Aligning Best Practices Across Payors & Disease Management Protocols – How to Execute and Deploy

Agenda

- Introductions & Learning Objectives
- Community Health Provider Alliance
- Ardent Health
- Geisinger
- Discussion & Wrap-Up

Speakers

Brandi Apodaca, RN, BSN

Chief Performance Officer

CCMCN - CHPA

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Learning Objectives

- How to align best practices across payers to drive success in Accountable Care Organizations (ACOs) and value-based care (VBC) programs.
- The importance of consistency in strategies, flexibility to meet payer-specific requirements, and collaboration to optimize outcomes for patients and providers.
- How to identify shared priorities and leveraging payer data to streamline operations, improve quality, and achieve financial success while adapting to the unique nuances of individual payer contracts.

Community Health Provider Alliance (CHPA)

DBA of Colorado Community Managed Care Network (CCMCN)

CCMCN-CHPA Merger

As of January 1, 2025 Community Health Provider Alliance (CHPA) and Colorado Community Managed Care Collaborative (CCMCN) have merged.

Stronger Together! The Impact of our Merger | Aligning CHPA as an accountable care organization—focused on supporting performance in value-based care contracts—with CCMCN's expertise in community data integration and public health means:

- **Enhanced Data & Coordination** – CHPA's accountable care organization function is now powered by a stronger data infrastructure, dedicated data science teams, and advanced community care coordination systems.
- **Maximized Performance & Savings** – Higher quality outcomes, greater cost savings, and increased member revenue.
- **Greater Impact** – Improved population health, financial stability, and health equity across our communities.
- **Streamlined Support** – Increased efficiency for members by reducing the number of organizations from three to two, with CHPA-CCMCN working in close alignment with Colorado Community Health Network (CCHN).

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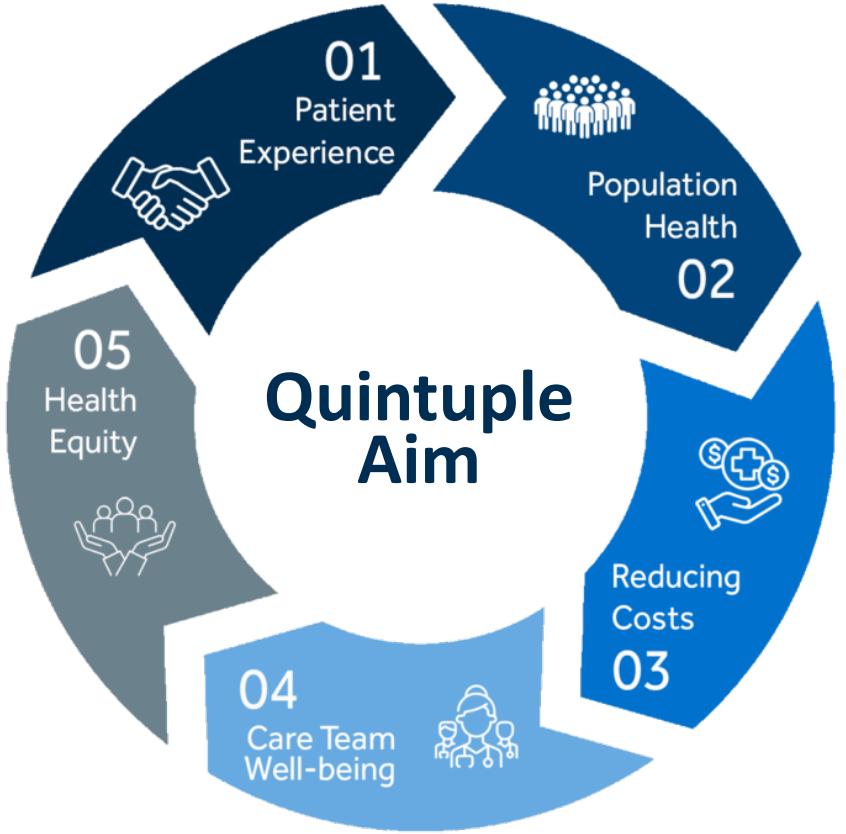
Community Health Provider Alliance (CHPA)

CHPA was formed in 2014 as a 501(c)(3) organization and is focused on value-based contracts and the quintuple aim.

CHPA's network is comprised of 20 Colorado Federally Qualified Health Centers (FQHCs) and one urban Indian health program:

- 243 locations and 1,000+ medical and behavioral health providers
- Serving 832,000+ patients with a focus on those who are uninsured, underinsured, and under-resourced
- All participants are fully integrated with Medical, Dental and Behavioral Health services
- Over 75% of population with co-morbidities and are struggling with the social determinants of health (SDoH)



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Our Members

AXISHealth System

CLINICA family health

Colorado Coalition for the Homeless — Creating Lasting Solutions

Denver Indian Health and Family Services

Tepeyac Community Health Center

Denver Health — est. 1860

Mountain Family Health Centers

High Plains Community Health Center

ICH — Inner City Health

Pueblo Community Health Center — Your Health. Our Mission.

MarillacHealth

Northwest Colorado Health — Formerly Northwest Colorado Visiting Nurse Association—VNA

Peak Vista Community Health Centers

River Valley Family Health Center

Salud Family Health

Sheridan Health Services

STRIDE Community Health Center

summit community Care Clinic

sunrise Community Health

UMC — Uncompahgre Medical Center

Valley-Wide Health Systems, Inc.

