# Welcome to the 2023 ACO Engagement Summit

October 10, 2023

# WIFI Information:

**Network:** MarriotBonvoy_Conference

**Password:** 2023Medica

# Coming up at 2:15 pm!
# The Idea Sandbox
# (an open conversation)

Share an example of something creative or bold your teams have done and did not work out as hoped or planned. Here are some questions to think about.

- Describe what you tried to do?  What was the “why” behind it and what were you hoping to accomplish?
- What did happen?  How did you gauge success vs. the lack of success?
- What did you learn?  How did that inform future work or your next steps?  Any “silver linings”?

# Welcome to the 2023 ACO Engagement Summit

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# The 2023 ACO Engagement Summit Planning Committees

## Clinical Committee

- Hailee Buehler, Chair
- Lori Skinner

## Operations Committee

- Alyssa Hodnik, Chair
- Leah Halverson
- Naira Polonsky

## Steering Committee

- Kristen Kopski, MD, Chair
- Lisa Spann
- Lori Skinner
- Penny Tatman

# General Information and Housekeeping

| In-person attendees | Virtual attendees | Survey & Continuing Education Credit | 2023 ACO Engagement Summit Website |
|---|---|---|---|
| • Wi-Fi information is available on your table<br>• Restrooms<br>• Networking Happy Hour & Awards starting at 4:30 p.m. | • To ask a question during any session: enter your question in the monitored chat box and it will be relayed to the speaker(s) | • A post-Summit survey and information for CMEs/CEUs will be sent out tomorrow<br>• QR provided for survey at the end of the day | • Agenda, speaker biographies, and more<br>• Link in chat box |

# Opening Remarks

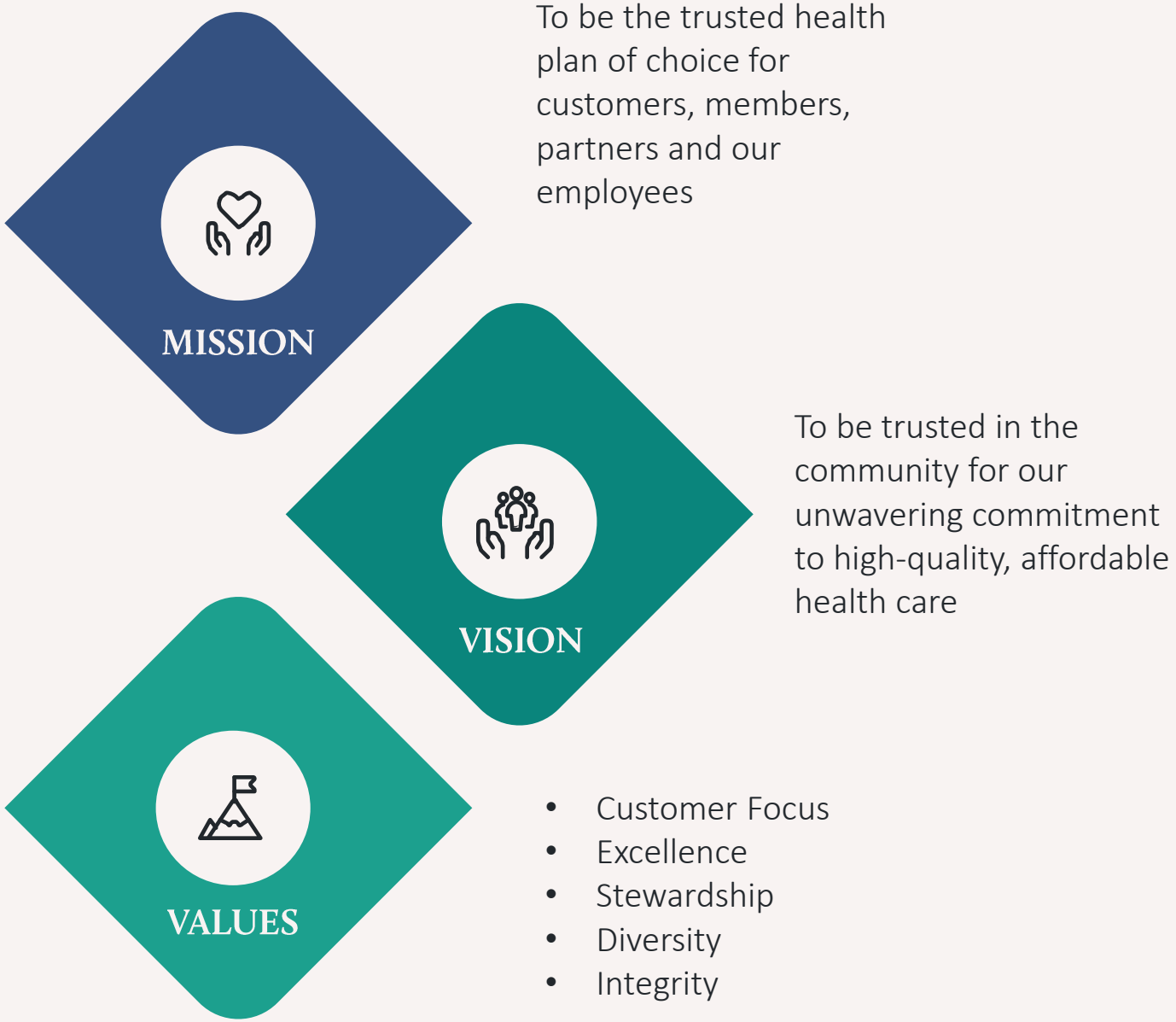
# Lisa Erickson, Senior Vice President & Chief Financial Officer

Lisa Erickson partners with the Senior Leadership Team to develop business strategy and cultivate growth. She leads the planning, development, implementation and evaluation of fiscal functions and performance, including actuarial, analytics strategy and data governance, and risk adjustment and quality.

Lisa also serves as a liaison to the financial community and other key stakeholder groups, including provider organizations.

Previously she served as SVP at Optum, leading pharmacy network contracting and relationships, network operations, and pricing and underwriting. She also served as CFO of OptumInsight, and in financial leadership roles in several other organizations, including Best Buy, General Mills, The Pillsbury Company, and TCF Bank.

# Our foundation



# Continued Focus on our Growth Strategy Pillars

## Key levers to drive enterprise growth

### Growth Strategy Drivers

| *Provider Relations* | *Provider – Based Solutions* | *Diversification* |
|---|---|---|
| Continue to build unique provider relationships | Leverage provider relationships to build innovative and sustainable products & solutions | Expand product portfolio in new & existing geographies and pursue inorganic opportunities |

### Growth Strategy Enablers

| *Platform and Infrastructure* | *Clinical Value* | *Consumer Experience* | *Employees and Culture* |
|---|---|---|---|
| Continue to build business platform and operational strength & efficiencies | Improve clinical value and medical affordability for all members & providers | Transform our digital strategy and evolve the consumer experience | Continue to communicate with and engage our team of diverse employees |

# Provider-based Solutions | Value-Based Model

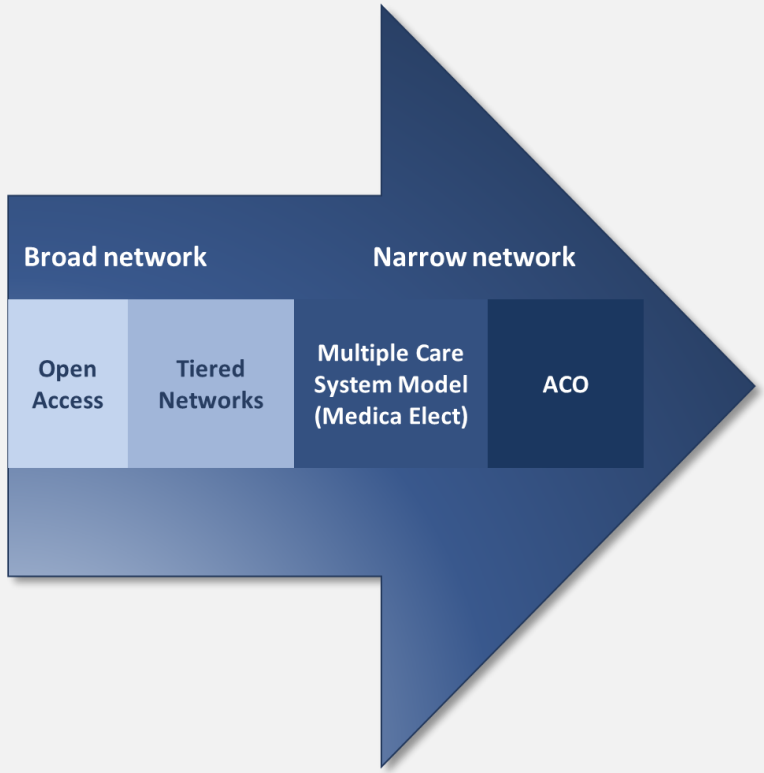
## Enhancing Brand, Patient Experience and Financial Performance

- Increase membership through a unique value proposition
- Collaboration on data analysis to optimize our population health efforts
- Maintain and grow affiliated physician relationships, keeping care local and creating patients for life
- Commitment to co-invest in capabilities to differentiate our work
- Opportunity to share in financial results on all shared members

# Diversification

## Diversified Product Portfolio

**Responding to market demands with a comprehensive range of product & network options**

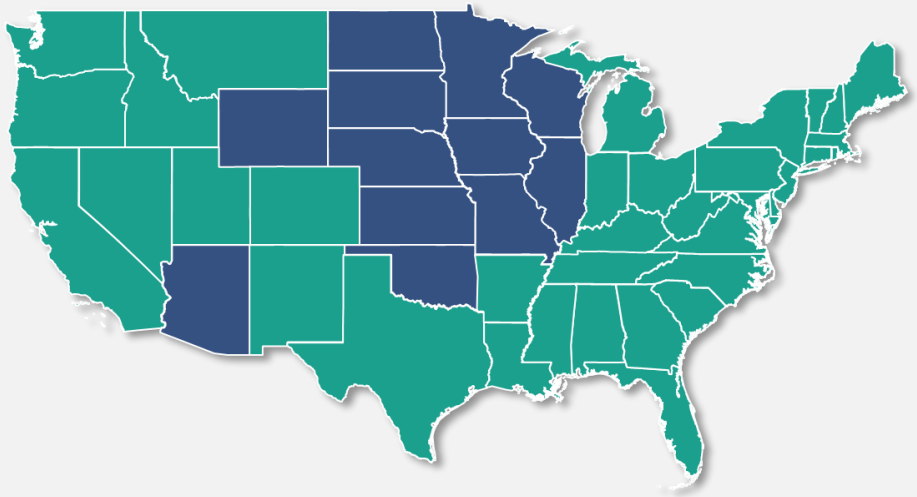



## Service Area Focus

**Pursuing select geographic growth opportunities**

**Maintain & Grow**

**Land & Expand**



# Partnership in Action

## Medica

- ***Maintain & Grow*** **market growth**
- ***Land & Expand*** **market growth**
- **Affordability**
- **Operational maturity & efficiency**

## Care System Partner

- **Innovative, high-quality care**
- **Mature population health capabilities**
- **Provider engagement**
- **Aligned incentives and shared risk**

## Member Impact

**Proactive connection to health system**

**Care navigation and coordination**

**Personalized care models exceeding patient/member expectations**

*You're not just covered, you're cared for*


Medica®

Medica

# Keynote Speaker

## Sarah Wiley

Managing Director, Kaufmann Hall & Associates, LLC

# Sarah Wiley
# Managing Director at Kaufmann, Hall & Associates, LLC

Sarah Wiley is a Managing Director with Kaufman Hall in the firm's Strategy Practice. Sarah has more than 25 years of healthcare industry experience, working across a spectrum of areas including market and growth strategy, program strategy design and implementation, and innovation. Her responsibilities include developing value-based market strategies between payers and providers across different lines of business.

Prior to joining Kaufman Hall, Sarah was with Deloitte Consulting, where she was promoted through the ranks from consultant to Managing Director. There she partnered with senior executives at leading healthcare organizations to develop and implement strategies to drive growth and adapt to changing market expectations. As part of Monitor Deloitte, she focused on working with national and regional health plans in the payer/provider space. She is a strategy leader with proven success in developing market and operational programs including telehealth, social health, and value-based care strategies, as well as benchmarking, and performance management. Sarah was Co-leader of Deloitte Consulting's Healthcare Chief Strategy Officer program and a culture carrier who led several key talent and development initiatives for the firm.

She earned her AB from Duke University and went on to receive her MS in Health Science from The Johns Hopkins University School of Hygiene and Public Health (now the Bloomberg School).

KaufmanHall

# The Promise and the Challenge of Virtual Care

## *Delivering 21st -century care in a 20th century system*

***Sarah Wiley***

October 10, 2023

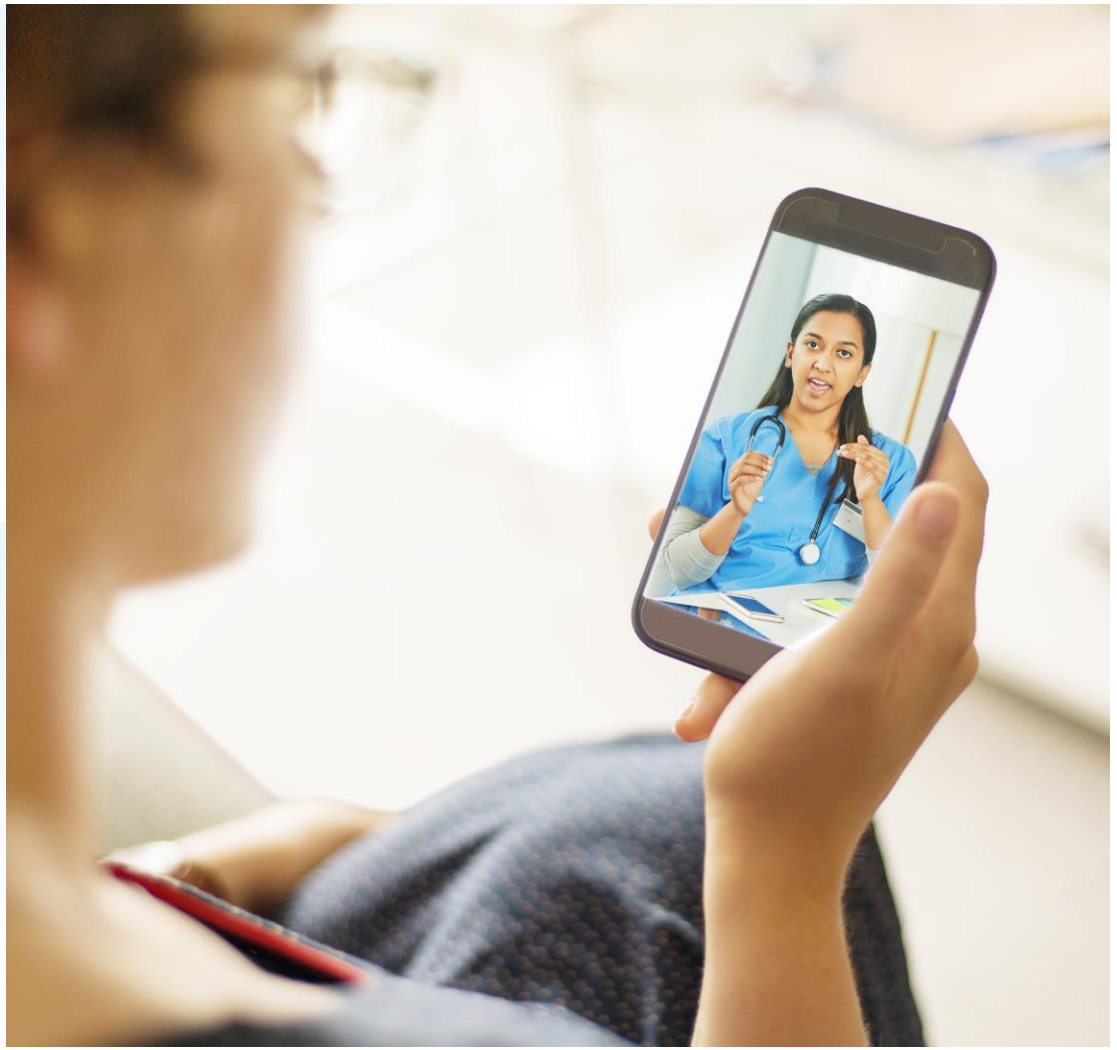
# The Promise

## VIRTUAL CARE…

- Increases convenience and access to care
- Supports and reinforces the provider-patient relationship

## …AND CAN…

- Improve quality and outcomes
- Reduce costs
- Delight the patient
- Improve the provider experience



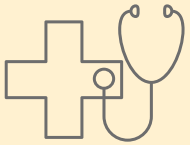
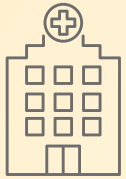
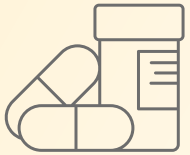
# The Challenge

*How do we take advantage of the promise and the potential of virtual care in a world that was designed around 15-minute, face-to-face visits?*

*How do we enable and support patients and providers to identify and select the interaction that best meets the clinical need and patient preference*

*How do we need to think differently…what do we need to solve for and what do we need to change?*

# The Definition

| | | | | | |
|---|---|---|---|---|---|
| ***Modalities*** |  Video |  Telephone |  Messaging |  Chat |  Remote Patient Monitoring |
| ***Care Interactions*** |  Synchronous |  Asynchronous | | | |
| ***Care Settings*** |  Primary Care |  Facility-Based |  Specialty Care |  Home-Based | |
| ***Participants*** |  Patient |  Family/Caregiver |  Care Team | | |

# The Statistics

**10%**
**of all outpatient visits** are telehealth visits

**+4%** More in urban areas

**-3%** In lower income areas

**-6%** In Medicare

**+6%** Commercial Behavioral Health

*Virtual care adoption by specialty*

**57%** Behavioral health

**14%** Medical specialties

**5%** Procedural specialties

An additional **50 million** in-person visits per year **could be virtual** if all patient groups utilized virtual care equally

***Health plans, employers, health systems and patients are all driving a shift towards virtual care….***

Source: McKinsey & Company, Chartis

# The Value to Stakeholders

## Providers

- ✓ Supports collaboration
- ✓ Improved patient compliance and engagement
- ✓ May support automation
- ✓ May reduce burnout
- ✓ May reduce practice costs

## Patients & Providers

- ✓ Improves patient/provider relationship
- ✓ Supports continuity of care
- ✓ Flexible and convenient – anytime, anywhere
- ✓ More efficient
- ✓ Timely
- ✓ Decreases urgent care & ED visits

## Patients

- ✓ Matches their experience with other industries
- ✓ Supports caregiver involvement
- ✓ Reduces patient costs

# The “Minor” Barriers

## OPERATIONAL BARRIERS

- Rethinking and reshaping **front office staffing models and training**
- Ensuring **proper triage and allocation** of patients
- Determining how to integrate virtual care into **practice schedules**
- Addressing any **documentation challenges**

## TECHNOLOGICAL BARRIERS

- Bridging gaps in **patient devices** and **digital literacy** across patient groups
- **Broadband coverage** and **speed** especially in rural and low-income areas
- Need for **user-friendly interfaces** and **technical support**
- Creating an **integrated virtual care platform**

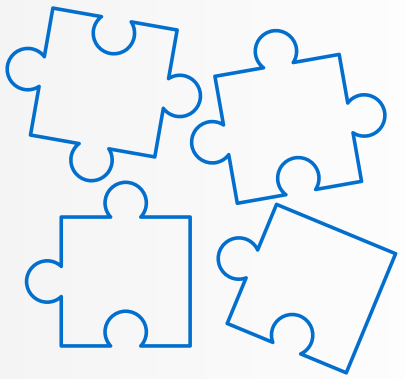
***Ultimately organizations need to address these barriers to empower providers and patients to choose the care that best meets both clinical needs and patient preferences***

# The Major Barrier

**FINANCIAL BARRIERS**

- **There are multiple billing codes**
- **Payments are based on time increments**
- **Difficult and time consuming to figure out appropriate documentation and which one to bill**
- **Hard for patients to understand**

*Today's **process-based payment models** don't support the cohesive adoption and integration of virtual care*



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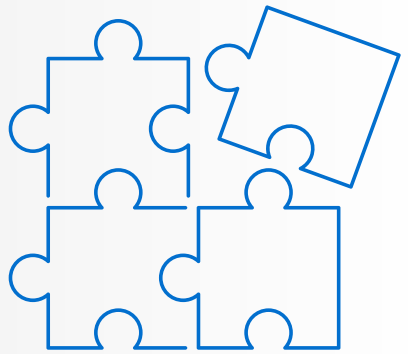
# The Solution

## WHAT IS THE GOAL?

A model that allows providers and patients to choose the form of care based on clinical need and patient preference….rather than payment model/financial incentives

*The components of the model support the seamless integration of virtual care into care delivery*



## WHAT MIGHT IT LOOK LIKE?

**Outcomes-Based Models:**

- Focus on results and outcomes, not inputs and process
- Recognize and value/reward the work required to drive outcomes
- Support continuity of care and center around the provider-patient relationship
- Remove/reduce potential sources of friction between payer/ provider
- Consistent and aligned incentives up and down the value chain

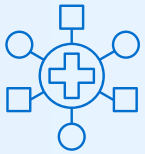
# What does “Good” look like?
## *A Kaiser Permanente Case Study*

KAISER PERMANENTE®

**An integrated delivery system serving ~12.6 million members across 8 states and the District of Columbia.**

### VIRTUAL CARE OFFERING:

**“Get Care Now”** feature which supports care navigation support through **online chat** and a **guided triage tool** to help members identify and access the “best/right” care to meet their need

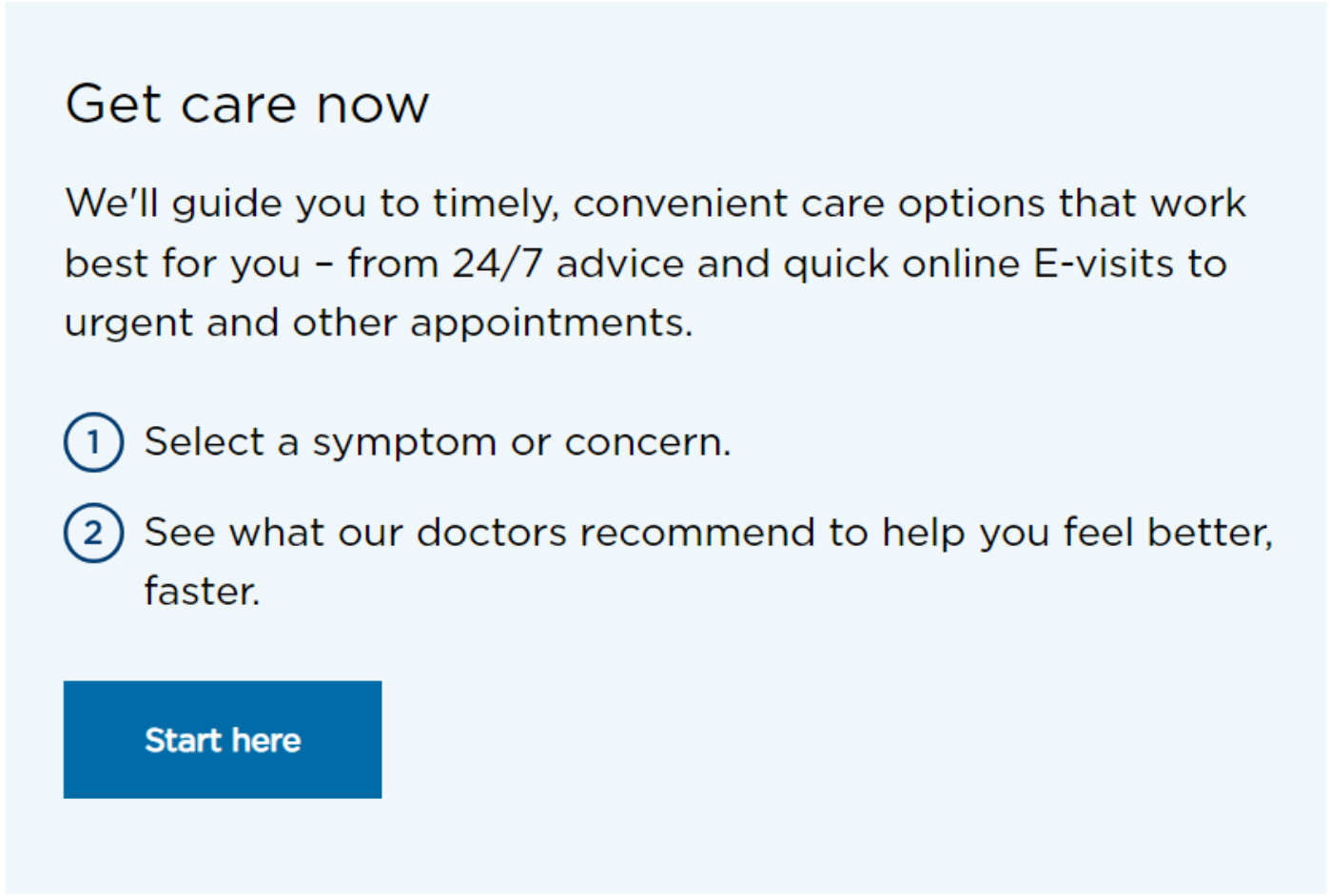


**Network of physicians** providing **24/7 care** across **all 50 states**
**Same-day /immediate** access or scheduled within a few days with your personal doctor

