LEHIGH VALLEY HEALTH NETWORK | Your health deserves a partner.

Moderators

ChristianaCare

Anthony "Tony" Reed

- Vice President of Population Health Operations at ChristianaCare
- NAACOS Board Chair Elect
- 2nd Term NAACOS Board of Director
- 25 years of experience in health care industry (health care delivery, health insurance and medical device manufacturing)

Lehigh Valley Health Network

Nina Taggart, MA, MD, MBA, FAAO

- Senior Medical Director for Accountable Care for the Lehigh Valley Health Network (LVHN) and Medical Director for the LVHN ACO
- NAACOS Board of Director
- Holds degrees from Bryn Mawr College, Haverford College, Alvernia University, and Weill Cornell Medical College and is a certified professional in healthcare information technology. She is a board-certified ophthalmologist.
- 30 years of experience in health care industry (payer, provider & population health).

Value Based Programs at Lehigh Valley Health Network

Nina Taggart MA, MD, MBA, FAAO

Lehigh Valley Health Network

WHO WE ARE

LEHIGH VALLEY HEALTH NETWORK

9 HOSPITAL CAMPUSES

3 INSTITUTES

1 CHILDREN'S HOSPITAL

300+ PRACTICE LOCATIONS

9 COMMUNITY CLINICS

25 HEALTH CENTERS

20 EXPRESSCARE LOCATIONS

2 CHILDREN'S EXPRESSCARE LOCATIONS

55 REHABILITATION LOCATIONS

80+ TESTING AND IMAGING LOCATIONS

19,300+ EMPLOYEES

1,600+ PHYSICIANS

850+ ADVANCED PRACTICE CLINICIANS

3,700+ REGISTERED NURSES

72,800 ACUTE ADMISSIONS

235,500 ED VISITS

1,700+ LICENSED BEDS

A COMPLETE HEALTH NETWORK

LVH–Cedar Crest

LVH–Muhlenberg


LVH–17th Street

LVH–Hazleton

LVH–Pocono

Lehigh Valley Reilly Children's Hospital


LVH–Schuylkill E. Norwegian Street

LVH–Schuylkill S. Jackson Street


LVHN–Tilghman


Coordinated Health

LVH–Carbon


LVH–Dickson City

LVH–Hecktown Oaks

LVHN ExpressCARE

Health Centers


Lehigh Valley Physician Group

Lehigh Valley Health Network

LEHIGH VALLEY HEALTH NETWORK **ACHIEVEMENTS**

2019

TOP PLACES TO WORK IN THE LEHIGH VALLEY
The Morning Call

150 TOP PLACES TO WORK IN HEALTHCARE
Becker's Healthcare

BEST-IN-STATE EMPLOYER
Forbes

LGBTQ HEALTHCARE EQUALITY TOP PERFORMER
Human Rights Campaign's Healthcare Equality Index, (LVH–Cedar Crest, LVH–17th Street, LVH–Muhlenberg and LVHN–Tilghman)

EXCELLENCE IN PATIENT SAFETY
Hospital and Health System Association of Pennsylvania (HAP), (LVH–Cedar Crest, LVH–Muhlenberg, LVH–Schuylkill, LVH–Hazleton and LVH–Pocono)

CERTIFIED AS A PRIMARY STROKE CENTER
The Joint Commission (LVH–Schuylkill)

LEAPFROG "A" GRADE FOR QUALITY AND PATIENT SAFETY
The Leapfrog Group (LVH–Cedar Crest, LVH–Muhlenberg, LVH–Hazleton and LVH–Pocono)

LEAPFROG "TOP TEACHING HOSPITAL" FOR QUALITY AND PATIENT SAFETY
The Leapfrog Group (LVH–Cedar Crest)

2020

MAGNET® RECOGNIZED
Fifth Consecutive Designation from American Nurses Credentialing Center (ANCC), (Lehigh Valley Hospital)

LEAPFROG "A" GRADE FOR QUALITY AND PATIENT SAFETY
The Leapfrog Group (LVH–Cedar Crest, LVH–Muhlenberg and LVH–Hazleton)

PATIENT SAFETY EXCELLENCE AWARD
Healthgrades (Coordinated Health Allentown)

BEST MATERNITY CARE HOSPITAL
Newsweek (LVH–Pocono)

BEST PHYSICAL REHABILITATION CENTER
Newsweek (LVH–Cedar Crest)

NO. 1 HOSPITAL IN THE REGION
Seventh Consecutive Designation from U.S. News & World Report (Lehigh Valley Hospital)

LGBTQ HEALTHCARE EQUALITY LEADER
Human Rights Campaign's Healthcare Equality Index, (LVH–Cedar Crest, LVH–17th Street, LVH–Muhlenberg, and LVHN–Tilghman)

BEST-IN-STATE EMPLOYER
Second Consecutive Designation from Forbes

STROKE GOLD PLUS QUALITY ACHIEVEMENT AWARD
Get With the Guidelines® (LVH–Cedar Crest, LVH–Muhlenberg, LVH–Hazleton and LVH–Pocono)

HEART FAILURE GOLD PLUS QUALITY ACHIEVEMENT AWARD
Get With the Guidelines® (LVH–Schuylkill and LVH–Hazleton)

ACCREDITED CHEST PAIN CENTER
American College of Cardiology (LVH–Schuylkill and LVH–Hazleton)

GREAT PLACE TO WORK-CERTIFIED™
Great Place to Work®

LEVEL 10 ACUTE DIGITAL HEALTH CARE'S HEALTH MOST WIRED®
College of Healthcare Information Management Executives

LEVEL 10 AMBULATORY HEALTH CARE'S MOST WIRED®
College of Healthcare Information Management Executives

2021

BEST WORKPLACE IN HEALTH CARE & BIOPHARMA™
Fortune

GREAT PLACE TO WORK-CERTIFIED™
Second consecutive designation by Great Place to Work®

PATIENT SAFETY EXCELLENCE AWARD™
Healthgrades (Coordinated Health–Allentown)

BEST AMBULATORY SURGICAL CENTER
Newsweek (Eastern Pennsylvania Endoscopy Center)

NO. 1 HOSPITAL IN THE REGION
Eighth Consecutive Designation from U.S. News & World Report (Lehigh Valley Hospital)

BEST-IN-STATE EMPLOYER
Third Consecutive Designation from Forbes

How We Are Organized

LVHNACO

Est. 2014

- To foster a collaborative delivery of patient centered, high value care to support individuals in the achievement of better health & well being
- Pathways to Success BASIC Track Level E with 40K beneficiaries
- First year in downside risk

Valley Preferred

LEHIGH VALLEY HEALTH NETWORK

Est. 1993

- Physician Hospital Organization with 1,400+ member physicians and 800+ participant APCs
- Supports physician engagement and quality improvement
- Supports employed and independent physicians

Populytics

How HEALTHIER Happens.℠

Est. 2013

- Population health management analytics firm
  - Population health analytics
  - Clinical care coordination
  - Health benefits administration & consulting
  - Employer health services
- Enables virtual integration
- Supports LVHN's journey to value-based care

LVHN Vision

We will build on our foundation as a premier academic community health system and become an **innovative population health leader** that creates superior quality and value for the patients and communities we serve.

What Payers & Providers Want from VBR Contracts

What Payers Want	What Providers Want
Serve their customers – employers & employees	Serve our customers - patients
Low-cost products with demonstrable high clinical quality	Financial rewards for providing highly managed high quality patient care
Aligned financial incentives	Aligned financial incentives
Increased market share	Increased market share
High performing network of quality providers	Differentiated as a high performing provider network
Strong partnerships with providers	Strong partnerships with payers
Predictable cash flow from customers	Predictable cash flow from payers
Meet customer expectations of value	Successful outcomes in VBR
Serve the community	Serve the community

Not as Different as One Might Think

LVHN Steps to Successful VBR

- Establish LVHN strategic direction
  - Senior leadership sets the overall course
- Determine key performance indicators
  - Set measurable KPIs to track success
- Assign accountability
  - Assign stakeholders directly accountable to achieve KPIs
- Develop operational success plan
  - Accountable parties develop operational plan to achieve KPIs
- Implement measurement process
  - Build measurement dashboards – details that roll up to KPIs
- Operational success plan adjustments
  - Ops team adjusts plan throughout performance period to achieve KPIs

Source: Optum Provider Actuarial Services

LVHN VBR Contract Considerations

Operational Success Plan: build to network strengths, develop, monitor & measure KPIs deployment of care management resources,

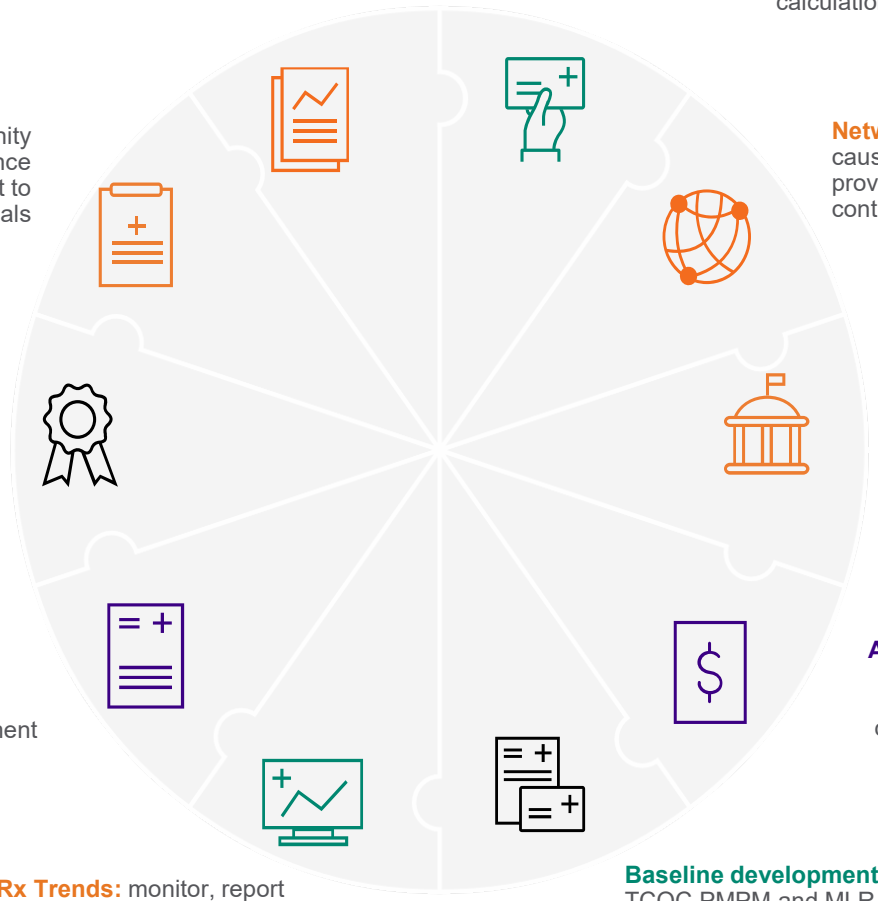
Methodology Development: provide guidance and expertise for product/risk terms, forecasting and reconciliation calculations

Risk Coding: opportunity identification, performance improvement and impact to financials

Network Composition: identification and root cause analyses for high/low performing providers, analyze providers impact to risk contracts

Quality/Stars: opportunity identification, monitor and report on quality metrics to impact performance and improve financials

Underlying FFS reimbursement and compliance changes: analyze and forecast impact to risk based on changes in FFS rate schedules and product design



Appetite for Risk: provide guidance and expertise on required coverage levels and impact to overall risk management including catastrophic case & cohort protection

Attribution: provide guidance and expertise for attribution methodologies, complete root-cause episodic analyses to inform performance management

Medical and Rx Trends: monitor, report and identify TCOC PMPMs and key price and utilization trend drivers, inform contract terms

Baseline development: develop TCOC PMPM and MLR baselines to inform risk contracts and performance management process

Value Based Contracting 101

Transforming Contract Challenges into Opportunities for both Payers and Providers

Barry Dahllof Jr.
Vice President - Enterprise Contracting & Payor Relations

ChristianaCare

AGENDA

- Overview of Value Based Arrangement Types
- Mechanics of Value-Based Contracting
- Actuarial Support with Data
- Data in action through engagement and optimization

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Overview of Value Based Arrangement Types

Upside Only Shared Savings Program	Risk Sharing Program	Full Risk or Capitation Program
Fee for service payment with upside-only shared savings available when outcome scores are sufficient. Cost and quality measure negotiated, along with shared savings opportunity.	Fee for service payment with risk sharing Upside available when outcome scores are sufficient and downside resulting refunds if cost measures are not met	Prospective capitation PMPM or Bundle Prospective negotiated payment. Providers manage full cost of care with additional quality opportunities possible.
↑ Upside Risk Only	↑↓ Upside & Downside Risk	= Full Risk
Standard fee for service rates apply with the opportunity to achieve an additional negotiated amount or increase on existing rates	Standard fee for service rates apply. Provider manages cost and quality for patients. High dollar risk capture and exclusion negotiated. Opportunity to achieve payment or refund based on total cost of care	No standard fee for service payment. Management of services provided, providers utilized, and all cost associated with patients is key. Opportunity is achieved by managing to a cost less than the PMPM or bundle.