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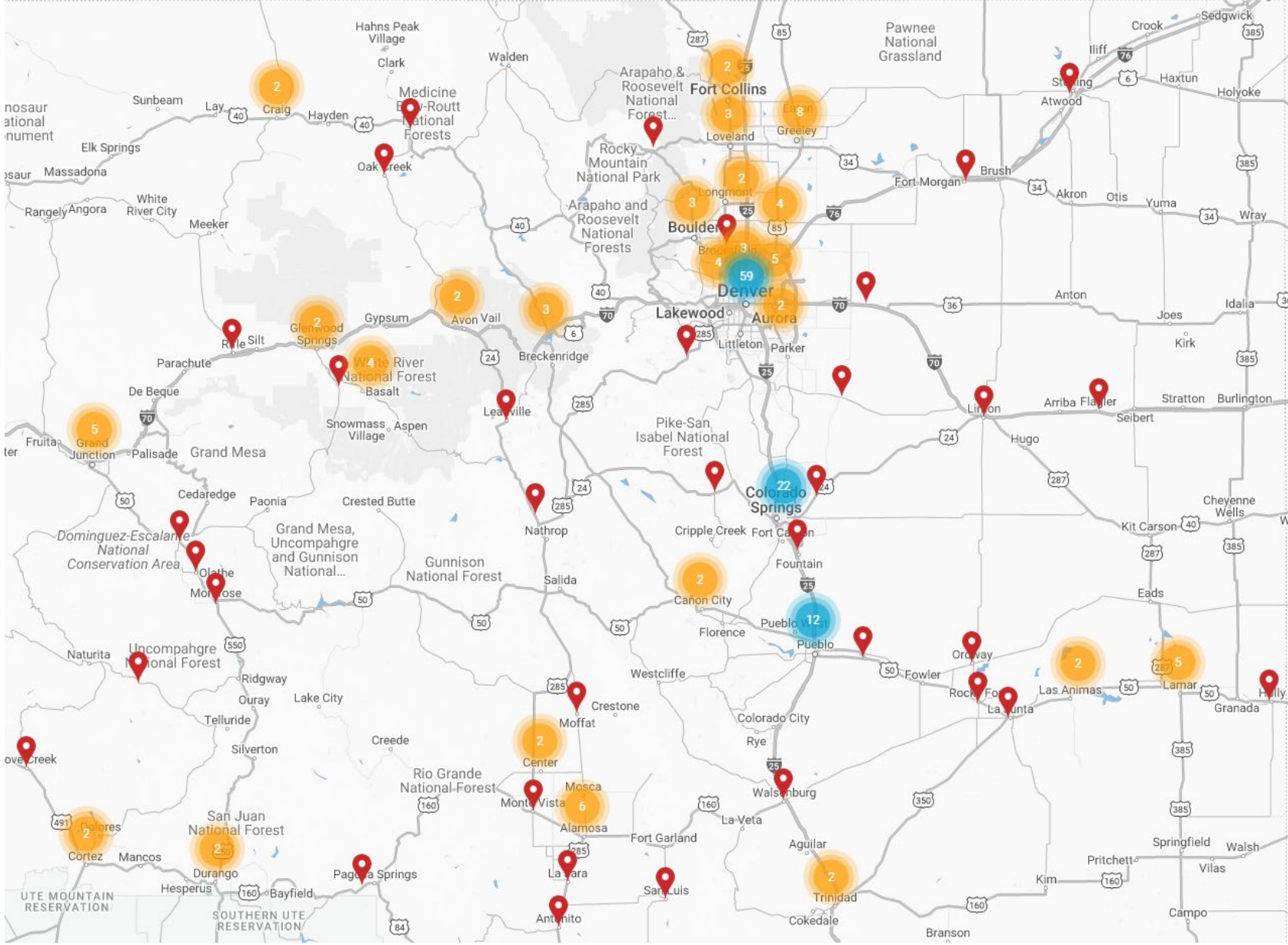
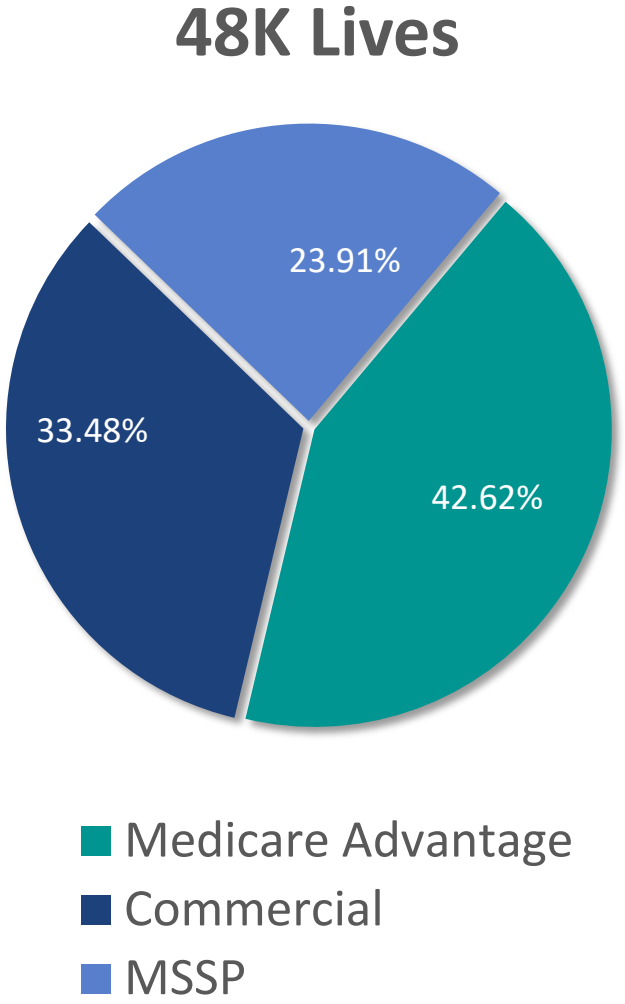
Member Locations



CHPA Snapshot

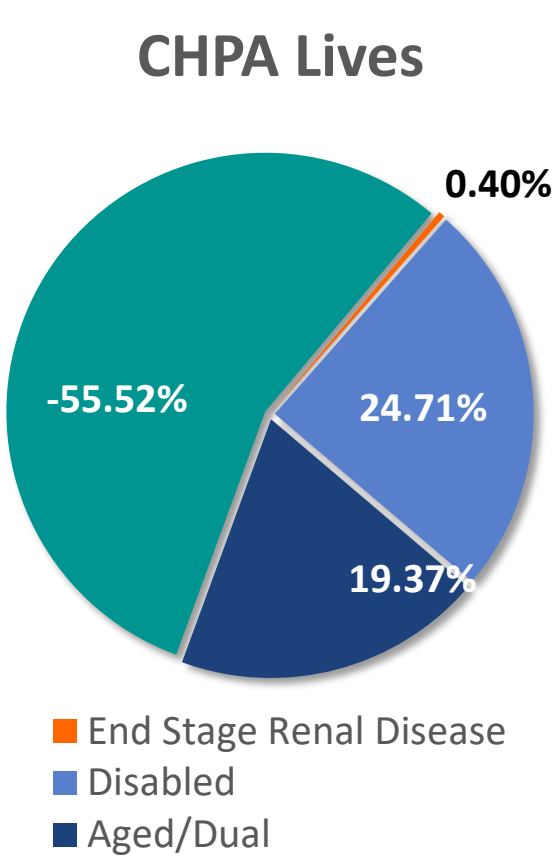
- Participating in Medicare Shared Savings Program (MSSP) since 2017
  - Started in *Basic* track, entered *Enhanced* in 2025
  - Started earning savings in the third performance year, earned for the fifth consecutive year in 2023
  - Providing $70 million in total savings for CMS over the last five years
- Participating in six Medicare Advantage contracts
- Participating in two commercial contracts
- Eight electronic health records (EHRs) but each member on their own instance even if on same EHR

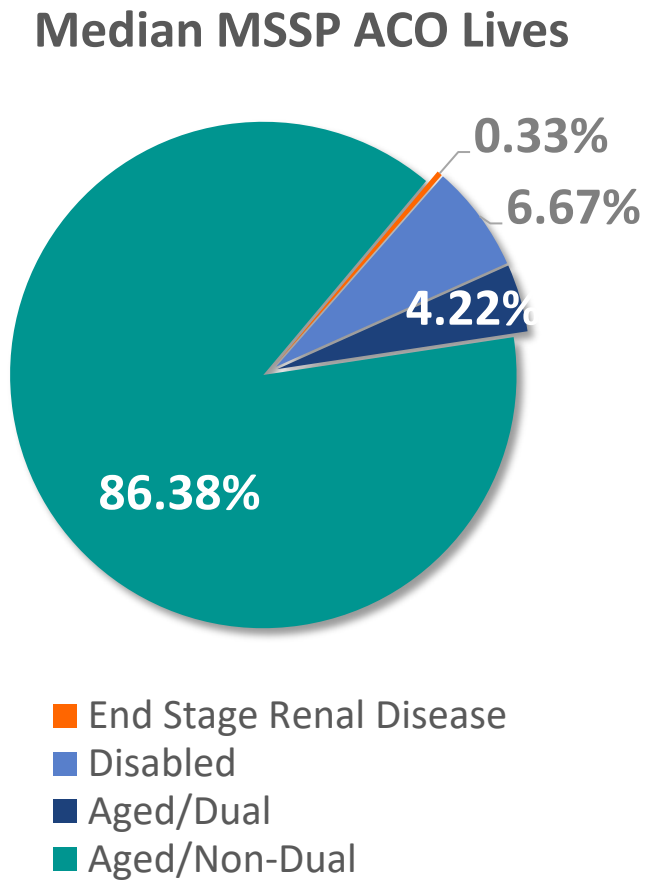


CHPA MSSP Lives

Currently *Enhanced Track*

	CHPA	MSSP
End Stage Renal Disease	45	40
Disabled	2808	798
Aged/Dual	2201	504
Aged Non-Dual	6309	10,329
Total Lives	11,363	11,957





