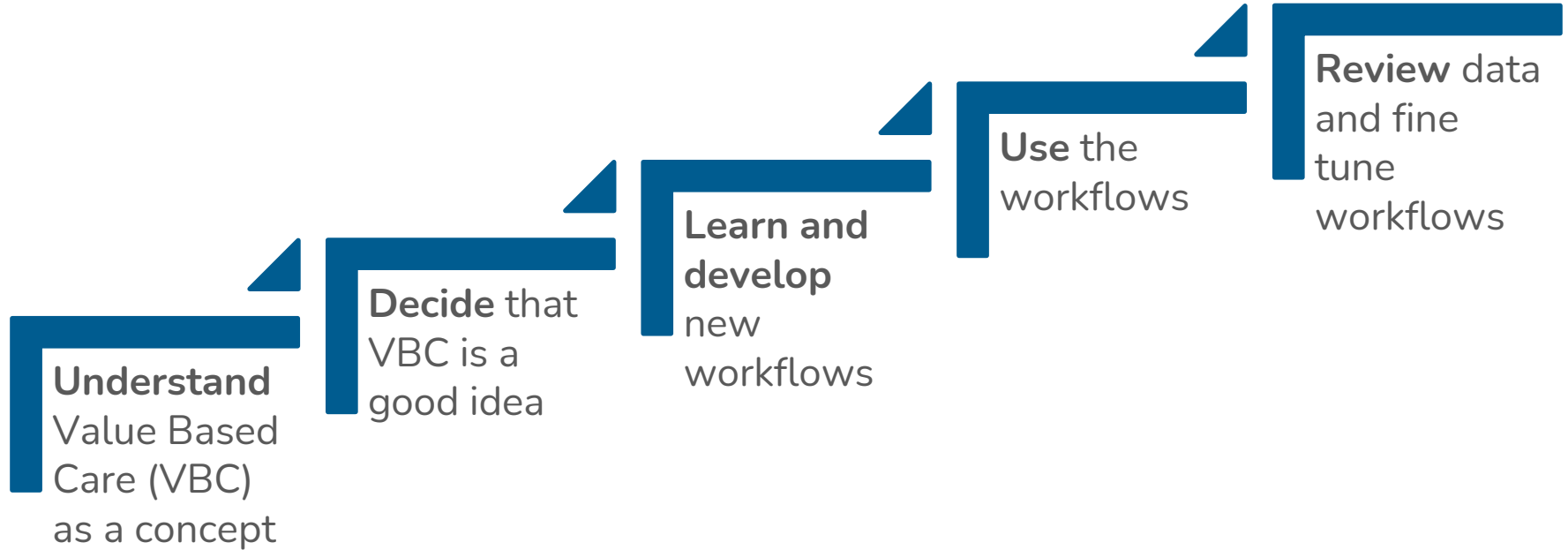


# Physician Engagement

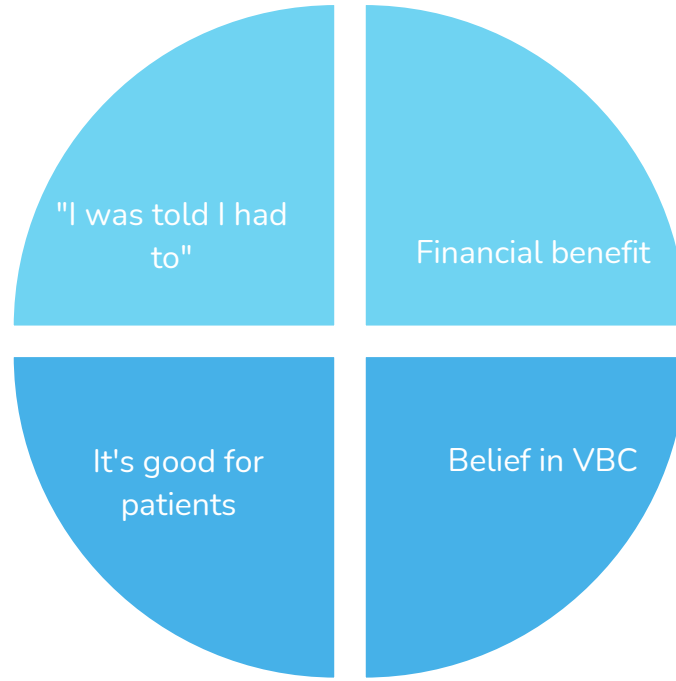
Catherine Smitas, MD FACP  
Regional Medical Director, Aledade