**Seamless** virtual and in-person transitions through use of a **comprehensive electronic medical record**
All KP providers always have the **most up-to-date information**

# The Virtual Care Journey

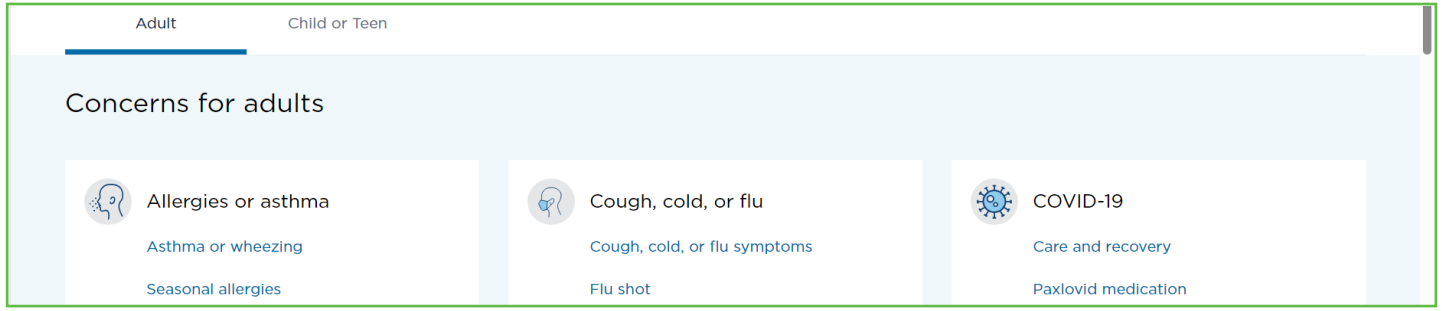
## *KP's "Get care now" button on its website and mobile app makes virtual care easily accessible for patients*



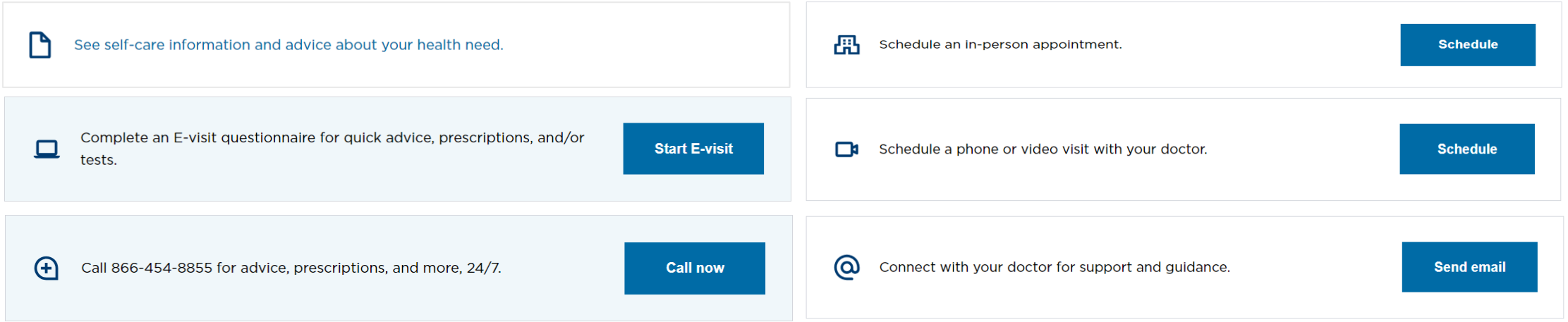

Source: Kaiser Permanente website

## *The "Get care now" button takes patients to a triaging tool that help s them identify and select the appropriate forms of care for their concern:*

*Select Concern*

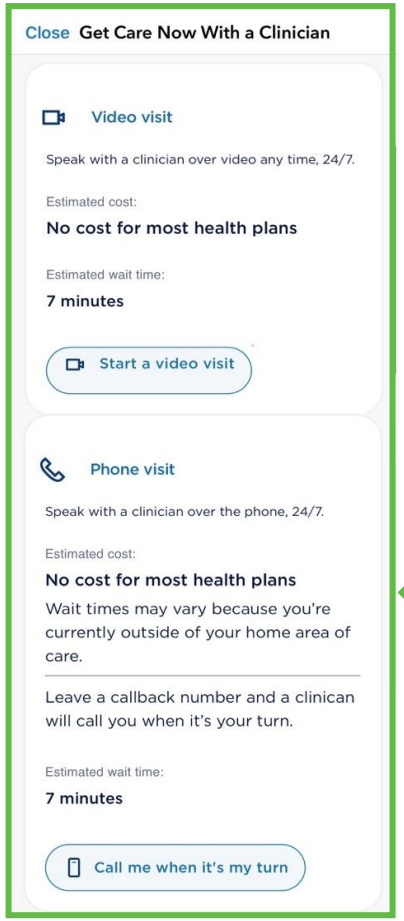



*Care Options*

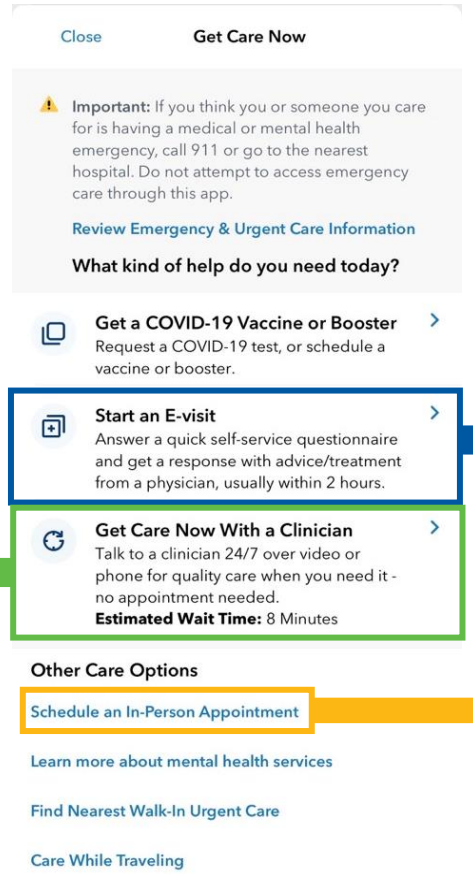



Source: Kaiser Permanente website

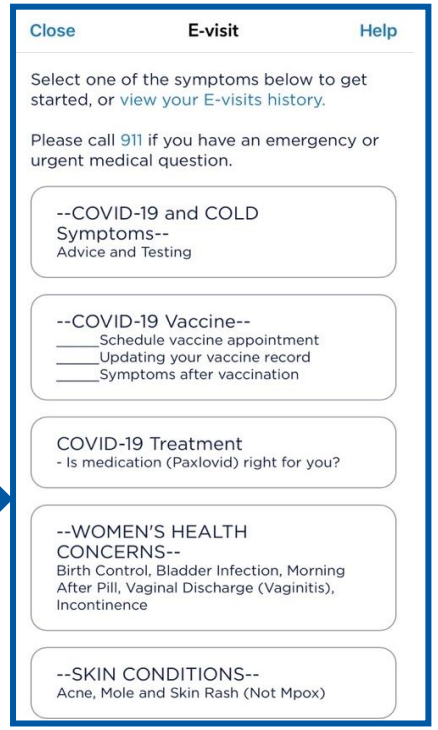
# *When considering virtual care, patients are given options for e-Visits, 24/7 access to direct care, or the option to schedule future virtual or in-person visits*




*On-demand virtual visit*




*Message response from physician*




*Scheduling future in-person visits*

Source: Kaiser Permanente app

# *KP provides significant resources to patients to help them know what to expect and how to navigate virtual visits…*

## Video Visits

A video visit is a convenient way to see your doctor from anywhere. If you have a video visit scheduled now, you can join up to 15 minutes before the start time.

**Join your visit**

### Prefer joining from a smartphone or tablet?

Download our app for easy access to your video visit. You can also check appointment details, email your doctor, get health reminders, and more.

Learn more about our mobile app

### Want an interpreter?

Learn how to request a language interpreter for your video visit.

View interpreter services

### Need help getting started?

Make sure you're in a well-lit room, and your camera, microphone, and speakers are ready before your visit.

Check equipment

### Have questions?

Learn about video visits, how to schedule and join, and find help.

Get answers and help

### New to video visits?

See how to connect to a video visit quickly and easily.

Watch now

Source: Kaiser Permanente website

# What can we learn from this example….and from each other?

*How have your organizations been able to take advantage of the promise and the potential of virtual care?*

*How have you supported and enabled patients and providers to match the interaction to the clinical need and patient preference?*

*What are the barriers that you had to overcome and what can we learn from your experience?*

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# Roundtable: Gaining Clinician Engagement on Value-Based Healthcare and Reimbursement Models

**John Findley**, MD, President, Bryan Health Connect

**David Ottenbaker**, MD, Vice President of Ambulatory Clinical Programs, SSM Health

**Mary D Strasser**, MHL, Senior Vice President of Population Health, Essentia Health

# Dr. John Findley, MD, CPE
## President of Bryan Health Connect

Dr. John Findley, MD, CPE, is the president of Bryan Health Connect, a Physician Hospital Organization (PHO) in Lincoln, NE representing approximately 2000 providers, 25 Critical Access & 3 PPS Hospitals, over 250 clinics and an Accountable Care Organization (ACO) with over 60,000 covered lives across 9 value-based agreements. He has a wealth of experience working with patients, providers, health system administrators and payers in myriad value-based arrangements.

He is passionate thought leader and healthcare “transformationist” committed to re-engineering healthcare delivery to meaningfully improve outcomes, quality and cost for every patient every time. Dr. Findley career is grounded in the belief that proactive, team-based, care delivery is the only sustainable path forward.

He has served in various leadership roles during is medical career of 25 years, including Medical Director for Caravan Health, where he was responsible for leading and developing physician engagement strategies, content development, clinical programs and clinical analytics; Chief Medical Officer & Interim CEO in a rural Community Hospital; Medical Director of a Health & Wellness Clinic; Planetree Physician Consultant; and founder of LifeWoRx, a Lifestyle Medicine Program.

He attended Creighton University Medical School, completed his Family Medicine Residency at the University of Colorado, and was in private practice for 15 years in Western Colorado.

# David Ottenbaker, MD, MMM

## Vice President of Ambulatory Clinical Programs WI at SSM Health

As Vice President of Ambulatory Clinical Programs, Dr. Ottenbaker oversees all of SSM Health's Wisconsin medical group ambulatory clinical programs, which include the Greater Fond du Lac, Greater Madison Metro, Monroe, Nothern and Southern Regions. In this role, he works in a dyadic relationship with an operational administrator and is responsible for all aspects of the ambulatory clinical programs including, service excellence, patient experience, access and provider satisfaction.

His career has a span of 20 plus years in clinical practice, operations and leadership roles. He served on the MMPC Board of Directors where he was also chaired the recruitment committee. Early in his career he founded and became president of Horizon Medical, P.C., a 22 provider primary care group, from 1995-2006 when the group transitioned to a multi-practice group, MMPC. Prior to joining SSM Health, Dr. Ottenbaker served as the Associate Chief Medical Officer of Regions for the Spectrum Health Medical Group. In this role, he was responsible for providing strategic physician, executive and managerial direction for the system's geographic regions.

Dr. Ottenbaker earned his medical degree from Wayne State University School of Medicine and his undergraduate degree from Michigan State University. He earned his Master's in Medical Management (MMM) from Heinz College at Carnegie Mellon University in February, 2015. He is a member of the American Academy of Family Physicians, the Michigan Academy of Family Physicians and the Wisconsin Academy of Family Physicians.

# Mary D. Strasser, MHL
## Senior Vice President of Population Health at Essentia Health

Mary D. Strasser, MHL is a seasoned healthcare executive with over 25 years of managed care experience within health plans and health systems across the Midwest driving innovative solutions to improve health outcomes and manage the total cost of care.

As Essentia Health's Senior Vice President of Population Health, Mary D. leads the organization's value-based care journey with a focus on aligning incentives among healthcare stakeholders to foster partnerships, break down silos, and promote a holistic approach to healthcare delivery that incentivizes quality care over volume, resulting in improved patient outcomes, satisfaction, and reduced healthcare expenditures.


Medica®

# Coming up at 2:15 pm!
# The Idea Sandbox
# (an open conversation)

Share an example of something creative or bold your teams have done and did not work out as hoped or planned. Here are some questions to think about.

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# Innovations in Alternative Care Delivery Showcase

**Amanda Lake**, Addiction Care Team Case Manager Social Worker, MU Health Care

**Lori Tebbe**, Director of Care Coordination, MU Health

**Elaine Adams**, Manager for Ambulatory Social Work, CHI

**Jill Konstantinides**, PharmD, BCACP, Lead Clinical Pharmacist,  Allina

# Lori Tebbe, RN, MHA, ACM, NE-BC

## Director of Care Coordination at MU Health

Lori is the Director of Care Coordination at MU Health. Her career has spanned across many disciplines including critical care and case management for the past 37 years.  During this time, she has implemented an open- heart surgery program at a community hospital, designed and opened new intensive care units, and redesigned several care delivery models. She co-designed MU Health's Addiction Care Program after witnessing stigma, high utilization of services and moral distress of patients and caregivers of this population.

Lori's passions are building programs and removing barriers to assist the success of patients and health care workers. She loves a good challenge to think outside of the box.

# Amanda Lake, MSW, ASAM

## Addiction Care Team Case Manager Social Worker at MU Health Care

Amanda is the Addiction Care Team Case Manager Social Worker for MU Health Care. Previously, Amanda held a position of Warden with the Missouri Department of Corrections where she was instrumental in developing and implementing Addiction and Mental Health Programming throughout the Department. These programs and philosophies have been shared on a National Level and implemented throughout numerous facilities.

Amanda's passion is to assist people in obtaining recovery and a healthy life balance. Amanda has served in the Public Service Field for over 15 years with marked successes in program development and Leadership. Amanda is a leading force for the team to advance within the clinical setting as well as the community.

# Elaine Adams, MSW

## Manager for Ambulatory Social Work at CHI

Elaine is the Manager for Ambulatory Social Work and Community Health at CHI Health Partners in Omaha, NE. Her team of social workers and community health workers are integral in eliminating barriers to health-related social needs for the patients they serve.

Elaine received both her Bachelor and Master of Social Work at the University of NE at Omaha. She is a busy mom to 3 kids, Olivia (24), Addison (18), and Hayden (17).

# Jill Konstantinides, PharmD, BCACP

## Lead Clinical Pharmacist at Allina

Jill graduated from the University of Minnesota in 2016. After graduation, she completed a PGY-1 Pharmacy Practice Residency with an Ambulatory Care Focus and a PGY-2 Ambulatory Care Residency both at Hennepin Healthcare.

Jill joined Allina Health in Minneapolis in 2018 as a Clinical Pharmacist completing comprehensive medication reviews with patients and supporting interdisciplinary teams. In addition to patient care, Jill is the Lead Clinical Pharmacist. She supports a variety of initiatives to continue to grow clinical pharmacy services, as well as supports the care management service line at Allina Health.


# MU Healthcare

*Addiction Care*

YOUR HEALTH SYSTEM:

# 2023 in NUMBERS

**846,276**
*clinic visits (all sites)*

**27,333**
*patient discharges*

**26,874**
MAJOR
*surgical operations*

**85,059**
*ER + trauma visits*

**869**
PATIENTS
*transported by helicopter*

**266,444** TOTAL **PATIENTS**

**260,590** *Missourians*
**5,854** *out-of-state*

**7 HOSPITALS**

- Children's Hospital
- Ellis Fischel Cancer Center
- Missouri Orthopaedic Institute
- Missouri Psychiatric Center
- University Hospital
- Women's Hospital
- Capital Region Medical Center
  — 26-Year Affiliation

**2,514**
BIRTHS

**335,377**
*radiological exams + treatments*

**2,571,134**
*lab tests*

**5,930,963**
*pharmacy orders*

**6,733** *total staff*

**775** MEDICAL STAFF
**5,958** OTHER STAFF

**598** BEDS

*156 intensive care • 442 acute care*

# Substance Use Disorder at MUHC

- In the last 2 decades, nearly 841,000 people died in the United States from opioid-related drug poisoning.
- At MUHC, 1 in 7 hospitalized patients suffers from a Substance Disorder (SUD).
- Avoidable Delays in discharge have an estimated direct cost of $531k-1.7 million.

**Treatment Saves Lives**

- MOUD associated with larger mortality reduction than any antihypertensive, diabetic agent, or statin; more than aspirin after STEMI *Larochelle, Annals IM, 2018; Poorman, NEJM 2021*

# OUR EXPERIENCE

## Admissions for diagnoses requiring prolonged IV antibiotics are associated with a significant number of potentially avoidable hospital days

| | Number of Visits | Observed to Expected Length of Stay | Average LOS (Days) | Median LOS (Days) |
|---|---|---|---|---|
| **Endocarditis** | 204 | 1.4 | 21.25 | 16 |
| **Osteomyelitis** | 1278 | 1.27 | 14.18 | 10 |
| **Septic Arthritis** | 346 | 1.33 | 14.92 | 10 |
| **Prosthetic Joint Infection** | 250 | 1.1 | 10.4 | 8 |

Data from 1/1/19 - 4/30/22; PowerBI

# Case Presentation

LOS: 32 days
Billed: $438K
Re-imbursed: $31K

| | |
|---|---|
| **Presentation (12/10/)** | 30-year-old who injects heroin presented to OSH on 12/10/21; found to have infective endocarditis of the aortic valve |
| **MUHC Course** | Underwent valve replacement with complicated post-operative course requiring multiple procedures |
| **Discharge** | Pain was limiting factor for discharge and finally “under control” on 1/11/22 with an order to establish care with a PCP and 7 days of oral opioids |

# Case Presentation Readmission (4 mths)

**39 hospital days could have been avoided had this approach been implemented at admission**

**$507k charges for this admission**

| | |
|---|---|
| **Presentation (4/23)** | Presents with chest pain, found to have MSSA bacteremia with new prosthetic aortic valve. Regurgitation and infection of prosthetic valve 4 months post-operative |
| **MUHC Course** | Cardiac Surgery consulted. Patient is poor surgical candidate as active IV drug use and homeless. Team discusses hospice options. Infectious Disease recommends 6 weeks of IVAB in house as no outpatient resources available and surgery is not an option. |
| **Discharge** | Plan devised using tools from Oregon Health and Science IMPACT program. Options DC conference held. Surgery is completed with a post operative rehabilitation plan. Patient discharged to a Texas inpatient substance rehabilitation. One year follow up. Patient arrives with mother, wife and son. Clean for over a year. Note states, “he does look healthy, more lively and happy. Denies any complications in the past year” |

**[Patients] ended up either dead or reinfected. Nobody wanted to do stuff because we felt it was futile. Well, of course it's futile...you're basically trying to fix the symptoms. It's like having a leaky roof and just running around with a bunch of buckets, which is like surgery. You gotta fix the roof... otherwise they will continue to inject bacteria into their bodies.**

Cardiac surgeon reflecting on Oregon Health's IMPACT Program experience. Englander et al, JHM 2018

# Physician and Case Manager Survey

Only 4 in 10 physicians reported being able to prescribe suboxone

75.3% of physicians believe we should treat SUD patients during IP stay.

- A well-defined standard of care and consultative services were the most popular ways to increase this number.

42.9% of physicians are interested in receiving specialized SUD treatment training.

## Key metrics

13.4% of respondents feel MUHC has adequate treatment options available for SUD patients

34.7% of respondents feel like they have the resources they need to treat SUD patients

64.2% of respondents report feeling moderate to extreme levels of stress treating the SUD patient population

80% of respondents report feeling that MUHC handles addiction moderate to poor

## CHALLENGES

1. System stigma or bias
2. Limited provider availability
3. Lack of treatment options (suboxone, outpatient programs, etc.)

