



Leveraging ACO Infrastructure for the Entire Organization

NAACOS Fall 2021 Conference

September 30, 2021

Population Health Management is an iterative process, improvement in overall performance is dependent upon how quickly the critical success factors can be addressed and replicated across the entire organization. Today we will learn from leading healthcare organizations on how they are leveraging their ACO infrastructure to expedite value-based success across all populations and lines of business.

Leveraging ACO Infrastructure

Format



90 MINUTE SESSION



**EACH SPEAKER WILL
PRESENT FOR 20-25
MINUTES**



**QUESTIONS WILL BE
TAKEN AFTER THE
LAST SPEAKERS
FINISHES**



Presentation Order



**Dr. Daniel
Elliott and Dr.
Rose Kakoza**



**Dr. Mark
Gwynne**

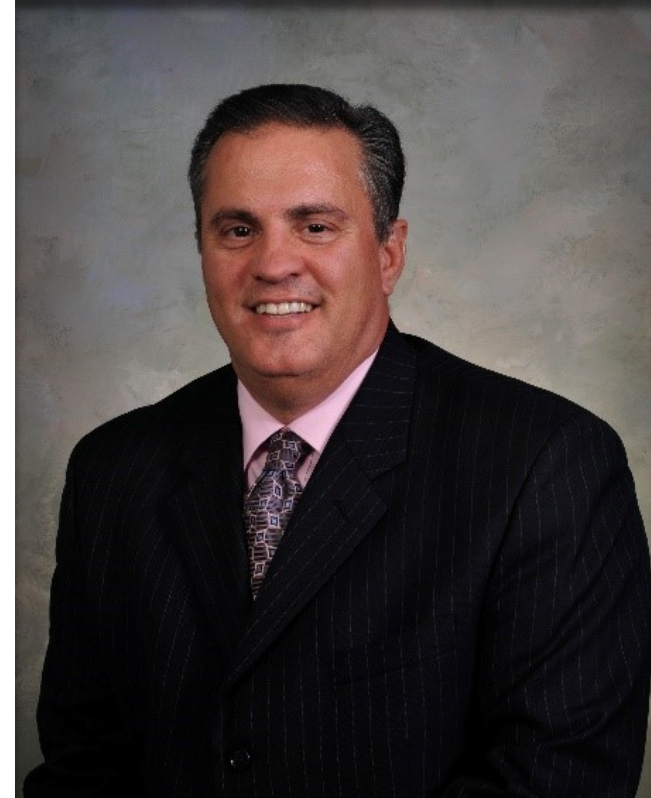


**Dr. Carrie
Nelson**

Moderator

Anthony “Tony” Reed

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

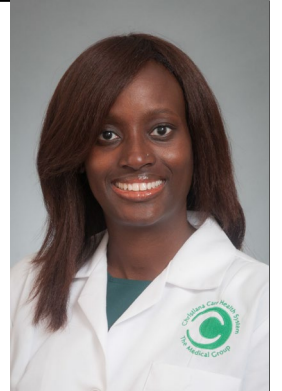


Speakers



**Daniel Elliott, M.D., MSCE, FACP
FAAP**

- **Executive Director of the eBrightHealth Accountable Care Organization, and Senior Medical Director for Value-Based Programs and Network Performance at ChristianaCare.**
- **In addition to his work with EBH ACO and ChristianaCare, Dr. Elliott cares for patients as a primary care physician and is currently the Governor of the Delaware Chapter of the American College of Physicians.**



Rose Kakoza, MD, MPH

- **Senior Clinical Network Director for Population Health and Medical Director for the health system's Medicaid Accountable Care Organization at ChristianaCare.**
- **Dr. Kakoza is passionate about cultivating health equity and advocating for health policy that addresses structural barriers facing underserved populations**

Speakers

Mark Gwynne, DO

- **President and Executive Medical Director for UNC Health Alliance, University of North Carolina's Clinically Integrated Network, Next Generation ACO and Population Health Services Organization**
- **Dr. Gwynne is a clinician educator and administrator with more than 15 years of faculty experience teaching interdisciplinary learners and developing the next generation of care teams. He is mission-driven and committed to ensuring the highest quality of care is delivered to all patients, particularly those most vulnerable to poor outcomes.**



Speakers

Carrie Nelson, M.D., M.S., FAAFP

- **System vice president and CMO for population health and health outcomes at Advocate Aurora Health.**
- **Dr. Nelson's systemwide responsibilities include patient safety, health outcomes and risk management in addition to population health across Advocate Aurora Health's 400-mile footprint. For population health, she focuses on the clinical programs to drive results in value-based care.**





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Leveraging ACO Infrastructure



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.



Admissions
53,121



Outpatient Visits
620,939



Radiology Procedures
426,240



Births
6,035



Medical Aid Unit Visits/
Urgent Care Center Visits
80,717



Surgical Procedures
37,390



Alzheimer's Day
Program Visits
5,751



Primary Care Physician
Office Visits
255,513



Home Health Visits
288,817



Lab Tests
3,711,019



19 School-Based Health
Center's Student Visits
31,491



Emergency Department Visits
195,602

*Christiana Hospital 104,137
Wilmington Hospital 63,444
Middletown Ed 28,021*

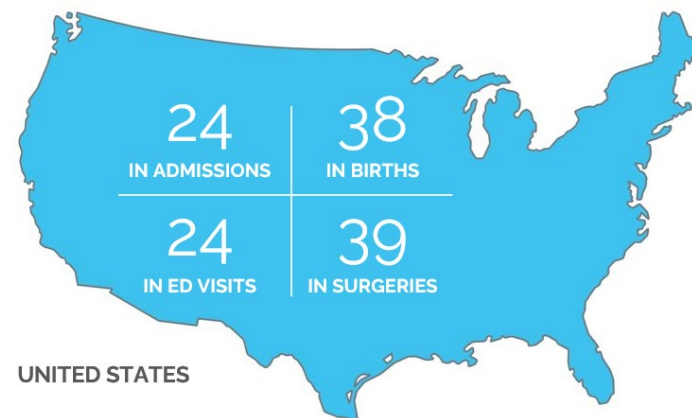


Serving Delaware, Maryland, Pennsylvania and New Jersey

- Newark Campus
- Wilmington Campus
- Cecil County Campus
- Middletown Campus

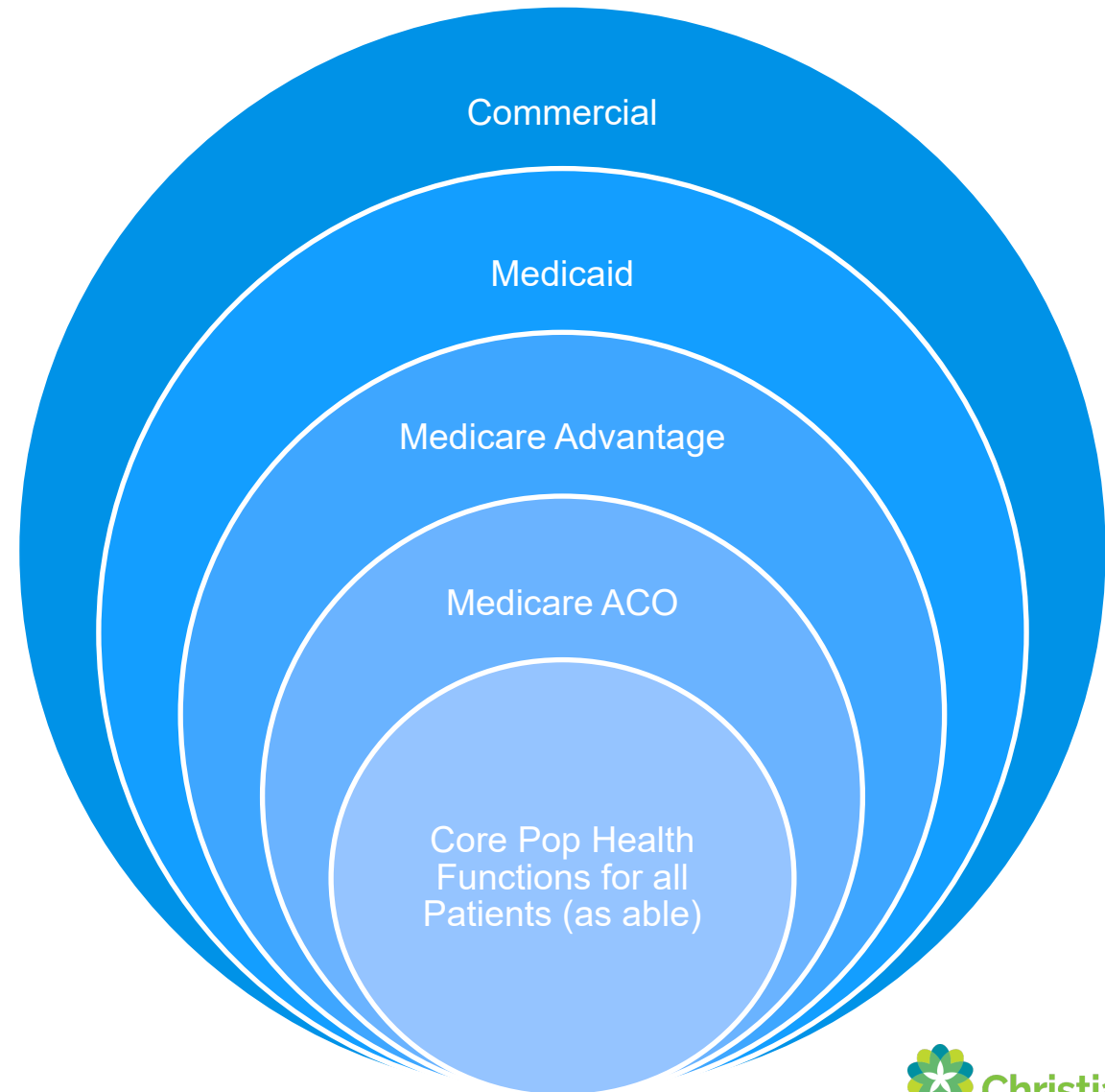
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ChristianaCare | GoHealth
Urgent Care Centers

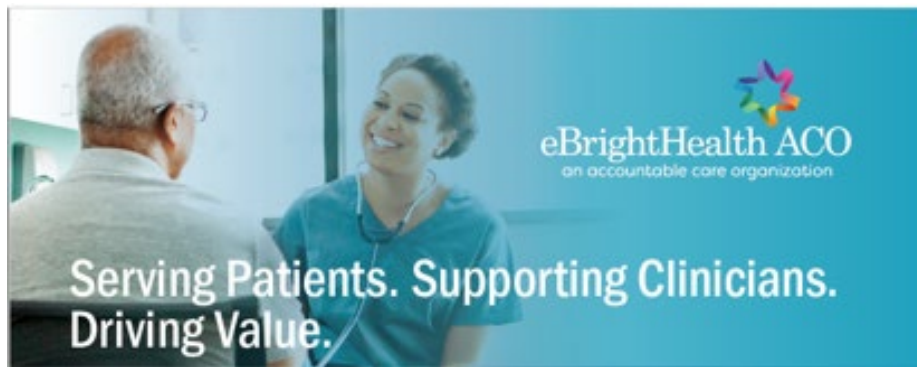
120+
Practices & Locations



Population Health Journey

Contract/LOB	Count
Employees/Dependents	~20K
eBrightHealth ACO	~43K
Medicare Advantage	~2K
Medicaid	~23K
Commercial Full Risk	~3K





Who We Are

- MSSP Participant since 2016
- Basic Track Level C (to E in 2022)
- 4 Health Systems, 5 private practices, 2 FQHCs
- > 1500 Primary and Specialty Care Clinicians
- ~43K Beneficiaries

Performance

- 2016-2019: > \$18 M generated savings
- 2020 –
 - 19.4M generated Savings
 - 9.6M Shared Savings
 - 98.75% Quality Score



Our Approach



eBrightHealth ACO. Serving Patients. Supporting Clinicians. Driving Value.