# Steps Towards Engagement



# Why do Clinicians Begin Value Based Care?



# Two Extremes

A small Independent practice only  
motivated by finances

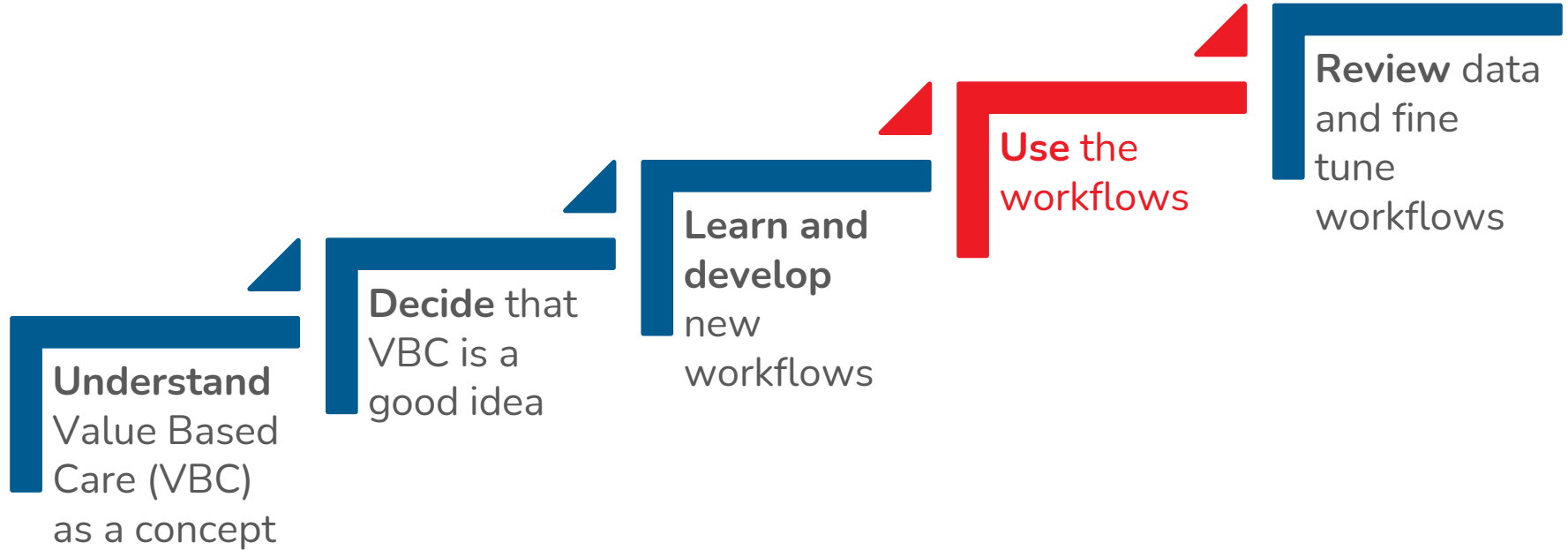


**Vs.**

A large FQHC with 100 clinicians



# Where do clinicians start?



# Financial Motivation Only

- Quick to change and achieve milestones
- Focus on winning the game
- Lose track of the big picture and stall or get distracted



# Large Organization, Employed Physicians

- Change will happen slowly
- Difficult to get all on the same page and to sustain the focus on the work



# Tools for Engagement for any practice

- Distribution Formula
  - Attendance at meetings
  - Performance Metrics
- Competition
- CME
- Having a broad definition of what is important in VBC – be useful
- Keep it clinically meaningful and patient specific whenever possible
- Encourage transparency about how the money is being spent



# Engagement with FQHCs – Balancing Approaches

Initial Strategies	Additional Strategies
Engage with Leadership	Engage with Individual doctors
Wait until they are ready	Try to push forward before they are ready
Virtual Meetings	In Person Meetings
Large Meetings	1:1 Meetings
Clinicians Meetings	Multidisciplinary Meetings
Metrics comparing across the ACO	Metrics showing individual clinicians
Focus on the Mission	Focus on the Money (encourage \$ incentives)
Good Cop	Bad Cop



**Thank you!**



# UNC Health Alliance

A Clinically Integrated Network & Population Health Services Organization

Laura Gay, MD, MPH, Medical Director, Population Management  
NAACOS Fall 2023, Provider Engagement Panel



# Overview

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- UNC Health Alliance Overview
- Population Management Overview
- Employed and Independent Practices: Unique Challenges
- Provider Partnership and Engagement Workgroups
- Population Management Services Care Management Examples and Insights Gained

# UNC Health's Strategic Transition to Value-Based Care

UNC Health's transition to Value -- investment in infrastructure to clinically integrate across care settings, contract for new, value-based payment models, and manage the health of populations across geographies

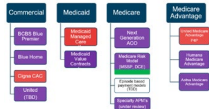
2015  
2017  
2019  
2021  
2022



**2012-2015** **system-wide commitment** to build our **population health infrastructure** to support enhanced care for patients and providers



**2015-2017** created UNC Health Alliance, our **statewide Clinically Integrated Network**



**2017-2020** launched **Next Generation ACO**, our first Advanced Alternative Payment Model and expanded risk portfolio to 15 value contracts across market segments and geographies