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Mechanics of Value-Based Contracting

- Engage Key Stakeholders
- Understand Contract Components
- Prepare for Contract Life Cycle
- Contract Best Practices
- Relationships and Continuing the Evolution

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Engage Key Stakeholders

Providers

- Individual physicians/practitioners, Medical groups
- Hospital Systems
- FQHCs and large medical groups
- ACOs, IPO/IPAs, CIN's
- Smaller providers including community-based organizations (CBOs)

Payors

- Commercial Payors
- Medicaid MCOs
- Medicare Advantage
- Direct to Employer

Management Services

- Care Management/Disease Management
- Care Coordination
- Actuary Services
- Reporting/Data Management
- Contract Monitoring

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Understand Contract Components

1. Arrangement Type/ Services Included
2. Measurement Period
3. Attribution
4. Targeted Medical Budget – Benchmarking
5. Quality Measures
6. Shared Savings and Losses
7. Financial Protections
8. Reporting

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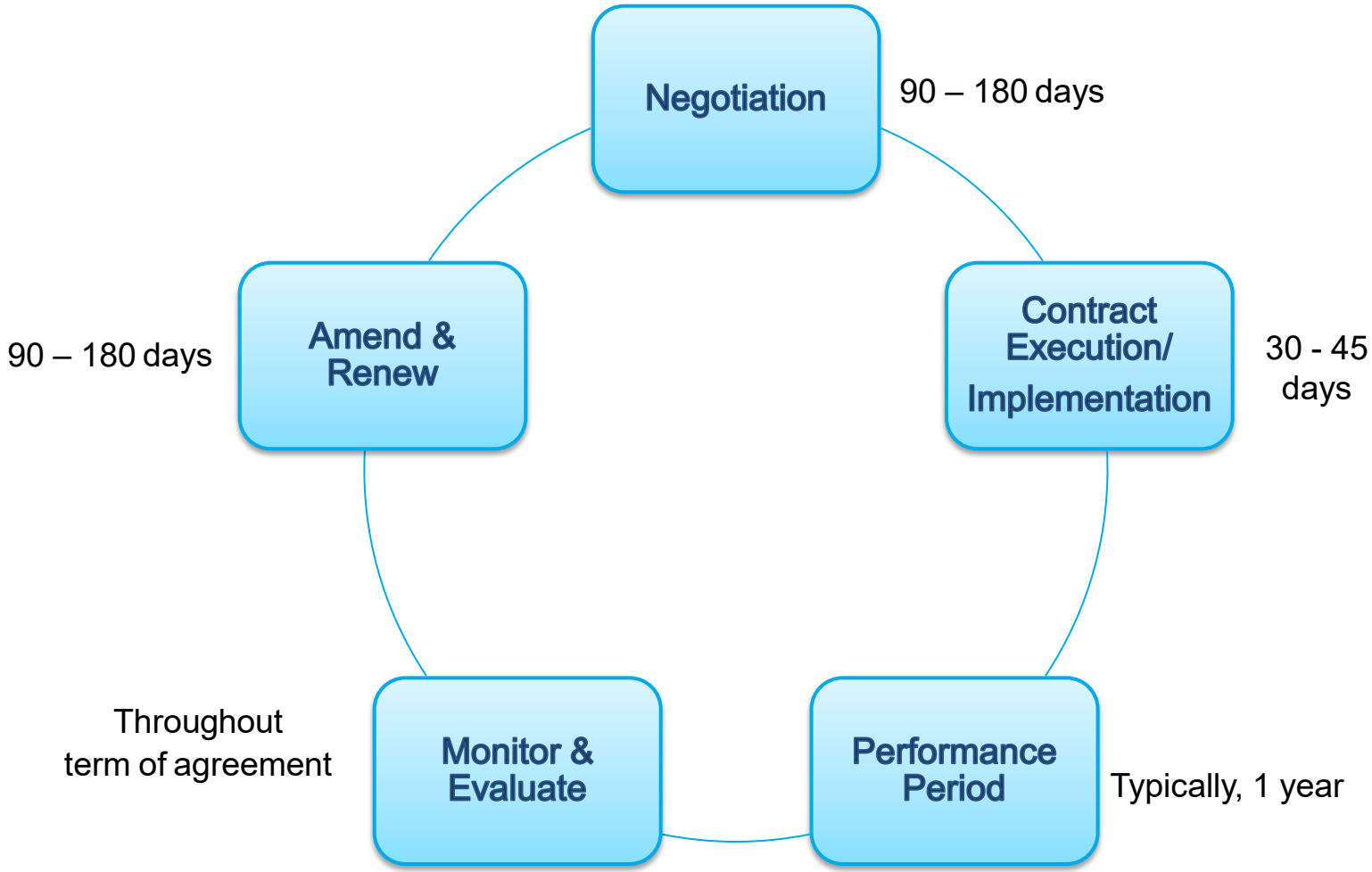
Prepare for Contract Lifecycle



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Contract Best Practices

Understand your organization

- Mission
- Financial Position
- Appetite for Risk
- Data capabilities
- Honestly assess your quality performance
- Risk Partners Relationship – this is a journey and not a destination

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Contract Best Practices

Negotiate with the right people

- Authority to make decisions
- Vested interest
- Actively communicate
- Coordination internal stakeholders
- Strategic partner

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Contract Best Practices

Spell out the details

- Intent
- Rights and obligations
- Milestones and timeframes
- Be specific
- Get it in writing

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Contract Best Practices

Specify Key Terms

- Data share requirements – components & timeline
- Payment methodology
- Attribution
- Reconciliation
- Dispute resolution
- Termination provisions

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Contract Best Practices

Monitor Progress

- Understanding of the population you serve
- Data sharing
- Timely dashboard reports
- Joint operating committee meetings
- Communicate the results – good or bad

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Relationships and Evolution

A strong relationship and partnership are the building blocks for success in contracting and especially in Value Based Care.

Be open to change and look for opportunities to partner.

Be the advocate for change within your organization for the relationship.

Encourage feedback and open communication.

Meet with your contacts regularly. Meet in person, when possible, even just to catch up.

Network your contact to other individuals of impact within your organization.

Partner in external events and arenas. Communicate jointly for aligned members.

Establish and maintain contact list for all partners internal and external. Add details about the individual

Follow up and Follow through!! Be true to your word and be accountable.

Take the lead on resolving issues and barriers. Set up meetings and hold others accountable.

Be fair and honest!!

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Actuarial Support with Data

- Independent party to validate data
- Develop models and tools to:
  - ➢ Forecast financial risk
  - ➢ Risk score
  - ➢ Impact of membership changes
  - ➢ Reconciliation

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Data in Action through Engagement and Optimization

- Leverage both internal data and actuarial data
- Understand the “why’s”
- Engage clinical and operational teams
- Speak the Truth with Courage and Empathy

ChristianaCare

The ChristianaCare Way

We serve our neighbors as respectful, expert, caring partners in their health. We do this by creating innovative, effective, affordable systems of care that our neighbors value.

We serve together guided by our values

Love & Excellence

We anticipate the needs of others and help with compassion and generosity.

We embrace diversity and show respect to everyone.

We listen actively, seek to understand and assume good intentions.

We tell the truth with courage and empathy.

We accept responsibility for our attitudes and actions.

We commit to being exceptional today and even better tomorrow.

We use resources wisely and effectively.

We seek new knowledge, ask for feedback, and are open to change.

We are curious and continuously look for ways to innovate.

We are true to our word and follow through on our commitments.

ChristianaCare®

Data Science to Drive Success

Michael Weiss MPH

Analytic Domains

- Financial Modeling during Negotiation
- Integration of Claims and EMR data
  - Clinical Intervention
  - Opportunity Analysis
  - Performance Reconciliation
  - KPI Tracking
- Financial Performance Reporting
- Provider Incentive Programs

Comprehensive Financial Modeling

- As incentive metrics change, models are developed to assess:
  - Likelihood of gaining maximum dollars from program
  - Consistency between all VBR contracts where possible
  - Weighting of quality measures
  - Past performance
- Evaluate overall impact of contracting initiatives on financial performance
  - Overall impact of FFS/VBR
  - FFS impact on VBR shared savings/risk
  - “What if” scenarios on shared savings/risk
  - Budgeting of VBR dollars for finance
  - ROI of key initiatives

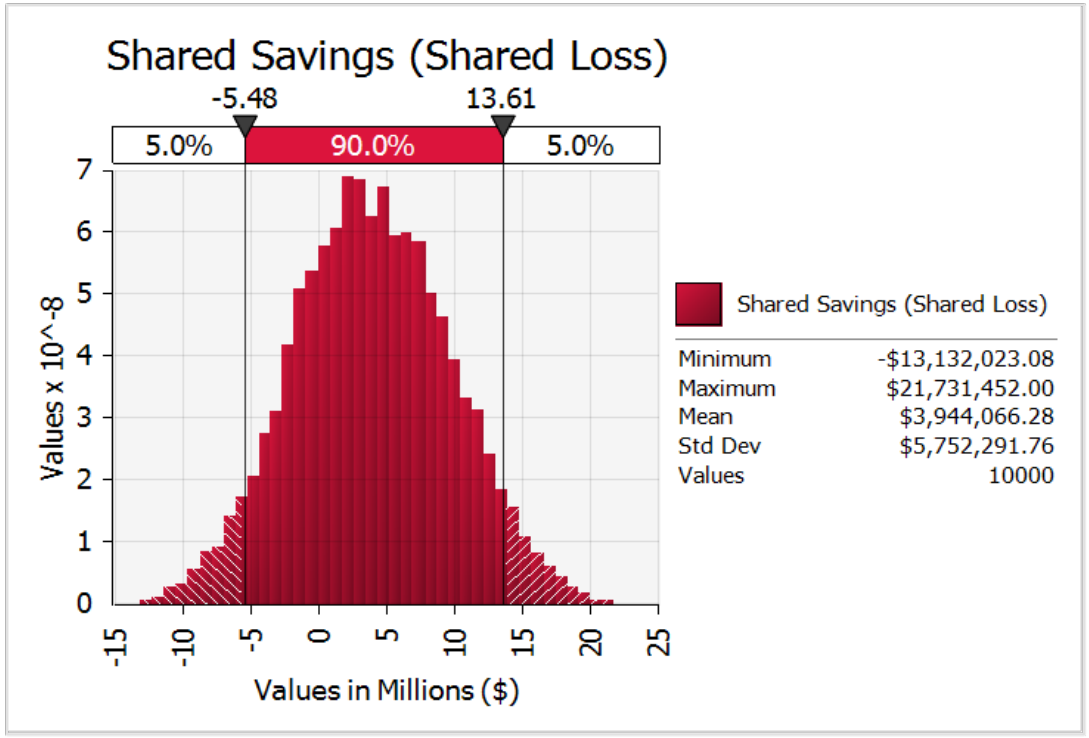
Modeling to Forecast Overall Contract Value