AMBULATORY CARE GOALS

IMPROVE Follow-Up Post ED or Hospital Visits

INCREASE Primary Care Visits for Chronic Conditions Management

INCREASE Annual Wellness Visits by 50%

KEY ACTIONS

Optimize
Transitions
of Care

Real-Time Event
Notification

Engage
Primary Care &
Specialist Practices

Data Quality Reviews

Improve
Chronic Disease Care
& Documentation

Clinical Best Practices Coding
& Documentation

Promote
Wellness &
Prevention

Annual Wellness Visits &
Standardized Documentation

Create
High-Risk Patient
Management Plans

Patient List Review
& Individual Action Plans

Transform
Practices

Enhanced
Access

ACUTE CARE GOALS

DECREASE Total Inpatient Costs

REDUCE Readmission Rate

IMPROVE Proportion of Discharge
to Post-Acute Care Facilities

ENHANCE Patient Satisfaction

KEY ACTIONS

Optimize
Transitions
of Care

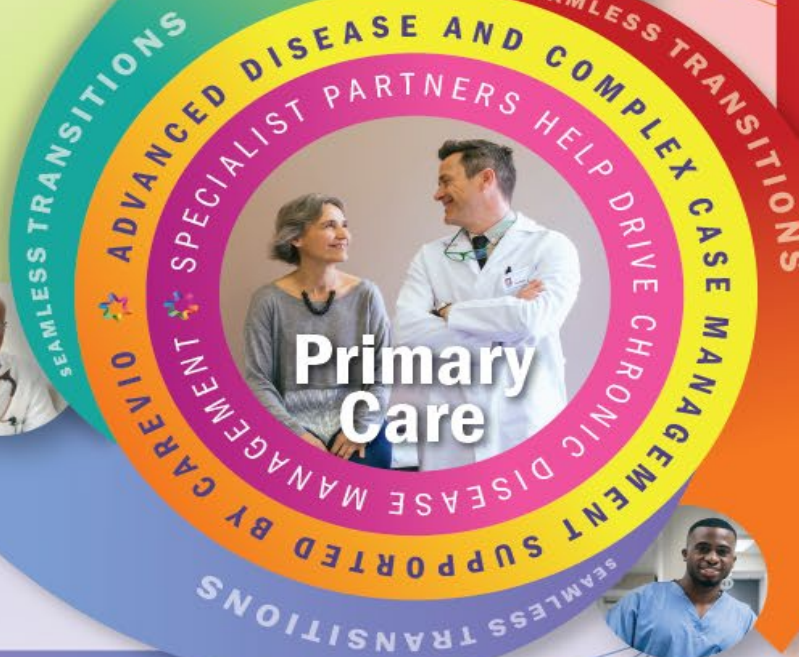
Engage
Patients

Streamline
Discharge
Process

Ensure
Appropriate
Levels of Care

Communicate
with PCPs

Conduct
Interdisciplinary
Patient Reviews



KEY ACTIONS

Optimize
Transitions
of Care

Commit
to Weekly
Post-Acute Facility Calls

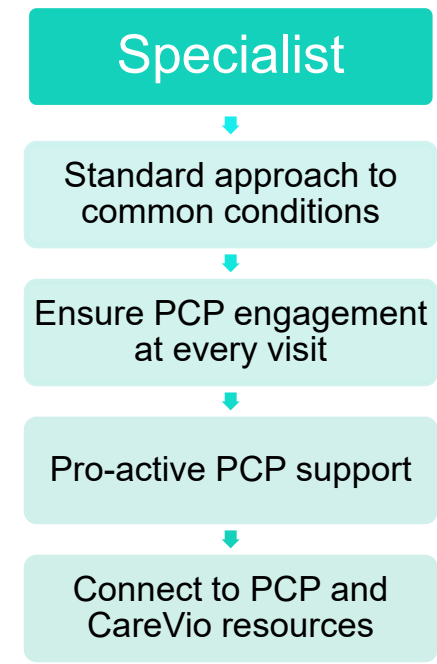
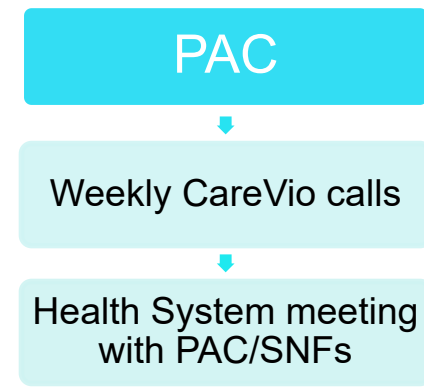
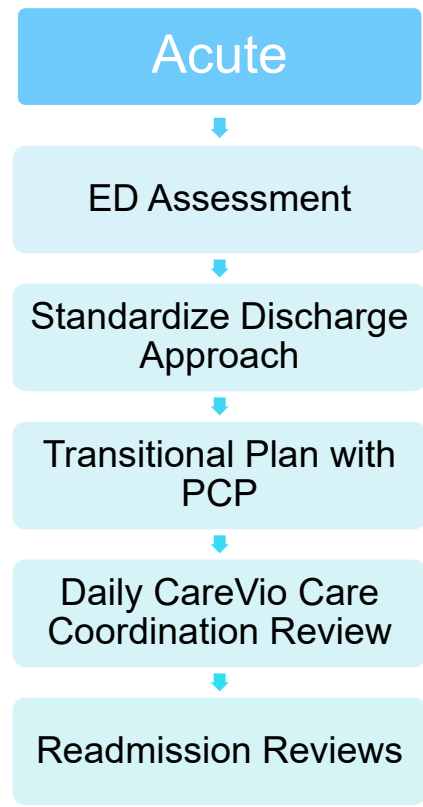
Prioritize
Monthly Node
Leadership Meetings

POST-ACUTE CARE GOALS

REDUCE Readmissions

REDUCE SNF/IRF Average Episode Costs

REDUCE SNF/IRF Utilization



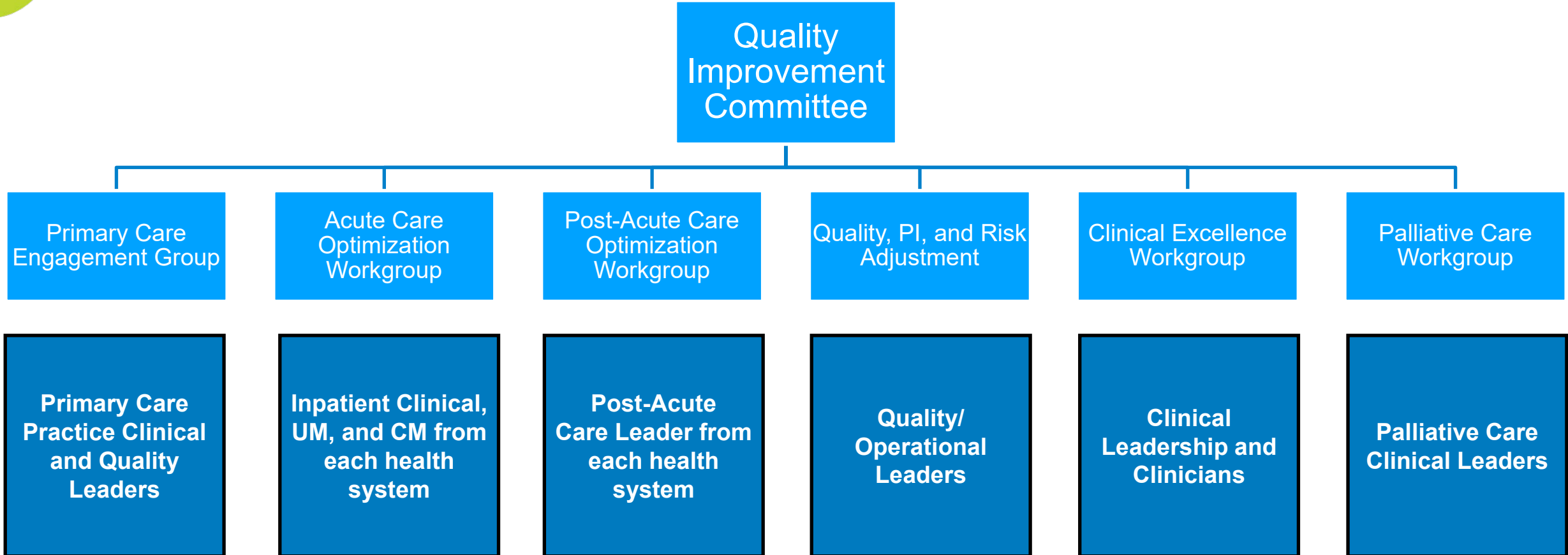


The Fundamentals...

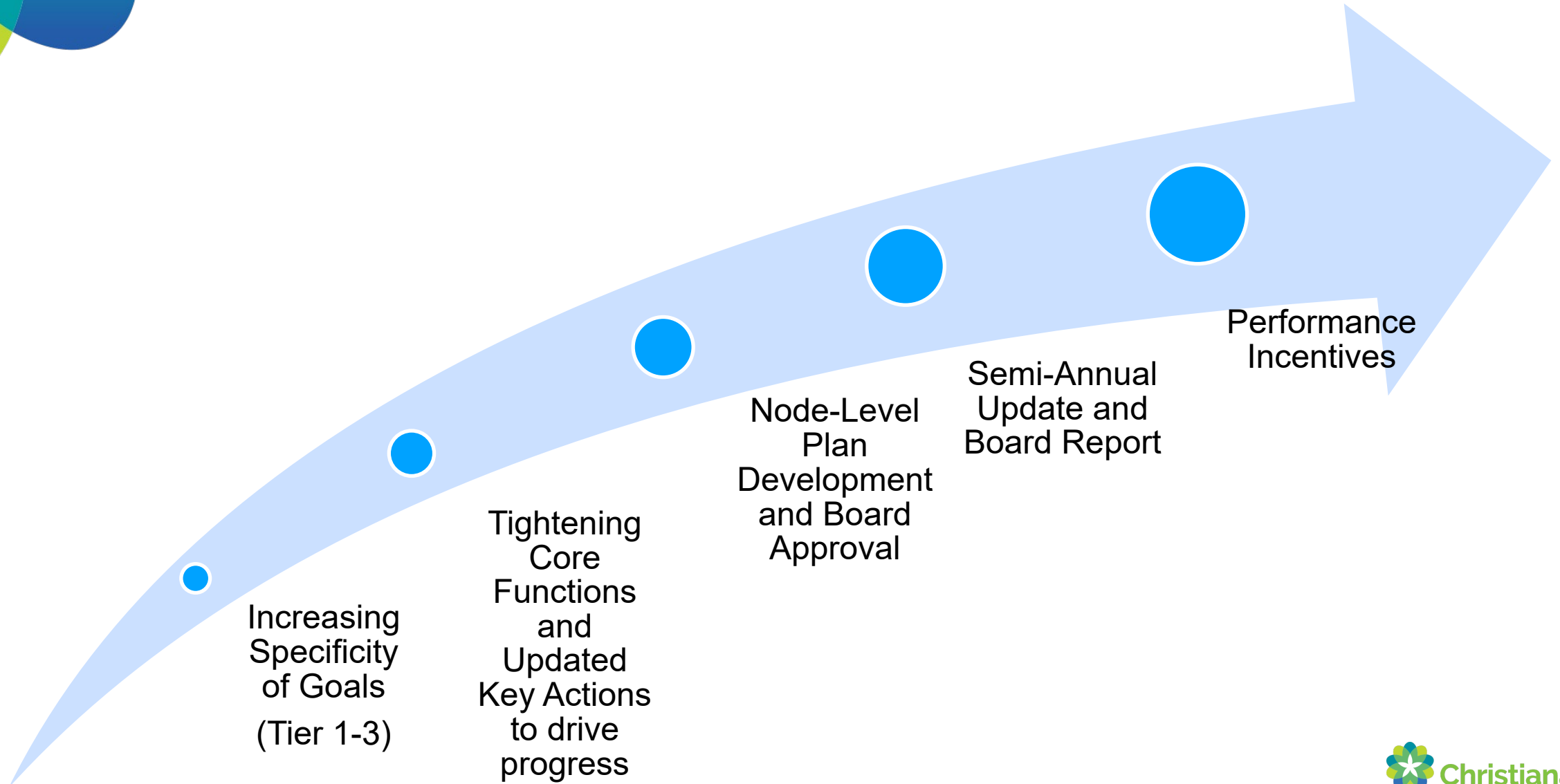
- ✓ **Twice a year visit for every Medicare patient**
- ✓ **AWV for ALL Medicare patients**
- ✓ **Quality capture and documentation**
- ✓ **HCC coding for risk capture**
- ✓ **TOC visit for EVERY Hospital discharge**
- ✓ **TOC eval ± visit for EVERY ED discharge**
- ✓ **Strong, aligned Care Coordination**
- ✓ **GOC conversation for high-risk patients**
- ✓ **Performance Review and Learning**

Standard Process...
100
Percent of the time...

