ACO Showdown

October 1, 2024
2:00 pm to 3:00 pm ET

Housekeeping Items

- We request that participants be on camera only when presenting or asking contestants questions regarding their presentations.
- To ask a question, please raise your hand and turn your camera on.
- Questions are not only welcomed, but they are also imperative to enhance everyone's experience.
- Please mute your microphone when not speaking and unmute when speaking.
- Please add your First and Last Name to Zoom.
- When it is time to vote after all presentations are completed, a survey will be launched allowing ample time for everyone to cast their vote.

CLINIGENCE HEALTH

an assurecare® brand

Chuck Kandzierski

Founder & President
678-315-9784
Chuck.Kandzierski@clinigence.com

or

Info@clinigence.com

www.clinigencehealth.com

Speakers

	Marisela Irizarry Vice President of Operations Varmed
	Justin Leitzen CEO ProviDRS Care
	Rhonda Hamilton Chief Operating Officer Silver State ACO

VARMED's Predictive Model for Population Management

ACO Innovation Showdown

VARMED MANAGEMENT GROUP

Agenda

1

Introduction

About Us

2

Need for Innovation

John Hopkins Model in a nutshell

3

Stratification Model

Varmed's Stratification Model Description

4

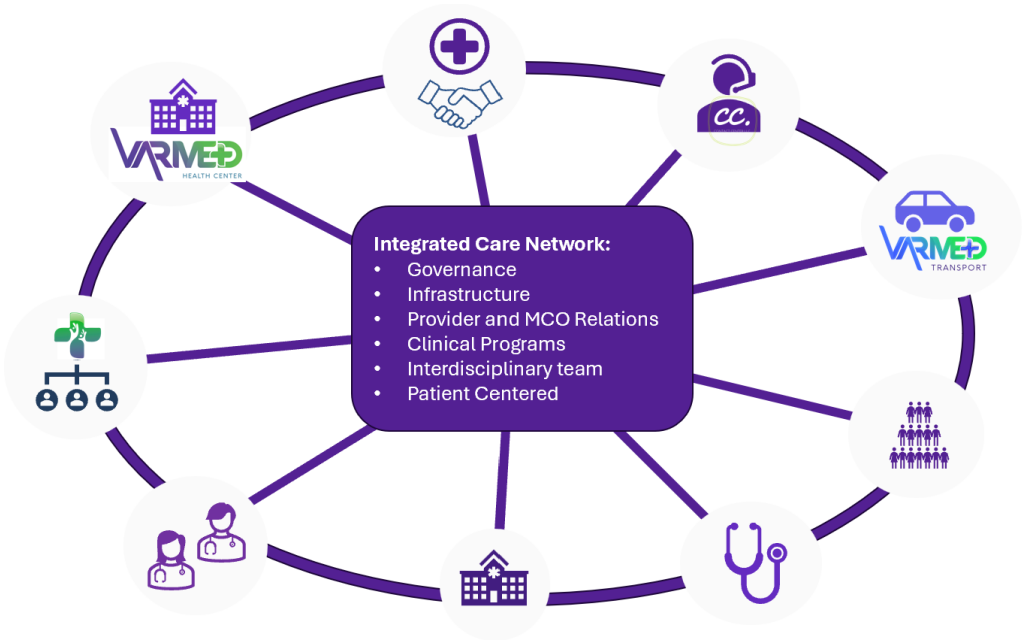
Our Results

Understanding the High-Cost Indicators

About Us

- ✓ Varmed Management Group LLC is an integrated solutions provider established in Puerto Rico in 2010.

- ✓ Focused on using **innovation** and **technology**, Varmed strives to **improve the population's health outcomes** by identifying and closing barriers to care throughout the patient's health continuum.



VARMED
MANAGEMENT GROUP

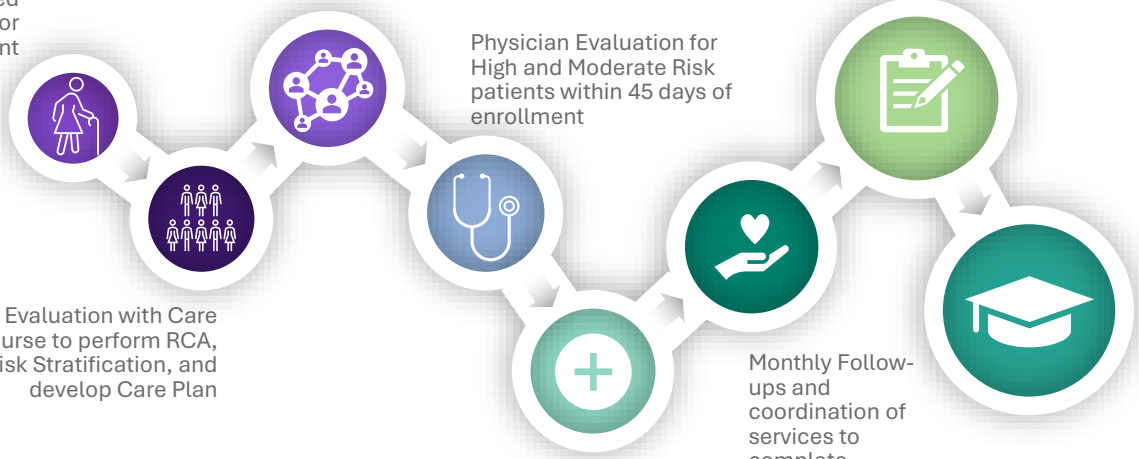
About us

- ✓ Our care model is designed to improve the health of high-cost, chronically ill, and vulnerable beneficiaries with special needs known as high-cost, high-need populations.