## SOLUTIONS/RESOURCES NEEDED

1. Knowledge of Resources (inside & outside the system)
2. Education & Training
3. Multi-disciplinary, specialized, comprehensive care

*Source: MUHC Planning & Business Development*

# MU Health's Complex Transitions of Care Team and Substance Use Disorders

An interprofessional hospital-based addictions team (based on the Oregon Health & Science University model) that meets people with substance use disorder (SUD) during the reachable moment of hospitalization

## PRINCIPLES

**Person-Centered Care**

**Full Assessment and Coordination of Care**

**Medication Assisted Therapy**

**Linkage to Aftercare**

**Harm Reduction Support**

# STAKEHOLDER ENGAGEMENT

## MUHC

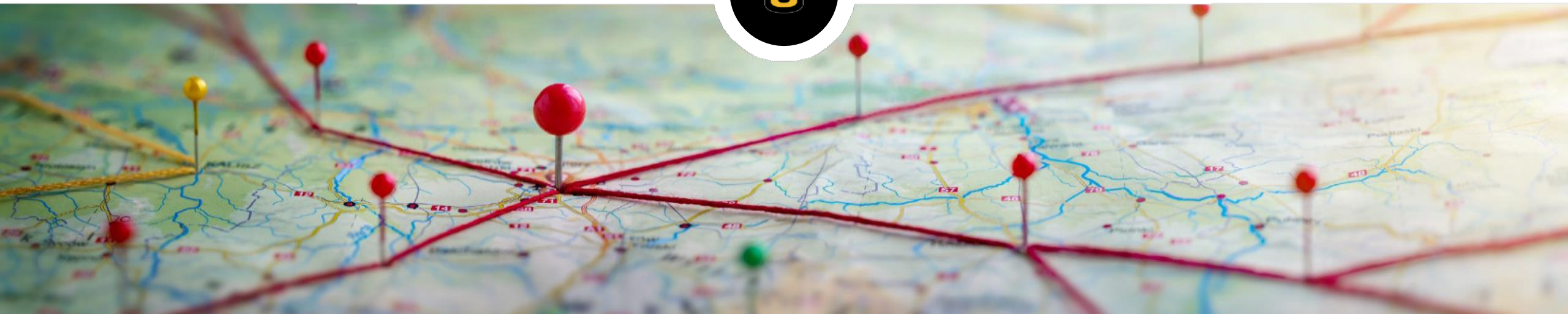
- ✓ Physicians providing SUD treatment
- ✓ Cerner to understand EMR
- ✓ Multiple, Cross-Continuum Meetings

## LOCAL

- ✓ Department of HHS
- ✓ Missouri Hospitalist Association
- ✓ Executive Director of MO Coalition Recovery Support Providers
- ✓ Director, Phoenix House
- ✓ Director, Recovery Services
- ✓ Boone County Health
- ✓ Option Care Home Health
- ✓ Local Coalitions
- ✓ EPICC Recovery Coalition

## REGIONAL

- ✓ Director, Oregon IMPACT
- ✓ Wash U, Northwestern




# Improving Addiction Care

*Amanda Lake*

# Primary Function

- Consults for individuals admitted to the hospital with Substance Use Disorder (SUD) diagnosis or seeking treatment for aftercare
- Clarify treatment goals of patient; include patient in process and to assist in determining their care. Provide options to encourage choice
- Collaborate with OPAT team for safe discharge plans and follow up
- Hold Multi-disciplinary team meetings for aftercare
- Assistance in starting Medication Assisted Therapy (MAT)
- Complete American Society of Addiction Medicine Assessment (ASAM)
- Determine Level of Care for Aftercare
- Determine Level of Care for Aftercare
- Improve comfort level of faculty and staff in treating patients with SUD

# PROCESS

01

## PATIENT IDENTIFICATION

Automated algorithm identifies potential patients and sends list to the team

02

## ASSESSMENT

Case Manager performs ASAM Assessment, Provider completes medical assessment for MAT, Peer Support identified

03

## TREATMENT PLAN

OPTIONS-DC is a scripted, multidisciplinary meeting which results in a comprehensive, person-specific treatment plan

04

## OUTPATIENT FOLLOW-UP

Team coordinates outpatient follow-up with emphasis on SUD services

# Identification

1. **Identification Markers Include**
   - Current Unit
   - Current Service
   - IV Antibiotic Days,
   - Infectious Disease Consults
   - Admission History/Drug & Alcohol Use
   - Active Drug/Opioid/Alcohol on Problem list
   - Positive Toxicology
   - CIWA Doc
2. **List is generated from identification markers**
3. **Patient Navigator reviews list and coordinates with patient's primary team**
   - **Primary Team and Emergency Department can refer straight to Consult Team**
4. **OPAT and CCTT Case Managers debrief daily for cases and discharge barriers**

| Last Name | Financial Number | LOS - Inpatient | Current Unit | Current Service | Primary Health Plan | IV Antibiotic Days | ID Consults | Admission History Drug/ Alcohol Use | Active Drug / Opioid / Alcohol on Problem List | Active Drug / Opioid / Alcohol on Diagnosis List | Positive Toxicology | CIWA Doc |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

# Process and Documentation

- CM and patient create plan for discharge with options for success (1, 2 and 3)
- Options Discharge Meeting with Multi-disciplinary teams present
- Review of resources and ability for plan to be implemented
- Linkage to resources
- Discharge Planning with follow up in place depending on services needed
- Safety Planning
- Risk/Harm reduction Planning
- Relapse Prevention
- PICC Line Community Safety Assessment
- Wrap Around services put into place

# OPTIONS-DC


### ID Synopsis

What treatment options are available? What are the risks if the disease is not treated/ treated optimally?

### SUD & Mental Health Assessment

What is the patient's substance use history? Have these chronic medical conditions been addressed?

### Safety Assessment

Is the patient safe to have a PICC? Is the patient able and willing to travel for care? Access to running water? Access to a telephone? Emergency contacts?

### Harm Reduction

Has a relapse prevention plan been completed? Does the patient have scheduled PCP and addiction support follow-up?

### Patient values

What are the patient's values and preferences?

# SYSTEM IMPROVEMENTS

## SUD AS A CHRONIC DISEASE

Frames SUD as a chronic disease (rather than a moral failure) which warrants comprehensive treatment like any other medical diagnosis.

## PATIENT SAFETY

- ✓ PICC Safety Assessment
- ✓ Clear Expectations for Patient Behavior
- ✓ Diversion Control Protocols
- ✓ Early Use of Peer Support

## IMPROVED MEDICAL MANAGEMENT

Development of clinical decision support surrounding management of acute withdrawal, initiation of MAT, management of acute pain for patients on MOUD

# American Society of Addiction Medicine Assessment

There are 6 dimensions that the ASAM covers for the bio-psychosocial assessment-includes history, imminent danger and safety assessing:

Dimension 1-Acute Intoxication and/or Withdrawal

Dimension 2-Biomedical Conditions and Complications

Dimension 3-Emotional, Behavioral, or cognitive conditions and complications

Dimension 4-Readiness to Change

Dimension 5-Relapse, Continued Use, or Continued Problem Potential

Dimension 6-Recovery/Living Environment

# Level of Care for Discharge

| Levels of Care | Brief Description |
|---|---|
| 0-1.0 (Out-patient low intensity-OP) | 9 hours or less of intervention a week |
| 2.1- (Intensive Out-Patient-IOP) | 9 hours or more of intervention a week |
| 2.5-(OP High Intensity- PHP) | 20 or more hours a week |
| 3.1-Residential Low Intensity (Halfway House) | 5 or more hours a week |
| 3.3-Residential High Intensity (Special Populations) | 7 days/week-Imminent Danger |
| 3.5-Residential High Intensity (Clinically managed) | 7 days/ week –Imminent Danger |
| 3.7- Intensive Medically Monitored Inpatient | 24 hour Nursing w/ Physician Consultation Available 24 hr-Imminent Danger |
| 4.0-Intensive Medical Managed Inpatient | 24 hour nursing and physician Evaluation Daily-Imminent Danger |

# Case Presentation

25 y/o transferred via air from OSH with a thoracic aortic aneurysm. Hx of IVDU, leaving AMA and not following through with care at multiple hospital systems.

Pt underwent repair with new aortic graft and soft tissue repair of an aorto- esophageal fistula.

After multiple interventions, care Meetings, family meetings and OPTIONS DC conferences, pt transitioned to LTACH for the duration of IV abx and complex needs due to fistula repair.

Substance disorder treatment was arranged while at the LTACH and pt was transitioned with MAT for her opioid use disorder.

Discharged from LTACH to a sober living community near her family.

Pt returned 4 months later for a successful esophageal reconstruction.

Pt has now discharged home with family and eventually returned to her sober living community.

We have included a taped interview with patient as she discussed the types of care and her personal experience for viewing.

# ACT/OPAT UPDATE

| FY2023 FINANCIAL REVIEW | | |
|---|---|---|
| | Projection 1YR | *Actual 6 Mons |
| DAYS SAVED | 729 | 558 |
| REDUCTION IN READMISSION | 187 | *Pending |
| POTENTIAL NEW DISCHARGES | 161 | 101 |
| CONTRIBUTION MARGIN IMPACT | $1,747,494 | $1,486,104 |
| **IMPACT PROGRAM COST** | **$(692,865)** | $(113,253) |
| **NET CONTRIBUTION MARGIN** | **$1,054,630** | **$1,372,851** |

- ACT/OPAT program started in January of 2023. Within 6 months, the program has already reached it's original one-year goal
- Currently, 2.0 FTE's support the ACT/OPAT program
- Readmissions KPI will be updated at the end of the first year.

*Date Range: 1/1/23 - 7/7/23*
*Data Source: MUHC Finance*


# Thank You

*Lori Tebbe, Director: tebbel@health.missouri.edu*
*Amanda Lake, Case Manager: alb975@health.missouri.edu*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# Community Link

## Medica ACO Summit 2023

Presented by Elaine Adams
CHI Health Partners
Nebraska/Southwest Iowa

CommonSpirit™

# Health vs Social

I had known and adored Jeremy's family for several years. So when the sandy-haired, good-natured 8-year-old came to see me in my clinic with abdominal pain, I bent over backward to find out why his tummy hurt. I poked and prodded; did tests of his urine, stool and blood; and took X-rays, over the course of several months. When those tests came back normal, I did more. I had trained at a top medical school and gone on to one of the best residencies in my specialty; in Jeremy, I thought I had identified a real clinical mystery.

But in the end, the mystery was not a best-seller: It turned out that Jeremy's family couldn't afford to buy food. It had never even occurred to me to ask his mother about how much food there was in the house.

In Jeremy's case, I had diagnosed "abdominal pain" when the real problem was hunger; I confused social issues with medical problems in other patients, too. I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as noncompliance. In one older patient, I mistook the inability to read for dementia. My medical training had not prepared me for this ambush of social circumstance.

Laura Gottlieb, MD, MPH, is a Professor of Family and Community Medicine at UCSF.

A former National Health Services Scholar and safety-net family physician with fellowship training in social determinants of health, Dr. Gottlieb now serves as Principal Investigator on multiple quantitative and qualitative projects examining the integration of social and medical care services.

# Center for Medicare and Medicaid Services

"*Many of the largest drivers of health care utilization and costs fall outside the clinical care environment…There is emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and impact costs.*"—Center for Medicare and Medicaid Services[1]


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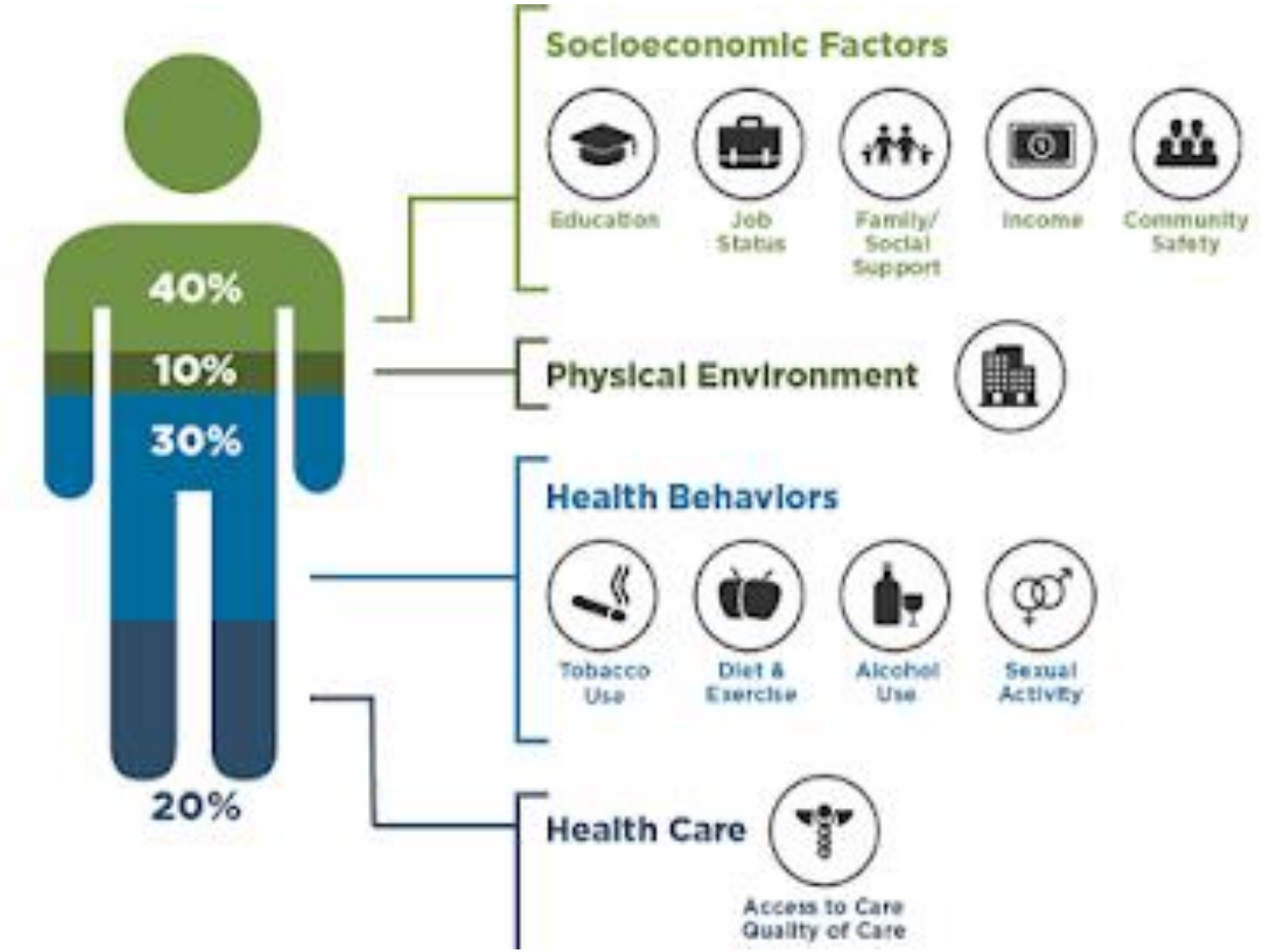
# Why is addressing SDOH important?

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# Why is addressing SDOH important?

CommonSpirit represents many and diverse communities, and as a leader in mission-driven care delivery, we have the opportunity to inform and transform the role of healthcare as a partner, collaborator, and advocate to advance health equity in our communities: ***ensuring individuals and families have every opportunity to live the healthiest lives possible.***


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# Community Link

- Community Link is a **grant funded program through CHI Health Mission and Ministry established to identify and address social determinants of health in the primary care setting.**
- The program launched on September 30, 2016.
- The program currently has **FIVE** Community Link Advocates (CLAs) and covers the Omaha/metro area collaborating with the Social Work team.
- Community Link has a **physical presence** at 4 primary care clinics - but cover 24+ primary care and specialty clinics remotely.

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# CL Guiding Principles

1. Improve health outcomes for patients we serve
2. Provide meaningful learning opportunities for students, building future healthcare leaders with an understanding of the relationship between health status and access to basic resources.
3. Develop a financially and operationally sustainable population health model.
4. Create a program and operational structure that aligns with system goals and strategy
5. Create a model that allows for scaling/replication within CHI Health Partners & CHI Health

# How has CHI Health addressed SDOH? 2017-2018

**First Round of Funding:**


- Screening
- Team had very limited scope
- Team was completing a full intake and entering data
- Program was “resource only” or “opt-in”
- CLA’s were limited to 30 open cases
- Documenting in EHR and TAV Health CM platform (lengthy intake/assessment)

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# Key Learnings

- Positive impacts for patients and clinic team were reported
- Work to integrate with clinic team and clarify roles and responsibilities was critical
- Took more time than anticipated to gain awareness of the program; more work to do on the "why"
- Pre-visit planning/intake/data entry was time consuming
- Follow up with patients was a challenge

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# How has CHI Health addressed SDOH?

**2019:**

- Stopped screening
- Integrated with Social Work team
- New Care Mgmt Platform - Innovaccer
- Simplified protocol to make documenting more efficient

**2020:**

- New screening tool created
- Pilot universal screening at one clinic location using paper screening
- Midwest Division requested integration of SDOH screening in our EHR

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# Screening Tool

**Patient Name**_____ **DOB**_____

1. Do you ever have a hard time paying for needs like food, housing, medical care, or utilities? *(gas, electric, water)*

   YES NO

2. Do you have trouble finding or paying for a ride to medical appointments?

   YES NO

Would you like help with any of these needs?

YES NO

---

****If you would like to talk to someone before you leave today, please tell your doctor. Otherwise, someone will call you soon to talk about your needs.*

Best phone number to reach you _____

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**CHI Health Clinic Florence**
8613 N 30th Street
P 402-453-9900

CHI Health Community Link

# Key Learnings

- Screening **does** identify patients with needs
- In-clinic referrals to address SDoH increased
- We educated **clinic staff/providers**
- We educated **clinic patients**


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# Key Learnings

**Staff Feedback** (prior to implementation)

- Front desk staff **and** providers initially expressed some concern with offending patients by presenting screening

**Staff Feedback** (after implementation)

- Positive support and response from clinic staff/providers
- One provider verbalized his excitement of CLA being at the clinic as well as his support of the program/pilot

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# Key Learnings

**Patient Feedback**

- “it’s wonderful that you are doing this because there are probably a lot of people who aren’t going to volunteer this information on their own”
- Comments written in on screeners “thanks for asking”
- Positive response from patients overall

# Screening Results

| Date | Total appts scheduled | No Shows | Declined | Tele-health | Missed Opps | Total Screened | Negative | Positive | % positive from total screened |
|---|---|---|---|---|---|---|---|---|---|
| Weekly Total | 473 | 54 | 2 | 12 | 157 | 248 | 176 | 72 | 29% |
| Weekly Total | 496 | 57 | 1 | 30 | 164 | 257 | 157 | 100 | 39% |
| Weekly Total | 404 | 38 | 3 | 19 | 140 | 213 | 159 | 54 | 25% |
| Weekly Total | 323 | 35 | 4 | 11 | 63 | 217 | 133 | 71 | 33% |
| Weekly Total | 497 | 41 | 36 | 22 | 107 | 280 | 194 | 86 | 31% |
| Weekly Total | 474 | 45 | 31 | 21 | 180 | 199 | 144 | 54 | 27% |
| TOTAL TO DATE | 2873 | 290 | 77 | 115 | 856 | 1555 | 1064 | 477 | 31% |

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# 2021-2022 Interdisciplinary Team Pilot (IDT)

**Team approach-**

Transitioned to an approach in which CLA's are integrated into an interdisciplinary team with PHCs, social workers, clinicians and others working together to develop and implement a plan to holistically assess and address each patient's clinical and non-clinical needs ("CL interdisciplinary approach").


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# Key Learnings

- N0 statistically significant changes in the outcomes of interest
- Many **challenges and limitations** of this evaluation
  - data abstraction
  - small sample sizes
  - potential variability in fidelity in the implementation processes
  - potential selection bias.
  - abstraction and transfer of data was delayed
  - final analytic sample sizes were much smaller than expected


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# 2023 Screening via MyChart (patient portal)

- Feb 14th a 24-question Social Factors/SDoH Screening Questionnaire pushed out via MyChart for Primary Care & WHS
- Epic standard/foundation questionnaire
- 4-question screener created to be asked on a more frequent basis as we know patients needs can change
- The intent is for patients to complete the screeners themselves
- A BPA will fire for certain questions on the full screener

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# Key Learnings

**Over 7,000 unique positive screens were identified**

- The full 24-question screener does not ask the patient if they **want help**
- The BPA was not making it's intended impact, noted by the number of "no action taken"
- Potential safety issue related to the intimate partner violence question (does the patient have a proxy that might see this, placing the patient in an unsafe situation)
- Providing the patient with false hope that someone is going to provide assistance with one of the questions we asked about
- **Staff capacity**

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# What we know today

1. CLAs are effective in connecting patients with social risk factors to community-based resources to mitigate HRSN (e.g. emergency food, transportation to follow-up appt, etc.).
2. Patients receiving CL services and clinical staff who are familiar with the program agree it adds value.
3. Literature indicates CHWs are effective in improving health status (e.g. cancer prevention, diabetes, hypertension and asthma self-management, etc.) in defined populations, esp. low-income, underserved and ethnic minority communities.
4. Ambulatory HRSN screening, if/ when implemented, will significantly increase the identification of patients' HRSN AND current CL workforce is insufficient to meet increased demand for current services.

Kim K, Choi JS, Choi E, Nieman CL, Joo JH, Lin FR, Gitlin LN, Han HR. Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review. Am J Public Health. 2016 Apr;106(4):e3-e28. doi: 10.2105/AJPH.2015.302987. Epub 2016 Feb 18. PMID: 26890177; PMCID: PMC4785041.

# What we know today

5. CSH is increasingly investing in social care integration programs
6. Most traditional CHW programs go beyond resource provision and have specific education to improve health measures, like asthma, diabetes, cardiovascular disease, etc.-
7. CL has received additional funding to continue this great work!


Kim K, Choi JS, Choi E, Nieman CL, Joo JH, Lin FR, Gitlin LN, Han HR. Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review. Am J Public Health. 2016 Apr;106(4):e3-e28. doi: 10.2105/AJPH.2015.302987. Epub 2016 Feb 18. PMID: 26890177; PMCID: PMC4785041.

# Thank you

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# Analytic Platform to Improve Performance for MTM Pharmacists

**Jill Konstantinides, PharmD, BCACP**
Allina Health, Lead Ambulatory Clinical Pharmacist
October 10, 2023

# ALLINA HEALTH AMBULATORY CARE TEAM

18 PHARMACIST IN 30+ CLINIC LOCATIONS

COMPREHENSIVE MEDICATION REVIEWS

COLLABORATE WITH CARE MANAGEMENT

LOCATIONS:

CLINIC, TELEPHONE, VIRTUAL, HOME

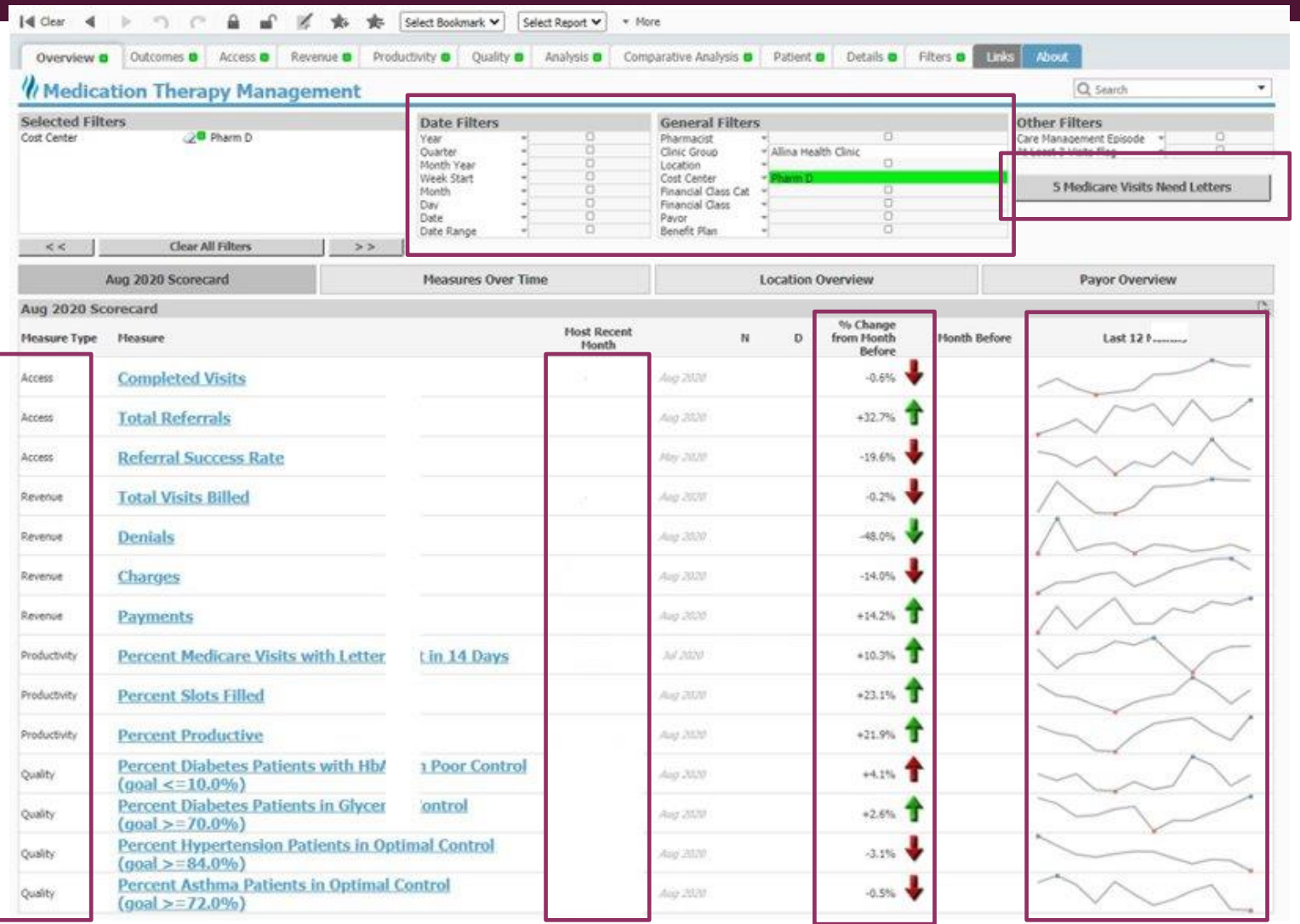
# WHAT IS A DASHBOARD?

