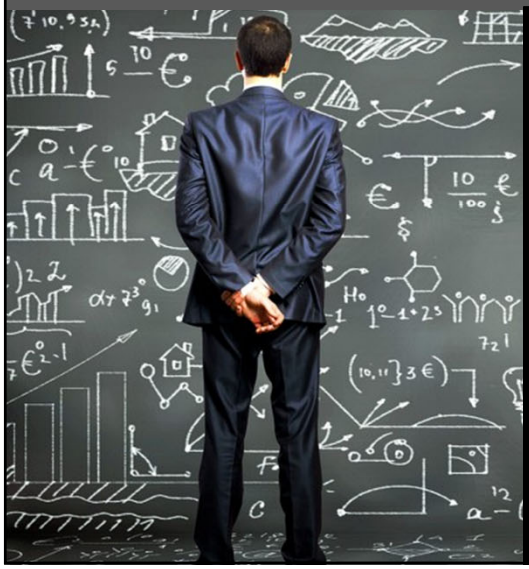
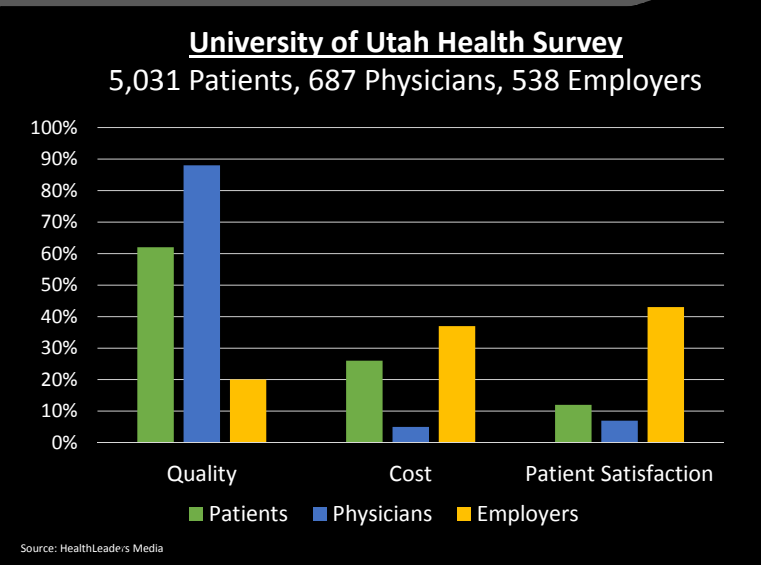
Atrium Health

The Value Perspective

Ruth Krystopolski
SVP, Population Health

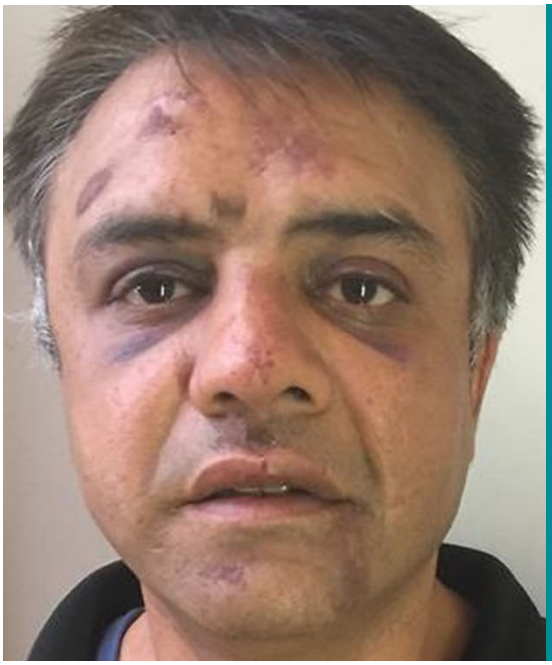
How is "Value" Defined?...It Depends…





Meet Joe

- **Highest ED utilizer in the Atrium Health System**
- **1500+ service visits** within Atrium Health
- Jan – April 2018 (120 calendar days) = **104 ED visits**
- Other 16 days spent inpatient or observation
- ED, Inpatient, and Observation Facility Charges from 2015-2017 = **$1,570,900**
- YTD 2018 charges = **$366,125**