- ✓ Varmed's model improves outcomes for this population by linking financial and health risk assessments with integrated clinical care and community-based interventions.

VARMED MANAGEMENT GROUP

Varmed's Population Management Method



Member data is analyzed and stratified prior to recruitment for Care Management

Initial Evaluation with Care Manager Nurse to perform RCA, validate Risk Stratification, and develop Care Plan

Referral to Nutritionist, Social Worker, Psychologist or special discipline based on specific member needs

Physician Evaluation for High and Moderate Risk patients within 45 days of enrollment

Re-assessment performed at 6 months to document changes in Care Plan Goals

Monthly Follow-ups and coordination of services to complete preventive assessments (Gaps In Care)

Continuous communication with Primary Care Provider to share member progress and support services coordination

Member graduation upon completion of program goals.

Comparison of metrics pre and post program enrollment.

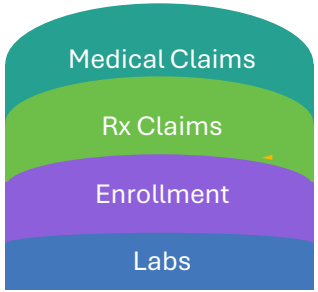
Need for Innovation

Problem and Solution

- Quick population growth.
- Need to better direct patients to their required level of care.
- Need to be proactive predicting future costs and complications.

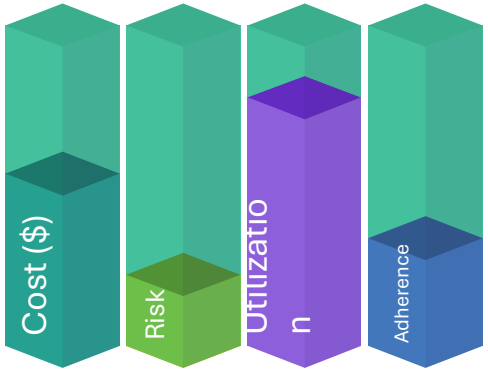
- Develop a new strategy for patient management.
- Perform a population analysis using predictive modeling tools from **Clinigence Health.** A new Population Stratification Model was developed.

Predictive Risk Modeling



Historical Data

Algorithms & Statistical Models



Predict and Forecast what is likely to happen in the future

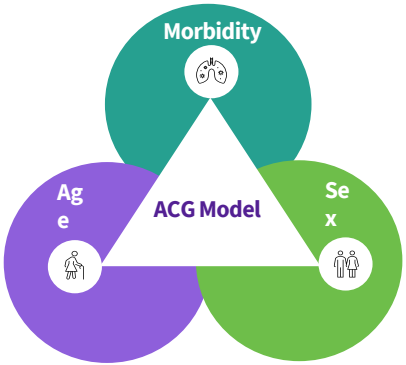
CLINIGENCE HEALTH

VARMED MANAGEMENT GROUP

John Hopkins ACG Predictive Model

What is an “ACG” or “Adjusted Clinical Group”?

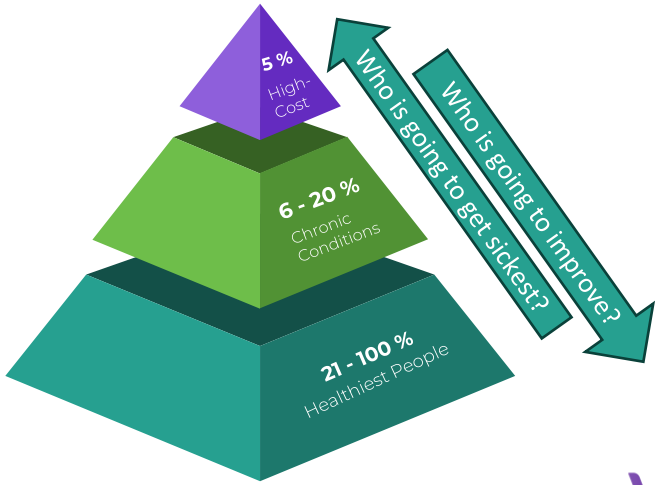
- ✓ A series of health status categories defined by morbidity, age, and sex.



- ✓ Calibrated for the specific population case-mix.

How does it support Care Management?

