

Bold Moves: Redefining the Game in Value-Based Healthcare with Technology and Collaboration

Seth Edwards, Vice President – Advisory Services, PINC AI

Chris Elfner, VP, Accountable Care Strategy, Bellin Health

Dr. P. Geoffrey Nicholson, Jr, Senior Vice President & Chief Clinical Officer
of WellSpan Population Health

Today's Conversation



I. Intro / Welcome / Purpose

II. Overview of Premier's approach to Population Health partnerships
Seth Edwards – VP of Population Health and Value-based Care



III. Case Study: Bellin Health
Chris Elfner – VP of Clinically Integrated Network

IV. Case Study: WellSpan Health
Dr. P. Geoffrey Nicholson, Jr. – Sr. VP and Chief Clinical Officer, WellSpan Population Health



V. Q & A / Adjourn



CHALLENGES to Achieving an Effective Population Health Strategy



Need for expert guidance, feeling isolated in tackling population health strategy issues.



Challenges in navigating healthcare policies for value-based care strategies.



Uncertainty in identifying areas of opportunity and devising / implementing a change strategy.



Missing peer benchmarks for focused improvement insights and system comparisons.



PREMIER'S VALUE-BASED CARE CONSULTING AND COLLABORATIVES

BEST IN KLAS 2024, 2023 AND 2022



“Premier is **our go-to expert around anything healthcare related, especially value-based care.** We view them as the experts on healthcare policy. Premier consultants are always very responsive to questions, and they really get to know our organization. We have been working with some of the same people for several years. They understand our organization, so when we talk about things, it is more of a collaboration.”

– Customer Executive who responded to the survey



MULTIPLE PARTNERSHIP MODELS TO SUPPORT SUCCESS IN POPULATION HEALTH

Premier leverages collaborative, consulting and technology solutions paired with Advocacy/ Public Policy insights to meet members where they are in their journey.



Join Premier's Population Health Management Collaborative for Guidance and Success in Value-Based Care

Support specifically tailored to your Population Health journey

CONNECT WITH MEMBERS · LEARN BEST PRACTICES · ACCELERATE CHANGE · ENHANCE CARE DELIVERY · ALLEVIATE SHRINKING PROFIT MARGINS



DEDICATED PARTNERS

With over a decade of operational experience, our Premier team brings a wealth of expertise to answer member questions, make member connections and provide individualized advisement.



PERFORMANCE BENCHMARKING & ANALYTICS

Access unblinded benchmarking and analytics on Accountable Care Organizations' (ACO) performance. Leverage peer-to-peer networking for comparative operational practices.



ASSESSMENTS AND GROUP LEARNING

Topics include person-centered healthcare, advanced primary care, high-value care delivery, population health informatics and technology, governance and operations, and payor partnerships.



NATIONAL MEETINGS

Bi-annual meetings with member success stories, organization best practice sharing and industry-leading speakers.

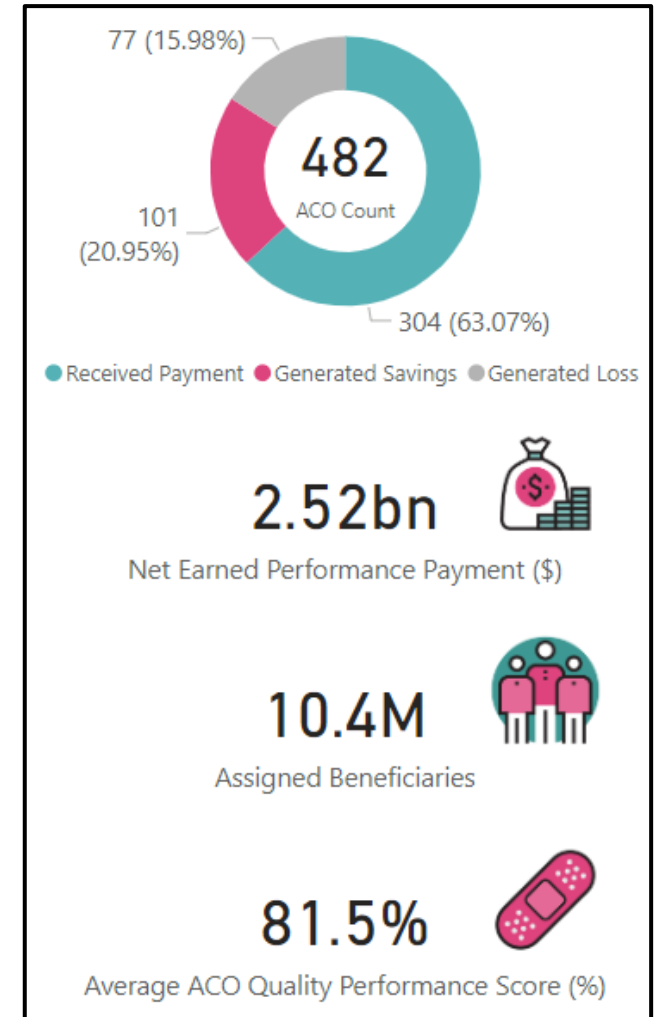
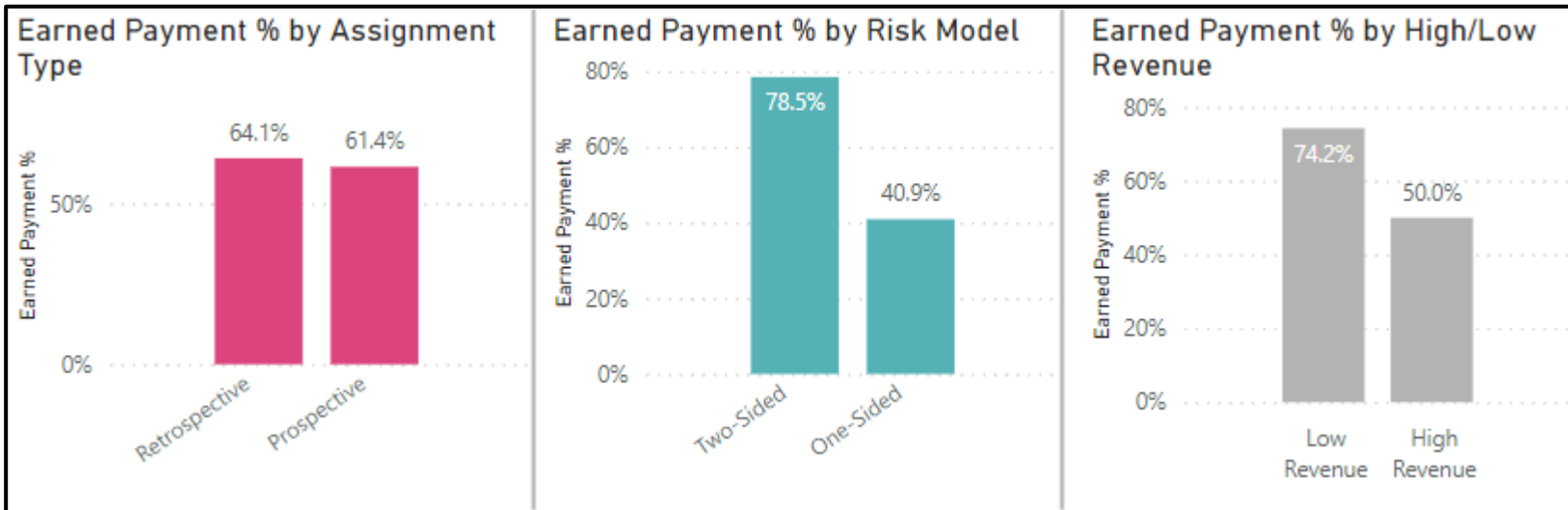
Annual topic-specific meetings focused on value-based care and payer capabilities, leading practices.



