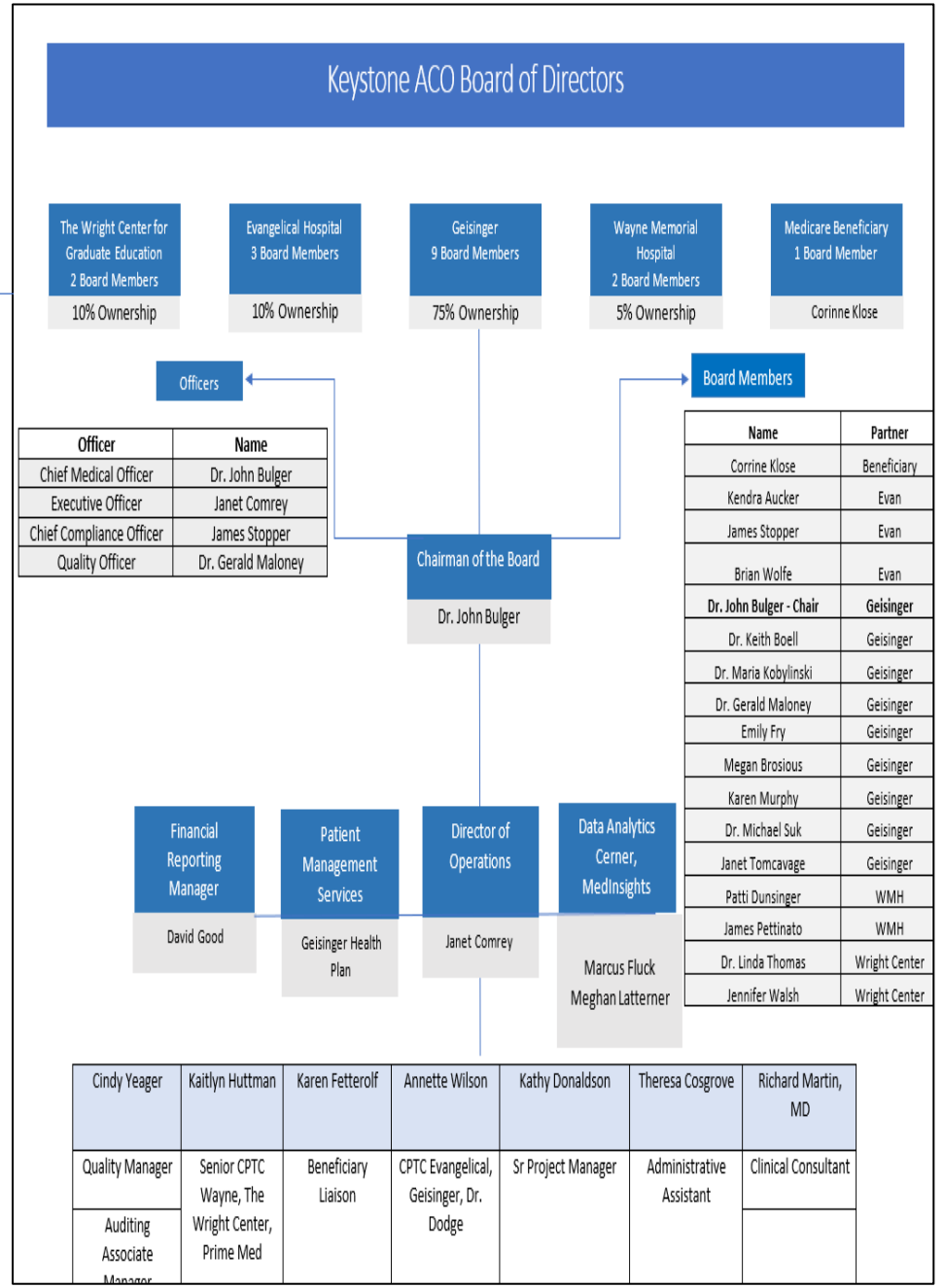
The Infrastructure



Medical Home Meetings/Collaboration
Chief Medical Officer Consortium
Operations Managers Consortium
SNF Network
At Home Services
MTDM Pharmacists
Medication Affordability Coordinators