# GOALS FOR DASHBOARD

- Support clinical pharmacists
- Monitor clinical and operational performance
- Data to empower leadership
- Research projects

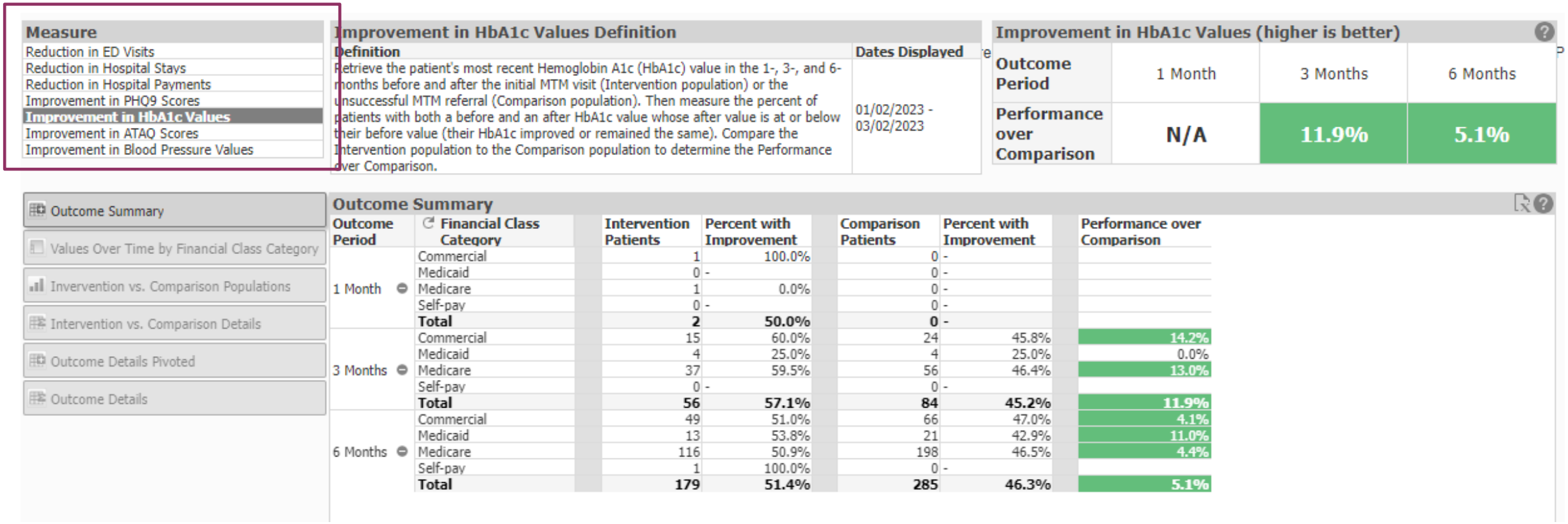
# DASHBOARD OVERVIEW

# MONTHLY SCORECARD



# DEEPER DIVE INTO COMPONENTS

# OUTCOMES



**Measure**

- Reduction in ED Visits
- Reduction in Hospital Stays
- Reduction in Hospital Payments
- Improvement in PHQ9 Scores
- **Improvement in HbA1c Values**
- Improvement in ATAQ Scores
- Improvement in Blood Pressure Values

**Improvement in HbA1c Values Definition**

| Definition | Dates Displayed |
|---|---|
| Retrieve the patient's most recent Hemoglobin A1c (HbA1c) value in the 1-, 3-, and 6-months before and after the initial MTM visit (Intervention population) or the unsuccessful MTM referral (Comparison population). Then measure the percent of patients with both a before and an after HbA1c value whose after value is at or below their before value (their HbA1c improved or remained the same). Compare the Intervention population to the Comparison population to determine the Performance over Comparison. | 01/02/2023 - 03/02/2023 |

**Improvement in HbA1c Values (higher is better)**

| Outcome Period | 1 Month | 3 Months | 6 Months |
|---|---|---|---|
| Performance over Comparison | N/A | 11.9% | 5.1% |

- Outcome Summary
- Values Over Time by Financial Class Category
- Invervention vs. Comparison Populations
- Intervention vs. Comparison Details
- Outcome Details Pivoted
- Outcome Details

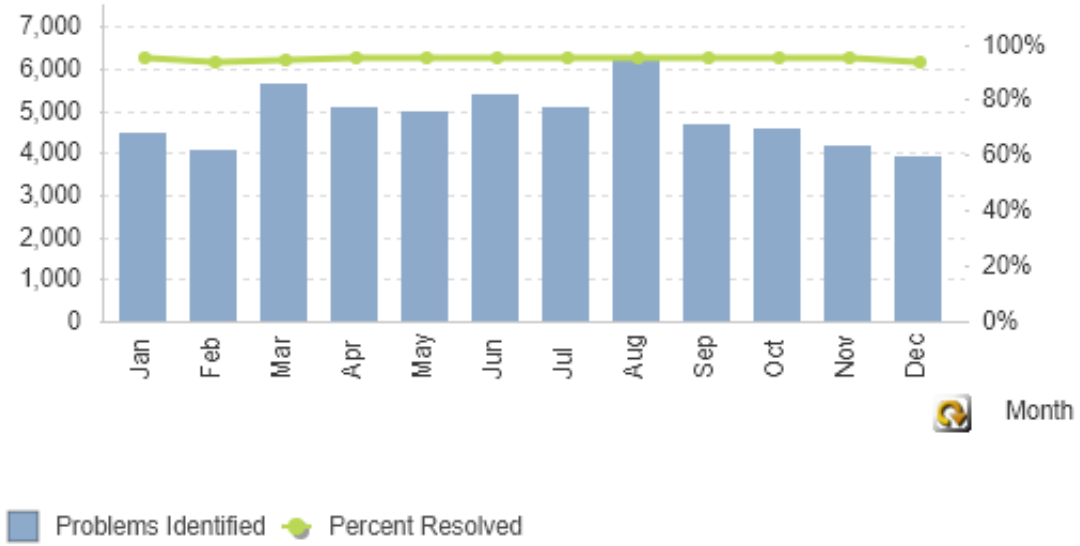
**Outcome Summary**

| Outcome Period | Financial Class Category | Intervention Patients | Percent with Improvement | Comparison Patients | Percent with Improvement | Performance over Comparison |
|---|---|---|---|---|---|---|
| 1 Month | Commercial | 1 | 100.0% | 0 | - | |
| | Medicaid | 0 | - | 0 | - | |
| | Medicare | 1 | 0.0% | 0 | - | |
| | Self-pay | 0 | - | 0 | - | |
| | **Total** | **2** | **50.0%** | **0** | - | |
| 3 Months | Commercial | 15 | 60.0% | 24 | 45.8% | 14.2% |
| | Medicaid | 4 | 25.0% | 4 | 25.0% | 0.0% |
| | Medicare | 37 | 59.5% | 56 | 46.4% | 13.0% |
| | Self-pay | 0 | - | 0 | - | |
| | **Total** | **56** | **57.1%** | **84** | **45.2%** | **11.9%** |
| 6 Months | Commercial | 49 | 51.0% | 66 | 47.0% | 4.1% |
| | Medicaid | 13 | 53.8% | 21 | 42.9% | 11.0% |
| | Medicare | 116 | 50.9% | 198 | 46.5% | 4.4% |
| | Self-pay | 1 | 100.0% | 0 | - | |
| | **Total** | **179** | **51.4%** | **285** | **46.3%** | **5.1%** |

# QUALITY

Medication Analysis | Problem Detail | Medication Detail

## Medication Therapy Problems



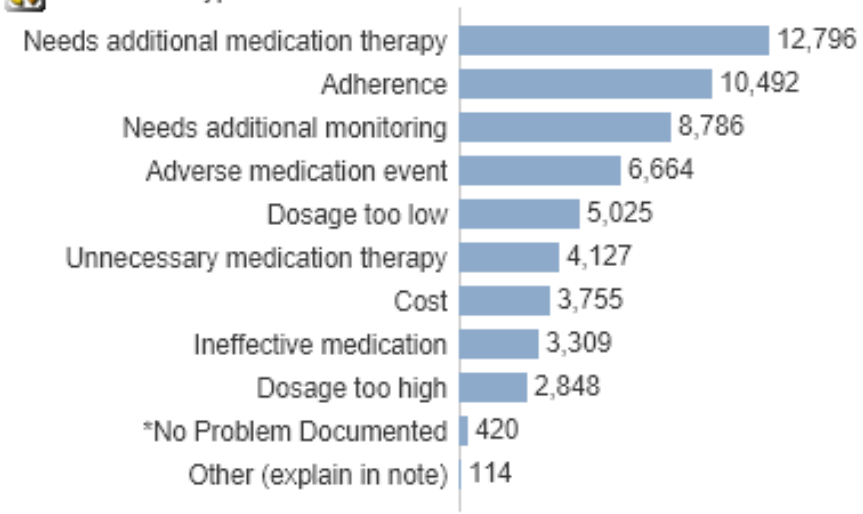

## Medication Analysis

| Pharmaceutical Class | Problems Identified | Percent Resolved |
|---|---|---|
| **Total** | **58,266** | **94.7%** |
| *No Medication Identified | 13,652 | 92.3% |
| INSULINS | 3,128 | 96.7% |
| ANTIHYPERLIPIDEMIC-HMGCOA... | 1,862 | 93.5% |
| ANTIHYPERGLYCEMIC, BIGUANI... | 1,739 | 95.9% |
| ANTICONVULSANTS | 1,658 | 94.4% |
| PROTON-PUMP INHIBITORS | | |
| BETA-ADRENERGIC BLOCKING A.. | | |
| SELECTIVE SEROTONIN REUPTA.. | | |
| VITAMIN D PREPARATIONS | | |
| ANTIHYPERGLY,INCRETIN MIME.. | | |
| PLATELET AGGREGATION INHIB.. | | |
| CALCIUM REPLACEMENT | | |
| BETA-ADRENERGIC AND GLUCO.. | | |
| ANTIHYPERGLYCEMIC, INSULIN-.. | | |
| ANALGESIC/ANTIPYRETICS,NON.. | | |
| CALCIUM CHANNEL BLOCKING A.. | | |
| SEROTONIN-NOREPINEPHRINE .. | | |
| LAXATIVES AND CATHARTICS | | |

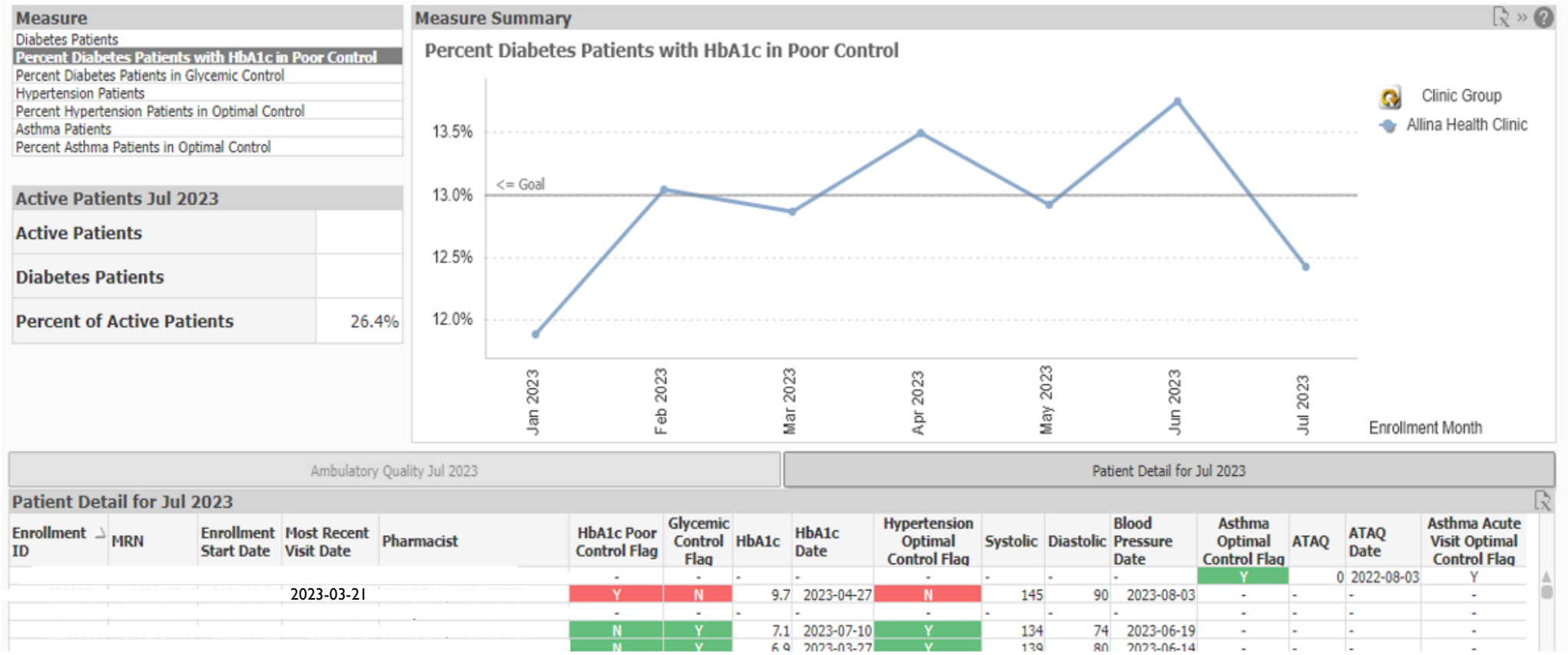
## Medication Therapy Problems Breakdown

### Problems Identified

Problem Type



# QUALITY (CONTINUED)



| Measure |
| --- |
| Diabetes Patients |
| **Percent Diabetes Patients with HbA1c in Poor Control** |
| Percent Diabetes Patients in Glycemic Control |
| Hypertension Patients |
| Percent Hypertension Patients in Optimal Control |
| Asthma Patients |
| Percent Asthma Patients in Optimal Control |

| Active Patients Jul 2023 | |
| --- | --- |
| Active Patients | |
| Diabetes Patients | |
| Percent of Active Patients | 26.4% |



Ambulatory Quality Jul 2023 | Patient Detail for Jul 2023

**Patient Detail for Jul 2023**

| Enrollment ID | MRN | Enrollment Start Date | Most Recent Visit Date | Pharmacist | HbA1c Poor Control Flag | Glycemic Control Flag | HbA1c | HbA1c Date | Hypertension Optimal Control Flag | Systolic | Diastolic | Blood Pressure Date | Asthma Optimal Control Flag | ATAQ | ATAQ Date | Asthma Acute Visit Optimal Control Flag |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | | | | - | - | - | - | - | - | - | - | Y | 0 | 2022-08-03 | Y |
| | | | 2023-03-21 | | Y | N | 9.7 | 2023-04-27 | N | 145 | 90 | 2023-08-03 | - | - | - | - |
| | | | | | - | - | - | - | - | - | - | - | - | - | - | - |
| | | | | | N | Y | 7.1 | 2023-07-10 | Y | 134 | 74 | 2023-06-19 | - | - | - | - |
| | | | | | N | Y | 6.9 | 2023-03-27 | Y | 139 | 80 | 2023-06-14 | - | - | - | - |

<u>Application by Clinician:</u> Patient's A1c was 9.7% in April 2023 which was after the last PharmD visit. Time to schedule up to address?

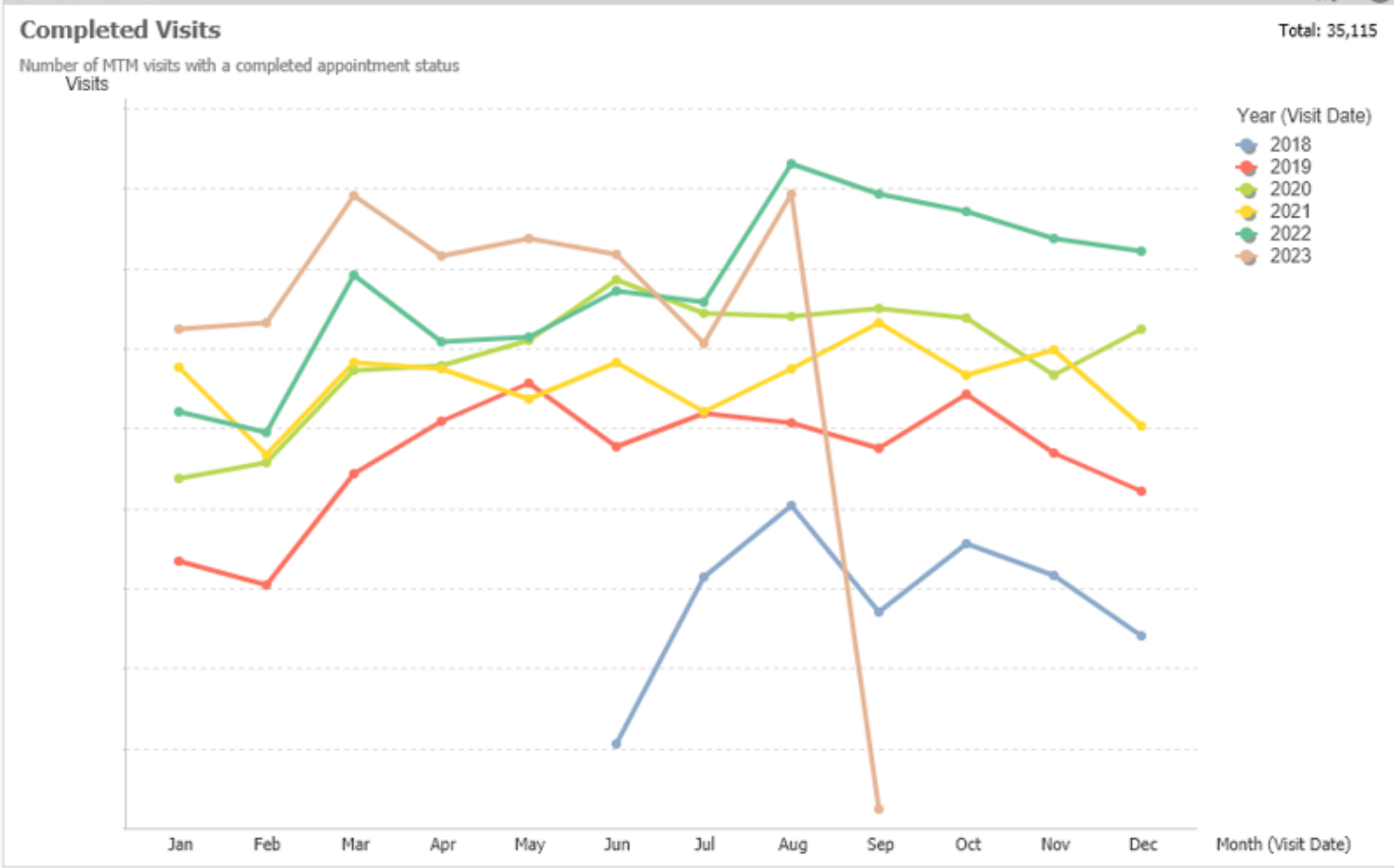
# ACCESS

Control Chart | Year over Year | Pareto | Pivot Table

**Measure (* = on scorecard)**

- Access: Total Visits
- Access: Total Patients
- **Access: Completed Visits** *
- Access: Percent Visits Completed
- Access: No Shows
- Access: Percent Visits No Showed
- Access: Canceled Visits
- Access: Percent Visits Canceled
- Access: Same Day Cancels
- Access: Percent Visits Canceled Same Day
- Access: Telephone Visits
- Access: Percent Visits in Telephone Setting
- Access: Home Visits
- Access: Percent Visits in Home Setting
- Access: Clinic Visits
- Access: Percent Visits in Clinic Setting
- Access: Virtual Visits
- Access: Percent Visits in Virtual Setting
- Access: Total Referrals *
- Access: Referral Success Rate *
- Access: Average Referral to Visit Turnaround Time
- Revenue: Total Visits Billed *
- Revenue: Total Patients Billed
- Revenue: Initial Visits Billed
- Revenue: Follow Up Visits Billed
- Revenue: Additional Minutes Billed
- Revenue: Denials *
- Revenue: Percent Transactions Denied
- Revenue: Charges *
- Revenue: Payments *
- Revenue: Adjustments
- Revenue: Active AR
- Revenue: Average Visits Billed per Patient
- Productivity: Medicare Visits that Need Letter Sent
- Productivity: Percent Medicare Visits with Letter Sent in 14 Days *
- Productivity: Available Slots
- Productivity: Slots Filled
- Productivity: Percent Slots Filled *
- Productivity: Template Hours
- Productivity: Available Hours
- Productivity: Percent Hours Available
- Productivity: Unavailable Hours