Long-term Partnerships for Sustainable Success...

85 percent of Premier's Population Health Management Collaborative (PHMC) members generated more than \$362 million in savings to Medicare.

More than half of PHMC members achieved shared savings in 2022.



HCC product Line: Quality Documentation, Quality Care

 CODINGCARE



Efficient Pre-Visit Prep



AI-assisted, prioritized chart pre-visit chart review of all CMS-HCC conditions



Direct push of actionable guidance to providers

 CODINGGUIDE



Streamlined Provider Workflow



'Always On' opportunity checklist



Automatic suggestions



Built-in end-of-encounter compliance checks to mitigate coder queries

 CODINGCARE



Coordinated Post-Visit Follow-Up



Track RAF performance and other key value metrics



Schedule follow-ups



Drive care management programs



Stanson Health CDS Members



468,000+ providers | >850 hospitals | >14.9B alerts analyzed



Chris Elfner

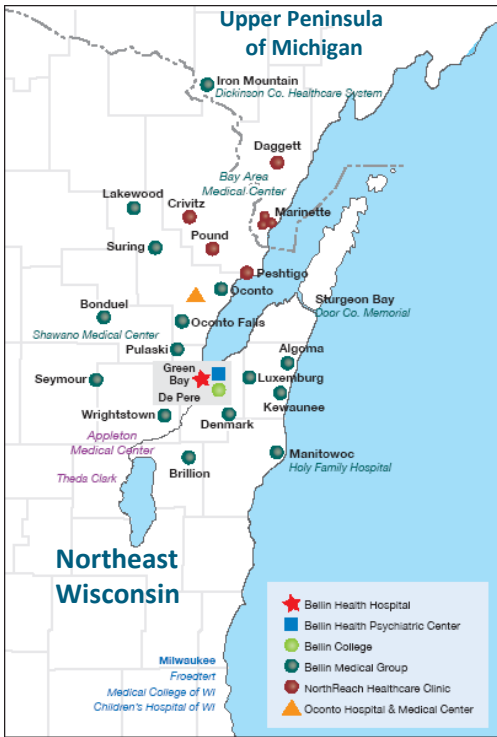
Vice President of Clinically Integrated Network
Bellin Region, Bellin Gundersen Health System |
Bellin Health Partners

Agenda

- + Bellin's Journey to Value
- + How we started and how it spread
- + Bellin's RAF Improvement Journey
- + Results/impact so far
- + Where we're going next



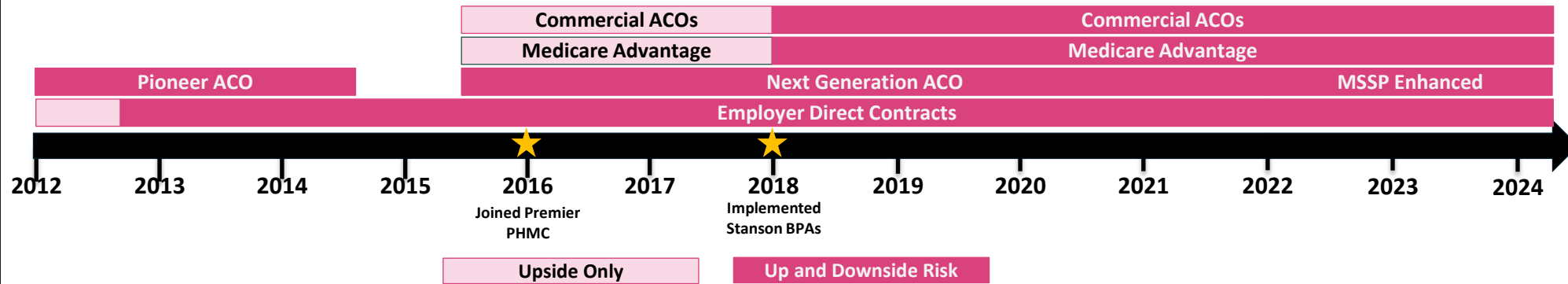
Our Region
650,000 People



Our Vision

All people in our region will be at their healthiest during every stage of their lives and will be able to afford the exceptional patient care we provide.