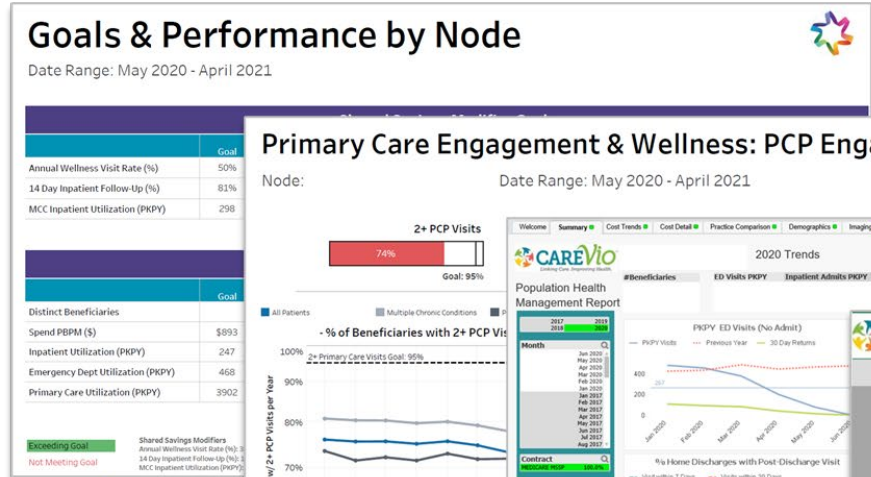
Structure → Function



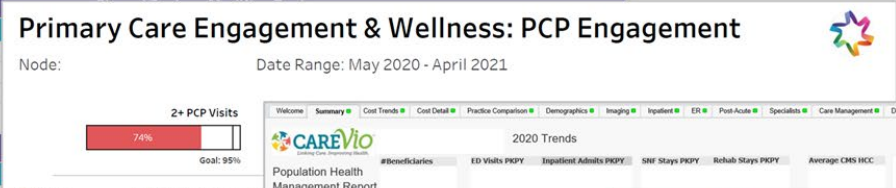
Journey of Increasing Accountability



Data and Reporting



Overall Goal Summary (Monthly)



Practice-Level Dashboard (Monthly)

Node-level Dashboard (Monthly)

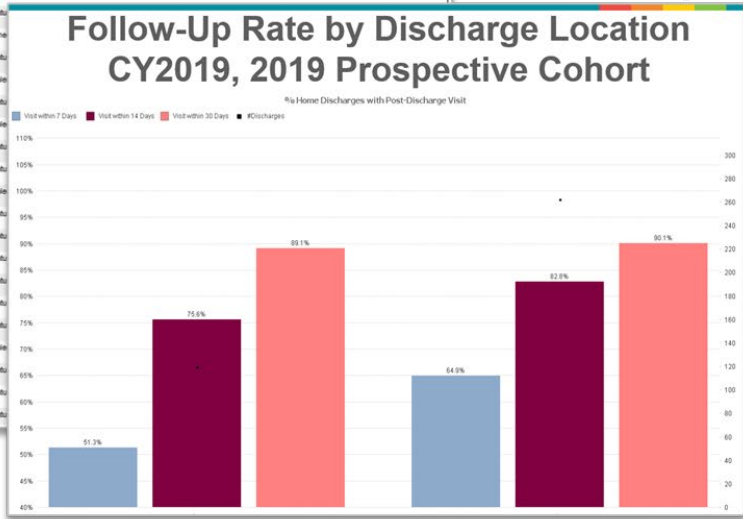
Patient-level Reports (Weekly & Monthly)

Data Deep Dives (Ad Hoc)



Welcome to the Care Management High Cost List!
Data run through 2020-05-13 13:12:24

Practice Attributed Provider	Last Name	First Name	Birth date	Eligibility Flag	AWV - 12 mo	COPD	CHF	Total Claims	Benchmark	HCC Risk Score	Inpatient 12mo	Emergency 12mo
				Y	N	Y		35,781.81	9,378.00	3.52	3	1
				Y	Y	Y		222,065.70	9,378.00	12.18	10	2
				N	N	N		307,825.94	9,378.00	0.69	8	3



Care Coordination

Core Service Domains



CareVio will focus on 4 Core Service Domains in partnership with the growing node Care Coordination Teams.



Acute Care Surveillance & Targeted Care Coordination

Focused multidisciplinary support with local Acute and Ambulatory Care Coordination partners to identify and address the needs of high-risk and at-risk patients.



Post-Acute/SNF Management

Focused multidisciplinary support in collaboration with node post acute leaders to engage facilities, patients and families to optimize successful transitions



Comprehensive Case Management

Focused multi-disciplinary support for patients with high-risk medical, behavioral, and social conditions.



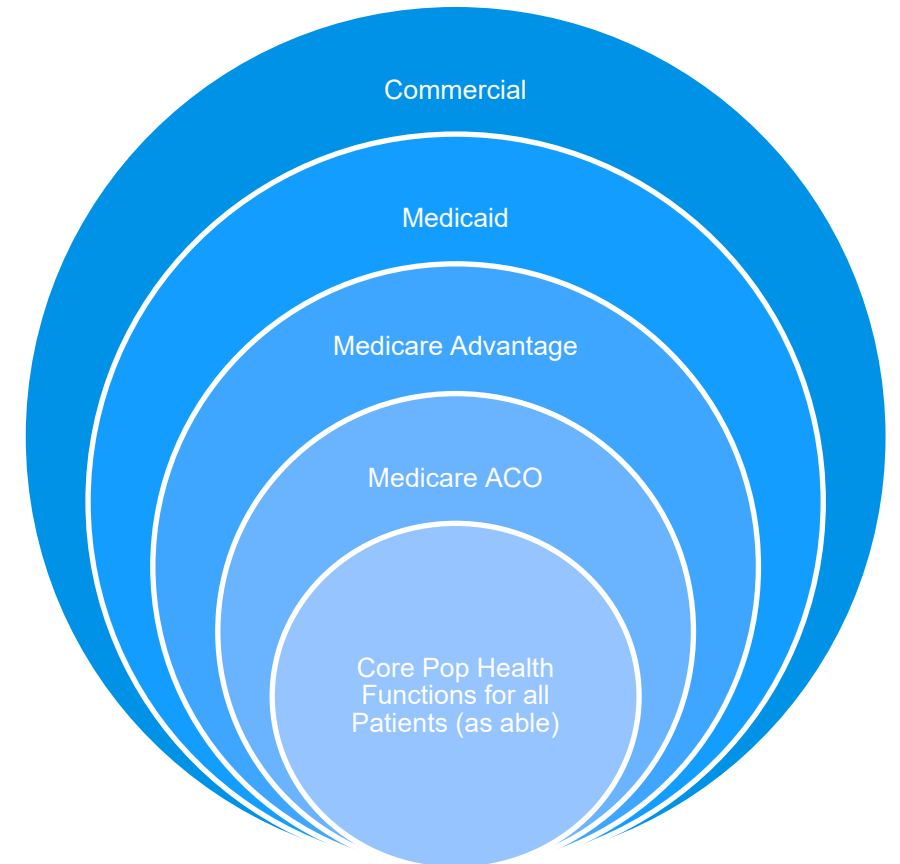
Advanced Disease Case Management

Focused multi-disciplinary support for patients with specific medical conditions that works in partnership with the member's clinical team.

Focus: Better Coordinated Care. Better Health. Better Use of Resources

Building on the Foundation

- Alignment with AOP Goals
- Internal Consistency and Accountability
- Governance
- Engagement with Payers and Payor Programs
 - Strategic, Structural, Operational
- Final Common Pathway
 - People, Process



Who We Are

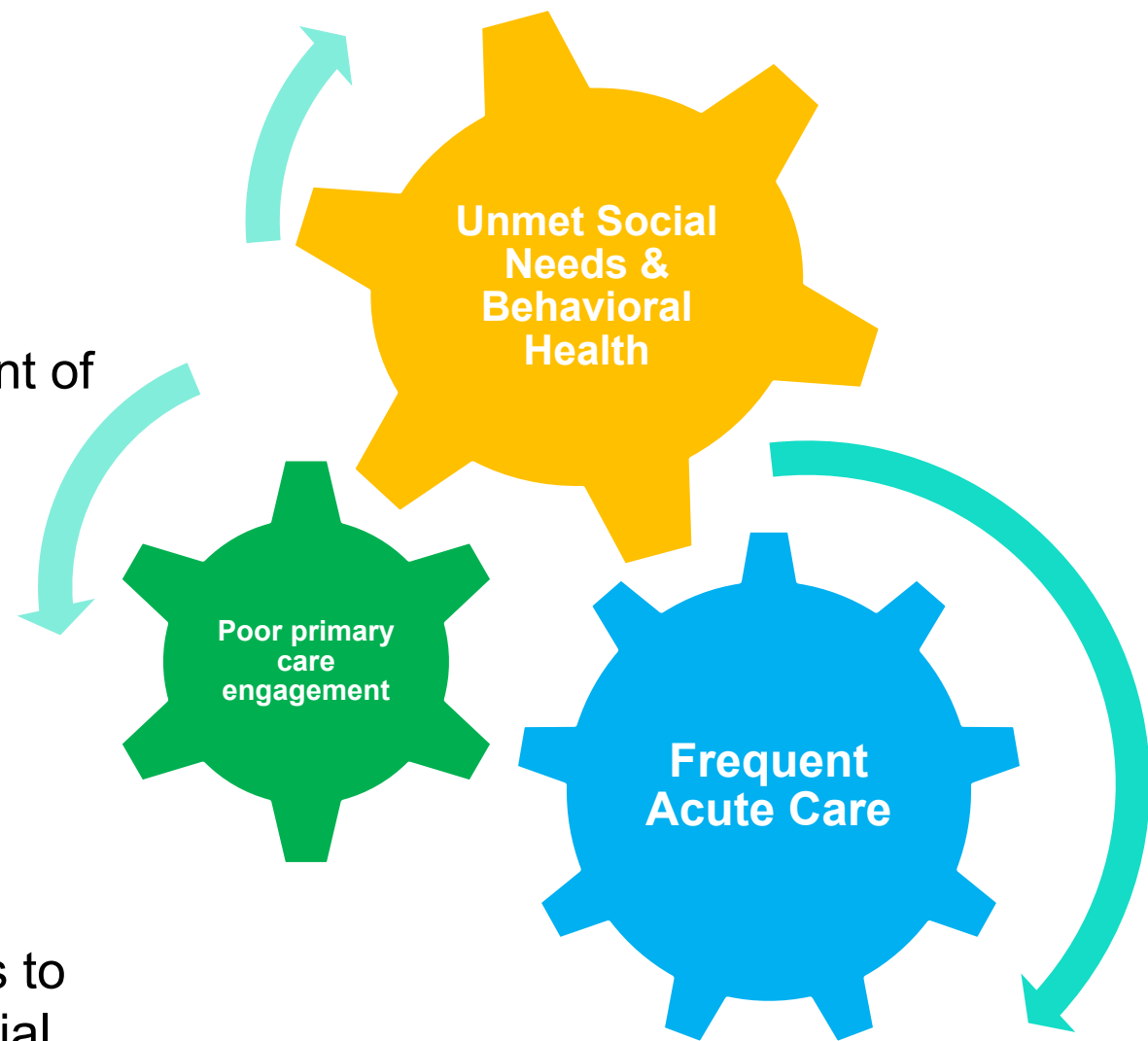
- Upside/downside risk in Medicaid since 2019
- Medicaid ACO launched in 2021
 - Progress to full risk at year 3
- ChristianaCare Health System
- ~23K Beneficiaries
 - 30% Pediatric

Performance

- CY2019: \$2M loss
- CY2020: \$5.4M savings

Medicaid: High Risk Patient Characteristics

- **Characteristics of high-risk, high cost Medicaid patients**
 - Small percent of patients account for a large percent of costs
 - High rates of co-occurring behavioral health and substance use disorders
 - High-risk pregnancy
 - Significant social determinants of health as barriers to care: housing insecurity, transportation, lack of social supports



Key Features of Successful Medicaid ACOs

- **4 Key Features of Care Delivery**

- 1. Complex Care Management**

- Early financial success dependent on successful management of high-cost patients with medical and social complexity

- 2. Integration of Behavioral Health Services**

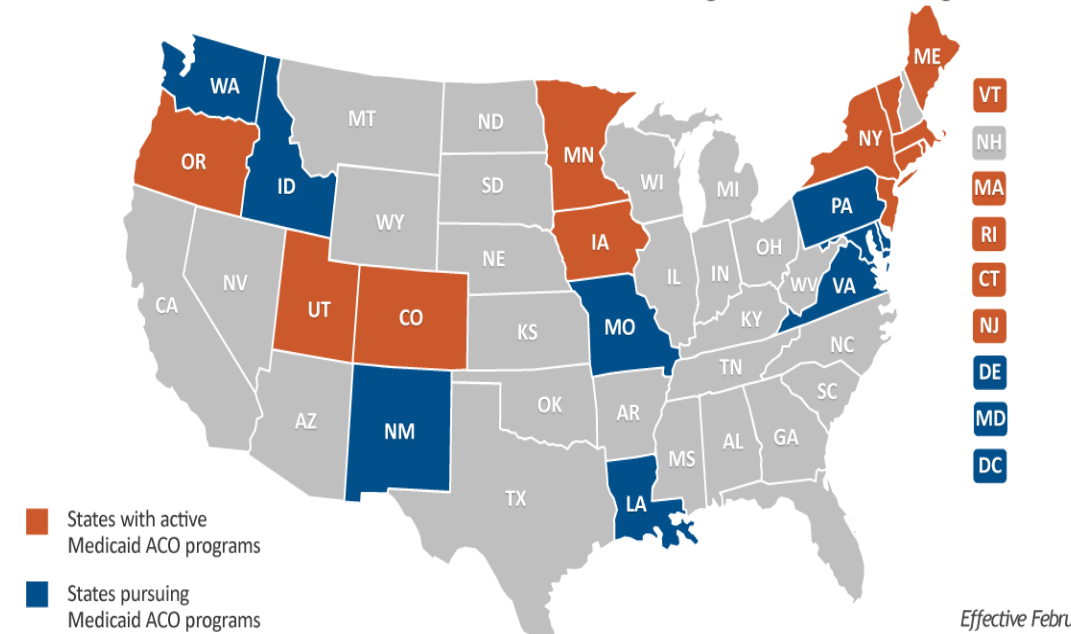
- Essential for successful complex care management

