Welcome to the 2022 ACO Engagement Summit

October 11, 2022

General Information and Housekeeping

- **2022 ACO Engagement Summit Streaming Platform**
  - Agenda, speaker biographies, materials from previous Summits, and more
  - Technical support for virtual attendees
  - Making connections

- **Survey & Continuing Education Credit**
  - A post-Summit survey and information for CMEs/CEUs will be sent out immediately after our closing remarks tomorrow afternoon
- **In-person attendees**
  - Wi-Fi information is available on your table
  - Restrooms
  - Snacks and refreshments
  - Networking dinner at ***6Smith*** restaurant at 5:00 p.m.
- **Virtual attendees**
  - To ask a question during the keynote, roundtable, or behavioral health panels:
    - Enter your question in the monitored chat box and it will be relayed to the speaker(s)
    - Use the 'Wall' feature to add your thoughts, comments, and questions from the day

The 2022 ACO Engagement Summit Planning Committees

Clinical Committee

- Hailee Buehler
- Haley Holtan
- Jerid Bass
- Kristen Kopski, MD
- Leah Halverson
- Lori Skinner, Chair
- Lukas Johnson
- Valerie Stachour

Operations Committee

- Alyssa Hodnik
- Amber Hinkle
- Christy Kriha
- Endegena Desta
- Hugh Curtler
- Julie Willert
- Leah Halverson
- Naira Polonsky, Chair
- Shannon Martin
- Tasha Klesk

Steering Committee

- Amy Wallingford
- Christy Kriha, Co-Chair
- Gail Morland
- John Piatkowski, MD, Executive Sponsor
- Kristen Kopski, MD, Co-Chair
- Leah Halverson
- Lisa Spann
- Lori Skinner
- Naira Polonsky
- Penny Tatman
- Scott Myhre

Special thanks to Medica's IT and facilities departments: Sue, Josh, Shawn, and Theo

Time	Agenda
12:30 – 12:45 p.m.	**Welcome: ACO Engagement Summit Day 1**
12:45 – 1:45 p.m.	**Keynote Speaker** **Lauran Hardin, MSN, CNL, FNAP, FAAN,** Vice President and Senior Advisor, National Health Care & Housing Advisors *Connected Communities of Care: Next Wave Strategy*
1:45 – 2:00 p.m.	**Break**
2:00 – 2:50 p.m.	**Breakout Sessions**
	Breakout session #1: Innovations out of the COVID-19 pandemic During this breakout session attendees will learn about innovative care delivery models that resulted from the COVID-19 pandemic. M Health Fairview will present on the establishment of their COVID-19 long hauler clinic. Mayo Clinic will share their hospital at home program.
	Breakout session #2: Biosimilars: Key considerations across the health care industry In this breakout session, attendees will hear from Essentia Health and Medica subject matter experts on key factors and considerations influencing the adoption of Biosimilars across the health care industry. This session will include insights on one of the most significant exclusivity losses in the history of pharmaceuticals: Humira.
	Breakout Session #3: Strategies to engage providers in Social Determinants of Health (SDoH) reporting Attendees will hear from St. Luke's Health System and Phoenix Children's Care Network on how they engage providers in conducting universal SDoH screening, including data collection and capture. During this session, attendees will also learn about strategies on how to connect patients with appropriate resources.
3:50 – 3:05 p.m.	**Break**
3:05 – 3: 55 p.m.	**Breakout Sessions**
	Breakout session #4: Risk recapture strategies to support providers and members Attendees will hear from a health system and payer on how they are partnering to engage providers in risk recapture strategies to ensure the risk of the population is accurately captured.
	Breakout session #5: Engaging patients with primary care During this breakout session attendees will learn approaches to engaging patients with primary care. Attendees will learn from Park Nicollet on how they use their care consultants to ensure patients at risk receive appropriate follow-up and care. Medica will present member outreach models that have targeted non-users, preventable emergency department utilization, as well as out-of-network utilization.
4:00 – 4:15 p.m.	**Day 1 Closing Remarks**

Thomas Lindquist
Senior Vice President Markets, Medica

Thomas Lindquist is responsible for the strategic planning and plan operations for Medica's product lines; this includes accountability for profit and loss, product development, compliance, product viability and growth, and operations for the business segments. Mr. Lindquist is also responsible for the organization's relationship with the Minnesota DHS and Centers for Medicare and Medicaid Services.

Before joining Medica, Mr. Lindquist held executive positions with UnitedHealth Group and served as a health insurance industry liaison to the Congressional Budget Office and the Centers for Medicare and Medicaid Services. He received his Bachelor of Science in Mathematics from Penn State University.

Mr. Lindquist currently serves on the Board of Directors at Mentor MN, on the Penn State Honors College External Advisory Board, and previously served on the board for the Institute for Clinical Systems (ICSI). Mr. Lindquist also provides volunteer math tutoring for students from elementary school through college.

Welcome

Medica's 5th Annual ACO Engagement Summit

100% of our Value Based Health System Partners are represented today

RIDGEVIEW

HennepinHealthcare

UnityPoint Health

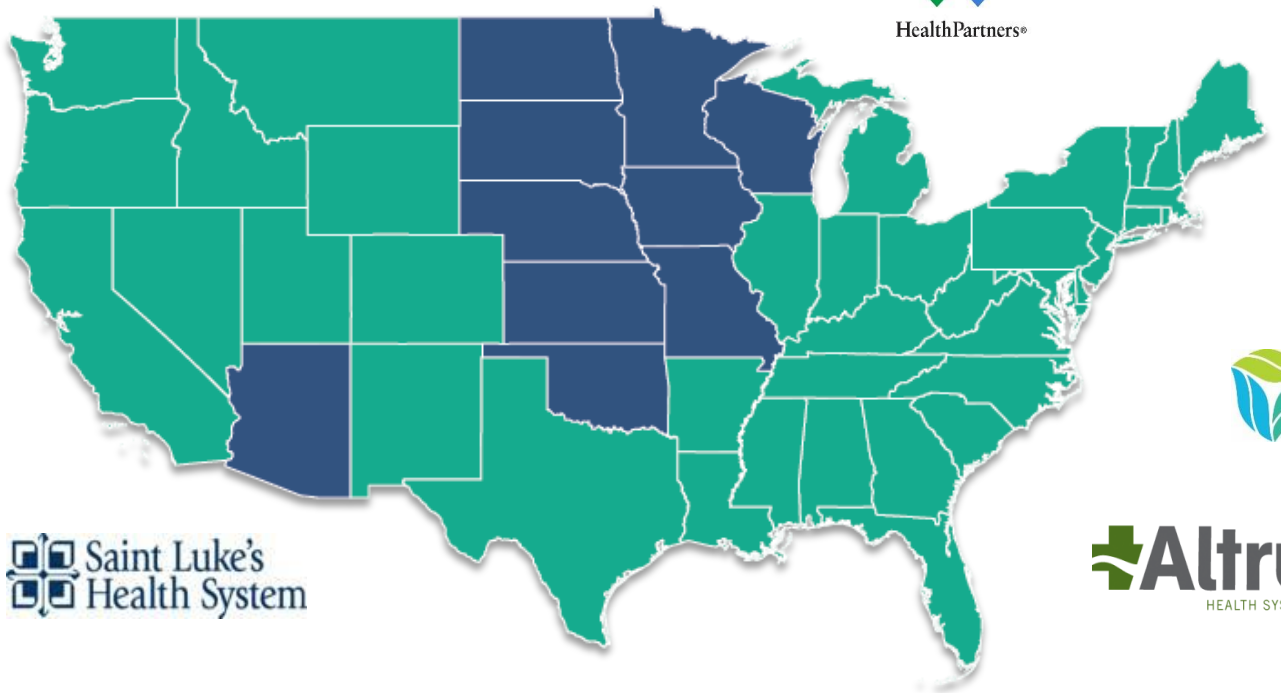
CHI Health Partners

Park Nicollet HealthPartners

Health Care

MAYO CLINIC

HEALTH FAIRVIEW



UNIVERSITY OF IOWA HEALTH CARE

Dignity Health

Essentia Health

Phoenix Children's

Saint Luke's Health System

Altru HEALTH SYSTEM

Ascension St. John

Bryan Health

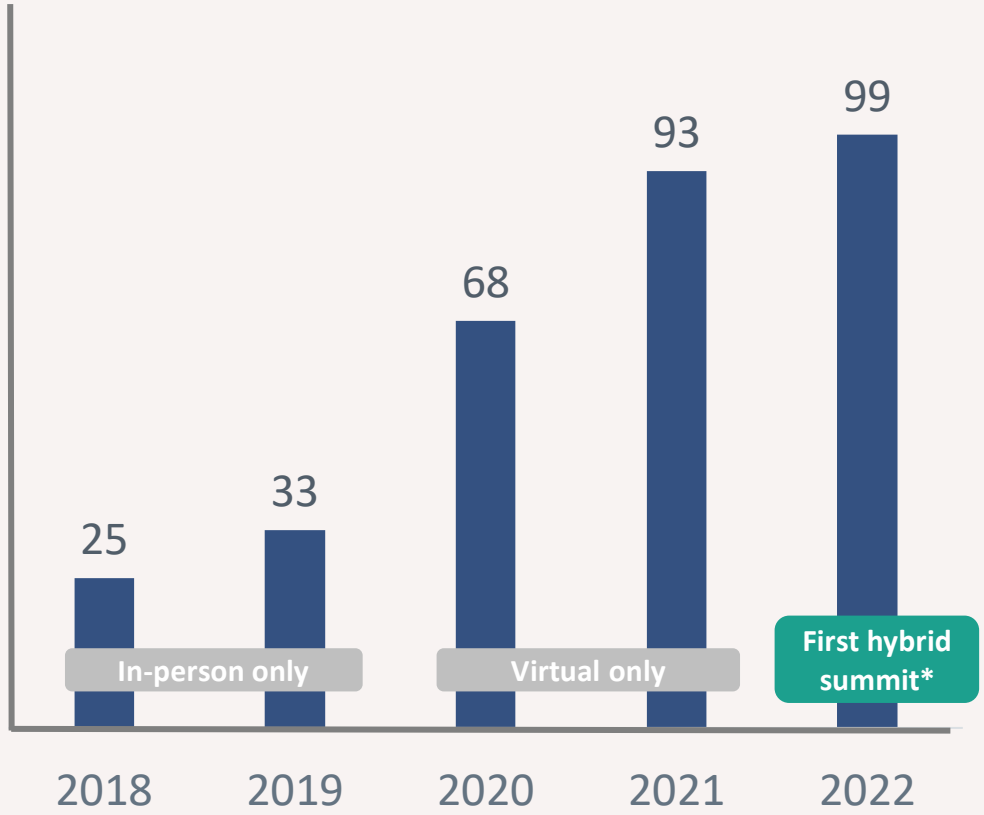
NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

NORTH MEMORIAL HEALTH

MercyHealth

Allina Health

Health System Partner Attendance



*pending final registration #s

- 35% of you attended the 2021 Summit
- 65% of you are new to our summit
- **All** our new and established value-based partnerships are represented today. (100%)

Trusted health plan of choice

Medica's Strategic Growth

Sustainable expansion through new and deepening partnerships

Prioritizing value-based care delivery through improved provider connectivity

Market differentiator with focus on communities

David Webster, MD

Medica's Chief Clinical & Provider Strategy Officer

David leads, organizes and directs activities that impact health services, medical management, pharmacy, provider strategy, affordability, value creation, innovation, contracting and quality. He participates in the development and implementation of short-and-long term strategic plans required for Medica's ongoing growth and success.

David joined Medica from Highmark Health where he was an Executive with the integrated Health Plan and Care Delivery system. He has also served in clinical leadership roles for a number of health plan and provider organizations including Humana, Concentra and The Center for Wound Care and Hyperbaric Medicine at Baptist Health System. He is board certified by the American Board of Family Medicine and earned his medical degree at the University of Michigan Medical School. He has an MBA from the University of Florida and a Bachelor of Science degree from the University of Michigan.

He brings to Medica a breadth of experience serving various communities. He has served on the Board of Directors at East Liberty Family Health Care Center Pittsburgh, PA, and on the Board of Directors for African American Chamber of Commerce Foundation of Western Pennsylvania. He is active in the American College of Healthcare Executives, American Association for Physician Leadership and the American Medical Association.

Medica's Value Based Partnerships

- Medica's highest priority
- Initiatives to continue to pursue clinical value alignment
  - Member retention through shared sales strategies
  - Provider integration through data sharing
  - Affordability framework
    - Aim to improve value for member/patient, health system, and Medica

Keynote Speaker

Lauran Hardin, MSN, CNL, FNAP, FAAN,

Vice President and Senior Advisor, National Health Care & Housing Advisors

Lauran Hardin is a nationally recognized leader, highly skilled at partnering with communities, health systems and payers to co-design models and interventions for complex populations. She most recently served as Senior Advisor for the Camden Coalition's National Center for Complex Health and Social Needs.

Hardin's past work includes leading care management in ACOs & BPCI, and developing an award-winning Complex Care model that creates better patient navigation, decreased hospitalizations and costs for vulnerable populations. Aspects of the care model were implemented in more than twenty Trinity Health sites in both rural and urban communities across six states. The model was recognized as an exemplary practice in the National Academy of Medicine Future of Nursing Report 2020-2030.

Recent projects include co-designing a cross-sector community-based equity ecosystem model called Project Restoration, working with the State of Vermont to develop state-wide interprofessional community-based complex care teams , and co-designing a model for uninsured patients in Memphis. Hardin was named AARP Culture of Health Scholar in January of 2017, earned "Edge Runner" recognition from the American Academy of Nursing, was named Distinguished Fellow of the National Academies of Practice in 2018 and Fellow in the American Academy of Nursing in 2019. She was recently appointed as the first nurse representative and co-chair of the U.S. Government Accountability Office's Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Hardin earned her master's degree in nursing from the University of Detroit Mercy, with certifications as a Clinical Nurse Leader, Pain Management, and Hospice. She trained as a facilitator with the Elisabeth Kubler-Ross Center, spent several years working in hospice, and co-developed the first Pain and Palliative Care service in the West Michigan region.

Connected Communities of Care: Next Wave Strategy

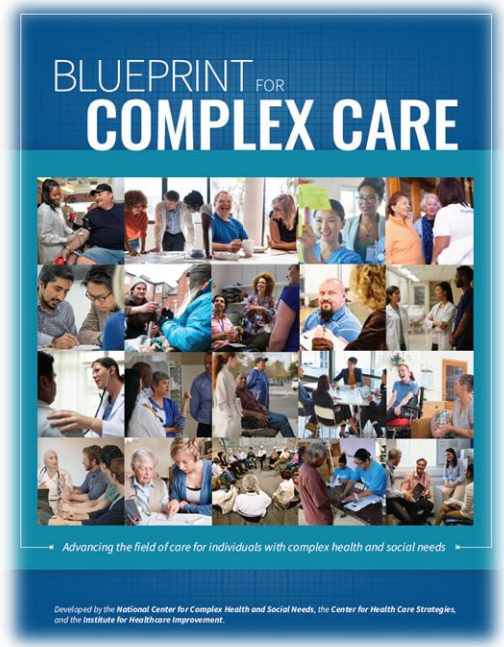
Lauran Hardin MSN, CNL, FNAP, FAAN
National Healthcare & Housing Advisors
lhardin@nhhadvisors.com

Unprecedented Challenges

Accelerated Community Approaches


Why I
went to the
emergency
room…


Other social services (e.g education, employment)
Physical health
Transportation
Behavioral health
COMPLEX CARE ECOSYSTEM
Criminal justice & legal services
Pharmacy
Food access & nutrition
Home care
Housing
Public health


BLUEPRINT FOR
COMPLEX CARE
Advancing the field of care for individuals with complex health and social needs
Developed by the National Center for Complex Health and Social Needs, the Center for Health Care Strategies, and the Institute for Healthcare Improvement.

Innovations in Priorities

CMS Strategy: Advance Comprehensive Care and Equity

Strategic Aims:

- All Medicare Part A/B beneficiaries in a care relationship with accountability for quality and total cost of care by 2030
- Majority of Medicaid beneficiaries in a care relationship with accountability for quality and total cost of care by 2030
- Embed health equity in every aspect of CMS models and increase focus on underserved populations
- CMS will support system-wide healthcare reform for whole-person, accountable care

Trends in Priorities

- Telehealth/Virtual Engagement
- Equity
- Total Cost of Care/All Payer Models
- Health Related Social Needs
  - Food Security, Housing, Transportation
  - Mental Health, Substance Use, Safety Employment
- Integration of Community Based Approaches
- HHS Strategic Plan to address SDOH
- Z-codes for SDOH

Innovations in Financing

Emerging Trends

- ACO REACH – health equity plans
- Payment for SDOH screening and equity outcomes
- Medicaid 1115 waivers
- ARPA & Incentive dollars
- Enhanced Care Management
- Community Supports
- HHS/ACL Community Care Hubs
- Blending & Braiding of Dollars for Impact

One Example of Current Incentive Dollars

Overview of CalAIM and Incentive Programs

The *California Advancing and Innovating Medi-Cal (CalAIM)* is a long-term California Department of Health Care Services (DHCS) initiative to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. This includes **launching Enhanced Care Management (ECM) benefit and optional Community Supports (CS).** DHCS has developed several incentive programs in order to support CalAIM implementation:

CalAIM Incentive Payment Program (IPP)

Funds flow from DHCS to MCPs to:

1. Support implementation and expansion of ECM and CS
2. Invest in provider capacity and delivery system infrastructure;
3. Bridge current silos across physical and BH care service delivery;
4. Achieve improvements in quality performance;

600 M/yr

Housing and Homelessness Incentive Program (HHIP)

Funds flow from DHCS to MCPs to:

1. Reduce and prevent homelessness
2. Ensure MCPs develop the necessary capacity and partnerships to connect their members to needed housing services

1.2 B

Providing Access and Transforming Health (PATH)

Funds flow from DHCS to counties, WPC Lead entities and other providers to:

1. Maintain, build, and scale services, capacity and infrastructure for providers to ensure successful implementation of CalAIM
2. PATH is focused on justice involved, WPC transitioning and other initiatives

1.8 B

Behavioral Health Quality Improvement Program (BH-QIP)

Support Behavioral Health Plans (BHPs) to prepare for CalAIM participation changes. BHPs include:

1. Mental Health Plan (MHP),
2. Drug Medi-Cal State Plan (DMC-SP) or
3. Drug Medi-Cal Organized Delivery System (DMC-ODS)

21 M

Behavioral Health Continuum Infrastructure (BHCIP)

1. Competitive grants awarded to qualified entities to invest in infrastructure, including mobile crisis, to expand the community continuum of BH treatment resources.
2. Funds flow from DHCS to Counties, cities, tribal entities, non-profit and for-profit entities.

2 B

Innovations in Approach

The Complex Care Center Model:

Changing the System for complex patients

- Expert Nurse Consultation
- Comprehensive Assessment (Medical, Social, Behavioral, System)
- Cross Continuum Case Conferencing
- Shared Plan of Care in the EMR
- Process Improvements – delivery change
- Community Collaboratives – root cause change

↓ 44% Inpatient and ED visits

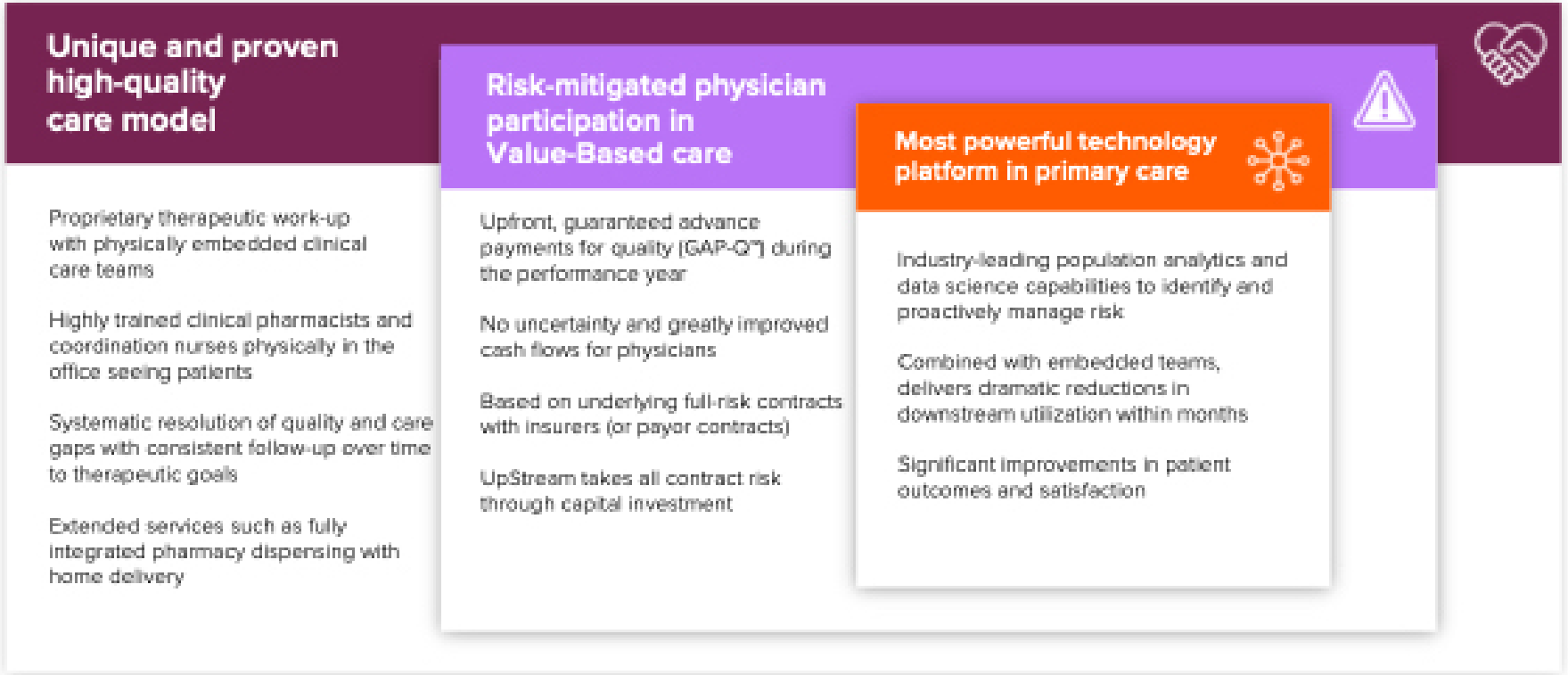
↑ 23% Return on Investment (1000 Patients)

↑ Housing, Access to Insurance & PCP, QOL

https://www.aannet.org/initiatives/edge-runners/profiles/edge-runners--complex-care-center

Innovation in Partnered Delivery: Upstream

Unique, Proven and Scalable Platform



New Community Approaches

- “Care Traffic Control” roles
- Integrated Teams
- Network Lead Entity
- Cross Sector Collaborative
- System of Care Approach

What is Possible:
The Story of 3 Communities

Memphis, Tennessee: Developing a health and well-being ecosystem for uninsured Memphians

"Life is better now. I'm taking things one day at a time, but I feel great. ONEHealth gave me a new chance." **-** Clarence Gray, ONEHealth program participant

ONEHealth's program results over two years

11M
reduction in costs

439
people served

16M
financial gain over 2 years

200+
community partnerships

Won Honorable Mention **Gage Award** and featured in **Health Affairs**

Adventist Health Clear Lake

Lake County, California

- Ranked last in health outcomes
- 75% of county burned in wildfires of the past 5 years
- High rates of poverty and substance misuse

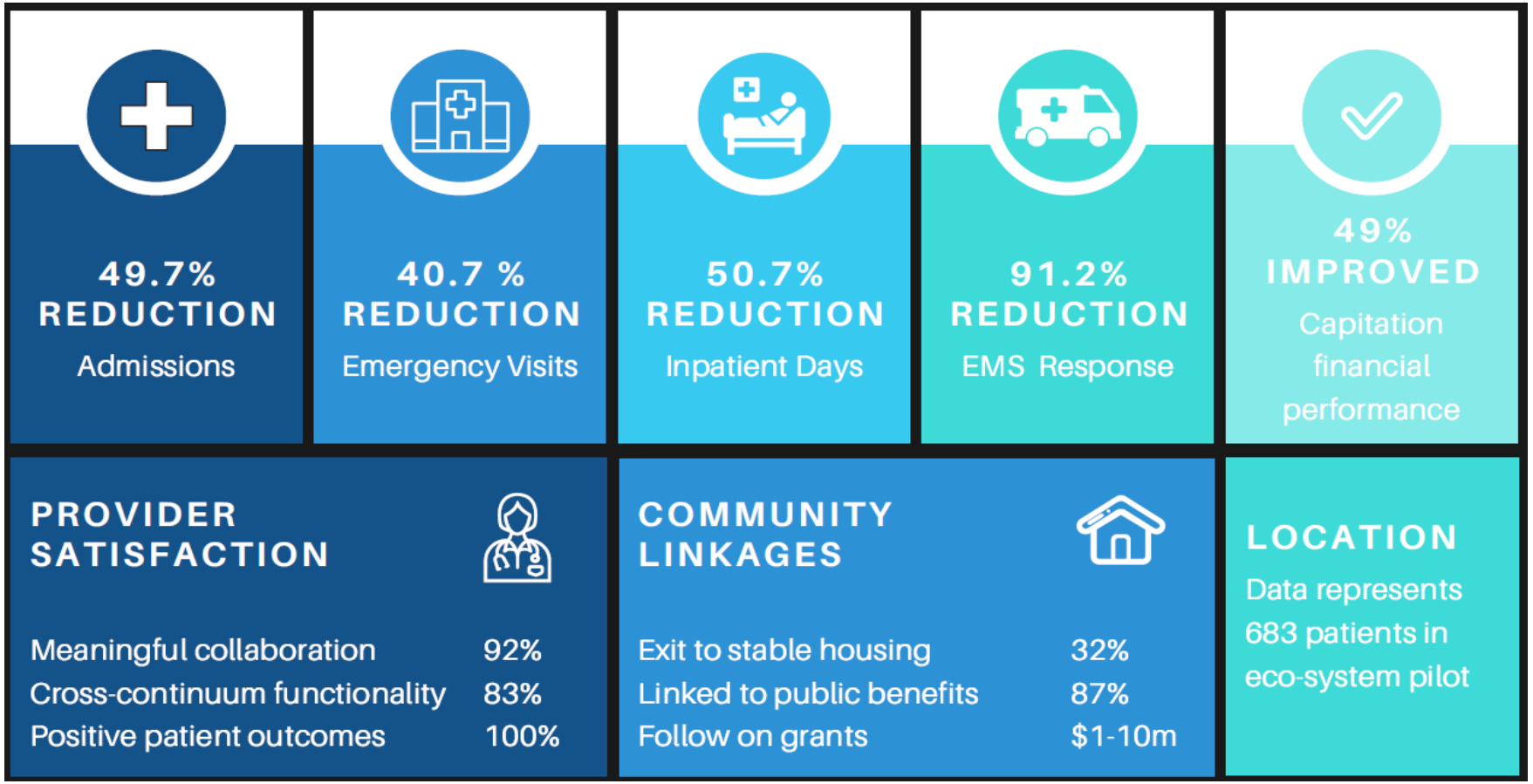
Project Restoration

- County-wide cross-sector collaborative (Police, Fire, EMS, Criminal Justice, Mayor, Health, Social Services, Education)
- Shared data
- Process improvements to change root cause

Adventist Health

Adventist Health Project Restoration – Community of Care Approach

683 Clients 12 months after intervention



Developments in the Community Ecosystem

Before Project Restoration

- ✓ Hope Rising collaborative (broad health outcomes)
- ✓ IOPCM Complex Care Management (payer specific)

After Project Restoration

- ➢ Restoration House -Transitional Housing
- ➢ Integrated Complex Care Management for the Community
- ➢ Shower Trailer for the homeless
- ➢ BackPack Street Nursing for the homeless
- ➢ Substance Use Navigator
- ➢ ED Bridge Program for Medication assisted treatment
- ➢ Behavioral Health Pilot in the ED
- ➢ Substance use services Hub & Spokes
- ➢ Elijah House, Thule House & Warming Center (Shelters)
- ➢ Hope Center & Community Pathways (Navigation Center)
- ➢ Healthy Homes Project – micro-community
- ➢ Tiny House Village
- ➢ Employment and Development Campus

York County PA

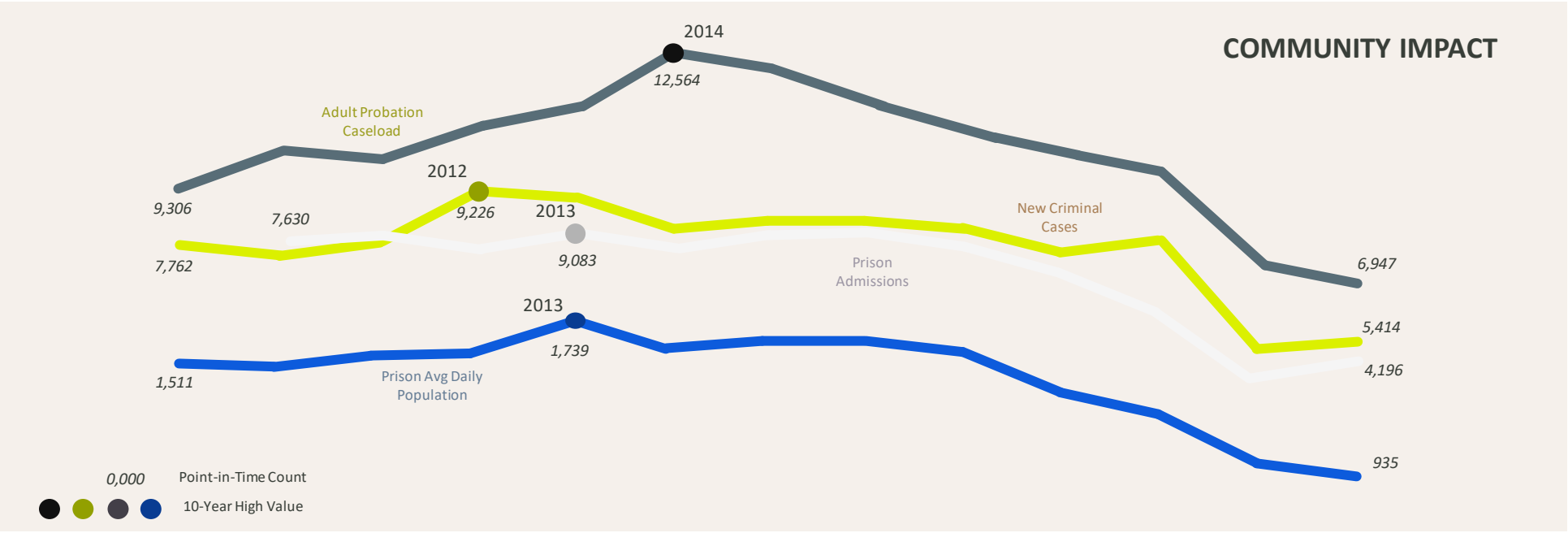
Safer, healthier community by working collaboratively to connect people with justice involvement to health care and social services.

- Improved access to behavioral health services
- Increased access to Medication Assisted Treatment (MAT)
- Driving systems change through CARD
- Development of a Reentry Opportunity Center (ROC) to streamline needs identification and referrals
- Trauma-informed trainings
- National Ecosystem Learning Collaborative site with Camden Coalition, National Center for Complex Health & Social Needs

COMMUNITY IMPACT

- **38% reduction in County Prison population over 10 years***
- **1400+ emergency room diversions since 2021****
- **4M emergency room cost avoidance**
- **93% decrease in wait times for behavioural health over traditional outpatient treatment****
- **88% decrease in inpatient admissions for Reentry Team clients*****

* Data courtesy of CARD & York County Prison.
** Since beginning of START clinical operations on 7/21/21
*** 6 months pre-incarceration inpatient admissions compared to 6 months post-release.



Adult Probation Caseload

25% since 2009

44% from 10-yr high

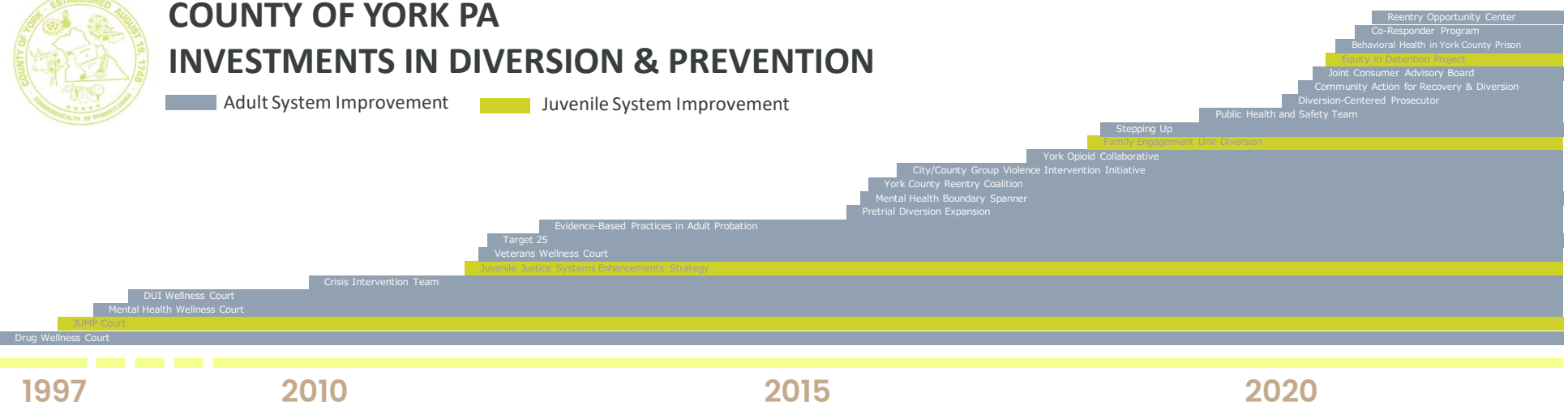
COVID-19 Pandemic

New Criminal Cases Filed

30% since 2009

41% from 10-yr high

COUNTY OF YORK PA
INVESTMENTS IN DIVERSION & PREVENTION



York County Prison Admissions

45% since 2010

54% from 10-yr high

Prison Avg Daily Population

38% since 2009

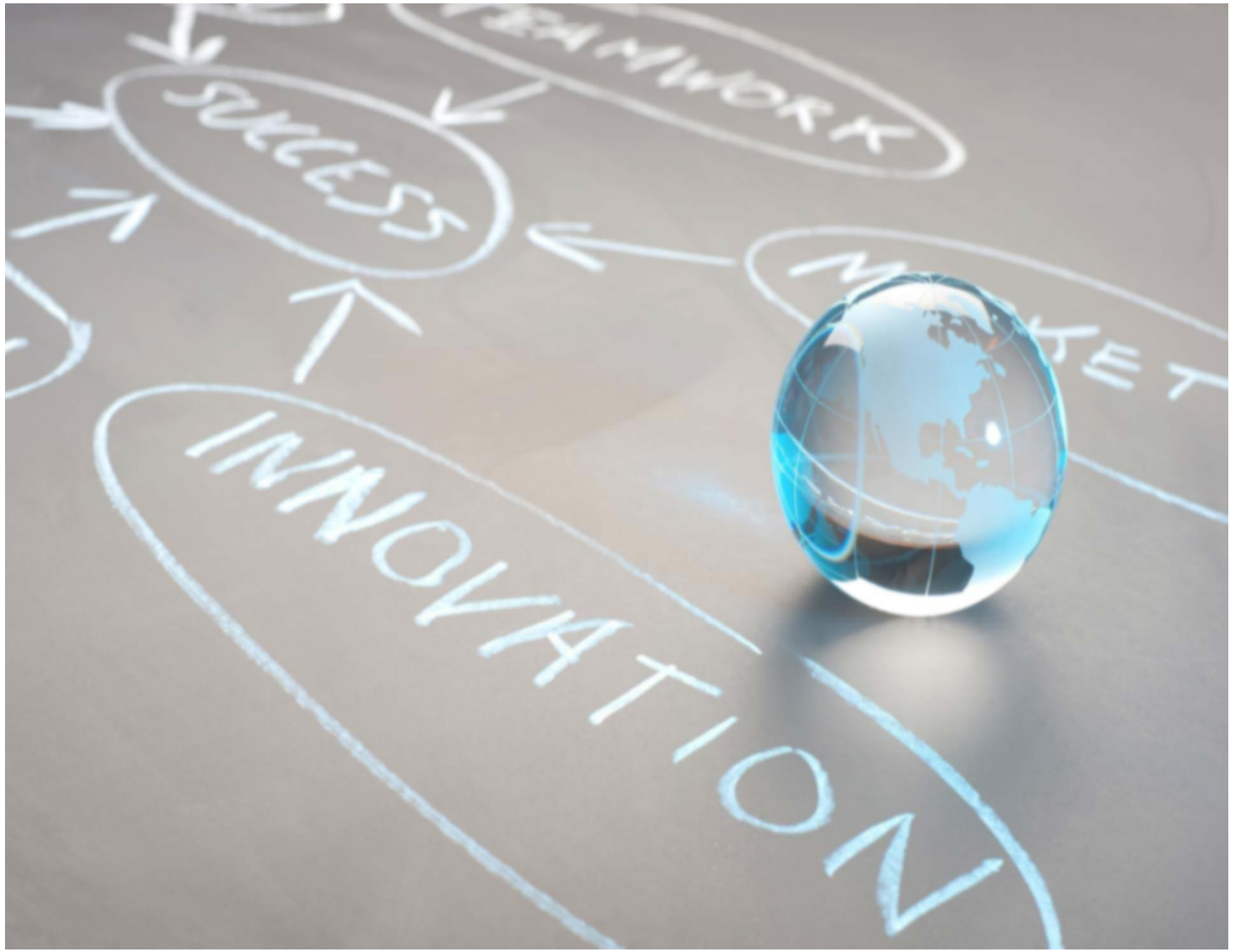
46% from 10-yr high

York County PA
Complex Care Ecosystem

Michele C. Crosson, LSW, MBA *(she/her/hers)*
Project Director WPH START
mcrosson4@wellspan.org

Connected Communities of Care & Medica

Lead the way……



Three Takeaways you can Implement Next:

- HRSN Screening & Data
- Integrated Teams
- Collaborate across your community

Thank You!

Lauran Hardin MSN, CNL, FNAP, FAAN
National Healthcare & Housing Advisors
lhardin@nhhadvisors.com

Best Housing and Healthcare Advisors - NHH Advisors

Hardin, L. & Mason, D. (June 2020). *Lessons from complex care in a Covid-19 world.* **JAMA Health Forum**. https://jamanetwork.com/channels/health-forum/fullarticle/2768610

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Vaida, B. (September, 2019). *For the Uninsured in Memphis, a Stronger Safety Net.* **Health Affairs.** https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00999

Thank you, Lauran!

Break

Upcoming at 2:00 p.m. - Breakout Sessions

Conference room 101

Breakout Session #1**:** Innovations out of the COVID-19 pandemic

During this breakout session attendees will learn about innovative care delivery models that resulted from the COVID-19 pandemic. M Health Fairview will present on the establishment of their COVID-19 long hauler clinic. Mayo Clinic will share their hospital at home program.

Conference room 105

Breakout Session #2: Biosimilars: Key considerations across the health care industry

In this breakout session, attendees will hear from Essentia Health, Medica, and Express Scripts pharmacy subject matter experts on key factors and considerations influencing the adoption of Biosimilars across the health care industry. This session will include insights on one of the most significant exclusivity losses in the history of pharmaceuticals: Humira.

Conference room 106

Breakout Session #3: Strategies to engage providers in Social Determinants of Health (SDoH) reporting

Attendees will hear from St. Luke's Health System and Phoenix Children's Care Network on how they engage providers in conducting universal SDoH screening, including data collection and capture. During this session, attendees will also learn about strategies on how to connect patients with appropriate resources.

Up next:

Breakout Session #1

Innovations out of the Covid-19 Pandemic

Start time: 2:00 pm

Welcome to Breakout Session I

Innovations out of the Covid-19 Pandemic

Breakout Session 1

Leslie Morse, DO, Chair and Professor, Department of Rehabilitation Medicine, University of Minnesota School of Medicine

Dr. Leslie Morse, DO, is Chair and Professor, Department of Rehabilitation Medicine, University of Minnesota School of Medicine. She is also Co-Project Director of the recently funded Minnesota Regional Spinal Cord Injury Model System. Her research, as well as her clinical focus, is the care of individuals with SCI, with a long-term goal of developing mechanism-based therapies to prevent and treat secondary health complications after injury. To that end, she is studying the impact of exoskeleton-assisted ambulation on bone health, neuropathic pain, and quality of life after SCI (a clinical trial supported by the Department of Defense). Dr. Morse completed her medical training at the University of New England and her residency in PM&R at Boston Medical Center. Author of more than 90 publications, she has received several national awards and presented her work nationally and internationally.