Our Value Based Contracts



ACO Contracts
Performance Year 2024

17
Total

6
Up and
Downside Risk

Employer Direct Contracts
Performance Year 2024

269
Total

24
Up and
Downside Risk

Attributed Lives
Performance Year 2024

120k





Bellin Gundersen Health System

- 11 Hospitals
- 110+ Clinics
- 1.4k Providers
- 2.5M Visits per year
- 35 Counties
- 4 States
- 14k Teammates



Bellin Region

Located in Northeast Wisconsin and the Upper Peninsula of Michigan

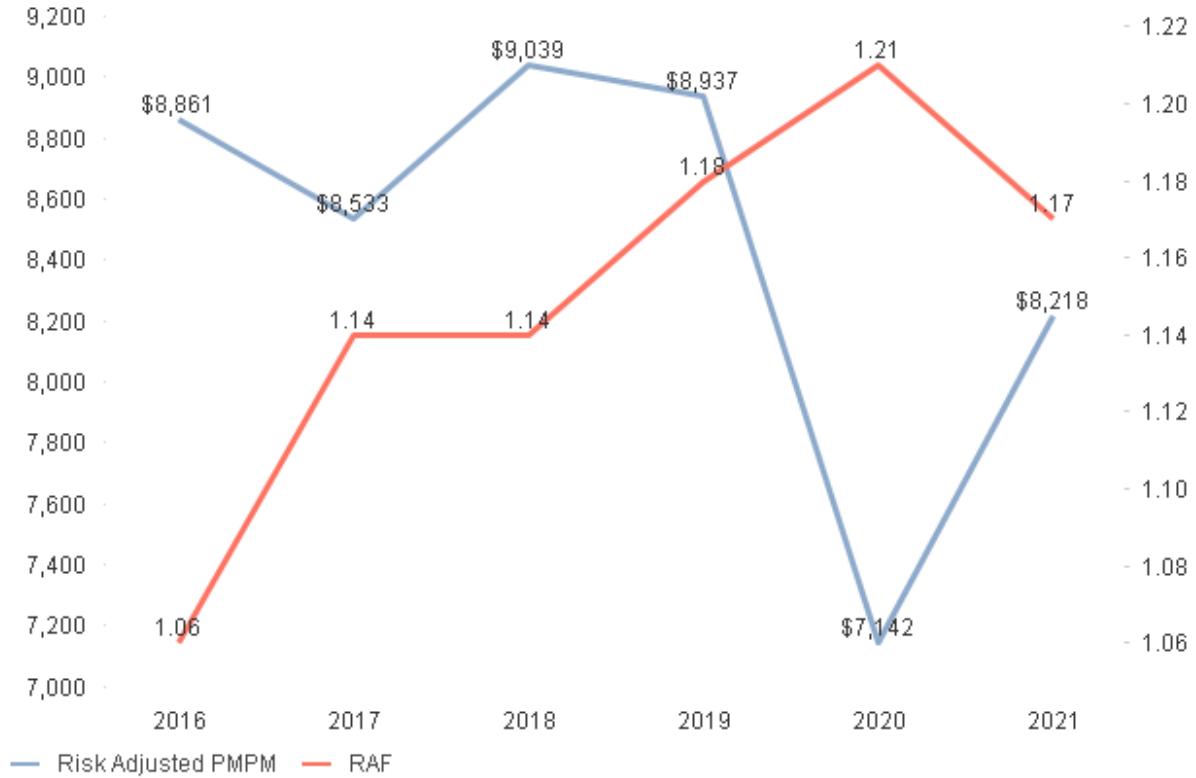
Bellin Health Partners ACO / CIN



Premier/Stanson Partner since 2018



How We Started



Next Gen ACO Participation Decision (2016)

- + Proven to be a high quality / low cost provider in Pioneer
- + Analysis indicated the program would lose money for us
- + Break with 3% (max) RAF improvement
- + Baseline RAF Score: 0.86
- + Engaged an internal and external team of experts to ensure success
- + Developed a triple aim scorecard with key metrics
- + Developed our Value-Based mindset, skillset, and toolset.

Key to our success: Annual Wellness Visits



Bellin's Participation in the Population Health Management Collaborative

Participation	1:1 Support
<ul style="list-style-type: none"> Participated in Premier's Population Health Management Collaborative since 2018 Regularly attends the PHM Collaborative's in-person meetings Active participation in all six of the PHM Collaborative's educational domains Serve on various advisory and member planning committees to ensure the collaborative's offerings are representative of the current membership 	<ul style="list-style-type: none"> Strong partnership with dedicated partners to drive ACO/CIN Strategy <ul style="list-style-type: none"> Bellin contacts: Naomi Wedin, Chris Elfner Premier contacts: Seth Edwards, Richard Doane Redesigned Post-Acute Care model based on Premier Assessment recommendations Redesigning Care Management based on Premier Care Management assessment
Data Analytics	Strategy
<ul style="list-style-type: none"> Participates in the PHM Collaboratives member performance meetings using unblinded data for benchmarking and learning Meets regularly with data analytics team to discuss emerging trends and identify key areas of opportunity Partner with Premier team to project ACO performance 	<ul style="list-style-type: none"> Partnered with Premier on CMS / CMMI program participation strategy and renewals Premier has provided guidance on governmental model evaluation and actuarial support to identify strategic approaches in an effort to maximize and sustain performance



Our Focus on RAF / HCC

2018 – Round 1

- Focus on tools and technology
- Payers imposed a strong desire to increase RAF scores
 - Worked the “Suspect” Condition Reports
 - Payers doing visits in patient’s homes