Aligning Measures

Potential Measure Sets

National Quality Strategy – Universal Foundation Measures	**10 measures**
UDS 2024 eCQMs	**17 measures** with no tie to value-based care (VBC) incentives
Alternative Payment Model Measures	**3 mandatory** and **3 choice** measure tied to Medicaid incentives
Accountable Care Collaborative	KPIs: **6 measures** tied to Medicaid incentives Performance Pool Measures: **6 measures** tied to Medicaid incentives
ACO Distribution Measures	Medicare: **4 measures** tied to VBC incentives Commercial: **3 Measures** tied to VBC incentives

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Potential Measures to Focus On

Domain	Measure	% Population	Alignment	Dollars
Wellness and Prevention	Colorectal Cancer Screening	4.20%	3	$
	Breast Cancer Screening	6.50%	3	$
	Cervical Cancer Screening	6.80%	2	$
	Adult Immunization Status	20%	2	$
	Childhood Immunizations	6.70%	2	$
	Adolescent Immunizations	7.80%	1	$
	Body Mass Index: Screening and Follow-Up Plan	41.90%	2	$
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	15%	2	$
	Tobacco Use: Screening and Cessation Intervention	22%	1	
	HIV Screening	0.40%	1	
	Early Entry into Prenatal Care	4.20%	2	$
	Premature Birth Weight	0.24%	1	$
	Contraceptive Care for Postpartum Women	4.20%	1	$
	Chlamydia Screening for Women	7%	1	$
	Dental Sealants for Children between 6-9 years	7%	1	
	Oral Evaluations	21%	1	$
	Lead Screening	2.70%	1	$
	Preventive Wellness Visits	100%	4	**$$$$**
Chronic Conditions	Controlling High Blood Pressure	48%	4	**$$**
	HgbA1c Poor Control	12%	4	**$$**
	Kidney Health Evaluation	12%	1	$
	Asthma Medication Ratio	7.70%	2	**$$**
	Statin Therapy for prevention and Treatment of Cardiovascular Disease	7%	1	
	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	3.60%	1	
	HIV Linkage to Care	0.01%	1	
Behavior Health	Screening for depression and follow-up plan	8%	3	$
	Antidepressant Medication Management	18%	2	$$
	Depression Remission at Twelve Months	29%	1	
	Initiation and engagement of substance use disorder treatment	16.70%	1	
	Follow-Up after ED visits for EtOH and Other Drug Abuse or Dependence	1.20%	1	$
	Follow-Up after Hospitalization for Mental Illness	0.04%	1	$
	Behavioral Health Engagement	100%	1	$
Care Coordination	Plan all-cause readmissions or all-cause hospital readmissions	8%	1	
	ED Utilization	43%	3	**$$$**
	Extended Care Coordination	12%	1	$
Person-Centered Care	CAHPS overall rating measures	100%	1	
Equity	SDOH Screening	100%	1	
Risk Adjustment	Risk Adjusted PMPM/HCC Recapture	78%	2	**$$$**

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Aligned Measures with Financial Impact

Domain	Measure	% Population	Alignment	Dollars
Wellness and Prevention	Colorectal Cancer Screening	4.20%	3	$
	Breast Cancer Screening	6.50%	3	$
	Cervical Cancer Screening	6.80%	2	$
	Adult Immunization Status	20%	2	$
	Childhood Immunizations	6.70%	2	$
	Adolescent Immunizations	7.80%		$
	Body Mass Index: Screening and Follow-Up Plan	41.90%	2	$
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	15%	2	$
	Early Entry into Prenatal Care	*4.20%*	2	$
	Premature Birth Weight	0.24%		$
	Contraceptive Care for Postpartum Women	4.20%		$
	Chlamydia Screening for Women	7%		$
	Oral Evaluations	21%		$
	Lead Screening	2.70%		$
	Preventive Wellness Visits	100%	5	**$$$$$**
Chronic Conditions	Controlling High Blood Pressure	48%	4	**$$**
	HgbA1c Poor Control	12%	4	**$$**
	Kidney Health Evaluation	12%		$
	Asthma Medication Ratio	7.70%	2	**$$**
Behavior Health	Screening for depression and follow-up plan	8%	3	$
	Antidepressant Medication Management	18%	2	**$$**
	Follow-Up after ED visits for EtOH and Other Drug Abuse or Dependence	1.20%		$
	Follow-Up after Hospitalization for Mental Illness	0.04%		$
	Behavioral Health Engagement	100%		$
Care Coordination	ED Utilization	43%	3	**$$$**
	Extended Care Coordination	12%		$
Risk Adjustment	Risk Adjusted PMPM/HCC Recapture	78%	2	**$$**

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Aligned Measures with Multiple Financial Impacts

Domain	Measure	% Population	Alignment	Dollars
Wellness and Prevention	Preventive Wellness Visits	100%	4	$$$$
Chronic Conditions	Controlling High Blood Pressure	48%	4	$$
	HgbA1c Poor Control	12%	4	$$
	Asthma Medication Ratio	7.7%	2	$$
Behavior Health	Antidepressant Medication Management	18%	2	$$
Care Coordination	ED Utilization	43%	3	$$$
Risk Adjustment	Risk Adjusted PMPM/HCC Recapture	78%	2	$$

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Measure Alignment

- MSSP eCQMs align with Utilization Data Set (UDS) and Colorado Medicaid at-risk funding
- Focus on Full Population Performance
  - Shared savings goals/distributions align
  - Practice Transformation support
  - Data reporting monthly