Research interests: spinal cord injury and osteoporosis, neuropathic pain, therapies for bone health in SCI, health benefits of exercise in SCI, biomarkers of neurological recovery

Breakout Session 1

Shelly Novotny, MBC, Neurosciences/MSK Service Line Manager
M Health Fairview Clinics and Surgery Center Neurosurgery, Spine, PM&R, Pain

Shelley Novotny has a background and a Master's degree in business communication, Shelley brings a unique skillset to healthcare leadership. Employed with M Physicians since 2013, Shelley has served in various roles. Currently, she serves as Neurosciences Service Line Manager at the University and Maple Grove locations with the following clinics: Physical Medicine and Rehabilitation, Pain, Neurosurgery, and Neurology.

Breakout Session 1

Margaret Paulson, DO, Assistant Professor of Medicine at the Mayo Clinic College of Medicine and Science

Dr. Margaret Paulson is an Assistant Professor of Medicine at the Mayo Clinic College of Medicine and Science. She has experience in providing care across the spectrum of Internal Medicine including outpatient and inpatient settings, nursing home, home health and correctional medicine. She currently practices as a rural hospitalist in the Mayo Clinic Health System in the Northwest Wisconsin (NWWI) region. In 2019, she became the Medical Director for NWWI in the exciting establishment of Mayo Clinic's Advanced Care at Home (ACH) program, an innovative platform offering hospital-level care in the home. The launch of ACH allowed Dr. Paulson to call upon her experience in outpatient and inpatient Internal Medicine to expand high quality telemedicine in transformational ways for Mayo Clinic. She also leads NWWI's Home Health program and is particularly interested in healthcare delivery innovations to improve patients' lives by partnering in-person and virtual teams.

MHealth Fairview Adult Post-COVID Clinic: An Innovative, Value Based Acute Care Delivery Approach

5th Annual Medica ACO Engagement Summit
October 22-24, 2020

Shelly Novotny, MBC
Neurosciences/MSK Service Line Manager
M Health Fairview Clinics and Surgery Center
Neurosurgery, Spine, PM&R, Pain

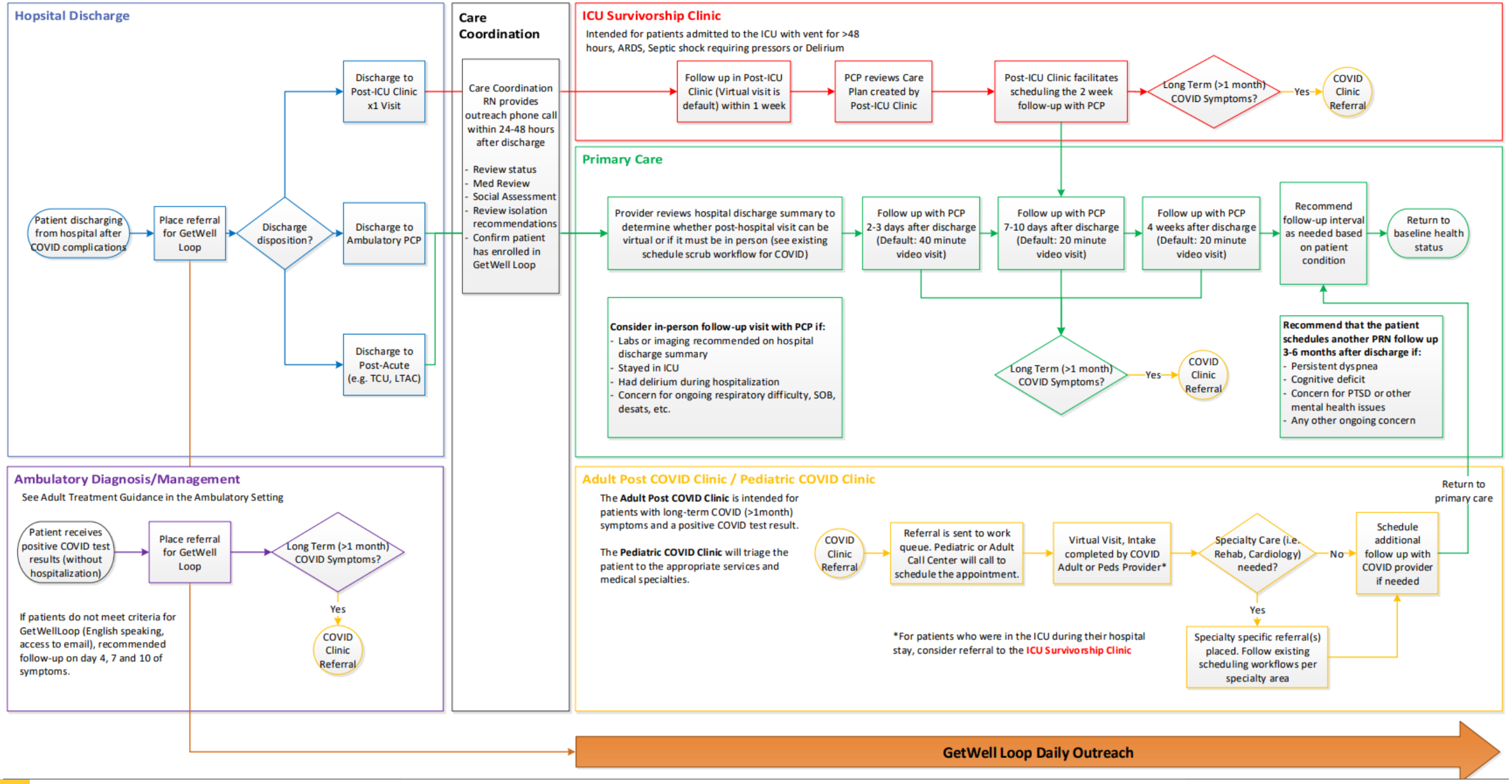
Leslie Morse, DO
Department Head and Professor,
Department of Rehabilitation Medicine
University of Minnesota School of Medicine

Disclosures/Conflicts

- No relevant disclosures or conflicts to report

Identification of a Clinical Need

- Care Map Developed and Implemented (2/2021)
- Clinics
  - ICU Survivorship Clinic
  - Post COVID Adult Clinic
  - Direct Therapy Referrals
  - Pediatric Clinic


Hospital Discharge
Patient discharging from hospital after COVID complications
Place referral for GetWell Loop
Discharge disposition?
Discharge to Post-ICU Clinic x1 Visit
Discharge to Ambulatory PCP
Discharge to Post-Acute (e.g. TCU, LTAC)
Care Coordination
Care Coordination RN provides outreach phone call within 24-48 hours after discharge
- Review status
- Med Review
- Social Assessment
- Review isolation recommendations
- Confirm patient has enrolled in GetWell Loop
ICU Survivorship Clinic
Intended for patients admitted to the ICU with vent for >48 hours, ARDS, Septic shock requiring pressors or Delirium
Follow up in Post-ICU Clinic (Virtual visit is default) within 1 week
PCP reviews Care Plan created by Post-ICU Clinic
Post-ICU Clinic facilitates scheduling the 2 week follow-up with PCP
Long Term (>1 month) COVID Symptoms?
Yes
COVID Clinic Referral
Primary Care
Provider reviews hospital discharge summary to determine whether post-hospital visit can be virtual or if it must be in person (see existing schedule scrub workflow for COVID)
Follow up with PCP 2-3 days after discharge (Default: 40 minute video visit)
Follow up with PCP 7-10 days after discharge (Default: 20 minute video visit)
Follow up with PCP 4 weeks after discharge (Default: 20 minute video visit)
Recommend follow-up interval as needed based on patient condition
Return to baseline health status
Consider in-person follow-up visit with PCP if:
- Labs or imaging recommended on hospital discharge summary
- Stayed in ICU
- Had delirium during hospitalization
- Concern for ongoing respiratory difficulty, SOB, desats, etc.
Long Term (>1 month) COVID Symptoms?
Yes
COVID Clinic Referral
Recommend that the patient schedules another PRN follow up 3-6 months after discharge if:
- Persistent dyspnea
- Cognitive deficit
- Concern for PTSD or other mental health issues
- Any other ongoing concern
Ambulatory Diagnosis/Management
See Adult Treatment Guidance in the Ambulatory Setting
Patient receives positive COVID test results (without hospitalization)
Place referral for GetWell Loop
Long Term (>1 month) COVID Symptoms?
Yes
COVID Clinic Referral
If patients do not meet criteria for GetWellLoop (English speaking, access to email), recommended follow-up on day 4, 7 and 10 of symptoms.
Adult Post COVID Clinic / Pediatric COVID Clinic
The Adult Post COVID Clinic is intended for patients with long-term COVID (>1month) symptoms and a positive COVID test result.
The Pediatric COVID Clinic will triage the patient to the appropriate services and medical specialties.
COVID Clinic Referral
Referral is sent to work queue. Pediatric or Adult Call Center will call to schedule the appointment.
Virtual Visit, Intake completed by COVID Adult or Peds Provider*
Specialty Care (i.e. Rehab, Cardiology) needed?
No
Schedule additional follow up with COVID provider if needed
Return to primary care
Yes
Specialty specific referral(s) placed. Follow existing scheduling workflows per specialty area
*For patients who were in the ICU during their hospital stay, consider referral to the ICU Survivorship Clinic
GetWell Loop Daily Outreach

Ambulatory COVID Care Options

Post COVID Care	ICU Survivorship	Adult Clinic	Pediatric Clinic	Rehab Therapies
Patient Criteria	*Any ONE of the following): Intubation > 48 hours, diagnoses of ARDS (Acute Respiratory Distress Syndrome), Shock of any kind, ICU delirium (COVID AND non-COVID patients).*	*Centralized service for patients experiencing ongoing, longer term physical and/or cognitive symptoms resulting from COVID (long haulers). Ideal patients will be 3-4 weeks post-hospital discharge or non-hospitalized with ongoing functional deficits.**	*Centralized evaluation service for pediatric patients who have been potentially exposed to COVID-19 or are COVID-19 positive (asymptomatic or symptomatic both acute and long-term) to facilitate optimal care.**	*Post COVID confirmed. Direct outpatient referrals to individual M Health Fairview Rehabilitation Services (PT, OT, Speech, Pulmonary Rehab, Cardiac Rehab) can be entered at any stage as needed (i.e., upon discharge, at follow-up with primary care, following post-COVID clinic, etc.).*
Description	*Centralized multi-disciplinary care for critical illness survivors, patients are seen by pulmonary/critical care specialists, as well as a clinical psychologist. The provider will identify unique patient needs, develop a treatment plan, and refer to other services if needed.*	*Clinic provides an initial comprehensive assessment virtually by a COVID provider designated by the M Health Fairview Physical Medicine and Rehabilitation Dept. The provider will identify the patients' needs, develop a treatment plan, and refer patients to physical therapy, occupational therapy, speech therapy, pulmonary rehab, cardiac rehab, neuropsychology, behavioral health, and other specialty services as appropriate.*	*Clinic providers an initial intake assessment virtually, by a specific provider at the UMP Peds ID Department, who will identify the patients' needs, develop a treatment plan, and refer patients pediatric physical therapy, occupational therapy, speech therapy, pulmonary rehab, cardiac rehab, neuropsychology, behavioral health, and other specialty services as appropriate.*	*If only one service is ordered, rehab therapists will screen for additional rehab needs and request further orders as needed. Therapists create individualized treatment plans to address each patient's unique post-COVID rehabilitation needs and goals. Clinical focus and therapist training are based on the most current COVID literature and best practices.*
Referral Options	*M Health Fairview Epic and Legacy HealthEast Epic: Go to Add Order; Search "ICU Survivorship Clinic" complete and sign order.* *OR* *Submit through COVID-19 Epic SmartSet.*	*Referrals will be routed via Epic to the Adult Call Center for scheduling. M Health Fairview Epic and Legacy HealthEast Epic: Go to Add Order; Search "Adult Post-COVID Clinic Referral"; Select Order; Complete and sign.* *OR* *Submit through COVID-19 Epic SmartSet.*	*Referrals will be routed via Epic to the Call Center for scheduling. M Health Fairview Epic and Legacy HealthEast Epic: Go to Add Order; Search "Pediatric COVID Clinic Referral"; Select Order; Complete and sign.* *OR* *Submit through COVID-19 Epic SmartSet.*	*Referrals – M Health Fairview and Legacy HealthEast Epic: Submit referrals to M Health Fairview Rehabilitation Services per the normal process. Indicate COVID-19 on the referral as appropriate.* *OR* *Submit through COVID-19 Epic SmartSet.*

Post COVID Adult Clinic

- The new M Health Fairview Adult Post-COVID Clinic was launched in December 2020 to respond to the unique recovery needs of COVID survivors. The Clinic intends to treat post-COVID patients who have either been hospitalized and are 3-4 weeks post-hospital discharge or have not been hospitalized but exhibit ongoing functional deficits. The Post-COVID Clinic will provide each patient with a virtual health assessment to identify predominant symptoms and rehabilitation needs in order to make an individualized treatment plan and refer the patient to the appropriate specialists. Featured specialties include physical therapy, occupational therapy, speech therapy, pulmonary rehab, cardiac rehab, neuropsychology, and behavioral health.
- Referrals (referrals will be routed via Epic to the Adult Call Center for scheduling)
  - M Health Fairview Epic and Legacy HealthEast Epic: Go to Add Order; Search Adult Post-COVID Clinic Referral; Select Order; Complete and Sign Order
  - OR Submit through COVID-19 Epic SmartSet
  - Call 612-626-6688

Novel Aspects of the Post Covid Adult Clinic

- Multi-disciplinary in nature but housed/supported by PMR Clinic
  - Collaborative in nature
  - Internal Medicine, Physiatrists, Infectious Disease, Neurology Providers
  - Entirely Virtual clinic with virtual rooming support from the Innovation Lab
  - Supported by Adult Neuropsychology Division
  - Framework for an interdisciplinary learner experience

Working Groups

- COVID Clinician Working Group
  - Continues to meet weekly to share challenging cases and current evidence-based clinical approaches
- COVID Research Group
  - Continues to meet weekly
- COVID Ops Working Group
  - Met weekly initially, now monthly to

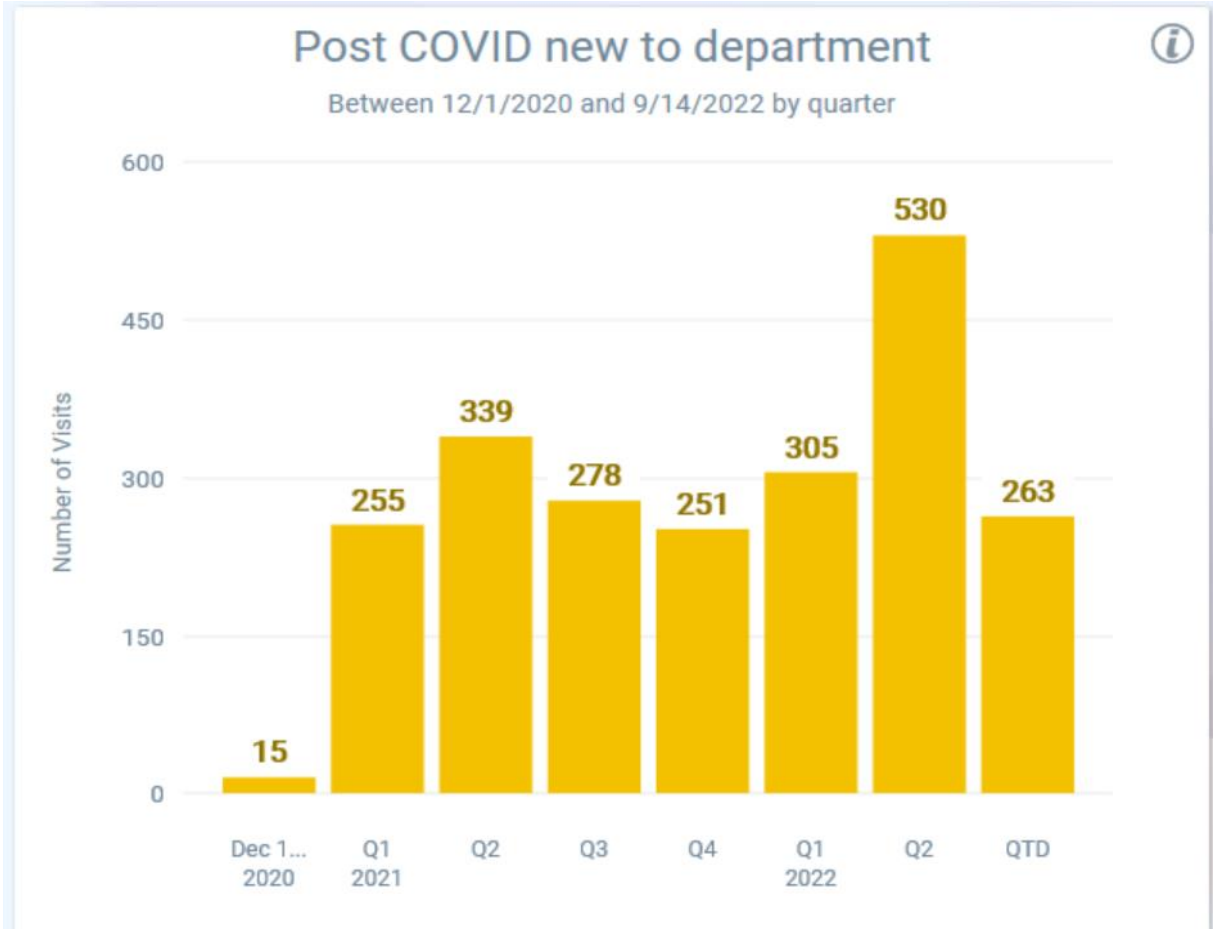
Meeting the Need

- All Initial Visits are Virtual
- Dedicated team of visit facilitators troubleshoot any technical challenges, “room” the patients and schedule follow-ups
- In 2021, access was a challenge most patients were scheduling several months out.
- In 2022, brought in additional MD and APP
- Currently, available access is one to two weeks out

It's very disappointing that it takes 3 months to get in for covid care

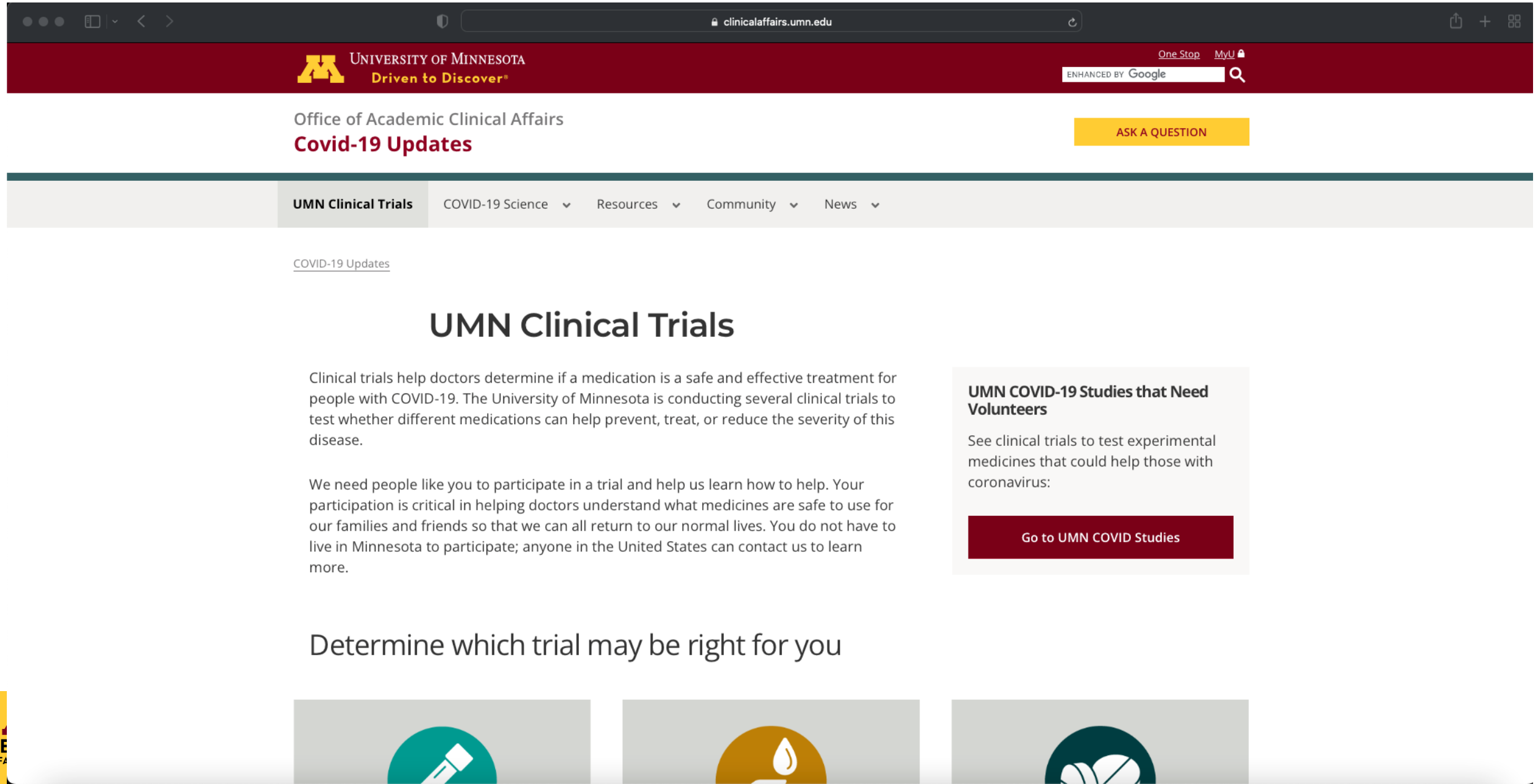
This appointment was at the post COVID clinic — was the best communication I have ever had with a provider — it was a virtual visit and I felt as though Elena's attention was totally focused on me — I have since told several people about this clinic knowing they will get the help they need to deal with this terrible illness — on a scale of 1 to 10 it rates a 10+++++++ — thanks for this opportunity

Patient Volumes



Having long Covid is such an isolating and difficult thing to live through. The caring nature of the team and the detailed and precise way of caring for me brought me to tears with relief. You made a positive difference in my life with just this first visit. Truly, thank you.

COVID Research



Long Term Neuropsych Outcomes

- UMN group published 3 papers describing long term (6 month) cognitive and psychological outcome from COVID-19
  - examined consecutive outpatients referred from our Long COVID clinic for neuropsychological evaluation
  - All cognitive domains, performance validity, and emotional functioning were examined

Whiteside, D.M., Naini, S.M., Basso, M.R., Waldron, E., Holker, E., Porter, J., Niskanen, N., Melnik, T., & Tayor, S. (2022b). Outcomes in Post-Acute Sequelae of COVID-19 (PASC) at 6 Months Post-Infection Part 2: Psychological Functioning. Published online in *The Clinical Neuropsychologist* on January 31, 2022 .

Whiteside, D.M., Basso, M.R., Naini, S.M., Waldron, E., Holker, E., Porter, J., Melnik, T., Niskanen, N., & Tayor, S. (2022a). Outcomes in Post-Acute Sequelae of COVID-19 (PASC) at 6 Months Post-Infection Part 1: Cognitive Functioning. Published online in *The Clinical Neuropsychologist* on February 8, 2022.

Whiteside, D.M. Olynick, V., Holker, E., Waldron, E., Porter, J., & Kasprzak, M. (2021). Neuropsychological deficits in three patients with COVID-19 infection in post-acute physical rehabilitation: A case series and proposed model. *The Clinical Neuropsychologist, 35(4),* 799-818 .

Cognitive Functioning in Long COVID-19

- Results suggest that objective cognitive functioning and subjective complaints do not match up
- Results were consistent with other new research suggesting that biomarkers for neurological dysfunction normalized after 6 months post-infection (Kanberg et al., 2021)
- Objective results are related to mood/anxiety rather than neurological dysfunction
- Other factors such as fatigue may play a role
- PVTs need to be included
- Mental Health interventions important for Long COVID patients

Psychological Functioning Conclusions

- Somatic pre-occupation and anxiety are common
- Depression is also common
- Anxiety about cognitive functioning was also prevalent
- Is this a somatization disorder?
  - Many participants did not fit this diagnostic category well in spite of the somatic preoccupation
  - Seems to more depression/anxiety
  - Considerable stress for many participants and high prevalence of premorbid psychiatric issues

Conclusions

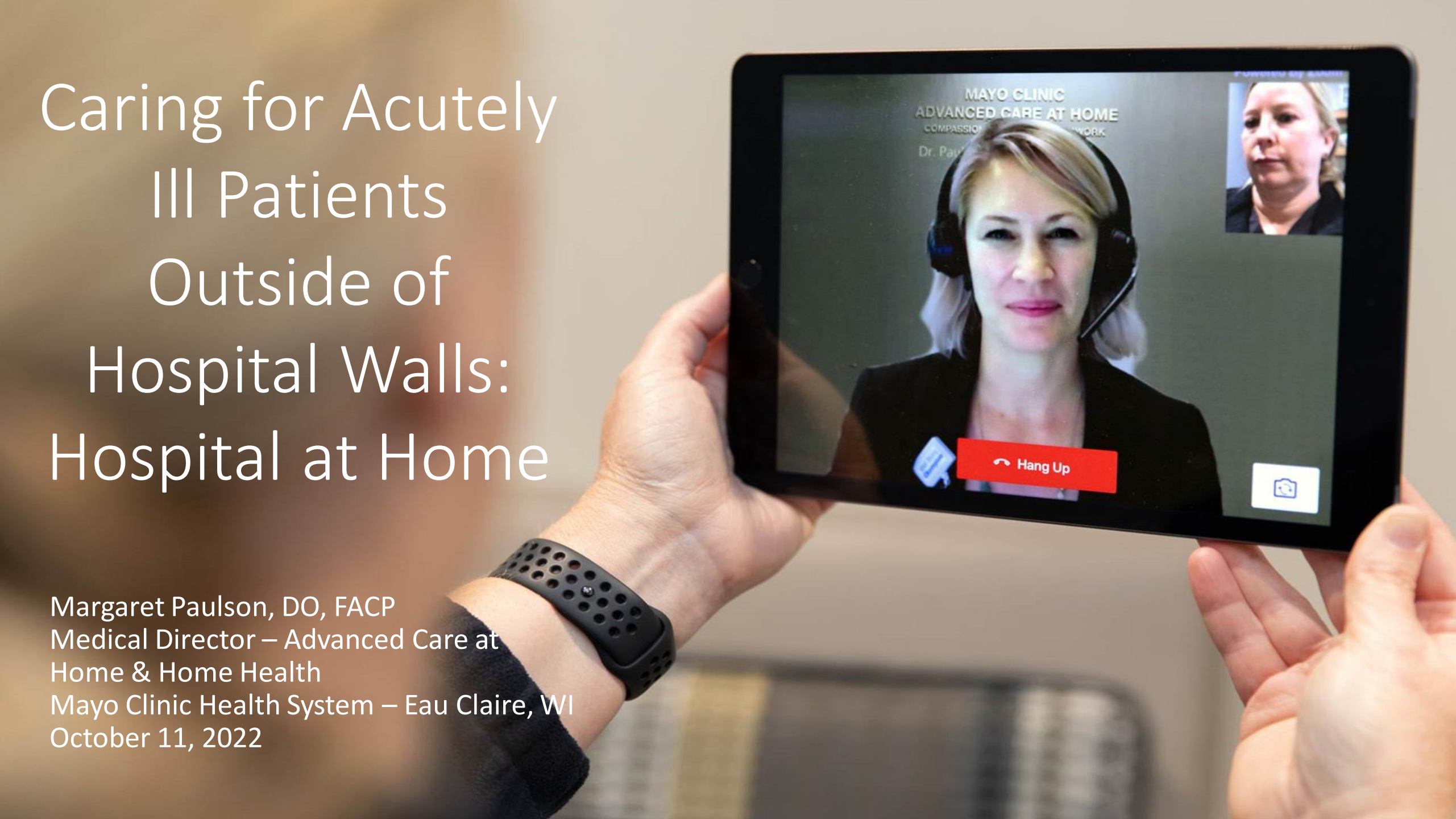
- Increasing evidence that cognitive concerns in PASC are related to current psychiatric and psychological issues
  - Clinicians should include recommendations/referrals for mental health issues
- Disrupted sleep, fatigue and pain may also play a role
- Evidence argues against neurological disruption at this time
- However, the research is still limited
- Cognitive complaints and objective cognitive functioning are not correlated.
  - Why?
  - Misattribution of symptoms, overestimation of premorbid functioning, and even intentional feigning should be considered

Clinical Research Efforts

- Existing Clinical Databases
  - Neuropsych retrospective and prospective
  - Rehab (retrospective)
- ALPS-COVID trial: A longitudinal bioassay study of Covid-19 and angiotensin receptor blockade
  - Chris Tignanelli, MD
  - Mike Puskarich, MD
- Planned Projects
  - assess mortality (post ICU)
  - Patient registry

Thank You!

Caring for Acutely Ill Patients Outside of Hospital Walls: Hospital at Home



Margaret Paulson, DO, FACP
Medical Director – Advanced Care at Home & Home Health
Mayo Clinic Health System – Eau Claire, WI
October 11, 2022

Disclosures

- None

Advanced Care at Home

The Original Home Hospital

The Doctor 1891 Oil on Canvas by Luke Fildes

Advanced Care at Home

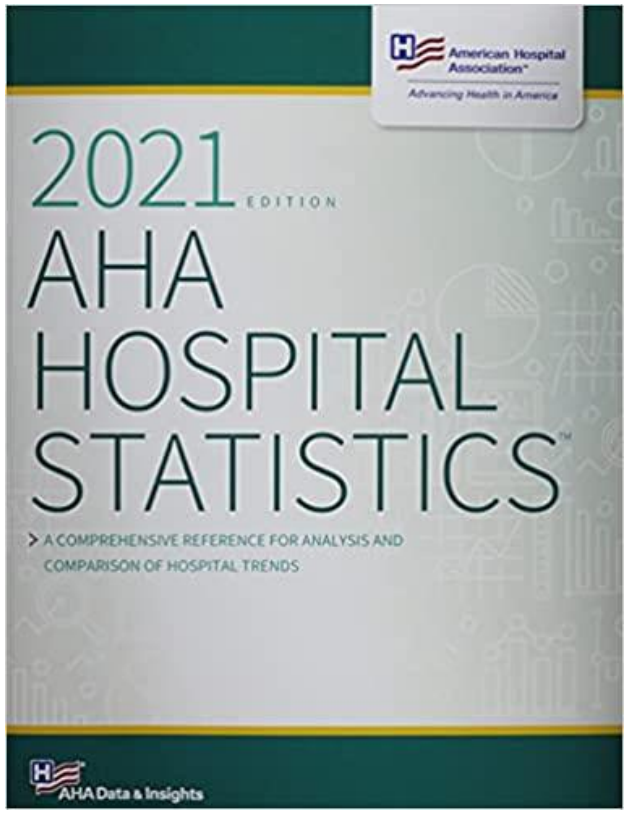
First Hospital in the United States

Photograph by Matt Freed, Post Gazette

- Pennsylvania Hospital -1751
  - Dr. Thomas Bond and Ben Franklin
  - “To care for the sick-poor and insane who were wandering the streets of Philadelphia”

From 1751 to 2021

- Over 6000 hospitals in the United States
- >900,000 hospital beds
- >36 million admissions annually
- >$1.1 trillion – hospital costs



MAYO CLINIC

Annals of Internal Medicine®

Ideas and Opinions | 6 October 2020

How Hospital Stays Resemble Enhanced Interrogation

Kenneth J. Mishark, MD, Holly Geyer, MD, Peter A. Ubel, MD

Author, Article and Disclosure Information

https://doi.org/10.7326/M19-3874

Advanced Care at Home

MAYO CLINIC

What problems can hospital at home solve?

Problem Solved: Capacity

National

Inside a hospital as the coronavirus surges: Where will all patients go?

An open bed is "a gift" at a Wisconsin hospital where patients can't belie people still don't take covid-19 seriously

Mayo Clinic paramedic Adam Glass, center, helps load an ambulance that will take her from the Eau Claire, W will finish her recovery while being monitored electro/ by Michael S. Williamson/The Washington Post)

StarTribune

CORONAVIRUS

'No beds anywhere': Minnesota hospitals strained to limit by COVID-19

Open ICU beds were down to single digits in some parts of Minnesota last week, when Gov. Tim Walz ordered a four-week shutdown of bars and other venues.

By Jeremy Olson Star Tribune | NOVEMBER 22, 2020 — 11:40AM

GALLERY GRID 1/12

Related Covera

Minnesota reports 6 COVID-19 cases, 5 deaths

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By The Numbers

Federal Data Reveal Which Hospitals Are Dangerously Full This Week. Is Yours?

February 8, 2021 · 3:15 PM ET

SEAN MCMINN AUDREY CARLSEN

TRACKING THE CORONAVIRUS

U.S. cases Hospitals Vaccines World cases

Problem Solved: Quality

2009 Meta-Analysis

- Meta-analysis of 10 HaH RCTs including n=1,372 patients
- 38% reduction in six month mortality ($p<0.05$)
- Trend toward higher patient satisfaction
- Trend toward reduction in cost.

2012 Meta-Analysis

- Meta-analysis of 61 HaH RCTs including n=6,992 patients age >16 yrs
- 19% reduction in mortality ($p<0.05$)
- 25% reduction in readmission ($p<0.05$)
- Significant reduction in cost
- Higher patient satisfaction

Shepperd S, Doll H, Angus RM, et al. Avoiding hospital admission through provision of hospital care at home: a systematic review and meta-analysis of individual patient data.CMAJ. 2009. 180(2):175-182.
Caplan, GA, Sulaiman NS, Mangin DA, et al. A meta-analysis of "hospital in the home". MJA. 2012 197(9): 512-519.

Problem Solved: Quality

JAMA Internal Medicine | Review

Alternative Strategies to Inpatient Hospitalization for Acute Medical Conditions
A Systematic Review

Jared Conley, MD, PhD, MPH; Colin W. O'Brien, BS; Bruce A. Leff, MD; Shari Bolen, MD, MPH; Donna Zulman, MD, MS

- Improved sleep
- Increased mobility
- Improved recovery rates
- Reduced fall rates
- Higher patient engagement levels
- Reductions in the rates of incident delirium
- Reduced use of physical or chemical restraints
- Reduced sedative medication use
- *Beyond these measured patient outcomes, the research revealed high levels of provider satisfaction with the model*

Annals of Internal Medicine | ORIGINAL RESEARCH

Hospital-Level Care at Home for Acutely Ill Adults
A Randomized Controlled Trial

David M. Levine, MD, MPH, MA; Kei Ouchi, MD, MPH; Bonnie Blanchfield, ScD; Agustina Saenz, MD, MPH; Kimberly Burke, BA; Mary Paz, BA; Keren Diamond, RN, MBA; Charles T. Pu, MD; and Jeffrey L. Schnipper, MD, MPH

Clinical

- HaH patients used fewer healthcare resources
- Improved activity levels, equivalent functional status, fewer safety events
- Length of stay, patient quality & safety measures, patient satisfaction similar between groups

Readmission

- No HaH patients were transferred back to an acute care hospital in this study
- Patients were significantly less likely to require readmissions within 30 days (7% vs. 23%)

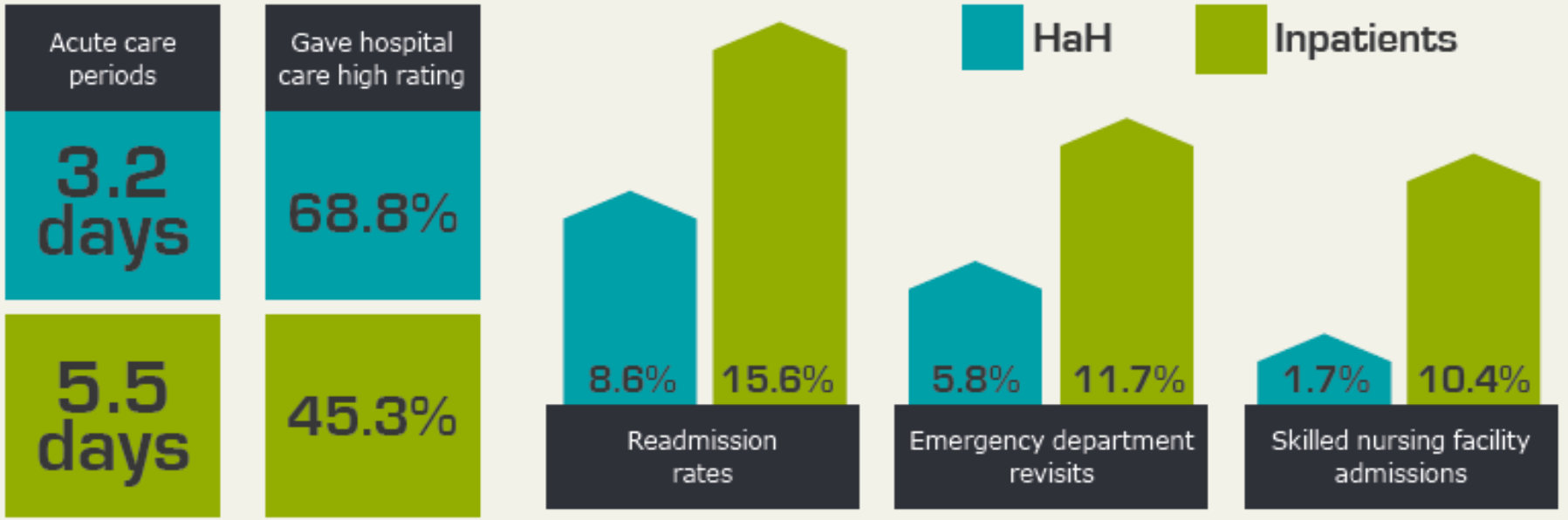
Cost Reduction

- Adjusted direct cost of HaH [and HaH acute plus 30-day post–acute period] was by 20-40% of inpatient hospital control arm

Problem Solved: Utilization

Hospital-at-Home vs. Hospital Inpatients

In 2014, the Center for Medicare and Medicaid Innovation gave the Icahn School of Medicine at Mount Sinai a grant to study the clinical effectiveness of hospital-at-home (HaH) care bundled with a 30-day postacute period of home-based transitional care. The researchers compared the outcomes of 295 patients participating in the HaH project and 212 concurrently admitted hospital inpatients who were HaH eligible but refused participation or who were seen in emergency departments when a HaH admission could not be initiated. Results included the following:



Source: JAMA Intern Med 2018;178(8):1033-40.

resounding yes. In fact, we couldn't be more serious.

Mount Sinai's number one mission is to keep people out of the hospital. We're focused on population health management, as opposed to the traditional fee-for-service medicine. So instead of receiving care that's isolated and intermittent, patients receive care that's continuous and coordinated, much of it outside of the traditional hospital setting.

programs designed to help people stop smoking, lose weight and battle obesity, lower their blood pressure and reduce the risk of a heart attack. By being as proactive as possible, patients can better maintain their health and avoid disease.

Our Mobile Acute Care Team will treat patients at home who would otherwise require a hospital admission for certain conditions. The core team involves physicians, nurse practitioners, paramedics, care coaches, physical therapists, occupational therapists, speech therapists, and home health aides.

Meanwhile, Mount Sinai's Preventable Admissions Care Team provides transitional care services to patients at high risk for readmission. After a comprehensive bedside assessment, social workers partner with patients, family caregivers and healthcare providers to identify known risks such as

continuing support after discharge.

It's a sweeping change in the way that health care is delivered. And with the new system comes a new way to measure success. The number of empty beds.