- FFS & VBR component interplay
- Models and sensitivity analyses elicit overall value of each arrangement and drive negotiation

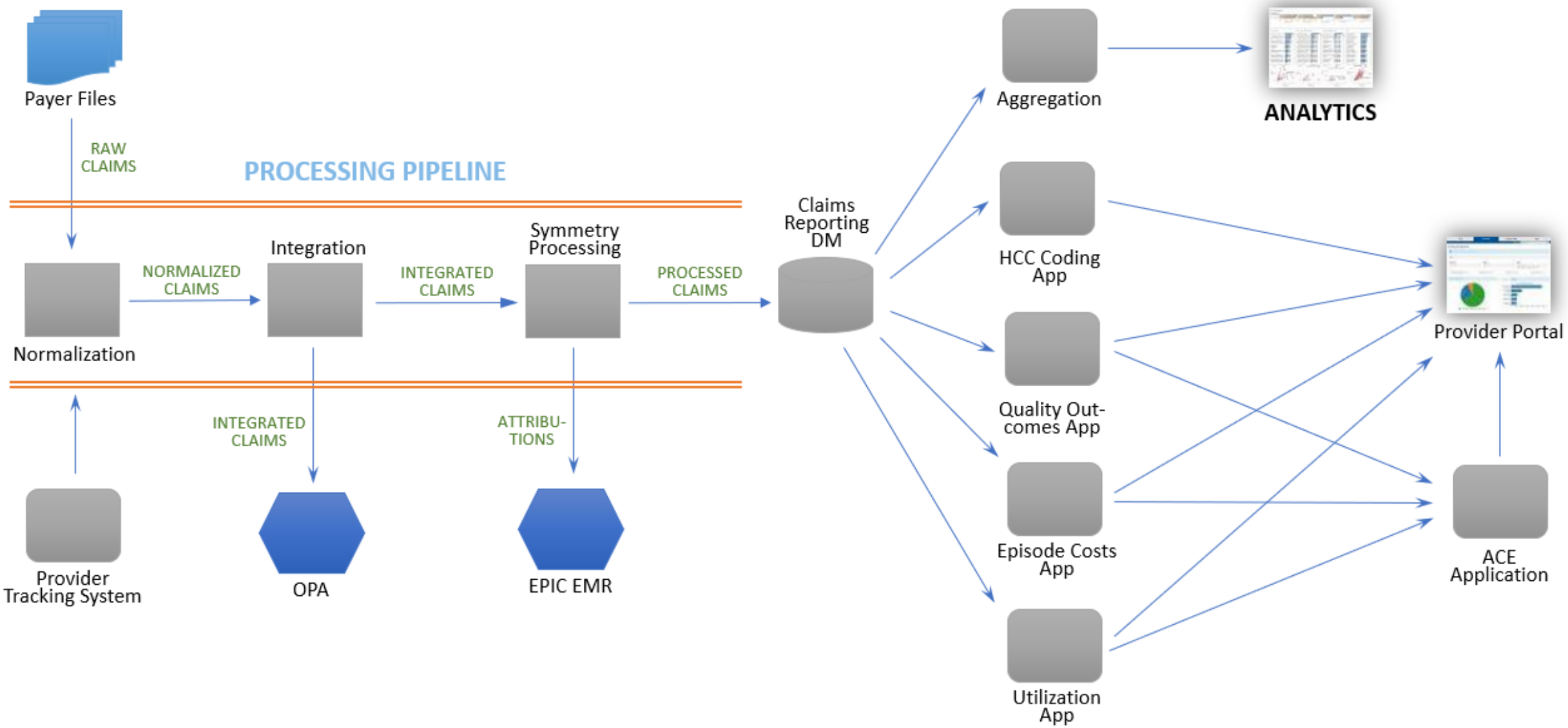
Total Dollars (grand total dollars to be achieved through the overall [redacted] contract)													
Fiscal Year	Facility FFS	Facility VBR	Physician FFS	Facility FFS	Facility VBR	Facility FFS	Facility FFS	Provider 1 VBR	Provider 2 VBR	Total Dollars		Shared Savings Current State	Total
FY 2021	$ 342,200,000	$ 6,844,000	$ 86,106,000	$ 12,980,000	$ 129,800	$ 5,635,000	$ 2,318,000	$ 672,000	$ 5,113,856	$ 461,998,656		$ (243,667)	$ 461,754,989
FY 2022	$ 352,466,000	$ 10,266,000	$ 88,258,650	$ 13,499,200	$ 134,992	$ 5,747,700	$ 2,364,360	$ 672,000	$ 5,241,702	$ 478,650,604		$ (1,048,232)	$ 477,602,372
FY 2023	$ 363,039,980	$ 9,516,582	$ 90,465,116	$ 14,039,168	$ 140,392	$ 5,862,654	$ 2,411,647	$ 672,000	$ 5,372,745	$ 491,520,284		$ (445,117)	$ 491,075,166
FY 2024	$ 372,115,980	$ 10,165,119	$ 92,726,744	$ 14,600,735	$ 146,007	$ 5,979,907	$ 2,459,880	$ 672,000	$ 5,507,063	$ 504,373,436		$ (395,545)	$ 503,977,891
Fy 2025	$ 381,418,879	$ 10,783,921	$ 95,044,913	$ 15,184,764	$ 151,848	$ 6,099,505	$ 2,509,078	$ 672,000	$ 5,644,740	$ 517,509,647		$ (389,140)	$ 517,120,508
July-Dec 2025	$ 193,093,307	$ 5,526,760	$ 48,116,487	$ 7,744,230	$ 77,442	$ 3,080,250	$ 1,267,084	$ 336,000	$ 2,892,929	$ 262,134,490		$ (168,000)	$ 261,966,490
Total	$2,004,334,146	$ 53,102,382	$ 500,717,910	$ 78,048,097	$ 780,481	$ 32,405,016	$ 13,330,049	$ 3,696,000	$ 29,773,035	$ 2,716,187,117		$ (2,689,701)	$ 2,713,497,416

Budgeting

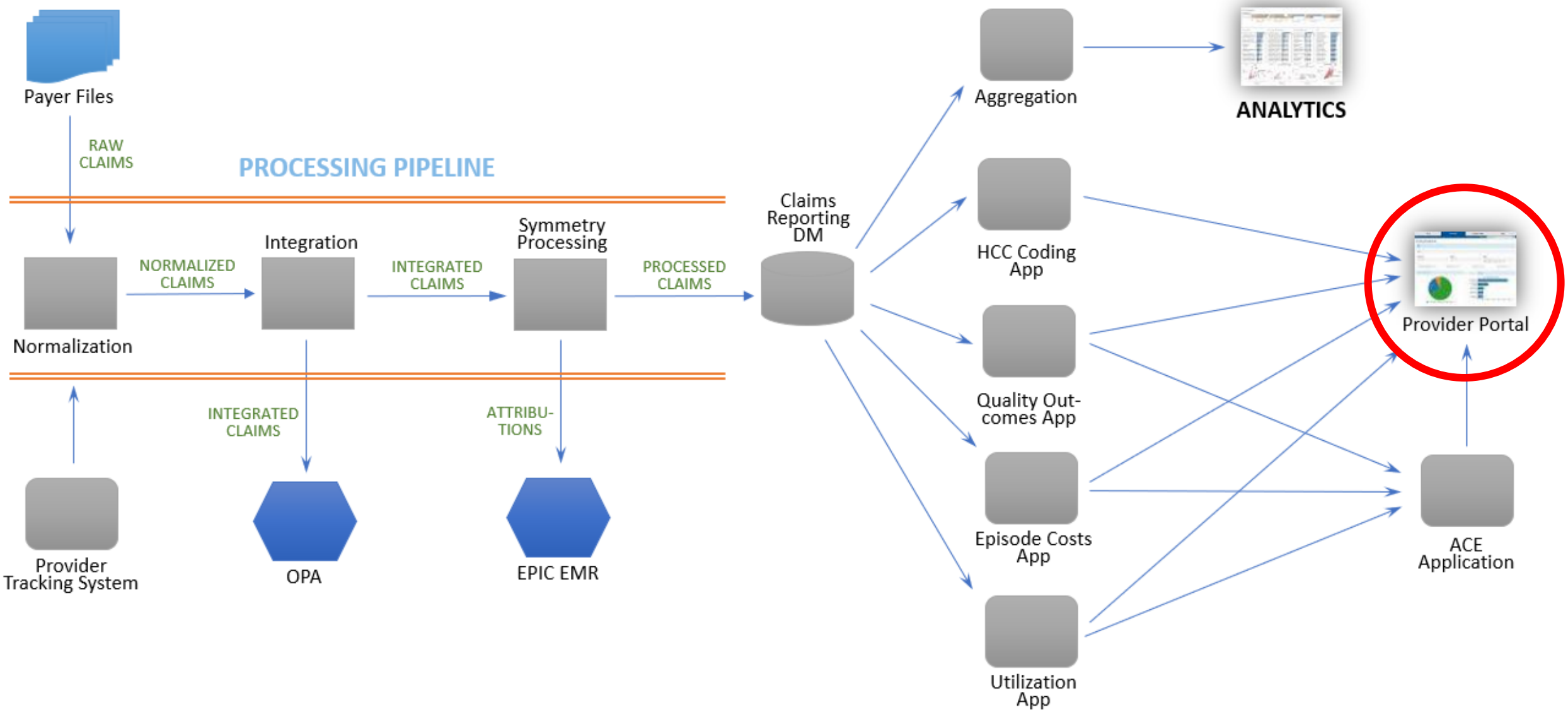
Summary Statistics for Shared Savings (Shared Loss)			
Statistics		**Percentile**	
Minimum	$ (13,132,023)	**5%**	$ (5,478,615)
Maximum	$ 21,731,452	**10%**	$ (3,389,676)
Mean	$ 3,944,066	**15%**	$ (2,024,011)
Std Dev	$ 5,752,292	**20%**	$ (1,010,139)
Variance	3.30889E+13	**25%**	$ (82,975)
Skewness	0.041314051	**30%**	$ 776,536
Kurtosis	2.735311508	**35%**	$ 1,607,140
Median	$ 3,822,243	**40%**	$ 2,360,827
Mode	$ 2,559,155	**45%**	$ 3,079,919
Left X	$ (5,478,615)	**50%**	$ 3,822,243
Left P	5%	**55%**	$ 4,606,176
Right X	$ 13,612,921	**60%**	$ 5,379,300
Right P	95%	**65%**	$ 6,209,620
Diff X	$ 19,091,536	**70%**	$ 7,028,940
Diff P	90%	**75%**	$ 7,912,510
#Errors	0	**80%**	$ 8,904,819
Filter Min	Off	**85%**	$ 10,063,426
Filter Max	Off	**90%**	$ 11,531,641
#Filtered	0	**95%**	$ 13,612,921



Claims Data Flows



Claims Data Flows



Provider Portal Monthly Processing Volumes

nextgen healthcare

2.4M Data Points for 61K Patients

Epic

Daily EMR Feed

OPTUM

EMR + Claims

11.9 B Records

Quality Outcomes Processing

Populytics How HEALTHIER Happens.