Practice Transformation/ Quality Improvement

** 2025 Performance Dashboard requirement*

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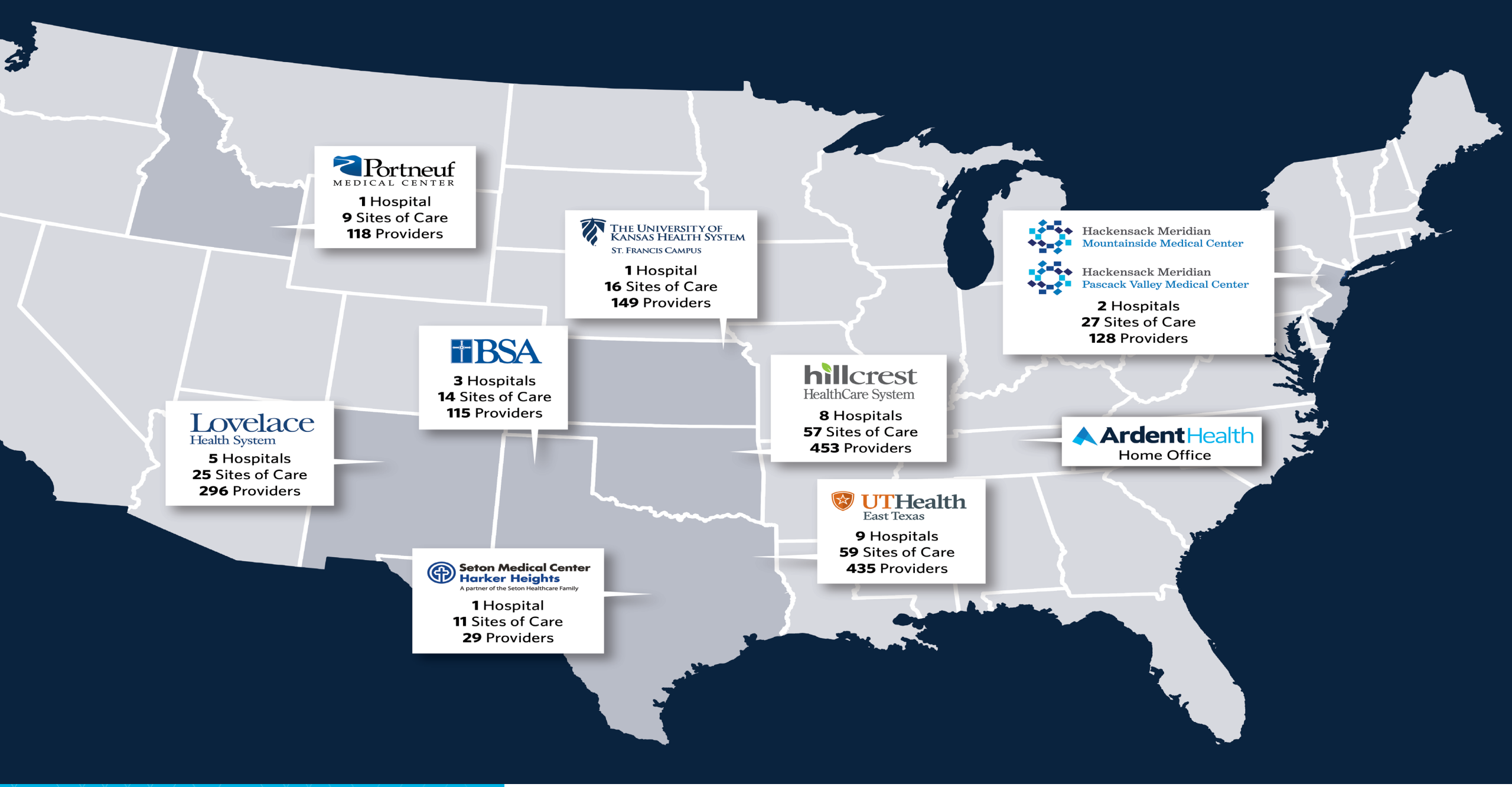
Questions?


ArdentHealth

Ardent Health

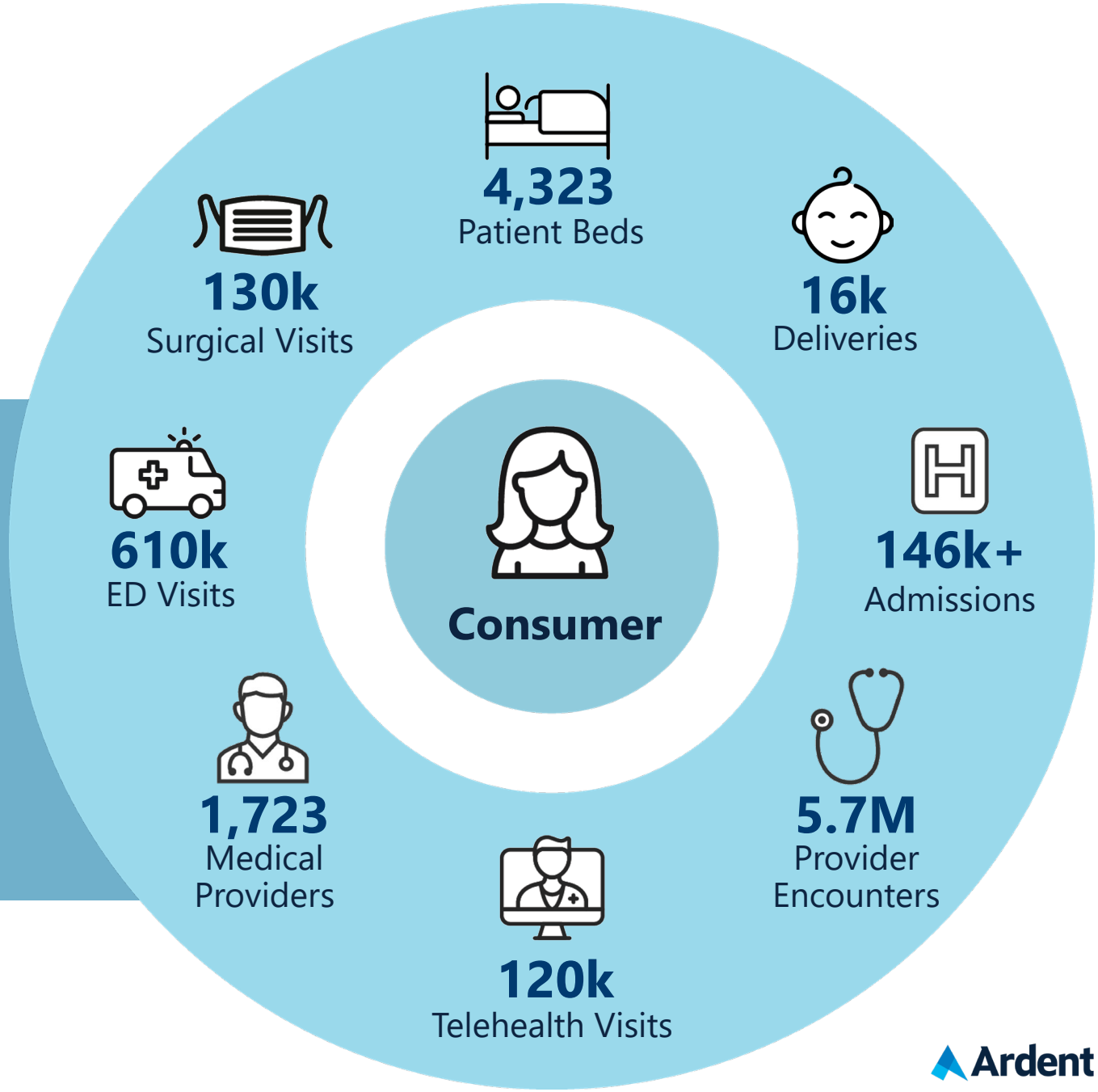
Aligning best practices across payers to drive success