**Year over Year**



# ACCESS (CONTINUED)

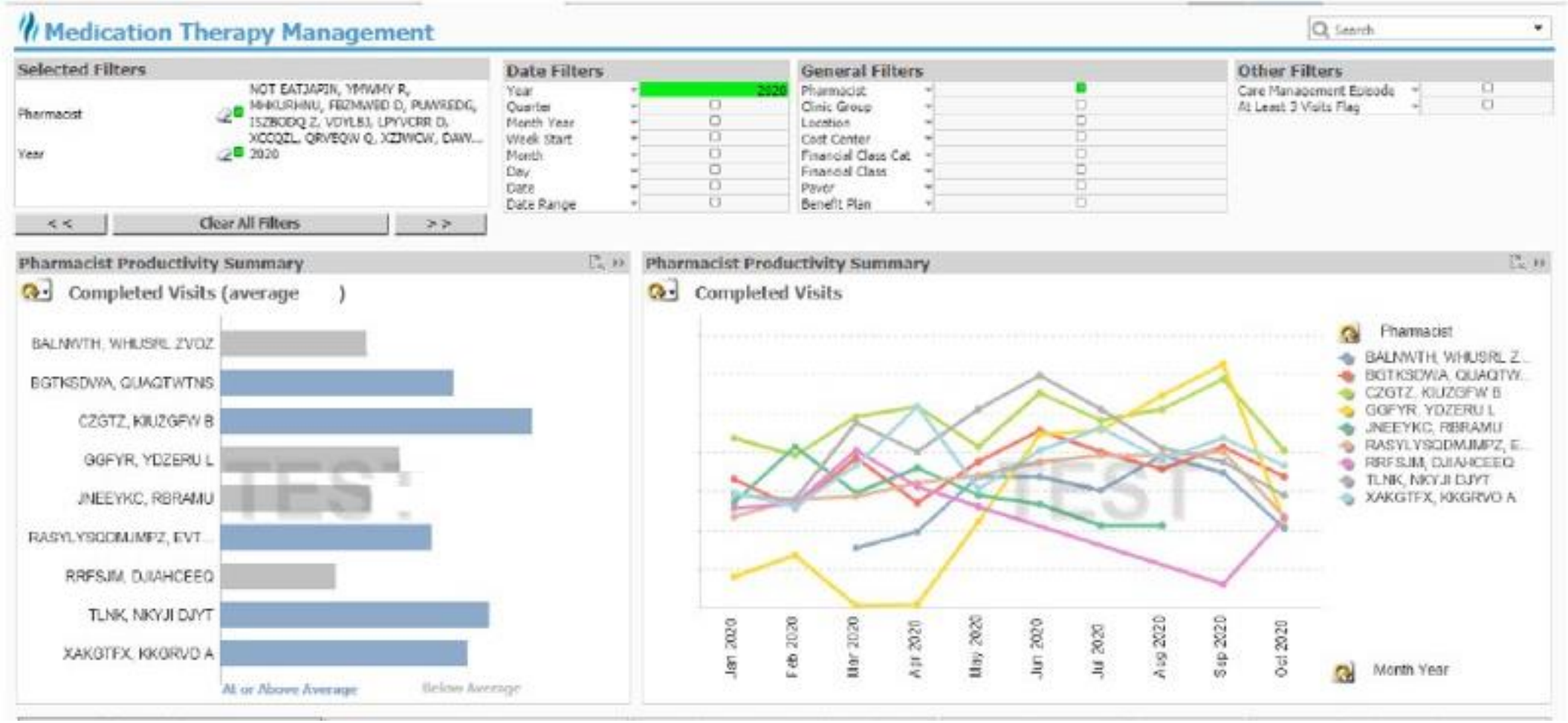
## Referrals

- Success rate
- Unsuccessful referral reason
- Payer-specific demographics

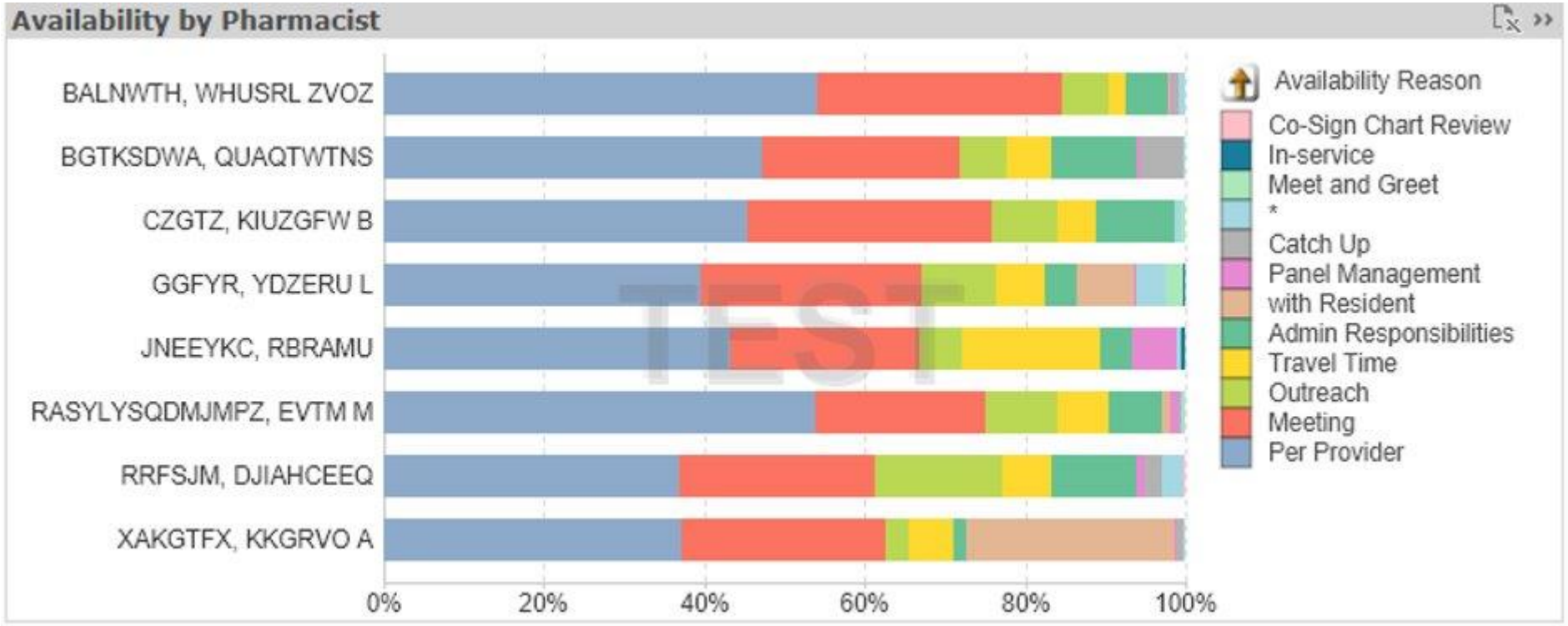
## Visits

- Number of completed visits
- No show rate
- Cancelations
- Location of visits
- Patient demographics

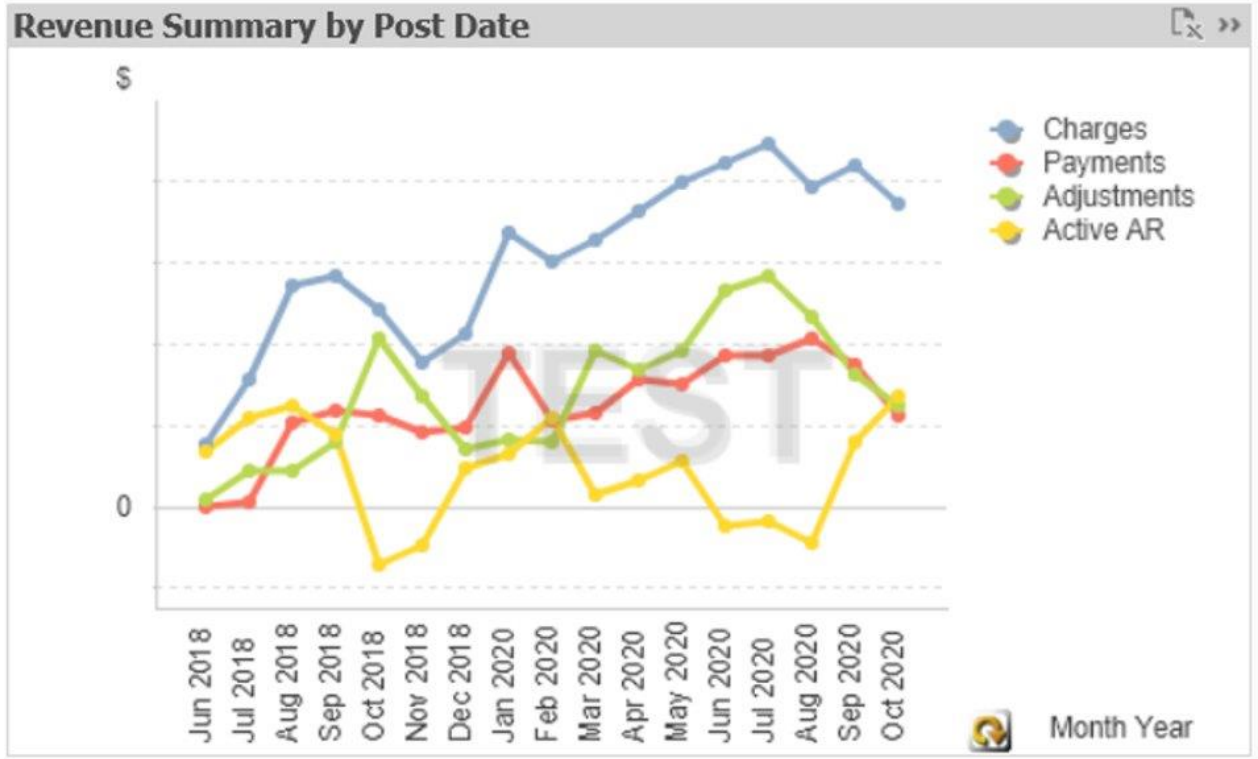
# PRODUCTIVITY

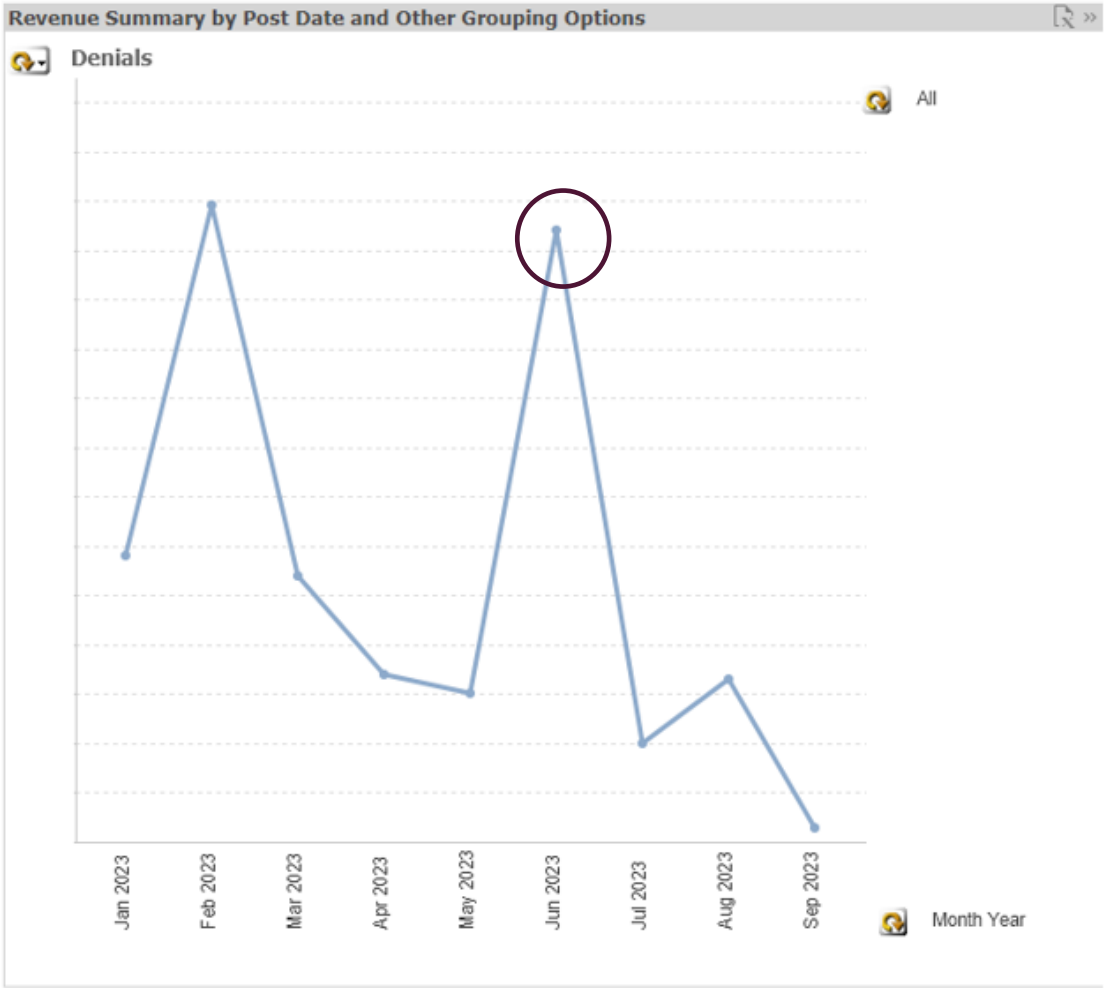


# PRODUCTIVITY



# REVENUE



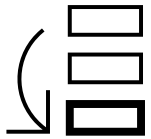

<u>Application by Leadership:</u> Denials increased in June 2023. Why is this happening?

# HOW TO CREATE?

# STEPS TO CREATE

**Create** your case

**Learn** who to ask



**Prioritize** work

**Determine** where data comes from

# LEARNINGS

- Use for one year and then make updates
- Continue to update data sources
- Ensure data integrity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# Coming up at 2:15 pm!
# The Idea Sandbox
# (an open conversation)

Share an example of something creative or bold your teams have done and did not work out as hoped or planned. Here are some questions to think about.

- Describe what you tried to do?  What was the “why” behind it and what were you hoping to accomplish?
- What did happen?  How did you gauge success vs. the lack of success?
- What did you learn?  How did that inform future work or your next steps?  Any “silver linings”?

# Reimagining the Behavioral Health Experience Showcase

**Sarah Nelson**, MD, Associate Medical Director for Population Care Management; Section Chair for Outpatient Psychiatry, Essentia Health

**Brian Grahan**, MD, PhD, Medical Director, Office-based Addiction Medicine Services; Director, Substance use related Project ECHO initiatives, Hennepin Healthcare

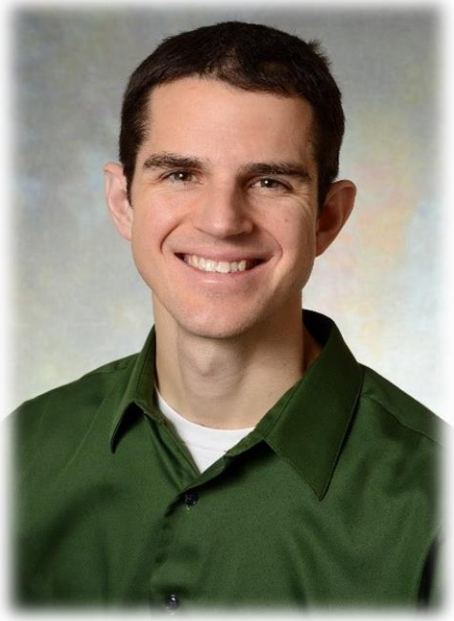
# Dr. Sarah Nelson

## Associate Medical Director for Population Health at Essentia Health

Dr. Sarah Nelson is the Section Chair for Outpatient Psychiatry and Associate Medical Director for Population Health at Essentia Health, where she has been since 2019. She completed combined training in Internal Medicine and Psychiatry at Duke Health in North Carolina, where she focused on providing high-quality care to patients with significant physical and mental health comorbidities in a variety of integrated settings. She has a BA in International Studies from Middlebury College and an MD from Harvard Medical School.

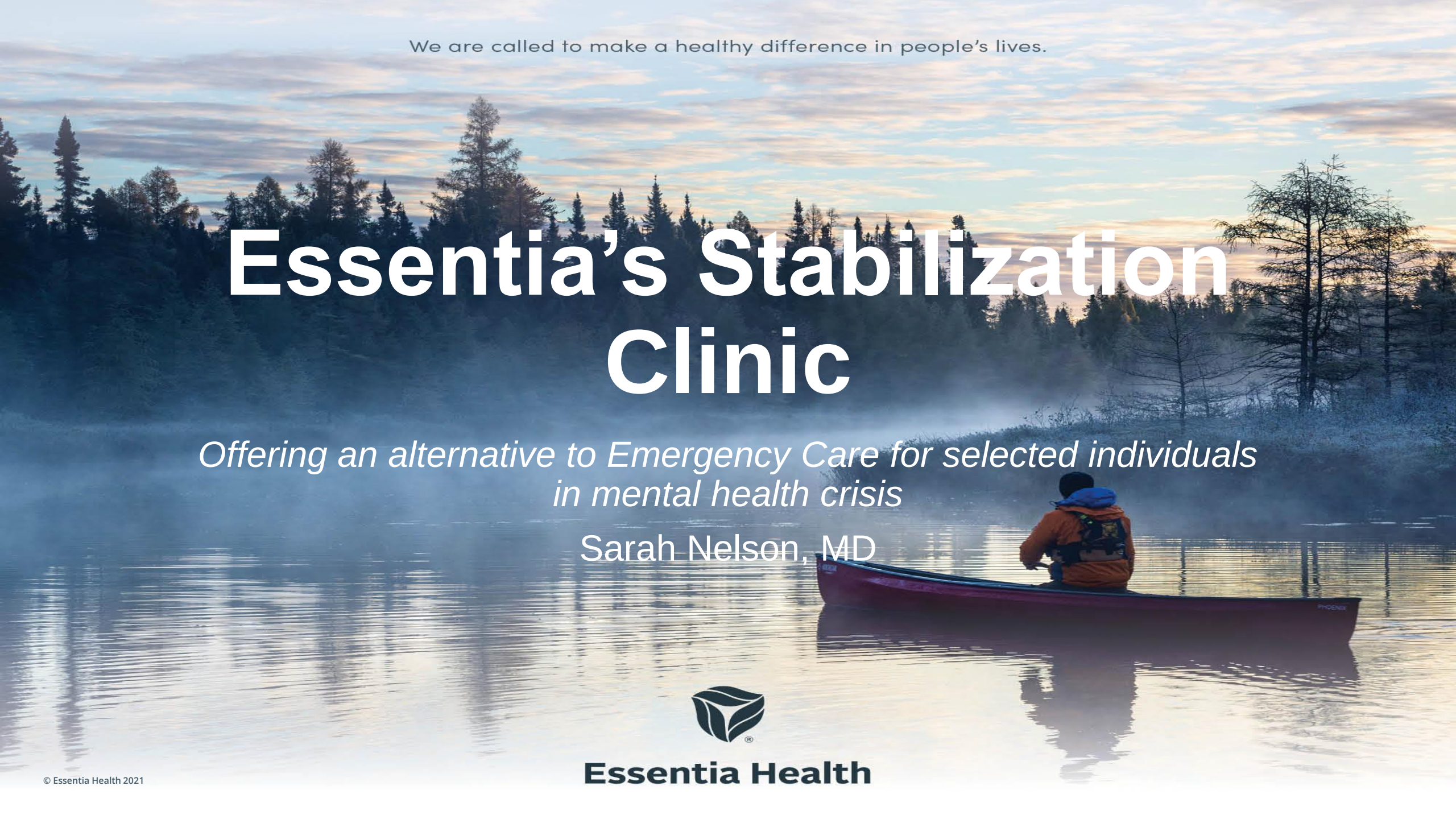
# Dr. Brian Grahan

## Medical Director at Hennepin Healthcare



Brian, MD, PhD is the founder and Medical Director of Hennepin Healthcare's (HH) office-based addiction treatment clinic, Director of HH's Opioid and Addiction Care related ECHO initiatives, and previous Co-Director of the Midwest Tribal ECHO. He completed his MD-PhD degrees at the University of Wisconsin-Madison with a focus on behavioral economics and population health, then moved to Minnesota for the University of Minnesota's combined internal medicine and pediatrics residency. After a chief residency in quality and patient safety at the Minneapolis VA Medical Center, Dr. Grahan completed the Minnesota Addiction Medicine fellowship with support from a Next Generation Award by the American Board of Addiction Medicine Foundation and Conrad Hilton Foundation enabling him to seek extra training in adolescent substance use.

Dr. Grahan seeks to create systems of care that reduce the impact of substance use disorders on individuals, their families, and their communities. Mentoring primary care and other healthcare providers in addiction medicine is a core part of these efforts and has been sustained by longitudinal funding from the State of Minnesota. His efforts have been recognized by the American Society of Addiction Medicine, the VA National Center on Patient Safety, and The Addiction Medicine Foundation.




# Essentia's Stabilization Clinic

*Offering an alternative to Emergency Care for selected individuals in mental health crisis*

Sarah Nelson, MD

Essentia Health

# Objectives

- Review trends in psychiatric illness and acute care utilization
- Describe development of a stabilization clinic
- Share preliminary findings
- Highlight successes, challenges, and next steps

# Crisis at hand

**In 2021:**

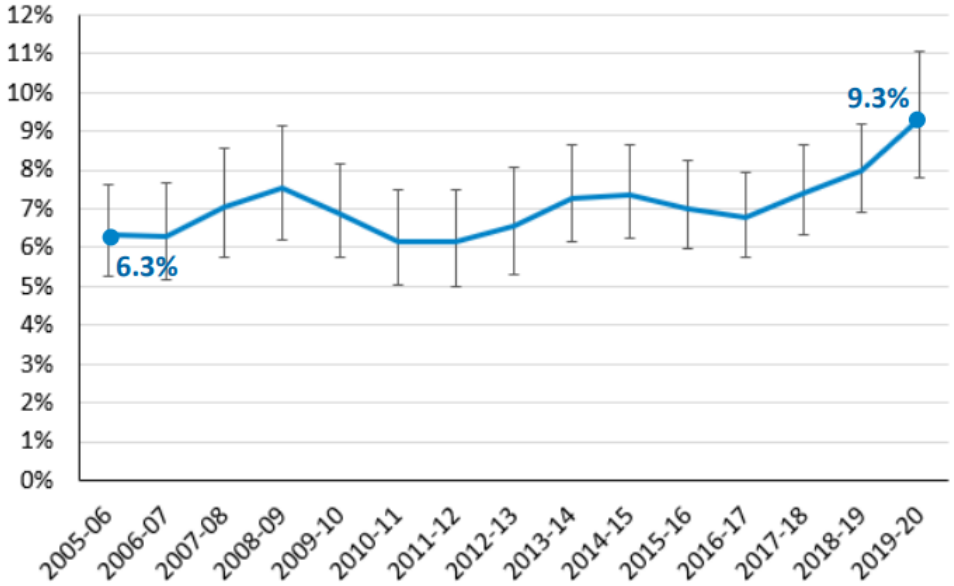
48,183 people died by suicide in US, ***or 1 death every 11 minutes***

12.3 million seriously thought about suicide

3.5 million adults made a plan

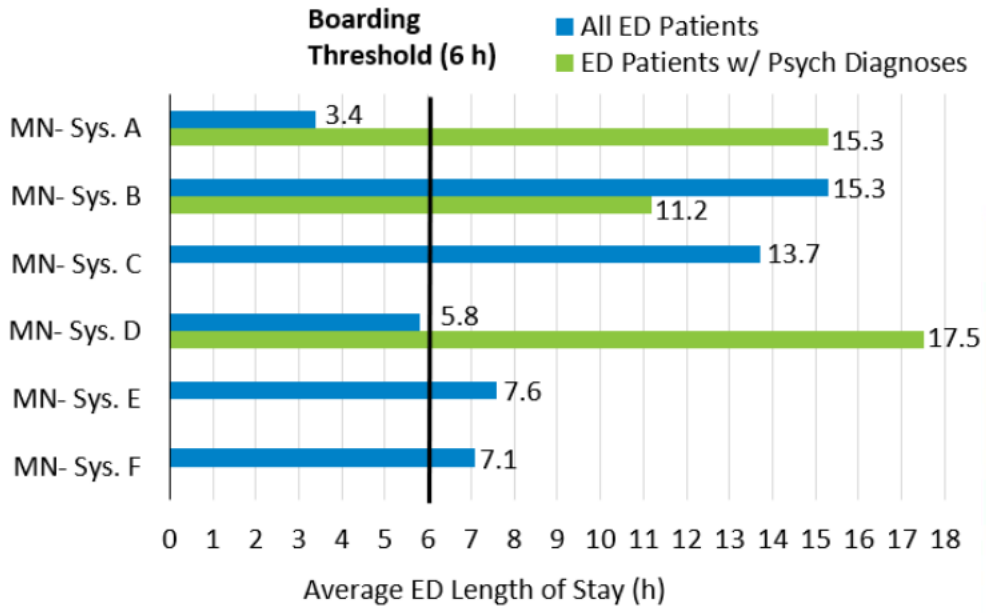
1.7 million attempted suicide

**Figure 7.** Percentage of Minnesota adults experiencing at least one major depressive episode in the past year (SAMHSA, 2022)



# ED boarding crisis

**Figure 4.** Average ED LOSs of six large Minnesota health systems, July to October 2019 (ICSI, 2019)




StarTribune

Business Opinion Variety Obituaries Classifieds Autos

## Minnesota doctors sound alarm over 'boarding' of psychiatric patients in ERs

A physician task force is calling for more mental health beds, an expanded workforce, better insurance coverage and new tools for patients to understand options.