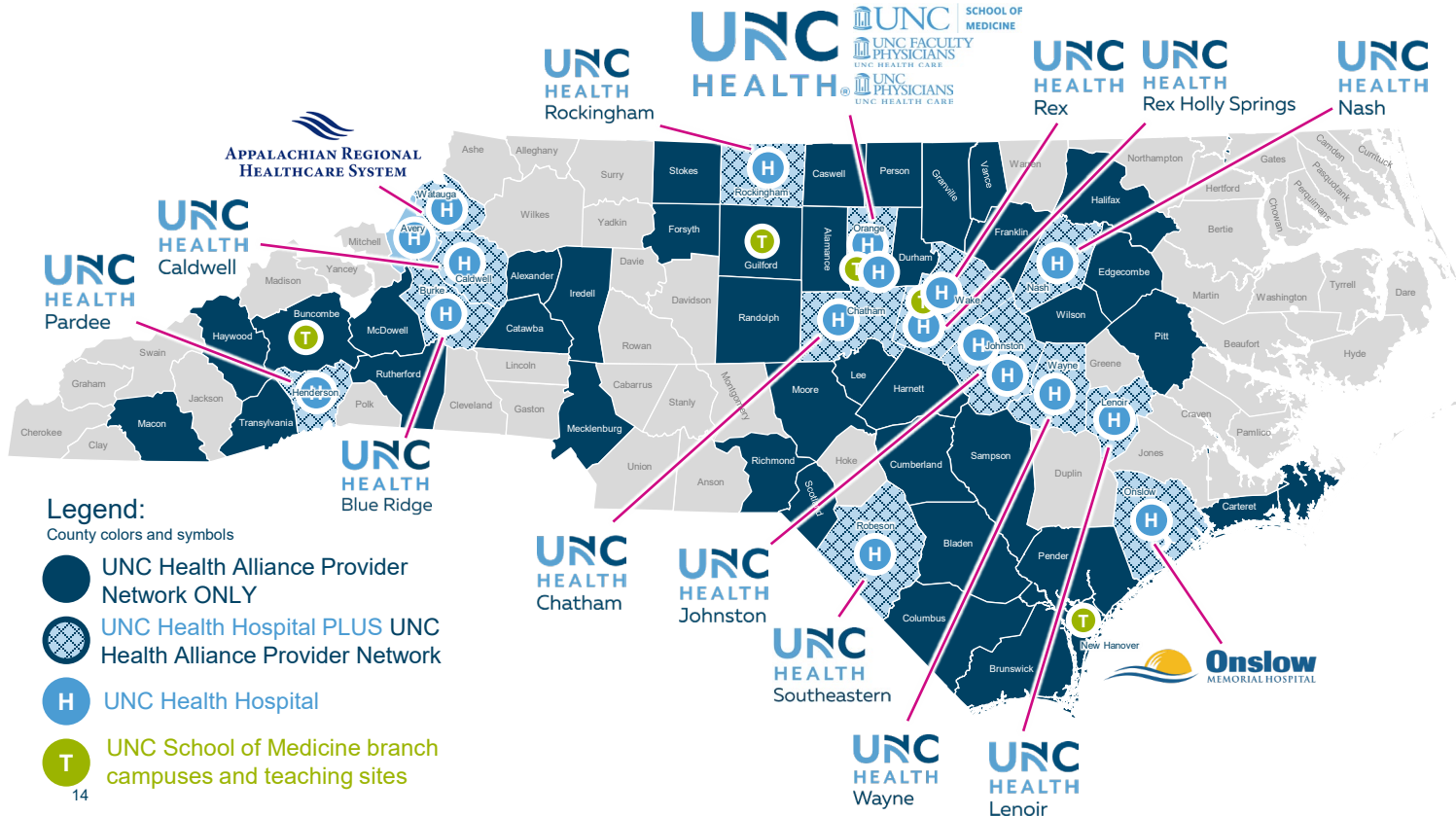
**2019** **partnered with BCBSNC** to offer **Blue Home** on the government market (ACA) as part of **Blue Premier**, the largest commercial Alternative Payment Model in North Carolina

**2022** partnered with **CMS in the Medicare Shared Saving Model** to reduce cost of care for Medicare beneficiaries



**2023** **regionalize the Care Model** and **differentiate Risk Pools** across North Carolina

# The Health Alliance Network Has 200+ Tax Identification Numbers (TINs) Participating in Value Contracts and Receiving Support Services



- Legend:**  
County colors and symbols
- UNC Health Alliance Provider Network ONLY
  - UNC Health Hospital PLUS UNC Health Alliance Provider Network
  - UNC Health Hospital
  - UNC School of Medicine branch campuses and teaching sites

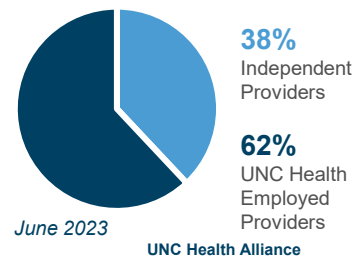
**UNC Health Alliance Provider Network**  
**1,066** **52** **13**  
 Locations Counties Hospitals

**7,500** with **2,800**  
 Providers Independent providers

**1,700** and **5,800**  
 Primary care providers Specialty providers

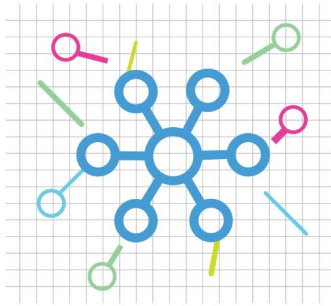
**164** SNF preferred network; home health preferred network  
 Specialty and subspecialties covered

**Community-based** palliative care and hospice programs

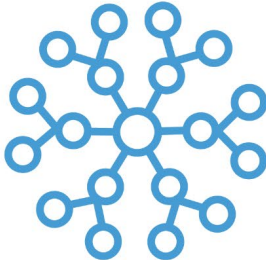


# Evolution of Our Health Alliance Network and Operations Is Built on the Principles of Quality Improvement

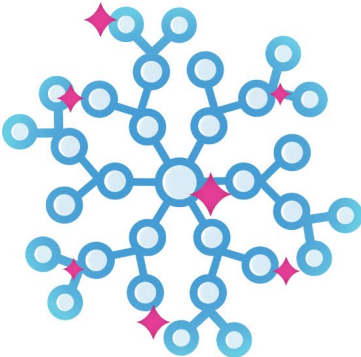
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**Network Growth**