- ✓ We can identify up to 25% more individuals for care management ***before*** they become high utilizers.



CLINIGENCE HEALTH

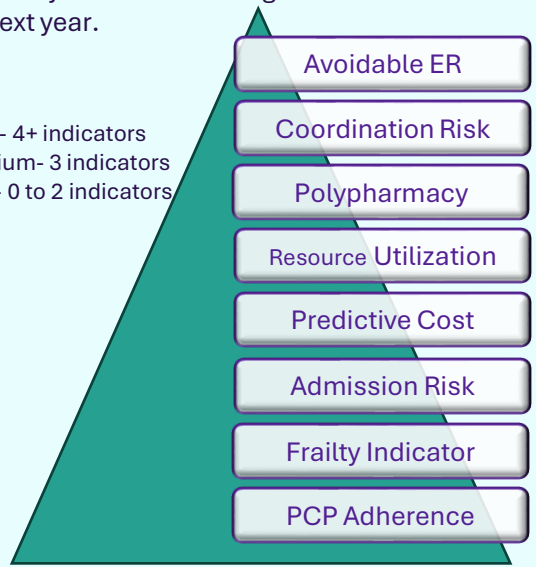
VARMED MANAGEMENT GROUP

Most Important Benefit of the ACG Model:

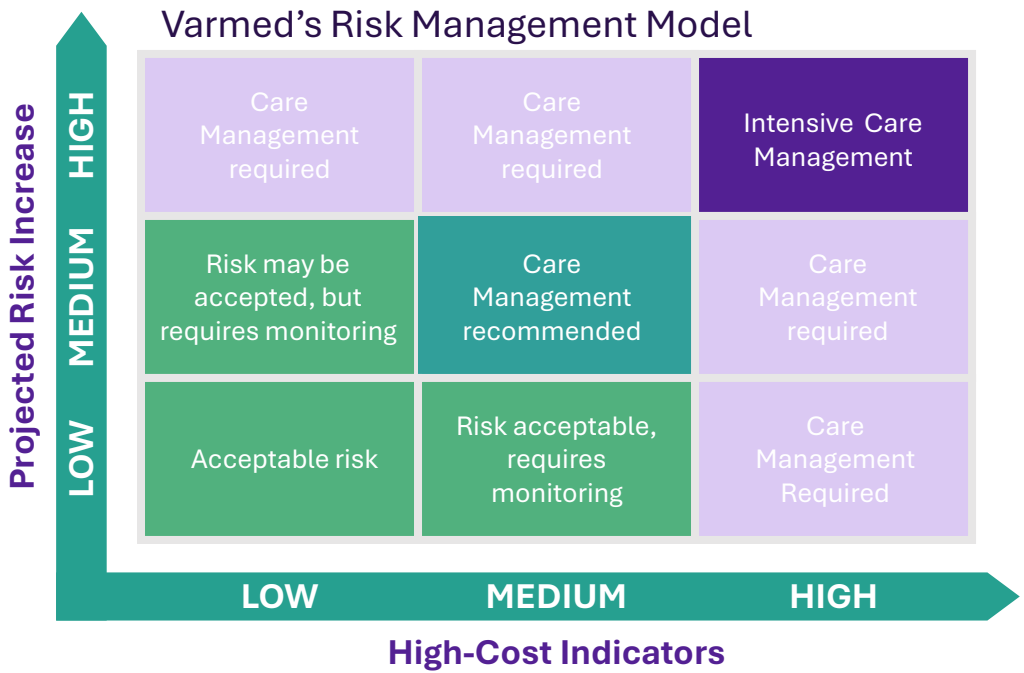
Allows you to be *proactive rather than reactive* when it comes to the population's unique health care needs.

VARMED's Predictive Model Stratification

Two Step Stratification

Membership and exclusions	1rs Stratification – Projected Risk	2nd Stratification – High-Cost Indicators
Exclusions: Non impactable diagnosis, Non Impactable High-Cost Medication, Terminated From Plan, Member with 6 month or less of data, Active Member in CM. Total Membership after exclusions	Based on changes between **Concurrent risk** and **Prospective Risk.** HIGH Projected Risk Increase MEDIUM Projected Risk Reduction LOW No Significant change in projected risk	High-Cost indicators identify patients as a High Utilizers. The more indicators the patient has, the more likely they are to have a higher utilization trend during the next year. * High- 4+ indicators * Medium- 3 indicators * Low- 0 to 2 indicators 

Recommended Population for Care Management



Opportunity

Cost Control: Projected to get sicker

Cost Reduction: Projected to get better

Cost Reduction: High Utilizers with no significant risk change

High - High Patient
Real Case Example

69 years old

Female

Non-Platino

IPA 930

Dx Clusters

- Anxiety, neuroses
- Asthma, w/o status asthmaticus
- Emphysema, chronic bronchitis, COPD
- Hypertension, with major complications
- Ischemic heart disease
- Low back pain
- Major depression
- Type 2 diabetes, w/ complication
- Peripheral vascular disease
- Major depression