2021 – Round 2

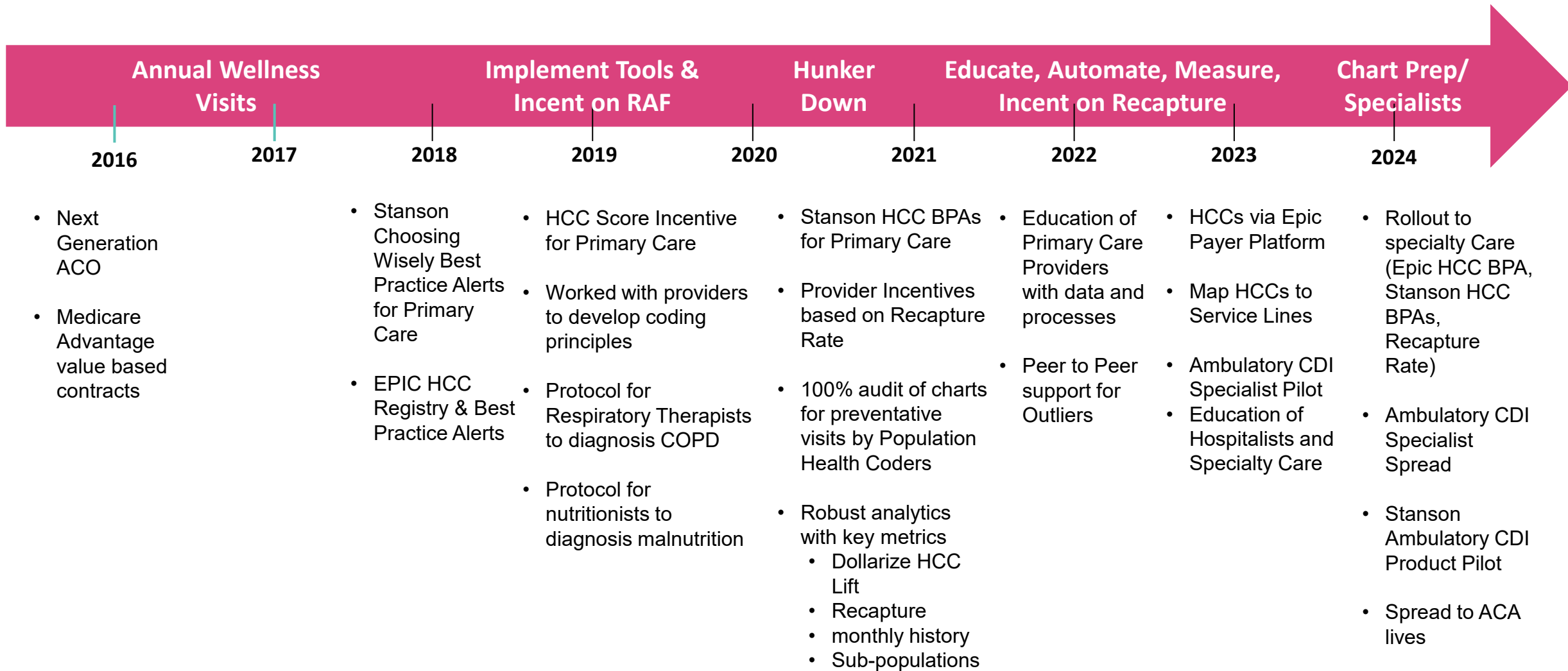
- Dollarized uncaptured opportunity for 2020 – that got leadership’s attention
- Created a cross functional team to work on mindset, skillset, and toolset improvements around accurate documentation and coding

Challenges

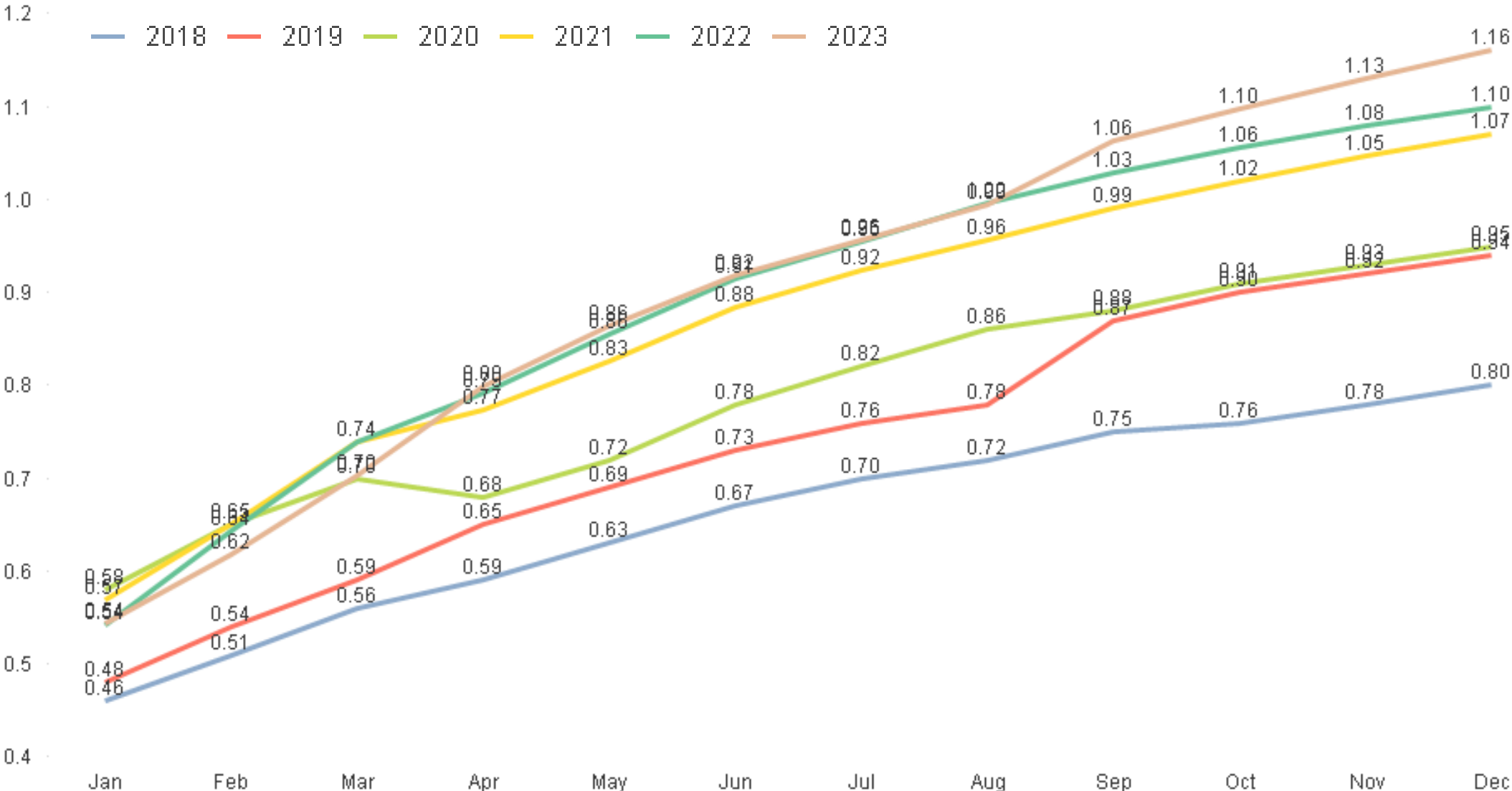
- Providers perception of coding improvement
- Viewed as a money grab
- Focused on the patient, not the population