CLOUDERA

HIGHMARK

Capital BLUE

CMS.gov

Lehigh Valley Health Network

Cigna

aetna

56M Claim Lines
394K Members

$11.4B in Claims

Integrated Claims Data

PCP Attribution

Translation, Integration & Data Processing

Populytics How HEALTHIER Happens.

OPTUMInsight

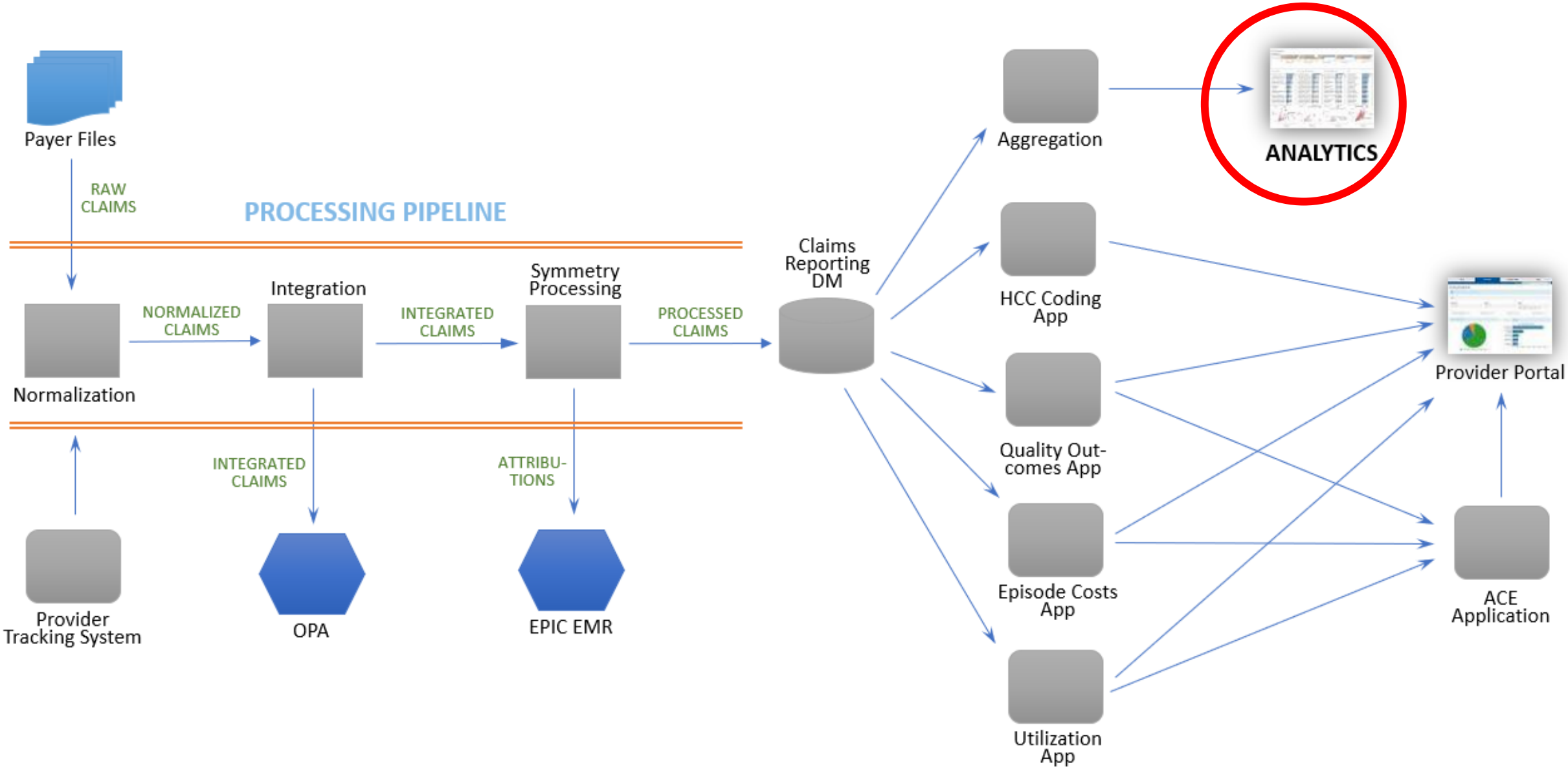
CLOUDERA

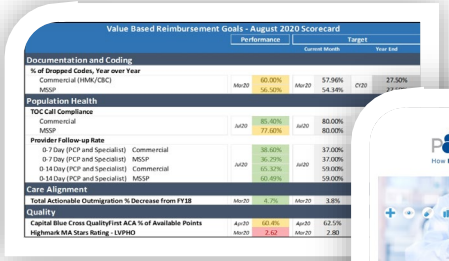
Utilization, Coding, and Episode Cost Processing

Populytics How HEALTHIER Happens.