1-800-MD-SINAI
mountsinaihealth.org

Mount Sinai

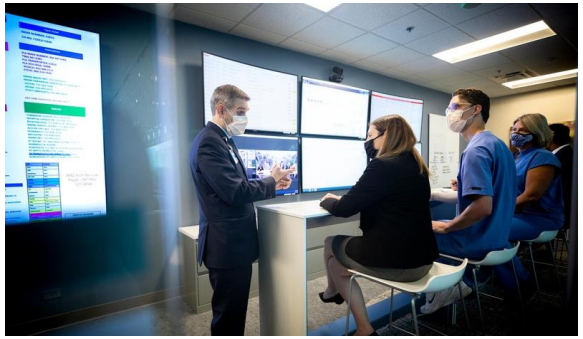
IF OUR BEDS

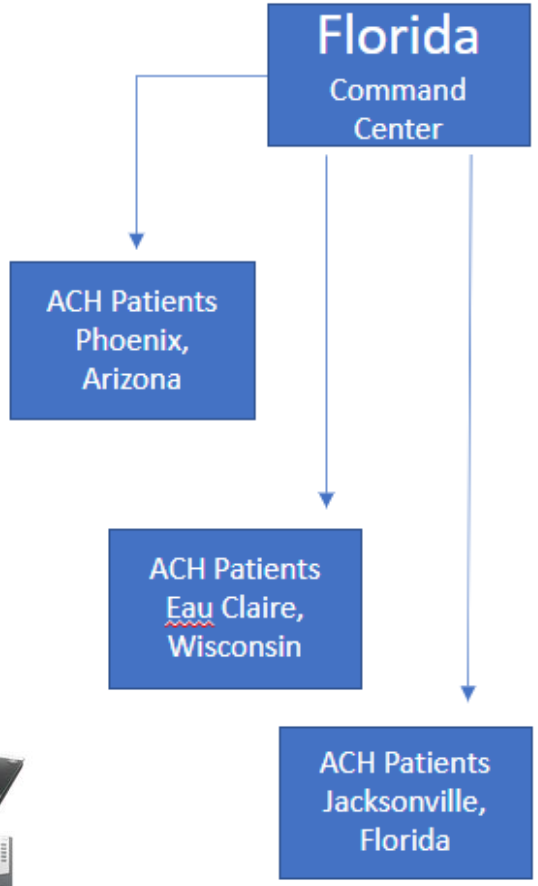
ARE FILLED,

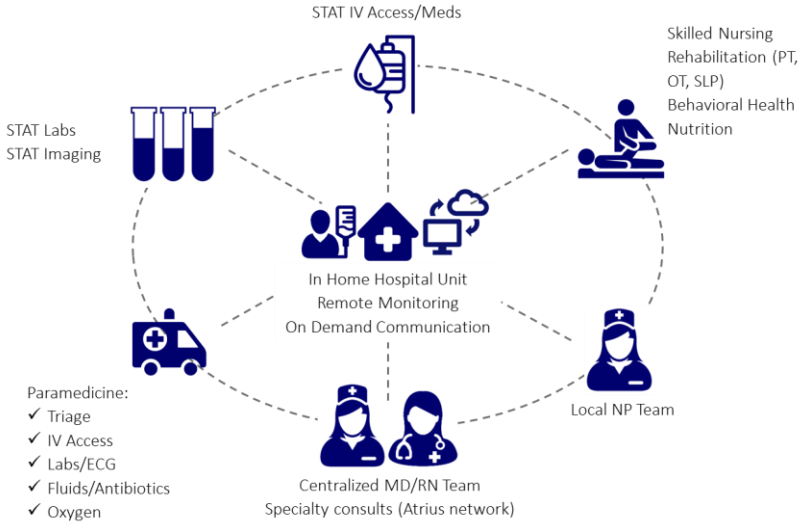
IT MEANS WE'VE FAILED.

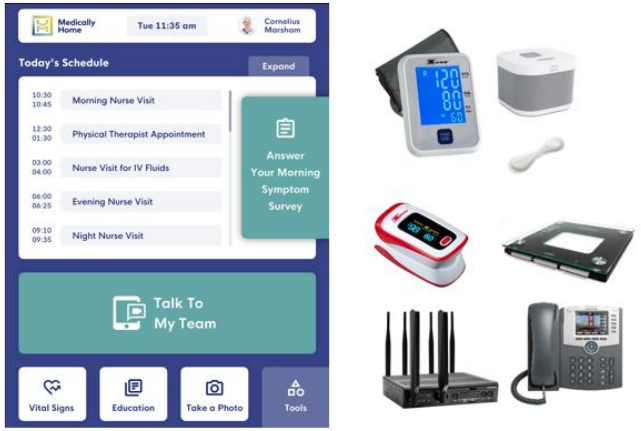
Advanced Care at Home Key Components

- Command Center
- In-Home Technology
- Supplier Network

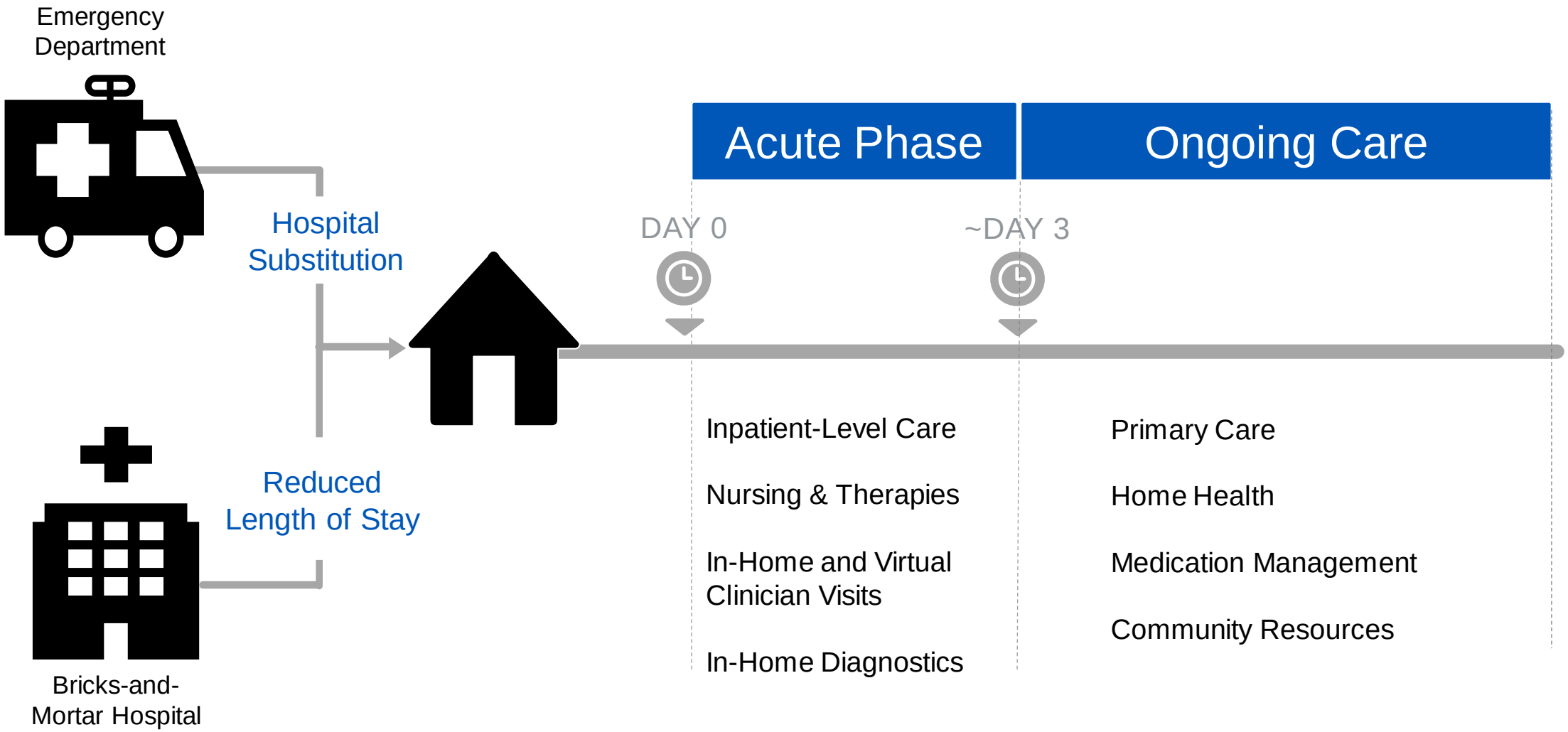








ACH Patient Journey



Mayo Clinic Experience Providing HaH Care

Severity of Illness

2.8

Acuity of patients in ACH is comparable to the B&M hospital demonstrating that acute, but stable patients can effectively be cared for at home

Reducing Readmissions

25%

30-day hospital readmission is approximately 25-30% lower than the comparable population within the traditional hospital practice

Post ACH Mortality

<2%

of patients that participated in ACH passed away within 30 days following their episode of care, not including hospice patients

Likelihood to Recommend

4.8

Patient ranking, on a scale of 1 to 5, of how likely they are to recommend ACH to a family member or friend

Patients Treated

1300+

Patients treated in our home hospital program since the inception of the program

Provider Experience

4.5

Provider ranking, on a 1 to 5 scale, of how likely they are to recommend ACH to their family and friends

Reimaging In-Home Care Across the Continuum

Advocacy

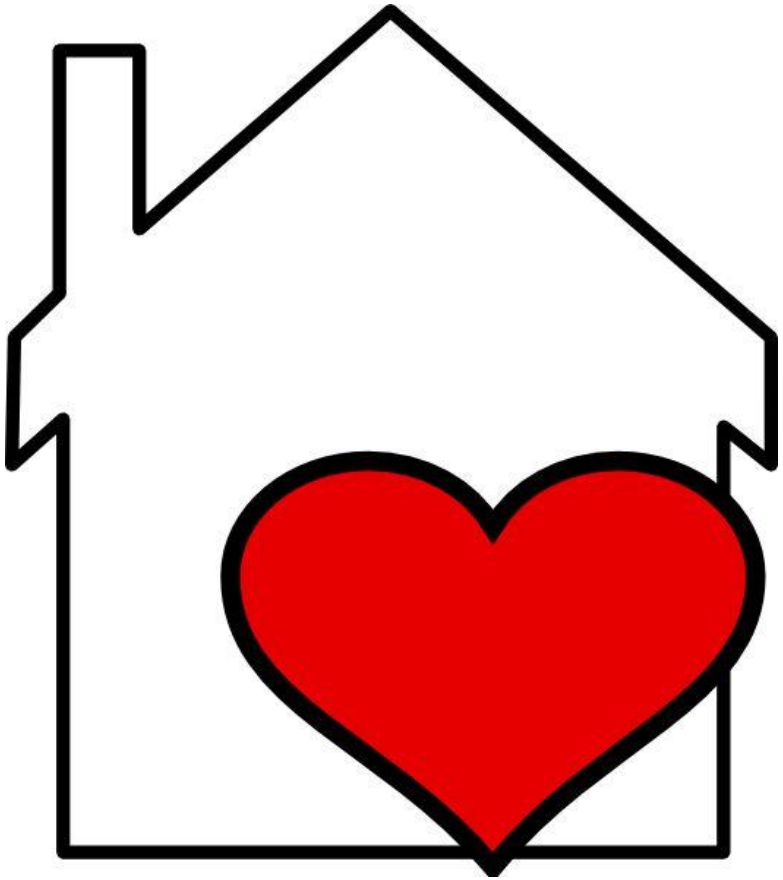
- Current CMS waiver reimbursing hospital at home care tied to PHE
- Hospital Inpatient Services Modernization Act
  - S.3792
  - H.R. 7053
- Payer and provider collaboration on emerging models of care

The Needs of the Patient Come First

Thank you!

Paulson.Margaret@mayo.edu

@DrMPaulson



Break

Upcoming at 3:05 p.m. - Breakout Sessions

Conference room 106

Breakout Session #4: Risk recapture strategies to support providers and members

Attendees will hear from a health system and payer on how they are partnering to engage providers in risk recapture strategies to ensure the risk of the population is accurately captured.

Conference room 101

Breakout Session #5: Engaging patients with primary care

During this breakout session attendees will learn approaches to engaging patients with primary care. Attendees will learn from Park Nicollet on how they use their care consultants to ensure patients at risk receive appropriate follow-up and care. Medica will present member outreach models that have targeted non-users, preventable emergency department utilization, as well as out-of-network utilization.

Up next:

Breakout Session #5

Engaging Patients with Primary Care

Start time: 3:05 pm

Welcome to Breakout Session 5

Engaging Patients with Primary Care

Breakout session 5

Hailee Buehler, RN, MBA Value Based Program Manager, Medica

Hailee Buehler RN, MBA is a Value Based Program Manager at Medica. Hailee's current role focuses on working closely with value-based care partners on clinical strategies and initiatives. Many of her projects involve implementing creative strategies to outreach to members to engage them with their ACO network. Hailee received her Bachelor's in Science Nursing from Winona State and recently completed her Master's in Business Administration. She is becoming a certified risk adjustment coder as risk adjustment is one of her areas of expertise. She has experience working as a clinical operations leader for a clinic that focused on delivering value based care to complex populations. This is where she developed a passion for engaging members with primary care as she feels it is an essential piece to managing complex patients.

Breakout session 5

Angela Booher, RN, Sr. Director Care Coordination & Population Health, Park Nicollet

Currently the Senior Director of Care Management/Care Coordination and Population Health at HealthPartners. Has worked the past twenty years across the care continuum as a nurse specializing in Care Management, Process Improvement and Value Based Care. Has had the privilege to experience multiple leadership roles across the care continuum including post-acute, payer, in-patient, ambulatory and consulting.

Breakout session 5

Dan Albright, MD, Regional Medical Director, Park Nicollet

Dan Albright, MD is a double-boarded physician of internal medicine and pediatrics. His expertise is in clinician compensation, population health and care model redesign. He has been a primary care operational leader for the past 13 years.

DRIVING VALUE-BASED CARE

Engaging Members with Primary Care

Hailee Buehler

RN, MBA, Value Based Program Manager

Program description: The beginning of this breakout session will explore the engagement efforts underway at Medica. This discussion will highlight two strategies that were implemented within our IFB population to engage members in primary care. The third strategy spans across all eligible members in Value Based products.

Agenda

Trusted health plan of choice

- Unattributed member campaign
- Alternatives to the Emergency Department (ED)
- Out-of-Network (OON) Warm Handoff Process

Strategic Initiatives- 2022

Strategic Engagement

	Met	Voted
Essentia Health	✓	✓
M Health Fairview	✓	✓
CHI Health	✓	✓
Park Nicollet	✓	✓
Altru	*	*
MU Health	✓	✓
Via Christi	✓	
Mayo Clinic	✓	✓
UnityPoint	✓	✓
Mercy Health	✓	
Hennepin Health	✓	
St. John	✓	✓
St. Luke's	✓	✓
Ridgeview	✓	✓
LifeCare	✓	✓
Nebraska Health Network	✓	✓
University of Iowa	*	*
North Memorial	*	*

2022 Medica Proposed Strategies

Quarterly Meeting Takeaways

Altru - No quarterly meeting
University of Iowa - No quarterly meeting

MEMBER BEHAVIOR OBJECTIVE

Benefit utilization

- Increase preventive care benefit utilization
- Reduce specialty care only users (Gain PCP attribution)
- Increase use of retail, telehealth and virtual care
- Decrease unattributed members

Network utilization

- Reduce avoidable ED utilization
- Reduce OON ED to inpatient care
- Increasing attribution or transitioning care to preferred PCP provider
- Keep care within network

Unattributed member campaign

What we wanted to do

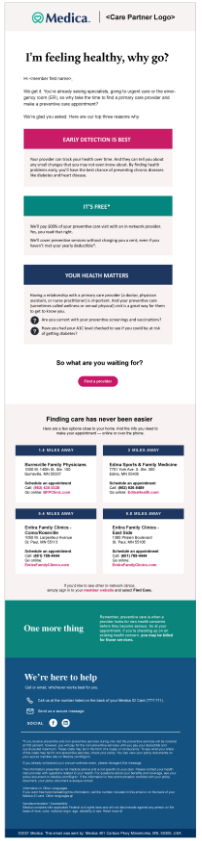
- Increase primary care attribution
- Reduce percentage of non-users and unattributed members

Removed the guesswork with personalization

- Closest primary care clinic locations (2-4)
- Details about how to schedule an appointment with each featured clinic
- Recommended care member based on age and sex

How we were going to drive response

- Non-users: Promotion of annual check up (preventive care services)
- Non-attributed: Establish with PCP

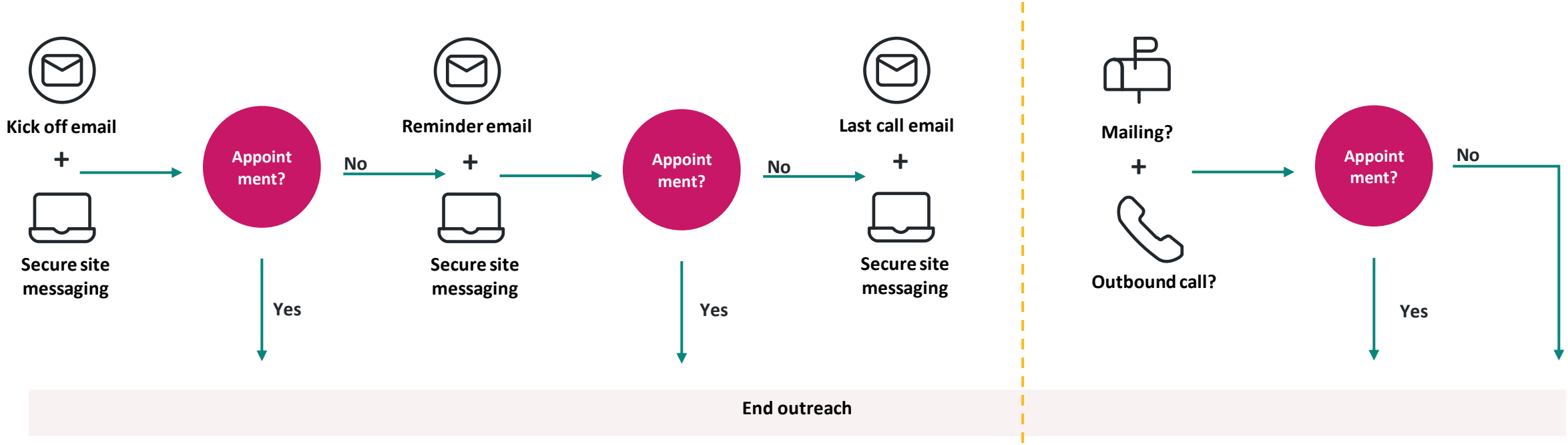


2022 Strategic Initiative:

- Decrease non-user rate by 2% in 2022

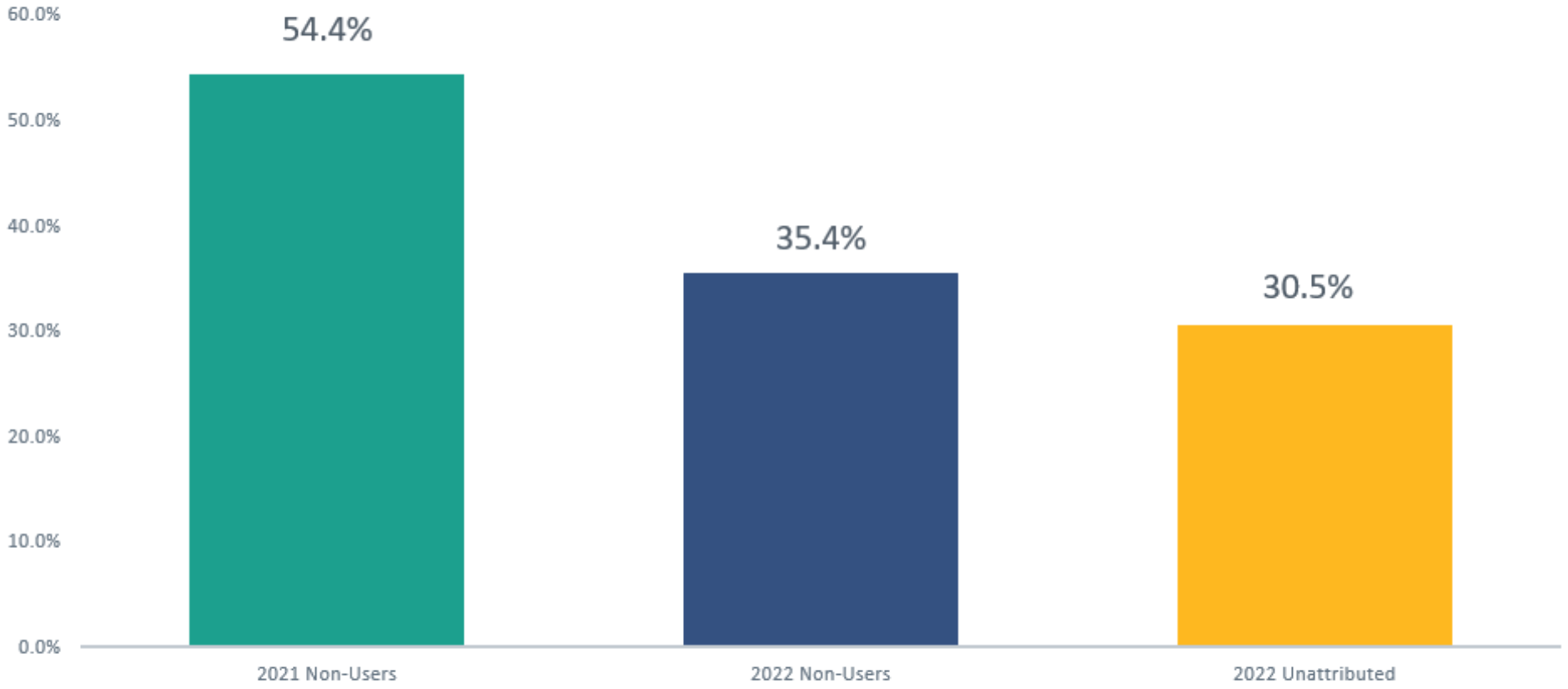
How we're communicating + [care system] support

Medica led digital outreach + opportunity for care system follow up. Members will only continue on the journey if they don't take action to schedule or complete a visit.



Optional: Targeting list hand off for additional outreach by [care system]

2021 and 2022 Unattributed Member Campaign Results



5,400 members in the campaign have become active users in 2022

Alternatives to the ED

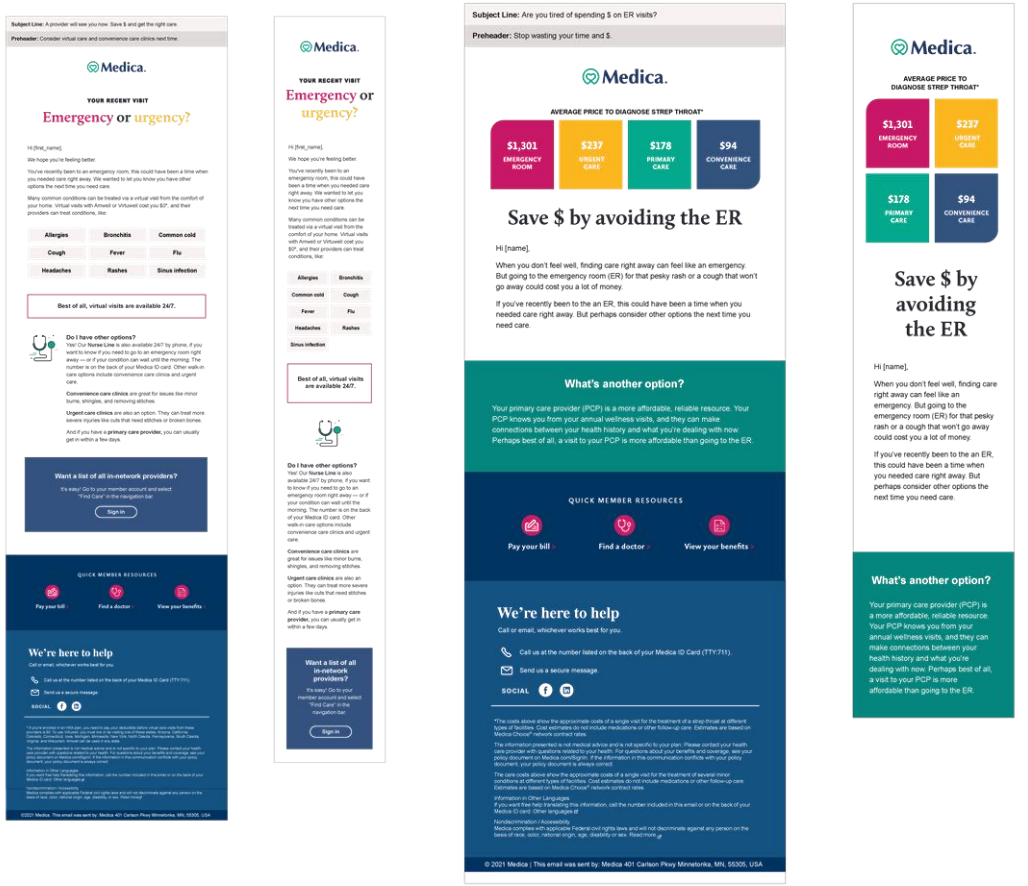
What we wanted to do

- Reduce avoidable ED visits by educating members on alternative options to the ED after a recent visit

How we were going to drive response

- Targeted outreach to help members understand costs for different care settings.
- 6 emails developed and will be deployed based on previous claims history and PCP attribution

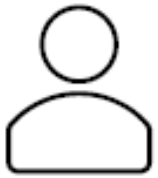
Note: Personalization was not available for phase 1, introducing in 2023.



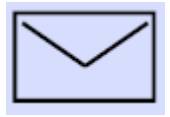
2022 Strategic Initiative:

- Reduce potentially avoidable ED visits by 1% in 2022

Avoidable ED visit reduction



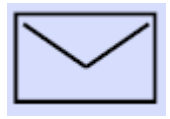
1st ED visit
(12 month look back)



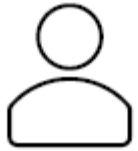
Email outreach

Wait 3 days

If member did not open 1st email, additional outreach

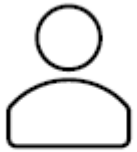


Email outreach



2nd ED visit
(12 month look back)

Email outreach



3rd ED visit
(12 month look back)

Does member have PCP?

Yes

Email outreach

Refer back to PCP

No

Email outreach

Establish with PCP

Alternatives to the ED- Measurement

Latest results

- Emails sent: 670
- Open rate: ~30%

Measurement

- Reduction of overall ED utilization
- Reduction of potentially avoidable ED utilization

Out-Of-Network (OON) warm handoff process

What we wanted to do

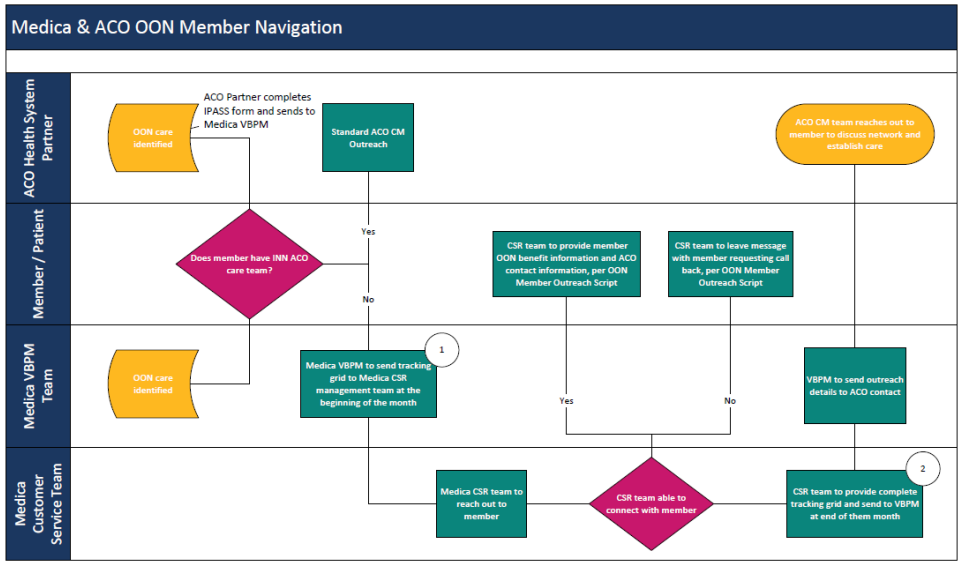
- Educate members on network benefits
- Increase direct spend
- Improve coordination of care
- Close the loop on member outreach

How we were going to drive response

- Medica customer service outreach

How members are identified

- Case management collaboration calls
- ACO identifies OON care
- Medica team identifies OON care



2022 Strategic Initiative:

- Decrease out-of-network utilization by 2% in 2022

So what's the Medica difference?

Member Impact of Warm Handoff Process

THANK YOU

Integration of Team Based Care is a win for patients

by improving quality, experience and efficiencies

Dan Albright, M.D., Regional Medical Director/ Population Health Medical Lead
Angela Booher, RN, MA, Sr. Director Population Health & Care Coordination

HealthPartners®

I	The Purpose and connecting the dots
II	Who we are
III	What we do
IV	Why we did it this way
V	How this helps Patients connect better with Provider(s) and Care Teams
VI	Toolbox

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Our Purpose

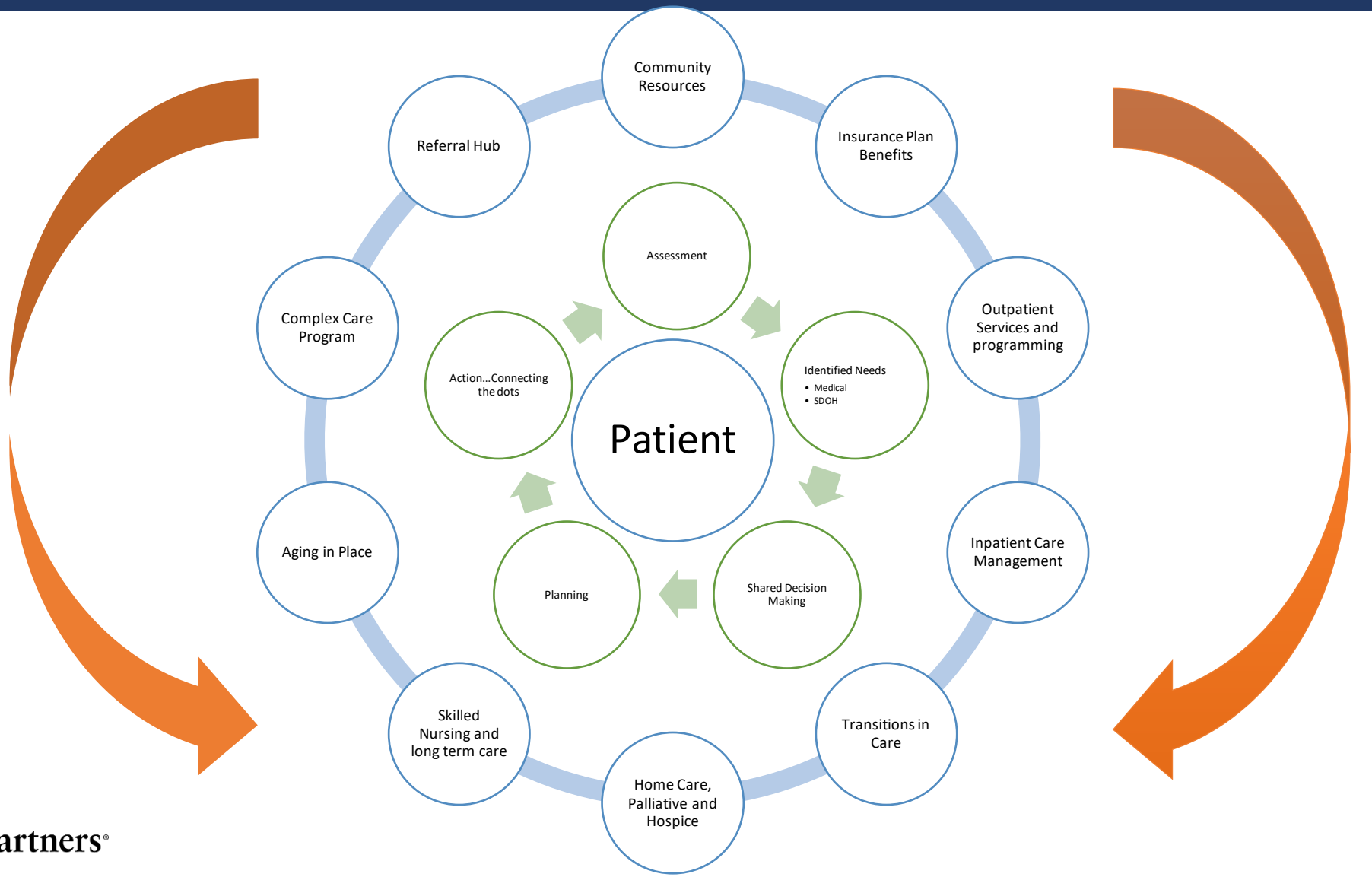
Value-based care flows directly from our vision…health as it could be, affordability as it must be through relationships built on trust

Right **Care**
Right **Provider**
Right **Setting**

with the care necessary to achieve optimal outcomes, with an aligned financial model

HealthPartners

Connecting the Dots



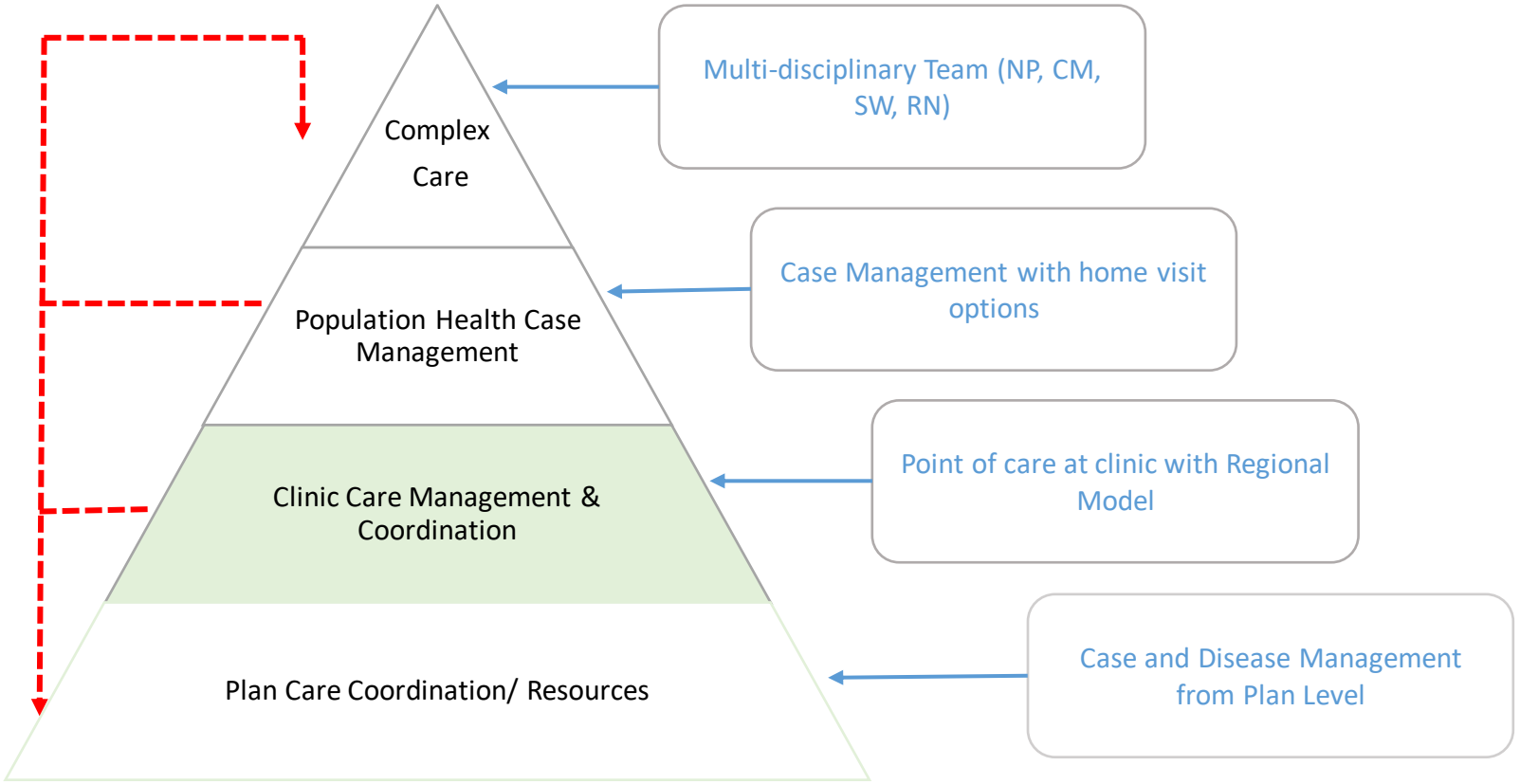
Integrate as a Team

HealthPartners®

Who we Are

Enrollment Triggers:
Patient has significant medical, behavioral or social risk factors (Moderate Complex, Complex, *some* New Chronic in the risk segmentation model)
***NOTE**: patients that are able to manage their own care effectively may not need the level of care management provided by care coordination.*

Key Success Drivers:
Progress towards either return to usual care (able to self-manage) or higher level of care (long-term supports in place); community resource connections; appropriate utilization during and after enrollment (e.g. ↓ER, ↓UC, ↓hospitalizations).



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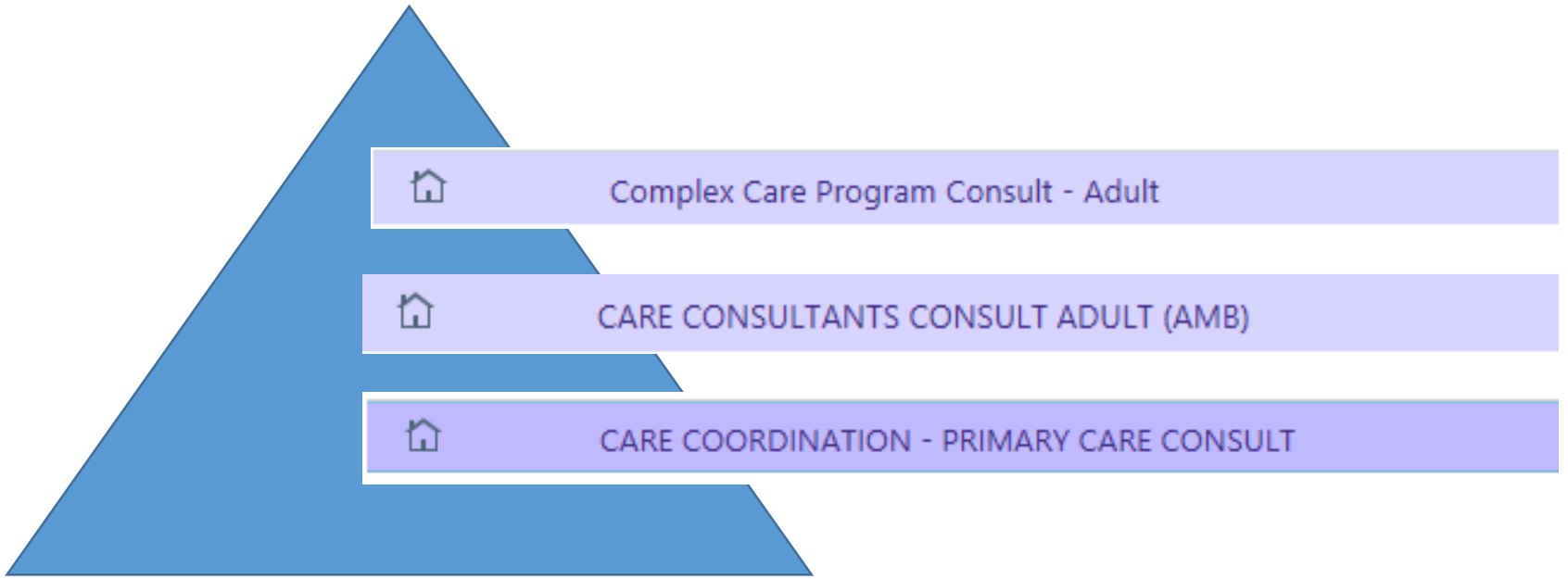
EPIC process for Entering Referral

Case Finding Goal: To catch opportunity prior to Provider entering referral

- Risk screening tools
- Opportunity Reports in EPIC
- Payer Reports
- Post discharge follow-up Reports
- Referral Hub

Referral as back-up: Provider can identify and enter as needed



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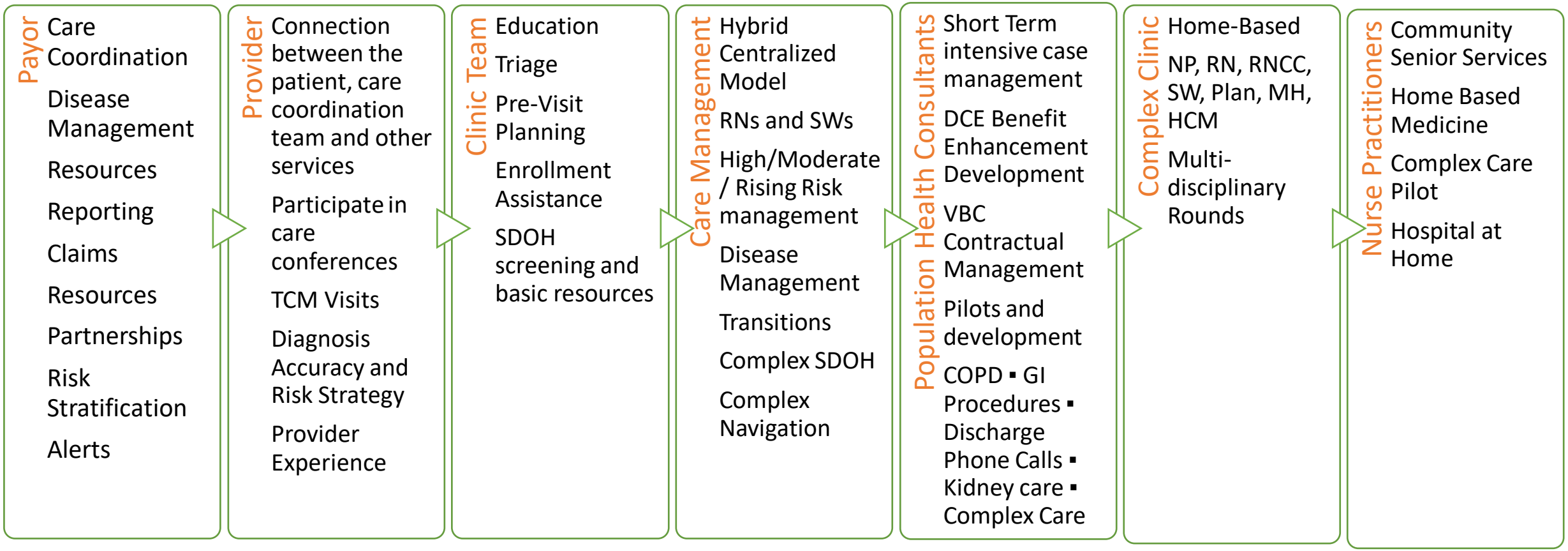
The Team



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Payment models are evolving to support value-based care

Commercial

- HealthPartners commercial plans
- Northwest Alliance
- Hennepin County ACO
- United HC
- Part Nicollet First/ Medica ACO (PN only)
- Medica Choice (PN only)

Medicare & Medicare Advantage

- HealthPartners Medicare Advantage
- Direct Contracting
- Ucare Medicare Advantage
- BCBS Medicare Advantage
- United Medicare Advantage
- Humana Medicare Advantage
- Medica Medicare Advantage
- Medicare Fee-for-Service (HPMG only)

Medicaid

- HealthPartners Prepaid Medical Assistance Program (PMAP)
- MNCare, Special Needs BasicCare (SNBC)
- Minnesota Senior Health Options (MSHO)
- Northwest Alliance (IHP)
- Prime West (MSHO, MSC+ and SNBC Hutchinson)

What we do

Pre-visit care

Proactive Case Finding

- Payer reports
- Risk stratification
- Utilization Trends
- Pharmacy reports
- Opportunity reports

Criteria for a referral –

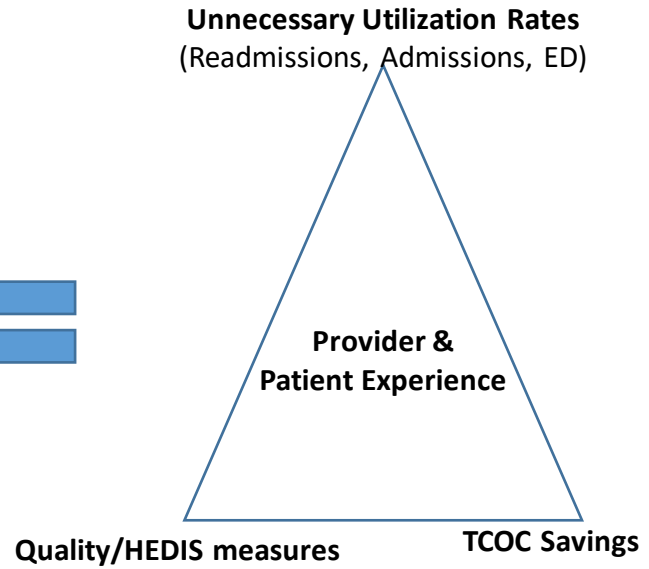
- Patient has significant medical, behavioral or social risk factors that put them at risk for adverse health consequences and need additional complex coordination and care management to achieve optimal outcomes

+

- High/Moderate/Rising Risk
  - Patient activation
  - Adherence/engagement concerns
  - Predictive modeling reports
  - Predictive tools
- Disease Management
  - Acute
  - Complex
- Complex Social Determinants of Health
  - Guardianship/POA
  - Advance Care Planning
  - Appropriate Housing
  - Substance Abuse
  - Complex social situations impacting health
- Transitions of Care
  - Level of Care
  - Utilization
  - Placement
- Complex Navigation Needs
  - Community Services
  - Multiple Providers
  - New to area
  - Newly diagnosed

=

Allows **Provider and Patient** to have **better outcomes** and focus on specific medical needs



Measurement of success – Patient feels empowered and are able to manage on their own or have been set up with the appropriate support(s) to reduce risk of health consequences

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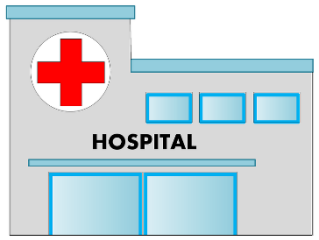
Transitional Care Management (TCM)



Patient discharges from Hospital

Has follow-up with healthpartners Provider

RN Care Consultant contacts patient within 48 hours

- Assesses high or moderate Risk
- Screens and assesses for SDOH
- Medication Reconciliation
- Schedules appointment
- Discusses referrals or needs prior to appointment

Patient arrives at clinic

Clinic Team member rooms patient and preps smartset for Provider

Flowsheet row information from outreach RN call prepopulates into smartset for Provider review

Provider and patient review discharge plan and impact to co-morbidities and update plan as needed

Individualized coordinated care from Hospital to Home

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Post-Discharge Outreach Call

Content Screened for prior to visit

- Does the patient's discharge plan include new or resumption of home care services?
- Does the patient have contact information for the home care agency?
- Was the patient discharged with new orders for DME
- Were there any referrals/orders placed as a result of this call

Questions asked during Discharge Call

I am calling to check in with you now that you are home from the hospital.