Our Journey to Accurate Coding and Documentation

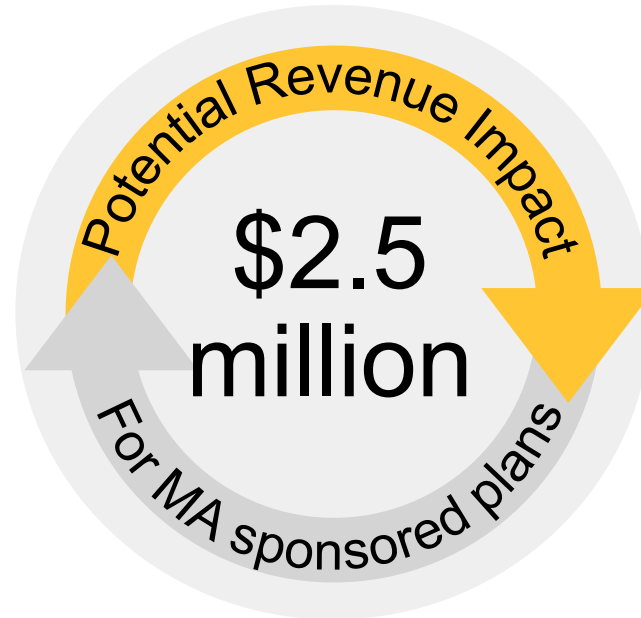


RESULTS: RAF Score for Attributed Lives

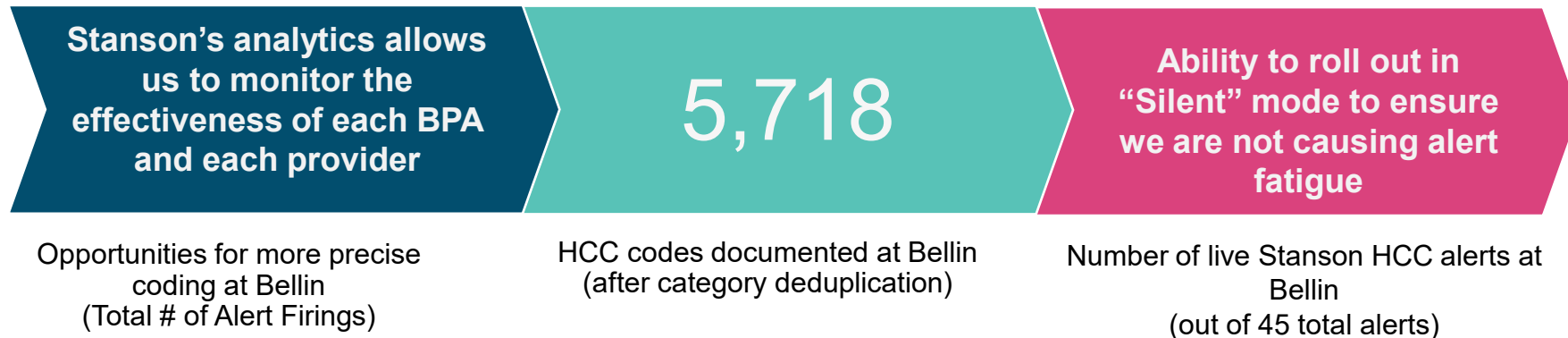


2023 Stanson HCC Key Results & Outcomes at Bellin

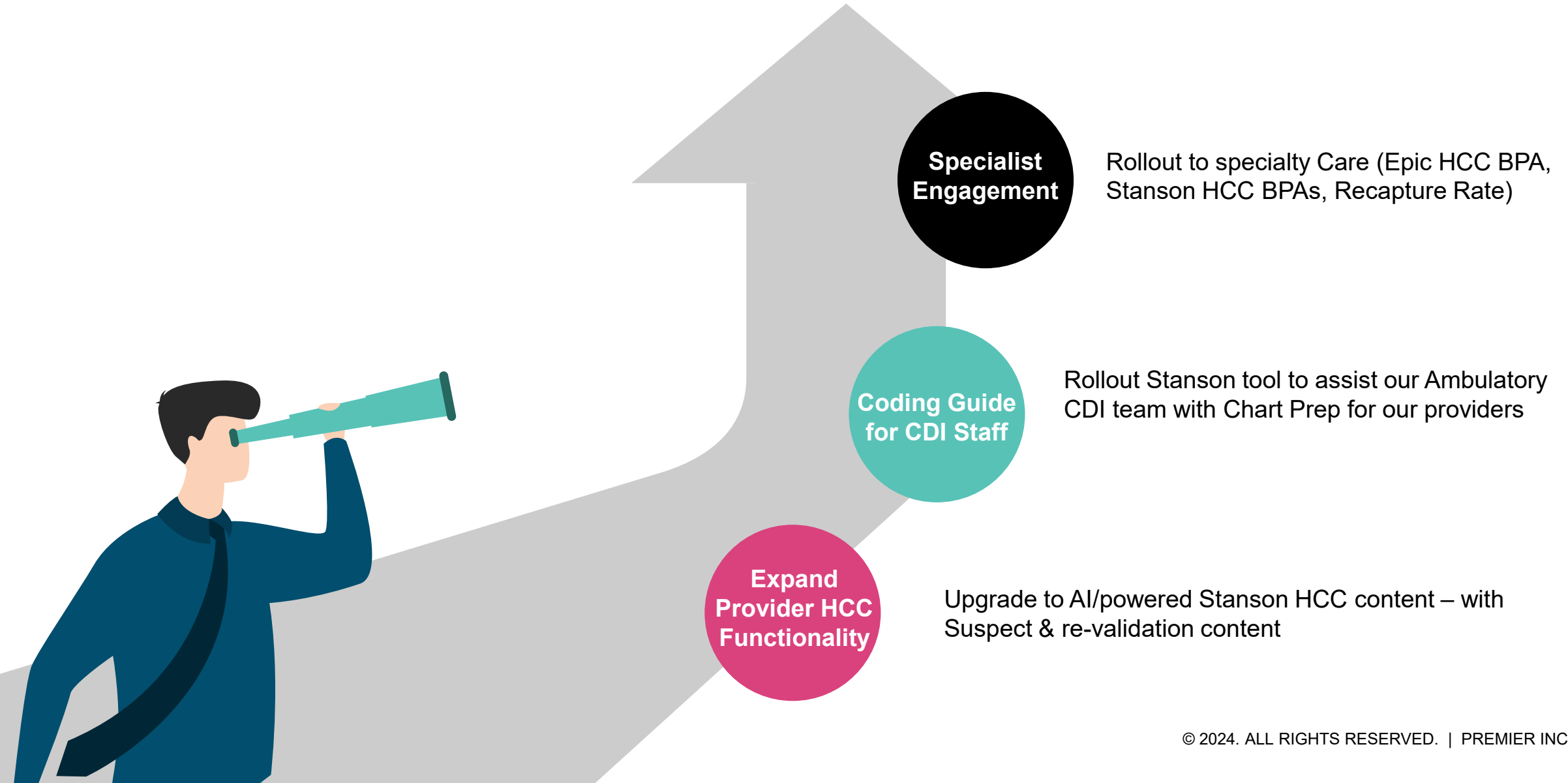
“We can toss out all the payer suspect condition reports. The