Predictive Indicators

Projected Cost	$30,000-$40,000
Coordination Risk	Likely Coordination Issues
Admission Risk 12 months	58%
Current Risk	3.16
Projected Risk	4.73

High Utilizer Indicators

Total Cost	> $30,000
ER Visits/Avoidable ER	29/14
Admissions/readmissions	9/4
Resource Utilization	Very High
Polypharmacy	45

High - High Patient: Plan of Care

Real Case Example

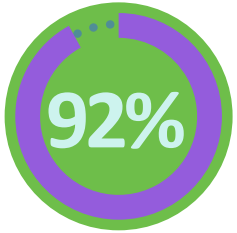
- ✓ Pharmacy Interventions
  - ✓ Corroborate polypharmacy with Pharmacy, patient, and PCP.
  - ✓ Discuss with PCP the possibility of reducing polypharmacy
- ✓ Interdisciplinary Team
  - ✓ Outreach visit - evaluate adherence to treatment, social determinants, and educate about proper use of inhalers for COPD.
  - ✓ Social worker referral - if patient needs a caretaker
  - ✓ If uncontrolled diabetes is present
    - ✓ Evaluation by a Nutritionist
    - ✓ Start diabetes protocol
- ✓ Care Coordination
  - ✓ Obtain the most recent laboratories and results of spirometry.
    - ✓ Request results to PCP.
    - ✓ If results are not available, will generate order with medical staff of the program and help with coordination of laboratories at home
  - ✓ ER visits and admissions due to respiratory condition
    - ✓ Corroborate if the patient has a pneumologist and a request progress note.
    - ✓ If not, will help the patient coordinate the pneumologist visit and transportation if needed.
    - ✓ Determine the need for possible oxygen with an Oximetry Test at home, due to recurrent admissions and ER visits.
  - ✓ Evaluate the need for medical equipment
    - ✓ If necessary, generate the order of equipment like nebulization machine, Position Bed, walker, glucometer, etc.
  - ✓ Orientation of medical conditions and glucose monitoring.

VARMED MANAGEMENT GROUP

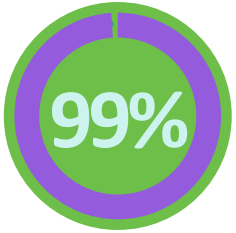
Our Results

Overall GIC Compliance

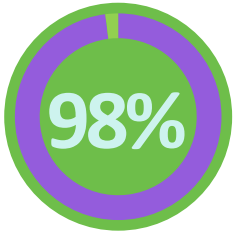
Transition of Care PT Engagement Under 30 days



Transition of Care MRPD



COA



Patient Satisfaction

50%

Admissions and ER Visits

2x

Assigned membership

5

STARS Rating

We Transform Lives

Contact us:

Marisela Irizarry-Pérez
Vice President of Operations
mirizarry@varmedmanagement.com

Let's Successful

VARMED MANAGEMENT GROUP

NAACOS National Association of ACOs

PROVIDRS CARE

Uncovering Untapped Value-Based Payment Opportunities

Commercial Population Health with Physician-Developed Value-Based Payment Models

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}} = \frac{\text{OUTCOMES PATIENT + EXPERIENCE}}{\text{DIRECT COSTS + INDIRECT COSTS}}$$

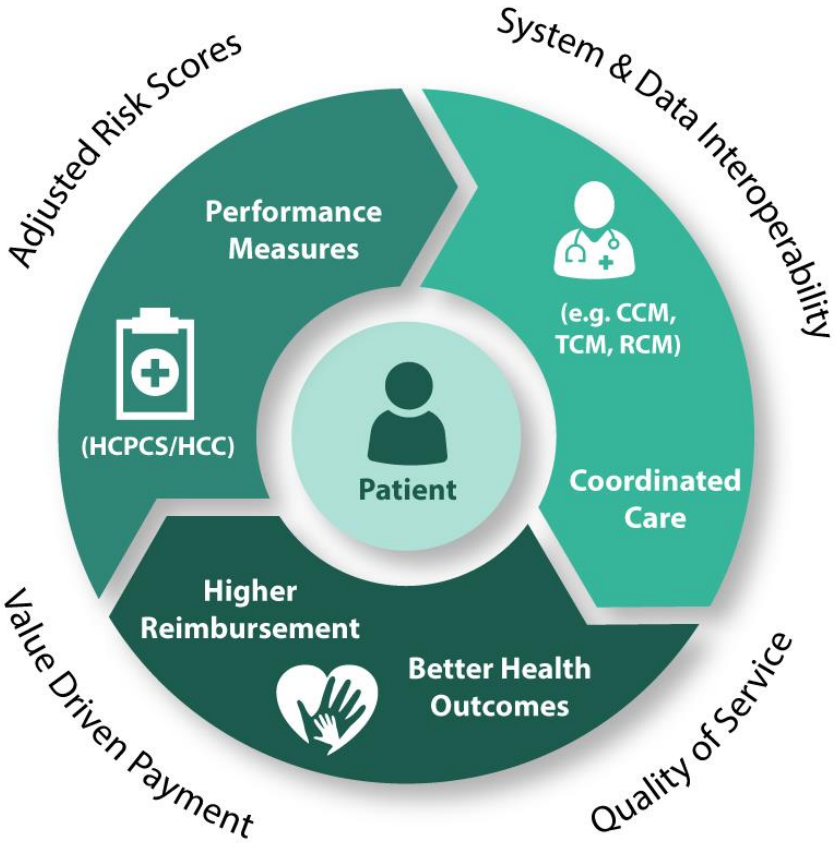
	VOLUME-BASED	VALUE-BASED ✓
PAYMENT	FEE-FOR-SERVICE	OUTCOME BASED
INCENTIVES	PASS-A-TUBE-GET-A-PAYMENT	KEEP-EM-HEALTHY-AND- MAKE-A-LIVING
FOCUS	EPISODES	POPULATIONS
ROLE OF THE PROVIDERS	INTERACTION ON INDIVIDUAL INTERACTIONS	TEAM-BASED CASE CONTINUUM
INFORMATION	RETROSPECTIVE	PREDICTIVE