By Christopher Snowbeck Star Tribune | MAY 31, 2023 — 10:46AM

# Lack of inpatient psychiatric beds

| Hospital Bed Type | Count | Per 100K pop. | Add'l Beds to Meet Rec. (50 per 100K pop.) | % Increase to Meet Rec. (50 per 100K pop.) |
|---|---|---|---|---|
| **Adult** | | | | |
| Psychiatric Beds | 1,128 | 25.7 | 1,066 | 95% |
| Chemical Depdendency Beds | 51 | 1.2 | -- | -- |
| **Pediatric** | | | | |
| Psychiatric Beds | 183 | 13.9 | 476 | 260% |
| Chemical Dependency Beds | 20 | 1.5 | -- | -- |
| **Total** | | | | |
| Psychiatric Beds | 1,341 | 23.5 | 1,512 | 113% |
| Chemical Dependency Beds | 71 | 1.2 | -- | -- |

# Stabilization Clinic


- In December 2021, Essentia established a “stabilization clinic” as a “clinic within a clinic” to serve patients in psychiatric crisis
  - Psychotherapy
  - Medication Management
  - Community Health Worker

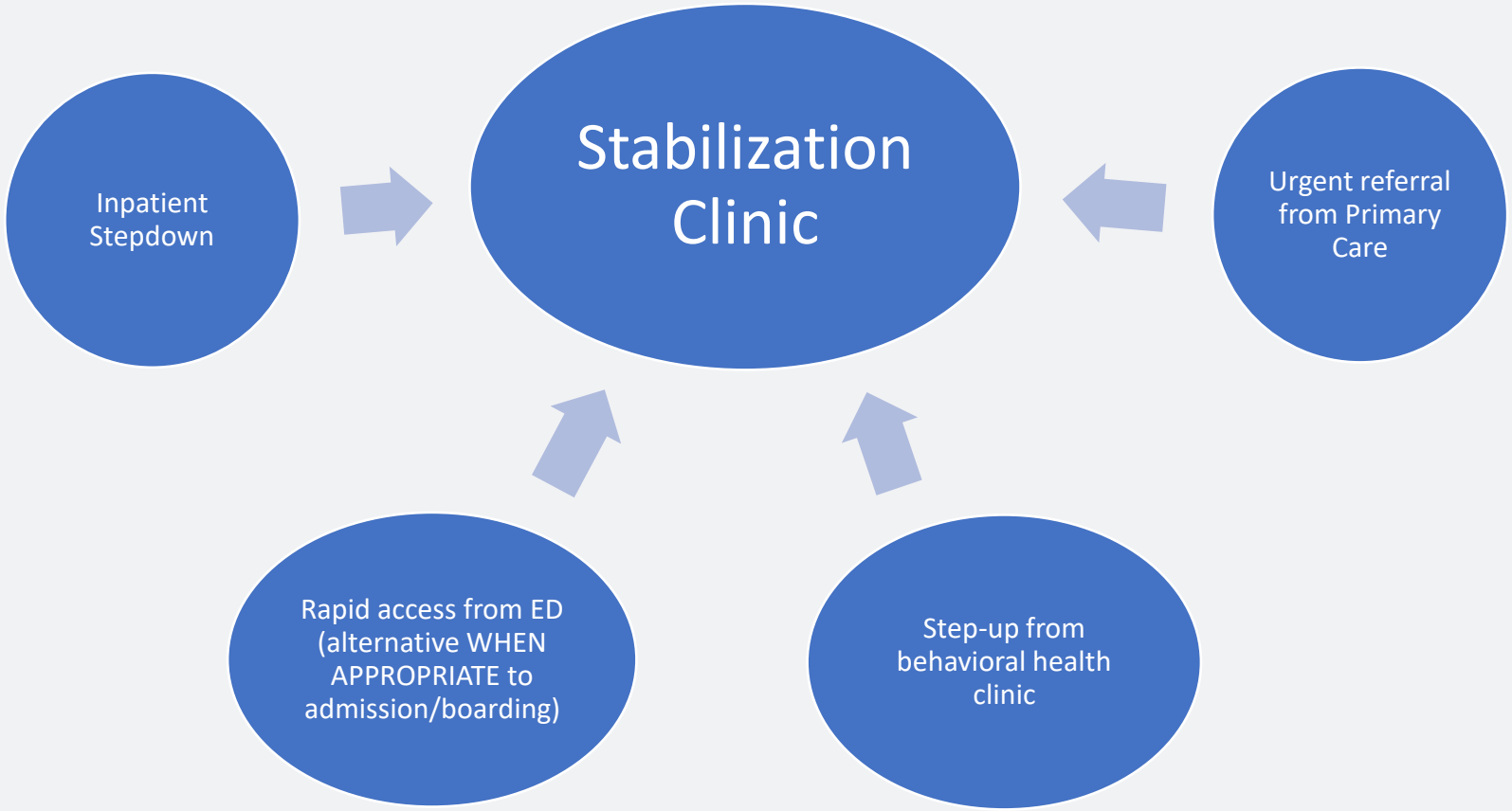
# Stabilization Clinic Goals

- Provide a patient-centered alternative to managing behavioral health crises that could otherwise lead to ED visits, ED boarding and inpatient hospitalization
- Save lives and prevent readmissions
  - Rapid access coordinated with providers across the continuum of care
  - Crisis-specific care using evidence-based interventions

# Theoretical underpinnings

- Right care at the right time
- Evidence base for suicide specific care
  - Holding environment
  - Therapeutic alliance
    - ok to talk about suicide – not “too much” or “too scary”
  - Skills, focused on here-and-now problems
    - DA can wait
  - Longer-term: suicidal drivers

# Many paths to Stabilization Clinic



# ED Workflow

- Patient presents to ED with crisis
- Assessed by member of PCS team (RN/LICSW/Psychiatry) to determine disposition
- For patients who are judged to be safe to discharge with close outpatient follow up, referral placed to stabilization clinic
- Real-time coordination with Stabilization Clinic team to set up follow up appointment
- RN and LICSW complete caring contact/transitional care call within 48h
- Patient meets with Stabilization therapist or med provider
- Community Health Worker meets with patient as needed to address health-related social needs

# Suicide-specific care

- Suicidal ideation or attempt is often a recurrent condition
- Patients often conceal to avoid/be discharged from hospital
  - Increased risk of death by suicide after discharge from IP (300x in first week, 200 x in first month)
- Suicide-specific intervention (evidence based)
  - Normalize and give words for talking about suicide in a safe and supportive environment; understand function of suicidal thoughts (SI as a symptom or defense mechanism)
  - Safety planning
  - Provide skills to manage suicidal thoughts and impulses
  - Address drivers of recurrent suicidality

# Rapid intervention as prevention:

- PTSD / Acute trauma response (common referral).
  - Education about what is “normal,” recovery and self care strategies, grounding.
  - Ability to gain access shortly following the trauma event, which improves outcomes, avoids harmful treatments (eg benzo)
- Post-partum depression, traumatic birth experiences
  - Rapid access helps address crisis quickly, keeps everyone safe
  - Not just for moms: father who was suicidal / overwhelmed and considering quitting his job
    - reframed, found a way to change his role in his current position so that he could focus more on his family without losing his job

# Avoiding multiple ED visits

- Anxiety and panic attacks.
  - Patient who had abruptly left work because of a panic attack, then went to the ED with his next one.
    - Psychoeducation and skill building – TIPP skills
    - With next panic attack and suicidal ideation, “I grabbed a bag of tater tots” and held it on his face, was able to calm himself down for the first time.
- Suicidal Crisis:
  - Several patients who now have the Stabilization Clinic as part of their safety / crisis plan, no longer come regularly but know that they will have access if they need it. Will reach out by phone or MyChart, can help avoid ED / hospital.

# Supporting the team

- Collaboration
  - Weekly Stabilization Clinic Meetings
  - Bi-Weekly High Risk Case Consultation
  - Physical proximity to promote easy collaboration and team-building
- Work-load balancing
  - Increased time for appointments, charting
  - Reduced patient limits (1 new consult, 3 follow ups per day for therapy)
  - Increased autonomy and flexibility to allow providers to easily schedule patients in crisis as needed

# Utilization Results

| | Events | | Per 1000 patients per year | | |
|---|---|---|---|---|---|
| | Before | After | Before | After | |
| Inpatient | 722 | 215 | 1,081 | 578 | (503) |
| Observation | 73 | 27 | 109 | 73 | (37) |
| Emergency Room | 1,143 | 515 | 1,698 | 1.384 | (313) |
| ED Boarder | 149 | 50 | 223 | 134 | (89) |
| | | | | | |
| Partial Psych Series | 117 | 78 | 175 | 210 | 35 |

**Before Enrollment: 1/1/2021 until day before initial Stabilization Clinic Visit**
**After Enrollment: Initial Stabilization Clinic Visit until 6/30/2023**

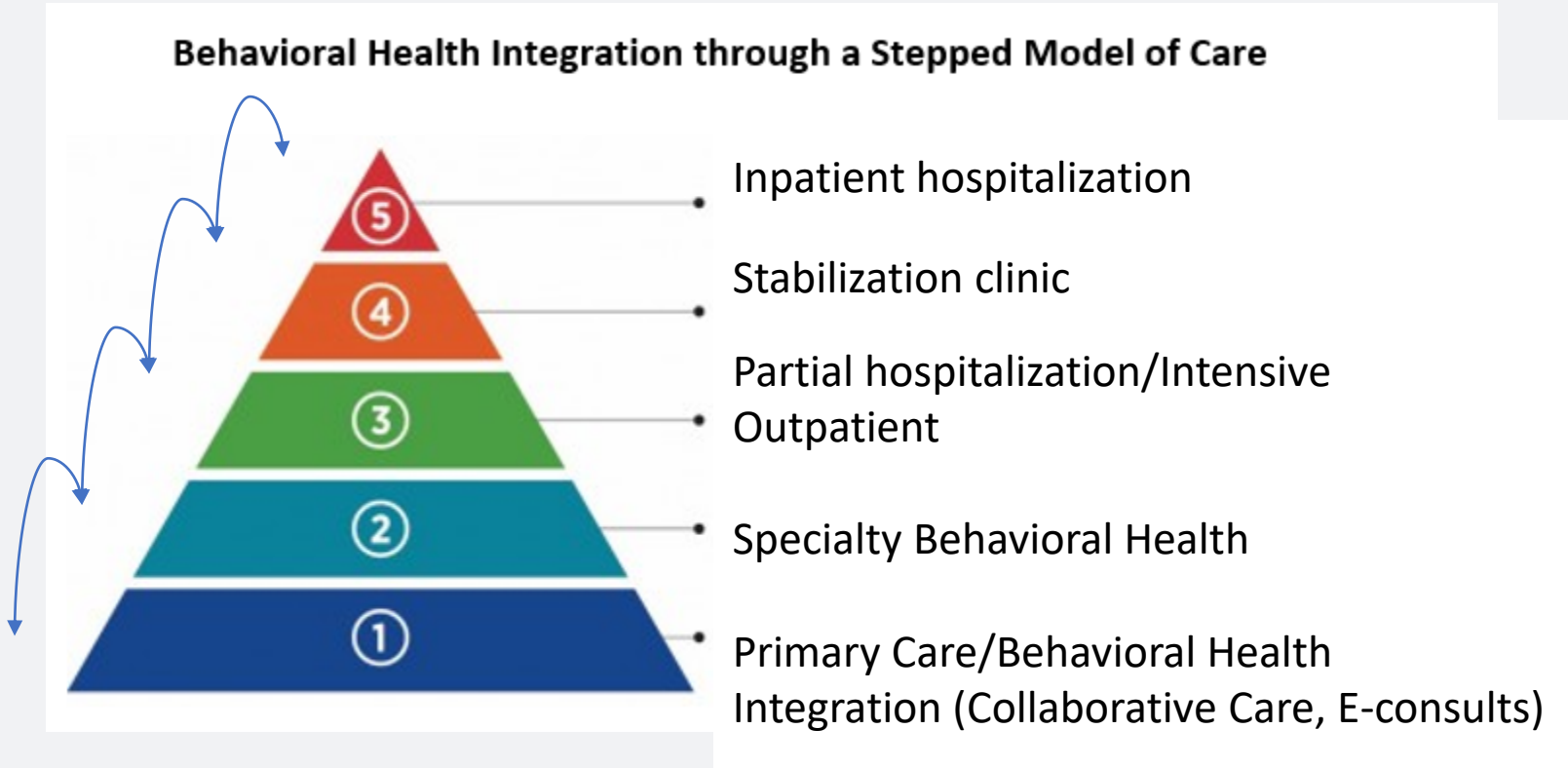
# Learnings

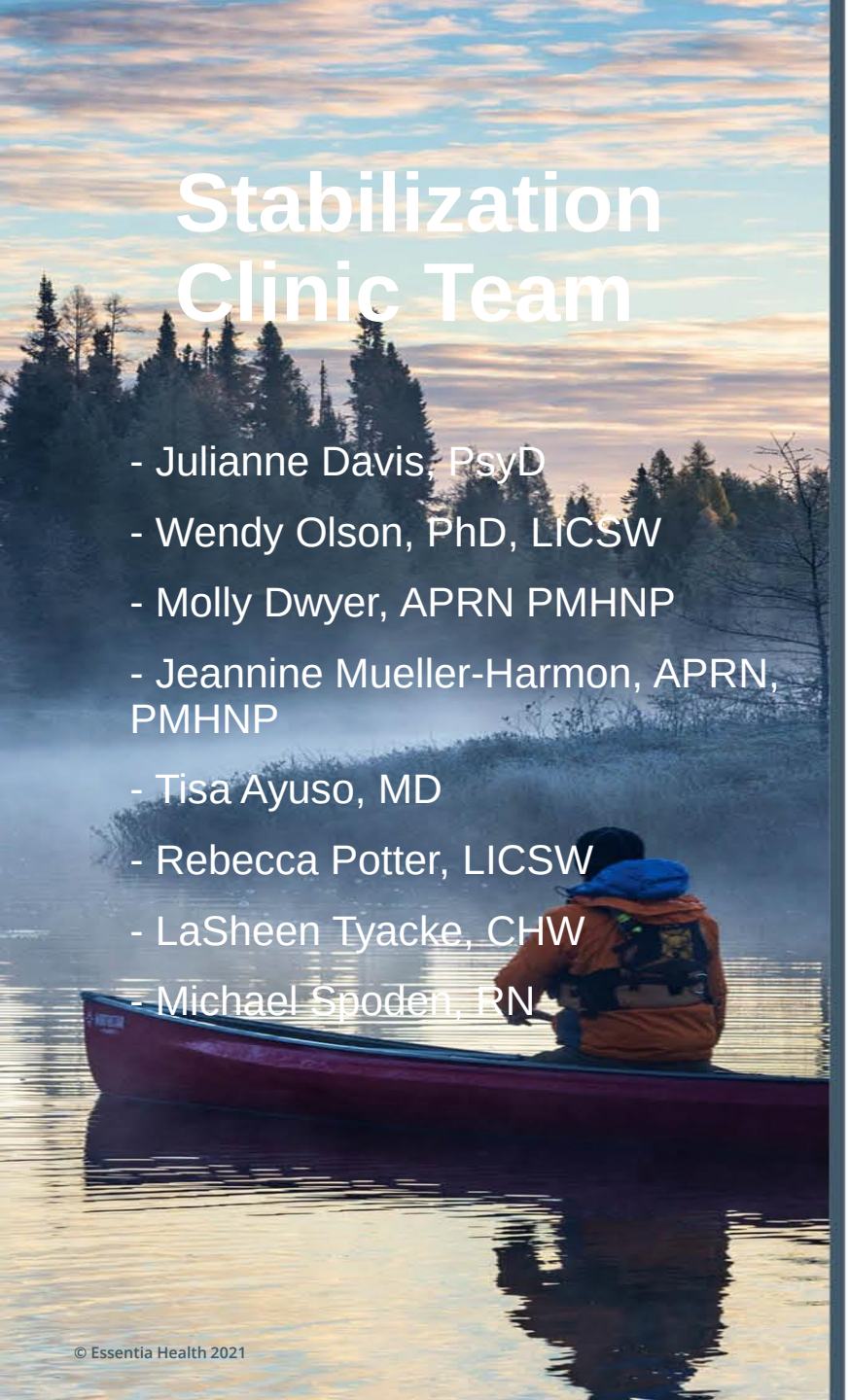
- Patients LOVE this program
  - Get the care and guidance they need in a timely way
  - Avoid ED/hospital when appropriate
- Patients are high acuity
  - Care navigation and inter-departmental collaboration is **essential**
  - Providers need skills, structure, and support to manage high-acuity patients
    - Strong background in evidence-based strategies
    - Template must reflect intensity of the work
    - Consultation/Collaboration is key
- Needs extend beyond suicidal thoughts and behaviors
  - Substance use disorders
  - Heath related social needs
- Drive-through can easily become a Parking lot
  - Case management/navigation needs
  - Create capacity within outpatient care
- Staff engagement

# Next Steps

- Expand scope of services
  - Dual Diagnosis – LADC and Addiction Medicine
- Expand staffing to serve more patients
- Improve navigation to longer term care
- Continue to analyze impacts
  - Utilization
  - ED boarding times
  - Outcomes (safety, engagement, functional improvement)

# Heading upstream






# Thank you!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# Systems Approaches to OUD Care

Brian Grahan, MD, PhD

Medical Director, Office-based Addiction Medicine Services

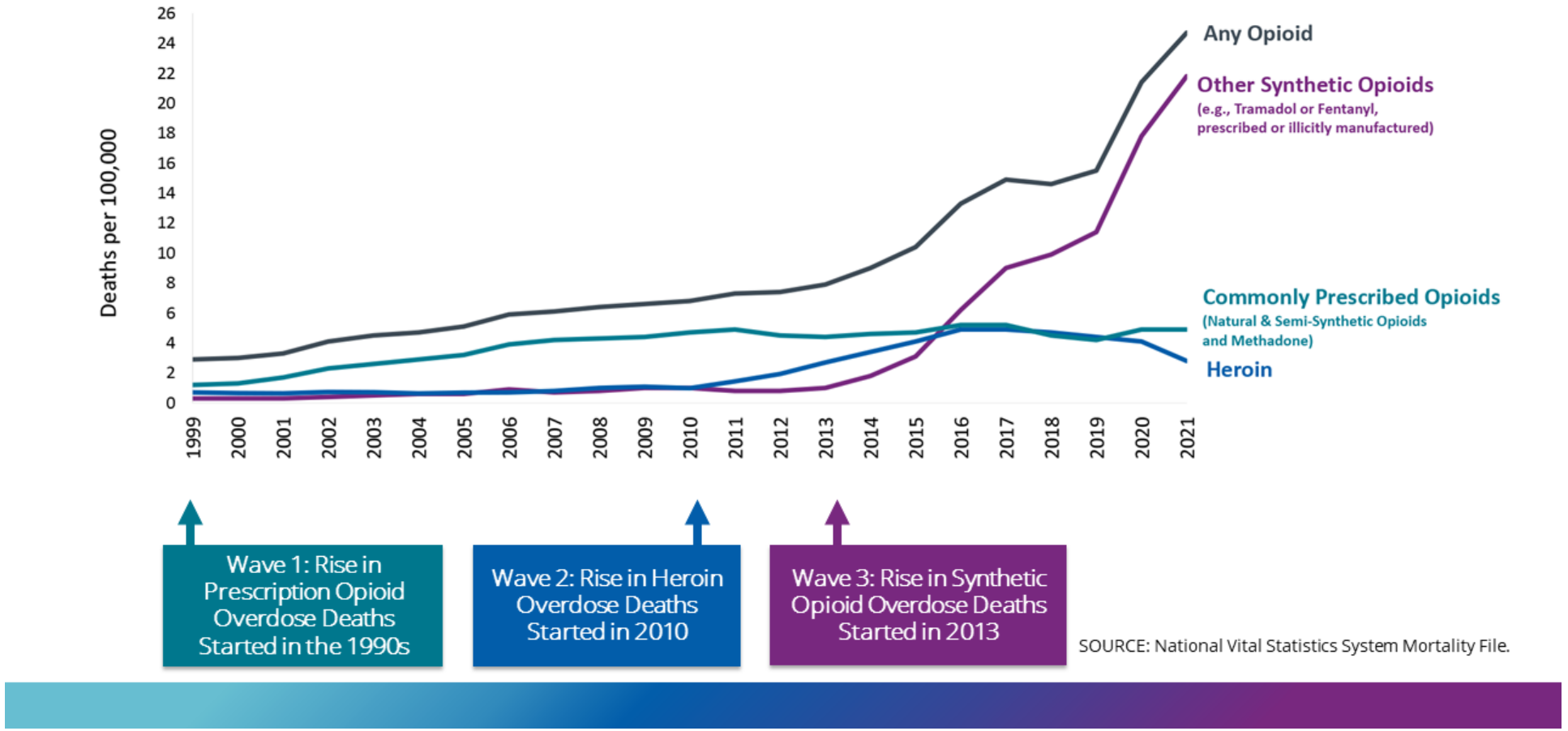
Hennepin Healthcare

# What is Opioid Use Disorder (OUD)?

| Category | Criteria |
|---|---|
| Impaired control | • Use in larger amounts or longer periods than intended<br>• Unable to cut down or control use<br>• Excessive time spent to obtain, use, or recover<br>• Craving or preoccupation |
| Social impairment | • Failure to fulfill major role obligations (work, home, school)<br>• Persistent or recurrent use-related social or interpersonal problems<br>• Important social, occupational, or recreational activities given up |
| Risky use | • Recurrent physically hazardous use<br>• Use despite persistent physical or mental harm from drug |
| Physical dependence | • Tolerance<br>• Withdrawal |