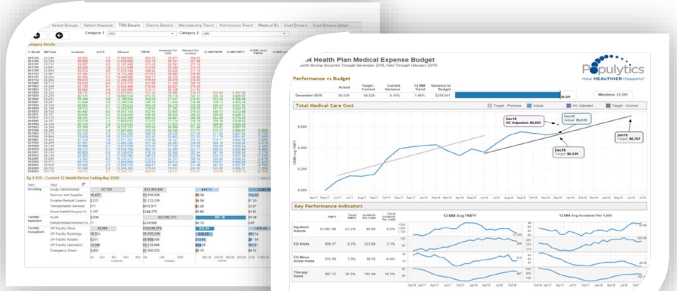
CLOUDERA

Claims Data Flows

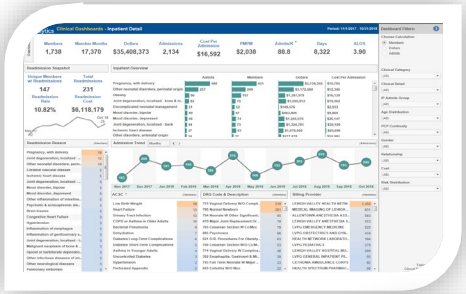




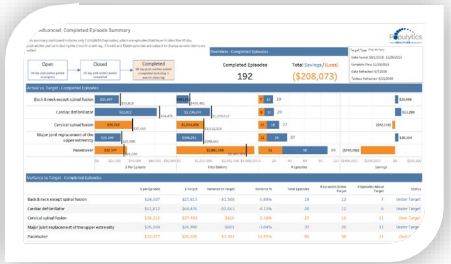
VBR Performance



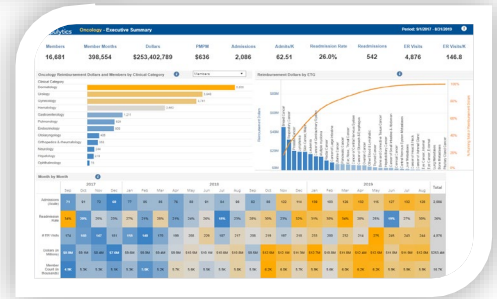
CCR/MEB



Clinical Dashboards



Bundle Performance



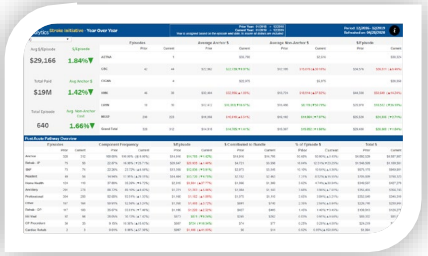
Service Line Dashboards

Performance

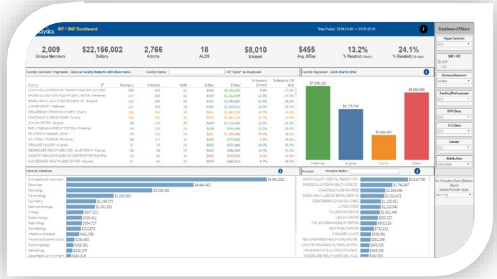
Analysis

Analytics

Intervention



YoY Analysis



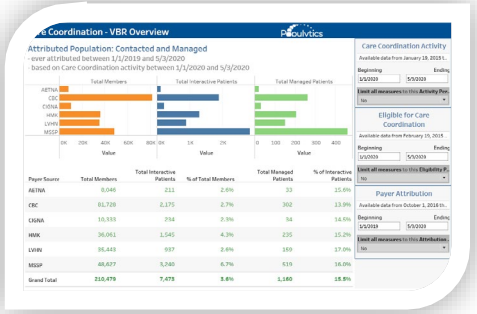
Post Acute

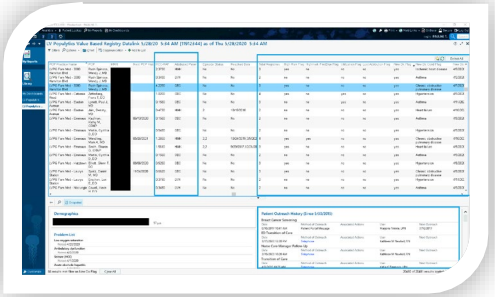
Care Management

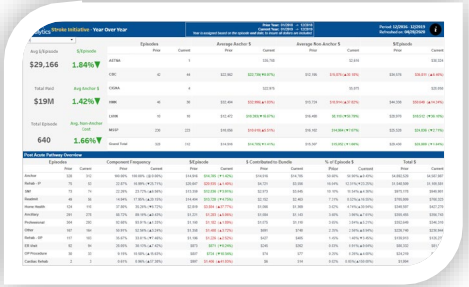
Registries

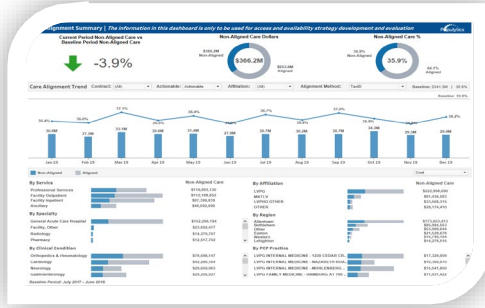
Clinical Pathway

Care Alignment









Clinical & Financial Analytics

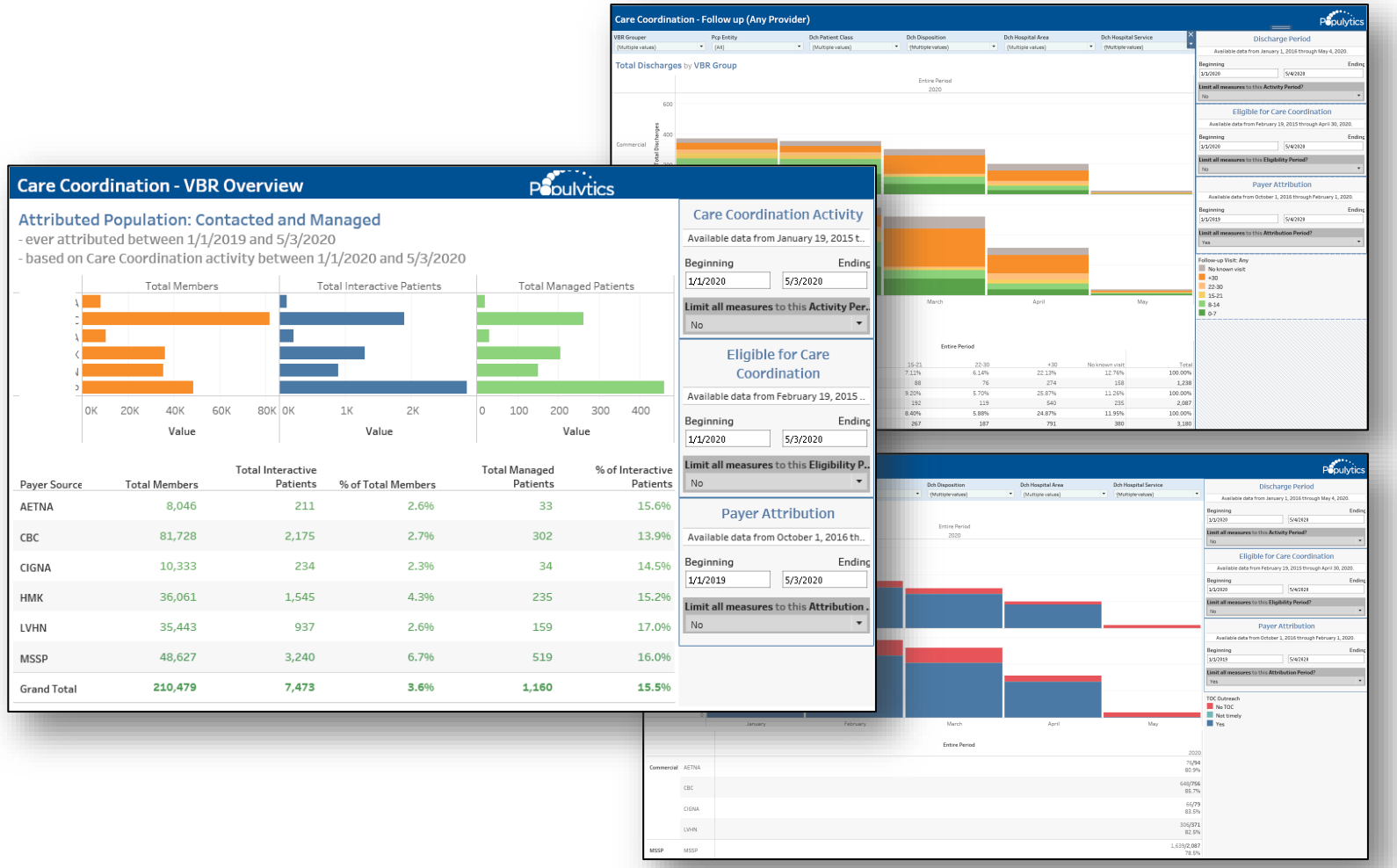
The risk of the population being managed is evaluated from several perspectives

- Clinical Risk
  - Risk Scores
  - Disease Prevalence
  - RX Pipeline
  - Care Gaps
- Attribution Risk
- Documentation and Coding Risk
  - Case-Mix Index
  - Hierarchical Clinical Conditions

- Medical Expense Budget
  - Experience Compared to Budget / Benchmark
- Care Cost Review
  - Identify Utilization Drivers by Type of Service or Clinical Condition
- Episodic Analytics
- Outmigration Analysis
- Care Pathways/Bundled Payments
- Accountable Care Metrics

Care Coordination Dashboard & Transitional Care Dashboard

- Tracks Care Management interactions with patient
- Care Coordination through registry or referral
- Transition of Care
- Integrated into EPIC workflow

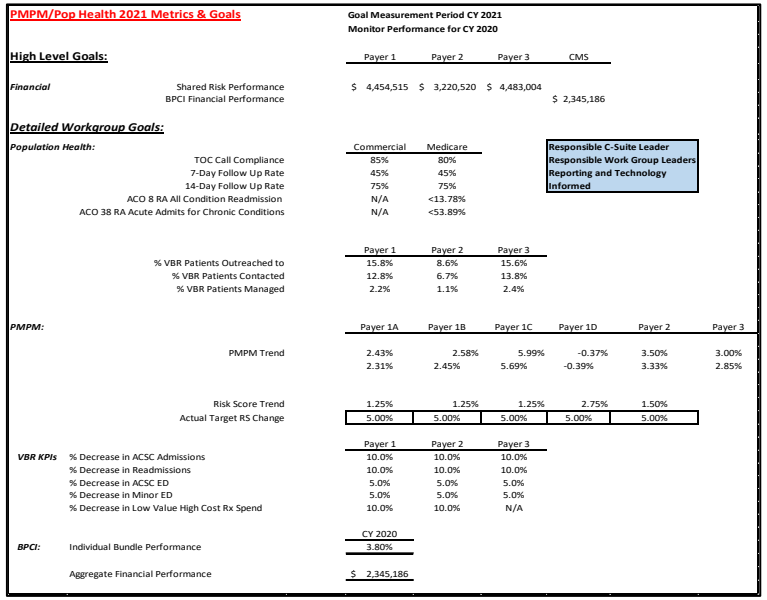


Clinical Dashboards

- Population Executive Summary
- Population Overview
- Inpatient
- ED
- Chronic
- Member List
- Member Profile

Continuous Monitoring of VBR performance

- VBR Briefs summarize VBR performance across payer arrangements
- VBR goals developed by accountable teams with high level & detailed goal monitoring



PMPM/Pop Health 2021 Metrics & Goals

Goal Measurement Period CY 2021
Monitor Performance for CY 2020

High Level Goals:

		Payer 1	Payer 2	Payer 3	CMS
Financial	Shared Risk Performance	$ 4,454,515	$ 3,220,520	$ 4,483,004	
	BPCI Financial Performance				$ 2,345,186

Detailed Workgroup Goals:

Population Health:

	Commercial	Medicare
TOC Call Compliance	85%	80%
7-Day Follow Up Rate	45%	45%
14-Day Follow Up Rate	75%	75%
ACO 8 RA All Condition Readmission	N/A	<13.78%
ACO 38 RA Acute Admits for Chronic Conditions	N/A	<53.89%

Responsible C-Suite Leader
Responsible Work Group Leaders
Reporting and Technology Informed

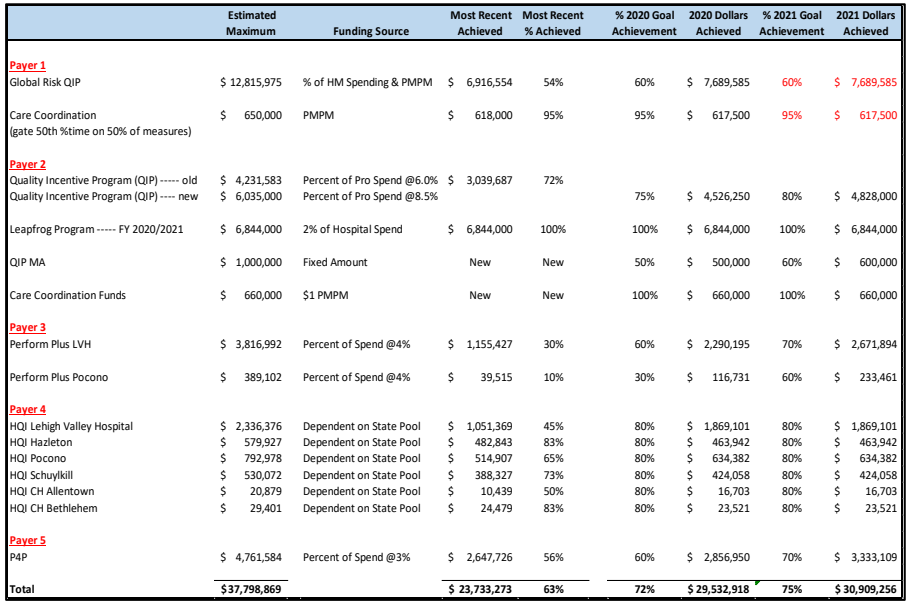
	Payer 1	Payer 2	Payer 3
% VBR Patients Outreached to	15.8%	8.6%	15.6%
% VBR Patients Contacted	12.8%	6.7%	13.8%
% VBR Patients Managed	2.2%	1.1%	2.4%

PMPM:

	Payer 1A	Payer 1B	Payer 1C	Payer 1D	Payer 2	Payer 3
PMPM Trend	2.43%	2.58%	5.99%	-0.37%	3.50%	3.00%
	2.31%	2.45%	5.69%	-0.39%	3.33%	2.85%
Risk Score Trend	1.25%	1.25%	1.25%	2.75%	1.50%	
Actual Target RS Change	5.00%	5.00%	5.00%	5.00%	5.00%	

		Payer 1	Payer 2	Payer 3
VBR KPIs	% Decrease in ACSC Admissions	10.0%	10.0%	10.0%
	% Decrease in Readmissions	10.0%	10.0%	10.0%
	% Decrease in ACSC ED	5.0%	5.0%	5.0%
	% Decrease in Minor ED	5.0%	5.0%	5.0%
	% Decrease in Low Value High Cost Rx Spend	10.0%	10.0%	N/A

		CY 2020
BPCI:	Individual Bundle Performance	3.80%
	Aggregate Financial Performance	$ 2,345,186



	Estimated Maximum	Funding Source	Most Recent Achieved	Most Recent % Achieved	% 2020 Goal Achievement	2020 Dollars Achieved	% 2021 Goal Achievement	2021 Dollars Achieved
Payer 1								
Global Risk QIP	$ 12,815,975	% of HM Spending & PMPM	$ 6,916,554	54%	60%	$ 7,689,585	60%	$ 7,689,585
Care Coordination (gate 50th %time on 50% of measures)	$ 650,000	PMPM	$ 618,000	95%	95%	$ 617,500	95%	$ 617,500
Payer 2								
Quality Incentive Program (QIP) ----- old	$ 4,231,583	Percent of Pro Spend @6.0%	$ 3,039,687	72%				
Quality Incentive Program (QIP) ---- new	$ 6,035,000	Percent of Pro Spend @8.5%			75%	$ 4,526,250	80%	$ 4,828,000
Leapfrog Program ----- FY 2020/2021	$ 6,844,000	2% of Hospital Spend	$ 6,844,000	100%	100%	$ 6,844,000	100%	$ 6,844,000
QIP MA	$ 1,000,000	Fixed Amount	New	New	50%	$ 500,000	60%	$ 600,000
Care Coordination Funds	$ 660,000	$1 PMPM	New	New	100%	$ 660,000	100%	$ 660,000
Payer 3								
Perform Plus LVH	$ 3,816,992	Percent of Spend @4%	$ 1,155,427	30%	60%	$ 2,290,195	70%	$ 2,671,894
Perform Plus Pocono	$ 389,102	Percent of Spend @4%	$ 39,515	10%	30%	$ 116,731	60%	$ 233,461
Payer 4								
HQI Lehigh Valley Hospital	$ 2,336,376	Dependent on State Pool	$ 1,051,369	45%	80%	$ 1,869,101	80%	$ 1,869,101
HQI Hazleton	$ 579,927	Dependent on State Pool	$ 482,843	83%	80%	$ 463,942	80%	$ 463,942
HQI Pocono	$ 792,978	Dependent on State Pool	$ 514,907	65%	80%	$ 634,382	80%	$ 634,382
HQI Schuylkill	$ 530,072	Dependent on State Pool	$ 388,327	73%	80%	$ 424,058	80%	$ 424,058
HQI CH Allentown	$ 20,879	Dependent on State Pool	$ 10,439	50%	80%	$ 16,703	80%	$ 16,703
HQI CH Bethlehem	$ 29,401	Dependent on State Pool	$ 24,479	83%	80%	$ 23,521	80%	$ 23,521
Payer 5								
P4P	$ 4,761,584	Percent of Spend @3%	$ 2,647,726	56%	60%	$ 2,856,950	70%	$ 3,333,109
Total	**$37,798,869**		**$ 23,733,273**	**63%**	**72%**	**$ 29,532,918**	**75%**	**$ 30,909,256**