Uncovering Untapped Value-Based Payment Opportunities in the Commercial Market

Commercial Market

Volume Based, Fee for Service

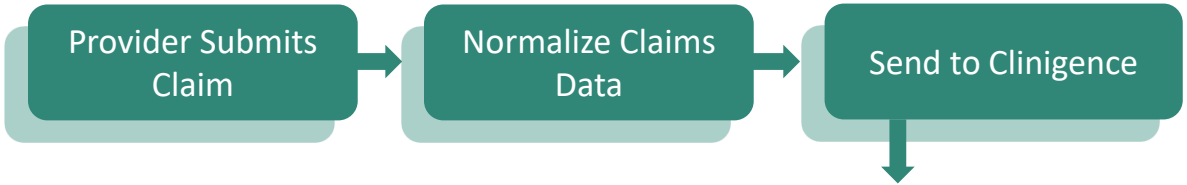
Uncovering Untapped Value-Based Payment Opportunities in the Commercial Market



Value Based Payment Model

Already Doing This – Let's take it to the Commercial Market together!

Leveraging Clinigence Data for Transparent, Actionable Insights



Our Workflow

90% of value-based payments are based on claims data, minimizing administrative burden!

ProviDRs Care

Ready to Elevate Your Commercial Population Health Strategy?

- With the **ProviDRs Care** approach:
  - Get higher reimbursement for better outcomes.
  - Gain seamless integration with current population health infrastructure.
  - Gain monthly, actionable insights with minimal administrative effort.

Maximize Your Commercial Market Potential Today!

TO GET STARTED: Call **(316) 683-0604** | Email: **JustinLeitzen@providrscare.net**

ProviDRs Care

Silver State ACO

Accountable Care Organization

Rhonda Hamilton,
Chief Operating Officer

Silver State ACO
Accountable Care Organization

ABOUT SILVER STATE ACO

Medicare Shared Savings Program, Enhanced Track

- **Started in 2014**
- **State of Nevada**
- **34,180 attributed lives, 52 TINs**
- **Earned Shared Savings last 8 years in a row**
  - ➢ **Saving CMS over $232.5 million**
  - ➢ **Earning over $137.8 million**

Silver State ACO
Accountable Care Organization

The Challenge

- **Deliver data to providers at point of care**
- **Over 50 different TINs on multiple EMR systems**
- **Avoiding costly EMR integrations**

Silver State ACO
Accountable Care Organization

CLINIGENCE HEALTH

Our Analytics & Quality Reporting Partner has the data we need to share with providers however…

Providers do NOT want to log into additional portals…so…

How can we deliver the data to the provider at the POC?