Stanson HCC BPAs provide us way more actionable information on potential diagnosis.”
- Primary Care Provider



“I don’t own stock in Stanson, but I do appreciate that they are walking the journey with us.”
- CMIO



Where Is Bellin Going Next



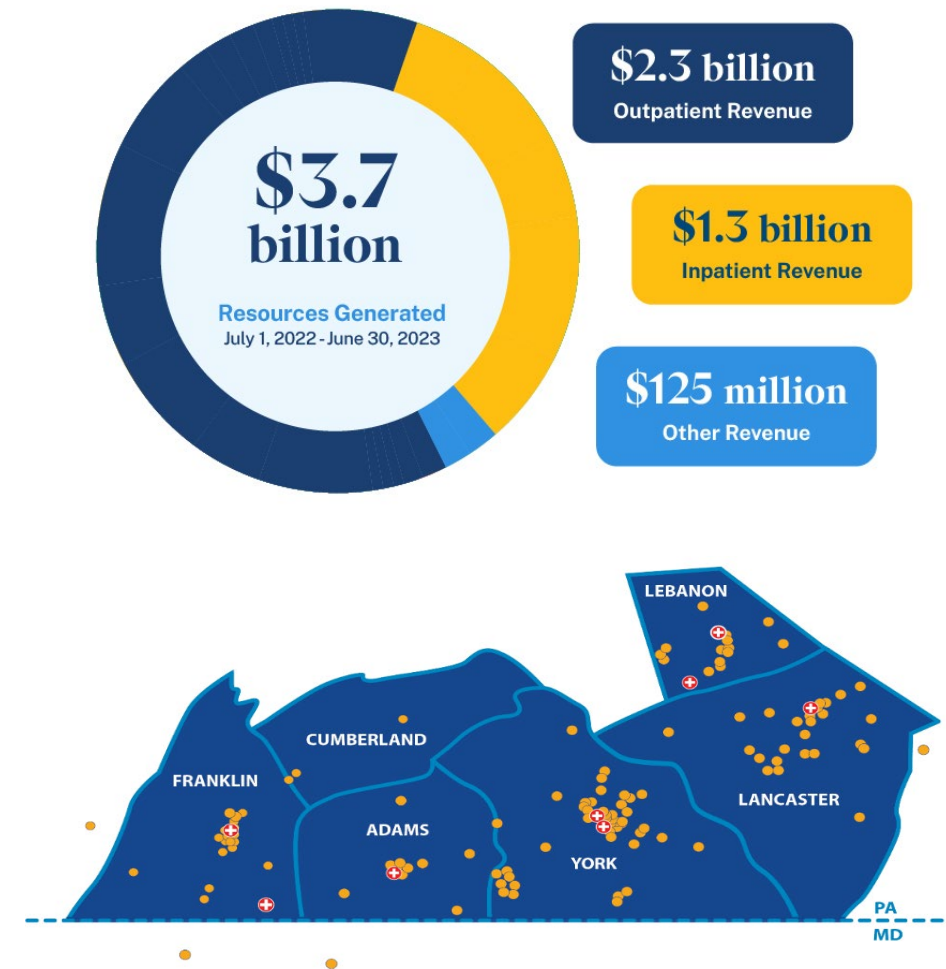


Dr. P. Geoffrey Nicholson, Jr.