- Did you Pick up and start any new medications that were prescribed during this hospital stay?
- Do you have any questions about any of your medications?
- Are you able to afford all of your current prescribed medications?
- Do you know who to call if you have new or worsening symptoms?
- Do you know what questions or concerns to ask your doctor or nurse at your follow up?
- Do you have transportation to your scheduled follow up appointments
- In the past 12 months have you ever run out of food before you had money to buy more
- Do you have financial concerns like rent, utilities or insurance
- Do you have steady housing or a safe place to sleep
- Is there anything else I can help you with today

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Provider Smart Text Draft

Current State Subjective Smart Text

@SUBJECTIVECOLLAPSED@
@PREFNAME@ is a @AGE@ @SEX@ was seen today for follow-up after being discharged from {HOSPITAL LIST HPG:99921000010013} {NUMBER:15880} days ago. The main problem requiring admission was ***. Patient concerns addressed today are ***.

@HPI@. {***(Optional):41603}

@OBJECTIVECOLLAPSED@
@VS@
{***(Optional):41603}

@ASSESSMENTPLAN@
@DIAGMEDREFRESH@
{***(Optional):41603}

@CERMSGREFRESH(1798111:47633)@

New Subjective Smart Text

- *This is a Transitional Care Management (TCM) visit for [Name] who was hospitalized [dates] at [hospital] for [conditions]. At discharge the following medications were discontinued or added:*
  [discontinued: Added:]

- *Insert as disappearing help text: As part of the TCM program [first name] has already been contacted by phone within 2 business days of discharge and has completed the TCM post-discharge assessment. Patients determined moderate risk are scheduled for a face-to-face visit within 14 days of discharge and high risk patients scheduled within 7 days with their PCP. Please provide prescriptions for any new on-going medications.*

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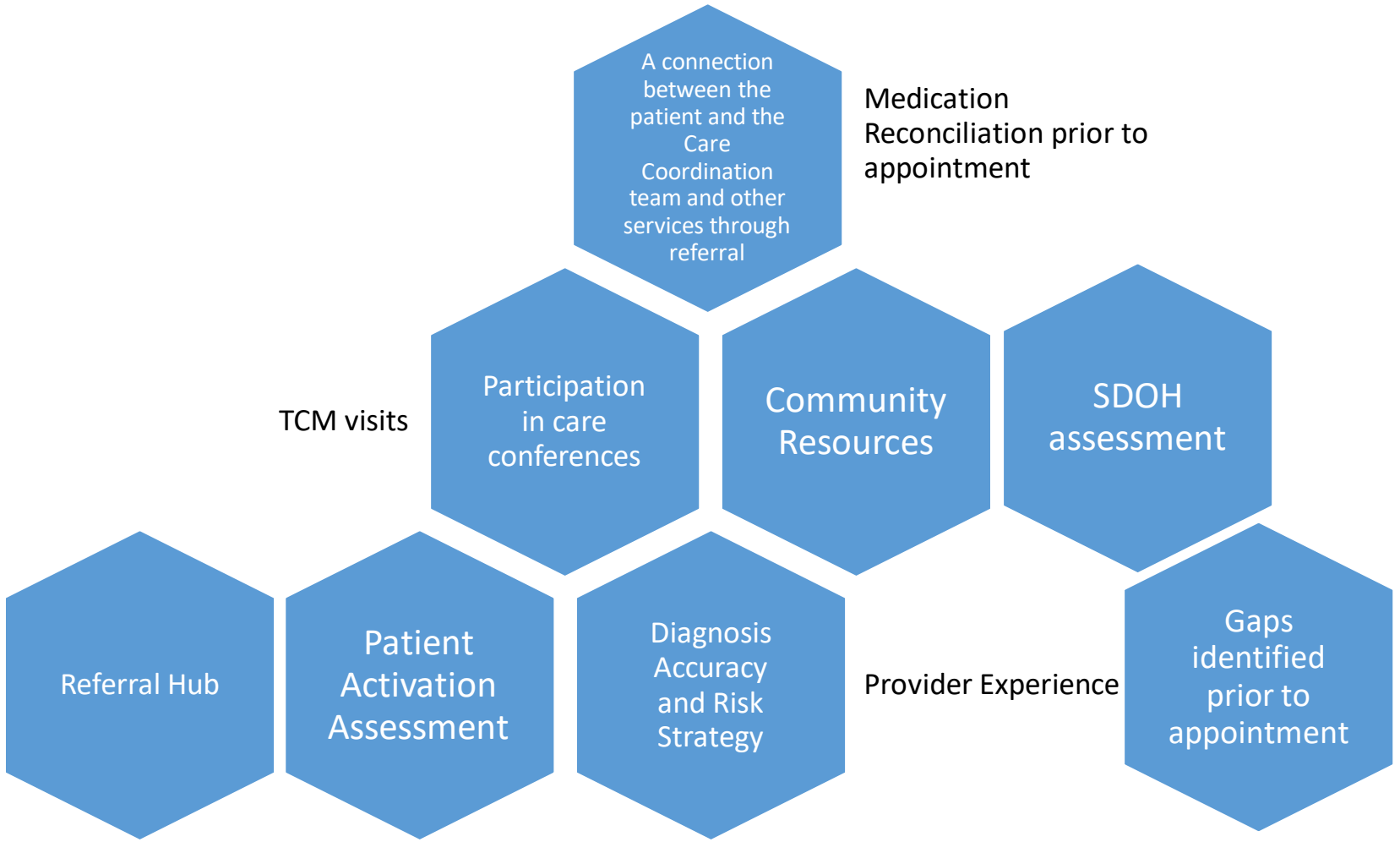
How it helps Patients, Providers and Care Team



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Provider Experience

Easy Button for referrals and proactive identification of needs

Proactive case finding

Easy Tools

Smart sets

Flowsheet rows with key information for diagnostic decisions

Standardized information that they need to make decisions

Shared Decision Making

HealthPartners

Toolbox

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Medica

Welcome to Breakout Session 2

Biosimilars: Key Considerations Across the Health Care Industry

Breakout session 2

Kim Dornbrook-Lavender, PharmD, BCPS, Director, Pharmacy Services, Medica

Kim joined Medica's Pharmacy Services team in October 2010 and has earned progressive leadership roles and responsibilities throughout her tenure. In her current role as Pharmacy Director, Kim leads the clinical pharmacy and pharmacy operations teams in achieving targeted strategic goals and optimizing the value medications provides members and stakeholders by providing pharmaceutical services across the pharmacy and medical benefit for the Commercial, Individual, Medicare, and Medicaid lines of business. Areas of focus include vendor management; business segment pharmacy strategy development and support; clinical program management; formulary strategy and contracting; clinical policy development and management; pharmacy operations; utilization management; drug pipeline surveillance; site of service optimization; Medication Therapy Management, and Medicare STARs initiatives.

Kim has more than 20 years of clinical pharmacy experience in a variety of roles. She spent several years as a Medical Science Liaison with Shire Pharmaceuticals and had a brief stint at CVS Caremark prior to joining Medica. Kim is a board-certified in pharmacotherapy and holds Doctor of Pharmacy degree from the University of Michigan and a Bachelor of Arts degree from Kalamazoo College. She completed a pharmacy practice residency at St. John Hospital & Medical Center in Detroit, MI followed by an academic fellowship at the University of North Carolina at Chapel Hill.

Breakout session 2

Roseann R. Hines, PharmD, Senior Director, Pharmacy Care Management, Essentia Health

Roseann Hines PharmD, is the Senior Director of Pharmacy Care Management at Essentia Health in Duluth, MN. Within this role, she supports teams and facilitates work within pharmacy care managements for value-based contracts, formulary management, anticoagulation services and antimicrobial programs within acute and ambulatory spaces as well as ambulatory pharmacy clinical service (MTM).

Dr. Hines is a graduate of the University of Wisconsin-Madison School of Pharmacy. She completed her General Practice Pharmacy Residency, at Ministry- St. Joseph's Hospital in Marshfield, Wisconsin. After her residency, Roseann worked as a clinical/staff pharmacist in Pediatrics at Ministry-St. Joseph's Children's Hospital for 4 years before her transition to WakeMed Health & Hospitals, Raleigh NC, as the Clinical Specialist in Pediatrics and then transitioned into clinical leadership roles within Essentia Health.

Medica.

Biosimilars: Key Considerations Across the Health Care Industry

Agenda

Biosimilars: Introduction and the Medica Experience

Kimberly Dornbrook-Lavender, PharmD, BCPS

Director, Pharmacy Services

Biosimilar Transition: Patient and Health Care Team Perspective by Essentia Health

Roseann Hines, PharmD

Senior Director, Pharmacy Care Management

Biosimilars – Introduction and the Medica Experience

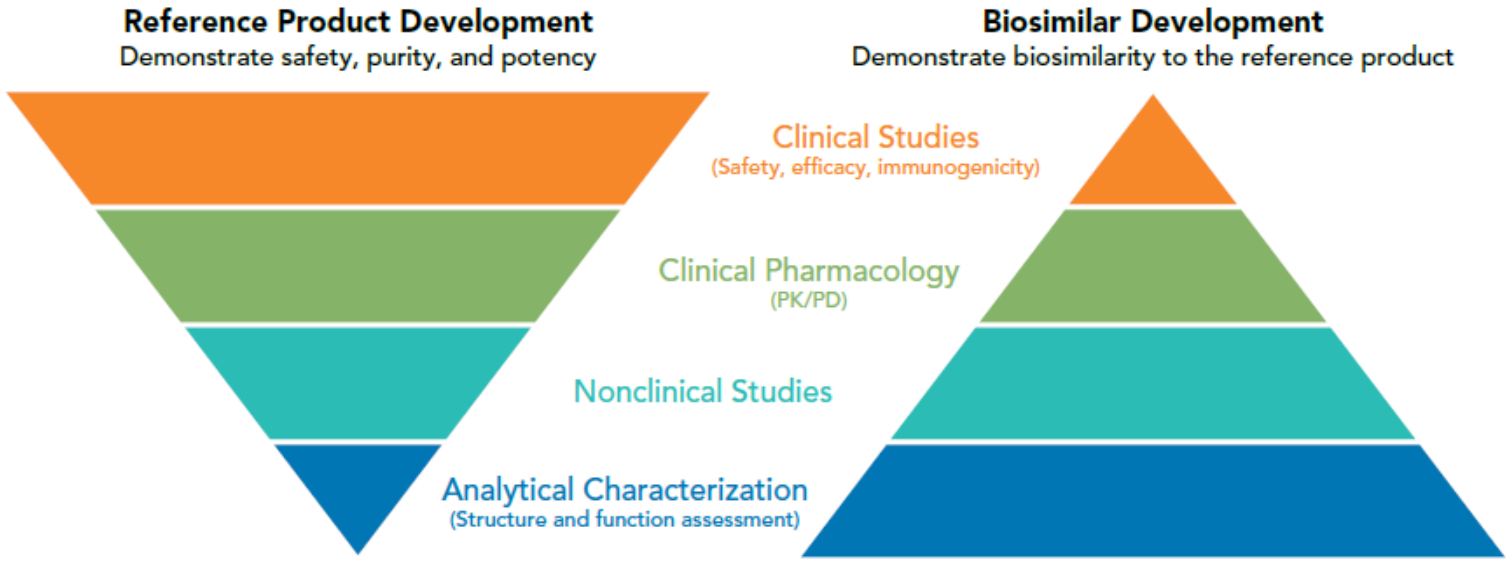
Kimberly Dornbrook-Lavender, PharmD, BCPS

Director, Pharmacy Services

What is a biosimilar product?

Biological drugs and the rise of biosimilars

- Biological products are large, complex molecules produced through biotechnology in a living system (microorganism, plant or animal cell)
- Biosimilar products *are highly similar* to the U.S. licensed reference biological product notwithstanding minor differences in clinically inactive components
- No clinically meaningful differences from the reference product in terms of safety, purity, and potency



Interchangeable biological product is a biosimilar that meets additional requirements and may be substituted for the reference product at the pharmacy, depending on state pharmacy laws

Differences between generics and biosimilars

	Generics	Biosimilar
Manufacturing	Chemical process	Made in living cells
Complexity	Small, simple, stable	Large, complex, unstable
Identical copy	Yes	No
FDA pathway	Abbreviated New Drug Application (ANDA)	351(k) Biologic License Application
Innovator exclusivity	7 years	12 years
Development time	3-5 years	8-10 years
Clinical trial required?	No	Yes
Substitution and interchange scenarios	Substitutable	• Biosimilar — not substitutable, therapeutic interchange allowed. • Interchangeable Biosimilar — substitutable, interchangeable
Examples	Atorvastatin (generic for Lipitor)	Semglee (biosimilar for Lantus) Inflectra (biosimilar for Remicade)

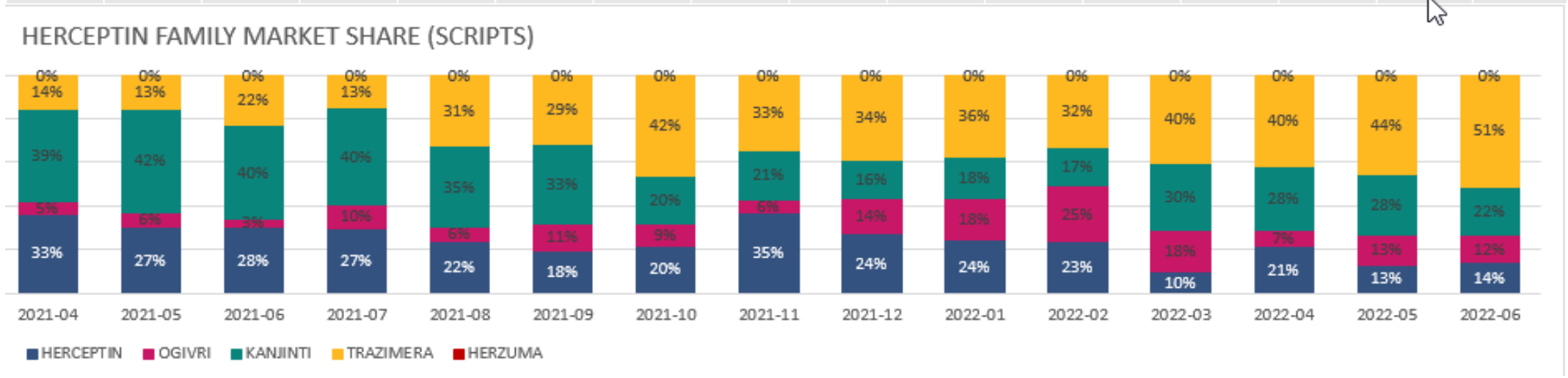
Medical pharmacy biosimilars

Originator/ Reference Product Name	Generic Drug Name	Biosimilars	Category	Strategy Effective Date
Neupogen	filgrastim	**Zarxio**, Granix, **Nivestym**	Oncology support	2017
Epogen/Procrit	epoetin alfa	**Retacrit**	Oncology support	2019
Remicade*	infliximab	Reneflexis, **Inflectra**, Avsola	Chronic inflammatory conditions	2021
Avastin	bevacizumab	**Mvasi, Zirabev**	Oncology	2022
Herceptin	trastuzumab	Ogivri, Herzuma, Ontruzant, **Trazimera, Kanjinti**	Oncology	2022
Neulasta*	pegfilgrastim	**Ziextenzo**, Fulphila, Undenyca, Nyvepria	Oncology support	2022
Rituxan	rituximab	**Truxima, Ruxience**, Riabni	Oncology	2022

**reference product and exclusive biosimilar co-preferred*

Medica's biosimilar dashboard: Tracking market shift

ACO															
MARKET SHARE (SCRIPTS)*															
2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06
28%	33%	27%	28%	27%	22%	18%	20%	35%	24%	24%	23%	10%	21%	13%	14%
7%	4%	6%	5%	6%	4%	4%	7%	4%	6%	0%	0%	0%	0%	0%	0%
45%	39%	42%	40%	40%	35%	33%	20%	21%	16%	18%	17%	30%	28%	28%	22%
2%	5%	6%	3%	10%	6%	11%	9%	6%	14%	18%	25%	18%	7%	13%	12%
0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
13%	14%	13%	22%	13%	31%	29%	42%	33%	34%	36%	32%	40%	40%	44%	51%



**Volume market share calculations include all place of service codes (Provider, Outpatient, and Home Infusion)*

Near-term patent expirations with a biosimilar

	INNOVATOR PRODUCT	MOST COMMON INDICATION
2021	Lantus (interchangeable Semglee)	Diabetes
2022	Lucentis Novolog (interchangeable Kixelle)	Ophthalmic Conditions Diabetes
2023	Humira (interchangeable Cyltezo) Actemra Stelara Tysabri Xolair	Inflammatory Conditions Inflammatory Conditions Inflammatory Conditions Multiple Sclerosis Asthma
2024	Eylea	Ophthalmic Conditions
2025	Prolia Soliris	Osteoporosis Blood Modifying

BIOLOGICS

43%

of all drug spend

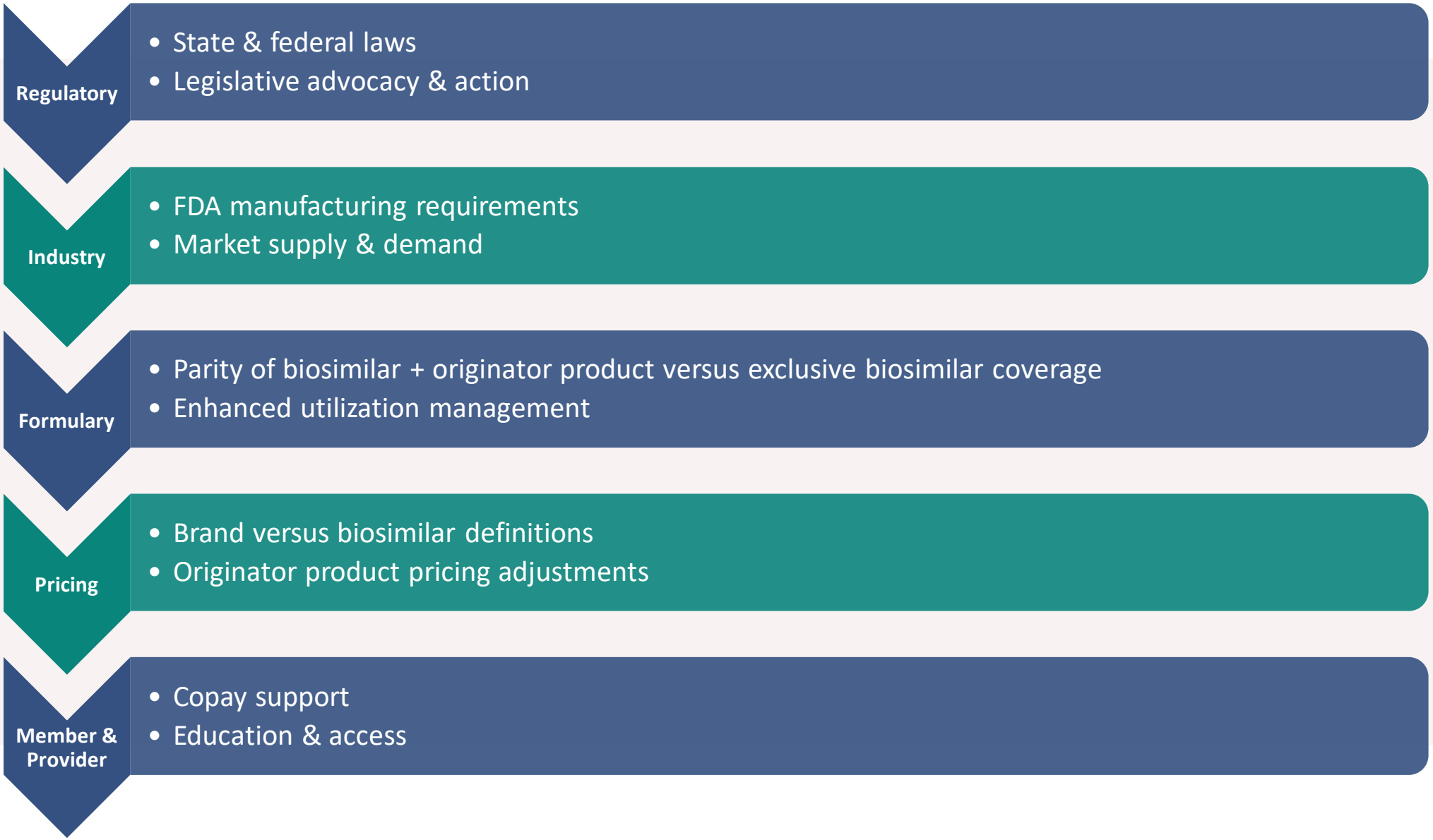
33

BIOSIMILARS
approved over 6 years

13-61%

MARKET SHARE
increase in the last 2 year

Biosimilars: Health plan strategic considerations



Current inflammatory conditions market space

Trend-driver drugs and classes

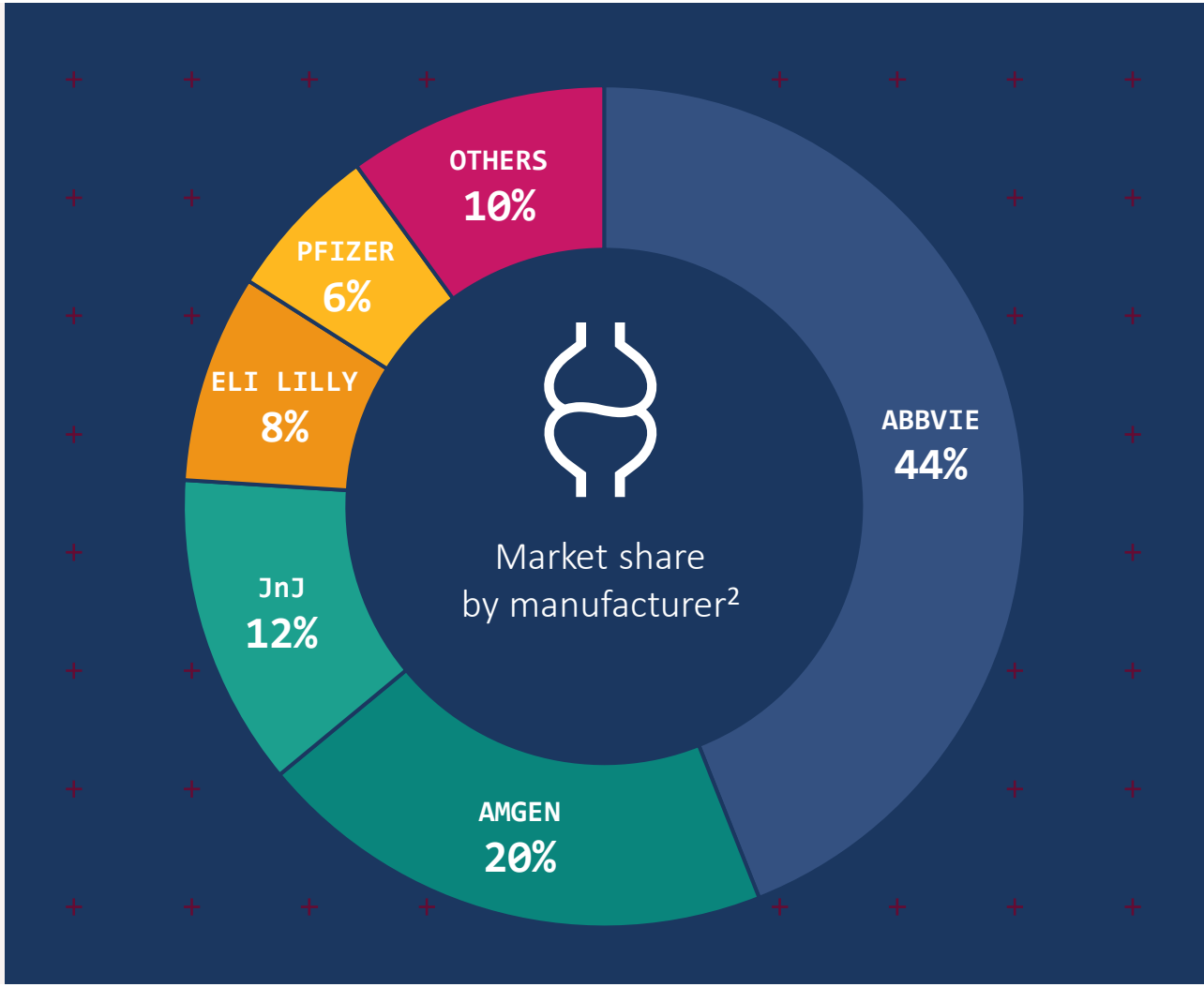
Key Market Dynamics Events

Prescribers are shifting to newer approved products vs. drugs that will have biosimilars over next 2 years

21 drugs currently on the market[1]

new drugs in pipeline or existing drugs with new indications

45% of current spend will have biosimilar competition by 2024 (Actemra (’23), Humira (’23), Stelara (’24))[2]



1. FDA Accessed 5/04/2022 2. Evernorth internal data

Humira biosimilar launch schedule

Bioismilar	Manufacturer	Citrate free?	High Concentration	Possible Launch
Amjevita[#] (adalimumab)	Amgen	Yes	No	01/31/2023
Hadlima[#] (adalimumab)	Organon	TBD	TBD	06/30/2023
Hukyndra[‡#] (adalimumab)	Alvotech/Teva	Yes	Yes	07/01/2023
Abrilada[#] (adalimumab)	Pfizer	Yes	No	07/01/2023
Cyltezo* (adalimumab)	Boehringer Ingelheim	Yes	No	07/01/2023
Hyrimoz (adalimumab)	Sandoz	TBD	TBD	07/01/2023
Yusimry (adalimumab)	Coherus BioSciences	Yes	No	07/01/2023
Hulio (adalimumab)	Viatris	Yes	No	07/31/2023
MSB11022[‡] (adalimumab)	Fresenius Kabi	TBD	No	09/30/2023
Yuflyma[‡] (adalimumab)	Celltrion	TBD	Yes	12/15/2023

*Interchangeable status Granted; #Seeking Interchangeability; ‡Pending FDA Approval

1. IPD Analytics. Market & Financial Insights. April 2022
2. Evernorth internal research

Driving biosimilar competition and adoption

Legislative advocacy and action

Patient support systems

Enhanced copay assistance for members

Formulary and utilization management enhancements

Supply consideration

Provider support

Biosimilar Transition: Patient and Health Care Team Perspective

Roseann Hines, PharmD

Senior Director, Pharmacy Care Management

Essentia Health Pharmacy Services

Foundational work

What is a biosimilar?

- Education designed for each impacted party
- Grand Rounds presentation, internal newsletters, reference materials

Organizational Policy

- Policy development
- Associated standard work for interchange

Nocebo Effect

- Presentation for care teams
- Infusion Center Teams

Health system biosimilar strategy

Formulary review and clinical assessment

- Content experts within system intentionally engaged at multiple points
- Medical group team meetings

Assessment and communication to impacted teams

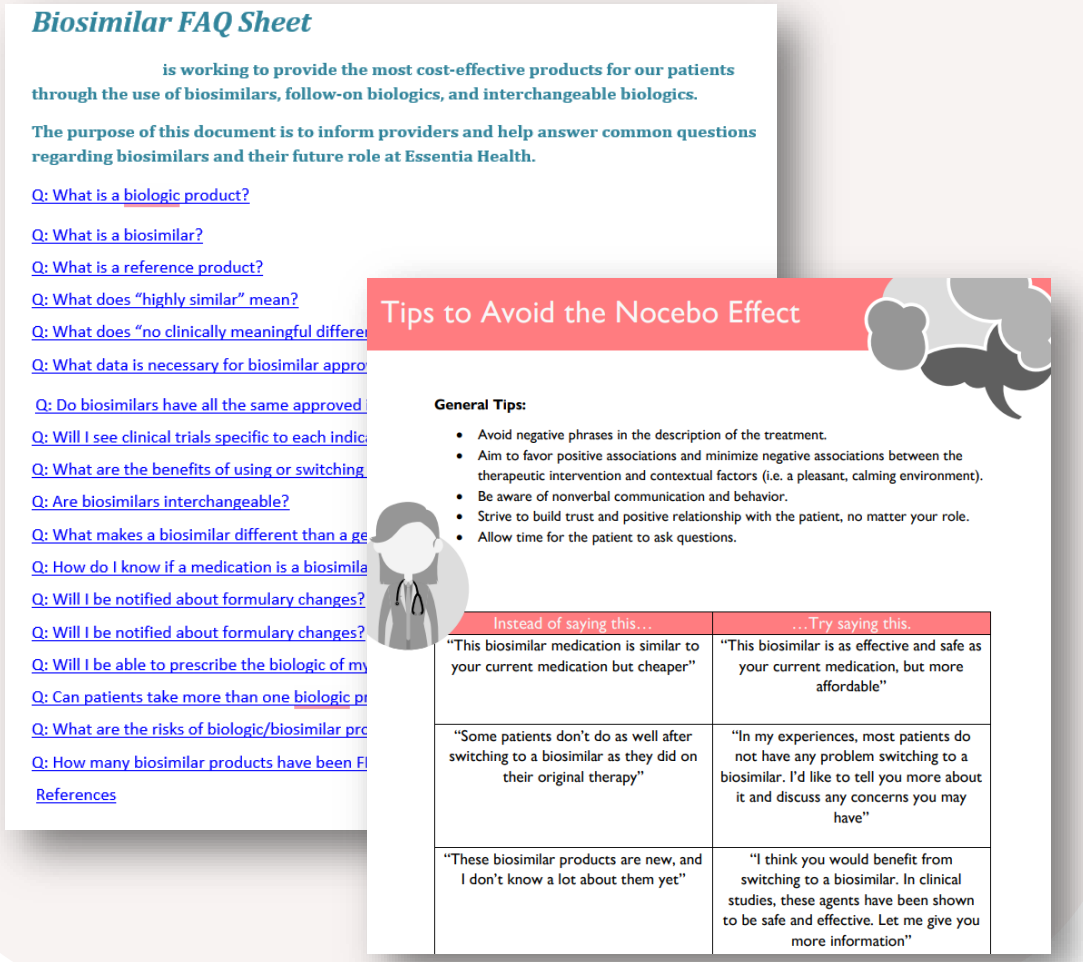
- Providers: general and targeted communications
- Infusion Center pharmacist
- Care and support team members

Provider tool kit

- Talking point for patient conversation
- Frequently Asked Questions

EMR updates

- Medication-specific transition information
  - Timeline
  - Tool changes
- Formulary compliance



Biosimilar FAQ Sheet

is working to provide the most cost-effective products for our patients through the use of biosimilars, follow-on biologics, and interchangeable biologics.

The purpose of this document is to inform providers and help answer common questions regarding biosimilars and their future role at Essentia Health.

Q: What is a biologic product?

Q: What is a biosimilar?

Q: What is a reference product?

Q: What does "highly similar" mean?

Q: What does "no clinically meaningful differe

Q: What data is necessary for biosimilar appro

Q: Do biosimilars have all the same approved

Q: Will I see clinical trials specific to each indic

Q: What are the benefits of using or switching

Q: Are biosimilars interchangeable?

Q: What makes a biosimilar different than a ge

Q: How do I know if a medication is a biosimila

Q: Will I be notified about formulary changes?

Q: Will I be notified about formulary changes?

Q: Will I be able to prescribe the biologic of my

Q: Can patients take more than one biologic pr

Q: What are the risks of biologic/biosimilar pro

Q: How many biosimilar products have been F

References

Tips to Avoid the Nocebo Effect

General Tips:

- Avoid negative phrases in the description of the treatment.
- Aim to favor positive associations and minimize negative associations between the therapeutic intervention and contextual factors (i.e. a pleasant, calming environment).
- Be aware of nonverbal communication and behavior.
- Strive to build trust and positive relationship with the patient, no matter your role.
- Allow time for the patient to ask questions.

Instead of saying this…	…Try saying this.
"This biosimilar medication is similar to your current medication but cheaper"	"This biosimilar is as effective and safe as your current medication, but more affordable"
"Some patients don't do as well after switching to a biosimilar as they did on their original therapy"	"In my experiences, most patients do not have any problem switching to a biosimilar. I'd like to tell you more about it and discuss any concerns you may have"
"These biosimilar products are new, and I don't know a lot about them yet"	"I think you would benefit from switching to a biosimilar. In clinical studies, these agents have been shown to be safe and effective. Let me give you more information"

Patient focused work

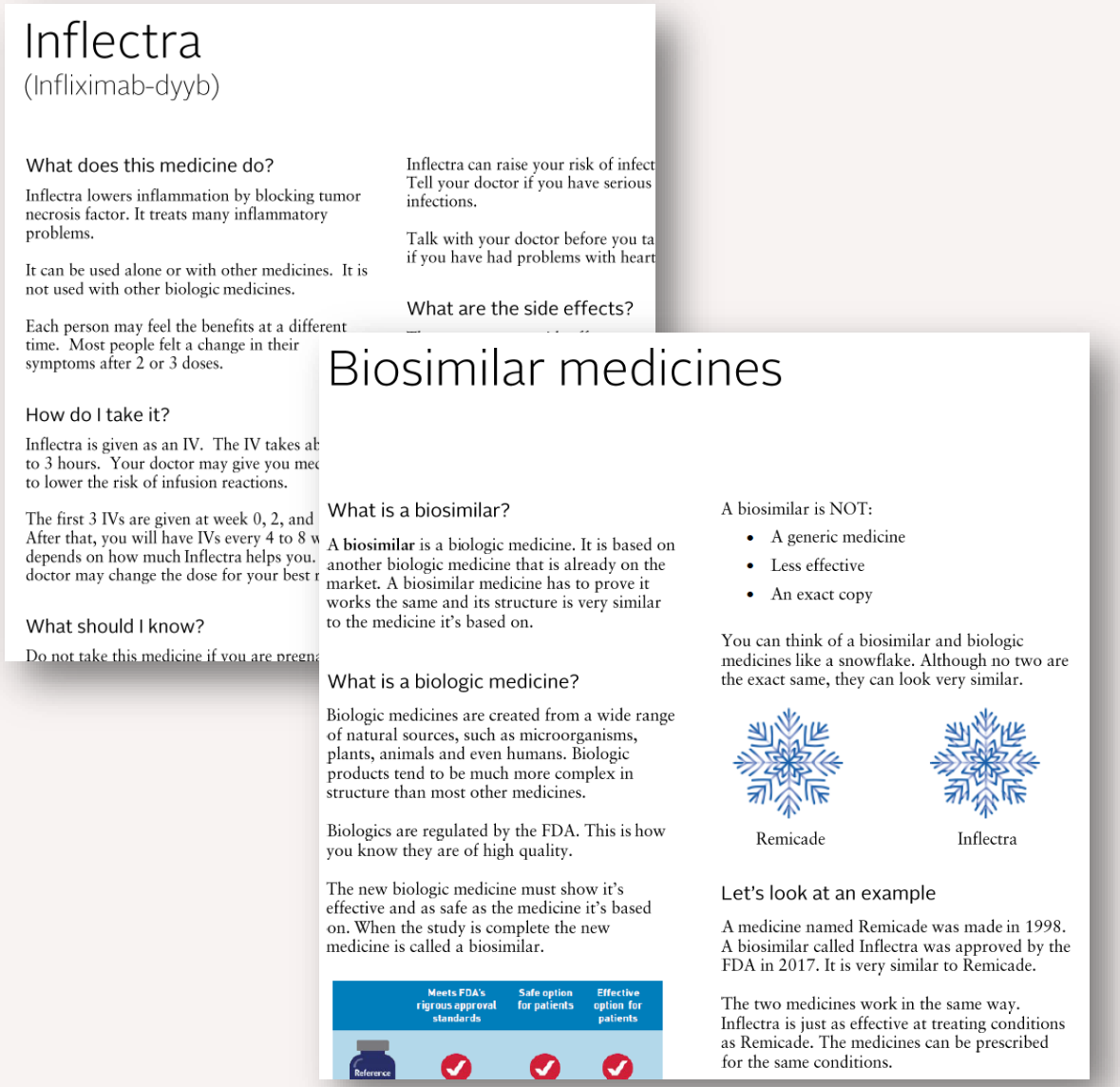
Patient communication

- Options for different learning levels
- Medication specific
- Source of information
- Time to consult with provider

Electronic tools and capabilities

Affordability and cost impacts

Patient assistance programs



Inflectra
(Infliximab-dyyb)

What does this medicine do?

Inflectra lowers inflammation by blocking tumor necrosis factor. It treats many inflammatory problems.