Silver State ACO
Accountable Care Organization

Clinigence brought partner IllumiCare to the table

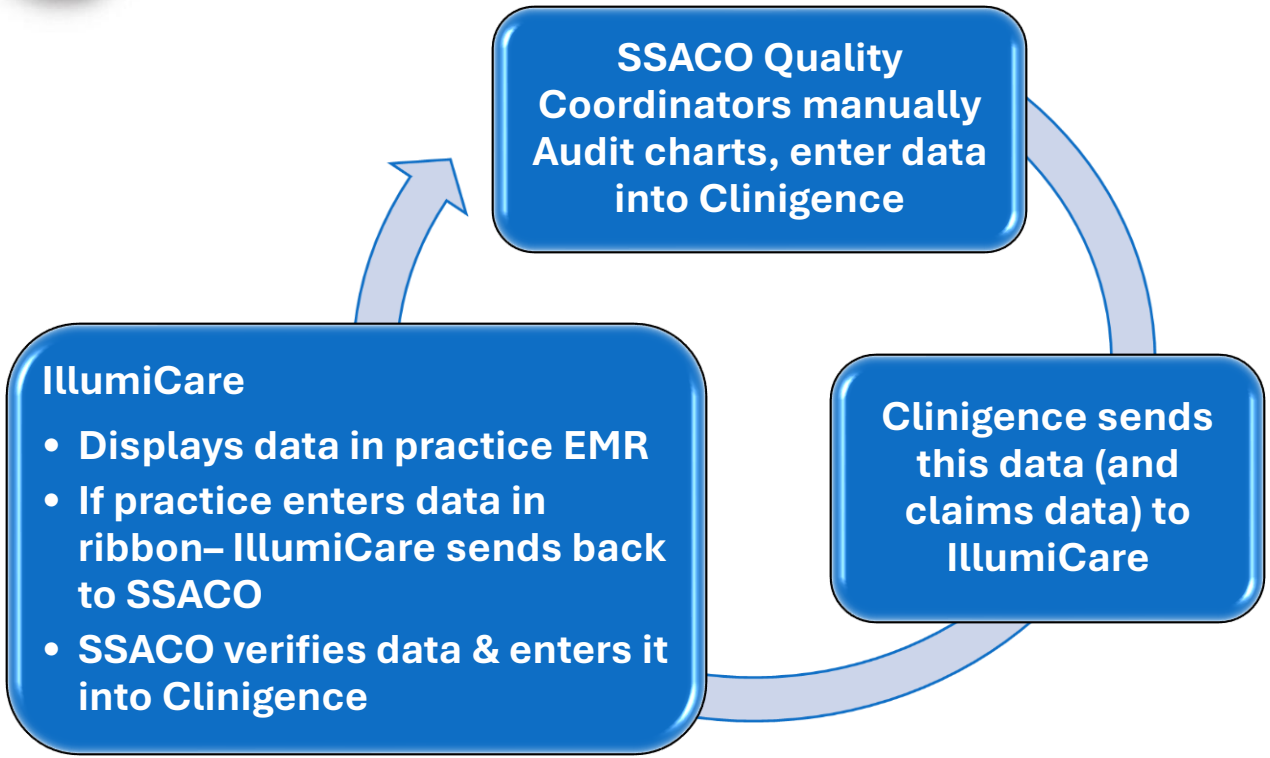
Their “Gaps App” is EMR agnostic; no costly EMR integration is needed

Pop-up ribbon provides data from Clinigence, including:

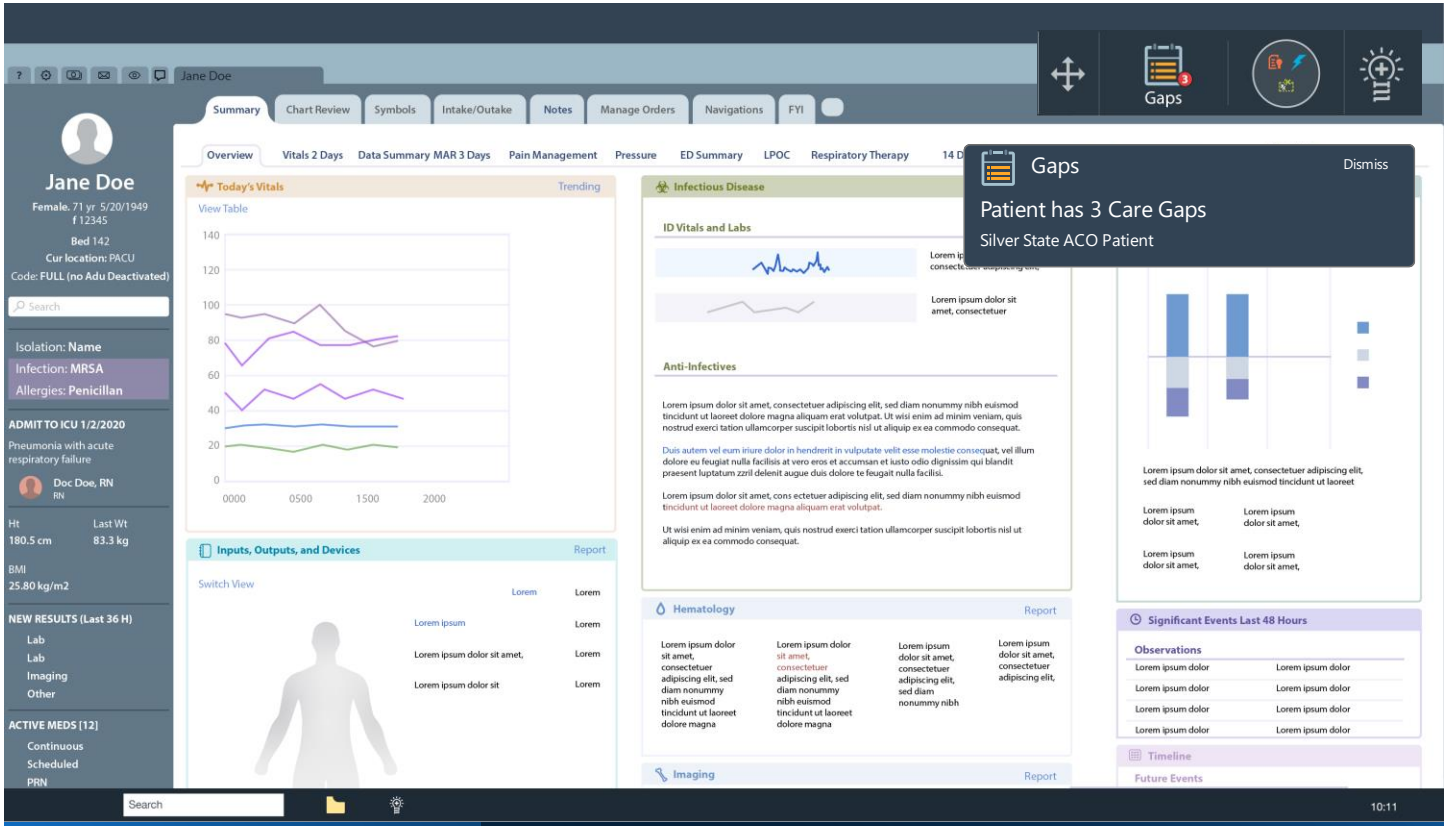
Care Gaps, Coding Gaps, ED & inpatient data and AWV Status