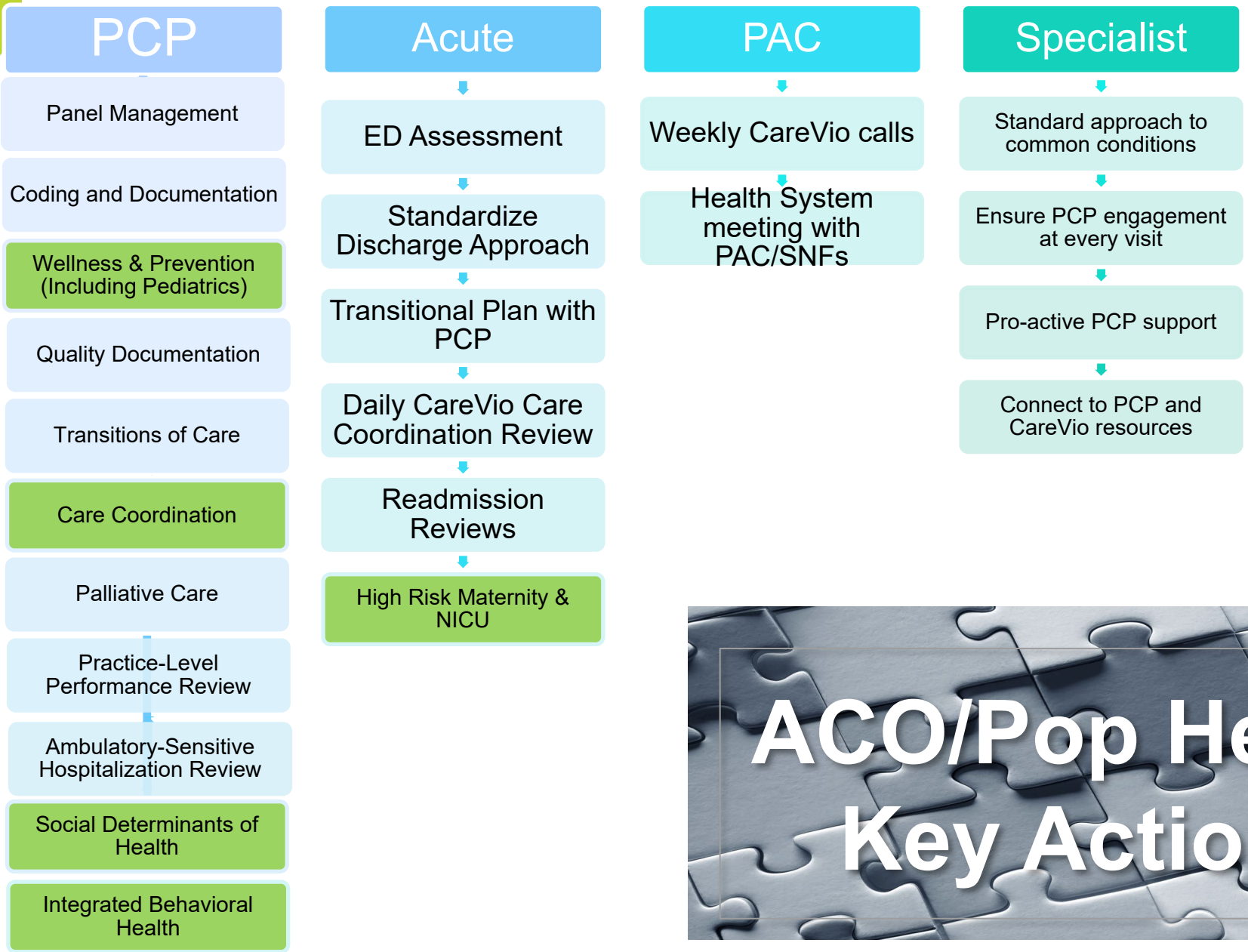
- 3. Address Social Determinants of Health**

- Community health workers/non-traditional providers
- Social service integration

- 4. Data & Analytic Support for effective care coordination and management**

State Medicaid Accountable Care Organization Programs





Care Coordination: Acute & Post Acute Care



Acute Care Surveillance & Targeted Care Coordination

Focused multidisciplinary support with local Acute and Ambulatory Care Coordination partners to identify and address the needs of high-risk and at-risk patients.



Post-Acute/SNF Management

Focused multidisciplinary support in collaboration with node post acute leaders to engage facilities, patients and families to optimize successful transitions

- Expand facility based acute care (inpatient, ED, OB triage, NICU) and post acute care coordination huddles to include Medicaid
- Deepen acute care collaboration with behavioral health facilities
- Integrate social work and community health worker care coordination support to identify and manage behavioral health and social determinant factors impacting acute care discharge planning

Advanced Disease Management and Comprehensive Case Management



Advanced Disease Case Management

Focused multi-disciplinary support for patients with specific medical conditions that works in partnership with the member's clinical team.



High Risk/ Comprehensive Case Management

Focused multi-disciplinary support for patients with high-risk medical, behavioral, and social conditions.

- Integrate high risk maternity and pediatric case management expertise
- Expanded community-based multi-disciplinary CM team with more social work support to manage patients with significant medical and behavioral health complexity (SPMI, SUDs) where virtual supports are ineffective
- Integrate social work care coordinators focused on patients where utilization and cost driven by behavioral health conditions
- Establish community health worker program to focus on patients where social determinants are driving cost and utilization



Social determinants of Health

Scaling duals focused programming:

- Scaling social determinant screening across ambulatory and specialty practices
- Community health worker programs embedded in primary care and women's health
- Deepening community partnerships

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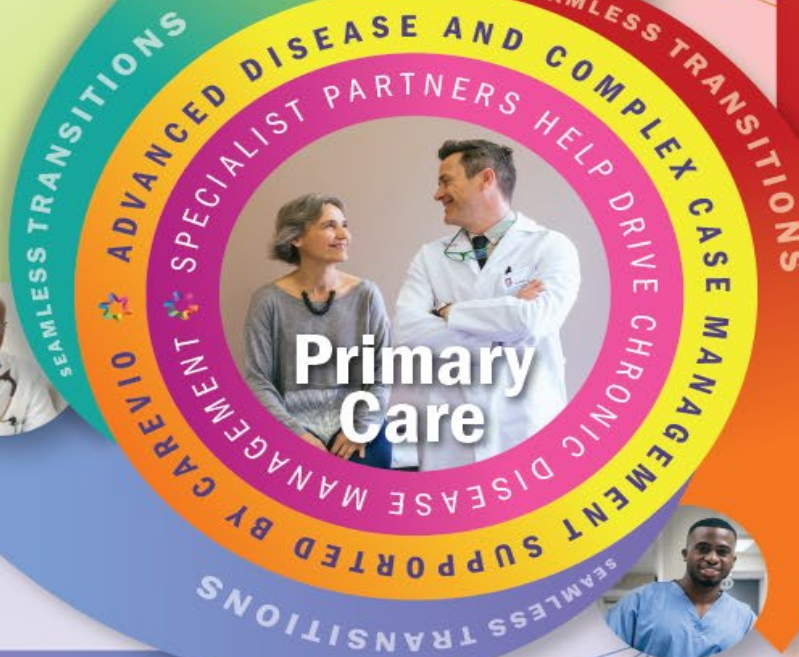
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Discharge
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Patient Reviews



**Primary
Care**

POST-ACUTE CARE GOALS

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REDUCE SNF/IRF Average Episode Costs

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KEY ACTIONS

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Transitions
of Care

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to Weekly
Post-Acute Facility Calls

Prioritize
Monthly Node
Leadership Meetings

**FOR THE LOVE
OF HEALTH™**



ChristianaCare®

UNC Health Alliance

Leveraging ACO Infrastructure for System Success in Value

Dr. Mark Gwynne
President



UNC Health Strategic Transition to Value-Based Care

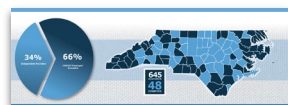
Investment in infrastructure to clinically integrate across care settings, contract for new value based payment models, and manage the health of populations across geographies

2015



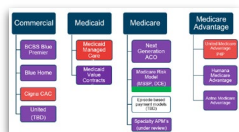
2012-2015 **system-wide commitment** to build our **population health infrastructure** to support enhanced care for patients and providers

2017



2015-2017 created UNC Health Alliance, our **statewide clinically integrated network**

2019



2017 launched **Next Generation ACO**, our first Advanced Alternative Payment Model
 2017-2021 **expanded risk portfolio to 15 value contracts** across market segments + geographies

2021

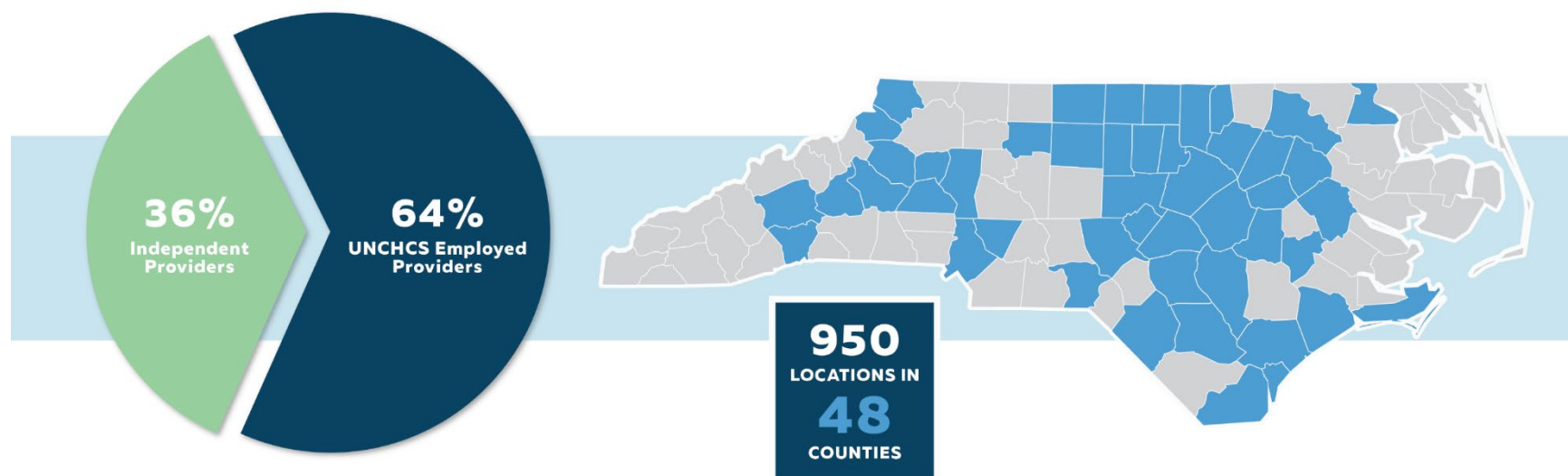


January 2019 **partnered with BCBSNC** to offer **Blue Home** on the government market (ACA) as part of **Blue Premier**, the largest commercial Alternative Payment Model in North Carolina

UNC Health Alliance Statewide Network

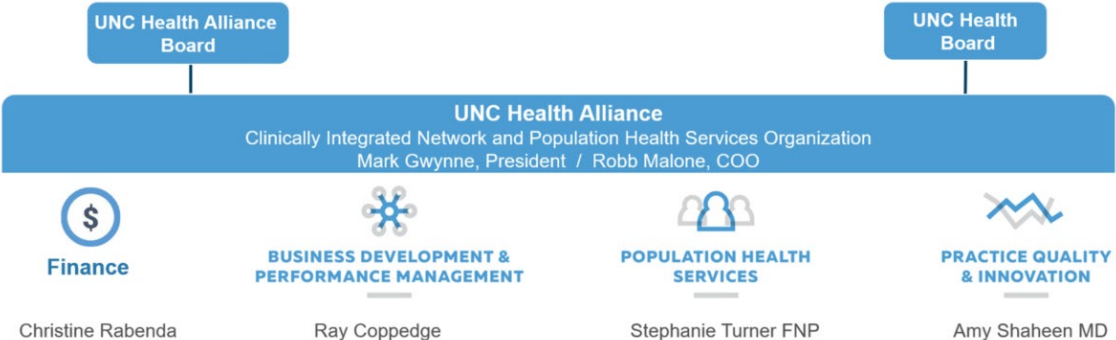
UNC Health's Clinically Integrated Network (CIN), Accountable Care Organization (ACO), and Population Health Services Organization