It can be used alone or with other medicines. It is not used with other biologic medicines.

Each person may feel the benefits at a different time. Most people felt a change in their symptoms after 2 or 3 doses.

How do I take it?

Inflectra is given as an IV. The IV takes ab to 3 hours. Your doctor may give you me to lower the risk of infusion reactions.

The first 3 IVs are given at week 0, 2, and After that, you will have IVs every 4 to 8 w depends on how much Inflectra helps you. doctor may change the dose for your best r

What should I know?

Do not take this medicine if you are pregna

Inflectra can raise your risk of infect Tell your doctor if you have serious infections.

Talk with your doctor before you ta if you have had problems with heart

What are the side effects?

Biosimilar medicines

What is a biosimilar?

A **biosimilar** is a biologic medicine. It is based on another biologic medicine that is already on the market. A biosimilar medicine has to prove it works the same and its structure is very similar to the medicine it's based on.

What is a biologic medicine?

Biologic medicines are created from a wide range of natural sources, such as microorganisms, plants, animals and even humans. Biologic products tend to be much more complex in structure than most other medicines.

Biologics are regulated by the FDA. This is how you know they are of high quality.

The new biologic medicine must show it's effective and as safe as the medicine it's based on. When the study is complete the new medicine is called a biosimilar.

A biosimilar is NOT:

- A generic medicine
- Less effective
- An exact copy

You can think of a biosimilar and biologic medicines like a snowflake. Although no two are the exact same, they can look very similar.

Remicade Inflectra

Let's look at an example

A medicine named Remicade was made in 1998. A biosimilar called Inflectra was approved by the FDA in 2017. It is very similar to Remicade.

The two medicines work in the same way. Inflectra is just as effective at treating conditions as Remicade. The medicines can be prescribed for the same conditions.

What's next?

Learnings

- Transition education and planning for chronic therapy patients
  - More time needed for patient and provider discussion
- Real-time provider feedback
- Increased collaboration between health systems and payers increases success
- Don't implement medication interchange in December or January ☺

Next Steps

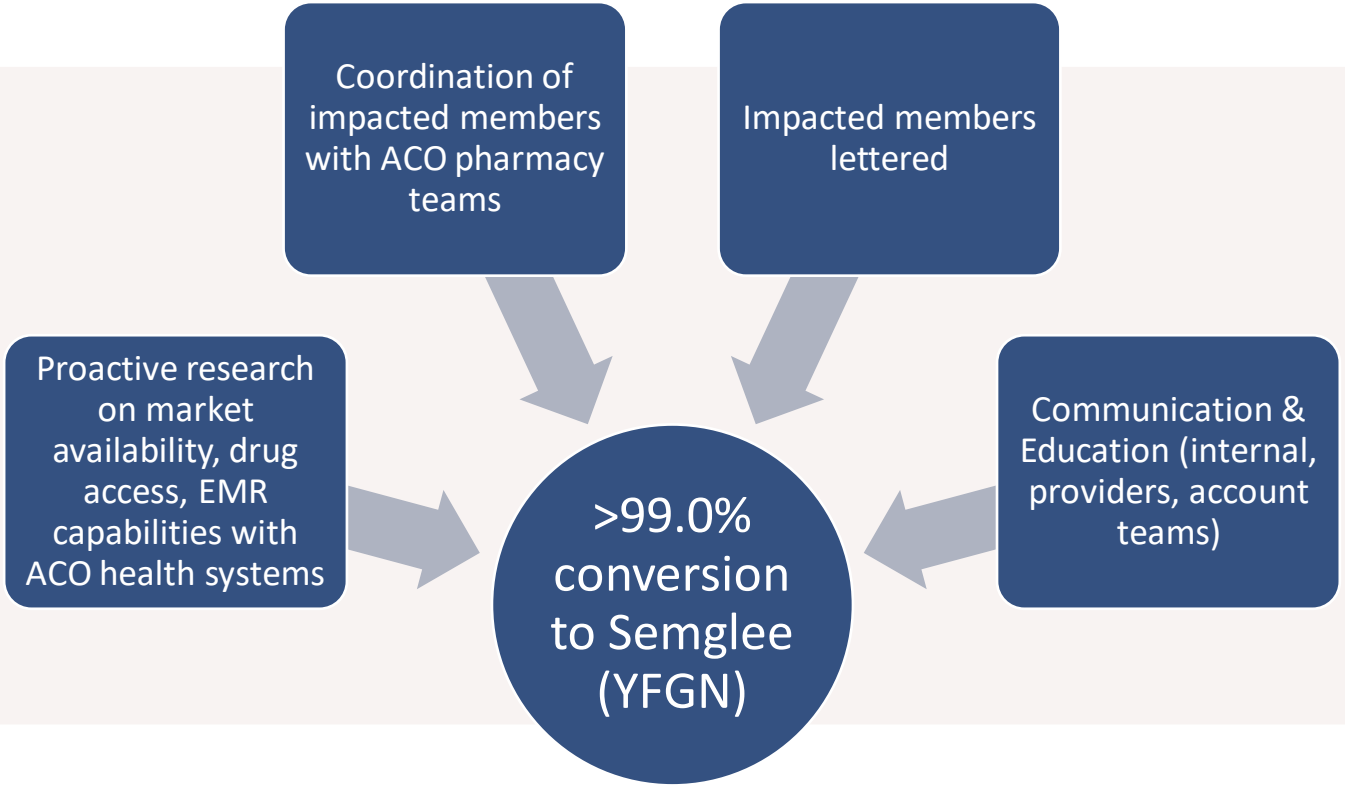
- EMR tool enhancements
  - Reduce clicks
  - Minimize provider interruption
  - Orderable to select interchange product-based payer formulary preference if not aligned with organization formulary
- Evaluate workflow update for medication within pharmacy benefit

Widespread Biosimilar Adoption

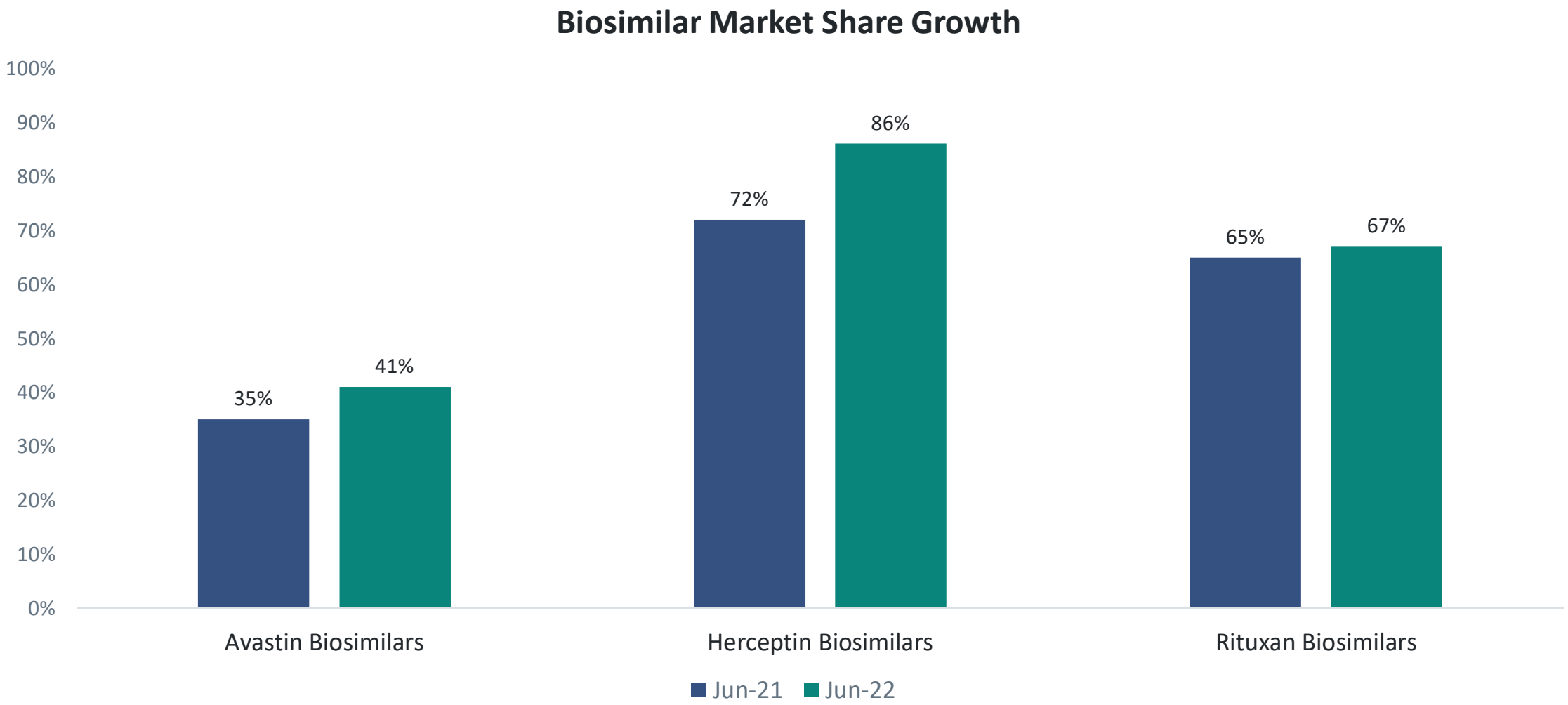
Call to Action and Open Discussion

Medica's biosimilar success: Semglee (YFGN)

- First interchangeable biosimilar product for Lantus/Lantus Solostar
- Effective 1/1/2022, Lantus removed from formulary & Semglee (YFGN) is the preferred rapid acting insulin

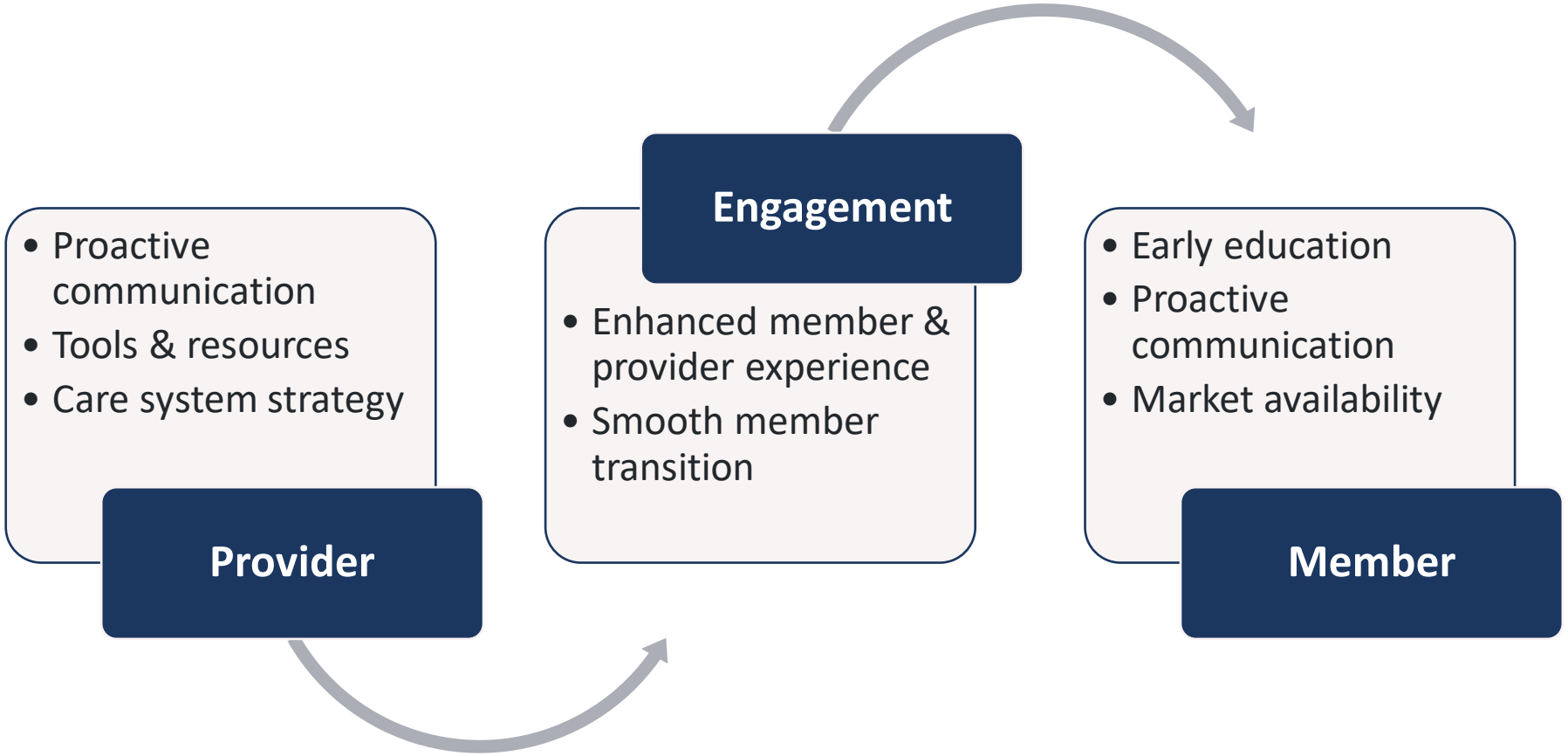


ACO biosimilar success: Medical pharmacy oncology agents



Call to action: Stronger together

Continued partnership to engage with providers and enhance member experience for successful adoption of biosimilar strategies.



Q & A

Thank you

Break

Upcoming at 3:05 p.m. - Breakout Sessions

Conference room 106

Breakout Session #4: Risk recapture strategies to support providers and members

Attendees will hear from a health system and payer on how they are partnering to engage providers in risk recapture strategies to ensure the risk of the population is accurately captured.

Conference room 101

Breakout Session #5: Engaging patients with primary care

During this breakout session attendees will learn approaches to engaging patients with primary care. Attendees will learn from Park Nicollet on how they use their care consultants to ensure patients at risk receive appropriate follow-up and care. Medica will present member outreach models that have targeted non-users, preventable emergency department utilization, as well as out-of-network utilization.

Welcome to Breakout Session 3

Strategies to engage providers in Social Determinants of Health (SDoH) reporting

Breakout session 3

Kristin Repp, PharmD, BCPS, Director Population Health, St. Luke's Health System

Dr. Kristin Repp completed a BS in Chemical Engineering and Doctor of Pharmacy degree from the University of Kansas. She completed a pharmacy practice residency and is board certified in pharmacotherapy. She has made her career at Saint Luke's Health System over the past 16 years and held positions from Director of Pharmacy to her current role as Director of Population Health.

Breakout session 3

Roy Jedeikin, MD, Chief Medical Officer, Phoenix Children's Care Network

Pediatric Cardiologist, Phoenix Children's Medical Group

As Chief Medical Officer for Phoenix Children's Care Network (PCCN), Dr. Roy Jedeikin is responsible for operations, quality and network development. His expertise in continuous quality improvement guides clinical integration within PCCN. In this role, Dr. Jedeikin leads the Quality Committee through engaging and enhancing PCCN's relationships with providers in clinical integration and quality improvement. His work continues to bring value to provider offices to enhance quality improvement processes. Dr. Jedeikin has been a Pediatric Cardiologist in Phoenix since 1984. He received his medical degree from the University of the Witwatersrand Medical School in South Africa in 1975.

Dr. Jedeikin is recognized as a nationwide leader for his expertise in continuous quality improvement. He has worked with the American College of Cardiology to develop pediatric cardiology quality metrics for adult congenital and pediatric cardiology and was involved in developing quality improvement modules for MOC participation in pediatric cardiology and contractual quality performance HEDIS measures.

Breakout session 3

Bryce Sherman, Director Business Operations & Clinical Programs, Phoenix Children's Care Network

Bryce Sherman is the Director of Business Operations with Phoenix Children's Care Network (PCCN). Bryce joined PCCN in August of 2014 as its Senior Data Analyst. He now manages the PCCN's Business Operations, Practice Integration, and Integrated Care Coordination teams. His role oversees PCCN's quality and operational integration with participating specialists and PCPs, operational infrastructure, project management, finances, approach to care coordination and day-to-day business operations. Bryce was a leading contributor and oversaw PCCN's journey in receiving the "Clinical Integration" accreditation from the Utilization Review Accreditation Commission (URAC). PCCN was the first Pediatric Clinically Integrated Network to earn this accreditation. Bryce is an enthusiastic healthcare professional with a passion for people and making a difference.

Social Drivers of Health

Kristin Repp, PharmD, BCPS

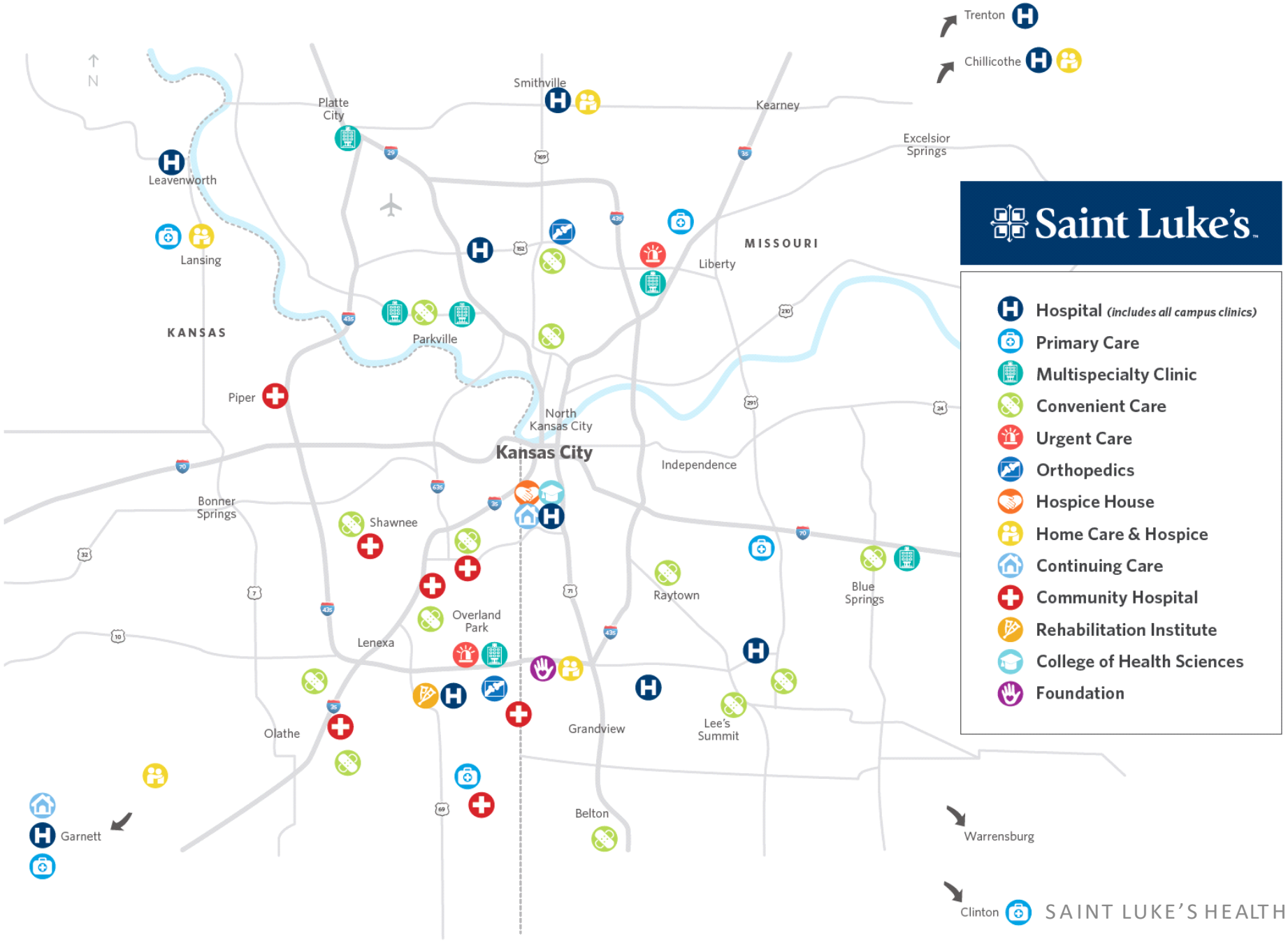
Director of Population Health

Saint Luke's





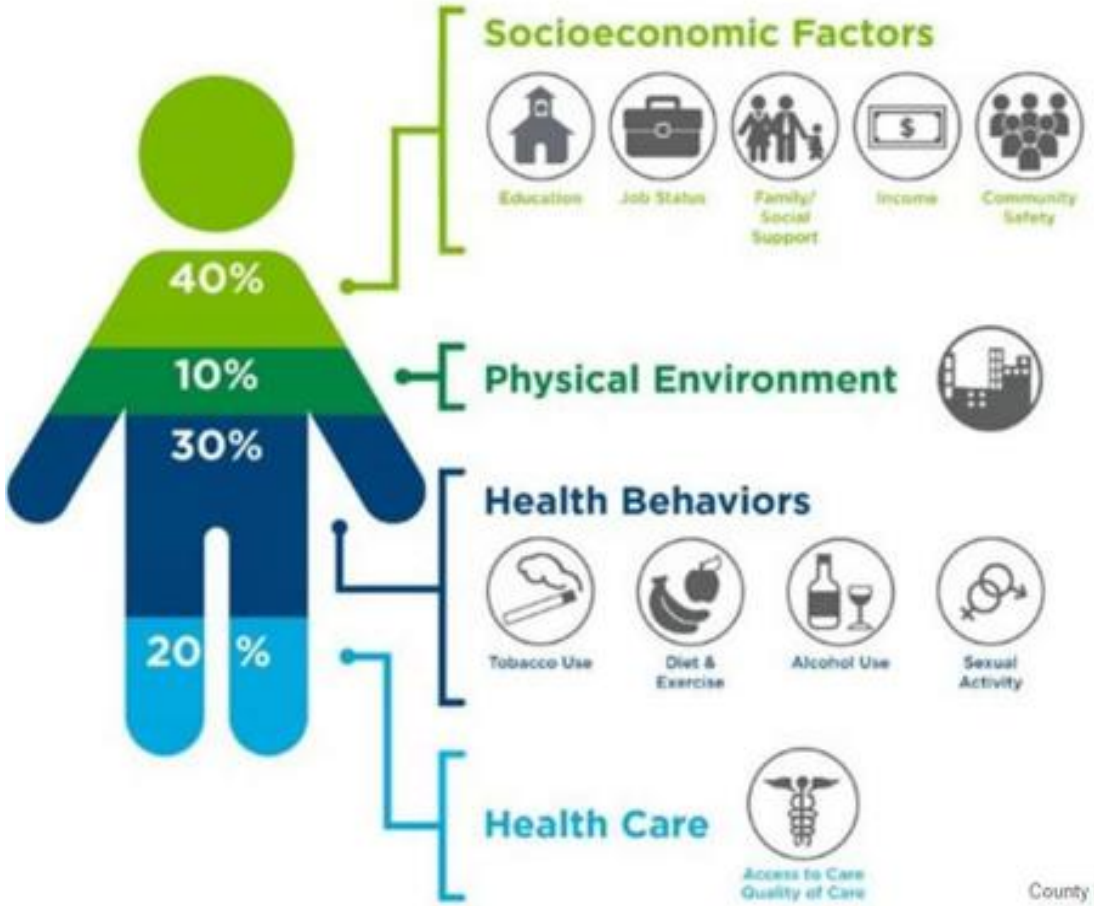

16	Hospitals and Campuses
3rd	Largest Private Employer in the KC Metro
12,000	Employees
1,400	Total Medical Staff Physicians
1,305	Licensed Beds
54,700	Convenient Care and Urgent Care Visits
1.6 Million	Saint Luke's Physician Group Provider Visits
173,693	Emergency Department Visits
73,871	Hospital Admissions
$1.775 Billion	Net Patient Revenue
43,395	Social Impact Volunteers/Hours
$201 Million	Community Benefit (2017)


N
Trenton
Chillicothe
Smithville
Platte City
Kearney
Excelsior Springs
Leavenworth
Lansing
KANSAS
MISSOURI
Liberty
Parkville
Piper
North Kansas City
Kansas City
Independence
Bonner Springs
Shawnee
Raytown
Blue Springs
Overland Park
Lenexa
Olathe
Grandview
Lee's Summit
Belton
Garnett
Warrensburg
Clinton
Saint Luke's
Hospital (includes all campus clinics)
Primary Care
Multispecialty Clinic
Convenient Care
Urgent Care
Orthopedics
Hospice House
Home Care & Hospice
Continuing Care
Community Hospital
Rehabilitation Institute
College of Health Sciences
Foundation

SDoH Journey at Saint Luke's Health System

- Started Screening for Social Drivers of Health in 2019 in limited capacity.
- Went live with Universal Screening January 2022 across all primary care clinics (13 clinics)
- Utilizing EPIC EMR for screening
- Utilizing Find Help – Community Resource Directory
- Continued Process Improvements for Operations and Electronic tools

Health is More than "Sick Care"



Triple Aim 2008

- 1. Better Outcomes
- 2. Lower Costs
- 3. Improve Patient Experience

Quadruple Aim 2014

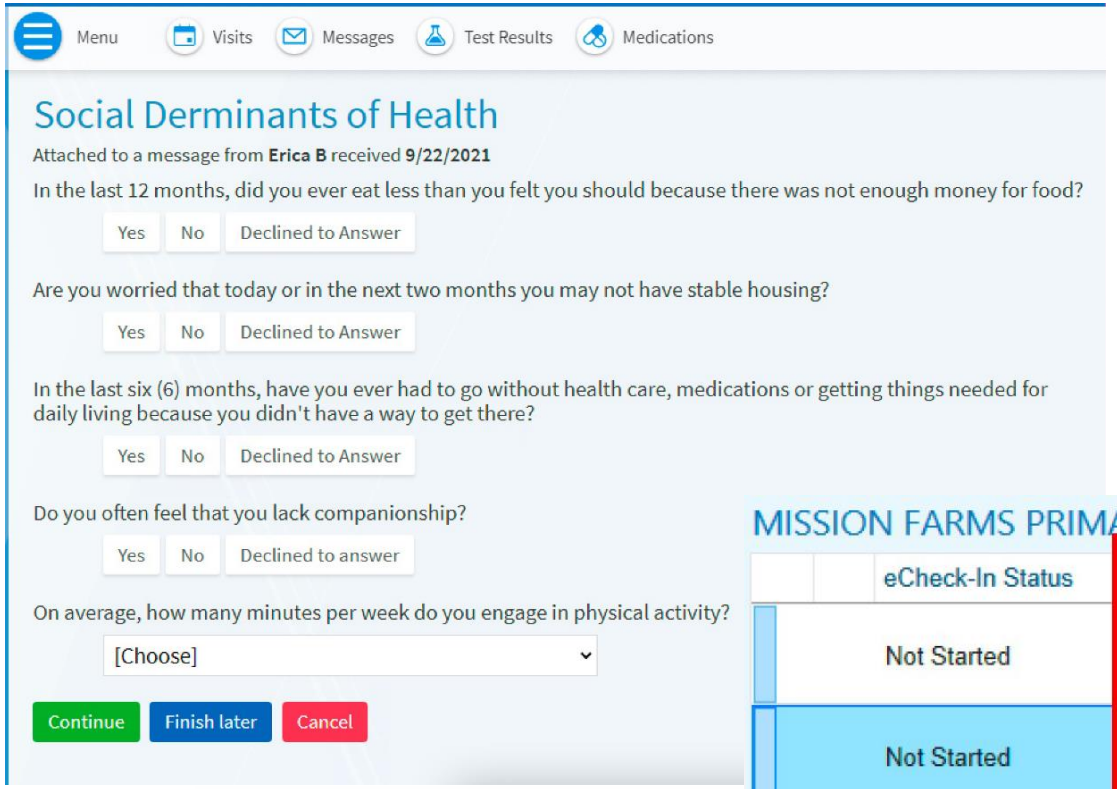
- 4. Clinician Well-Being

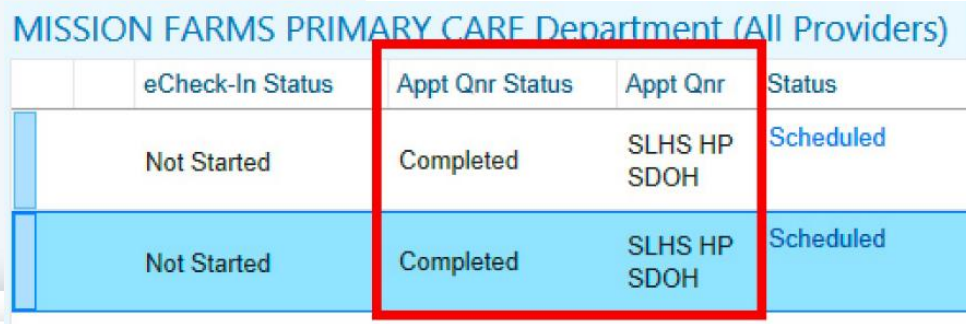
Quintuple Aim 2022

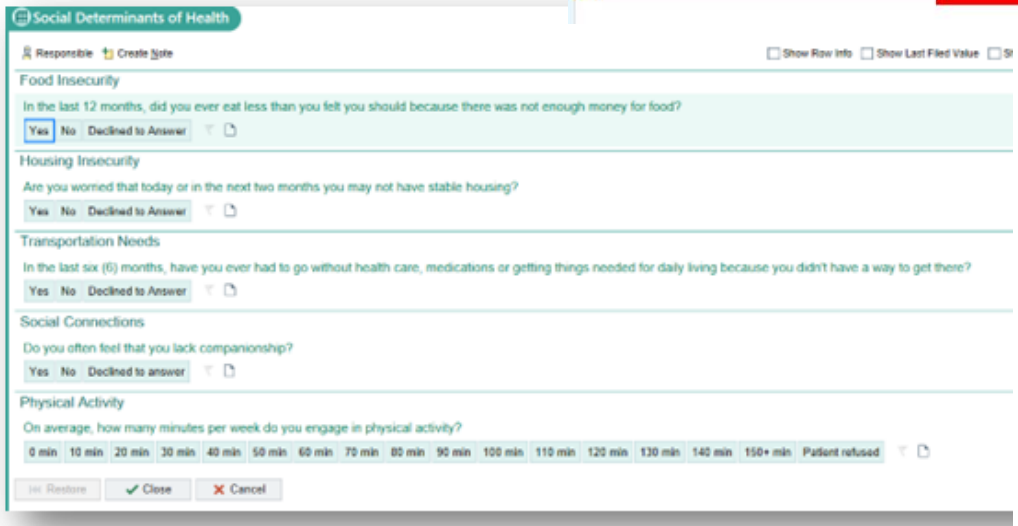
- 5. Health Equity

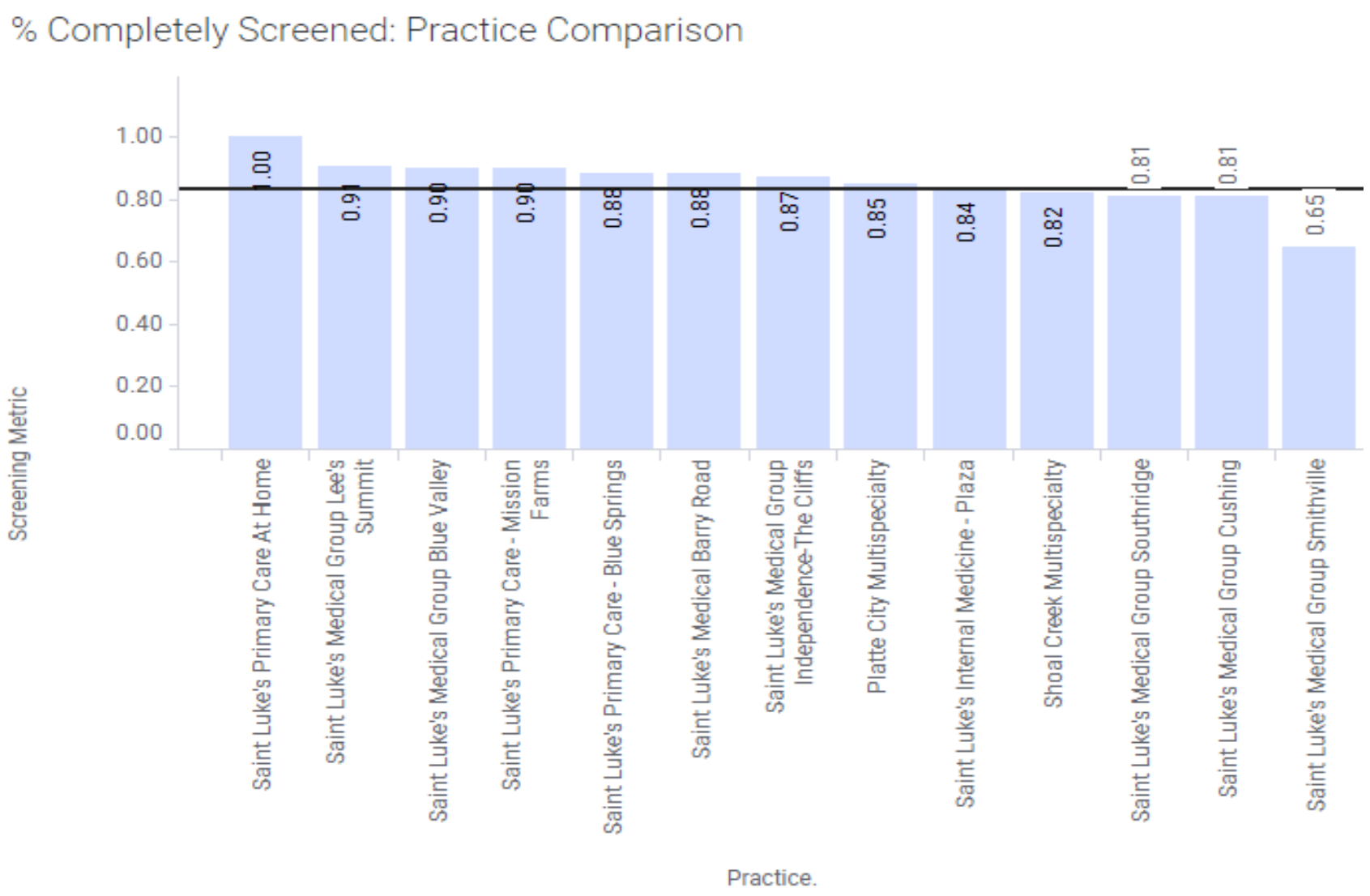
IHI.org and Article https://jamanetwork.com/journals/jama/fullarticle/2788483

Screening


Menu
Visits
Messages
Test Results
Medications
Social Derminants of Health
Attached to a message from Erica B received 9/22/2021
In the last 12 months, did you ever eat less than you felt you should because there was not enough money for food?
Yes
No
Declined to Answer
Are you worried that today or in the next two months you may not have stable housing?
Yes
No
Declined to Answer
In the last six (6) months, have you ever had to go without health care, medications or getting things needed for daily living because you didn't have a way to get there?
Yes
No
Declined to Answer
Do you often feel that you lack companionship?
Yes
No
Declined to answer
On average, how many minutes per week do you engage in physical activity?
[Choose]
Continue
Finish later
Cancel


MISSION FARMS PRIMARY CARE Department (All Providers)
eCheck-In Status
Appt Qnr Status
Appt Qnr
Status
Not Started
Completed
SLHS HP SDOH
Scheduled
Not Started
Completed
SLHS HP SDOH
Scheduled


Social Determinants of Health
Food Insecurity
In the last 12 months, did you ever eat less than you felt you should because there was not enough money for food?
Yes
No
Declined to Answer
Housing Insecurity
Are you worried that today or in the next two months you may not have stable housing?
Yes
No
Declined to Answer
Transportation Needs
In the last six (6) months, have you ever had to go without health care, medications or getting things needed for daily living because you didn't have a way to get there?
Yes
No
Declined to Answer
Social Connections
Do you often feel that you lack companionship?
Yes
No
Declined to answer
Physical Activity
On average, how many minutes per week do you engage in physical activity?
0 min
10 min
20 min
30 min
40 min
50 min
60 min
70 min
80 min
90 min
100 min
110 min
120 min
130 min
140 min
150+ min
Patient refused
Close
Cancel