Mild 2-3; Moderate 4-5; Severe 6 or more

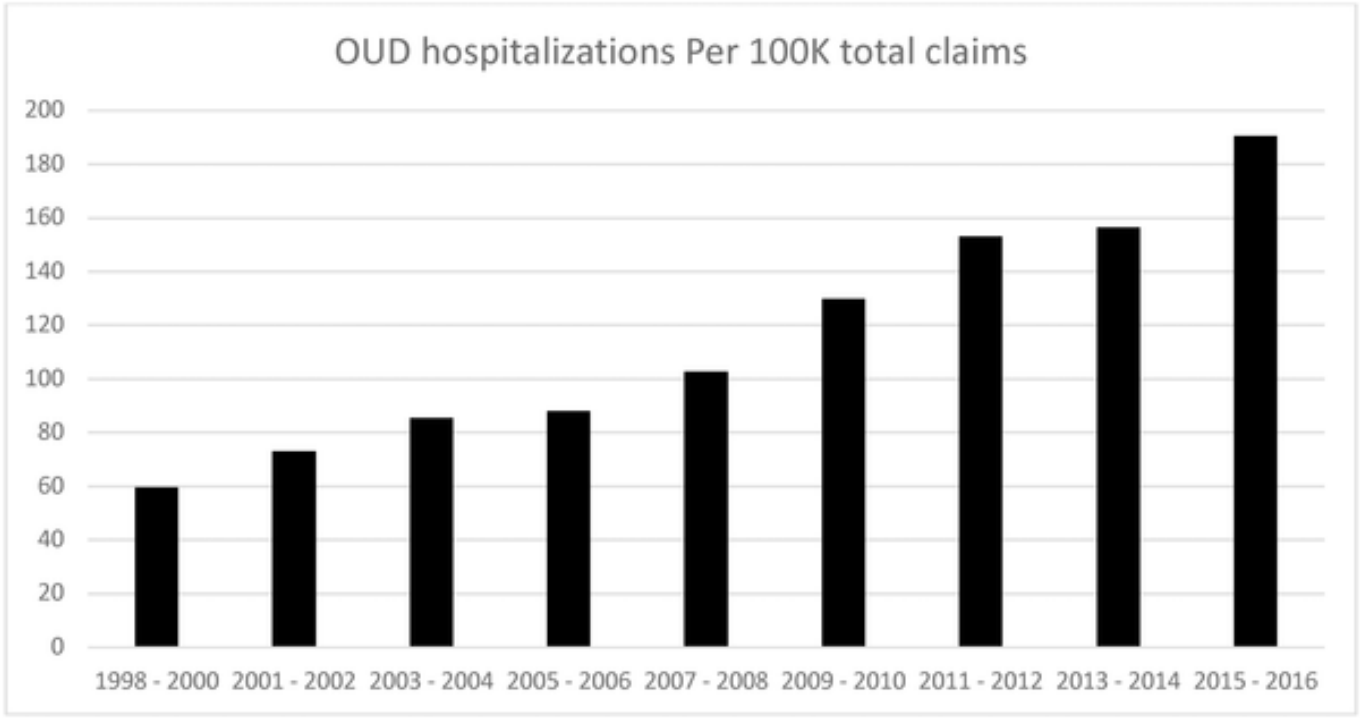
# Three Waves of Opioid Overdose Deaths






https://www.cdc.gov/opioids/basics/epidemic.html#three-waves.
Accessed 9/15/2023

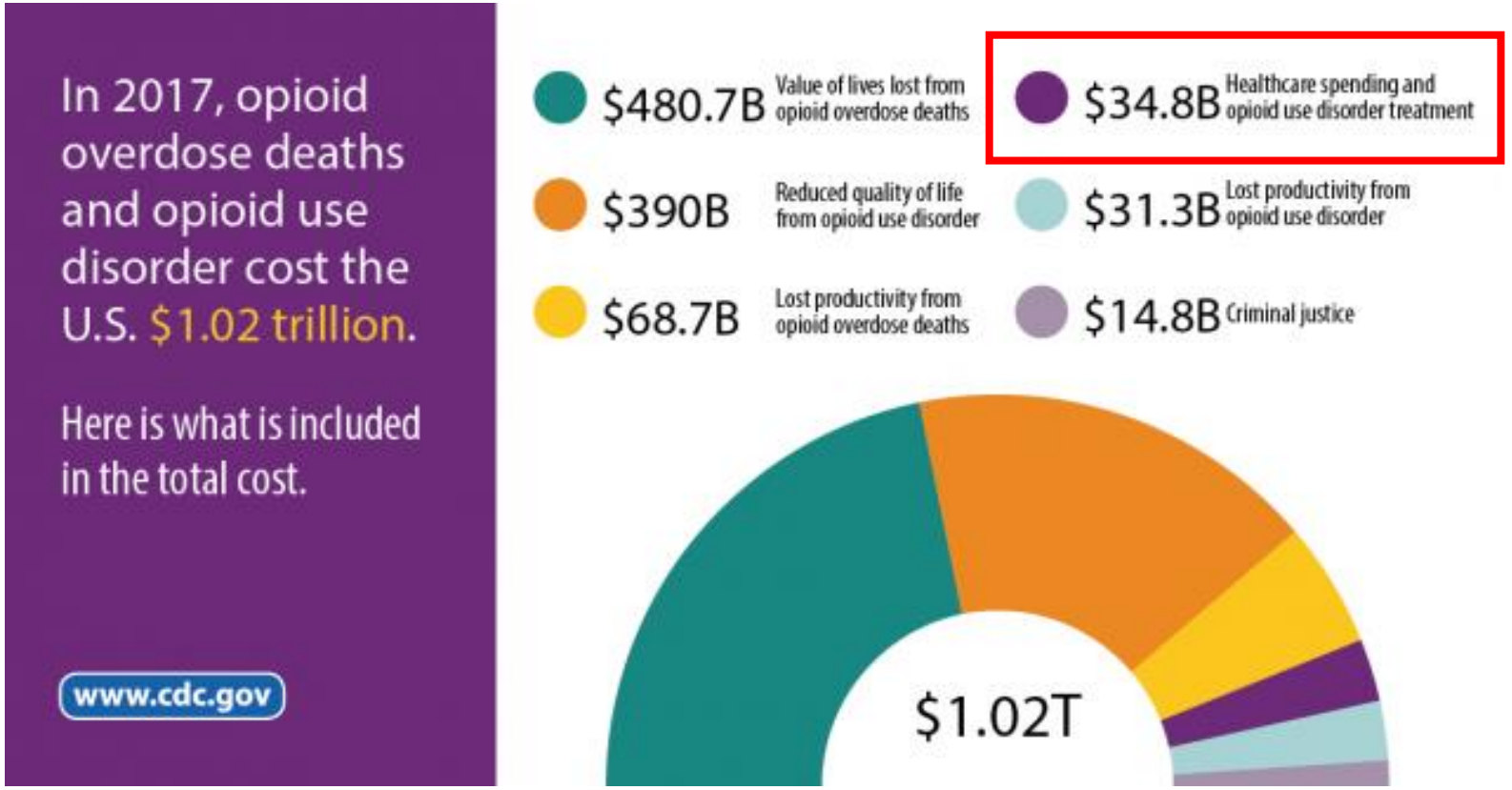
# Rising opioid-related hospitalizations






Singh JA, Cleveland JD. 2020. PLOS ONE

# Total Societal Cost



# Hospitals have been slow to respond

- Hospitalization often addresses the acute medical illness but not the underlying cause

- Most hospitals do not offer medication for OUD
  - Leads to untreated opioid withdrawal
  - Patients avoid or leave the hospital
  - Missed opportunity to offer life-saving treatment



Velez JGIM 2017
Priest et al, JGIM 2020

# What does Hennepin Healthcare offer for OUD?

# Core concepts: Addiction & treatment

- **Addiction is a chronic disease**
  - Medications are needed to treat many chronic diseases
  - Medications prevent return to addiction
  - Medications help normalize brain functions disrupted by opioid addiction

- Addiction is **uncontrolled drug use with biopsychosocial consequences**
  - Use of medications ≠ uncontrolled drug use
  - Use of medications decreases consequences

# Addiction Medicine Services

Hennepin Healthcare

## •Office-Based Addiction Medicine Clinic

- Downtown- afternoon clinic sessions only
- 4 community PC clinic sessions per week
- Scheduled by internal referral or patient request
- E-consults available

## •Opioid Treatment Program (OTP)

- Methadone or buprenorphine + FDA-approved meds for alcohol use disorder
- Structured, directly observed therapy with contingency management
- Federally regulated with LADC program coordination

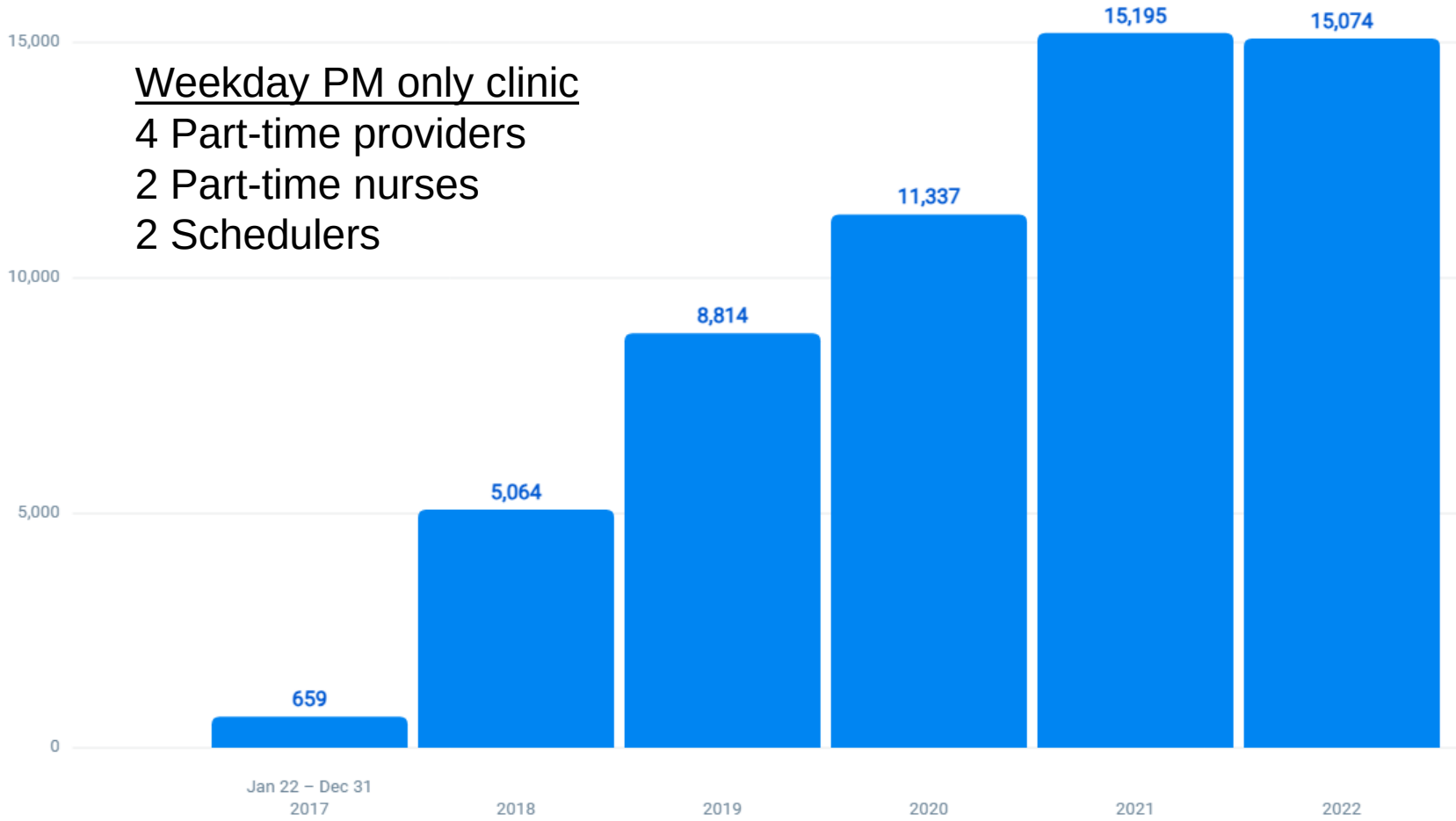
## •Inpatient consult team

- Monday-Friday consults by both providers and LADCs

# “No wrong door”

- Goal is to engage patients whenever and wherever they seek care
    1. Ambulatory clinic(s)
        - Specialty addiction medicine clinic
        - Primary care clinics
        - Longitudinal specialty clinics (e.g., Pain, Psychiatry, Women’s Health, Adolescent, etc.)
    2. Hospital consult service
    3. Emergency departments
        - Emergency medical services

# HHS Specialty Clinic encounters, 2017-2022




Weekday PM only clinic
4 Part-time providers
2 Part-time nurses
2 Schedulers

# Prevalence of SUD at Hennepin Healthcare

**Table 3. Prevalence of social risk factors among IHP-attributed adult population of patients.**

| Social Risk Factor | Hennepin Healthcare System, Inc | Minnesota Medicaid |
|---|---|---|
| Substance use disorder | 28.42% | 16.32% |
| Serious and persistent mental illness (subset of individuals with SMI) | 8.69% | 5.88% |
| Serious mental illness (SMI) | 36.92% | 27.55% |
| Deep poverty (<=50% FPL) | 44.36% | 37.41% |
| Homelessness | 16.20% | 7.87% |
| Past prison incarceration | 7.83% | 4.50% |

# Patient perspective on treatment

- Most patients with high-risk drug use wanted to cut back or quit
- Many want medication to start in the hospital
- Gap time and care fragmentation with community treatment can be a significant barrier to treatment retention
- Patients **want treatment choice and providers that understand substance use disorder**

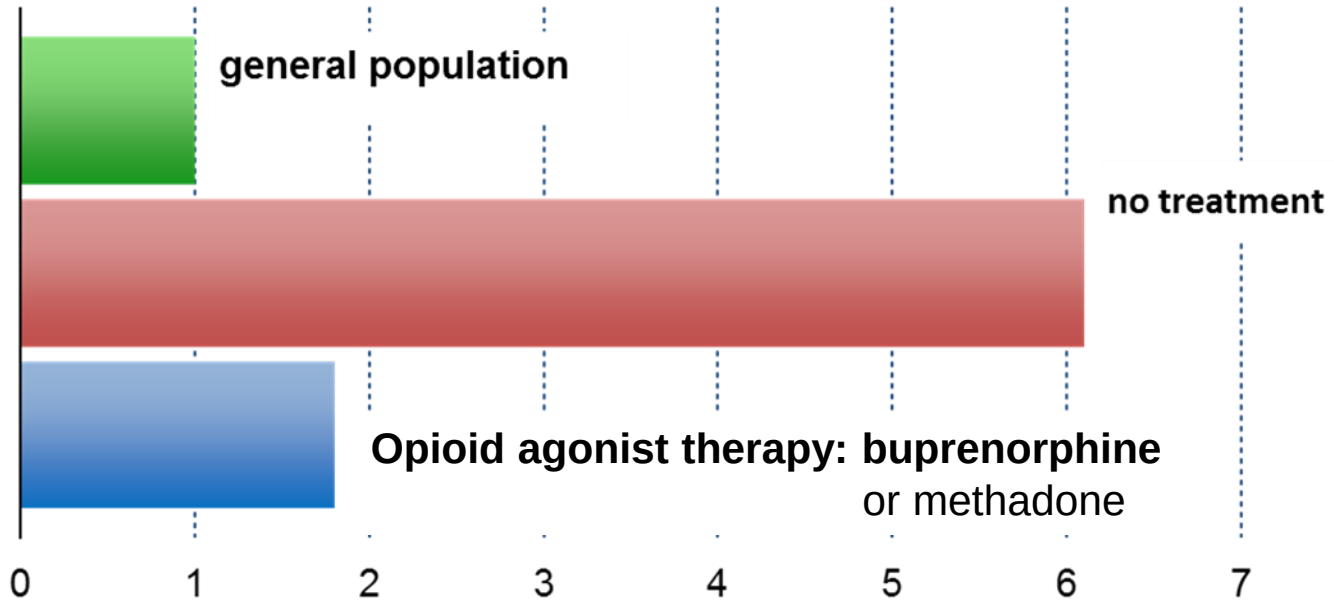


Velez et al., JGIM 2016
Englander et al., JHM 2017

# Impact of MOUD

# Medications for Opioid Use Disorder (MOUD)

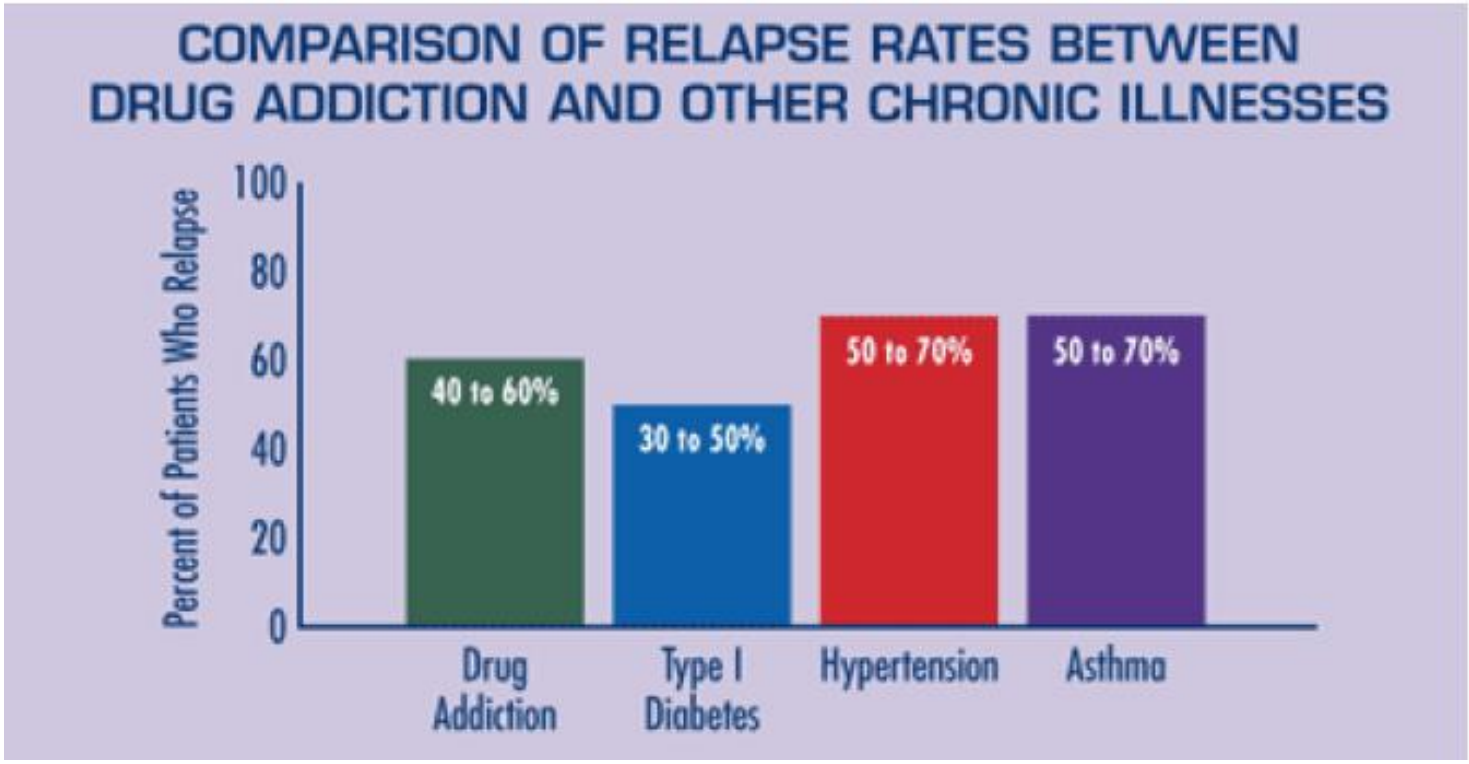
**Death rates:**






Russolillo et al. 2018; Sordo et al. 2017; Dupouy et al., 2017; Evans et al., 2015

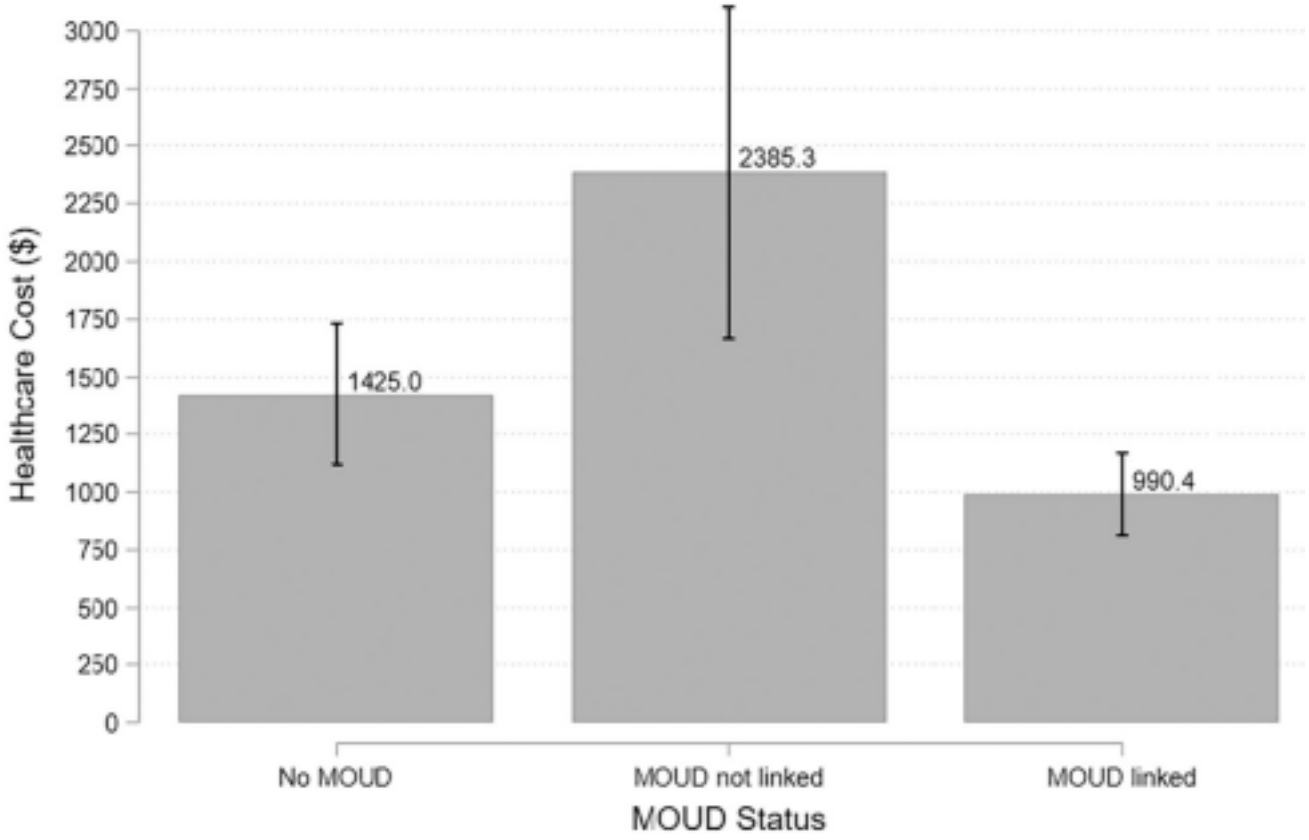
# What's the point?






McLellan et al., 2000

# Ambulatory OUD: linked to care, big impact




HennepinHealthcare

Toseef et al. Preventive Medicine. 2023; 166.

# TCOC impact of MOUD care

| Table 3 Adjusted mean annual cost 2008 U.S. dollars | Mean annual cost (95% CI) | PMPM est. ($) |
|---|---|---|
| Counseling only | 17,017[†] (16,751 – 17,285) | 1418 |
| Little or no addiction treatment | 31,035[**] (30,433 – 31,637) | 2586 |
| Buprenorphine plus counseling | 13,578 (13,364 – 13,791) | 1132 |

Costs are adjusted for age, gender, months of eligibility in the health system, site, and propensity of type of treatment received.