- **7,200** providers with more than 2,600 from independent practices
- **1/3 primary care physicians** and advanced practice providers
- **2/3** specialty providers, covering 170 specialties & subspecialties
- **13** UNC Health Hospitals and counting ...
- **30** SNF's and Home Health agencies in a preferred network and community-based palliative care



Organized Within UNC Health to Leverage System-ness

Health Alliance organizationally aligned to system physician and hospital entities



- Coordinate strategy for Value Based Care across physician entities
- Align strategy for value based care and population health with hospital partners
- Align and coordinate quality initiatives across UNC Health via system quality governance

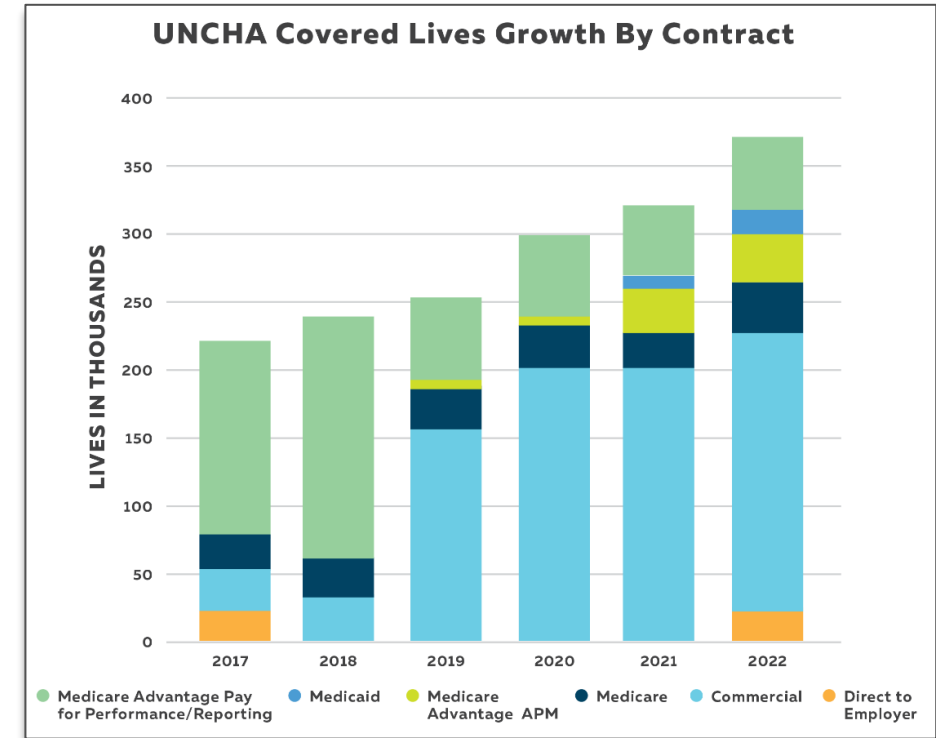
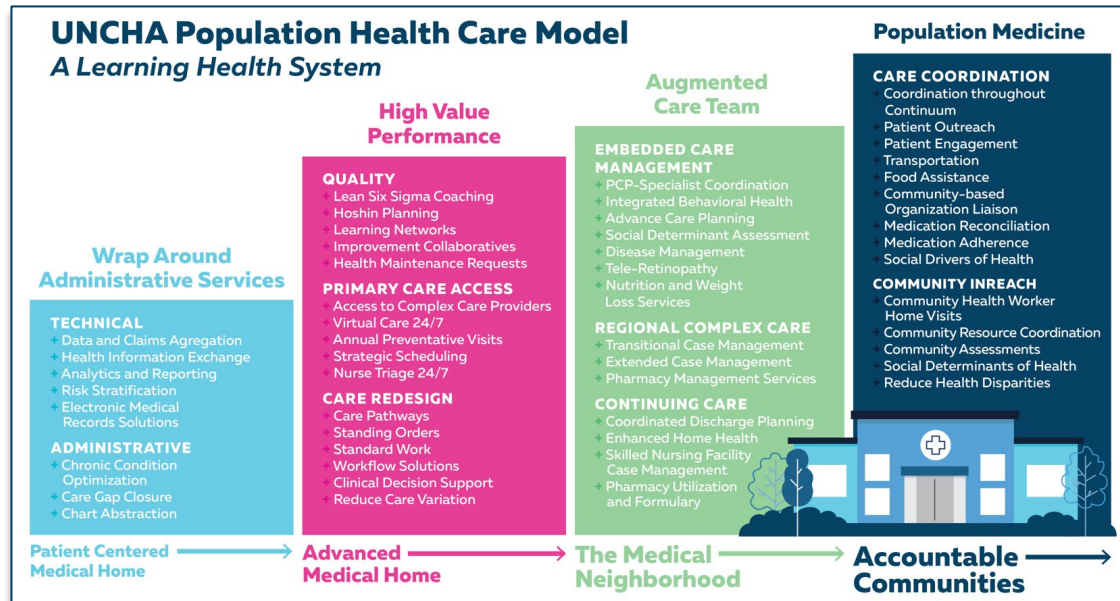


Systemness is the ability of a health system to ... progress toward goals, as one unified organization, *because of its scale, not in spite of it* ... exemplified by making complex decisions centrally and rapidly, operating consistently, and achieving superior performance and goals otherwise difficult as individual entities.
 - Advisory Board

Success in Value Built on a High Value Network, Strong Foundation of Population Health Services, and Strategic Growth of Value Portfolio

A successful care model and operations...

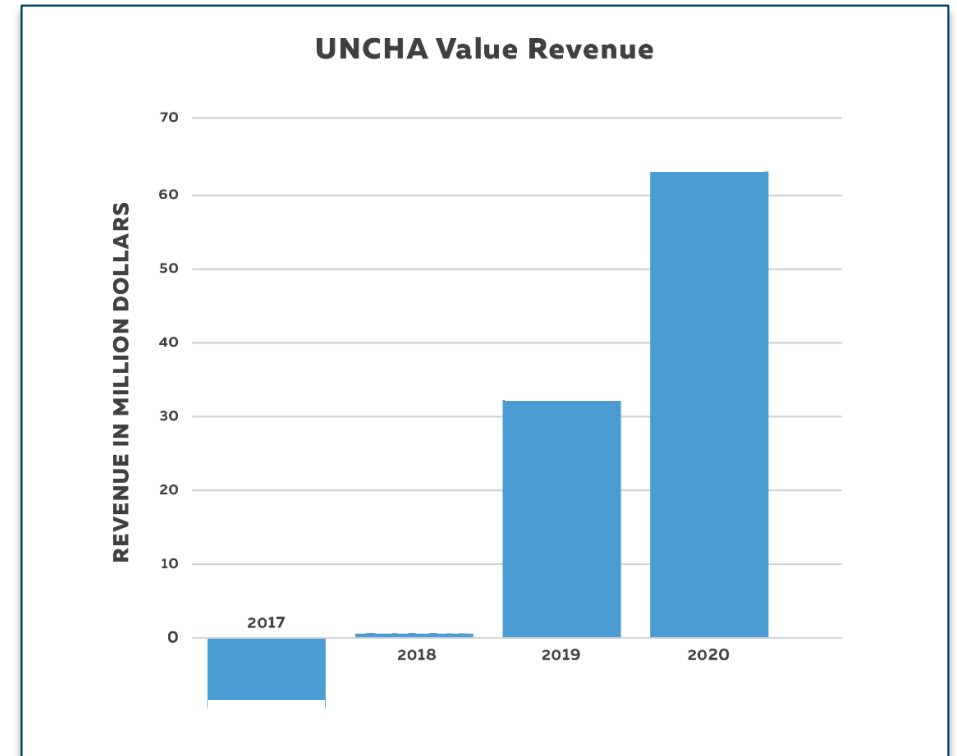
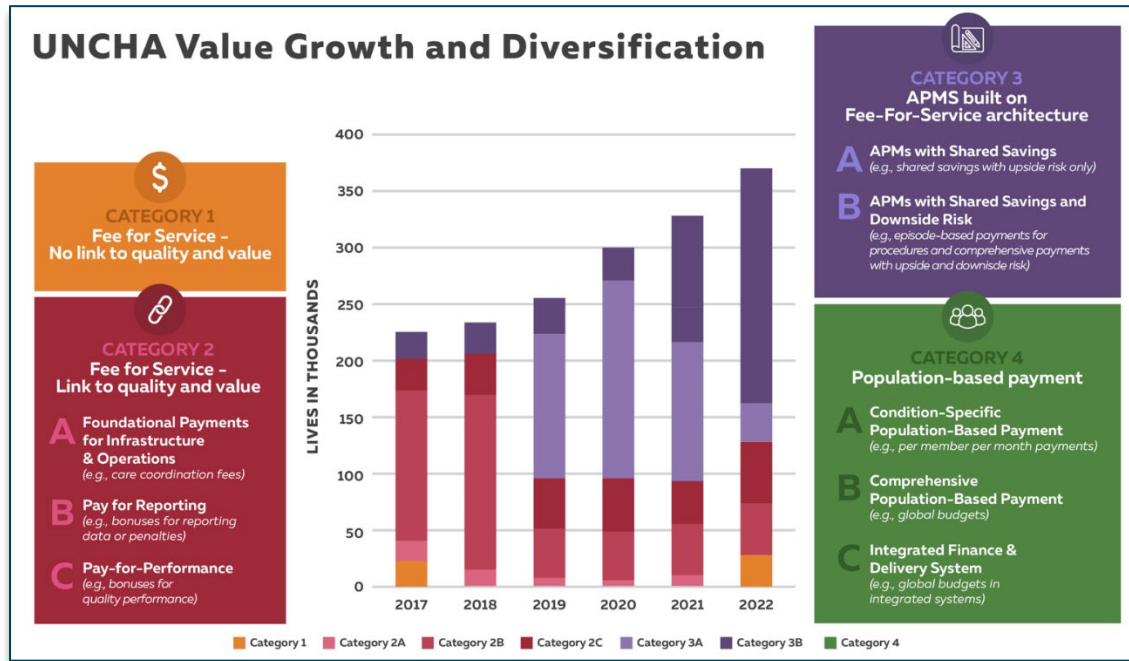
... coupled with thoughtful and significant growth



Success in Value Built on a High Value Network, Strong Foundation of Population Health Services, and Strategic Growth of Value Portfolio

Growing a diverse Value portfolio...

... has facilitated rapid improvement in Value



Over the past two years, the UNCHA Network realized > \$100M in new Direct Value Revenue (our portion of shared savings and quality incentives) while achieving the highest quality performance across populations

Leveraging ACO Infrastructure Across Populations and Markets

The Network is the chassis

Alliance of physicians, hospitals, and post-acute specialists aligned to improve care and reduce cost while optimizing health



Services are the engine

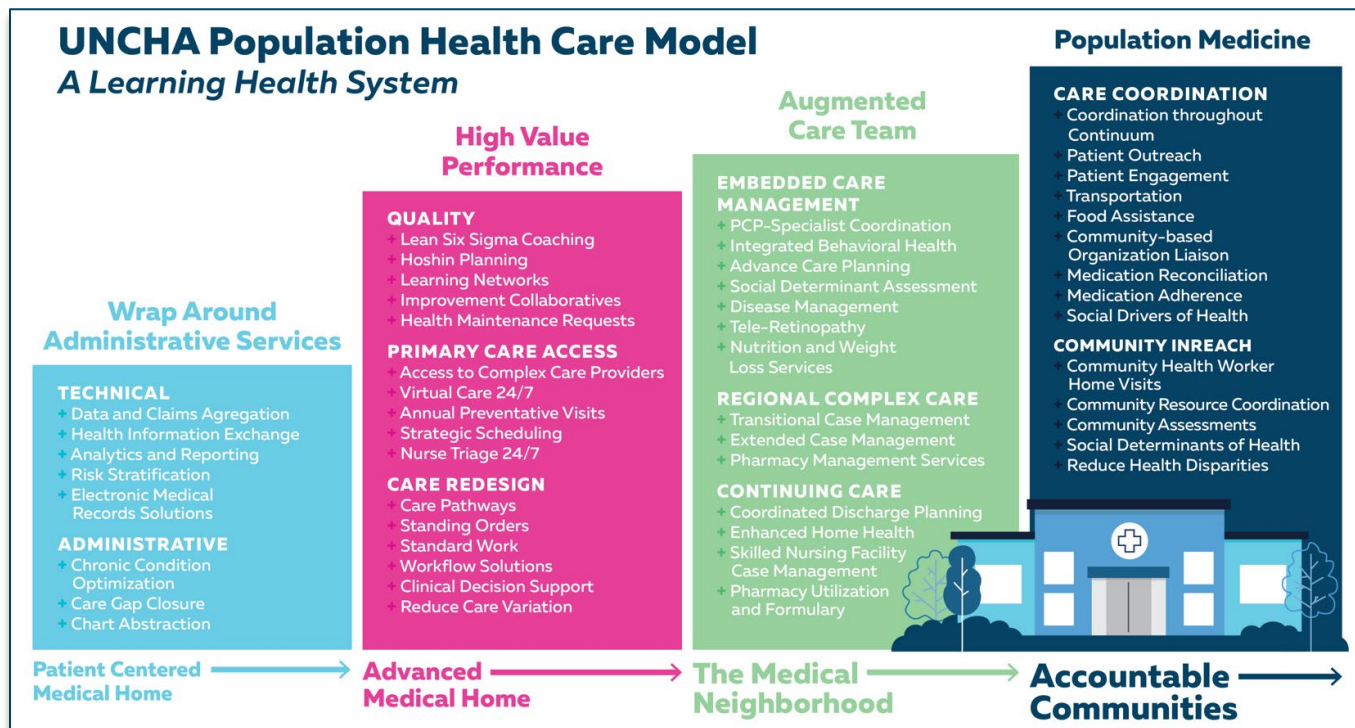
Our APM portfolio in addition to clinical and operational services, quality improvement, finance and analytic support.