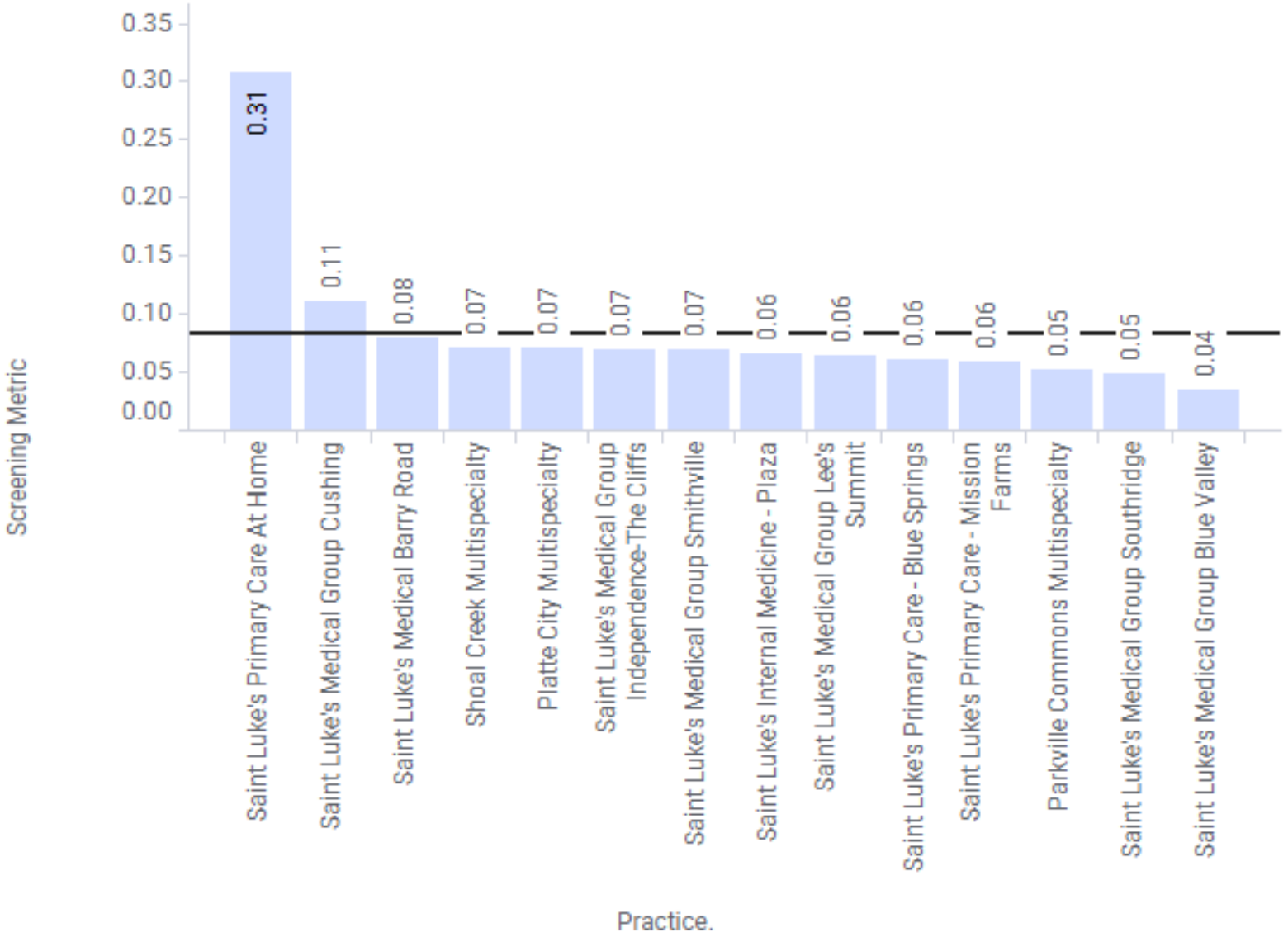
DATA: Jan – Aug 31st 2022

50% Goal Set in Jan

83% Average

86% Screened

% of Screened Patients w/ Need: Practice Comparison

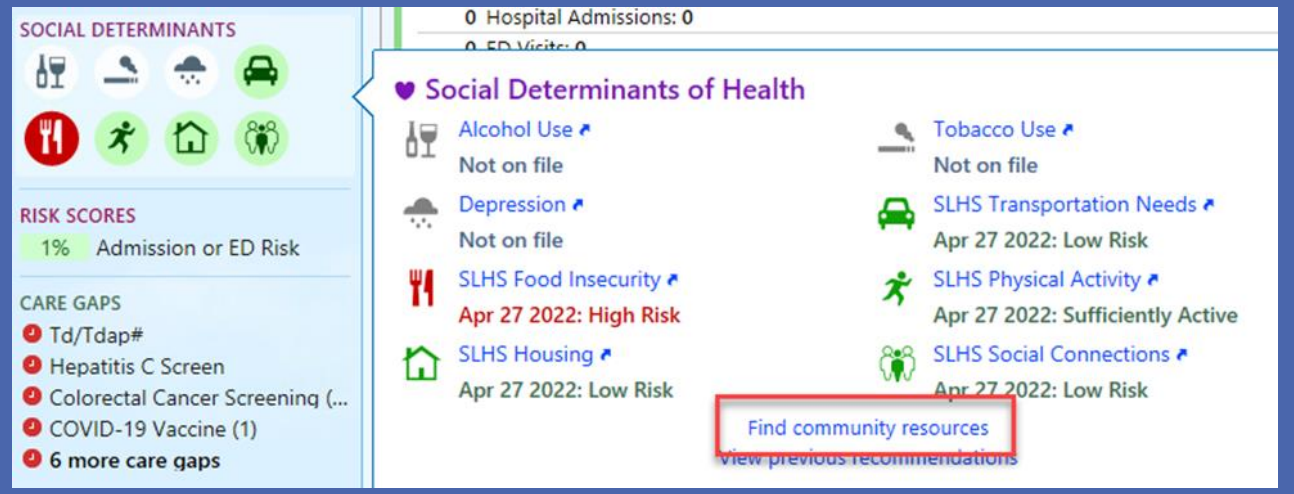


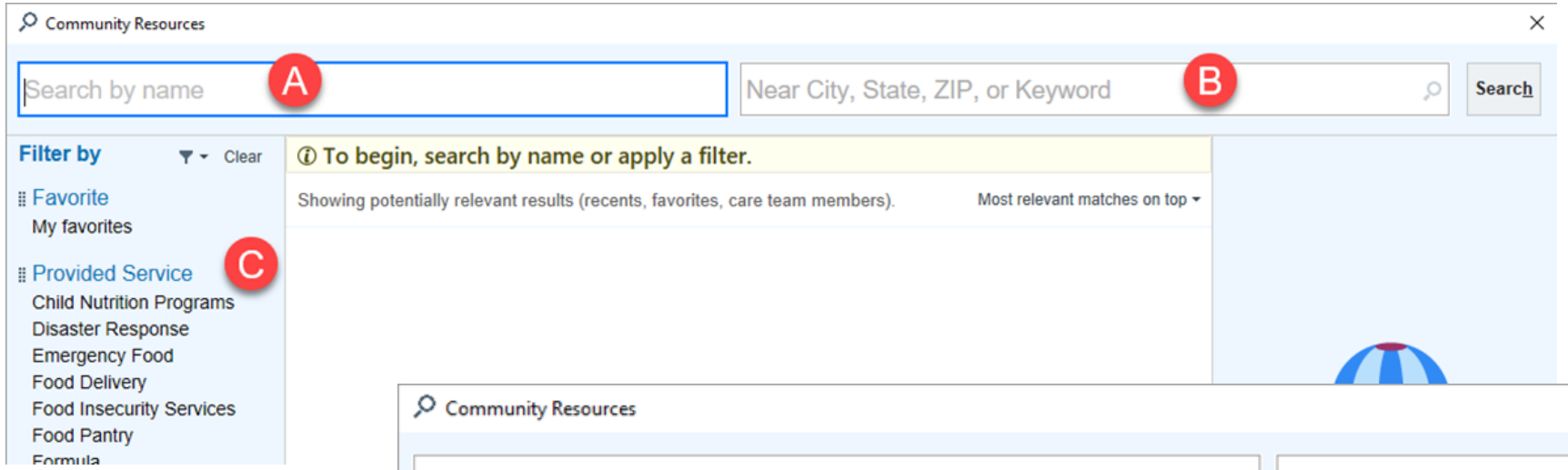
DATA: Jan – Aug 31st 2022

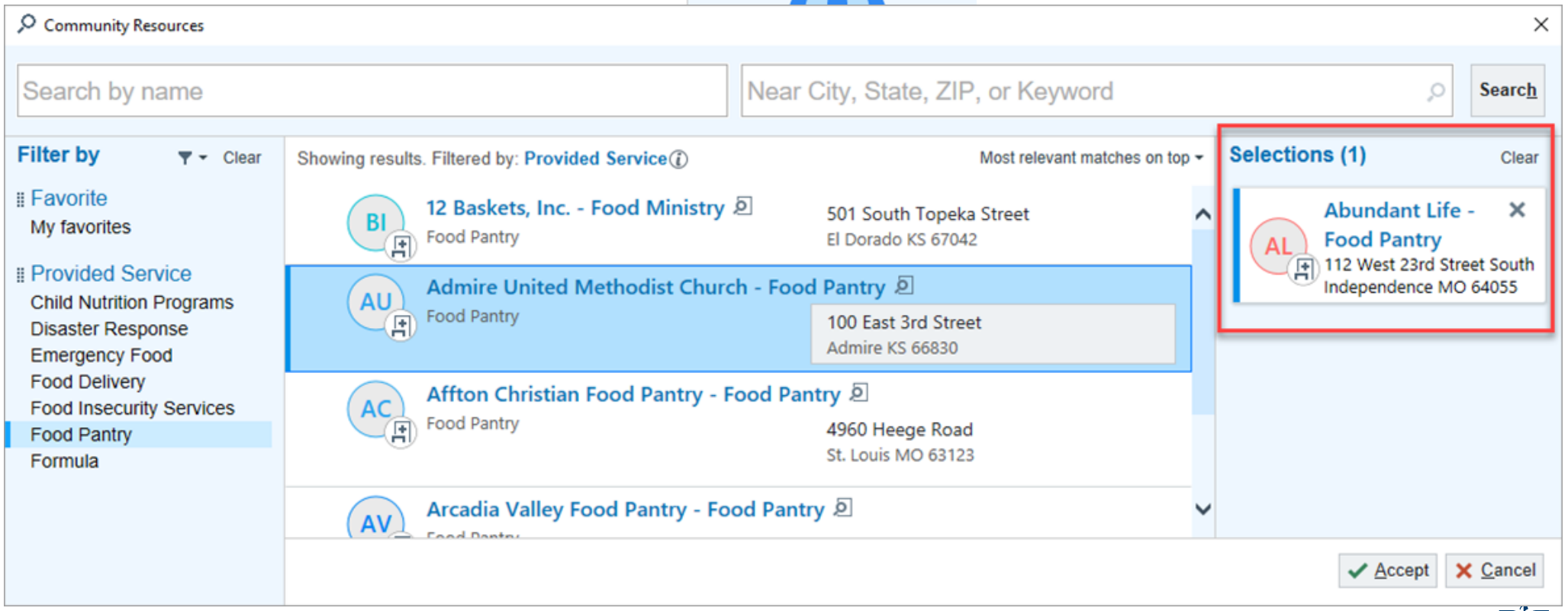
6.5% Positive

5,779 Patients had a need identified


Social Determinants of Health
Find community resources


SOCIAL DETERMINANTS
RISK SCORES
1% Admission or ED Risk
CARE GAPS
Td/Tdap#
Hepatitis C Screen
Colorectal Cancer Screening (...
COVID-19 Vaccine (1)
6 more care gaps
0 Hospital Admissions: 0
Social Determinants of Health
Alcohol Use
Not on file
Tobacco Use
Not on file
Depression
Not on file
SLHS Transportation Needs
Apr 27 2022: Low Risk
SLHS Food Insecurity
Apr 27 2022: High Risk
SLHS Physical Activity
Apr 27 2022: Sufficiently Active
SLHS Housing
Apr 27 2022: Low Risk
SLHS Social Connections
Apr 27 2022: Low Risk
Find community resources
View previous recommendations


Community Resources
Search by name
A
Near City, State, ZIP, or Keyword
B
Search
Filter by
Clear
To begin, search by name or apply a filter.
Favorite
My favorites
Showing potentially relevant results (recents, favorites, care team members).
Most relevant matches on top
Provided Service
C
Child Nutrition Programs
Disaster Response
Emergency Food
Food Delivery
Food Insecurity Services
Food Pantry
Formula


Community Resources
Search by name
Near City, State, ZIP, or Keyword
Search
Filter by
Clear
Favorite
My favorites
Provided Service
Child Nutrition Programs
Disaster Response
Emergency Food
Food Delivery
Food Insecurity Services
Food Pantry
Formula
Showing results. Filtered by: Provided Service
Most relevant matches on top
BI
12 Baskets, Inc. - Food Ministry
Food Pantry
501 South Topeka Street
El Dorado KS 67042
AU
Admire United Methodist Church - Food Pantry
Food Pantry
100 East 3rd Street
Admire KS 66830
AC
Affton Christian Food Pantry - Food Pantry
Food Pantry
4960 Heege Road
St. Louis MO 63123
AV
Arcadia Valley Food Pantry - Food Pantry
Selections (1)
Clear
AL
Abundant Life - Food Pantry
112 West 23rd Street South
Independence MO 64055
Accept
Cancel

The Resource is Added to the AVS

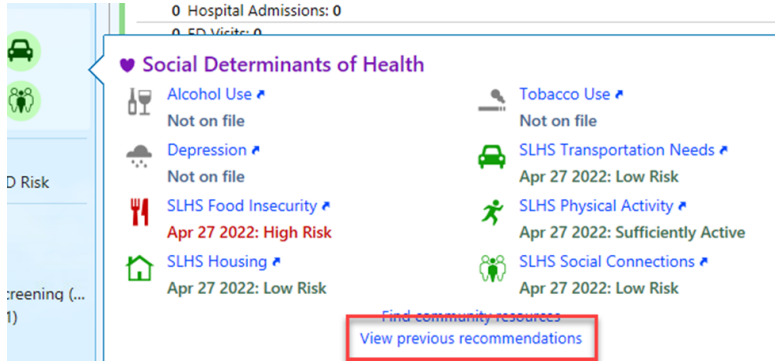
Continuing Care

SLHS HP Community Resources

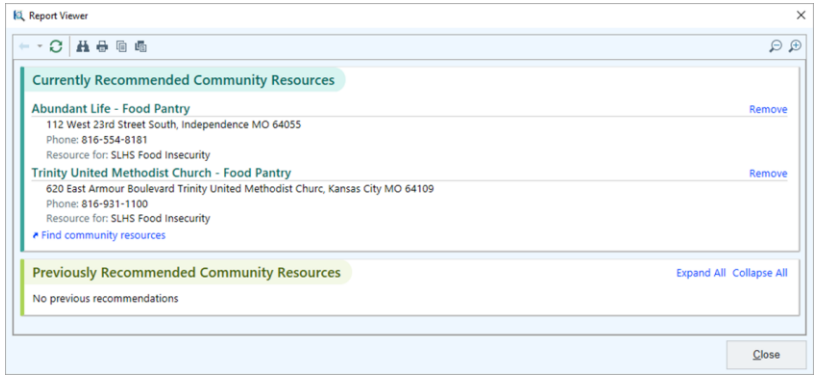
Abundant Life - Food Pantry

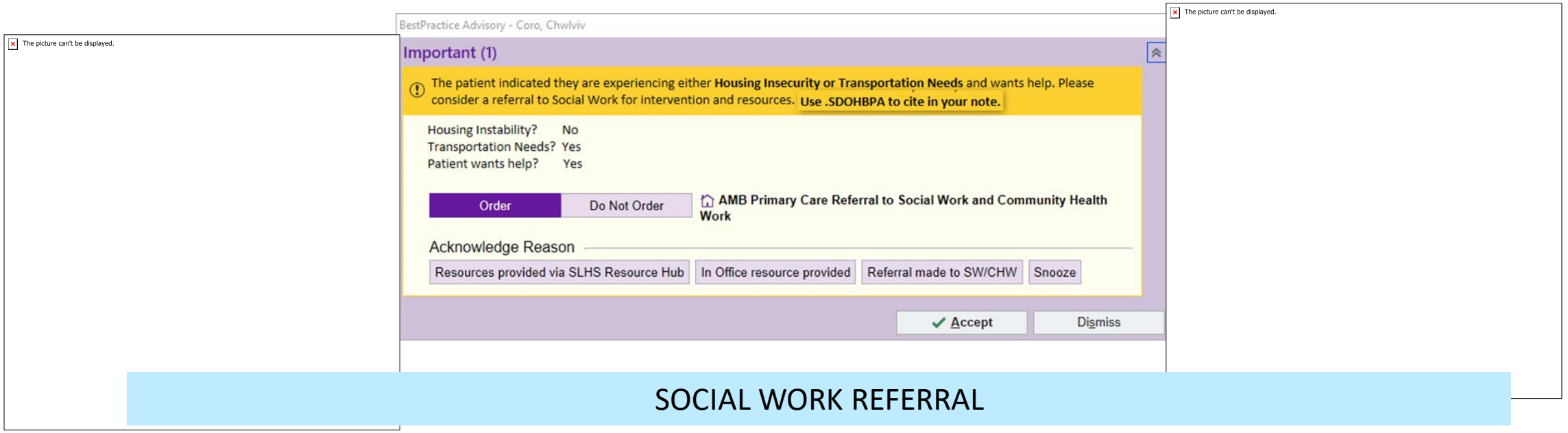
Address: 112 West 23rd Street South, Independence MO 64055
Phone: 816-554-8181
Website: https://livingproof.co/ministry/foodpantry/
Languages: English
Cost: Free
Hours of Operation

Sun	—
Mon	—
Tue	3:00 PM - 6:00 PM
Wed	—
Thu	—
Fri	—
Sat	—



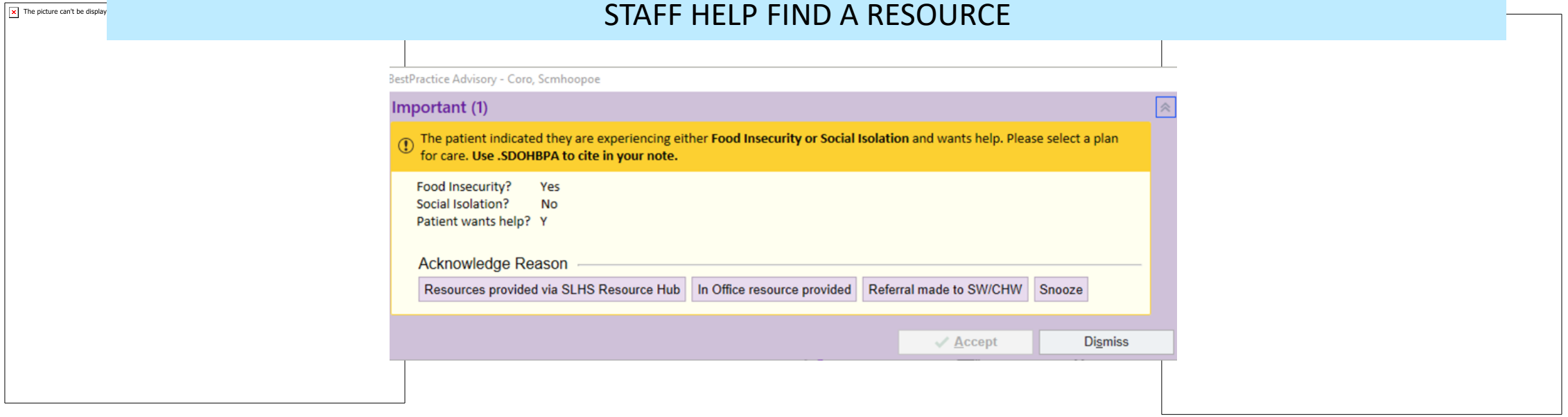
The Resource is Saved and can be viewed again for follow up





SOCIAL WORK REFERRAL

STAFF HELP FIND A RESOURCE



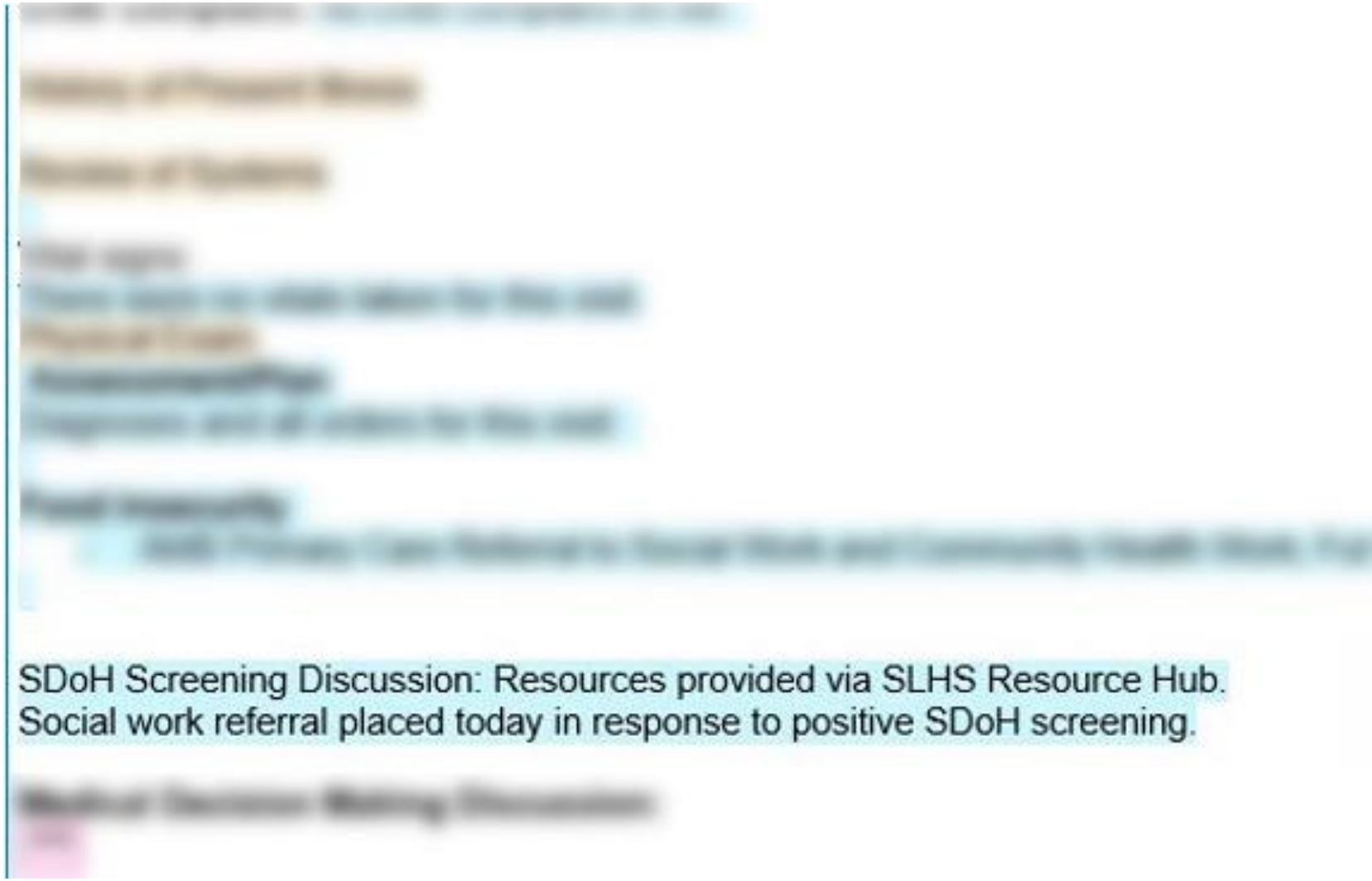
Charge and Diagnosis Codes

- Screening is captured with the following non-payable CPT II codes:
  - **G9920**: Screening Performed and Negative
  - **G9919**: Screening Performed and Positive with Provision of Recommendations

- If a screening is positive, at least one of following ICD-10 codes will be reported on the claim indicating the applicable SDoH reason:

Food Insecurity	Z59.41	Lack of adequate food and safe drinking water
Housing Insecurity	Z59.819	Housing instability, housed unspecified
Transportation Need	Z91.89	Other specified personal risk factors, NEC (transportation difficulty)
Social Isolation	Z60.9	Problem related to social environment, unspecified

Documentation of Interventions Offered In the Note



SDoH Screening Discussion: Resources provided via SLHS Resource Hub.
Social work referral placed today in response to positive SDoH screening.

What are we learning from our community?

Why this? Why here? Why now?

- Food insecurity, second highest SDOH need in our patient population and we have many resources in the community
- Priority zip codes (Identified Jan 2022, based on Dec 2021 data):
  - 64133, 64134, 64055
  - Expanding to (Aug 2022):
    - 64014, 64015, 64050, 64053

Target Zip Code Nearest Patient

Harvesters Coordinator

SLHS

Patient

SDoH Positive Screen

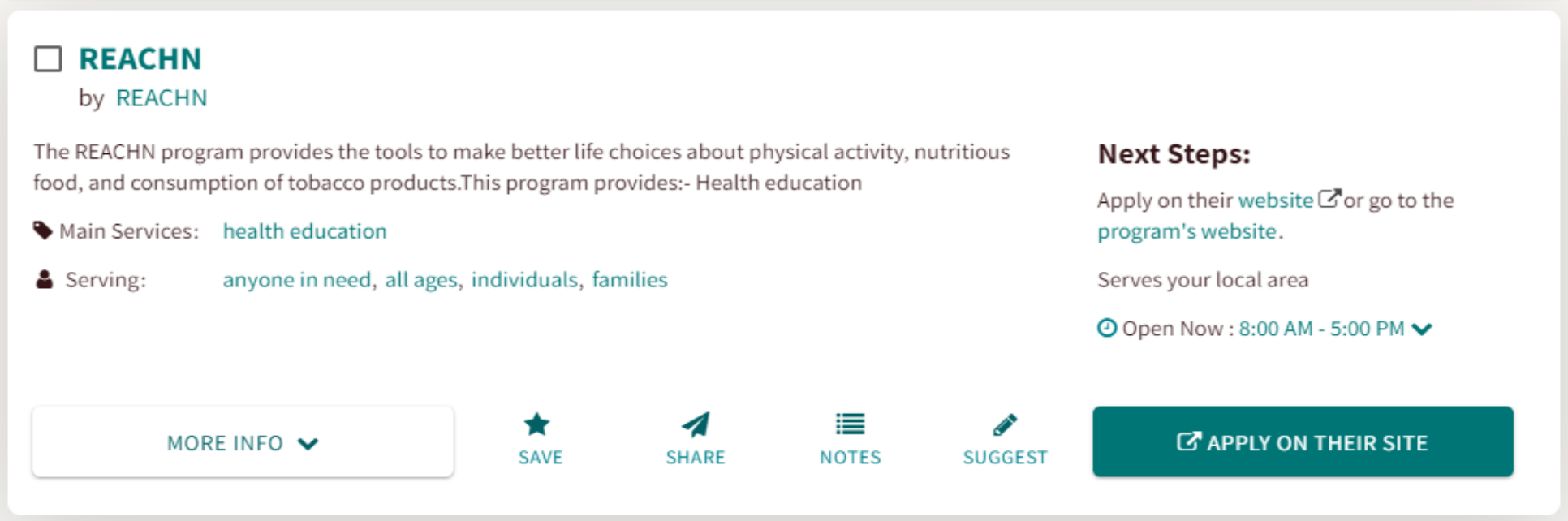
CHW connects patient to SLHS programs & places referral

CBO Referral Platform

findhelp

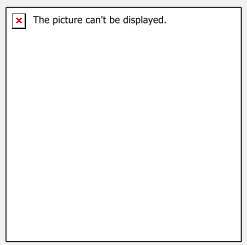
Resource for Social Connection & Physical Activity

REACH'N
Resilience, Education, Activity, Community Health, Nutrition

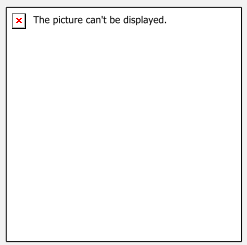


@reachnkc @teamreachn

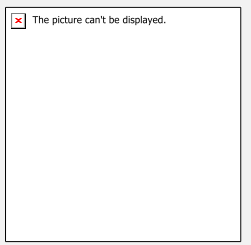
Additional Resources



SOCIAL WORKERS



COMMUNITY HEALTH WORKERS



CBO AND COMMUNITY PARTNERSHIPS

Resources

- Reporting on Custom Payer Programs with Epic https://galaxy.epic.com/Search/GetFile?Url=1!68!100!100075090
- Health Leads – Social Needs Screening Toolkit. https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/
- PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences. https://www.nachc.org/research-and-data/prapare
- AMA and ASSN https://www.ama-assn.org/delivering-care/patient-support-advocacy/how-improve-screening-social-determinants-health

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Phoenix Children's®
Care Network

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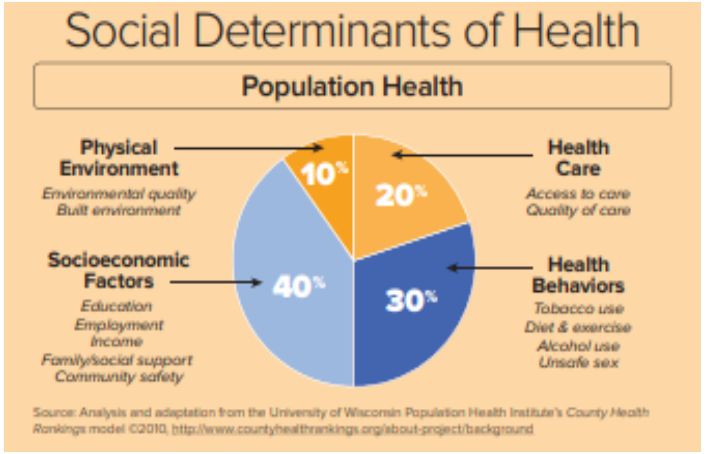
The Importance of SDoH Screening

"Health starts where we live, learn, work and play"

To provide the highest quality of care, it is important to understand the variety of factors that affect a child's overall health and well-being

- Unmet SDoH needs can significantly alter a child's health, well-being and socioeconomic trajectories.
- The American Academy of Pediatrics (AAP) recommends screening for SDoH during **all** patient encounters by using a tool to assess basic needs such as food, housing, and heat.
- **Systematically screening and referring for social determinants during well childcare can lead to the receipt of more community resources for families.**



Health Equity and Social Determinants of Health as Pivotal Concepts in Healthy People

- Health equity means that everyone has a fair and just opportunity to be healthy
- This requires removing obstacles to health, such as **poverty**, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care
- **Intersectionality between Health Inequities and Social Determinants of Health**

Marmot M, Friel S, Bell R, Houweling TA, Taylor S: Closing the gap in a generation: health equity through action on the social determinants of health. The Lancet. 2008;372:1661–1669.

Lopez N, Gadsen VL: Health Inequities, Social Determinants, and Intersectionality. National Academy of Medicine. Dec 2016, 1-15

Schillinger D. The Intersections Between Social Determinants of Health, Health Literacy, and Health Disparities. Stud Health Technol Inform. 2020;269:22-410020.

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Social Determinants of Health Screening in the Clinical Setting: Background

- **Social circumstances** such as food insecurity, housing instability, unmet transportation needs, and interpersonal violence comprise the social determinants of health (SDoH) and can significantly alter a child's health, well-being, and socioeconomic trajectories
- **SDoH screening and the associated referral process** have been demonstrated to **increase detection and discussion of patients' social needs and to increase families' receipt of beneficial resources**
- Research shows that up to **70% of a person's overall health** is driven by these social and environmental factors, and the behavior influenced by them
- **"The evidence is clear: *social determinants of health, such as access to stable housing or gainful employment, may not be strictly medical, but they nevertheless have a profound impact on people's wellbeing,*" said CMS Administrator Seema Verma. "**
- **Develop, operationalize, and implement a system wide SDoH screener to inform strategy and intervention**

Rationale for a Standardized SDoH Screening Tool:

- **Standardizing a set of SDoH screening questions** will help maintain strong network focus on SDoH
- **Questions that have been externally validated, scorable** and written at an accessible reading level have the potential to improve the effectiveness of screening, especially in the early and testing phases
- **Furthermore, having consistent screening questions and processes will allow for network collection of data with respect to the unmet needs of our population and their impact on health outcomes and costs – well-defined workflows**
- In turn, this **valuable feedback loop** will inform policy, planning and investment that can support **better ways to address unmet resource needs, improve the quality of care, and improve health care utilization over time**

PCCN SDoH Quality Improvement Process
CQI methodology – 7 question format

- **Data and research**
  - Significant population health concerns
  - Insufficient SDoH Screenings
  - Unmet SDoH needs
- **Goal**
  - Develop, implement, and operationalize a closed-loop system of referral for Social Determinants of Health issues and concerns in the pediatric population.
- **Measurement**
  - Baseline practice data.
  - Practices using the screening tool, patient needs met, and use of proper codes.
- **Analysis**
  - Run chart methodology
- **Changes to create improvement**
  - Educational programs
  - System Changes
- **PDSA cycle**
  - Continual process improvements to meet changing needs of program

Phoenix Children's Care Network Quality Improvement Module Social Determinants of Health (SDoH)
Screening in the Clinical Setting

Develop, operationalize, and implement a system wide SDoH screener to inform strategy and intervention

Background:

Social circumstances such as food insecurity, housing instability, unmet transportation needs, and interpersonal violence comprise the social determinants of health (SDoH) and can significantly alter a child's health, well-being, and socioeconomic trajectories. This impact on health is well-documented. Research shows that up to 70% of a person's overall health is driven by these social and environmental factors, and the behavior influenced by them. Currently, 90% of health care spending in the United States is on medical care in a hospital or doctor's office. Many healthcare organizations are developing innovative methods to address SDoH within clinical settings as a possible strategy to enhance patient care, improve health outcomes, and prevent avoidable health care utilization. One approach endorsed by the American Academy of Pediatrics is SDoH screening. This process takes place within clinical care settings and relies on clinical teams to administer a validated and standardized survey, which seeks to identify unmet social needs or adverse social circumstances within the patient's experience. Results are discussed with the patients and their families and an action plan is developed to address their needs. Referrals to community resources are the most common. Overall, screening is a complex process that will require considerable deliberation before implementing. Clinical care settings will need to consider their staffing capabilities, patient needs, and other variables before deciding upon a tool to use. With proper implementation, SDoH screening and the associated referral process have been demonstrated to increase detection and discussion of patients' social needs and to increase families' receipt of beneficial resources. Despite the numerous benefits associated with pediatric screening, no standardized procedure nor tool exists. This policy brief reviews many of the models which implement screening and the characteristics that individual care settings should consider when selecting a tool for their institution. In addition, this brief discusses general implementation strategies and assesses the merits and evidence base of different comprehensive screening tools currently in use. To improve SDoH screening, action is needed at the policy, clinical care setting, and community levels. In terms of policy, innovative funding mechanisms should be implemented to promote screening and care coordination with community resources. Efforts should be made to institutionalize screening and ICD-10 codes should be expanded to account for the full spectrum of SDoH. Clinical care settings must adapt their electronic medical records to include data on patients' social needs and invest in provider training on SDoH screening. Finally, at the community level, clinical care settings and community partners should work together to develop comprehensive resource lists and establish feedback mechanisms to report on the appropriateness, quality, and quantity of referrals.

Phoenix Children's Care Network Quality Improvement Module Social Determinants of Health (SDoH) Screening in the Clinical Setting

Rationale for a Standardized SDoH Screening Tool:

Standardizing a set of SDoH screening questions will help maintain strong network focus on SDoH. Questions that have been externally validated and written at an accessible reading level have the potential to improve the effectiveness of screening, especially in the early and testing phases. Furthermore, having consistent screening questions and processes will allow for network collection of data with respect to the unmet needs of our population and their impact on health outcomes and costs. In turn, this valuable feedback loop will inform policy, planning and investment that can support better ways to address unmet resource needs, improve the quality of care, and improve health care utilization over time.

Development of a Standardized SDoH Screening Tool:

Development of standardized SDoH screening questions has been grounded on the following principles:

- First, the screening questions need to include domains where high-quality evidence exists linking them to health outcomes and must identify needs for which there are some resources and services in the community available to address them.

- Second, the screening questions must be simple, brief, and applicable to most populations, so that they can be easily integrated into workflows in diverse and varied settings across the state. The questions do not have to address all nuances of need; rather, a positive response on a screening question should trigger a more in-depth assessment that allows a greater understanding of specific needs and more targeted navigation to resources by a community health worker, care manager, social worker or other member of the team. Since the questions are intended in time to be used by providers in diverse settings there should be flexibility for providers to include additional domains as needed or desired by the setting or population being served.

- Third, the questions must be validated, draw from best practices and must be written at accessible reading levels to ensure that they can be effectively used.

- Fourth, to the greatest extent possible, the questions should align with existing screening tools (e.g. Bright Futures Questionnaire, Meaningful Use, Uniform Data Set (Community Health Centers), PRAPARE (Community Health Centers), Accountable Health Community, Pregnancy Medical Home Screen. This intentional alignment to existing tools will allow for easier implementation and similar data collection.

Phoenix Children's Care Network Quality Improvement Module Social Determinants of Health (SDoH) Screening in the Clinical Setting

Team Composition:

Dr. Roy Jedeikin, Chief Medical Officer
Jodi Brigola, Manager Practice Integration and Quality Programs Nathan Larsen, Sr. Practice Integration Rep
Griffin Baker, Sr. Practice Integration Rep Brittany Baarson, Sr. Health Informatics Analyst
Bryce Sherman, Director Business Operations and Clinical Programs Kelley Guerriero, Manager Integrated Care Coordination

Goal:

To support practices and providers in adopting a screening tool to assist in identifying and managing the social needs of patients and families.

- Develop, implement, and operationalize a closed-loop system of referral for SDOH issues and concerns in the pediatric population.
- Increase the percentage of practices / providers using SDoH screening tool and Z-codes by 25% in 6 months.

Measurement:

Outcome Measure:

- Development of baseline provider practice data relating to practices conforming to consistent use of SDoH screener tool.
- Measure the percentage of practices using the screening tool.
- Measure the percentage of patients who received a referral for SDOH needs assessment.
- Measure the percentage of practices utilizing SDoH Z-codes using payer claims data

Measurement Analysis:
Run chart methodology

Phoenix Children's Care Network Quality Improvement Module Social Determinants of Health (SDoH) Screening in the Clinical Setting

Changes to Create Improvement:

Educational Programs:

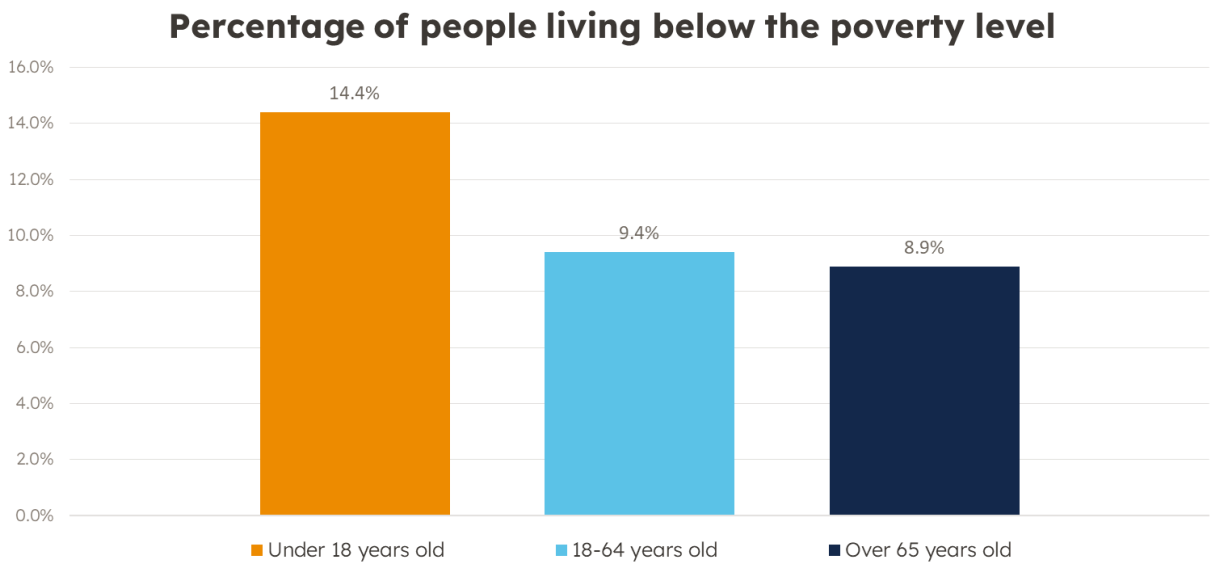
- Define SDoH and educate practices and PCCN clinical teams
- Coding assistance
- Best practice information
- Proper use of screening tool
- Referral process
- Define source of truth for Z-codes
- Include Z-codes on reverse side of screening tool
- Define workflow process

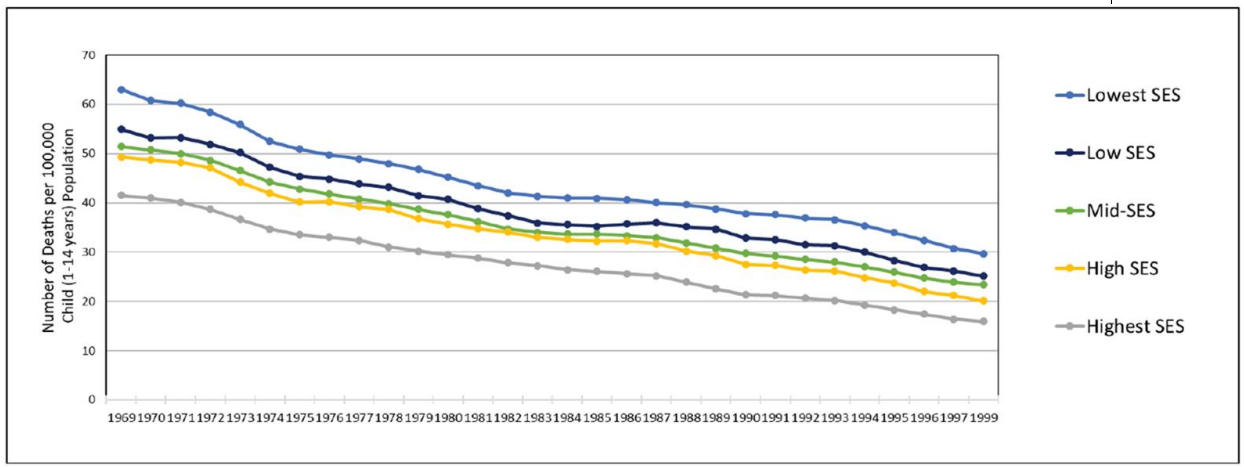
System Changes:

- PCCN system changes
  - ICC team will accept SDoH referrals
    - Standardized tool created by PCCN
    - SCM orders (PCMG PCH internal process)
    - Previously established SDoH tool used by practice
  - ICC team follow-up
    - Team member contacts family
    - Refers to community resources
    - Confirms resource utilization by family
    - Closes loops with PCP
- Practice system changes
  - Screen every patient every visit
    - SDoH tool completed pre-visit (available via email and/or website)
    - SDoH tool completed at check-in
  - Use of a screening tool
    - PCCN standardized tool
    - Established practice tool
  - Documentation in EMR
    - Patient screened
    - Use of Z-code with correlating diagnosis
    - Referral sent
  - Discuss needs with family
    - purpose / function of PCCN interaction
  - Refer to ICC team

Are there SDoH concerns for children?