Sr. VP and Chief Clinical Officer
Wellspan Population Health

About WellSpan

- 20,000 team members
- 2,750 aligned providers
 - 2,200 WellSpan Medical Group
 - 550 WellSpan Provider Network
- Accountable Care Organization (ACO)
- 220 patient care locations
- 6 Acute Care Hospitals
- 2 Specialty Hospitals
- 4 Ambulatory Surgery Centers
- Regional Behavioral Health Organization
- Regional Home Health Organization
- \$344.4 million in community benefit
- Top 20% Credit Rating: AA- (stable)/Aa3 (stable)



Note: Per FY23 data



2022 MSSP ACO Success

2022 Total Savings

\$21,925,202

Resulting from **high quality, low cost care** provided by ACO physicians & care teams

WellSpan's ACO produced more savings than **92%** of ACOs

Leading our region in value

2,084 ACO clinicians
249 sites of care
15 Independent practices
Working As One

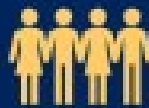


Higher quality score than **87%** of ACOs nationally

- Better diabetes A1c control than 95% of reporters
- Performed tobacco screening & cessation on 93% of patients
- Improved admit rates for patients with multiple chronic conditions
- Low readmission rates



Largest ACO in South Central PA



67,205

Medicare patients received primary care in our ACO, 51,367 became attributed.

Providing the best care at the lowest cost

Over the last 6 years our ACO has saved our patients and the Medicare program

\$42,492,889



Documenting patient health risks



ACO clinicians closed

92%

of patient health risk gaps

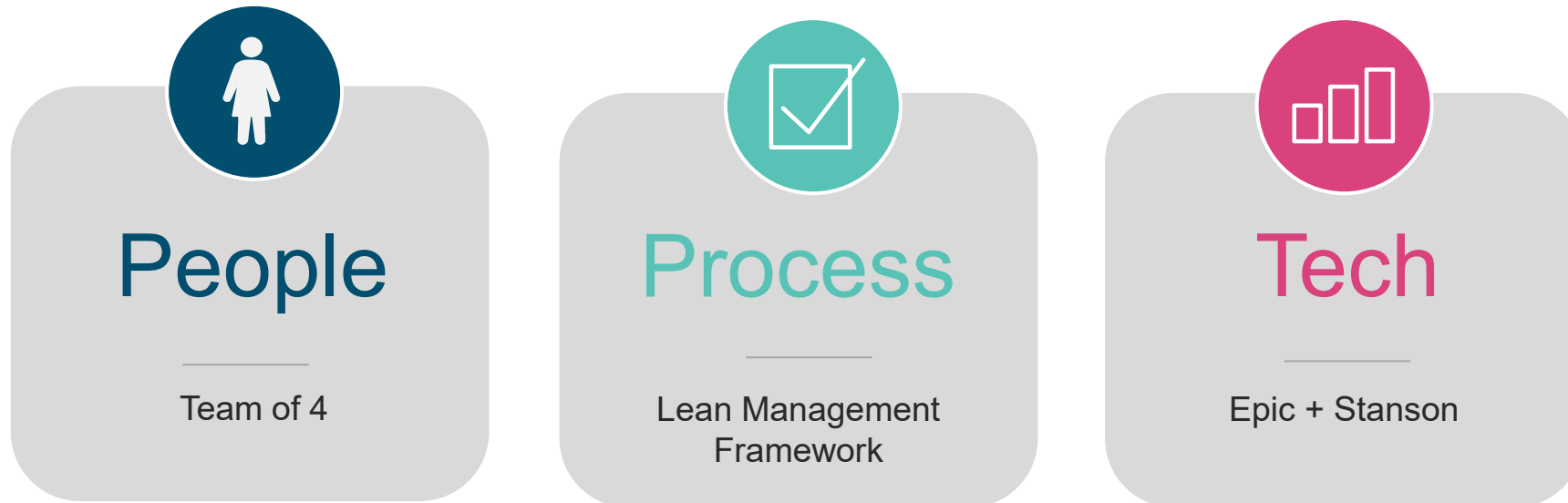
88%

of patients with risk gaps received a timely appointment.

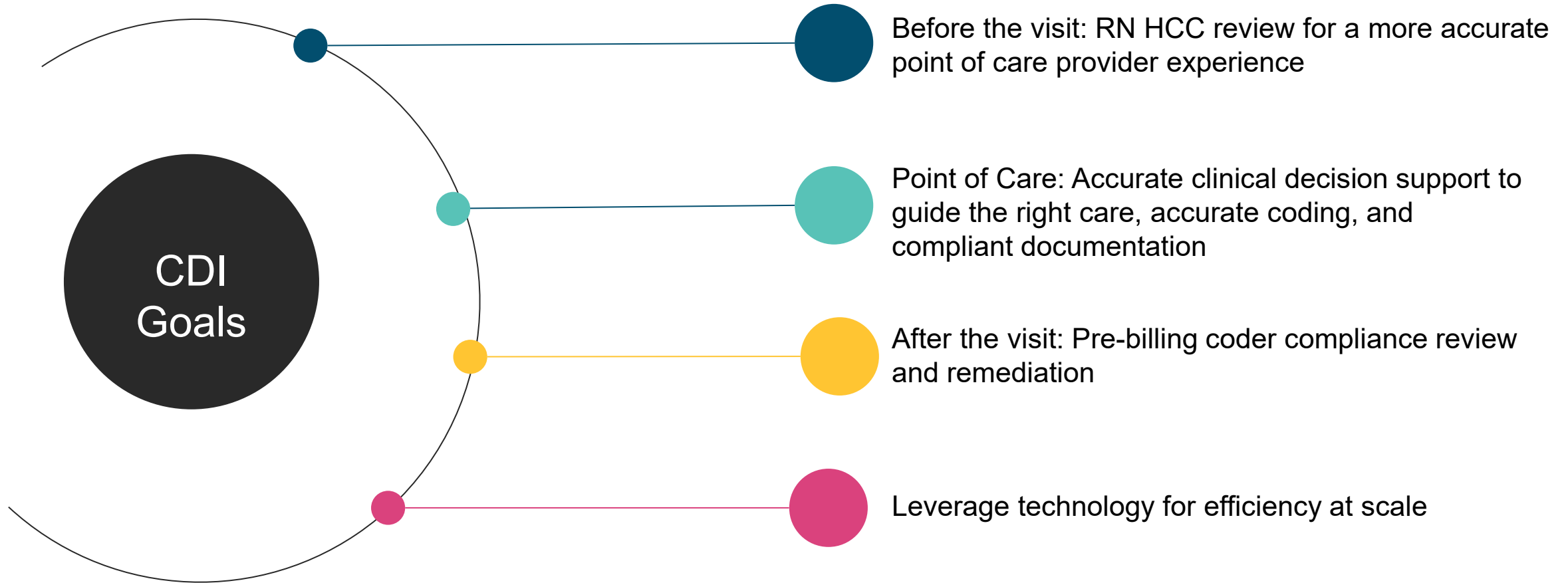
Our uncapped HCCs are now higher than **79%** of ACOs