Key strategies to advance Population Health and Value across populations and markets

- Care Model and Care Redesign
- System and Network-wide Data and Analytics
- Community Based Initiatives
- Financial Modeling and Economics of Value
- Provider and Network Engagement

Population Health Care Model and Operations

Introduce and Scale Population Management Strategies



Core Population Health Services

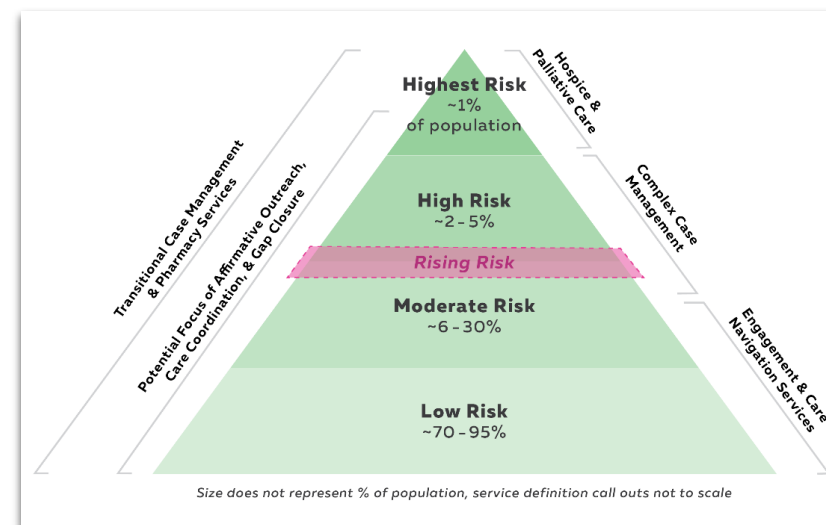
- Clinical Services
- Administrative Services
- Analytics and Reporting
- Quality Improvement and Collaboratives
- Risk Stratification
- Population Segmentation
- Electronic Health Record Solutions
- Community Engagement (such as Social Determinants of Health (SDOH) interventions)

Core payer agnostic capabilities + Population Specific tactics
With Partnerships across the continuum

Health Alliance's Care Management Across Populations

Along with targeted interventions, we provide core system care management capabilities tied to Value priorities:

- Transitions of Care across UNC Health
- Complex Case Management
- Embedded Case Management within Primary Care Practices
- Embedded Behavioral Health
- Targeted Pharmacy Solutions



We also resource Value Contracted Populations at the portfolio level across contracts and populations: Data driven resource allocation (low, medium, high) based on multiple factors:

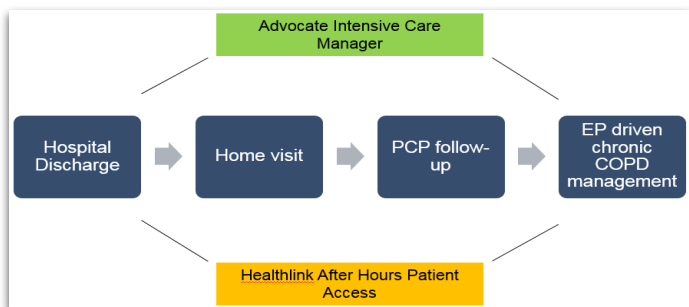
- Contract Risk, Population Risk and Impactability
- Population utilization rates, Quality and Community Resource needs
- Embedded practice based resource need

Population Health Assumptions - CY22	CY22 Q1&Q2	3%	5%	10%	10%	10%	10%	10%	10%	10%	10%	10%
High-Risk Patients - % of Population		3%	5%	10%	10%	10%	10%	10%	10%	10%	10%	10%
High-Risk Patients - % of Engagement		15%	15%	15%	65%	65%	65%	65%	65%	65%	65%	65%
Transitions to 1000		250	250	250	800	800	800	800	800	800	800	800
Transitions (outreach/1000)		53	53	53	250	250	250	250	250	250	250	250
ICM		Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	No
LCSW		No	No	No	No	No	No	No	No	No	No	No
Dietician		No	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	No
Med Adherence		Yes	No	No	No	No	No	No	Yes	No	No	No
Community Paramedicine		No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	No
Transitions		Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Gap Closure/Abstraction-Employed		Low	Low	Low	Moderate	No	Moderate	Moderate	High	Low	Low	High
Gap Closure/Abstraction-indep		High	High	High	Moderate	No	High	High	High	High	High	High
Strategic Scheduling-Employed		High	High	High	High	No	High	High	High	High	High	High
Strategic Scheduling-indep		Low	Low	Moderate	High	No	Low	Low	High	Low	Low	High
HMBE		No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No
Community Health Worker		No	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes	No
LCSW/RD Prior Authorization		No	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes	No
HCC/RAF Education and Support		No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No
Home Visit Nurse Practitioner		No	No	No	No	No	No	No	No	No	No	No
Transportation Coordinator		No	Yes	Yes	No	No	Yes	Yes	No	No	No	No
Outreach Coordinator		No	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	No
Strategic Scheduling-Employed		No	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	No
Strategic Scheduling-indep		No	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	No
Go-Live Abstraction		No	No	No	No	No	No	No	No	No	No	No
Tele-IR Coordinator (PH Only)		No	Yes	Yes	No	No	Yes	Yes	No	No	No	No
Optometrist		No	No	No	No	No	No	No	No	No	No	No
# of Contract Months out of 12		12	12	12	12	0	12	12	12	12	12	0

Care Model Redesign Across a System

Unwarranted Variations in Care

Expected Practices for key high volume and high cost conditions: Chest Pain, Low Back Pain, GERD, COPD and others



Regional Care Redesign utilizing Geographic Service Areas (GSA) with aligned incentives across local providers and facilities



Care Redesign Department with enterprise priorities and operations

Leveraging Quality Performance Measurement and Improvement Across a System: Target efforts to meaningful measures and align incentives

Top 20 analysis
completed twice-a-year



Quality Improvement
Collaborative Priorities



Provider Incentive Plan



Network Value
Revenue Distribution



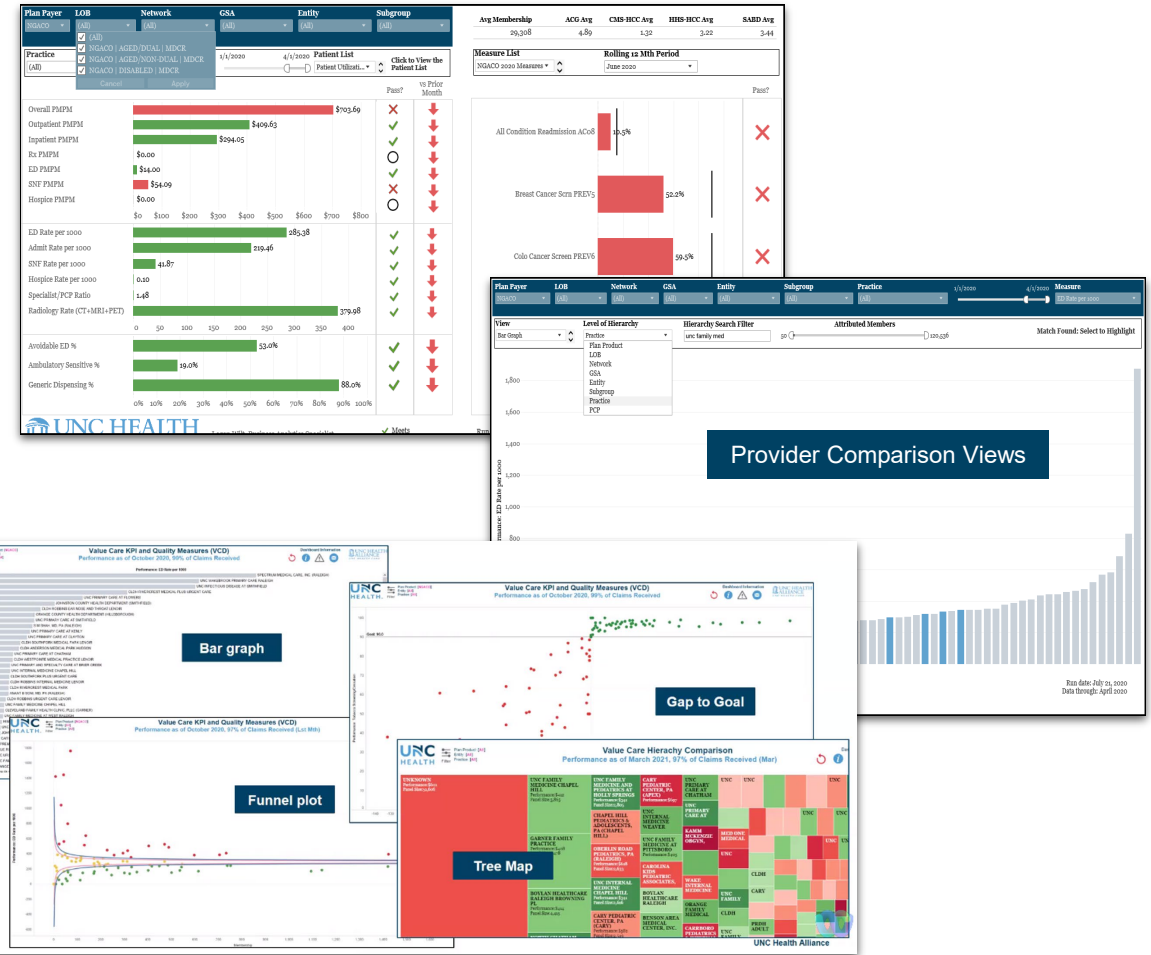
Ultimately, align resources to Quality Improvement Collaborative (Learning Organization) → *Primary Care Improvement Collaborative (Adult and Pediatrics, + Urgent Care), Cancer Care Quality Collaborative, Independent Provider Improvement Collaborative*

Interactive Value Care Dashboard Across Populations and Contracts

Provider self serve data to access payor agnostic measures and patients at risk

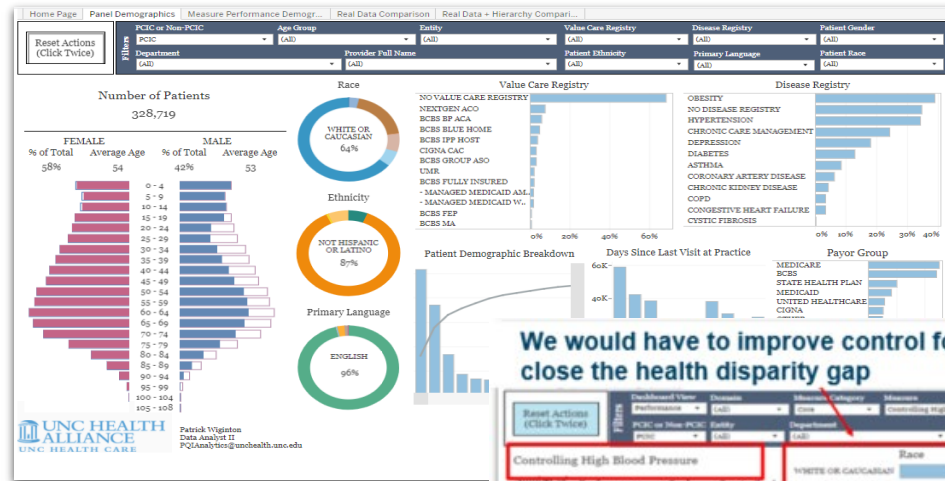
Dashboard Features:

- Key Performance Indicators (KPI):**
 Displays performance on key utilization and quality indicators by Value contract and Line of Business
- Comparison:** Allows the user to compare performance within a filterable variable (e.g. Network, Entity, Practice) on select metrics.
- Patient Lists:** Patient level detail by practice and provider for Admits, Discharges and ED visits.