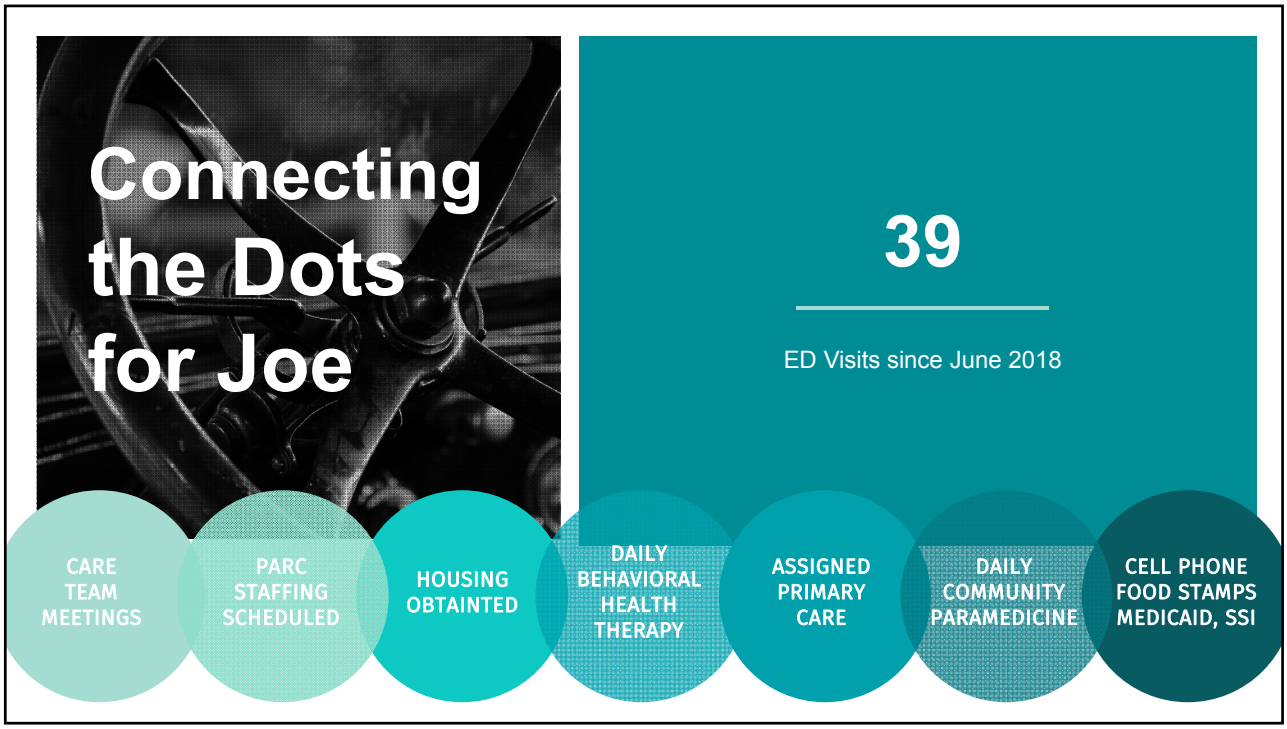


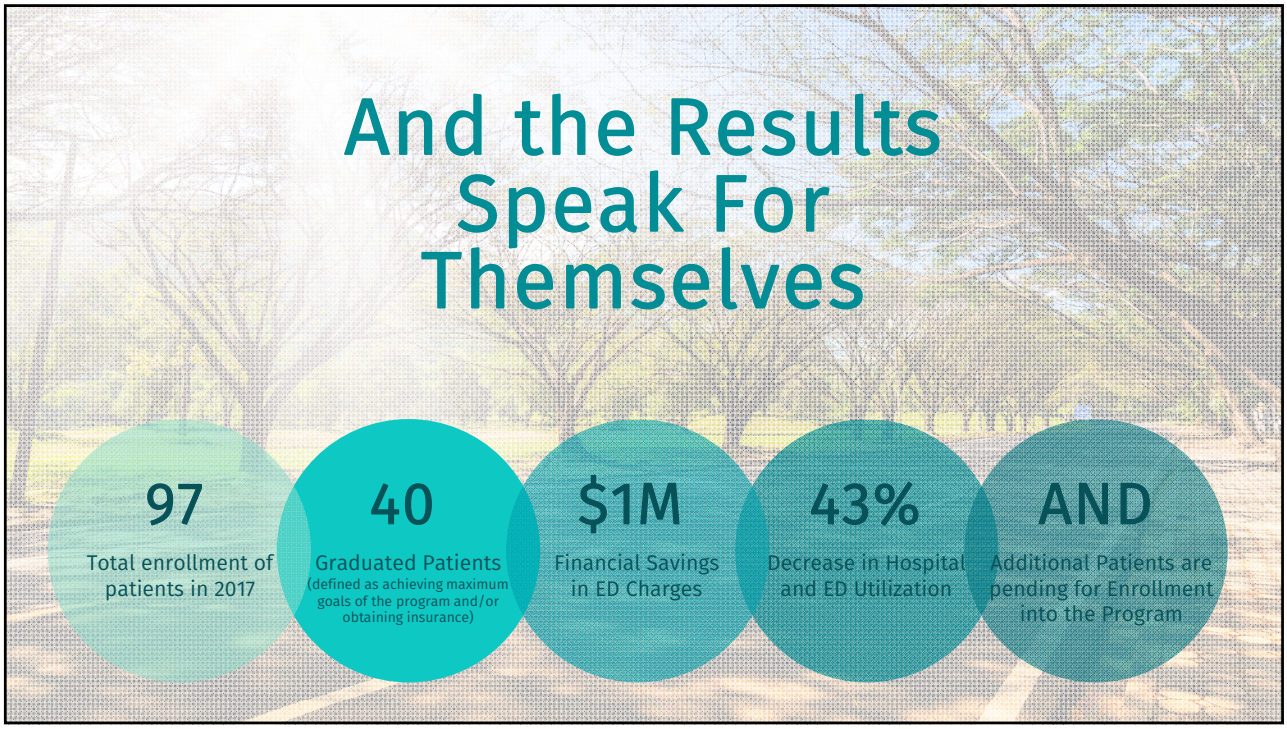
- ✓ **PTSD**
- ✓ **Overwhelming anxiety**
- ✓ **Hypochondriasis**
- ✓ **Major Depressive Disorder**
- ✓ **Alcohol Use Disorder**