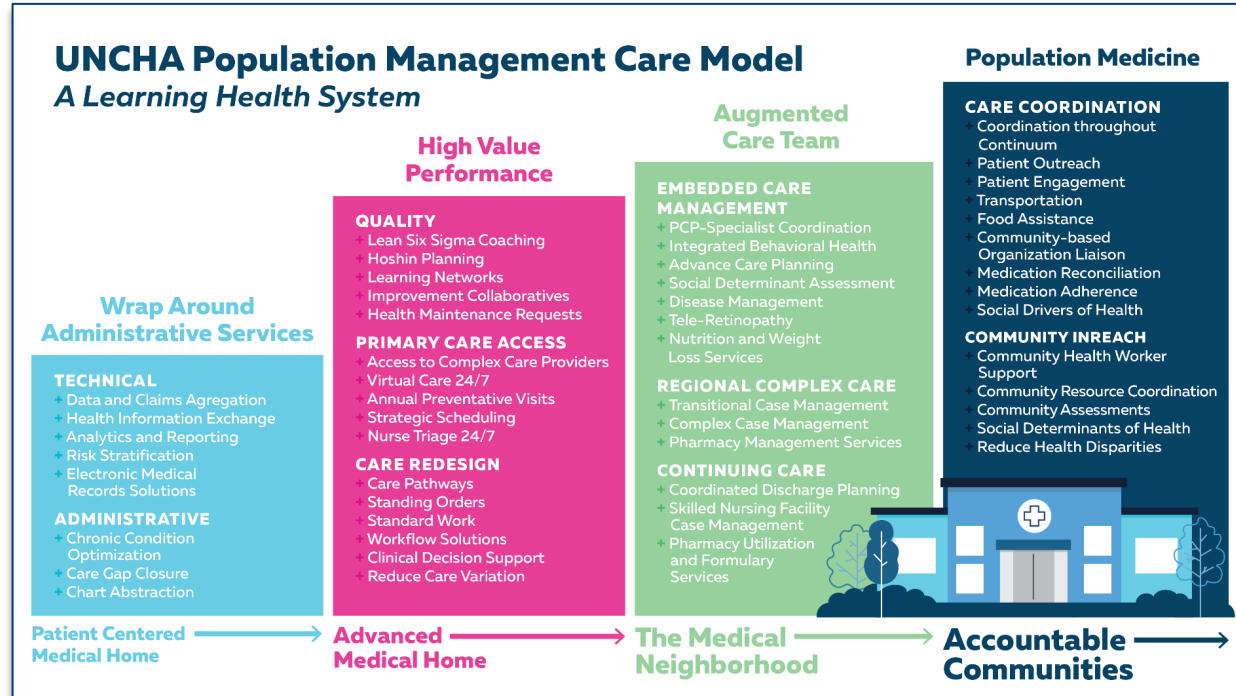


**Network Integration**



**Network Performance**

# Our Population Management Model has Matured Over Time As We Continue to Invest in Our Solutions



- ## Core Services
- Clinical Services
  - Administrative Services
  - Analytics and Reporting
  - Quality Improvement and Collaboratives
  - Risk Stratification
  - Population Segmentation
  - Electronic Health Record Solutions
  - Community Engagement (such as Social Determinants of Health interventions)

## Engaging and Empowering the Network at Every Level

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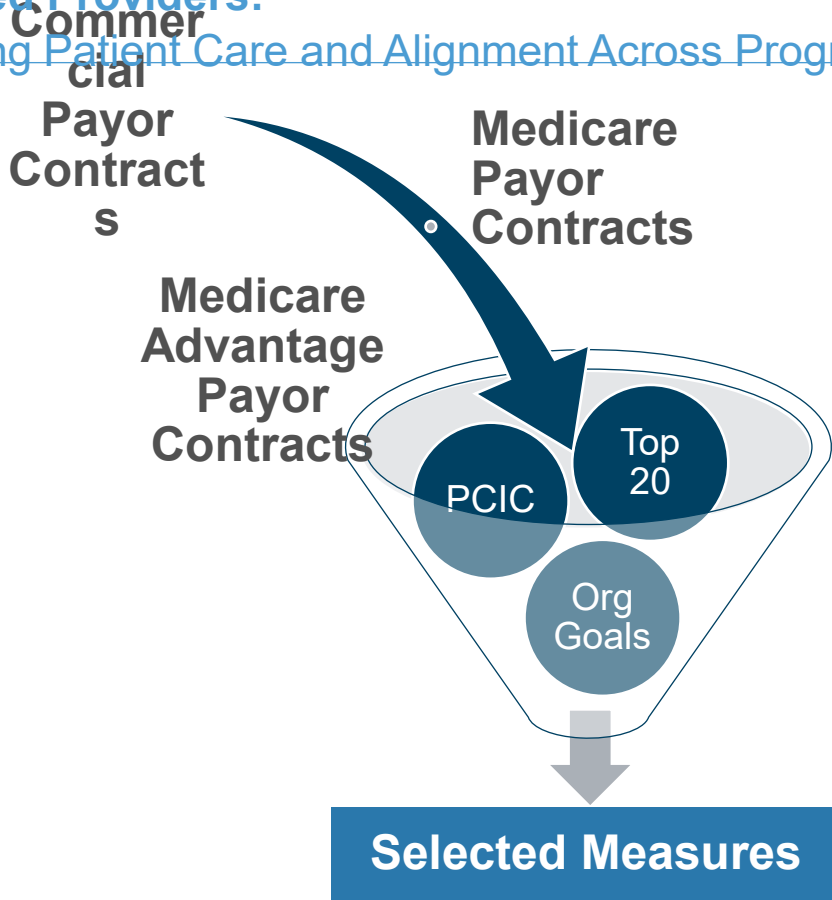
**Whether independent or employed, we offer network-wide support through forums, services, multi-practice collaboratives and 1:1 practice/provider support.**

# Employed Providers: Primary Care Improvement Collaborative

	<b>Primary Care Improvement Collaborative</b>
<b>Maturity</b>	10 Years Connects Primary Care Practices Across the System
<b>Governance</b>	Physician Led Committees Provides Overall Strategic Direction & Leadership All Representative Entities Have a Voting Voice Approve Annual Measures & Goals
<b>Objectives</b>	All Teach All Learn Expand Accountability to Improve Patient Outcomes Fulfill the Quintuple Aim
<b>FY24 Participants</b>	123 Primary Care Practices 5 Entities
<b>Attributes</b>	Alignment of Measures Across Value Care Programs Select Measures are Based on Clinical Pertinence & Patient Care Best Practices Shared Learning & Interactive Dashboards

## Employed Providers:

# Optimizing Patient Care and Alignment Across Programs Drives Measure Selection



### Other Considerations:

- Quintuple Aim
- Optimizing Patient Care
- Alignment Across Value Contracts
- Social Constructs
- Resource Capacity & Bandwidth