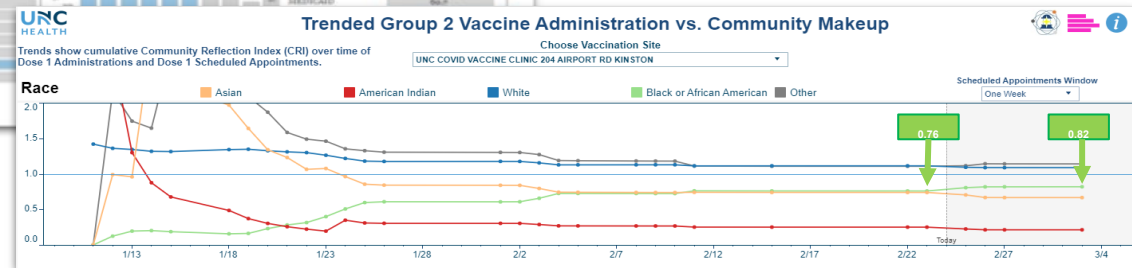
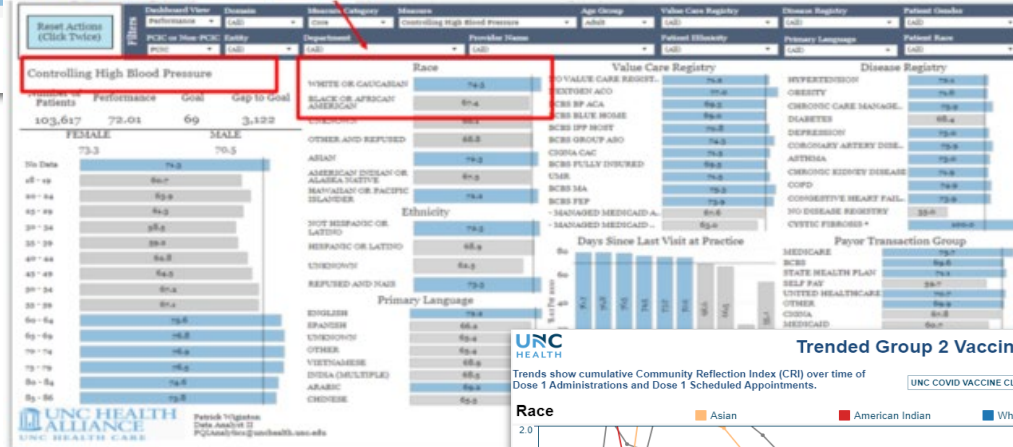


Addressing Health Equity: Pivot ACO Data and Analytics Infrastructure Improvement Collaborative Opportunities

Leverage the engine of quality improvement to identify health disparities to systematically and iteratively implement tests of change



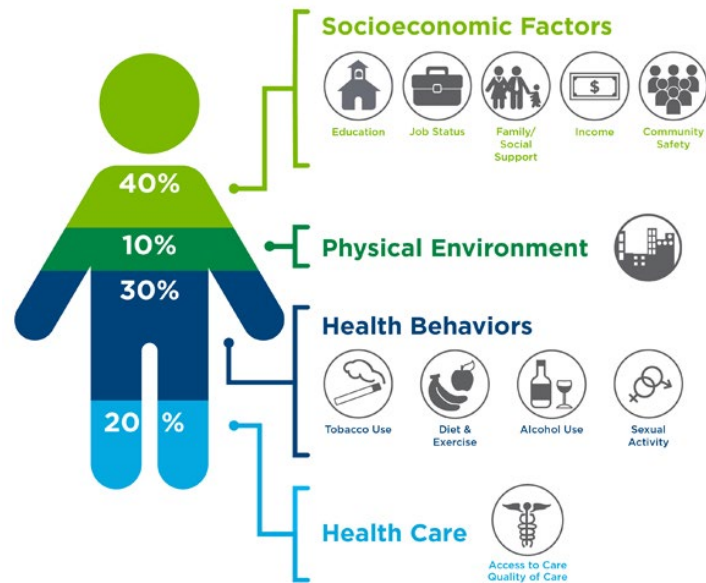
We would have to improve control for over 2000 black/AA patients in order to close the health disparity gap



Community Health Service: Partnership for Accountable Communities

Looking beyond our healthcare walls to understand health influences and *Social Drivers of Health*

What Goes Into Your Health?



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

The Bridgespan Group

- 80% of health outcomes are dependent on *nonclinical factors* like housing, food access, and built environment
- Health Alliance Initiatives Partnered with Communities:
 - Community Paramedicine
 - Universal screening for SDOH
 - Resource coordination support (training, education, and patient connections to community services)
 - Community Health Worker services
 - Transportation program for Medicare Accountable Care Organization patients
 - Mobile COVID testing/vaccination
 - Food insecurity initiatives

The COVID Crisis: A Public Health and Population Health Response

Our pivot to support community and home based care



Virtual Care

- Statewide Respiratory Diagnostic Centers
- Virtual Clinic Morrisville
- Virtual Care roll-out to primary and specialty care
- Virtual Behavioral Health
- Virtual Hospital



Transitions of Care

- Manage Transitions across UNC Health



UNC Health Chat

- COVID testing follow-up team
- ICM COPD outreach and management



Post-acute management

- Outbreak management and playbook
- Triangle ACO collaborative, NCDHHS collaboration
- Enhanced Home Health



Community Outreach – reduce disparities

- Mobile Testing Center Southeast Raleigh
- Community leader engagement



Analytics and Reporting

- COVID Tableau reporting
- Ambulatory Recovery modeling

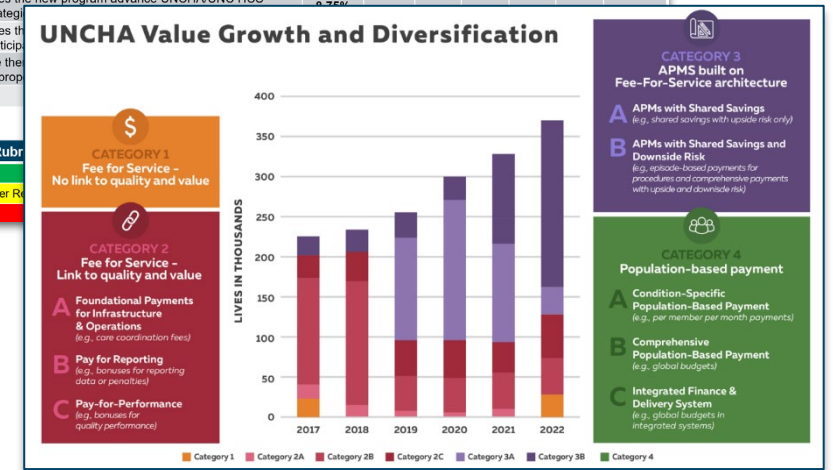
Daily phone calls to all positive patients provide ongoing monitoring for 14 days, totaling 44,000 calls from Mar-Aug 2020. Virtual MD visits and remote Behavioral Health

Population Health Teams pivot to address novel population health challenges

Financial Modeling and Contract Portfolio Management Across Market Segments

- Data and skillsets developed through ACO financial modeling translates across all contracts
- Rigorous evaluation of new value contracts to balance the portfolio and achieve network priorities while predictive modeling assesses likelihood of contract success

Principle	Brief Description	Weight	A 100%	B 75%	C 50%	D 25%	E 0%	Score
Financial Construct	Do we believe that we will be successful in this arrangement?	35%						
Quality Program Alignment	Do measures align with UNCHA priorities or efforts?	15%						
Attribution & Growth	Will UNCHA add significant covered lives via an appropriate methodology?	15%						
Data Quality and Requirements	Can the payor provide timely, accurate and complete data to support the program?	8.75%						
Strategic Importance	Does the new program advance UNCHA/UNC HCS strategy?	8.75%						
Maximize Network Parity	Does the program participate in the network?							
Defined Scope	Are the program and population well defined?							
Recommendation Rubric								
≥75% Move Forward								
50% - 74% Additional Analysis & Stakeholder Review								
≤50% Do Not Move Forward								



The economics of Value Strategy and Operations directly informs enterprise system strategy, growth, and investment including virtual care, site of service, service line growth and others...

Key Learnings and Barriers to Scale and Systemness

- 1) Engage providers on improving health outcomes across populations
- 2) Interpret and manage the **Chaos of Value** for care teams
- 3) Articulate the **Economics of Value** to drive system strategy
- 4) Thoughtfully balance **broad population health** resources with **targeted risk management**
- 5) Systematize Care Redesign
- 6) **Align incentives** and solutions across care settings

Thank You

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Living Well

Bringing health care
value to life

 AdvocateAuroraHealth[®]



BY THE NUMBERS



26 HOSPITALS

500+ SITES OF CARE



Top 12

NOT-FOR-PROFIT HEALTH SYSTEM



Top 10

IN QUALITY AMONG NATIONAL HEALTH SYSTEMS



70,000+
TEAM MEMBERS

22,000+ NURSES
10,000+ PHYSICIANS



3M UNIQUE PATIENTS

1.3M VALUE-BASED LIVES



53

INTEGRATED HEALTH & SAFETY MEASURES TRACKED



NEARLY
\$2.2B
COMMUNITY BENEFITS IN 2019



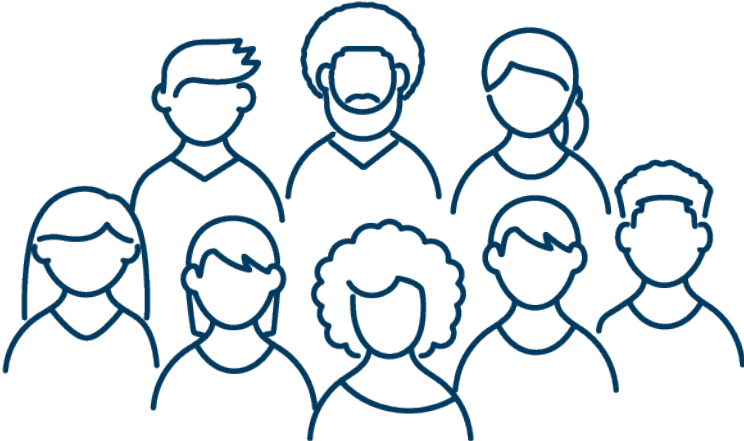
10,000+
VOLUNTEERS



1M+
LIVEWELL APP DOWNLOADS

Value

Caring for 1.3 million lives
in 30+ value-based contracts



Commercial
Shared Savings
577K lives



Commercial
HMO
221K lives



Medicare Shared
Savings Program
205K lives



Medicare
Advantage
98K lives



Advocate Aurora
Team Members
87K lives



Managed
Medicaid
87K lives

2020 Medicare Shared Savings Program

Advocate Aurora saves taxpayers **\$110 million**

Our largest total generated savings in a single MSSP performance year

Wisconsin

MSSP Track 1

- Quality Score: **99.38%**
- Generated Savings: **\$23M**
- Our Share: **\$11.4M**

MSSP Enhanced Track

- Quality Score: **98.75%**
- Generated Savings: **\$9.4M**
- Our Share: **\$6.96M**

Illinois

- Quality Score: **96.87%**
- Generated Savings: **\$77.6M**
- Our Share: **\$37.6M** – most in IL

LEARN MORE!