ArdentHealth

A Year At Ardent

More than
10,000
Lives touched each day



Ardent Health

Ardent – Value-Based Care Profile

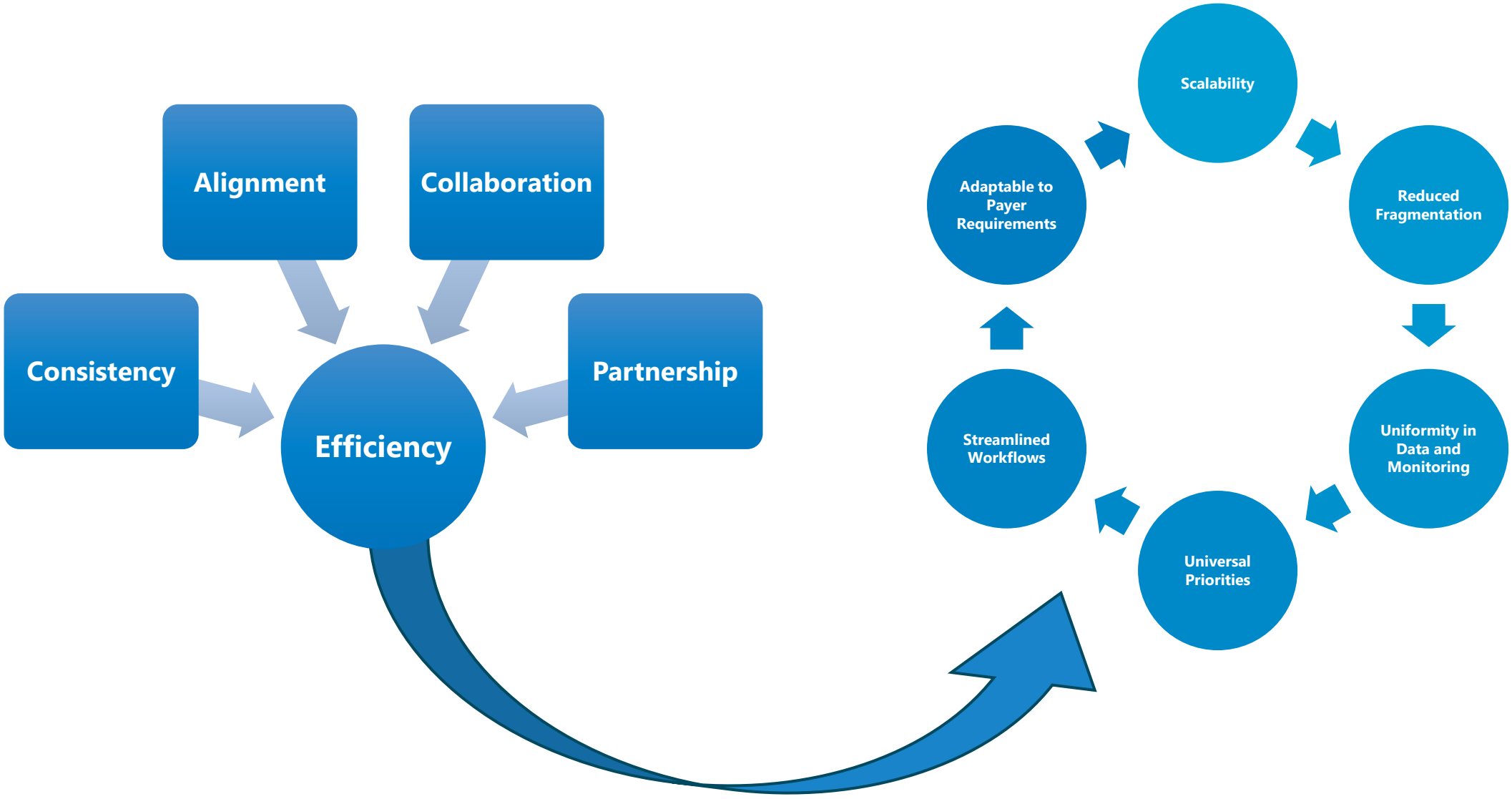
>81
Total number of unique VBC arrangements

>238K
Lives managed under a VBC arrangement

	Category 2 Payments linked to Quality	Category 3 Share savings and risk	Category 4 Population-based payments
Lives	~49K	~182K	~7.2K
Contracts	45	35	1

Ardent Health

Alignment to Efficiency



ArdentHealth

Importance of Payer Alignment

Consistency

Standardized workflows and quality metrics reduce administrative burden and enhance efficiency.

Scalability

Aligning best practices creates a replicable framework for managing diverse payer contracts.

Outcomes

Focused alignment ensures high-quality care, cost savings, and improved patient satisfaction.

Identify Commonalities

Quality Measures

- HEDIS
- Star Ratings
- MIPS
- CAHPS

Universal Priorities

- Care Coordination
- Chronic Disease Management
- Preventive Care

Incentive Opportunities

- Utilization management
- Coding and Documentation

Strategies for Effective Payer Alignment

Data Integration

Centralized data platforms to track performance across payers.

Care Models

Develop payer-agnostic care models with flexibility to address unique contract requirements.

Provider Engagement

Train providers to meet common and payer-specific metrics through actionable insights.