Buprenorphine + counseling similar healthcare costs to counseling only

- Either group $17,000 less than those with little to no treatment



Lynch FL, McCarty D, et al. Addiction Science & Clinical Practice 2014, 9:16

# Overcoming Barriers to MOUD

# If MOUD are so effective why do people avoid them?

- **Stigma**
  - “liquid handcuffs”
  - Employers
  - Criminal justice system
  - Family
  - Medical and mental health providers
  - Peer support networks


- **Lack of easy access**
  - Community not always aware when healthcare organizations offer it
    - Historically, healthcare doesn’t advertise addiction services
  - Provider confusion about DEA “waiver” training

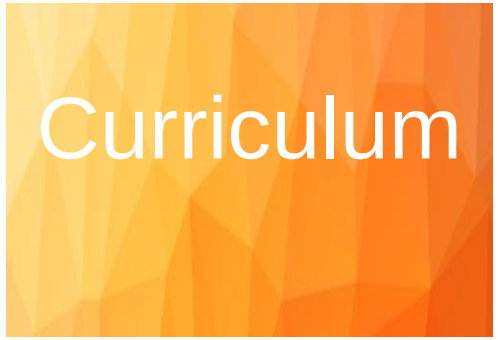
# How to foster practice change

- Mission-driven: Critical for communities
  - May have 1-2 clinical champions with a passion for this population
  - Create a supportive community of innovation

- Training necessary but not sufficient
  - ED provider waiver experience
  - Mentoring preferred

- Communication with community required
  - Connect with local SUD psychotherapy-based programs, sober housing, recovery communities
  - Flyers in the ED, clinics, community

# SUD Training in Primary Care – Mentoring Model




- **Training Implementation**
- Total time: 6 months per cohort of 2 PC clinicians in Addiction Medicine clinic

- **Months 1-3**
- Didactic: 4 hours per week for the first 6 weeks
- Clinical Experience: 1 session per week for the first 6 weeks;  2 sessions per week for the second 6 weeks

- **Months 4-6**
- Return to seeing patients in primary care clinic for SUD treatment
- Mentored case discussion: 1.5 hours/month
- Flex time for patient panel development & clinic operational workflows

**Program Cost**: $280,000

- Includes development and curation of online didactics

How to increase adoption of evidence-based practice for OUD?


www.hennepinhealthcare.org/echo

# Buprenorphine Boot Camp: 2-day workshop

## Goals:

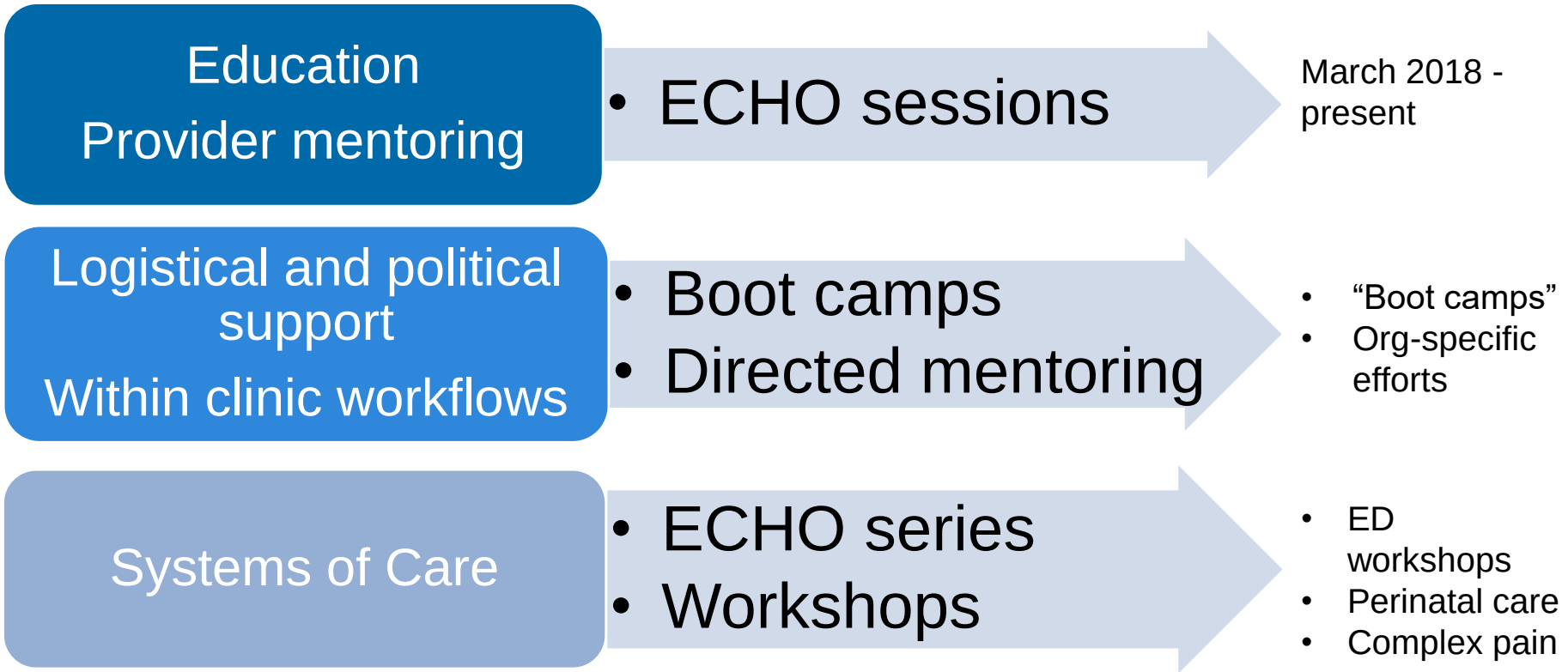
- Increase # of patients receiving buprenorphine for OUD

## Outcomes (at 18 mo)

- 33% increase in any buprenorphine Rx for OUD
- Share of patients with OUD who received Rx increased 7%

Source: Solmeyer, A. R., Berger, A. T., Barton, S. L., Nguyen, B., & Merrick, W. (2022). Evaluation of a Buprenorphine Boot Camp training program for healthcare providers in Minnesota. Minnesota Management and Budget. https://mn.gov/mmb/impact-evaluation/projects/evaluation-bootcamp-programs/

# Implementation needs more than education



# HHS Project ECHO Outcomes 2018-2021

## ECHO Sessions

**155** Sessions and Educational Events

**1,735** Individual Participants

**275** Minnesota Clinics Represented

## Waiver Training

**7** Events

**315** Prescribers Trained

**74** Minnesota Clinics Represented

## Buprenorphine Boot Camp

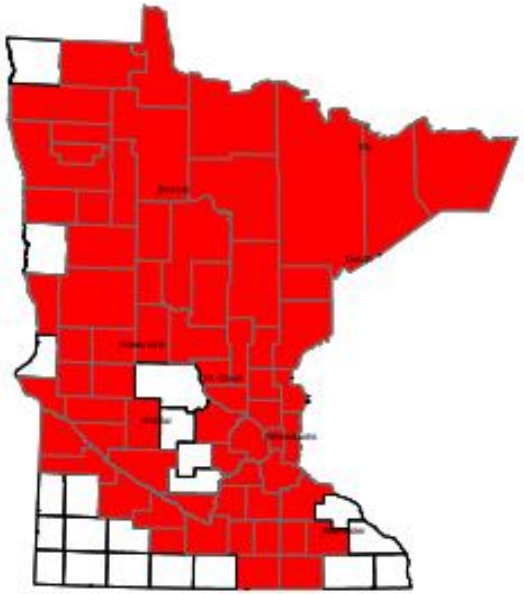
**2** Events

**293** Participants

**70** Minnesota Clinics Represented

## Location of ECHO attendees by county

The **counties shaded red** represent the locations of the 1735 individuals, from 275 clinics, who have participated in Project ECHO.



Brian.Grahan@hcmed.org

www.HennepinHealthcare.org/ECHO

Office: 612-873-5597

Clinic: 612-873-5500

# Questions?

Hennepin Healthcare

# Is ECHO for the early adopters?

# How to engage broader system of care?

# SUD Training in Primary Care – Mentoring Model

## Curriculum

### Training Implementation

Total time: 6 months per cohort of 2 PC clinicians in Addiction Medicine clinic

### Months 1-3

Didactic: 4 hours per week for the first 6 weeks

Clinical Experience: 1 session per week for the first 6 weeks; 2 sessions per week for the second 6 weeks

### Months 4-6

Return to seeing patients in primary care clinic for SUD treatment

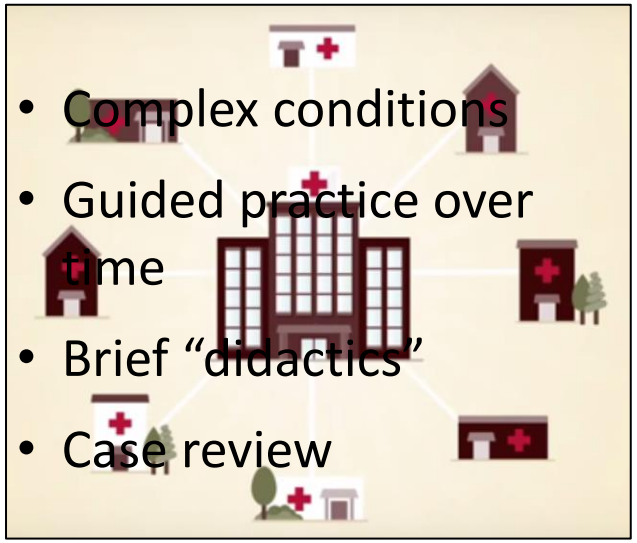
Mentored case discussion: 1.5 hours/month

Flex time for patient panel development & clinic operational workflows

**Program Cost**: $280,000

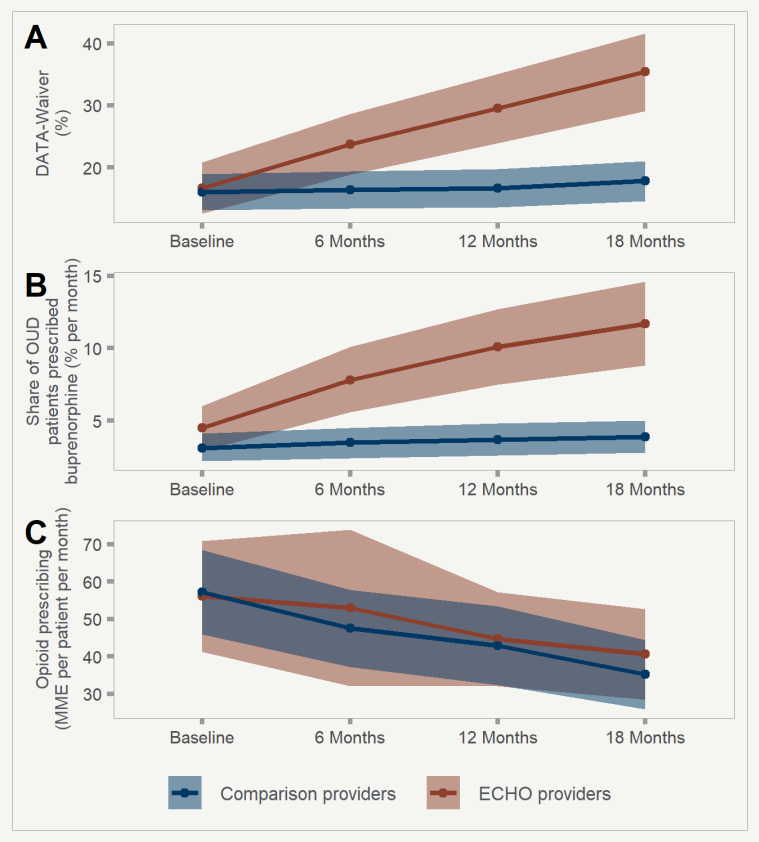
Includes development and curation of online didactics

# How does Project ECHO work?


"Moving knowledge, not patients"

# ECHO Engagement Results: Provider outcomes




- # providers who felt able to prescribe doubled over 18 months
- ECHO providers prescribed bup for 6.5 more OUD patients per 100 per month (Panel B)
- No impacts on opioid MMEs or high-dose opioid scripts (general downward trend observed in both groups; Panel C)

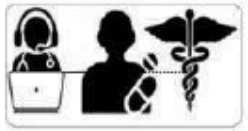
Source: Solmeyer, A. R., Berger, A. T., Barton, S. L., Nguyen, B., Kotasek K, Laradi M & Merrick, W. (2022). Evaluation of opioid-focused programs in Minnesota. Minnesota Management and Budget. https://mn.gov/mmb/impact-evaluation/projects/evaluation-opioid-focused-programs/

# Positive provider financial perspective

**Figure 1. Description of identified buprenorphine care delivery models.**

**OBOT with physician-led visits**

NCMs support waivered buprenorphine prescribers. Regular visits are prescriber led and billed. NCMs provide logistical (program coordination) and clinical (intake visit, telephone outreach, induction management) support and serve as the patient's first point of contact. Prescribers primarily focus on medication management.



**OBOT with nurse-led visits**

NCMs lead and bill patient visits and provider care management under the direction of a waivered buprenorphine prescriber. Patients meet with the prescriber every 3 months for medication management.

**OBOT with shared visits**

Prescribers lead weekly group visits with mental health professional and NCM, at which patients receive addiction-focused medical evaluation and management, buprenorphine prescription, and group psychotherapy. Before starting group psychotherapy, the patient has individual visits with the provider, NCM, and mental health professional and receives a bridging prescription.

**Solo prescriber**

The prescriber independently manages opioid use disorder without major structural support from other disciplines.

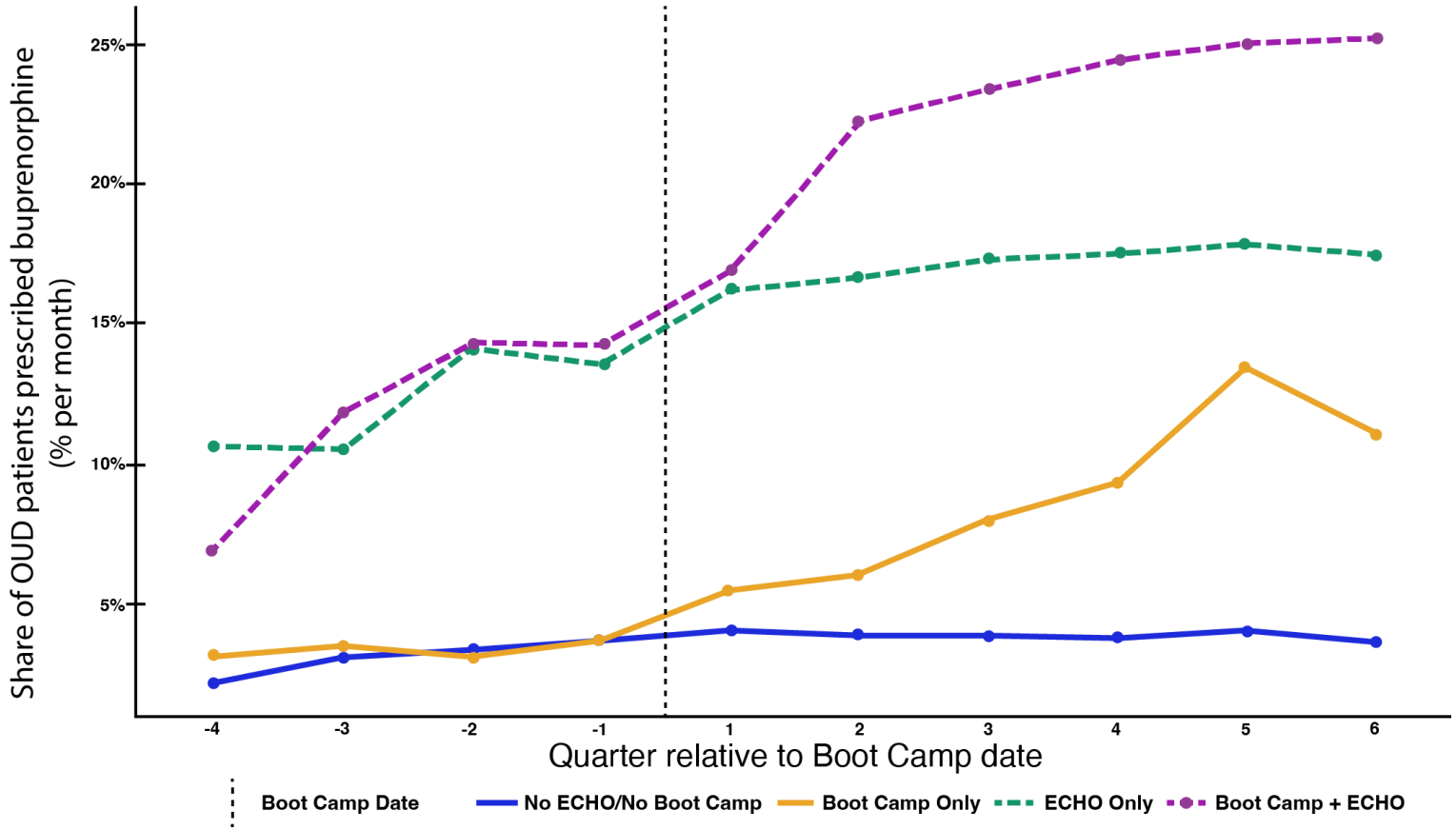
NCM = nurse care manager; OBOT = office-based opioid treatment.

- Net practice revenues would be expected to increase after introduction of any approach, in any market, by $18,000 to $70,000 per full-time physician in the first year
- Nurse-led approaches consistently yielded greatest net annual revenues
- Low threshold for success:
  - Positive annual net revenues with at least 9 patients and no-show rate <34%



Fried et al. 2020. Ann Fam Med 18(6)

# Boot Camps and ECHO

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# Idea Sandbox: Moving From Vision to Impact (open conversation)

**Kris Kopski, MD**

Sr. Medical Director, Value-Based Care, Medica

# 4 Key attributes for Intelligent Failure

1. New territory (moving away from the familiar)
2. Context-credible opportunity to advance toward a desired or meaningful goal
3. Informed by available knowledge (do your homework)
4. Failure is as small as it can be and still provide valuable insights

Bonus: lessons learned inform your next steps

*From "Right Kind of Wrong: The Science of Failing Well" By Amy Edmondson*

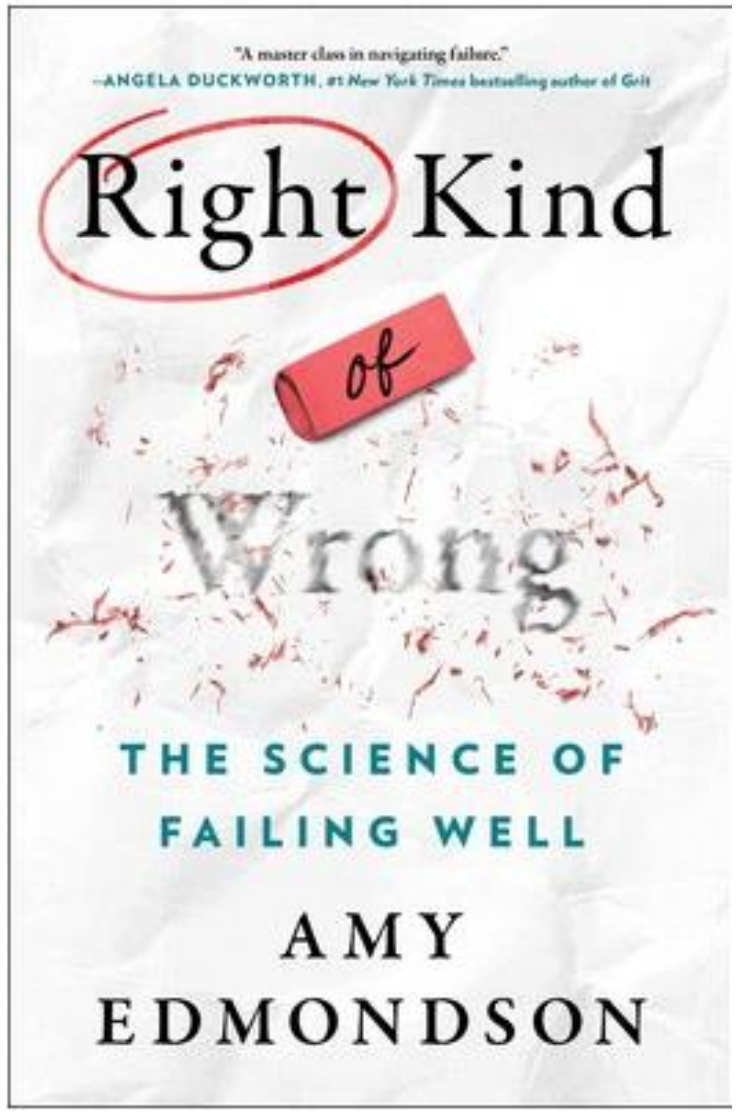
*"I have not failed. I've just found ten thousand ways that won't work"*

Attributed to Thomas A. Edison

Share an example of something creative or bold your teams have done and did not work out as hoped or planned. Here are some questions to think about.

- Describe what you tried to do?  What was the “why” behind it and what were you hoping to accomplish?
- What did happen?  How did you gauge success vs. the lack of success?
- What did you learn?  How did that inform future work or your next steps?  Any “silver linings”?

# For Further reading...




# Idea Sandbox QR Code

Vote on which care system deserves the **Creative Courage Award** for sharing their story.

# Break

Upcoming at 3:15 p.m.

**Roundtable Discussion: The Future of Value-Based Care at Medica**

# Roundtable Discussion: The Future of Value-Based Care at Medica

**Amit Khurana**, PharmD, Vice President of Pharmacy, Medica

**Carolyn Ringhofer**, Vice President and General Manager of Individual and Family Business, Medica

**Jeni Alm**, Vice President, Provider Partnerships and Solutions, Medica

**Kathryn Kading**, Vice President, Health Services, Medica

# Amit Khurana
## Vice President of Pharmacy at Medica

Amit provides leadership and direction in the development and delivery of all Medica pharmacy programs and services including network and product management. She directs the development and implementation of short- and long-term strategic plans and ensure they translate into clear tactical goals and objectives. In addition, Amit partners across the company to help ensure we can meet our member's needs in the areas of affordability, quality and customer experience.

Amit comes to Medica from Aetna, where she served as a Director, Pharmacy supporting various business segments at Aetna. Prior to Aetna, she held advisory and clinical pharmacist positions at the U.S. Department of Defense/Tricare Management Activity, UnitedHealthcare, TriWest Healthcare Alliance, and Humana. She also served as a staff pharmacist in various retails settings.

Amit holds a PharmD, Doctor of Pharmacy degree from Creighton University.

# Carolyn Ringhofer

## Vice President and General Manager of Medica's Individual and Family Business

Carolyn is responsible for leading strategy development, execution and business direction for the recently integrated Media and Dean IFB business across 10 states. She works with other leaders within the organization to prioritize key initiatives and is accountable for overall results of the Individual and Family Business.

# Jeni Alm

## Vice President, Provider Partnerships and Solutions at Medica

Jeni Alm has been with Medica for over three years in leadership positions on the Provider Network Management team.  Earlier this year, Jeni moved into her current role to oversee the Provider Contracting, ACO Relations, and Provider Finance teams.  Prior to joining Medica, Jeni held various positions in the Provider Network, Product Development, and Actuarial departments at Blue Cross Blue Shield of Nebraska where she led the development of the first Patient Centered Medical Homes and ACO arrangements in the state.

Jeni has a bachelor of science degree in finance from the University of Nebraska-Lincoln and a master's degree in business administration from the University of Nebraska-Omaha.

# Kathryn Kading
## Vice President, Health Services

Kathryn joined Medica five years ago and currently leads Health Services and is responsible for the overall leadership, financial/budget oversight, and the performance and compliance of all functions related to Health Services. A key responsibility is to optimize the core health services functions including Case Management, Utilization Management, Care Coordination, Behavioral Health, Medical Policy, and Health Services Optimization.

Prior to joining Medica, Kathryn spent 21 years with UHG/Optum in various clinical and leadership roles which included Quality, Clinical Call Center Operations, Utilization Management, Clinical Field Operations, Medicare SNPs, New Market Development and Clinical Integrations.

Kathryn received her Nursing degree from the College of St. Catherine.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# 2023 Summit Wrap-Up

**Dr. David Webster**

Chief Clinical & Provider Strategy Officer, Medica

# 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.

# ACO Engagement Summit Takeaways

- Provider partnerships are key to Medica's strategic growth
- Virtual care saw dramatic increases in utilization because of the COVID-19 pandemic. Now it’s time to re-evaluate what the future of virtual care means.
- Clinician engagement into value-based care needs to be multifactorial, including participation in the development process to continue to create sustainable models
- Primary care and behavioral health access continue to challenge health care systems, providers, and patients. Developing innovative models to address access issues can ensure those most at risk are receiving care in a timely fashion.
    - Alternative care delivery models open the conversation for what the future of health care delivery can look like.
- Not all ideas result in improvements; it is through failure that we can develop a deeper understanding how we can continue to advance innovation.

# Closing Remarks

2023 ACO Engagement Summit

**ACO Engagement Summit Survey**

We welcome your feedback for this event. Please take 2-3 minutes to complete this survey via the QR code on the next screen and on your tables

**Continuing Education Credit**

A post-Summit survey link and information for CMEs/CEUs will be sent out via email

**Onsite Guests**

Please join us for a networking happy hour and an awards ceremony at the Lake of the Woods Suite

# Thank You

## Post-Summit Survey

Your feedback helps us plan and create a meaningful experience for 2024!


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