Joe comes to ED because of an overwhelming fear he will die of numerous medical ailments

He lives in his car and moves between Atrium Health parking decks to have quick access to the ED

Joe says that the only thing that helps him feel normal is coming to the ED every day and having a doctor reassure him that he will be okay


Connecting the Dots for Joe
39
ED Visits since June 2018
CARE TEAM MEETINGS
PARC STAFFING SCHEDULED
HOUSING OBTAINTED
DAILY BEHAVIORAL HEALTH THERAPY
ASSIGNED PRIMARY CARE
DAILY COMMUNITY PARAMEDICINE
CELL PHONE FOOD STAMPS MEDICAID, SSI


And the Results Speak For Themselves
97
Total enrollment of patients in 2017
40
Graduated Patients
(defined as achieving maximum goals of the program and/or obtaining insurance)
$1M
Financial Savings in ED Charges
43%
Decrease in Hospital and ED Utilization
AND
Additional Patients are pending for Enrollment into the Program

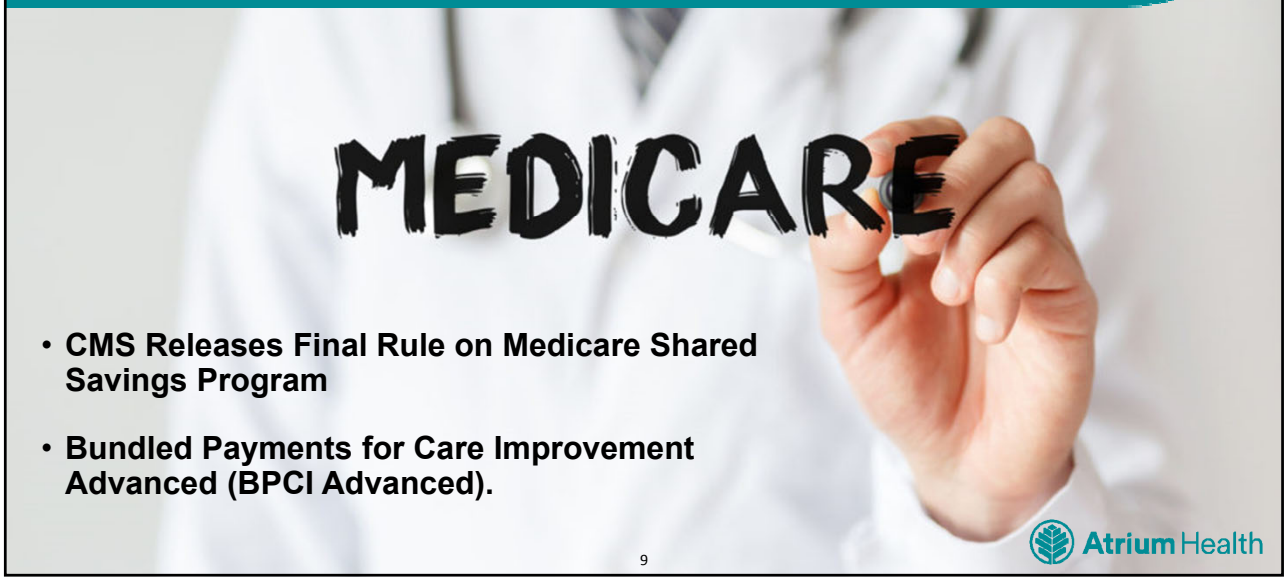
"

Yeah, things are now moving in the right direction …

I finally feel like a human again.