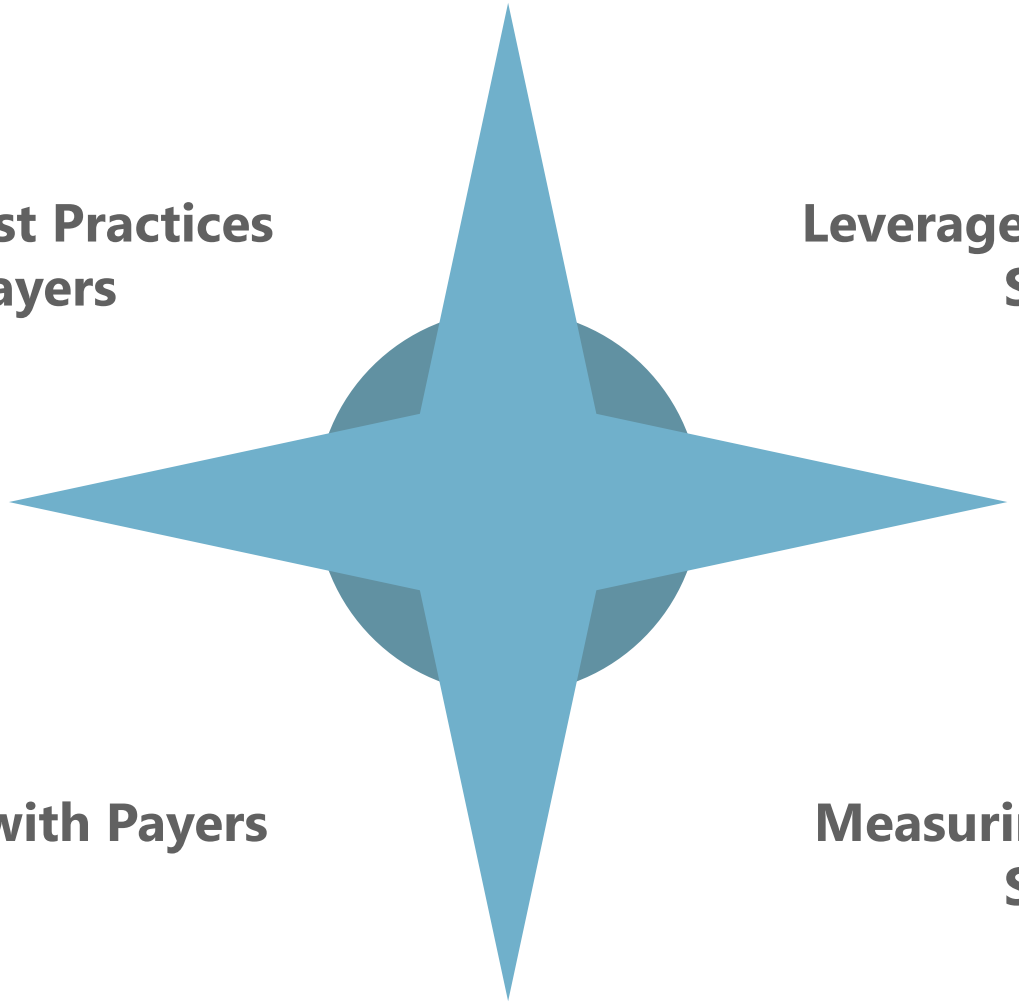
Collaboration and Communication

- Foster partnerships with payers to align on mutual goals (e.g., population health initiatives).
- Use payer feedback to refine care delivery strategies and identify opportunities for improvement.
- Understand individual payer contract nuances, including benchmarks, attribution methods, and bonus structures.
- Advocate for shared data, streamlined metrics, and joint initiatives to reduce fragmentation.

Key Takeaways for Payer Alignment

Standardize Best Practices Across Payers

Leverage Payer to Drive Success



Collaboration with Payers

Measuring and Scaling Success

Thank You.

Eloy Sena

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ArdentHealth

Disease Management Protocols

Post Acute Sepsis Management

Joann Sciandra, MHA BSN RN CCM
Vice President, Care Coordination and Integration

Geisinger

Keystone Accountable Care Organization

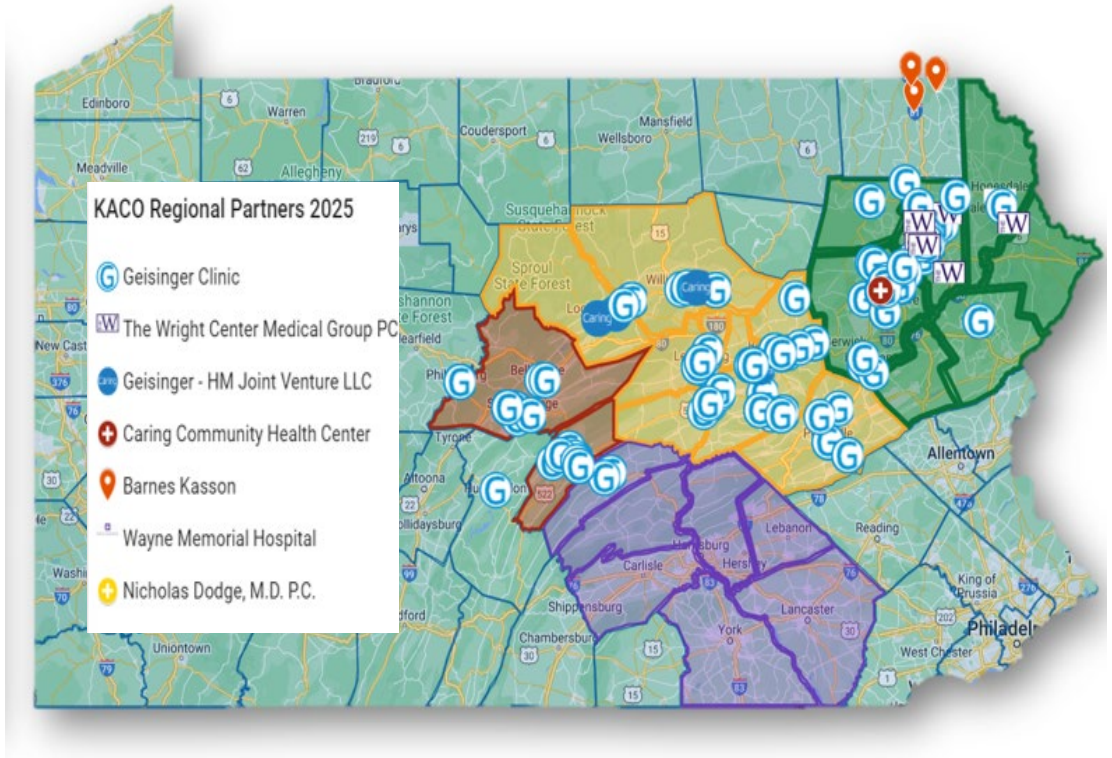
- Keystone ACO, LLC formed in 2012

Geisinger serves as **Convener** and **Participant**

2025

MSSP ENHANCED Level Risk Track

About 45,000 Beneficiaries
11 Medical Groups
10 Participating Hospitals
5 Disparate EMRs



BECKER'S HOSPITAL REVIEW

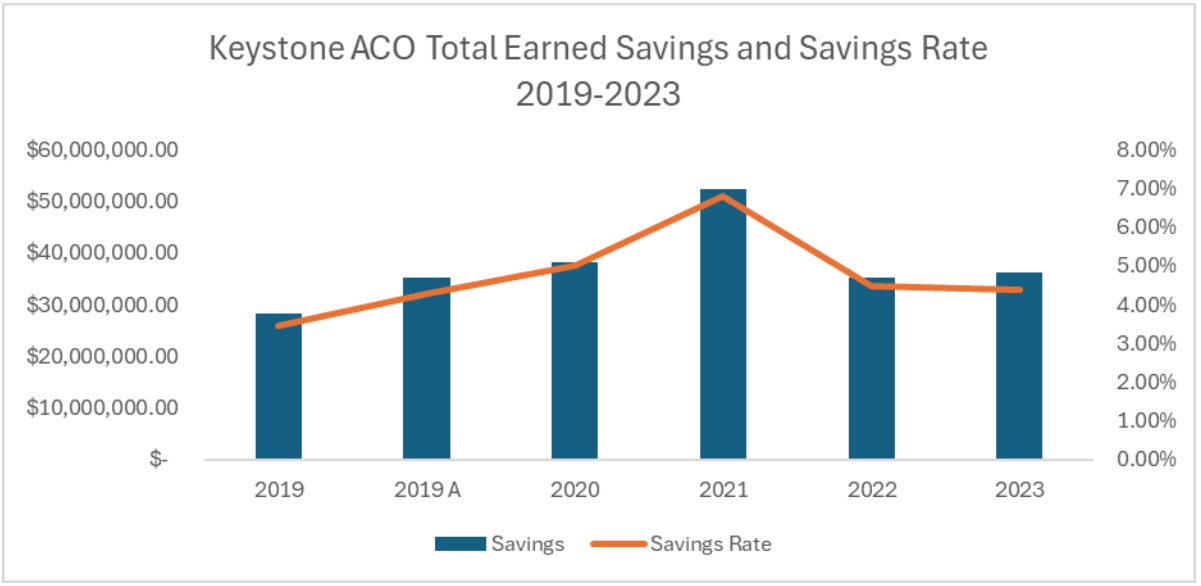
Twice named as TOP
ACO in Beckers Hospital Review
and total earned savings > $225M
since 2019.

BUSINESS NEWS: Keystone ACO Does It Again!