Value Based Reimbursement Goals - August 2020 Scorecard

		Performance		Target: Current Month		Target: Year End
Documentation and Coding						
% of Dropped Codes, Year over Year						
Commercial (HMK/CBC)	Mar20	60.00%	Mar20	57.96%	CY20	27.50%
MSSP		56.50%		54.34%		27.50%
Population Health						
TOC Call Compliance						
Commercial	Jul20	85.40%	Jul20	80.00%	CY20	80.00%
MSSP		77.60%		80.00%		80.00%
Provider Follow-up Rate						
0-7 Day (PCP and Specialist) Commercial	Jul20	38.60%	Jul20	37.00%	CY20	37.00%
0-7 Day (PCP and Specialist) MSSP		36.29%		37.00%		37.00%
0-14 Day (PCP and Specialist) Commercial		65.32%		59.00%		59.00%
0-14 Day (PCP and Specialist) MSSP		60.49%		59.00%		59.00%
Care Alignment						
Total Actionable Outmigration % Decrease from FY18	Mar20	4.7%	Mar20	3.8%	FY20	4.0%
Quality						
[illegible]QualityFirst ACA % of Available Points	Apr20	60.4%	Apr20	62.5%	FY20	75.0%
[illegible] Rating - LVPHO	Mar20	2.62	Mar20	2.80	CY20	4.00

Meets or Tracking to Target
Monitor Closely
Intervention Needed

Executive KPIs

Domain	KPI	Measure
Savings/Loss - Financial Performance	Savings/Loss	$ Amount
Quality	Quality Performance	$ Amount
Documentation and Coding	% of Dropped Codes	%
Documentation and Coding	% of Fully Coded Members	%
PMPM	PMPM	RA PMPM
PMPM	PMPM Trend	RA PMPM Trend
PMPM	HCLV RX	PMPM
Utilization	Admissions	/K
Utilization	Readmissions	%
Utilization	ACSC Admissions	/K
Utilization	ED Visits	/K
Utilization	ED Conversion Rate	%
Transition of Care	High Risk Patient Follow Up	1 and 3 day follow up %
Transition of Care	Rising Risk Patient Follow Up	7 day follow up %
Care Pathways	Compliance	Compliance %
Attribution	Total Attribution	# of Lives
Attribution	Welless Visits	# of Visits

Guiding Principles

- Start simply and add complexity as your organization gains competencies
- Know your audience and purpose for conducting analyses and generating reports
- Avoid ‘nice to have’ and analysis paralysis
- See the forest through the trees
- Key stakeholders in each professional domain need to be SMEs that are able to digest and translate to executive leadership
- Know your levers

Engaging Providers: Supporting & Rewarding Success

Nicole R. Sully DO,CPE

Lehigh Valley Health Network

Achieving Clinical Excellence® (ACE)

- **ACE IS A ROADMAP FOR PHYSICIANS & APCs TO PROVIDE QUALITY PATIENT CARE AND PERFORM WELL IN VALUE BASED CONTRACTS**
  - **ACE is our primary engagement tool for employed, aligned, and independent providers**
- Semi-Annual Practice-Based Group Incentive Plan: Designed with incentives to meet the Triple Aim
- Triggered by **payer claims and EMR data** from EPIC and Next-Gen
- Measurement Categories
  - Better Care: Patient Satisfaction Survey Performance
  - Better Cost: Risk Adjusted ALOS, Risk Adjusted Episode Cost, Potentially Avoidable Admissions and ED visits, 30-day all-cause Readmissions, and generic Rx Prescribing
  - Better Health: Evidence-based Quality Measures, QI Projects, ABMS Host for MOC
- Funding Sources: Include clinical integration, quality & shared savings distribution
- CME Opportunities/Online Modules
- Secure provider portal is our main tool to disseminate information to our providers

ACE Achieving Clinical Excellence®

ACE Plan Design Basics

- **Participation Component**
  - Payed out quarterly and directly to the providers
  - $ come from clinical integration budget
  - Included in reimbursement are the following:
    - Meeting attendance
    - Quality Improvement Projects
    - Clinical integration sessions
    - Care gap closure program
    - Transition of Care Program

- **Quality and Efficiency Component**
  - Semiannual practice payout
  - Formal QA program
  - $ come from two places:
    - Clinical integration budget
    - Quality and shared savings $ earned in VBR programs

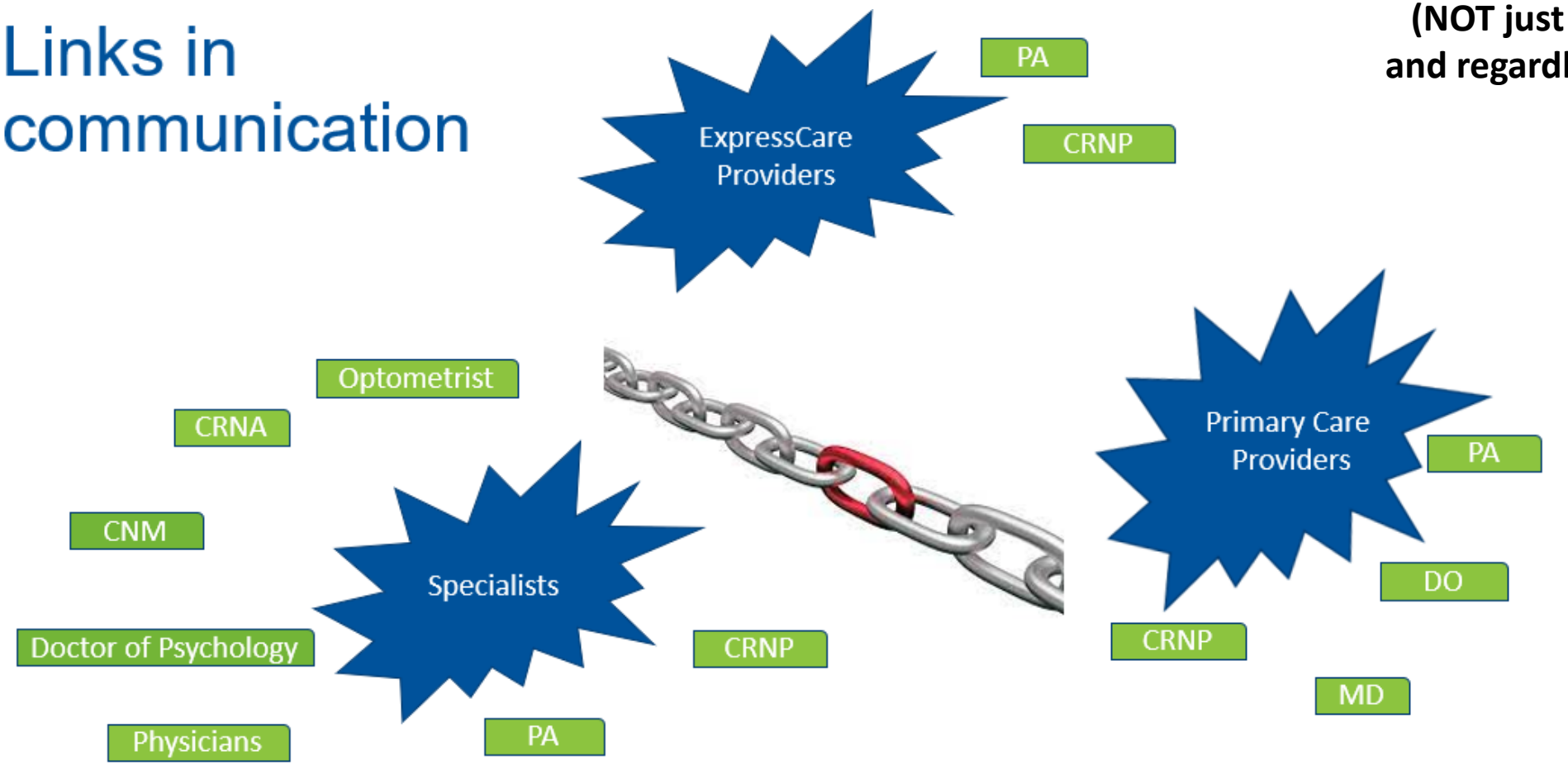
What Will Lead to our Success?

- Provider/practice engagement
- Close gaps in care
- Document/Code accurately - dropped codes, Hierarchical Condition Category (HCC) coding
    - Adjusts the target to reflect the risk of the population
- Pay attention to costs we create (admissions, readmissions, ED visits, cost of care overall)
- Optimize transitions of care
- Retain attribution of our patients

What Will Lead to our Success? TEAMWORK!!!!

Providers must practice patient-centered care on EVERY patient at EVERY visit (NOT just at a wellness visit and regardless if a PCP or SCP.)

Links in communication



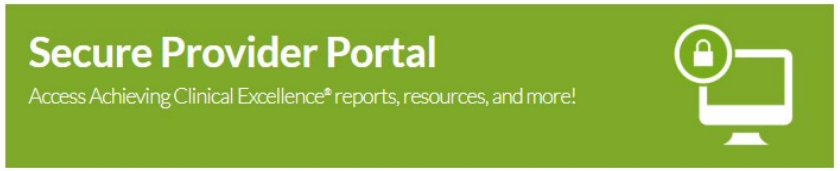
Physician Practice Outreach Visits

- Outreach Visits are the main touchpoint for VP practices
  - Visits focus on quality and cost performance, engagement, provider portal education and other ACE opportunities

- Scheduling practices based on:
  - Performance / engagement, past and present
  - Practices with the greatest opportunities
  - Higher utilizers, etc.
  - Requests for a visit

Secure Provider Portal

- Our primary tool for disseminating information/targeting VP initiatives. Includes data in the following categories:
  - ACE Performance
  - Attributed Patients
  - Quality Outcomes
  - Utilization
  - Transitions of Care
  - Episode Cost
  - Documentation/Coding



Secure Provider Portal

Providers:

Add A Filter...

For specific category dates visit the detail pages. Dates vary by category.