WellSpan VBC Journey/Problem

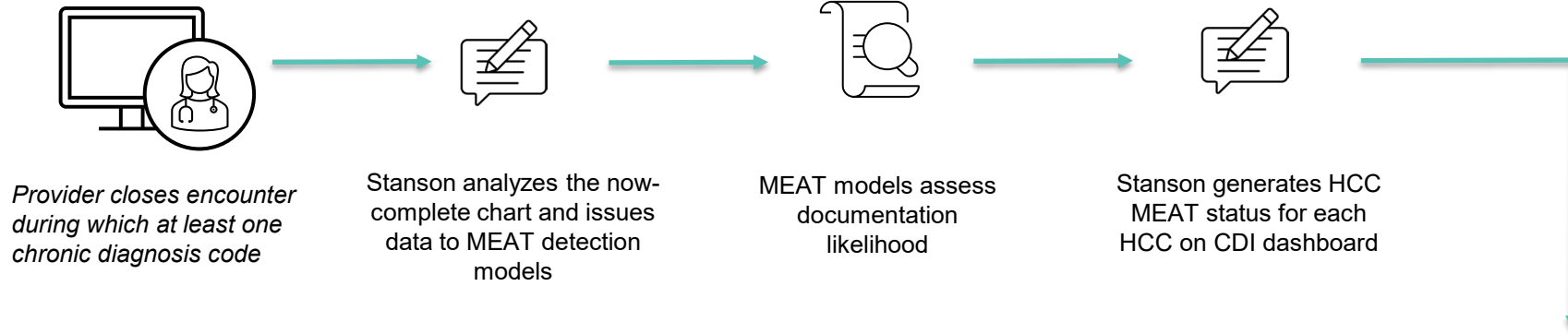
- WellSpan currently participates in multiple down-sided risk agreements across all lines of business
- Providers utilize integrated tools to identify and document risk conditions within their workflow – those risk conditions subsequently drive patient outreach, care management, and other targeted interventions to improve care and lower cost.
- Limited dedicated outpatient Clinical Documentation Improvement (CDI) team for optimizing risk capture.
- Collaboration with Stanson to create an AI-powered CDI solution for pre/post documentation review.



Evolving Outpatient Clinical Documentation Integrity



Example - Post-Encounter Dashboard



EARLY FINDINGS

- Stanson is 99% accurate at identifying documentation adequacy (MEAT present).
- Stanson is 74% accurate at identifying documentation gaps, but errs toward compliance.

PRE-ENCOUNTER		POST-ENCOUNTER				
Patient \ MRN ↓	Last Encounter	Likelihood	HCC Code	MEAT Status	Data Sources	Actions
Zztest, Steph 59 Years Old 00564846	Jan 9, 2024 Office Visit Lutz, J, NP Nurse Practitioner River Valley FP Department	0.86	☐ DM type 2 with diabetic mixed hyperlipidemia (CMS/HCC)	🟡 missing		<input type="radio"/> Documentation Found <input type="radio"/> Documentation Missing - Coder Update <input type="radio"/> Documentation Missing - Requested <input type="radio"/> Other
		0.76	☐ Dilated cardiomyopathy (CMS/HCC) [I42.0]	🟡 missing		<input type="radio"/> Documentation Found <input type="radio"/> Documentation Missing - Coder Update <input type="radio"/> Documentation Missing - Requested <input type="radio"/> Other
		0.85	☐ Pulmonary hypertension (CMS/HCC)	🟡 missing		
Zztest, Raymond 80 Years Old 00564846	Jan 8, 2024 Office Visit Coplan, M, MD Physician SPH Cardiology Department	0.88	☐ Type 2 diabetes mellitus with diabetic polyneuropathy (CMS/HCC)	🟢 found		<input type="radio"/> Documentation Found <input type="radio"/> Documentation Missing - Coder Update <input type="radio"/> Documentation Missing - Requested <input type="radio"/> Other
		0.53	☐ Longstanding persistent atrial fibrillation (CMS/HCC)	🟡 missing		

What's Next



Expand process across all risk-based populations and HCC categories



Realtime integration into provider workflow, reducing staffing needs



Questions?

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Join Us Tonight For(e) a Networking Event at Five Iron Golf

Premier is hosting a night out at Five Iron Golf tonight.

Join us and enjoy some time at one of Five Iron's seven simulation bays, putting greens, ping-pong tables or just enjoy networking with others.

Transportation to and from the event is provided.

We would love for you and anyone else from your team to attend.

Here is the registration link - <https://offers.pinc-ai.com/naacos-five-iron-golf-event-registration.html>

Date: April 11, 2024

Time: 6:30 – 9:30 pm EST

Location: Five Iron Golf – Baltimore