CHICAGO (September 2024) — *Becker's Hospital Review* is delighted to release the **2024 edition of its "ACOs to know" list.** The ACOs included on this list are recognized for their ability to find and implement cost savings in healthcare delivery. The listed organizations benefit both sides of the delivery spectrum, saving patients and providers millions of dollars annually. Becker's is thrilled to honor these groups, all of which strive to meet and exceed ACO standards. The *Becker's Hospital Review* editorial team accepted nominations for this list. The list aims to honor ACOs that are helping healthcare delivery become more affordable for patients and health systems alike.

The full list features individual profiles of all honored ACOs *Note:* The list is not exhaustive, nor is it an endorsement of included ACOs or associated healthcare providers. Organizations cannot pay for inclusion on this list.

Becker's Healthcare is the go-to source for healthcare decision-makers and one of the fastest growing media platforms in the industry. Through print, digital and live event platforms, Becker's Healthcare equips healthcare leaders with information and forums they need to learn, exchange ideas and further conversations about the most critical issues in American healthcare today.



Making better health easy

Geisinger: Integrated health system with $10 billion in combined revenues

We care for patients.

- **10** hospital campuses
- **126** primary and specialty clinics
- **26,000+** employees
- **1,700+** employed physicians

We provide quality, affordable healthcare coverage.

- **More than 550,000** Geisinger Health Plan enrollees
- **More than 65,000 c**ontracted providers in network
- **225+** hospitals in network

We shape the future of medicine.

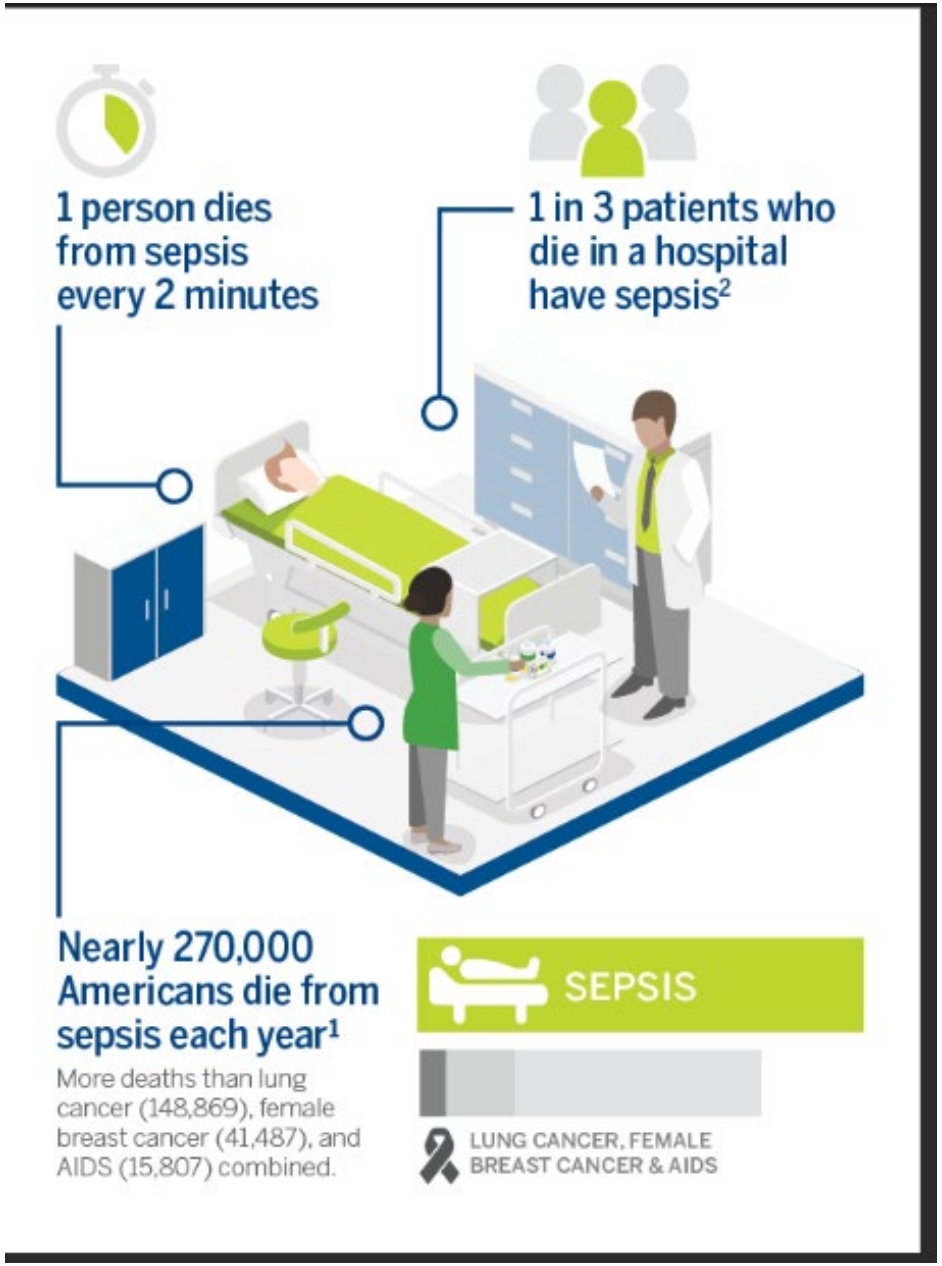
- **550+** MBS/MD students at Geisinger College of Health Sciences
- **70** students in School of Nursing
- **600+** residents/fellows
- **1,400+** active research projects

Sepsis…

- is a serious condition in which the body responds improperly to an infection. The infection-fighting processes turn on the body, causing the organs to work poorly.
- Sepsis may progress to septic shock. This is a dramatic drop in blood pressure that can damage the lungs, kidneys, liver and other organs. When the damage is severe, it can lead to death.
- **Early treatment** of sepsis improves chances for survival.

Sepsis - Symptoms & causes - Mayo Clinic

Impact of Sepsis



Joseph Doe

50-year-old male, open wound on left foot

Patient Background

Background/Hospitalization Admission

- 50 year old man Lives with wife
- >5 medications, + Insulin
- Podiatry managing foot ulcer for several months
- Ambulating with a cane

- Admitted to hospital after failing outpatient treatment for a left foot wound infection/diabetic ulcer
- Ulcer is draining yellow to serosanguineous
- Temp 100.3

Comorbid Conditions

Type 2 Diabetes for 30 years. Average Hemoglobin A1C 9.5
Hypertension
Coronary artery disease
CBGx2 5 years ago

Discharge Summary

- Oral antibiotics
- Ordered Home health for wound care and education for patient and family
- Follow-up appoint with podiatry in 3 weeks
- PCP appointment in 2 weeks
- No collaboration or coordination of care with outpatient