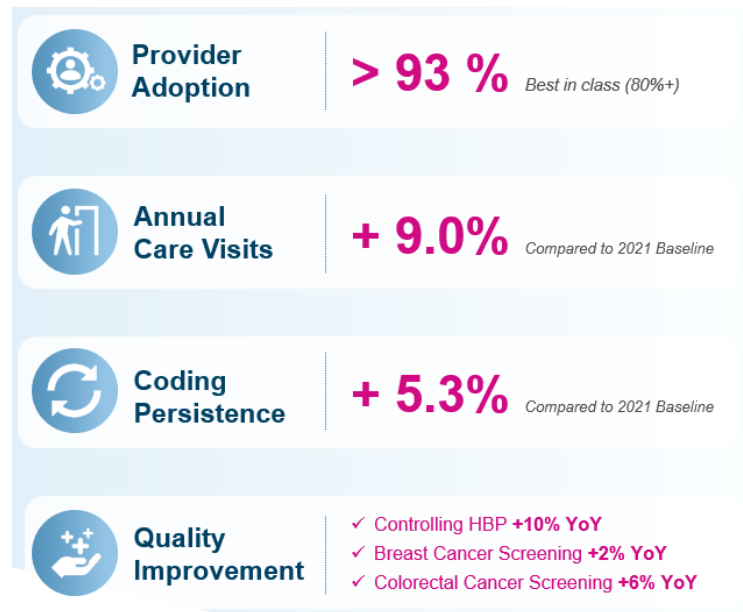
# Employed Providers: Tools for Practices & Providers Via Real-Time Measure Analytics Dashboards

- **Point of Care** decision support
- **Best Practice Advisory Committee** governed and supported by physicians
- **Foundation of Quality Improvement** coaching support provided for providers and practices



## Independent Providers: Offering Solutions to Provide Incentives to Independent Partners in Real Time

- Partnership to help incentivize value-added actions faster for independent providers
- Providers can see the impact of their performance-driving, value-added actions with monthly incentives
- UNCHA can manage practice performance in real-time
- A one-year pilot of providing incentive dollars to independents in real-time showed positive adoption, and an increase in engagement in key areas for network success



# Specialist and Primary Care Engagement: Developing Profound Knowledge in Critical Domains for Value Care

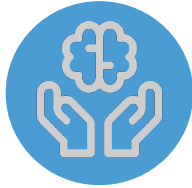
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Beginning in January 2022, the Health Alliance **launched 6 workgroups creating interdisciplinary teams of subject matter experts to develop a deep understanding of key drivers and change ideas** for high priority value care measures.

Cost



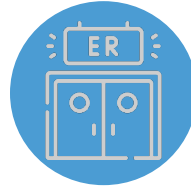
Depression



Diabetes



ED Utilization



Hypertension



Risk Coding



The goal is to **design, test, and implement solutions to address key drivers** and **identify best practices that can be scaled and spread across the network** to support value care success.



## Specialist and Primary Care Engagement: Diabetes Workgroup

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### Workgroup Members:

- Primary Care Providers: Academic and Non-Academic
- Endocrine Providers
- Dieticians
- Pharmacists
- Project Management, Analytics, Coaching, LCSWs, Care Redesign, Health Alliance Leadership

### Current projects:

- **“Team Based Connection”**: Chronic Care Management Support Specialists use standing orders to refer diabetics to Population Management services such as dietician and pharmacy services. Goal is to refer the right patient at the right time using algorithms designed by the workgroup.
- **Newly diagnosed diabetics** care pathway.
- Utilization and integration of **Continuous Glucose Monitoring**.

# Specialist and Primary Care Engagement: Chronic Care Management Pilot, May 2023

Diabetes



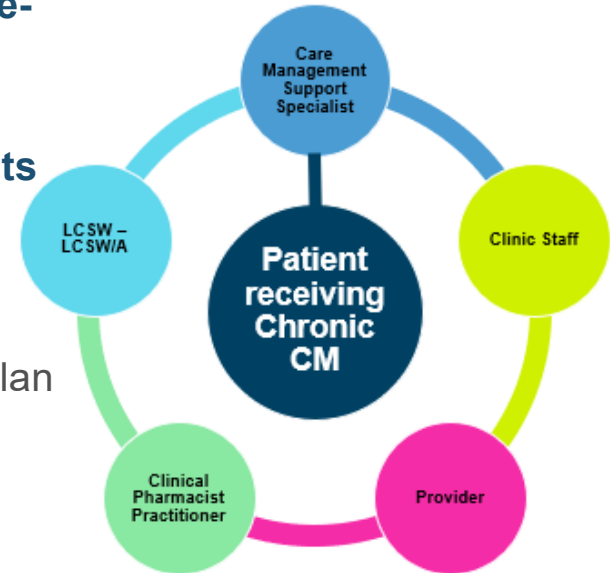
ED Utilization



Hypertension



- Medicare service that provides personalized, billable **non face-to-face and face-to-face care coordination** to patients with **two or more chronic conditions**.
- Care Management Support Specialists are **Medical Assistants** or **Registered Nurses** providing support to this provider-led service.
- Program success greatly depends on **provider buy-in**. **Providers are responsible for documentation** of the care plan which drives the Chronic Care Management visits.