- JOE

Current Landscape Update - Medicare



- **CMS Releases Final Rule on Medicare Shared Savings Program**
- **Bundled Payments for Care Improvement Advanced (BPCI Advanced).**

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MSSP Proposed Rule Change

- Released August 9th
- Eliminates Track 1 and Track 2 options
- Establishes **BASIC** and **ENHANCED** (current Track 3) Tracks
- Expands SNF and Telehealth Waivers
- Provides choice in beneficiary assignment methodology
- Establishes beneficiary incentive program
- Comments due by October 16, 2018 with final ruling released in Nov

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Advancing Care Models

Bundled Payments for Care Improvement

BPCIA assists in the elimination of low-value care by engaging providers in risk based models for clinical episodes

BPCIA encourages high quality, low cost care in alignment with our current initiatives

The non-binding application process will provide necessary data to evaluate for areas of opportunity

BPCIA will assist Atrium Health on our journey to value by allowing us to evaluate our systems for efficiency, engage in risk based models, and better understand our total costs of care

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Current Landscape Update - Medicaid

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Background

- **2015:** Session Law 2015-245 directs the Department to transition to managed care
- 2015-2018: Extensive collaboration with and feedback from stakeholders
- Aug 2018: RFP released
- Oct 2018: CMS approves 1115 waiver
- Feb 2019: Prepaid Health Plans selection announced

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Prepaid Health Plans for NC Medicaid Managed Care

- **Four Statewide PHP contracts:**
  - AmeriHealth Caritas North Carolina, Inc.
  - Blue Cross and Blue Shield of North Carolina, Inc.
  - UnitedHealthcare of North Carolina, Inc.
  - WellCare of North Carolina, Inc.
- **One Regional Provider-Led Entity:**
  - Carolina Complete Health, Inc. (Regions 3 and 5)

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Current Landscape Update - Commercial

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Current Landscape Update - Employer

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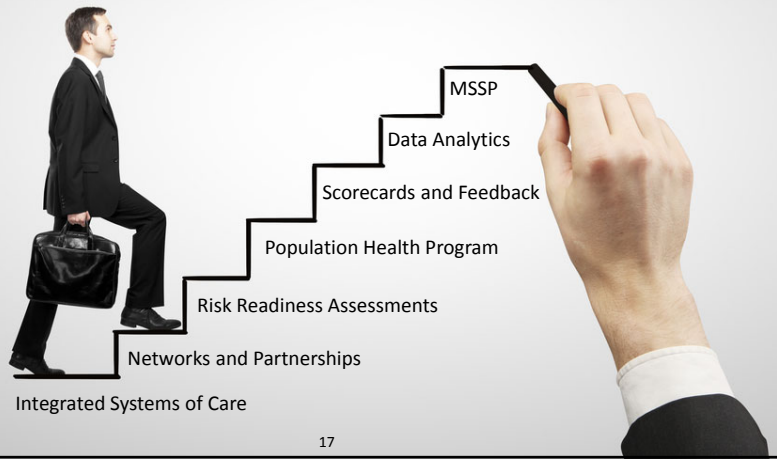
The Journey to Value

Preparation across the organization is on-going to get us ready for this new world by building on the past and into the future



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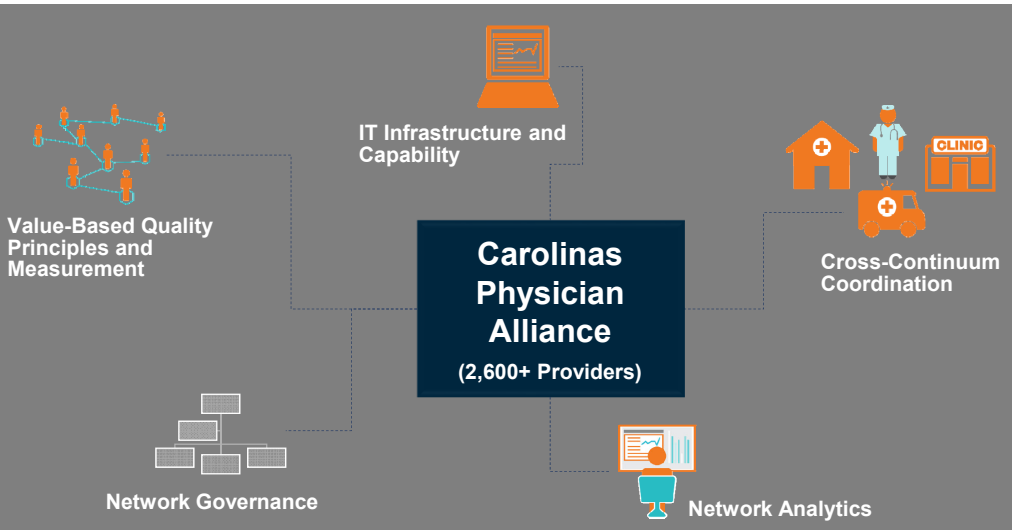
Building Networks