Providers can interact within the ribbon, closing gaps

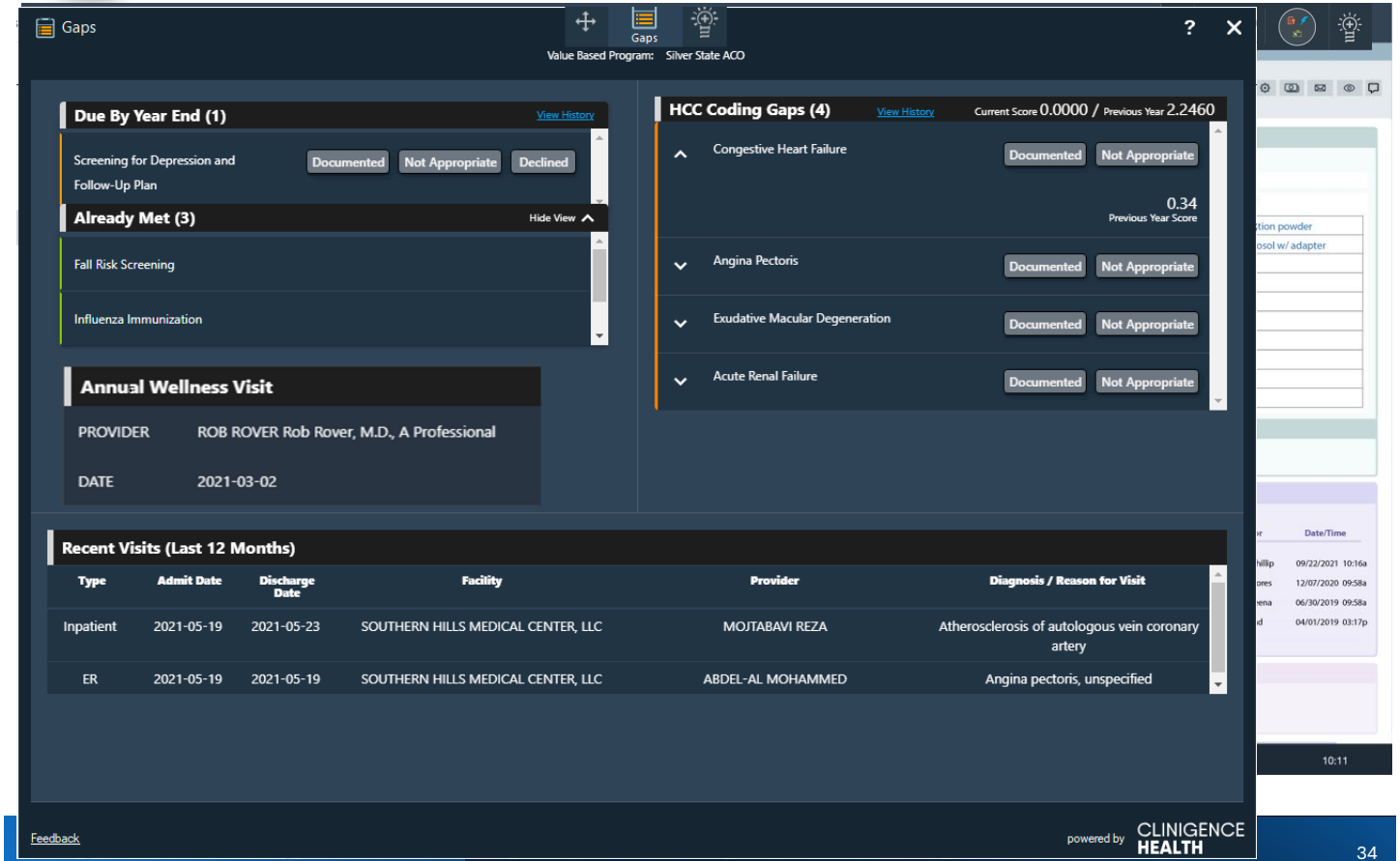
Silver State ACO
Accountable Care Organization