## CHRONIC CARE MANAGEMENT PILOT

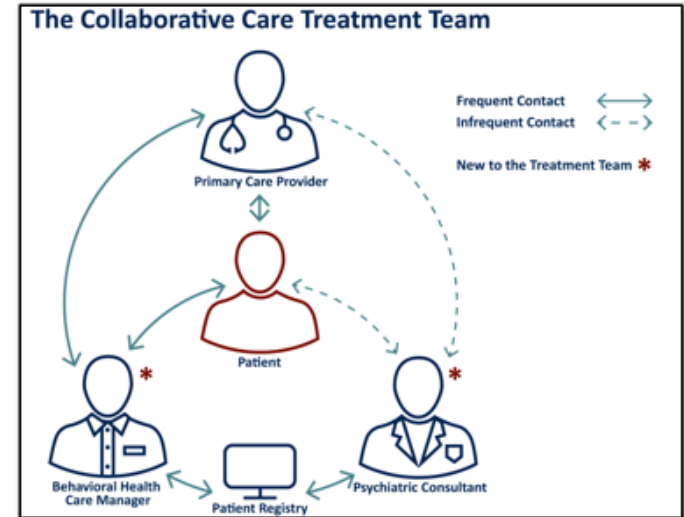
**104**  
Patients enrolled

**140+**  
Encounters



## Specialist and Primary Care Engagement: Collaborative Care Management

- **Collaborative Care Management** is an integrated care model developed at the University of Washington. It is used to treat mental health conditions that require systematic follow-up due to their persistent nature.
- It is a **team-based approach** involving the patient, their primary care provider, a behavioral health care manager and a consulting psychiatrist.
- **Primary Care Physician is the head** of the treatment team. Care Manager coordinates care between the patient, PCP, and Psychiatrist.



### — COLLABORATIVE CARE — MANAGEMENT

**156**  
Unique patients

**3.7k**  
Encounters

- **Average Patient Panel** 74 patients/month
- Depression remission in graduated and enrolled patients at one year **28-64%**, pending clinic site.

# Population Management Services: Insights Gained

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- Providers need **individualized support**
  - Education should use different modalities including virtual presentations, visual aids, at-the-elbow support, reminders in EMRs
- **Providers live in the EMR**, not email
- **Speak the provider language**
  - “What will this do for my patients?” **Report clinical outcomes**
  - “What will this do for me?” Highlight **services that offload providers and clinic staff and compensation**
- **Providers respond to their peers**
  - Bring in practicing clinical leaders in every layer of a service design and socialization of new initiatives
- Providers want to know **“their people”**
  - Simplify for your provider facing services
  - **Preserve the human touch**

# Thank You

Contact: [Laura\\_Cone@med.unc.edu](mailto:Laura_Cone@med.unc.edu)



## Appendix 1: Chronic Care Management Pilot: Care Management Support Specialists Responsibilities

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- Calls patient at least monthly and supports patient-initiated requests
- Provides Patient Education and Resources regarding chronic conditions
- Sends referrals to other services (clinical pharmacist practitioner, dietician, community health workers, AWWs)
- Identifies and Closes Care Gaps
- SDOH identification and Resource Coordination
- Coordinates care with PCP throughout a patient's enrollment



## Appendix 2: Collaborate Care Management Overview

### ECM Brief Treatment Model

- LCSW as billing provider
- Brief treatment provided by LCSWs only
- LCSW consults independently with PCP and Psychiatry as needed
- Outpatient psychiatry referral as needed
- 11 follow up visits
- Less severely ill patients
- Fee For Service under mental health insurance benefit
- Budget neutral
- Research supports effectiveness of brief treatment across many different diagnoses



### Collaborative Care Management (CoCM)

Patient centered  
Evidence based  
PCP is head of treatment team  
Embedded in primary care clinics  
Provide care management  
Regular monitoring of symptoms and appropriateness for level of treatment  
Care can be virtual or in person  
Complete sessions every 1-2 weeks  
Patients referred out for specialty/long term therapy treatment

- PCP as billing provider
- BH CM coordinates care between treatment team
- Care management can be provided by LCSW, RN, and MAs
- Psychiatrist recommends med adjustments implemented by PCP
- Service length is 6-9 months
- More severely ill patients
- Fee For Service under medical insurance benefit
- Cost benefit achieved through \*cost savings
- Most of the research focused on depression and anxiety in adults

\*Unutzer, J, Katon, W, Fan, M, Schoenbaum, M, Lin, E, Penna, R, Powers, D (2008). [Long-term Cost Effects of Collaborative Care for Late-life Depression](#). The American Journal of Managed Care (AJMC).

\*Reiss-Brennan, B, Brunisholz, K, Dredge, C, Briot, P, Grazier, K, Wilcox, A, Savitz, L, James, B (2016). [Association of Integrated Team-Based Care with Health Care Quality, Utilization, and Cost](#). The Journal of the American Medical Association (JAMA).