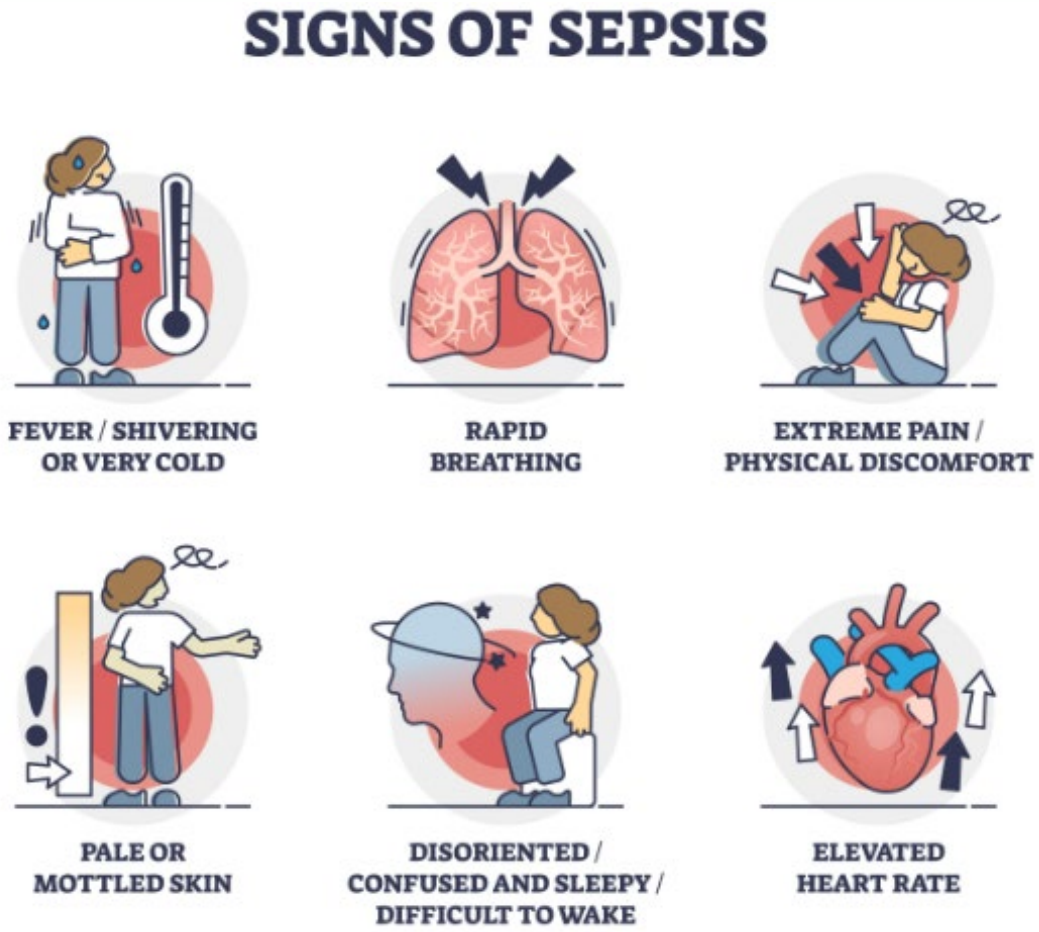
At Home

- Discharged to home.
- Home health 2 days post-discharge
- No change in wound vital signs stable, limited mobility, complains of still feeling weak and tired since hospital stay.
- Home Health daily wound care with goal of wife and patient completing
- Home Health visit, day 6, temp 99, patient asking why still not feeling better, decreased appetite, wife indicates he does not get up and move much without her help
- Day 7, home health completed wound care, no changes from prior day's assessment
- Day 8, (Friday) home health preparing to discharge patient, wife and patient independent in wound care. Temp 99.9, wife states seems to be getting weaker and less active, not eating. Home health nurse calls PCP, appointment moved up to Monday.
- Day 8 evening, patient complains of chills and feeling lightheaded. Wife calls 911, patient transported to emergency room, BP 80/60, HR 150, temp 101.4, admitted to hospital with diagnosis of sepsis.

Earlier Identification and Intervention is Key

Early indicators:

- **Weakness**
- **Tired**
- **Not progressing**
- **Limited mobility**



Creating a Care Model in our Communities

Supporting those with serious & significant health conditions

Coordinated Medical Care

- Comprehensive assessment
- Condition optimization & management
- Close coordination with PCP/SCPs

Integrated Social & BH

- Social determinants of health
- Behavioral health

Acute Care

- Mobile paramedics
- Case Management
- Home Health
- AP/CHW Virtual Visits
- ER Case Managers

Advanced Illness

- Plan of care
- Symptom management
- Palliative care
- Timely transition to hospice

Ambulatory Care Team

- Social Determinants of Health
- Benefit Management
- Chronic Condition Management
- Transitions Of Care

Sepsis Pilot

Who	• Geisinger NE Hospitals • Active Sepsis or Complicated Infection • Anticipated Home Disposition
Why	Sepsis continues to be the main driver of hospital admissions and readmissions.
How	Enhance TOC • Defined dosing and intervention • Remote patient monitoring
Update	• To date, 110 currently enrolled or have gone through the Sepsis Pilot. • Awaiting data on utilization and mortality rates

John Doe

60-year-old male KACO member and enrolled in Level 2 Complex Care Management

Patient Background

Hospitalization Admission

- Presented to GWV ED with fever and chills with worsening right sided abdominal pain
- In the ED, vitals and labs consistent with sepsis (tachycardia, tachypnea, hypotension, elevated lactate and leukocytosis).
- Sepsis alert called patient received IV fluid resuscitation and broad-spectrum antibiotics, admitted to medicine.
- Imaging consistent with pyelonephritis and blood cultures positive for E.coli.
- Treated for sepsis with planned for home discharge in 48 hours.

Comorbid Conditions

HTN,CKD3b, CAD, hyperlipidemia, Chronic systolic congestive heart failure, DM Type 2, COPD not requiring supplemental O2

48 hours Pre-Discharge

- Confirmation of Sepsis Dx and Collaborative D/C scheduling
- Determination of connectivity and **ordering** of Remote Pt Monitoring (RPM)
- Determination of need for PT/OT/Speech eval while inpt if not done and HH needs post-acute
- Goals of Care addressed inpt and align with previously established
- TOC Planned – Cadence and appropriate team members including Providers
- Potential SDoH barriers to discharge identified (transportation, food insecurity, caregiver support, etc) to be addressed at CHW follow up
- DME needs verified

Plan

24 hours after discharge – Home Visit by CHW with the goal being CM virtually

- Confirmation that patient received home RPM with continuous monitoring and that it is transmitting.
- Medication review assuring all new medications have been received and adequate supply of home medications in place with escalation if new Rxs or refills needed.
- Home environment assessment with confirmation or identification of new SDoH needs
- Set of manual vital signs with escalation of abnormal

48 hours after discharge – RNCM/CHW

- Medication review and reconciliation with focus on NEW medications (Abx adherence) and PTA potentially changed/held
- Patient and caregiver teach back on red flags, DME use and RPM (confirm it's transmitting)
- SDoH barriers revisited and addressed
- Focused Sepsis-Specific Assessments completed

72 hours after discharge

- Mobile labs (CBC, Renal Panel, etc) ordered and completed
- Telephonic Focused Sepsis-Specific Assessments completed

5 business days after discharge – KACO AP Telemedicine Visit

- Medication optimization complete following review of post-D/C labs, RPM data
- Sepsis-Specific Provider Assessments completed

End of first week after discharge

- Future red flags identified and discussed with patient/family with teach back to demonstrate understanding

Weekly Touches Post-Discharge for 3 weeks – Multi-modal

- Ongoing focus on early identification of new/recurrent infection and stability of co-morbidities such as HF, COPD, and CKD

Current Health Wearable

Leveraging telehealth tools

- CHW does home visit in place of licensed staff
- Connects to our “Remote Medical Collaborator”
- High patient and provider satisfaction
- Some connectivity issues in rural areas
- Early use for acute care as well
- Use of peripherals to enhance visit impact

Questions?

Thank you

Geisinger