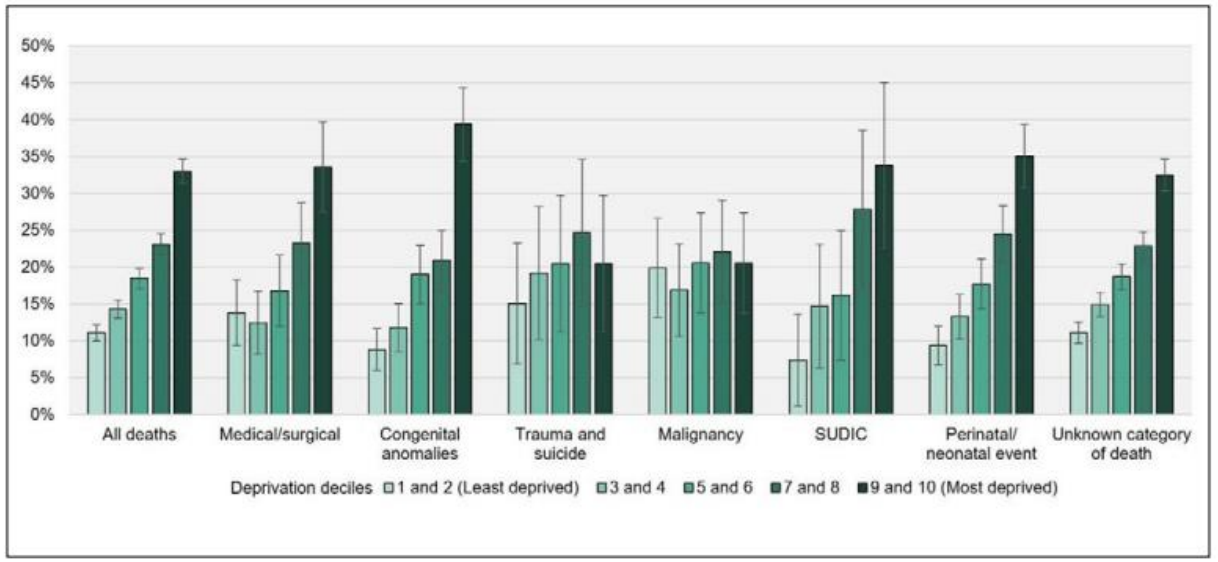
The relationship between health and socioeconomic status is true for children:
The lower the family income, the higher the health risks
Relative risk of all-cause mortality is 86% higher in low-income children





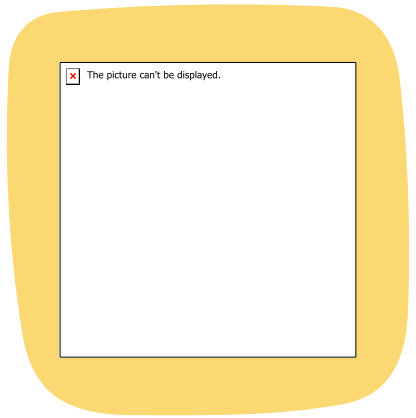
Child Mortality and Social Deprivation National Child Mortality Database Program Thematic Report Data from April 2019 to March 2020

Figure 1. The proportion of deaths in each pair of deprivation deciles for all deaths and across each category of death, including 95% confidence intervals. (Cohort 1)

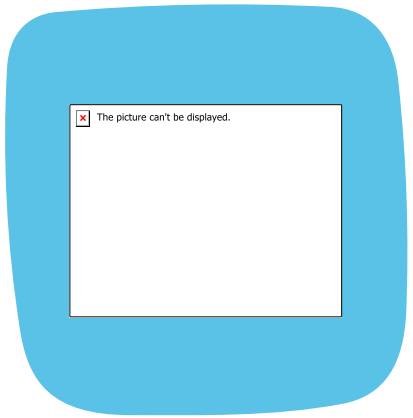


Cohort 1: Reported deaths. A total of 3,347 childhood deaths that occurred between April 2019 and March 2020 were reported to the NCMD

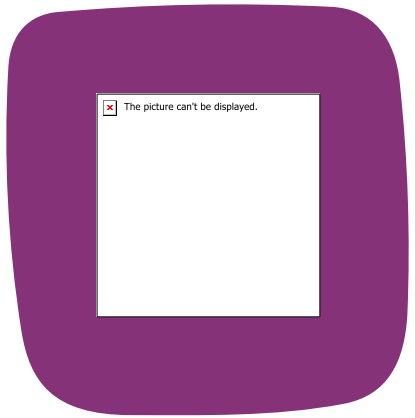
SDoH Screening Challenges



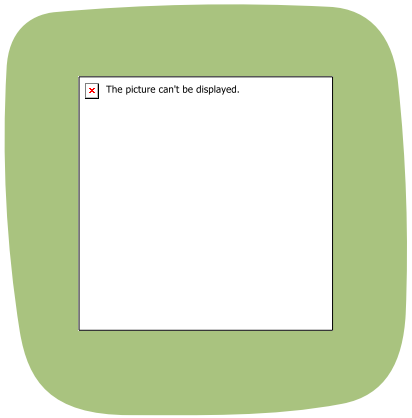
Developing a Screening Tool



Establishing a Workflow



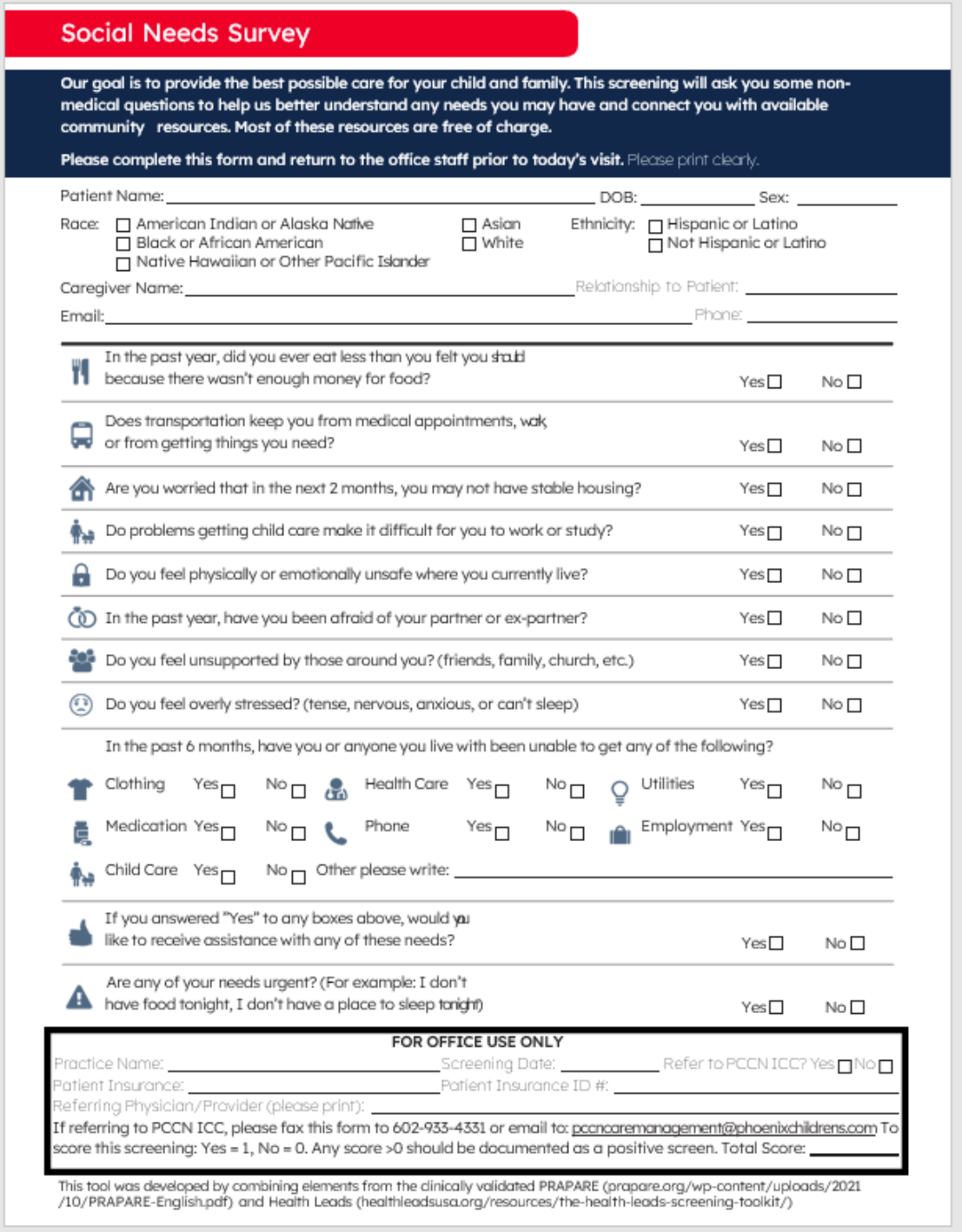
Addressing Positive Screens



Coding and Billing

Developing a Screening Tool

- PCCN developed a validated, standardized, and scoreable tool using PRAPARE and Health Leads
- Can be administered on paper or electronically
- Should be completed by the caregiver or patient (if appropriate) upon check-in
- Easy to identify the positive screens
- Ability to refer



Social Needs Survey

Our goal is to provide the best possible care for your child and family. This screening will ask you some non-medical questions to help us better understand any needs you may have and connect you with available community resources. Most of these resources are free of charge.

Please complete this form and return to the office staff prior to today's visit. Please print clearly.

Patient Name: _____ DOB: _____ Sex: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Caregiver Name: _____ Relationship to Patient: _____

Email: _____ Phone: _____

In the past year, did you ever eat less than you felt you should because there wasn't enough money for food?	Yes ☐	No ☐
Does transportation keep you from medical appointments, work, or from getting things you need?	Yes ☐	No ☐
Are you worried that in the next 2 months, you may not have stable housing?	Yes ☐	No ☐
Do problems getting child care make it difficult for you to work or study?	Yes ☐	No ☐
Do you feel physically or emotionally unsafe where you currently live?	Yes ☐	No ☐
In the past year, have you been afraid of your partner or ex-partner?	Yes ☐	No ☐
Do you feel unsupported by those around you? (friends, family, church, etc.)	Yes ☐	No ☐
Do you feel overly stressed? (tense, nervous, anxious, or can't sleep)	Yes ☐	No ☐

In the past 6 months, have you or anyone you live with been unable to get any of the following?

Clothing	Yes ☐	No ☐	Health Care	Yes ☐	No ☐	Utilities	Yes ☐	No ☐
Medication	Yes ☐	No ☐	Phone	Yes ☐	No ☐	Employment	Yes ☐	No ☐
Child Care	Yes ☐	No ☐	Other please write: _____					

If you answered "Yes" to any boxes above, would you like to receive assistance with any of these needs?	Yes ☐	No ☐
Are any of your needs urgent? (For example: I don't have food tonight, I don't have a place to sleep tonight)	Yes ☐	No ☐

FOR OFFICE USE ONLY

Practice Name: _____ Screening Date: _____ Refer to PCCN ICC? Yes ☐ No ☐

Patient Insurance: _____ Patient Insurance ID #: _____

Referring Physician/Provider (please print): _____

If referring to PCCN ICC, please fax this form to 602-933-4331 or email to: pccncaremanagement@phoenixchildrens.com To score this screening: Yes = 1, No = 0. Any score >0 should be documented as a positive screen. Total Score: _____

This tool was developed by combining elements from the clinically validated PRAPARE (prapare.org/wp-content/uploads/2021/10/PRAPARE-English.pdf) and Health Leads (healthleadsusa.org/resources/the-health-leads-screening-toolkit/)

Establishing a Workflow

Patient arrives for visit

Caregiver /patient completes SDoH screening at time of registration

Staff gives completed screening to provider

During patient visit provider addresses needs and asks if they would like any help

Does the patient want help?

YES

Is the patient aligned with PCCN?

YES

Fax or email the screening tool to the PCCN ICC Team

ICC Team reaches out to caregiver/ patient

Caregiver/ patient receives assistance

ICC Team closes loop with caregiver/ patient & provider

NO

Practice may provide list of resources and follow-up at next visit

NO

Practice may coordinate referral or provide list of resources

Practice should establish follow up process if not already in place

Addressing Positive Screens

Patients aligned with PCCN

- Send the completed screening tool to PCCN's Integrated Care Coordination (ICC) Team
  - Fax to 602-933-4331

  -OR-

  - Email to pccncaremanagement@phoenixchildrens.com
- SDoH concerns are addressed by the ICC Team through PCCN Patient Stratification Model, Payer Referrals, ED Visits, PCH Referrals, and Inpatient Discharge
- ICC Team contacts caregiver/patient, ensures needs are met and closes the loop with caregiver/patient and practice

- Care Management Tech
- Care Navigators
- Licensed Social Worker
- Social Worker Techs (SST)
- Nurses

Addressing Positive Screens

Patients not aligned with PCCN

- Refer to available community resources, options include:

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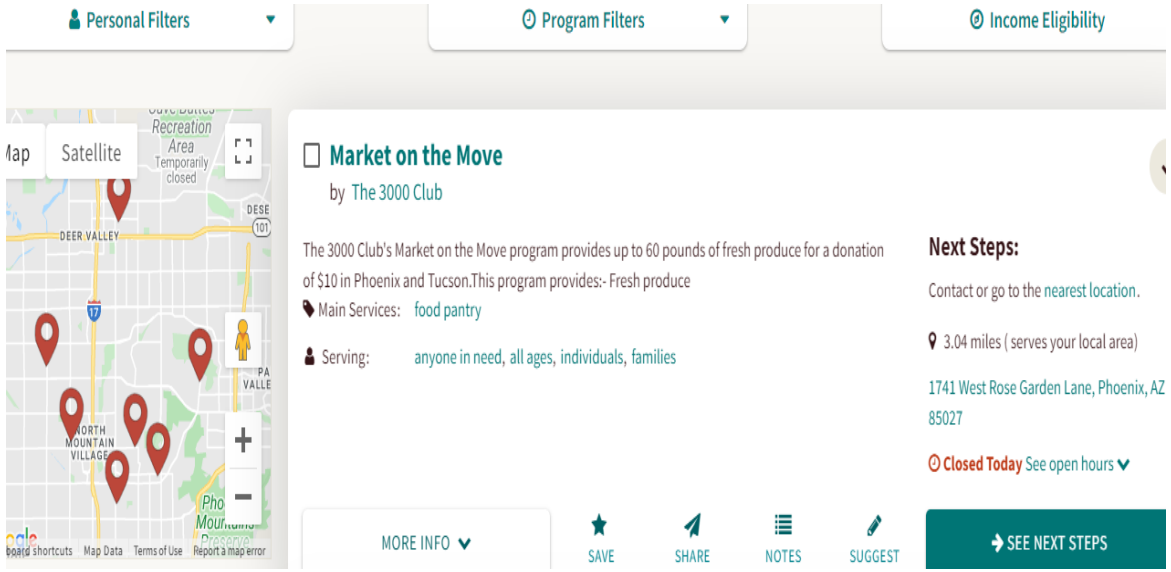

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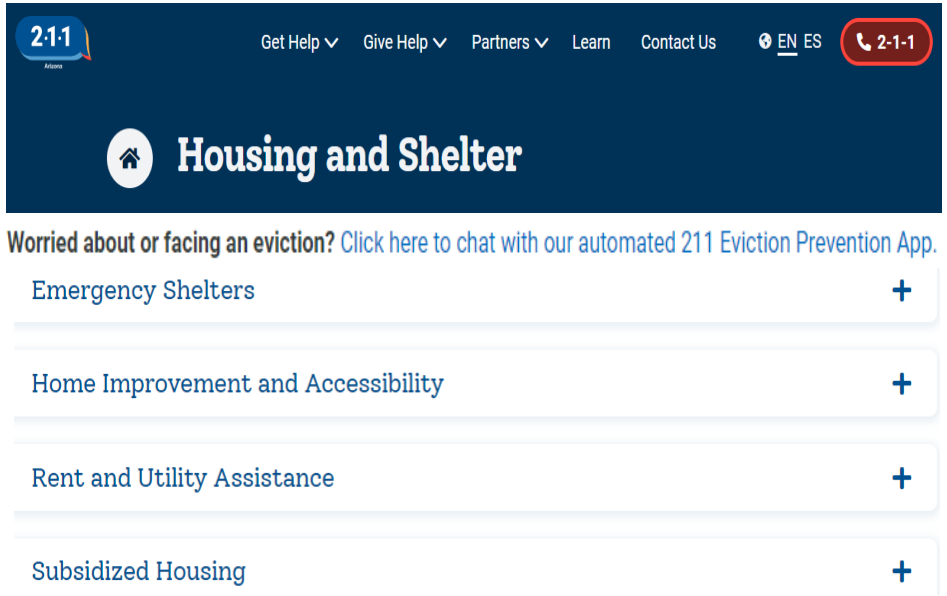
https://www.211.org/

Call 211 or use the 211 app



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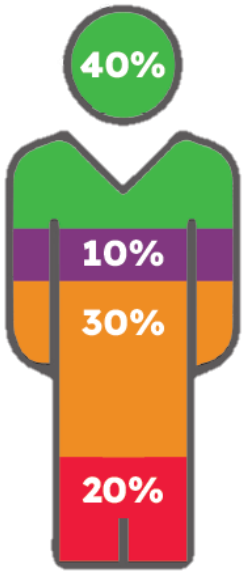
Addressing Positive Screens

- Employment resources, teen summer jobs, volunteerism
- WIC, medically-covered diapers, supplies
- AzEIP, Headstart, developmental preschool
- IEP/504 Plan, School advocacy
- Childcare
- Clothing
- School supplies
- Support Groups, parenting education

Physical Environment

- Housing resources
- Low-income housing
- Shelters
- Assistance with rent
- Utilities
- Summer camps
- Low-cost activities

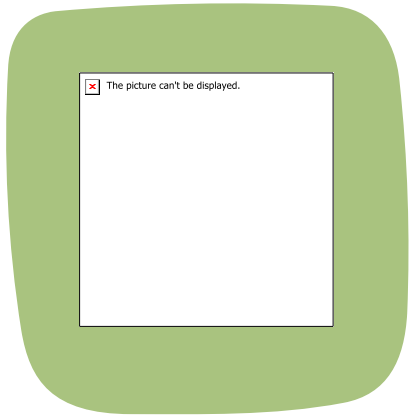


Health Behaviors

- Nutrition
- Food banks, pantries, SNAP
- Disease education
- Substance abuse – support groups, treatment, IOP, IP, outpatient, education
- Counseling, support groups, education, psychiatry, IOP, IP

- Coordinate with primary and secondary insurances
- Coordinate PA's, Appeals
- Financial assistance for medication
- Health Education
- Assist with insurance transitions

Coding and Billing



Reimbursement for Screening

Data Tracking and Analytics

Coding and Billing – Reimbursement for Screening

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

90 Years of Caring for Children—1930–2020

Quick Reference for Social Determinants of Health (SDOH) Coding

Determining SDOH Risk Factors

Via Standardized Instrument

If SDOH risk factors are determined by use of a standardized instrument, CPT code 96160 or 96161 can be reported:

96160 *Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument*

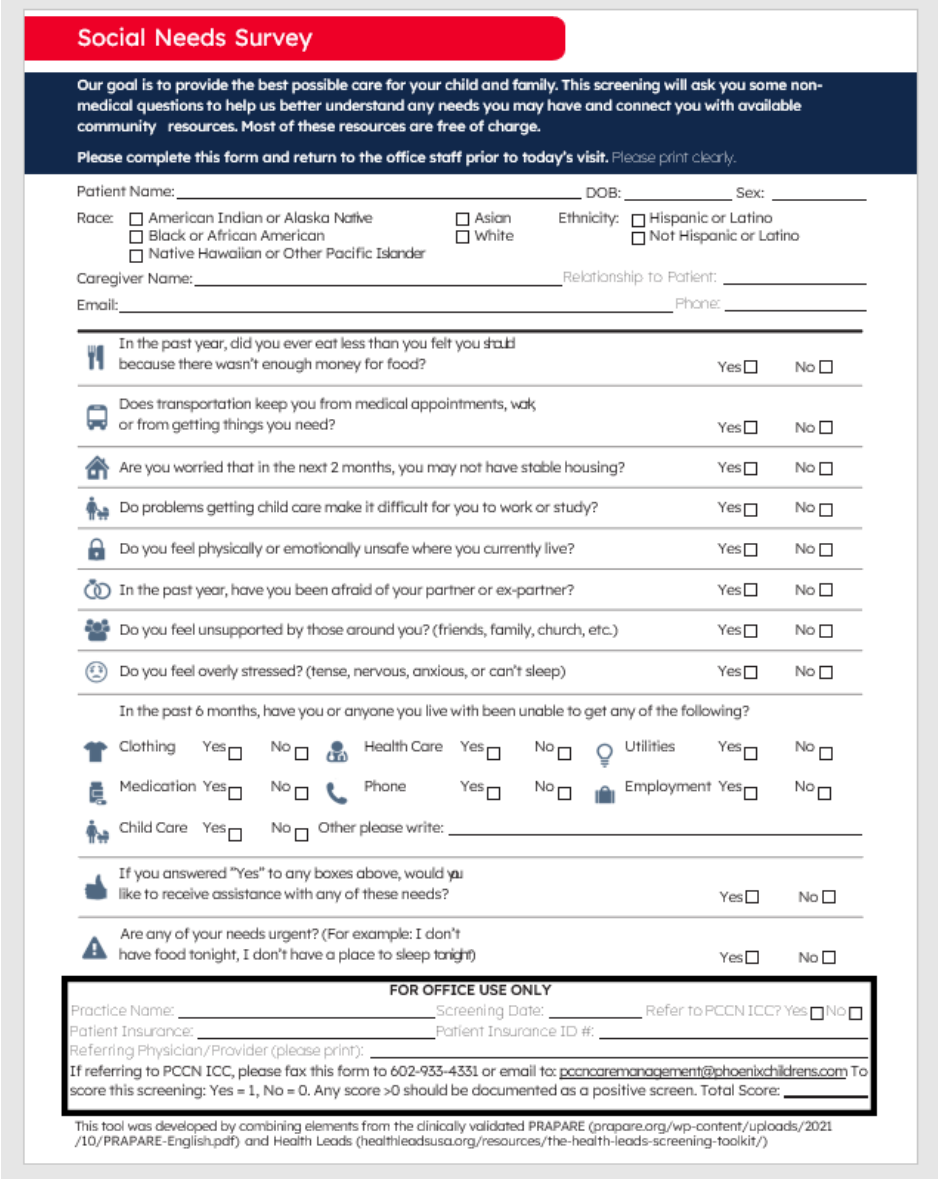
96161 *Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument*

CPT defines "standardized instruments" as follows: Used in the performance of these services. Standardized instruments are validated tests that are administered and scored in a consistent or "standard" manner consistent with their validation.

Codes 96160-96161 are reported in addition to the evaluation and management (E/M) code (eg, 99213).

Coding and Billing – Reimbursement for Screening

- The PCCN SDoH Screening Tool meets the criteria for use of CPT Code 96160
  - Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument



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Please complete this form and return to the office staff prior to today's visit. Please print clearly.

Patient Name: _____ DOB: _____ Sex: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Caregiver Name: _____ Relationship to Patient: _____

Email: _____ Phone: _____

In the past year, did you ever eat less than you felt you should because there wasn't enough money for food?	Yes ☐	No ☐
Does transportation keep you from medical appointments, work, or from getting things you need?	Yes ☐	No ☐
Are you worried that in the next 2 months, you may not have stable housing?	Yes ☐	No ☐
Do problems getting child care make it difficult for you to work or study?	Yes ☐	No ☐
Do you feel physically or emotionally unsafe where you currently live?	Yes ☐	No ☐
In the past year, have you been afraid of your partner or ex-partner?	Yes ☐	No ☐
Do you feel unsupported by those around you? (friends, family, church, etc.)	Yes ☐	No ☐
Do you feel overly stressed? (tense, nervous, anxious, or can't sleep)	Yes ☐	No ☐

In the past 6 months, have you or anyone you live with been unable to get any of the following?

Clothing	Yes ☐	No ☐	Health Care	Yes ☐	No ☐	Utilities	Yes ☐ No ☐
Medication	Yes ☐	No ☐	Phone	Yes ☐	No ☐	Employment	Yes ☐ No ☐
Child Care	Yes ☐	No ☐	Other please write: _____				

If you answered "Yes" to any boxes above, would you like to receive assistance with any of these needs?	Yes ☐	No ☐
Are any of your needs urgent? (For example: I don't have food tonight, I don't have a place to sleep tonight)	Yes ☐	No ☐

FOR OFFICE USE ONLY

Practice Name: _____ Screening Date: _____ Refer to PCCN ICC? Yes ☐ No ☐

Patient Insurance: _____ Patient Insurance ID #: _____

Referring Physician/Provider (please print): _____

If referring to PCCN ICC, please fax this form to 602-933-4331 or email to: pccncaremanagement@phoenixchildrens.com To score this screening: Yes = 1, No = 0. Any score >0 should be documented as a positive screen. Total Score: _____

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Coding and Billing – Reimbursement for Screening

ICD-10 Codes

- Z13.89
  - Billable and payable
  - Use in conjunction with 96160
  - Must be listed first
- SDoH Z-Codes
  - Use when screening detects SDoH need
  - Add appropriate diagnosis code(s) from list **after** Z13.89

Coding and Billing – Z-Code Categories

(Z55) Problems related to education and literacy
(Z56) Problems related to employment and unemployment
(Z57) Contact with and suspected occupational exposure
    Z57.5 Occupational exposure to toxic agents in other industries
(Z58) Problems related to physical environment
    Z58.6 Inadequate drinking-water supply
(Z59) Problems related to housing and economic circumstances
    Z59.0 Homelessness
    Z59.5 Extreme poverty
    Z59.6 Low income
(Z60) Problems related to social environment
(Z62) Problems related to upbringing
(Z63) Other problems related to primary support group, including family circumstances

(Z64) Problems related to certain psychosocial circumstances
    (Z64.0)Problems related to Unwanted pregnancy
(Z65) Experiences with crime, violence and the judicial system

(Z71) Drug or Alcohol Counseling
(Z72) Problems related to lifestyle
(Z73) Problems related to life management difficulty
(Z75) Problems related to medical facilities and other health care
    Z75.3 Unavailability and inaccessibility of health care facilities
(Z77) Contact with and suspected exposure
    Z77.011 Contact with and (suspected) exposure to lead
(Z91) Personal risk factors
    Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship

Coding and Billing – Data Tracking and Analytics

Valid Healthcare Common Procedure Coding System (HCPCS) codes should be used to ensure PCCN and payors are able to track and analyze SDoH data

G9919

Screening performed and positive for provision of recommendations

-OR-

G9920

Screening performed and negative

Well Care/SDoH Coding Examples

Vignette 1:

A four-year-old established patient is at a physician's office for her/his annual well-child examination. The patient is medically healthy, and SDoH screening is negative.

	Office visit CPT	SDoH Screening	Coding for Documentation of Screening
CPT:	99392	96160	G9920 (negative)
ICD10:	Z00.129	Z13.89	Z00.129

Vignette 2:

A three-year-old established patient is at a physician's office for her/his annual well-child examination. The patient is medically healthy with abnormal findings due to a positive SDoH screening for housing and food needs.

	Office visit CPT	SDoH Screening	Coding for Documentation of Screening
CPT:	99392	96160	G9919 (positive)
ICD10:	Z00.121	Z13.89	Z00.121
		Z59.8	
		Z59.4	

Sick Visit/SDoH Coding Examples

Vignette 3:

A two-year-old is seen for a sick visit and diagnosed with strep pharyngitis. The SDoH screening is negative.

	Office visit CPT	SDoH Screening	Coding for Documentation of Screening
CPT:	99213	96160	G9920 (negative)
ICD10:	J02.0	Z13.89	J02.0

Vignette 4:

A two-year-old is seen for a sick visit and is diagnosed with otitis externa, right ear. The SDoH screening is positive for homelessness and extreme poverty

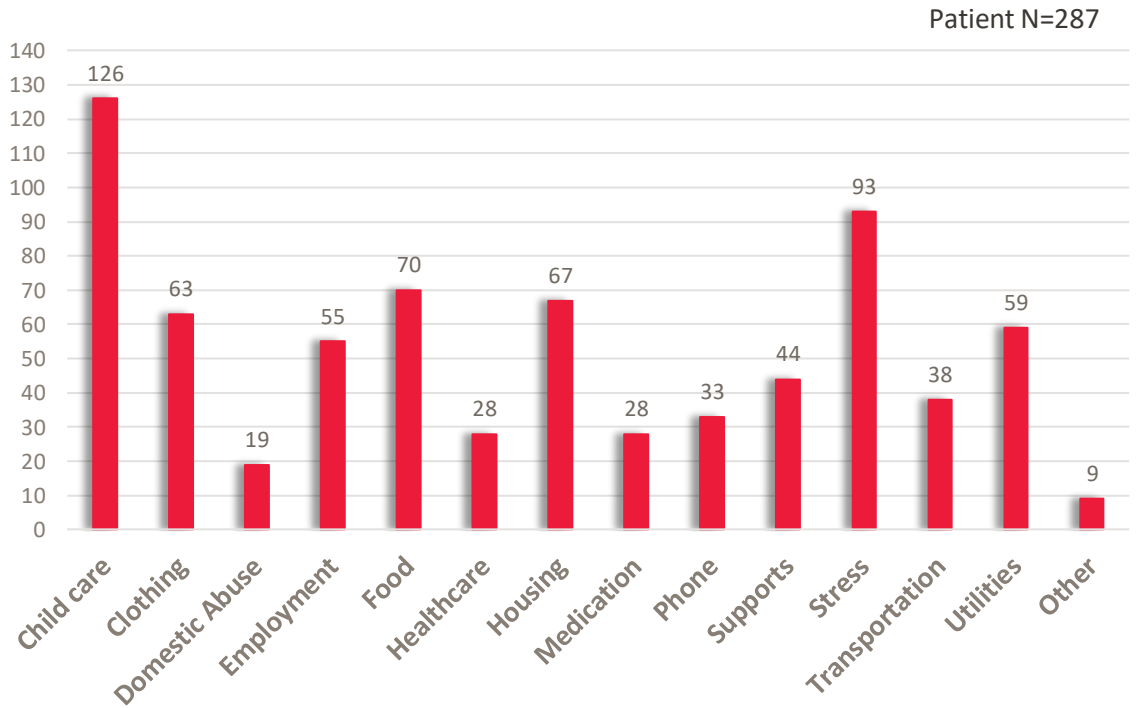
	Office visit CPT	SDoH Screening	Coding for Documentation of Screening
CPT:	99214	96160	G9919 (positive)
ICD10:	H60.391	Z13.89	H60.391
		Z59.0	
		Z59.5	

PCCN's SDOH Trends

By the numbers

- Participating Practices: 11
- Total Patients Screened: 2,578
- Total Positive Screens: 307 (12%)
- Patients Enrolled in ICC: 287
- Patients with Urgent Needs:14

Needs Identified



Program Effective Date: April 1, 2022
Program Data as of September 16, 2022

References:

Bright Futures Questionnaire: https://toolkits.solutions.aap.org/DocumentLibrary/BFTK2e_Links_Screening_Tools.pdf PRAPARE (Community Health Centers): https://www.nachc.org/research-and-data/prapare/
Data Set Directory of Social Determinants of Health at the Local Level: https://www.cdc.gov/dhdsp/docs/data_set_directory.pdf
National Institute of Health: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6779030/
National Institute of Health: The Journal of Ambulatory Care Management https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5705433/


ALLIED
COMMUNITY
IS
STRENGTH.
BE STRONG. LET'S LOOK OUT FOR ONE ANOTHER.

Break

Upcoming at 3:05 p.m. - Breakout Sessions

Conference room 106

Breakout Session #4: Risk recapture strategies to support providers and members

Attendees will hear from a health system and payer on how they are partnering to engage providers in risk recapture strategies to ensure the risk of the population is accurately captured.

Conference room 101

Breakout Session #5: Engaging patients with primary care

During this breakout session attendees will learn approaches to engaging patients with primary care. Attendees will learn from Park Nicollet on how they use their care consultants to ensure patients at risk receive appropriate follow-up and care. Medica will present member outreach models that have targeted non-users, preventable emergency department utilization, as well as out-of-network utilization.

Up next:

Breakout Session #4

Risk recapture strategies to support providers and members

Start time: 3:05 pm

Welcome to Breakout Session 4

Risk recapture strategies to support providers and members

Breakout session 4

Kristen Kopski, MD, PhD, CRC Senior Medical Director Value Based Care | Medica

Dr. Kopski is Medica's physician leader in clinical value-based care, collaborating with more than 20 health systems across 10 states using robust data and analytics to drive performance in the quadruple aim (quality, value, experience, and sustainability) for our members and care system partners. Prior to joining Medica, Dr. Kopski held leadership roles at Park Nicollet Health Services in St. Louis Park, MN. In her 16 years at Park Nicollet she led successful performance in value based contracts across multiple payers and populations, Dr. Kopski has a Bachelor's of Science degree in Biochemistry from The Pennsylvania State University, a PhD in Biochemistry from Cornell University, and an MD from Georgetown University. She completed her residency training at the University of Minnesota.

Breakout session 4

Dustin Cupp, DO, MSHD, CPE, FAAFP, Medical Director Ambulatory Services, Ascension St. John

Dustin Cupp, DO, MSHD, CPE, FAAFP is a board-certified family medicine physician who serves as themedical director for ambulatory services at Ascension St. John/Ascension Medical Group in Tulsa, Oklahoma. Dr Cupp has spent time practicing in rural and underserved locations in Oklahoma and Kentucky, providing comprehensive/full-spectrum primary care as well as practicing in the Tulsa metro area, including experience in graduate medical education. Dr Cupp has a special interest in developing innovations in care delivery that focus on population health, value based care and quality improvement. Dr Cupp has a passion for the underserved domestically as well as abroad, having led multiple international medical missions and disaster relief trips. Dr Cupp and his wife have 4 children and stay active with children's activities, sporting events, music/theater and traveling.

Supporting Risk Score Accuracy

Kristen Kopski MD PhD

Senior Medical Director Value Based Care

October 10,2022

Weaving together the "Why"

Business	Clinical
Plan revenue to better reflect the projected costs of the patient population	Understand and plan for the complexity of population and individuals
Compensate plans that enroll high-cost members	Identify people with higher medical need
Explain trends to assist in future forecasting of resources to deliver care efficiently	Monitor the population for changes
May influence payment & quality as patient needs are identified	Improve quality of care
Increase accuracy and completeness of data submissions	

Examples of risk score methodologies

CMS HCC	Medicare Hierarchical Condition Category
HHC HCC	Health and Human Services Hierarchical Condition Category
ACG	Adjusted clinical Groups-Outpatient
CDPS	Medicaid Chronic Illness and Disability payment systems
DRG	Diagnosis related groups- Inpatient

CMS-HCC Characteristics	HHS-HCC Characteristics
Primarily used for Medicare Advantage (Part C) reimbursement	Primary use is commercial payer managed care plans (Health Exchange plans under the Affordable Care Act)
Intended for patients over 65 and/or disabled patients	Intended for patients of all ages
Risk-adjusted attributes include age, gender, demographics, medical conditions, and **institutional status**	Risk-adjusted attributes include age, gender, demographics, medical conditions, and **financial status**
Data capture included in regular Medicare processes	Requires additional data capture for demographics
Predicts future medical spending	Predicts future medical and drug spending
Prospective: Uses diagnostic information from a base year to predict costs for the **following year**	Concurrent: Uses data from the current benefit year to predict costs for that **same year**
Includes a special needs plan for individuals with severe or disabling chronic conditions	Includes an adult model (age 21+), child model (age 2-20), and infant model (age 0-1)
Provides frailty adjustment to predict expenditures for the community-residing frail elderly	Contributing elements vary by age (e.g., child model does not include disease severity interactions and categories in the infant model are defined by birth maturity)

1. https://bok.ahima.org/doc?oid=302516#.Yxz333bMKUk

HCC Risk Scoring Models

- Not all ICD10 codes risk adjust
- Both HCC models group codes into clusters of conditions
- Both have an element of "Hierarchy"

Hierarchical Condition Category (HCC)	If the Disease Group is Listed in this column…	…Then drop the Disease Group(s) listed in this column:
Hierarchical Condition Category (HCC) Label		
8	Metastatic Cancer and Acute Leukemia	9,10,11,12
9	Lung and Other Severe Cancers	10,11,12
10	Lymphoma and Other Cancers	11,12
11	Colorectal, Bladder, and Other Cancers	12
17	Diabetes with Acute Complications	18,19
18	Diabetes with Chronic Complications	19
27	End-Stage Liver Disease	28,29,80
28	Cirrhosis of Liver	29
46	Severe Hematological Disorders	48
51	Dementia With Complications	52
54	Substance Use with Psychotic Complications	55,56
55	Substance Use Disorder, Moderate/Severe, or Substance Use with Complications	56
57	Schizophrenia	58,59,60
58	Reactive and Unspecified Psychosis	59,60
59	Major Depressive, Bipolar, and Paranoid Disorders	60

2. AAPC 2021 Medical Coding Training CRC

A side note on ACG

Why do we use this in our clinical reporting?

- Incorporates broader (Dx plus pharm)
- Generally better at predicting or explaining healthcare expenditures
- Provides useful population health tool and predictive analytics

Understanding opportunity: Retrospective reviews

- Goal is accuracy
  - Codes removed if documentation did not support the code
  - Codes added if documentation did support
- Roughly 1 new HCC for every 9 charts reviewed (net)
- Roughly a 6% increase in risk score

https://www.newyorker.com/humor/daily-shouts/catching-up-with-sisyphus

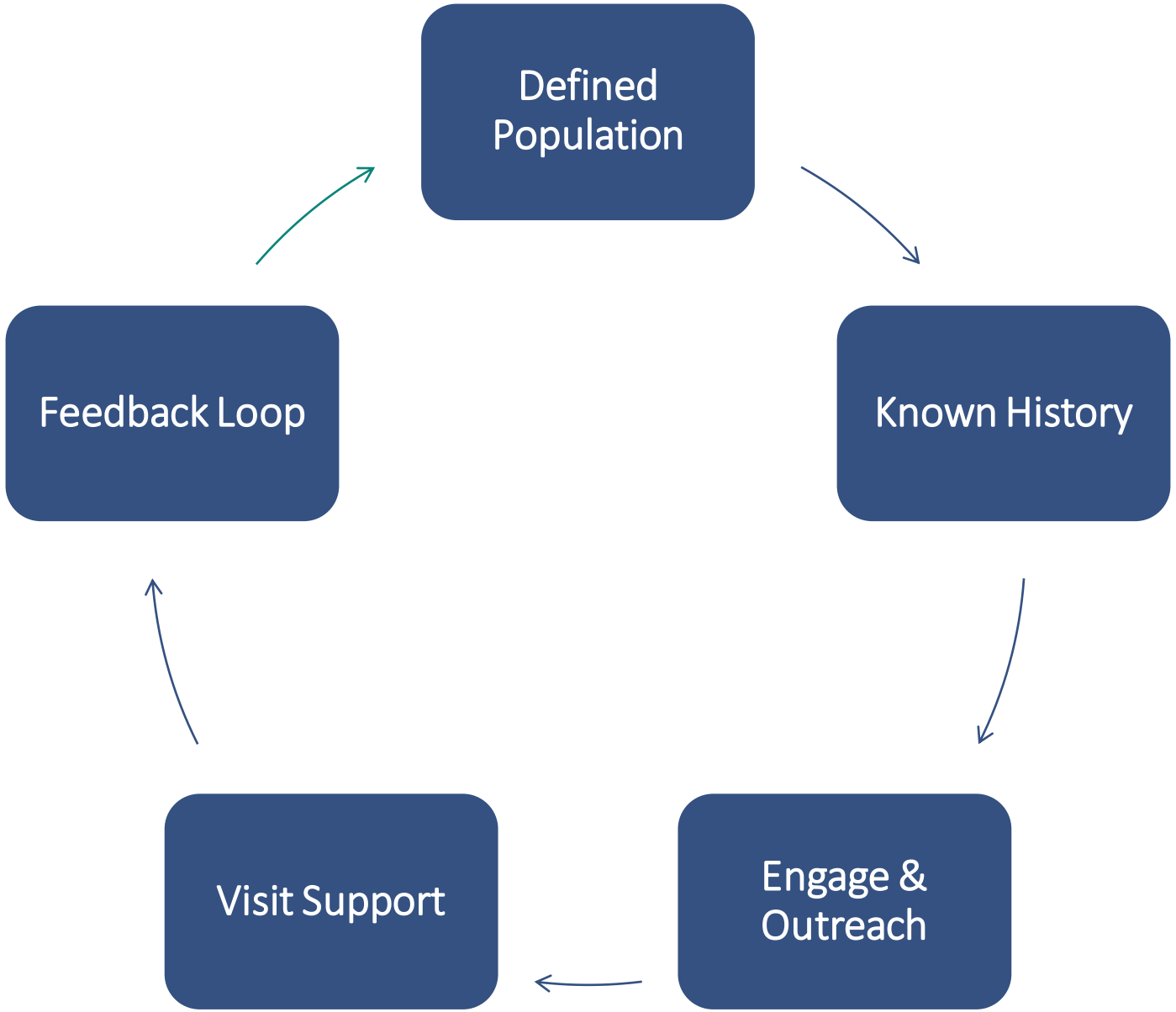
Sharing Best Practices

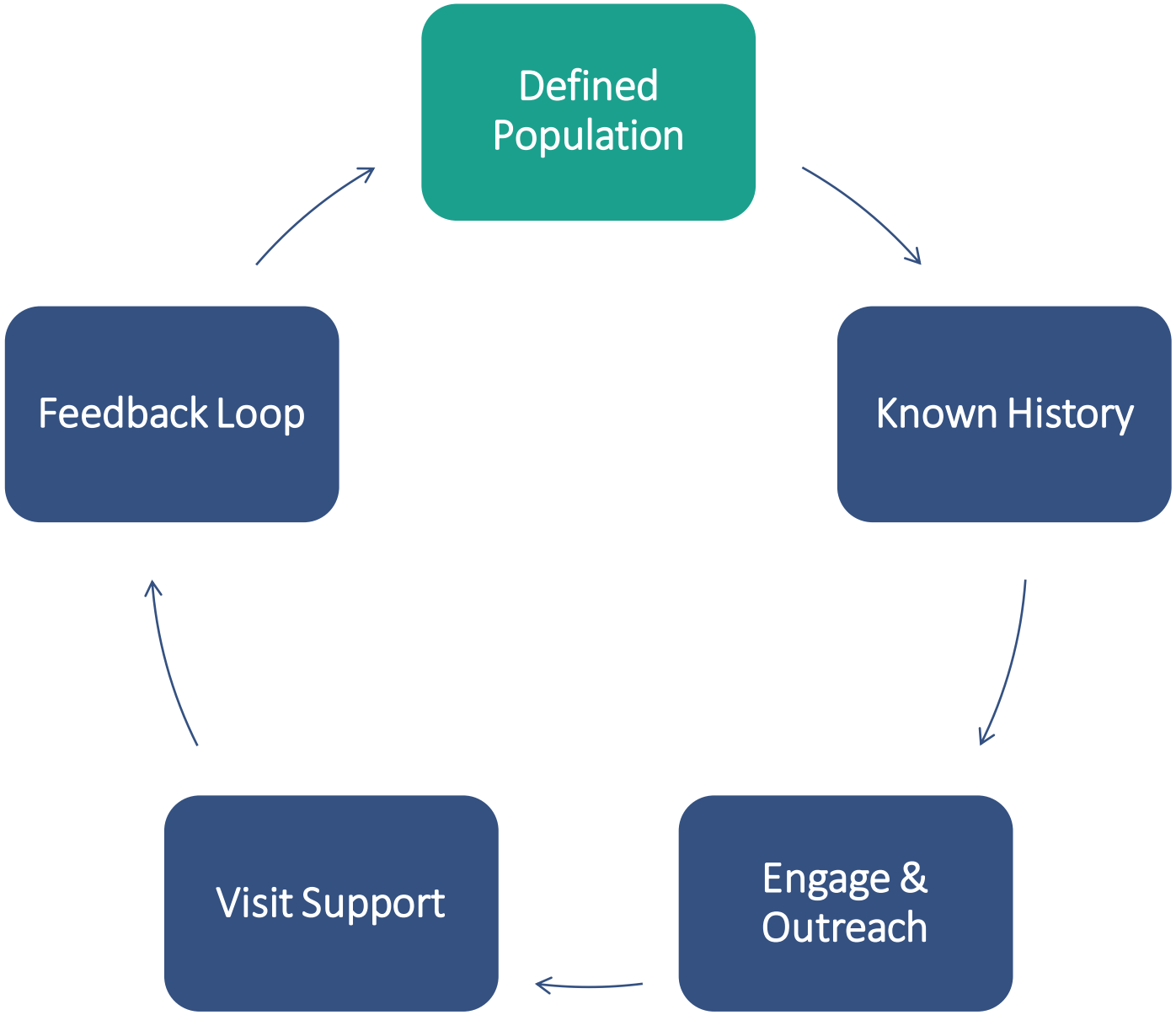
Ambulatory visits (office visits)