# Engaging Providers to Drive VBC Success

**Deepika Kewlani-Varkey, MBA PCMH CCE**  
*Lead Director, Strategic Planning, CVS Accountable Care*



September 22, 2023

CVS Health exists in  
people's lives  
throughout the care  
continuum



**Our 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

**>20,000**

CVS ACO providers\*

**~250,000**

aligned CVS ACO  
beneficiaries\*

**~800**

MinuteClinic® locations in  
our CVS ACO\*

*\*For calendar year 2024*



## Our approach to **finding value from across the continuum**



Building partnerships



Connecting providers and communities



Aligning incentives across the system of care



Using technology to improve care coordination



Address health disparities and SDOHs



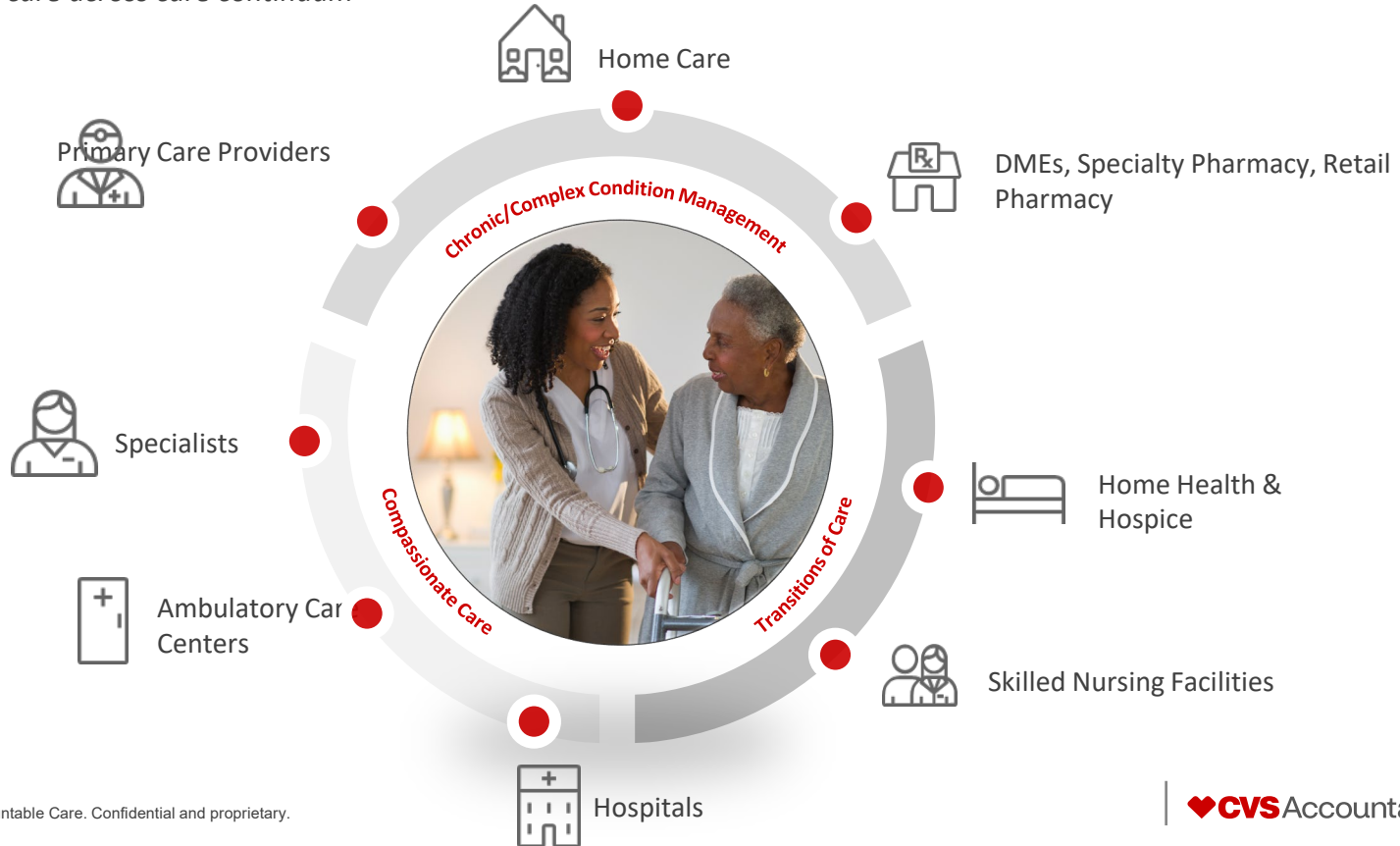
Focusing on preventative care and management of chronic conditions