Keystone ACO	Primary Responsibilities
Finance Committee	• Approval of the annual budget, long-range financial plans, capital requests • Definition and monitoring of financial metrics • Oversight of shared savings administration • Oversee audits • Approval of third-party contracts
Quality and Safety Committee	• Definition and monitoring of quality and performance metrics • Address quality and performance concerns • Ensure accurate and timely reporting of quality measures • Care management oversight and optimization • Working with Finance to develop and manage the Shared Savings program
Compliance & Credentialing Committee	• Oversee and monitor the implementation of the compliance plan, including standards of conduct • Ensure participant organizations have received, read, and understood the standards of conduct for the ACO • Ensure participant organizations educate employees and staff physician/suppliers on the ACO compliance plan
Analytics & Innovation Committee	• Coordinate the ACO activities with the Keystone Beacon Community and the KeyHIE • Oversee data collection, submission, and reporting • Oversee data analysis • Assist participants with their internal understanding and dissemination of reports • Definition, preparation, and reporting of ACO metrics (Dashboard) • Ensure HIPAA and HITECH standards are met by the ACO and its participants
Members Committee	• Review/approve existing Board members



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About Geisinger:

Integrated health system with $7+ billion in combined revenues

One Geisinger: Geisinger Clinical Enterprise | Geisinger Health Plan

We care for patients

- **10** hospital campuses
- **130** clinic sites
- **24,000** employees
- **1,800** employed physicians
- **Joint Venture** Inpatient Rehab Hospital
- **Addiction** Treatment Center

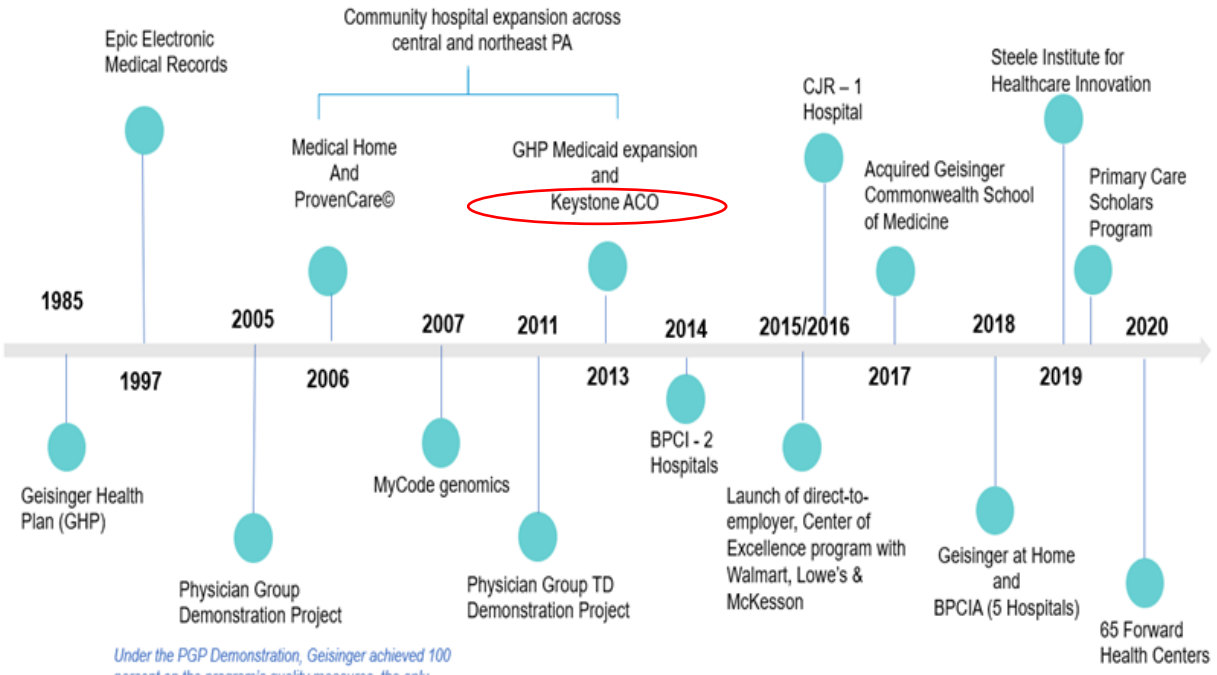
We care for GHP members

- **More than 600,000** risk lives managed
- **48,000** contracted providers in network

We teach, research and innovate

- **600** MBS/MD students at GCSOM
- **50+** students in School of Nursing, **2,300+** other nursing students
- **570** residents/fellows
- **1,000+** active research projects

Geisinger: 35 years of innovation



Vision: Making better health easy	Values:				
	Kindness	Excellence	Safety	Learning	Innovation

KeystoneACO