Primary care

Chronic persistent conditions

Not definitive, this is an evolving conversation



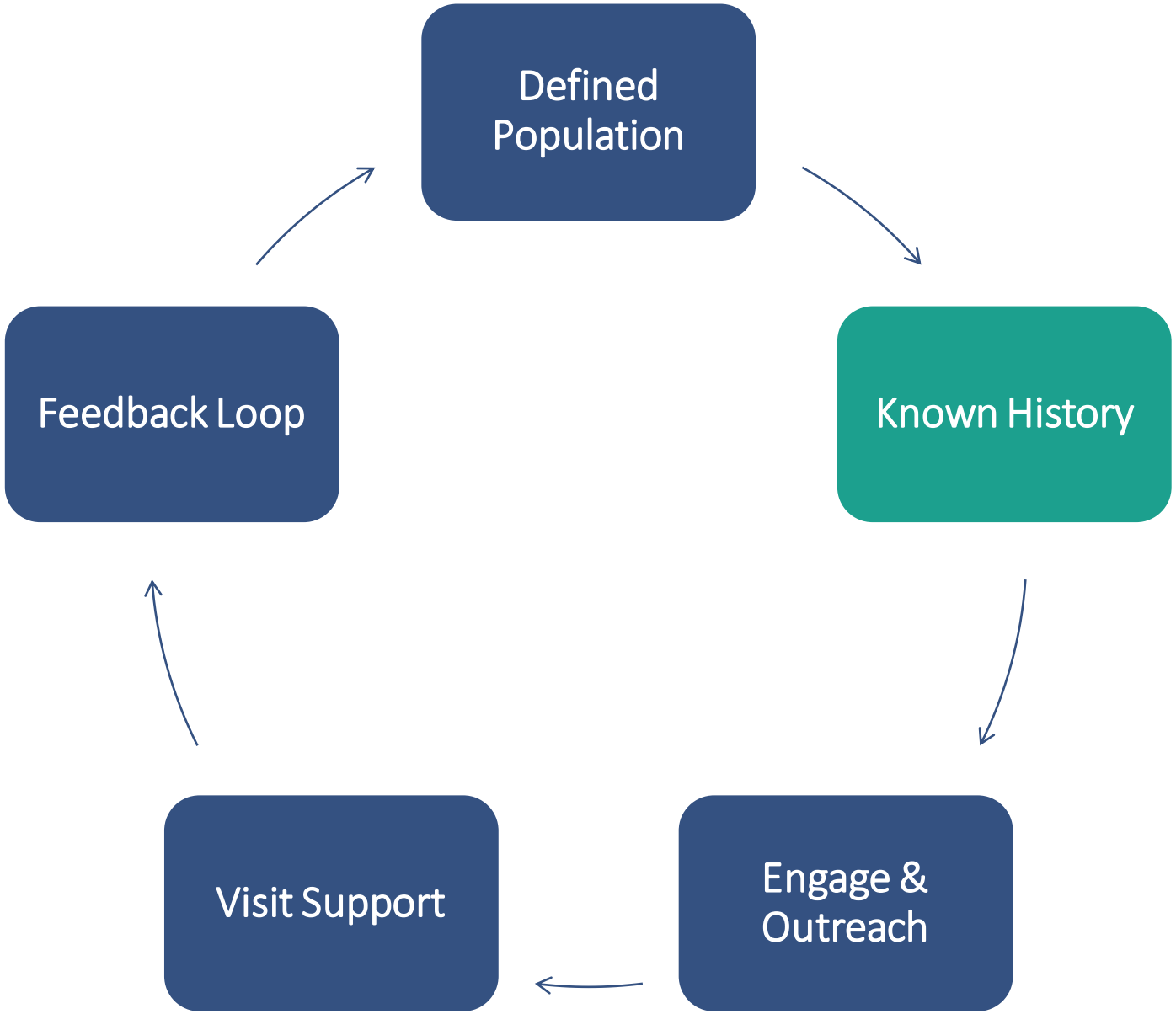


Care characteristics

- Proactive vs Reactive
- Narrow Network (Keepage)
- Do they have a PCP?
- Annual Visit (Well Visit, Preventive)

Patient/member

- Entire population vs. risk arrangement
- Stratify by age
- Differential support based on type of risk model

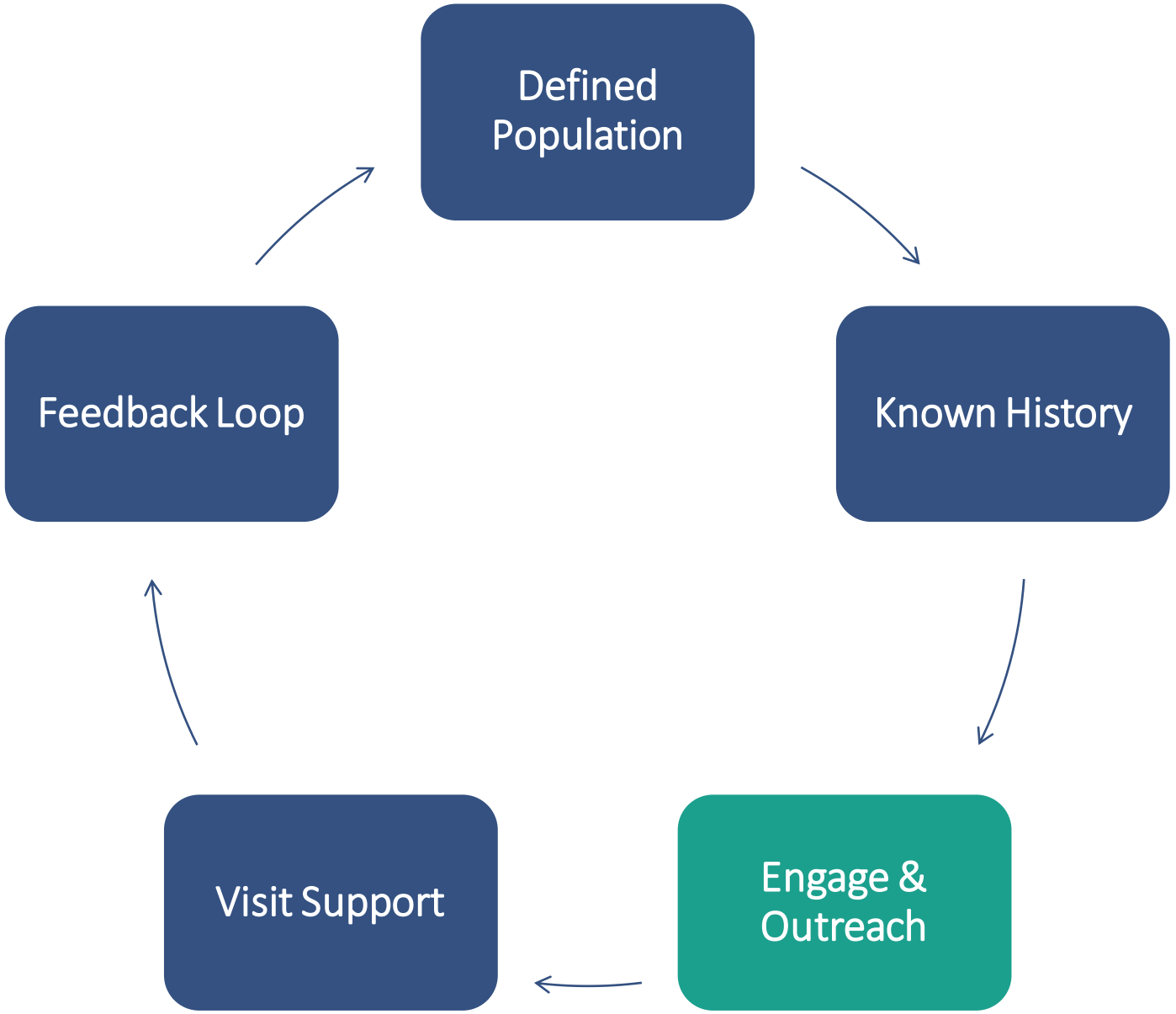


Problem List

Claims Sources

- Claims feeds
- CMS
- Recapture Lists

Person and Family



Connecting to primary care

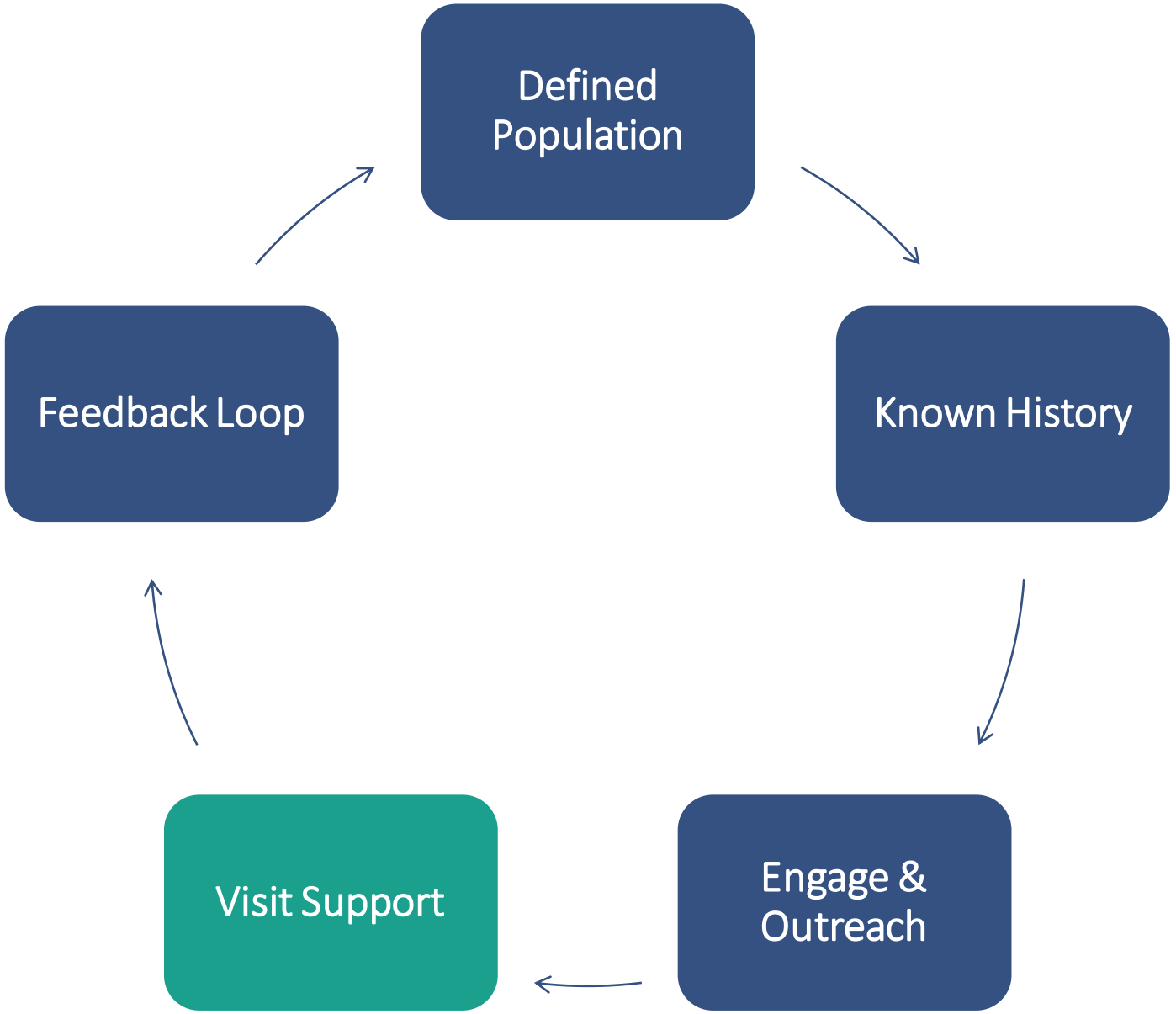
Annual Visit

Planned care, chronic condition follow up

- Expectations
- Perceived Value
- Patient and Family Engagement

"Gap" Lists

- Care needs
- Recapture lists



Gathering accurate information

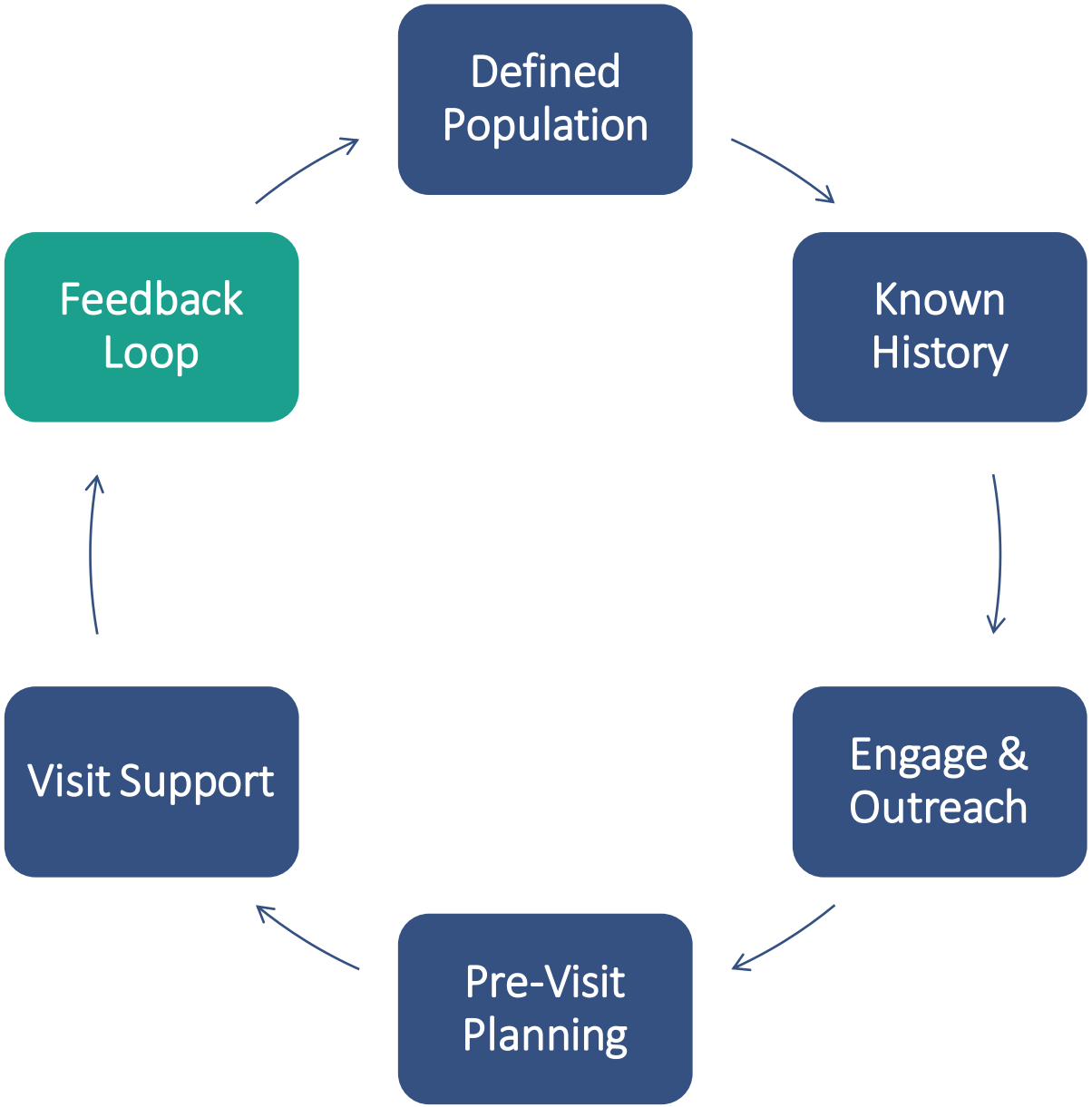
Problem List

Incorporation of Claims/outside data

Point of Care Support

- Reassessment Prompts

Time and Space



Coding review

Performance metrics

- Reassessment metric
- Coding Recapture

Common opportunities

- Reporting only the primary or principal diagnosis
- Coding "rule-out", possible, or probable diagnosis codes from ***outpatient*** records
- Infants- missing birth weights
- Children-asthma
- Adults-Diabetes, Asthma, COPD, Depression, CHF
- CMS adults- Diabetes chronic complications
- Coding resolved or historical conditions as current (e.g., MI or CVA)
  - MI (acute=4 weeks or less)
  - CVA
- Cancers—active treatment vs. "history of"
  - Active surveillance ("watchful waiting") is considered active cancer

References

1. Documentation and Coding Practices for Risk Adjustment and Hierarchical Condition Categories https://bok.ahima.org/doc?oid=302516#.Yxz333bMKUk
2. AAPC 2021 Medical Coding Training CRC
3. Integrating Chronic Care and Business Strategies in the Safety Net Toolkit https://www.ahrq.gov/ncepcr/care/chronic-tool/index.html
4. Grover, A. & Joshi, A. (2015) An Overview of Chronic Disease Models: A Systematic Literature Review. *Global Journal of Health Sciences* 7(2) 210-227
5. Mandal, A. et. Al (2017) Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and IMproved Survival. *Am J Manag Care* 23 (2) e41-49

Risk Based Coding: A Process Improvement Initiative

Dustin Cupp, DO, MSHD, CPE, FAAFP

Ascension Medical Group

The Who

Risk-Based Coding

- Ascension Medical Group, St John
  - Tulsa, Oklahoma
- 24 primary care sites of care
  - 124 physicians + APPs
- approx 300,000 outpatient visits/year
- Value-based care participation
  - Two ACO models
  - CPC I/+
  - Primary Care First

The What

Hierarchical Condition Category- HCC

- What is it?
  - Payment model mandated by the Centers for Medicare and Medicaid Services (CMS) in 1997 (implemented in 2004)
  - Designed to identify individuals with serious or chronic illness by assigning a risk adjustment factor score (RAF) to the person based upon a combination of the individual's health conditions and demographic details.
  - Health conditions are identified by ICD-10 diagnoses submitted on claims to insurers by providers
- Why is it important?
  - "In addition to helping predict health care resource utilization, RAF scores are used to risk adjust quality and cost metrics. By accounting for differences in patient complexity, quality and cost performance can be more appropriately measured." (AAFP)
  - Allows for more direct comparisons between populations

Hierarchical Condition Category- HCC

- CMS definition of an “average-risk” individual is a RAF score of **1.0**
- **Our medical group average RAF score in 2021 = 0.805**
  - **Highest end-of-the-year score in our medical group’s history!**
  - **Yet… is this good?**

Hierarchical Condition Category- HCC

- Never Satisfied!

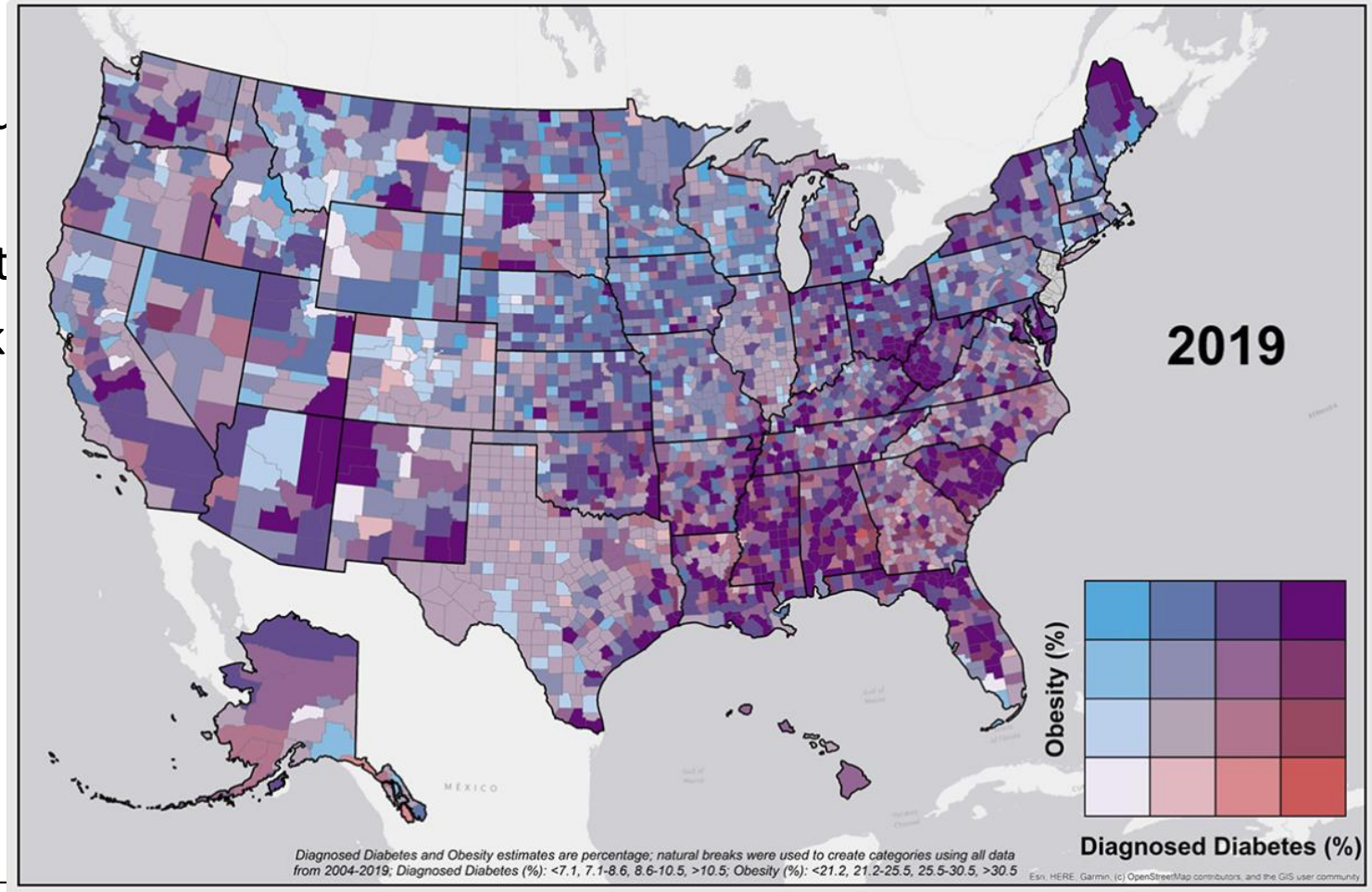
The Why

The Situation Changes

- Primary Care First
- New commercial value-based contracts
- COVID recovery

What do you Believe??

- Is our popu
  - OR
- Are we not :he true picture of health/risk



The How

Clinical Documentation Improvement (CDI)

- CDI team (physician lead, physician assistant, 4 registered nurses) plus ambulatory medical director
  - Mutual understanding on definitions and expectations revolving around management of the problem list (Cerner EHR)
    - Problem List Management Guideline
      - Containing definitions
      - Best practices for problem list management
      - Workflow for care gap closure and HCC recapture

Clinical Documentation Improvement (CDI)

- 3 phase educational plan
  - Presentation of the guideline to providers
  - Follow-up video from the CDI team
  - Process measure reporting with 1-on-1 feedback
    - 30 min virtual sessions with all primary care providers
      - Best practices
      - Coding accuracy for DM, HTN, CKD, Obesity
      - HCC recapture rate

Process Measure Feedback

Primary	Number Reviewed	Number of Provider HCC Patients	Number of Clinic HCC Patients Reviewed	% Fully Coded	% Onset Date Pass	% Comment Pass	At Risk AMI	At Risk Stroke	Any At Risk
Clinic **AMG Primary Care**									
AMG Primary Care			3725	49%					
AMG Primary Care	5109								
AMG Primary Care	5109								
AMG Primary Care			3725		6.7%	8.7%	5	15	93
AMG Primary Care	5109								

Process Measure Feedback

Primary	Number Reviewed	Display As	% Display As	Resolved Status	% Resolved Status	Belong Noise	% Belong	Duplicate and Synonym Noise	% Duplicate or Synonym
Clinic **AMG Primary Care**									
AMG Primary Care									
AMG Primary Care	5109								
AMG Primary Care	5109								
AMG Primary Care									
AMG Primary Care	5109	1386	27%	1333	26%	2652	52%	1406	28%
Clinic									

Process Measure Feedback

Primary	Number Reviewed	Number of Provider HCC Patients	Number of Clinic HCC Patients Reviewed	Diabetes Gap	HTN Gap	CKD Gap	Obesity Gap	Combined Focus Error Rate
Clinic **AMG Primary Care**								
AMG Primary Care			3725					
AMG Primary Care	5109							
AMG Primary Care	5109			840	786	506	227	46%
AMG Primary Care			3725					
AMG Primary Care	5109							

Process Measure Feedback

Primary	Number Reviewed	Number of Provider HCC Patients	Number of Clinic HCC Patients Reviewed	TOC ICD9 Present	% ICD9 Present	TOC Non Provider	% Non Provider
Clinic **AMG Primary Care**							
AMG Primary Care			3725				
AMG Primary Care	5109			847	17%	1738	34%
AMG Primary Care	5109						
AMG Primary Care			3725				
AMG Primary Care	5109						

Process Measure Feedback

- Level setting; non-punitive
- Focused review of low performance
- EHR demonstration
- Focused coding educational review
- Repeat chart audits
- Additional elbow-support
- Physician queries

Round 2

Upon Further Review… Follow-Up Chart Audit Data

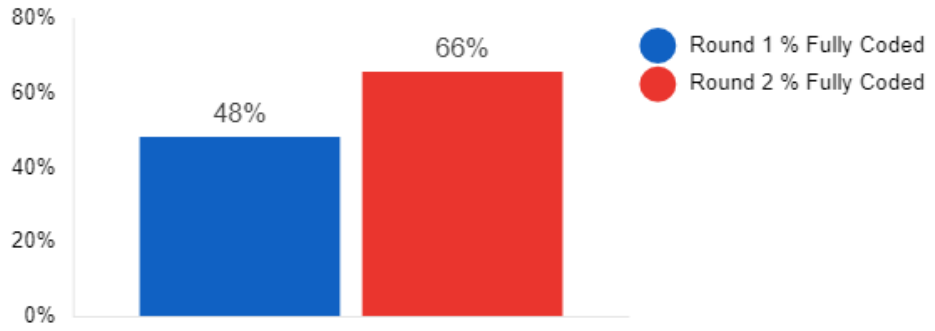
HCC Process CY 2022

Sample Size (Only Patients With HCCs)

Round 1 HCC Pt Sample	3579
Round 2 HCC Pt Sample	478

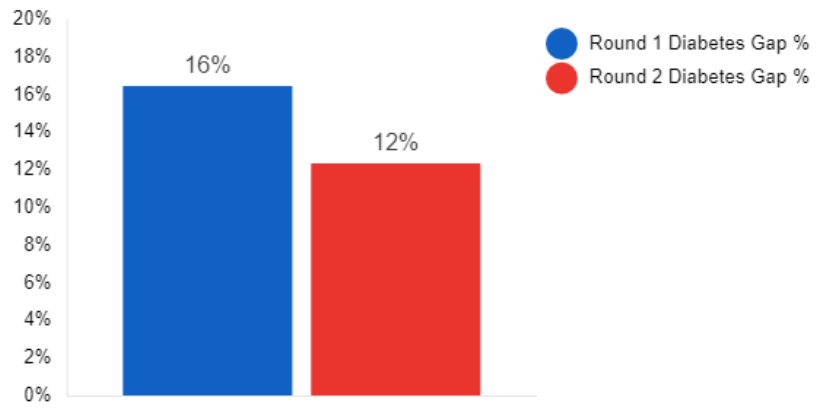
Fully Coded (All or None) Higher is Better

Fully Coded

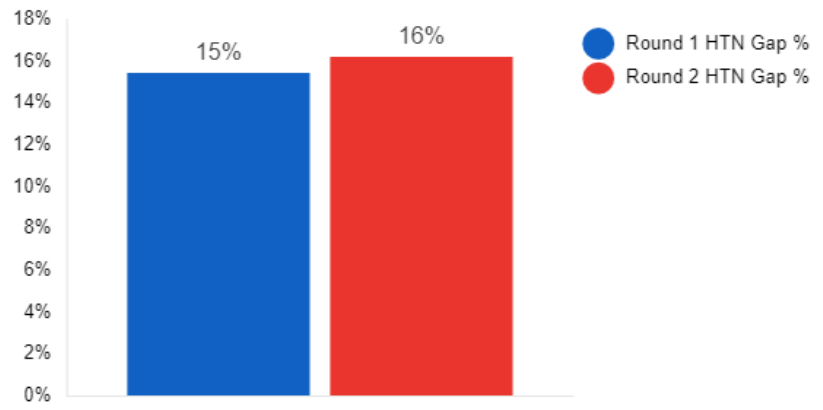


Coding Accuracy For Common Conditions in Primary Care
[AMG Problem List Guideline > 2. and 5.A]
Lower is Better

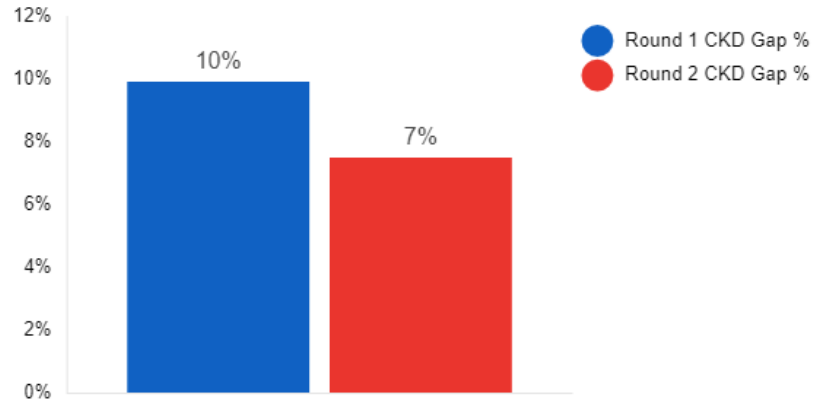
Diabetes



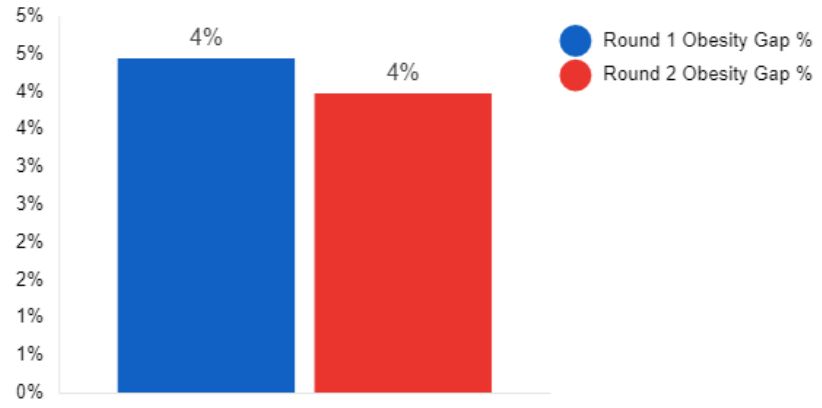
Hypertension



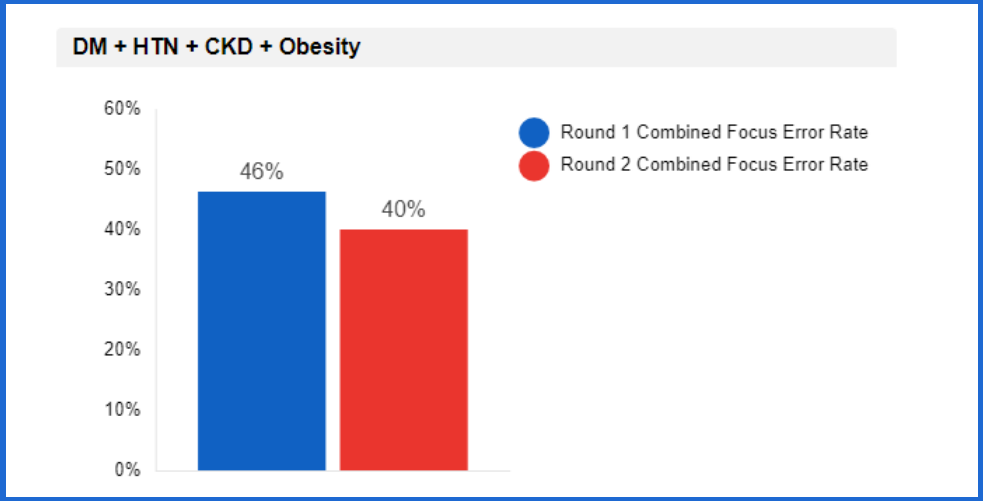
Chronic Kidney Disease



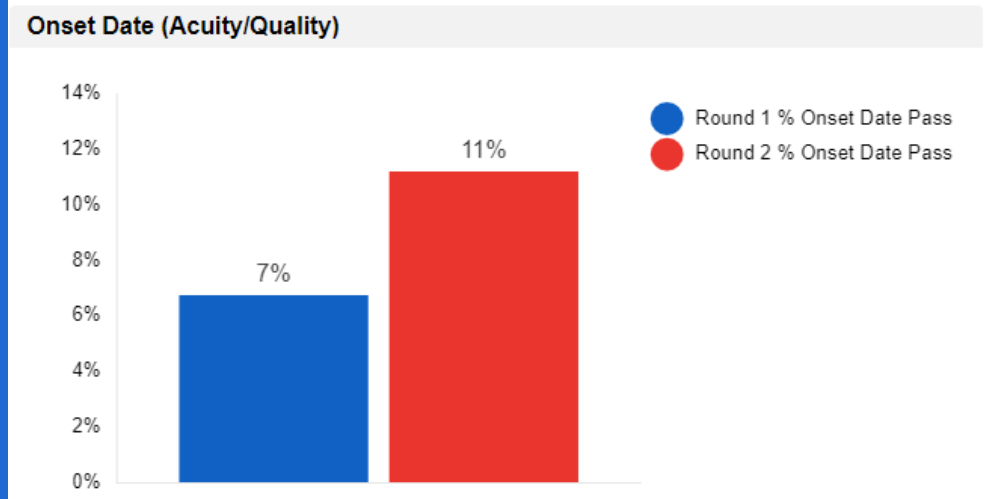
Obesity

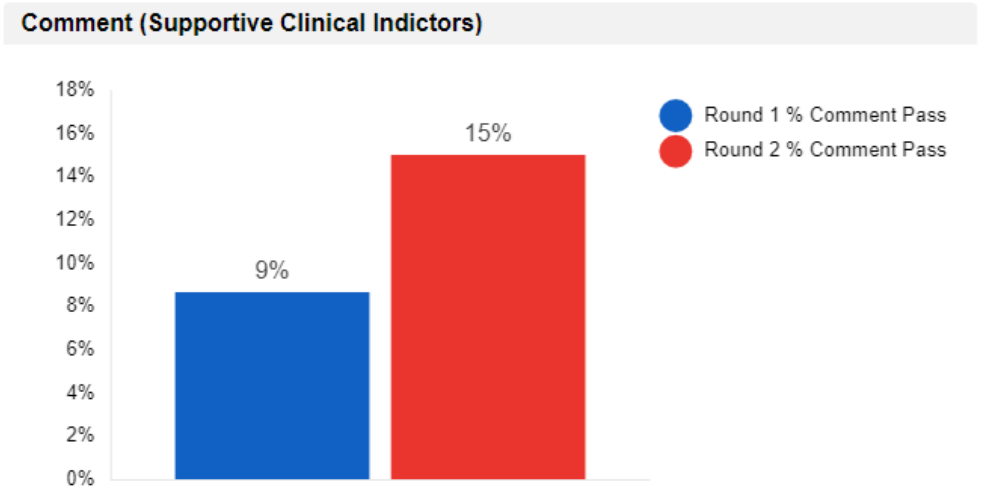


Overall Focused-Coding Error Rate



Clinical Validation [AMG Problem List Guideline > 5.C Veracity]
Two Required Elements
Higher is Better





Follow Up Message to Providers

Dr. ___

This is a follow up to our problem list/HCC data discussion. Below you will find data on process measure expectations and fully coded HCC diagnoses from a second audit of 30 charts after our recent conversation around your initial data on these same measures.

Clinical Validation:

Measure	Round 1	Round 2
Number of HCC charts reviewed	35	35
Onset Date Present	13%	32%
Comment Present	19%	41%

Focused Coding:

Measure/Diagnosis	Round 1	Round 2
Number of charts reviewed	54	41
Diabetes	3	2
HTN with Comorbidity	16	4
CKD	8	1
Morbid Obesity	1	0
Combined Error Rate	52%	17%

Fully Coded:

Measure	Round 1	Round 2
Number of HCC charts reviewed	35	35
% Fully Coded	65%	81%

Pre-Visit Planning:

Measure	Round 1	Round 2
Number of charts reviewed	54	41
ICD-9 Diagnoses Present	39%	51%
Non-Provider Diagnoses Present	65%	66%

Problem List Workflow/Best Practices:

Measure	Round 1	Round 2
Number of charts reviewed	54	41
'Display As' Modification Present	17%	5%
Problems needing to be Resolved	7%	5%
Problems that do not Belong on the Problem List	41%%	29%
Duplicate or Synonym Diagnoses on the Problem List	19%	24%

Follow Up Message to Providers

Observation Summary:

It is quite evident that you have made a concerted effort to improve your fully coded HCC diagnoses along with an effort to improve your clinical validation and onset dates of HCC diagnoses and noted improvements in the accuracy of the four common chronic conditions. The only area without noted improvement is noted in the area of pre-visit planning associated with ICD-9 diagnoses and non-provider diagnoses.

Recommendations:

Continue the strong efforts around recapture of HCC diagnoses to fully code each patient's chart and diagnostic accuracy. Nicely done!
Continue to update/remove inappropriate diagnoses from the problem list as identified in pre-visit planning and at the time of service.
Review the problem list for old ICD-9 diagnosis and non-provider diagnoses and remove them when identified. A quick scan of the problems and diagnosis page can be a more efficient method of addressing these two areas.

Please let me know if you have questions regarding this data or need further explanation.

Your hard work and efforts in this area are greatly appreciated!

Dustin

Questions?

Closing Remarks

Room 101

MISSION

To be the trusted health plan of choice for customers, members, partners and our employees.

VISION

To be trusted in the community for our unwavering commitment to high-quality, affordable health care.

VALUES

Customer-Focused • Excellence • Stewardship • Diversity • Integrity


Medica

Up next:

Closing Remarks

Start time: 4:00 pm

Closing Remarks

Dr. John Piatkowski

Vice President Physician Services

Day 1 Takeaways

2022 ACO Engagement Summit

- Collaboration across multiple stakeholders continues to be key to solving complex patient problems
- COVID-19 continues to provide opportunities for transformative care models, from providing long-term symptom management to providing care in non-traditional settings
- Biosimilars are providing a more affordable alternative for many patients; designing efficient systems is key to provider adoption
- Universal SDoH screening and community resource connections is imperative to providing holistic patient care
- Accurate risk coding ensures that care systems are capturing the complexity of their populations
- An integrated team approach provides the ability to address a patients complex medical and social needs

End of Day #1

2022 ACO Engagement Summit

Onsite Guests

Please join us for a networking dinner:

6Smith

294 Grove Ln E

Wayzata, MN

Day 2 Agenda

8:00 a.m. Networking Breakfast

9:00 a.m. Welcome Day 2

9:10 a.m. Roundtable Discussion

10:45 a.m. Behavioral Health Panel Presentation

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