Quality Measures

Practice Tier: 1 ↔ Practice Rank: 2 ↑

89.58 %
Quality Score
(Avg Measure Score)

12
Scored Measures
(Min of 5 opportunities)

* Hover graph to view measures within each section

Below 50th Percentile | Above 50th Percentile | Above 75th Percentile

CLICK FOR DETAILS →

Utilization

Potentially Avoidable ED Visits

Practice Tier: 1 ↔ Practice Rank: 31 ↓

9.38 %

21 Potentially Avoidable Visits / 224 Total Visits

Breakdown

Preventable:	10
Non Emergent:	9
Both:	2
Appropriate:	203

Potentially Avoidable Inpatient Stays

Practice Tier: 2 ↑ Practice Rank: 63 ↑

12.87 %

13 Avoidable Inpatient Stays / 101 Total Stays

Breakdown

Avoidable Acute:	0
Avoidable Chronic:	13
Appropriate:	88

30 Day All Cause Readmissions

Practice Tier: 2 ↔ Practice Rank: 51 ↓

9.47 %

9 Readmissions / 95 Total Admissions

CLICK FOR DETAILS →

Documentation / Coding

	Commerical		Medicare	
*All Metrics are YTD	Jan 2022	Jan 2021	Jan 2022	Jan 2021
RAF Gap:	2.44	0.00	0.63	0.64
RAF Captured:	0.98	0.00	0.27	0.21
Patients Fully Coded:	0.00 %	14.00 %	0.00 %	13.33 %
Codes Closed Per 1000 Patients:	0	200	300	733
Dropped Codes:	73.43 %	82.94 %	73.55 %	76.12 %

CLICK FOR DETAILS →

Episode Cost

Practice Tier:	1 ↔
Episodes:	1204
Actual Cost:	$757,918.13
Expected Cost:	$871,328.30
Ratio:	0.87

CLICK FOR DETAILS →

Transitions of Care

Practice Tier: 1 ↔ Practice Rank: 4 ↑

32.02 %

14.07 Deviation From Goal / 43.93 Expected Follow-ups

Cohort	Goal	Discharges	Follow-ups Expected	Follow-ups Actual	Deviation From Goal
Commercial ages <= 18	79.20 %	2	1.58	2	0.42
Commercial ages 19-64	37.60 %	30	11.28	12	0.72
Commercial ages 65+	42.60 %	2	0.85	1	0.15
Medicare	45.10 %	67	30.22	43	12.78

CLICK FOR DETAILS →

Focus On Quality Outcomes

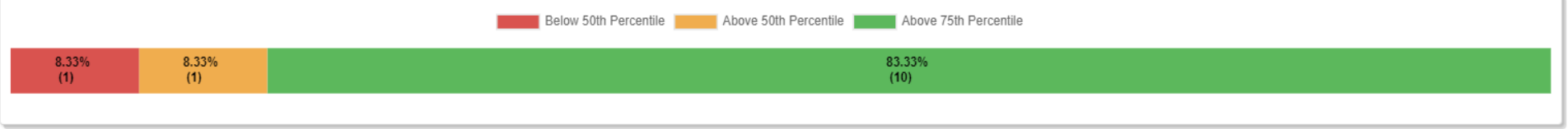
2/106 ↑	1 ↔
Practice Rank	Practice Tier

89.58 %	12
Quality Score (Avg Measure Score)	Scored Measures (Min of 5 opportunities)

Each measure is scored based on the gap closure percentage compared to the HEDIS percentiles, as shown in the table below.
To qualify as a scoreable measure, a minimum of 5 patient opportunities is required.

Gap Closure Rate	Measure Score
= 75th percentile	100%
>= 50th percentile	75%
< 50th percentile	0%

The measure scores for the practice are averaged to determine an overall quality score. The quality scores are then ranked from high to low and divided into quartiles to assign a practice tier, as shown to the left.



(Show All Measures)

Measures Below 50th Percentile
Preventive Age 16 - 24 Chlamydia

Measures Above 50th Percentile
Diabetes Age 18 - 85 Kidney Health

Measures Above 75th Percentile
Preventive Age 50 - 75 Colorectal Screening
Preventive Age 45 - 64 Ambulatory or Well Visit
Preventive Age 21 - 64 Cervical Screening
Preventive Age >= 20 Medicare Well Visit
Preventive Age 50 - 74 Mammogram
...5 More

Transitions of Care

Filters

4/99 ↔	1 ↔
Practice Rank	Practice Tier

- Eligible primary care providers will be incented on the number of patients discharged from the hospital that are seen within seven days of discharge.
- To qualify for the incentive there must be a minimum of 20 discharges in the previous rolling 12-month period.
- All Evaluation and Management (E&M) follow-up visits and Medicare TOC visits will be counted to fulfill this measure.
- Virtual visits also currently qualify.
- The gap in care will be closed when any provider sees the patient (e.g.: if a patient has a knee replacement and is seen by the surgeon within seven days of discharge, the TOC measure is viewed as closed for the attributed provider).

35.27 %

14.86 Deviation From Goal / 42.14 Expected Follow-ups

Discharges	Follow-ups Expected	Follow-ups Actual	Deviation From Goal
Commercial ages <= 18 (Goal: 79.20 %)			
1	0.79	1	0.21
Commercial ages 19-64 (Goal: 37.60 %)			
25	9.40	12	2.60
Commercial ages 65+ (Goal: 42.60 %)			
3	1.28	2	0.72
Medicare (Goal: 45.10 %)			
68	30.67	42	11.33
Total			
97	42.14	57	14.86

Show 10 entries Search:

Provider	Patient	Date Of Birth	Payor	Discharge Date	Discharge Facility	Follow-up Date	Follow-up Provider	Met Goal
Jaclyn Sperrazza	XXXXXXXXXXXXXX	01/01/2022	Highmark	04/25/2021	LVHN	04/30/2021	Jaan Naktin	✓
Jaclyn Sperrazza	XXXXXXXXXXXXXXX	01/01/2022	Medicare	12/28/2021	LVHN	01/04/2022	Joseph Habig	✓
Jaclyn Sperrazza	XXXXXXXXXXXXX	01/01/2022	Medicare	09/21/2021	LVHN	09/27/2021	Rizwan Tariq	✓
Jaclyn Sperrazza	XXXXXXXXXXXXXXXXX	01/01/2022	Medicare	08/05/2021	LVHN	08/11/2021	Kathleen Baldwin	✓
Jaclyn Sperrazza	XXXXXXXXXXXXXX	01/01/2022	CBC MA	04/13/2021	LVHN	04/19/2021	Jaclyn Sperrazza	✓
Jaclyn Sperrazza	XXXXXXXXXXXXXX	01/01/2022	Medicare	01/31/2021	LVHN	02/04/2021	Jaclyn Sperrazza	✓
Jaclyn Sperrazza	XXXXXXXXXXXXXXXXXX	01/01/2022	Highmark MA	03/20/2021	LVHN	03/25/2021	Jaclyn Sperrazza	✓
Jaclyn Sperrazza	XXXXXXXXXXXX	01/01/2022	CBC	07/01/2021	LVHN	07/02/2021	Jaclyn Sperrazza	✓
Jaclyn Sperrazza	XXXXXXXXXX	01/01/2022	Highmark	02/08/2021	LVHN	02/10/2021	Jaclyn Sperrazza	✓
Jaclyn Sperrazza	XXXXXXXXXXXX	01/01/2022	Medicare	03/23/2021	LVHN	03/30/2021	Jaclyn Sperrazza	✓

Communication/Outreach Methods

VBR Success

- Earned over $108M in VBR programs over the past three years
- Employed physician goals aligned with ACE program
- Partnership opportunities with payers
- Care Coordination
  - Populytics Care Coordination team recently achieved NQCA accreditation, positioning it to perform delegated care management services on behalf of the payer.
  - Improved patient experience
  - Taking responsibility (and revenue) from the Payer
- Co-branded products
  - Tiered to LVHN PHO physicians & facilities

Engagement & Implementation of Value Base Contracts that Drive Outcomes

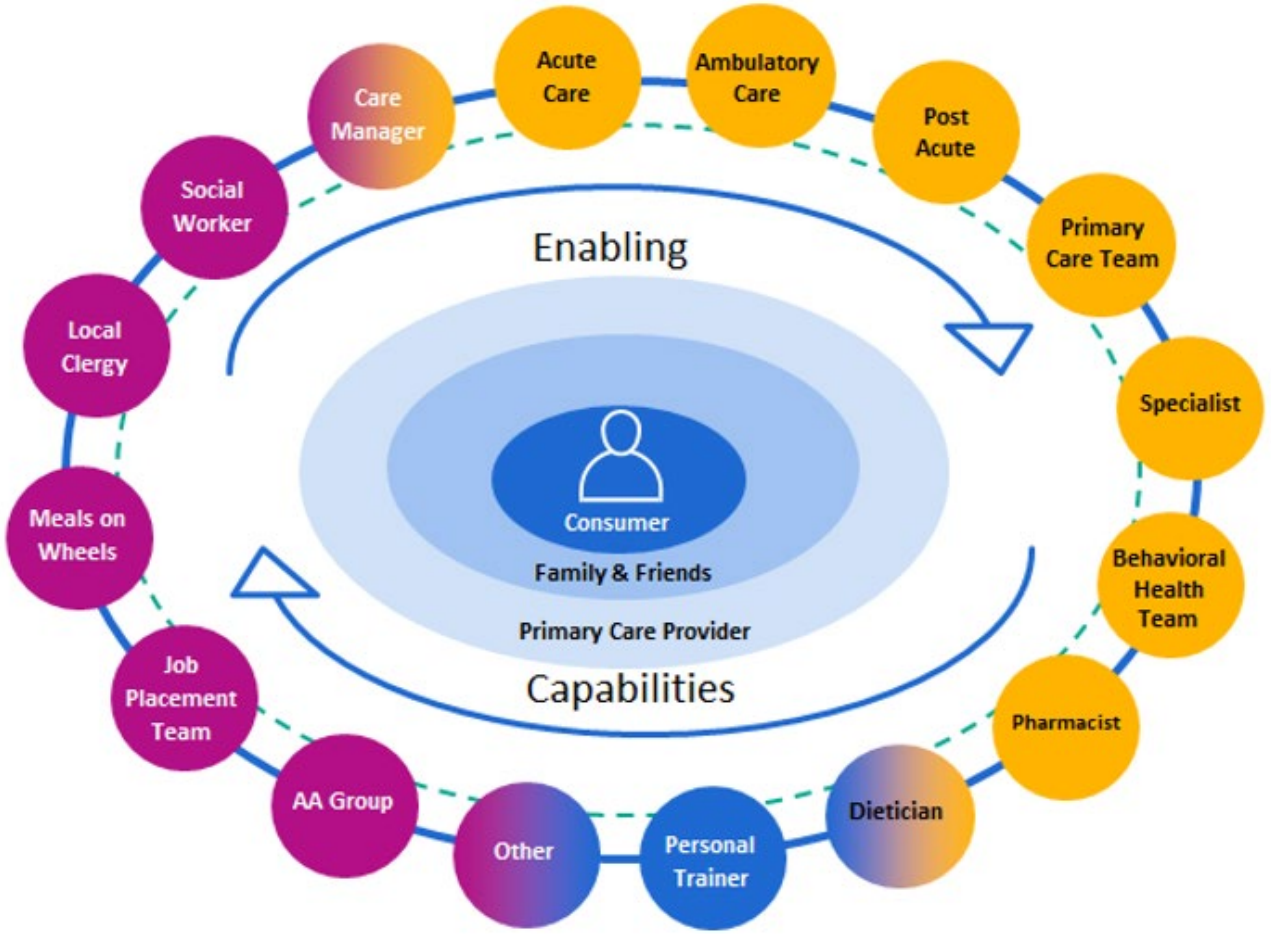
Rhonda Holcomb, MHA

ChristianaCare™

What Does Your Healthcare Look Like?