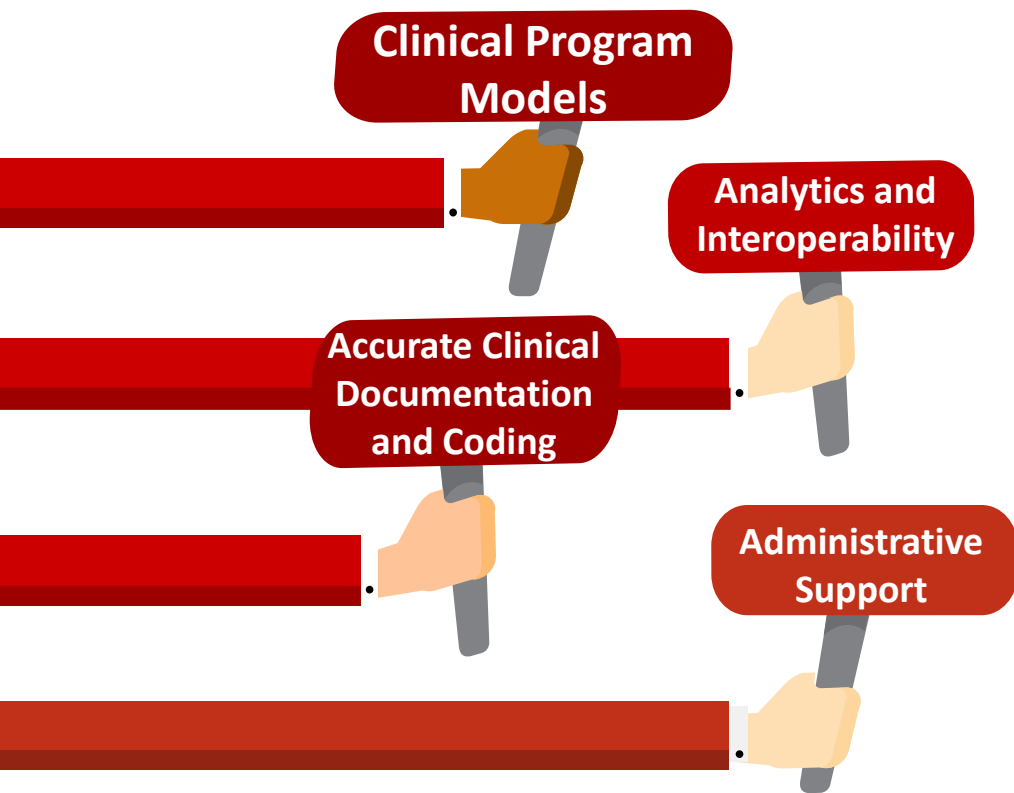


Monitoring and evaluating performance through robust analytics

# Alignment & collaboration across all provider types

*Transforming care across care continuum*





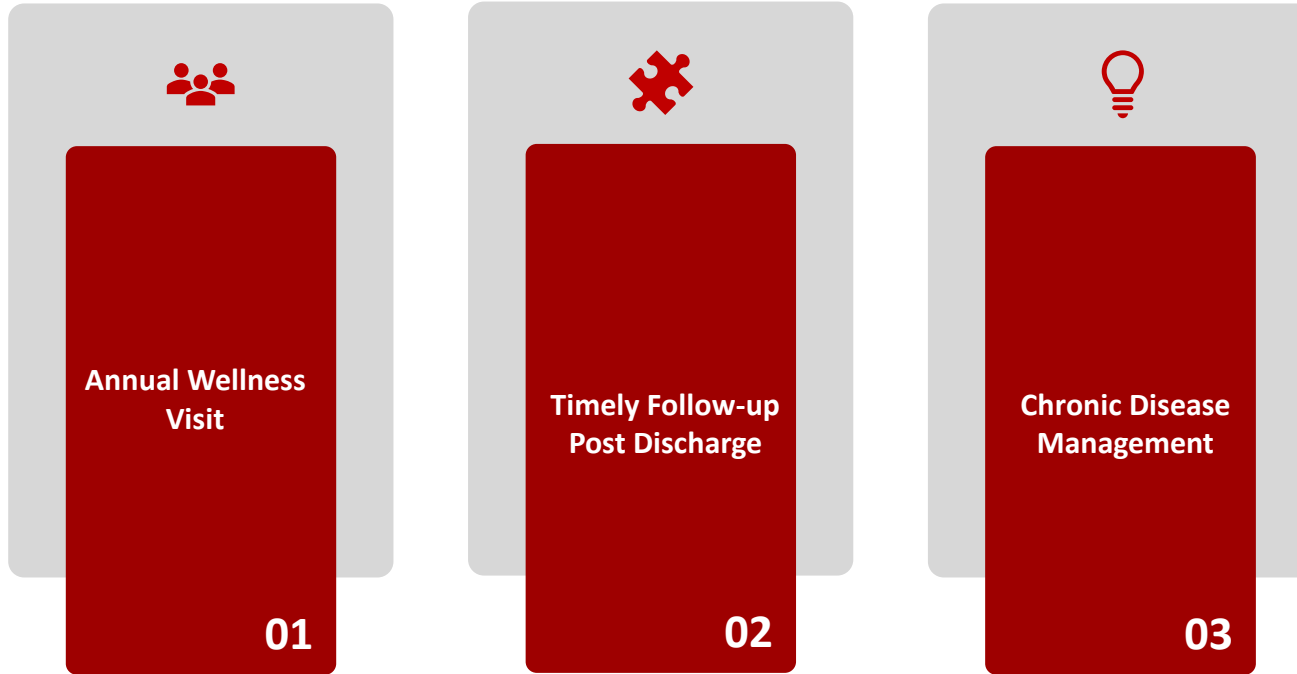
## Wraparound Services

*How do we engage a provider where they are on their value-based journey?*

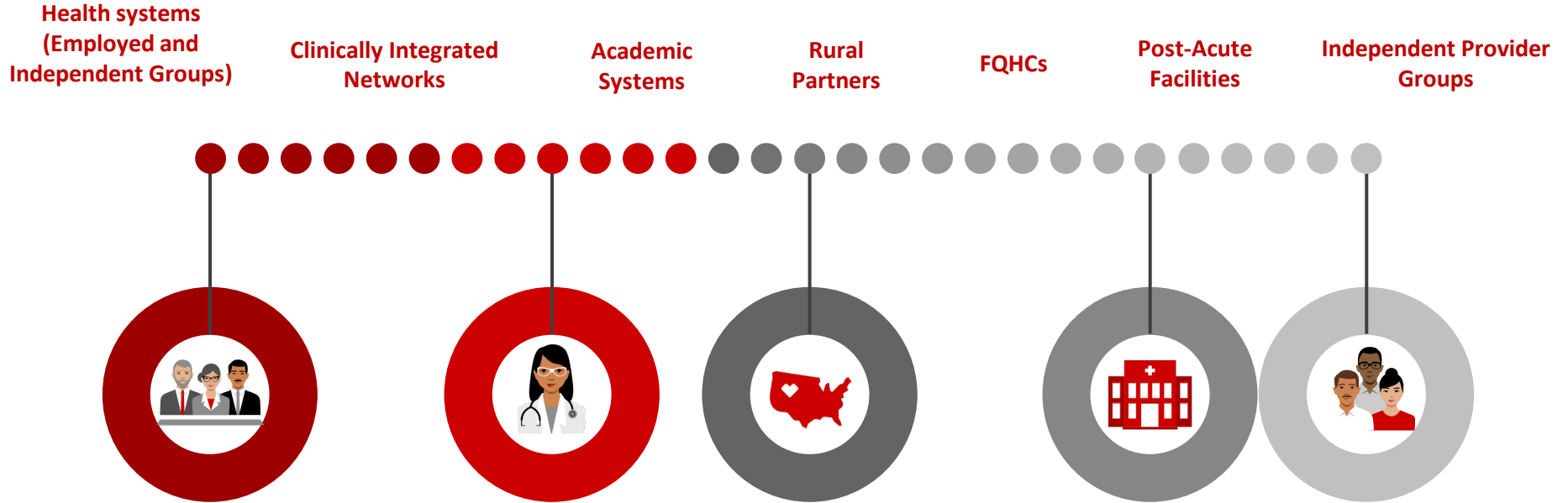


# Sample Primary Care Incentive Payments

*For Illustrative Purposes only*



# What Works?





LinkedIn



CVS Accountable Care