Read ["Advocate Aurora Health ACOs save taxpayers \\$110 million"](#)



Enterprise Population Health

*One Team
Across
Populations*



Population Health Approach Applied Across Patient Groups

Social Determinants of Health Screening and Referral

Patient and Family Advisory Councils

Clinical Risk Adjustment & Clinical Documentation Improvement Partnership

Health Equity Strategy and Goals

Community Health Workers

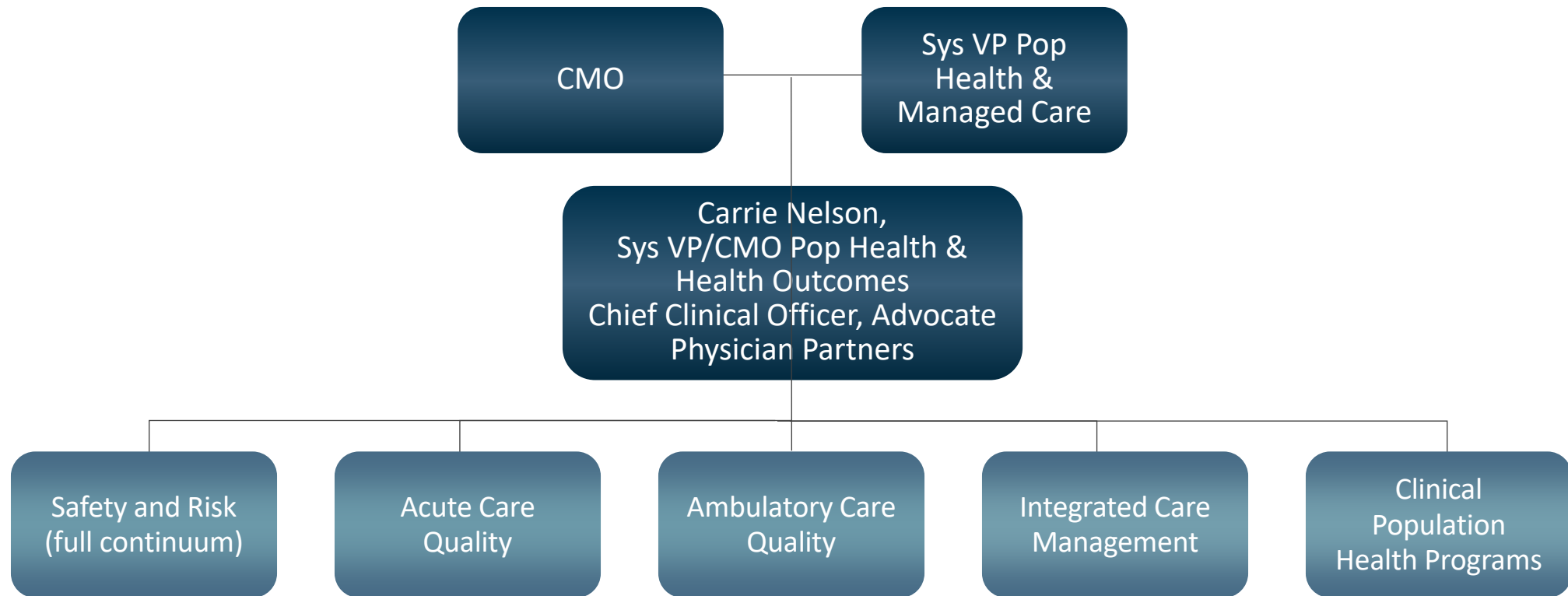
Bundled Payment for Care Improvement-Advanced (BPCI-A)

Quality & Safety Strategic Plan

Integrated Care Management

Quality and Safety Across the Continuum

System Level Health Outcomes and Population Health Oversight



Full Continuum View of the Quality Portfolio



Clinical Quality Governance

Executive Clinical Leadership Council (ECLC)

Membership: Senior Nursing, Physician and Pharmacy Leaders

Function: Final Decisions on Quality Priorities

Quality Leadership Collaboration Team (QLCT)

Membership: Leaders Across Quality Domains Representing the Continuum

Function: Review performance, recommend priorities and guide improvement approach

High Reliability Improvement System Roundtable (HiRISe)

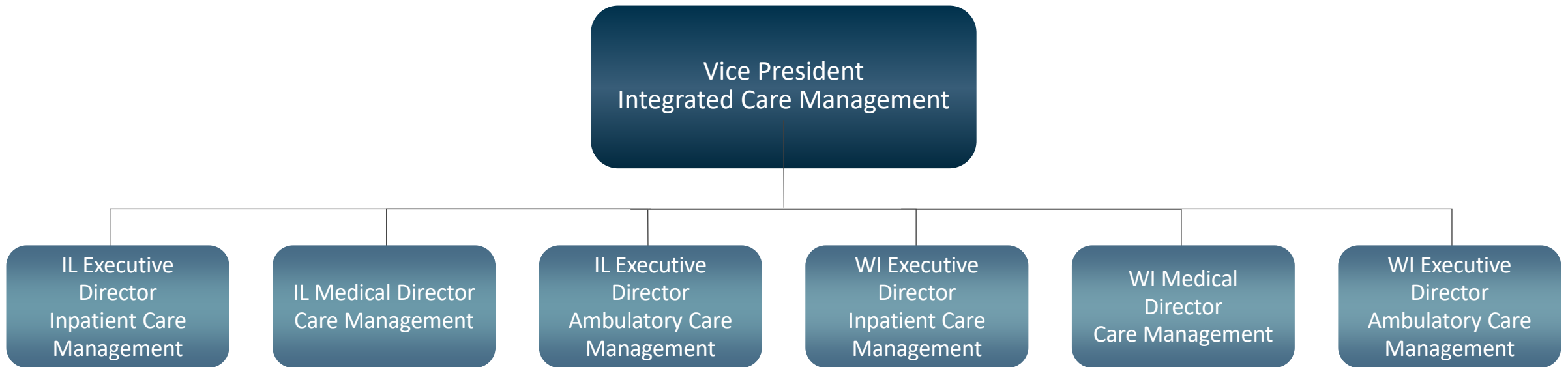
Membership: Site Quality Directors, CMOs, CNOs, Quality Domain Leaders

Function: Learning roundtable responsible for focusing on priorities, leading improvement

Integrated Care Management

Draft: for discussion purposes only

Integrated Care Management Organizational Structure



Advocate Aurora Health

Integrated Care Management (ICM) Vision

- *integrates*
- *coordinates*
- *simplifies*

the healthcare experience, impacting the "quadruple aim" and positioning our organization to be

- *successful*
- *innovative*
- *sustainable*

in current and future healthcare environments.

1 Improving the Health of the Patients We Serve



2 Improving the Patient Experience



3 Reducing the Per Capita Cost of Care



4 Enhance the Physician and Clinician Experience



Integrated Programs

HEALTH
OUTREACH
SERVICES

EARLY
AMBULATION

CARE
TRANSITIONS
PROGRAM

ACUTE
CARE
MANAGEMENT

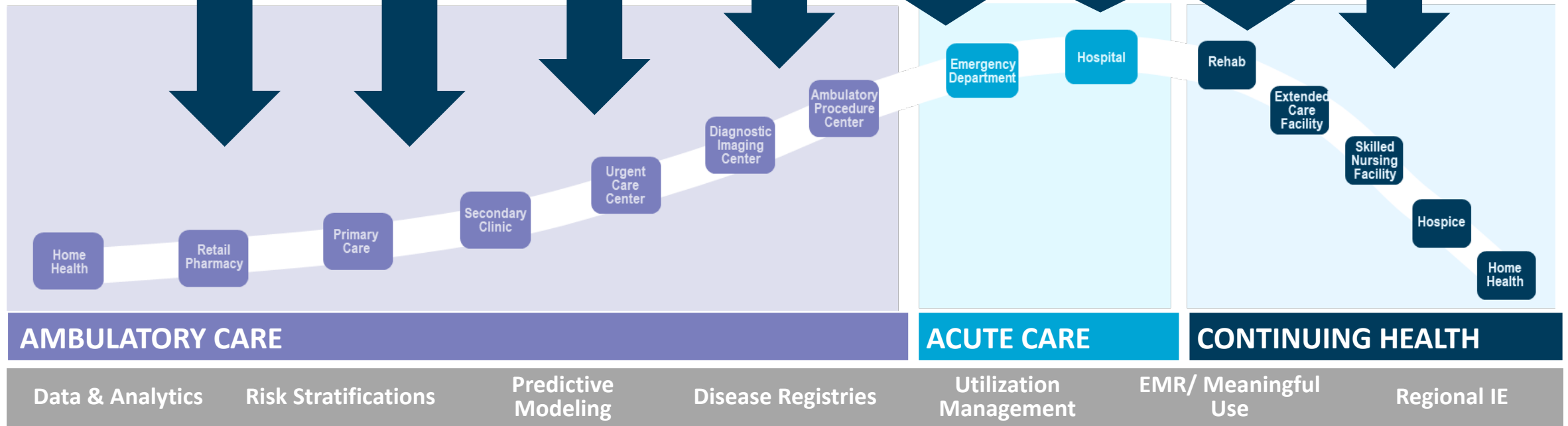
REFERRALS AND
UTILIZATION
MANAGEMENT

AMBULATORY
CARE
MANAGEMENT

INTERDISCIPLINARY
CARE TEAM
CONFERENCES

RIGHT
LEVEL
OF CARE

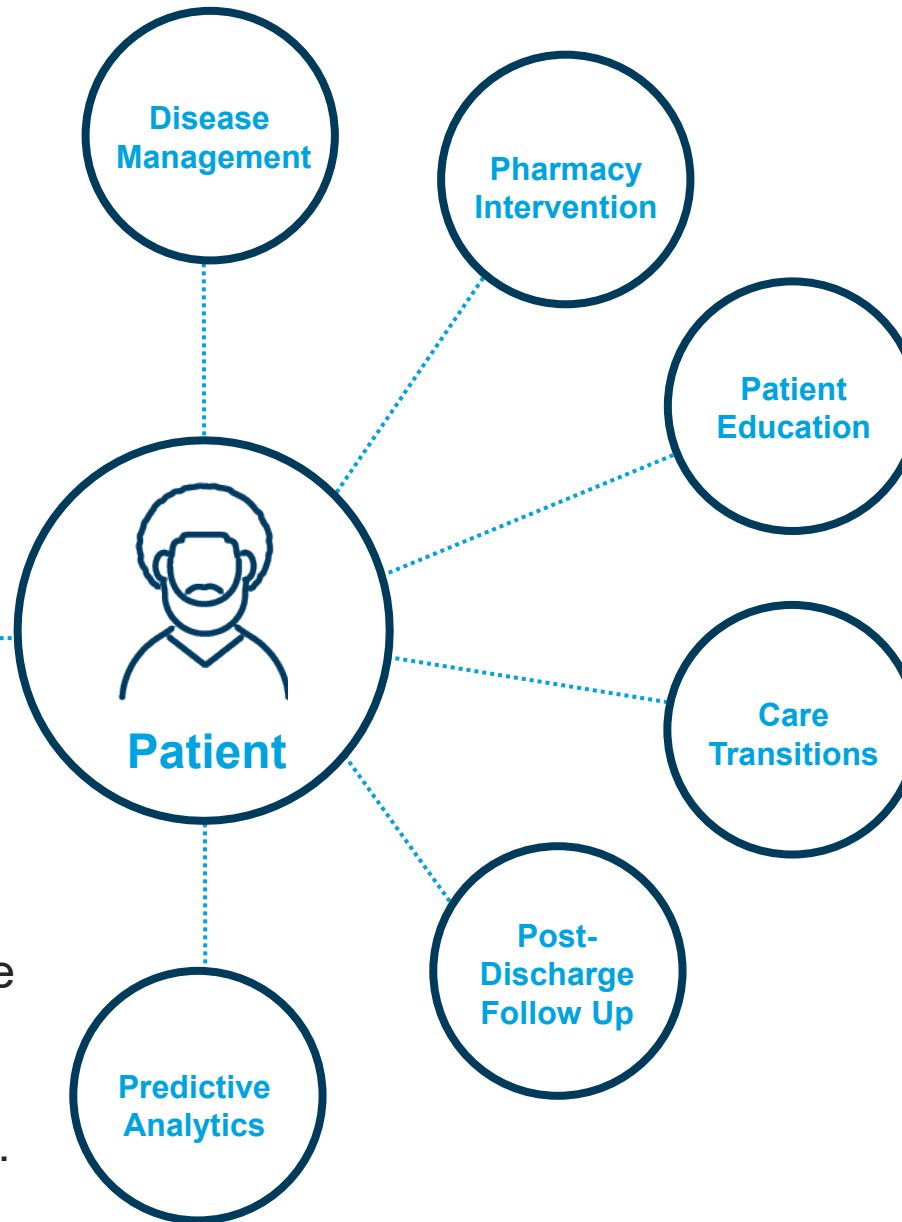
SOCIAL WORK
AND SUPPORT
SERVICES



Approach



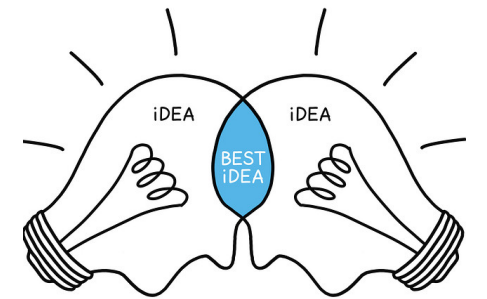
Care managers support and coordinate across a multi-disciplinary clinical team to ensure patients receive the **right care** at the **right time** in the **right setting** by the **right provider** to manage **health outcomes and costs**.



- ▲ Safety
- ▲ Quality
- ▲ Patient Experience
- ▲ Days at Home
- ▼ Hospital Admissions
- ▼ Readmissions
- ▼ ED Visits

Benefits of Integrated CM

- Same **language** and **goals**
- Shared **alignment** to organizational **strategic priorities** – e.g. Age Friendly Health System and SDoH screening adoption
- **Eliminates** site-based **variation**
- Onboarding/orientation and **staff development** enhanced – i.e. motivational interviewing skills education across the continuum
- **One voice** for both internal and external partners – i.e. IT build, payer meetings
- **Transition Care Management** visit collaboration
- Care Transitions Program applied to the Medicare FFS to impact **CMS penalties**





"At Advocate Aurora Health, physicians and team members work together to deliver top tier results – for our patients, our communities, and our employer and payer partners. We're acutely focused on performance because that means we're moving the needle on helping people live well."

Gary Stuck, DO
Chief Medical Officer
Advocate Aurora Health



Questions?