ChristianaCare™

Holistic Vision of Care



= Clinical
= Lifestyle
= Community

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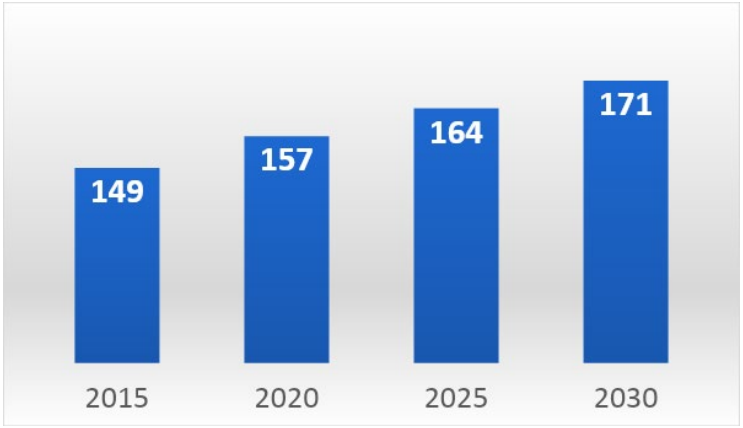
Adapting Care to Meet Growing Clinical and Social Needs

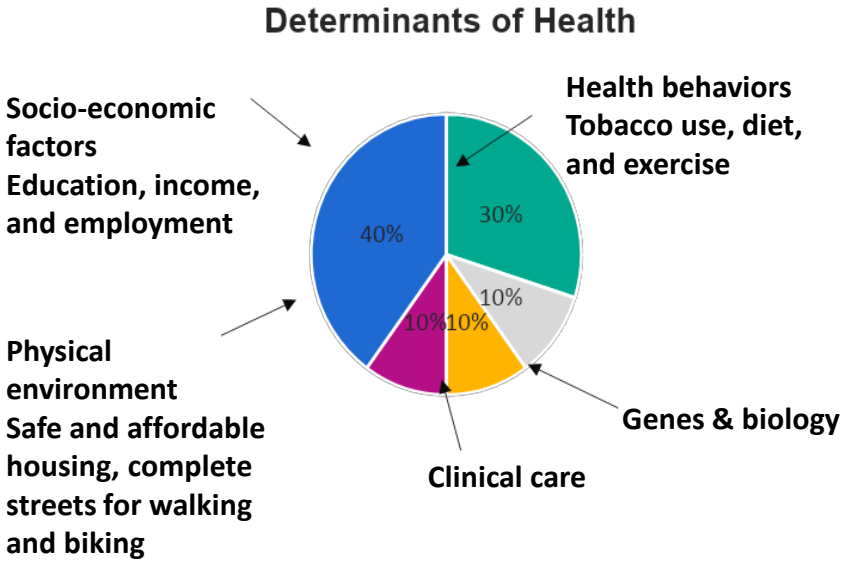
Chronic conditions are on the rise

Due to an aging population, over 20 million more U.S. adults will be living with 1 or more chronic conditions by 2030…[1]



Addressing SDOH is key to ensure holistic care

Clinical care alone cannot improve population health.



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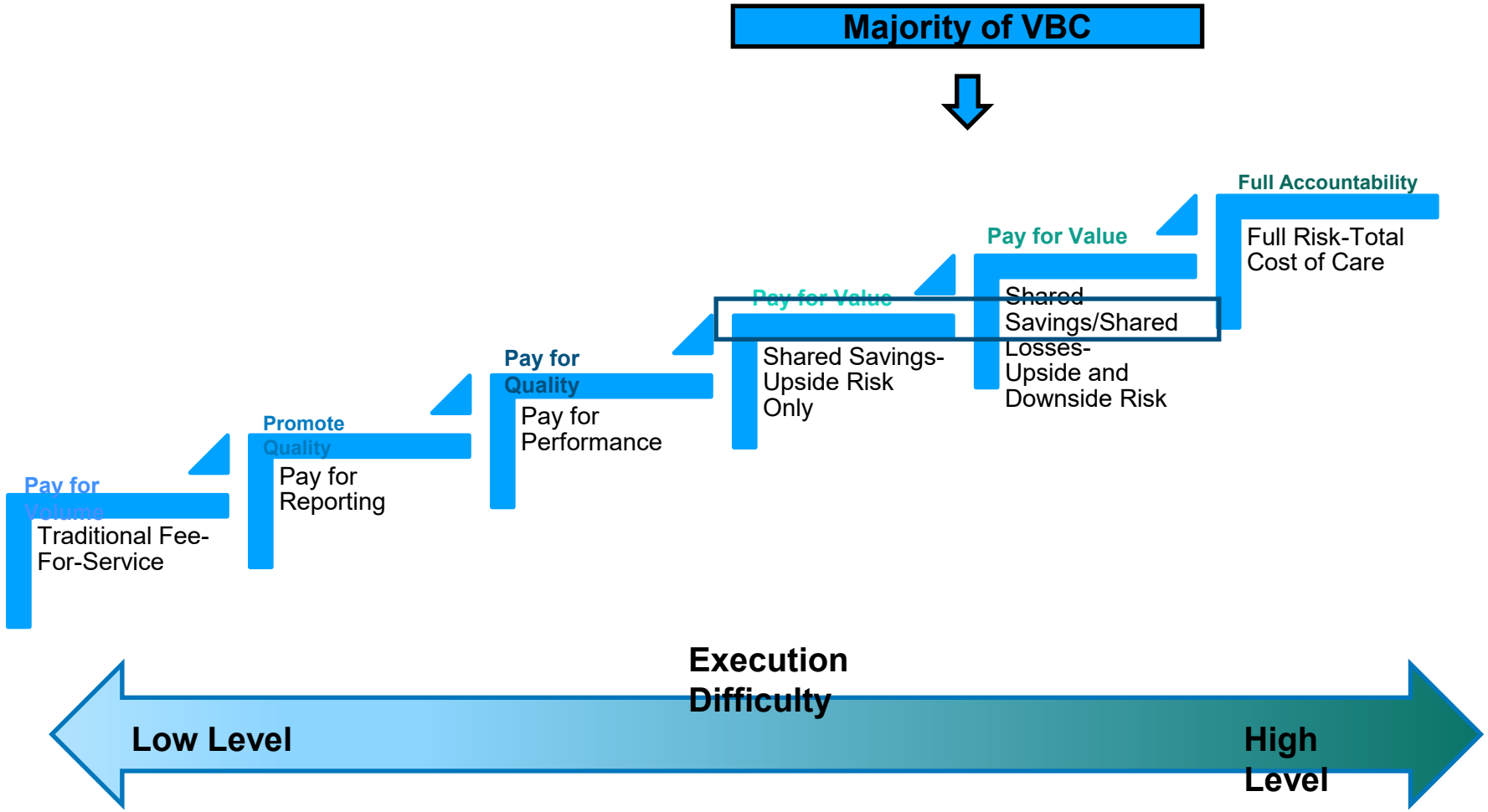
Stepping from Volume to Value



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Key Action Plan

PCP

- Panel Management
- Coding and Documentation
- Wellness & Prevention
- Quality Documentation
- Transition of Care
- Care Coordination
- Palliative Care
- Practice-Leve Performance Review
- Ambulatory-Sensitive Hospitalization Review

Acute

- ED Assessment
- Standardize Discharge Approach
- Transitional Plan with PCP
- Daily CareVio Care Coordination Review
- Readmission Reviews

PAC

- Weekly CareVio Calls
- Health System meeting with PAC/SNFs

Specialist

- Standard approach to common conditions
- Ensure PCP engagement at every visit
- Pro-active PCP support
- Connect to PCP and CareVio resources
- High Risk Maternity and NICU

Psychosocial

- Social determinant of health
- Racial and ethnic disparities
- Complex Care
- Behavioral Health
- Outreach for assigned patients

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Key Action Metrics

TOC within 7 days*
Annual Wellness Visit
Panel Size Management
HCC Capture
PCP Utilization*
ED Utilization*
Readmission Rate*
RVU (access)
Quality Measures

***Alignment to health system goals**

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What drives improvement in patient outcomes?

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Population Health Components –
Best Practice Implementation Levels for Primary Care

PHM Best Practice Level

	1 Patient Population Identification	2 Health Assessment	3 Risk Stratification	4 Engagement	5 Patient-centered Interventions	6 Impact Evaluation
Level V	Clinician receives real-time, patient & population specific data at point of care	Clinician auto-notified of new or conflicting info requiring resolution	Valid tools auto- stratify patients & population across all clinicians; gaps flagged for action	"Medical home"; clinician monitors, optimizes care plan & care team across all settings	Clinician/Patient collaborative care plan; 1°, 2°, 3° prevention focus; coordinated team	Real-time feedback; outcomes meet & exceed patient , peer, population goals
Level IV	Patient information available from all clinicians - ID, risks, condition control	Patient health, values, preferences assessed; clinician receives info for consideration	Stratification lists available based on claims, HA, labs, screening info	Clinician engages with patient in "medical home," coordinates across connected settings	Clinician aware of & responds to patient needs/preferences focus on 1°, 2°, 3° prevention	Clinician receives patient outcome info; performance goals set in peer organization
Level III	Clinician registry – key diagnoses, tests, Hx, and condition control	Clinician evaluates health risks based on year-over-year comparing assessments	New health risks identified through health assessments and via registry lists	Clinician engages with patient focusing on both past and newly identified risks	Clinician focuses on 1°, 2°, 3° prevention; strategies for risks identified	Clinician unaware of patient outcome unless directly involved in care
Level II	Clinician has patient list with diagnoses	Clinician asks patients for baseline health assessment; assesses patient at the visit	Risk based on "frequent flier" status & clinician lists with diagnoses	Clinician engages with patient episodically at patient presentation	Intervention based on current patient need and known health risk(s)	Clinician unaware of patient outcome unless directly involved in care
Level I	Clinician identifies patient through direct interaction and hard-copy records	Clinician assesses patient at the visit	Clinician aware of high-risk patients based on "frequent flier" status	Clinician engages with patient episodically at patient presentation	Intervention based on current patient need and known health risk(s)	Clinician unaware of patient outcome unless directly involved in care

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Foundational Framework

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Key Components of Engagement

Meeting people, processes and engagement where they are at.

Provide educational resources and tools that are easily accessible.

Allowing people to process through change.

Continuous process improvement activity

Give clear directives, expectations and leadership. Praise!

Allow feedback, ideas and failure

Tying data outcomes to patient stories

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Summary of Maturity in Value Based Care

ENTERPRISE VISION FOR POPULATION HEALTH MANAGEMENT

SEGMENT & STRATIFY POPULATIONS

- Processes to integrate community health and wellness needs
- 360 degree view of all patients
- Prospective stratification & disease progression
- Intervention analysis and clinical models tailored to segment needs

ADVANCE CLINICAL MANAGEMENT & CARE MODELS

- Highly effective, individualized care delivery
- Person-centered care coordination
- Evidence-based systems of care
- Performance management and improvement
- Advanced primary and chronic care model
- Patient and family preferences related to access

PROMOTE CONSUMER ENGAGEMENT & ACCESS

- Proactive patient care coordination (focus on rising risk)
- Network and product design to enhance Coc
- Synchronous and asynchronous access to caregiver support
- Upstream engagement of non-active consumers

ENGAGE PROVIDER & COMMUNITY PARTNERS

- Evolving sophistication of network development
- Community resource integrations to address SDoH
- Provider alignment on transformation efforts across care delivery settings
- Community agency integration W/ clinical care management
- Clearly aligned community health & wellness goals & activities

ALIGN ECONOMICS

- Contracting strategy and product portfolio
- Incentive distribution model & aligned comp model
- Refined incentive and risk based methodologies
- Revenue management predictive modeling
- TCOC proactive performance management

UNIFIED LEADERSHIP AND CULTURE

- Strong physician leadership and accountability
- Integrated interdisciplinary teams
- Incentive structure to support value-based care goals
- Disciplined performance improvement and change management culture

CREATE AND DEPLOY POWERFUL INFORMATION

- Refined data governance and management
- Unified data architecture, integration, & normalization
- Population attribution methodologies and algorithms
- Predictive modeling to drive patient engagement, intervention, risk adjustment based on outcomes
- Real time performance management
- Integrated decision support

“Our greatest weakness lies in giving up. The most certain way to succeed is always to try just one more time.”

–Thomas A. Edison

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