Silver State ACO
Accountable Care Organization



Silver State ACO
Accountable Care Organization



Silver State ACO
Accountable Care Organization

2023 Ribbon Utilization

20,697 Unique Notifications

10,200 Gaps Closed

49% Close Rate

Silver State ACO
Accountable Care Organization

The Results

Over 80% of our practices use the ribbon to close gaps at POC!

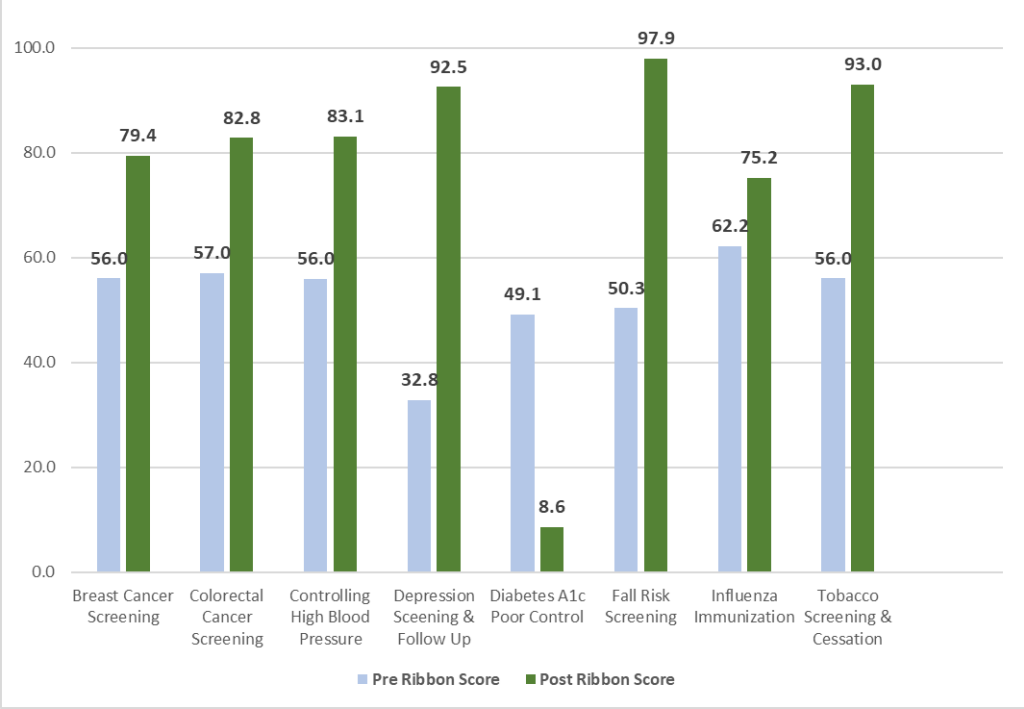
Positive feedback from our providers

The rollout was quick and painless

Quality scores improved immediately with ribbon usage!

Silver State ACO
Accountable Care Organization

Quality Score Improvements



Silver State ACO
Accountable Care Organization

Quality Score Improvements

Overall Calculated Score (based on CMS deciles)		
Pre Ribbon **62.60%**	Post Ribbon **95%**	**51.8%** Increase!

Silver State ACO
Accountable Care Organization

AWV Completion

Pre Ribbon	Post Ribbon	
30.45%	**48.13%**	**17.68 %** increase

Silver State ACO

Accountable Care Organization

Rhonda Hamilton, Chief Operating Officer

Contact Information:
Rhonda@silverstateaco.com
(702) 800-7084

Voting

AND THE 1st PLACE WINNER IS….

Congratulations to all our contestants on your innovations and presentations!

2nd Place: Silver State ACO Accountable Care Organization

3rd Place: ProviDRs Care

CLINIGENCE HEALTH

an assurecare® brand

Chuck Kandzierski

Founder & President
678-315-9784
Chuck.Kandzierski@clinigence.com

or

Info@clinigence.com

www.clinigencehealth.com

Contact Information

NAACOS Staff

- **Melody Danko-Holsomback, VP of Education:** mdholsomback@naacos.com
- **Karen Fetterolf, Education Manager:** kfetterolf@naacos.com
- **MaryJane Thomas, Membership Director:** mjthomas@naacos.com
- **Phil Meher, Membership Manager:** pmeher@naacos.com