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Ensuring Appropriate Utilization

ED High Utilizer Care Management

20+ Visit Cohort

- 339 Patients
- Over 7,000 ED Encounters
- 40% Reduction in Utilization
- 39% Reduction in Cost

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Creating Access to Engage Patients

Care Wherever and Whenever Needed

Virtual Health

Virtual Critical Care
TelePsych And Patient Placement
Telestroke
Infectious Disease
Behavioral Health Integration (Primary Care)
Virtual Visits
e-Synchronous Visits

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Value Grand Rounds

1. Identify Patients
2. Create A Diverse Interdepartmental Team
3. Meet Regularly to Discuss Difficult Cases
4. Use Existing Resources to Create Intervention
5. Identify Gaps in Care/Processes System-Wide for Improvement

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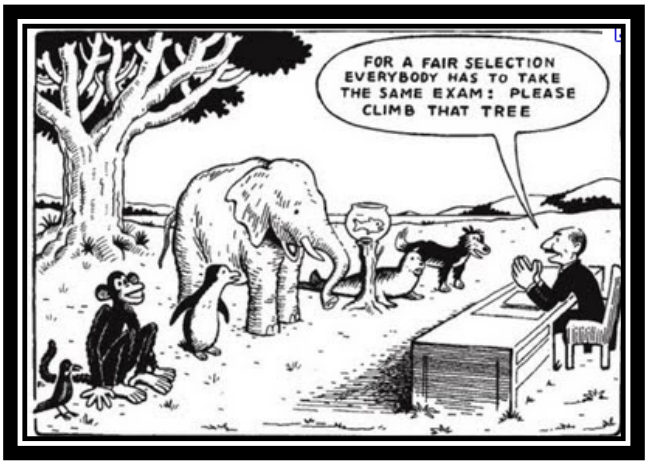
How Do We Work as A Team?



Ensuring Access by Eliminating Barriers to Care:

- $3 Copays at Urgent Care
- Presumptive Eligibility Scores for Regional Partners
- Barriers to Financial Assistance
- Encouraging Appropriate Utilization
- Identification of Patients in Need

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How do we need to work differently with our communities to improve health— for all?

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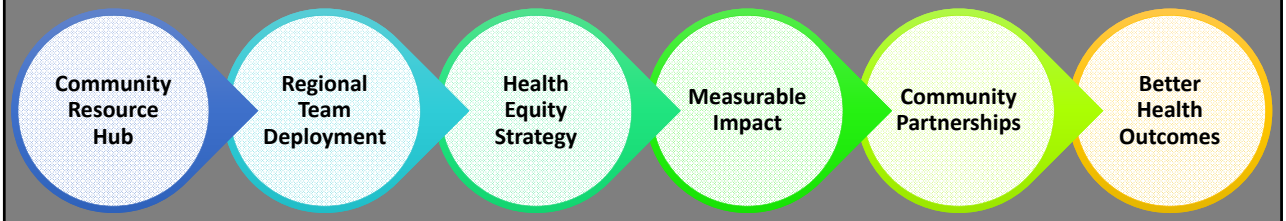
Creating a Supportive Infrastructure



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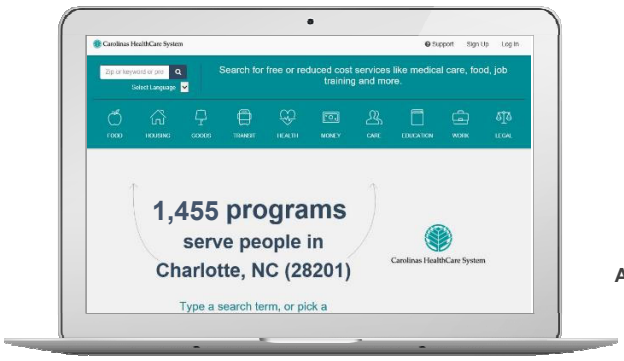
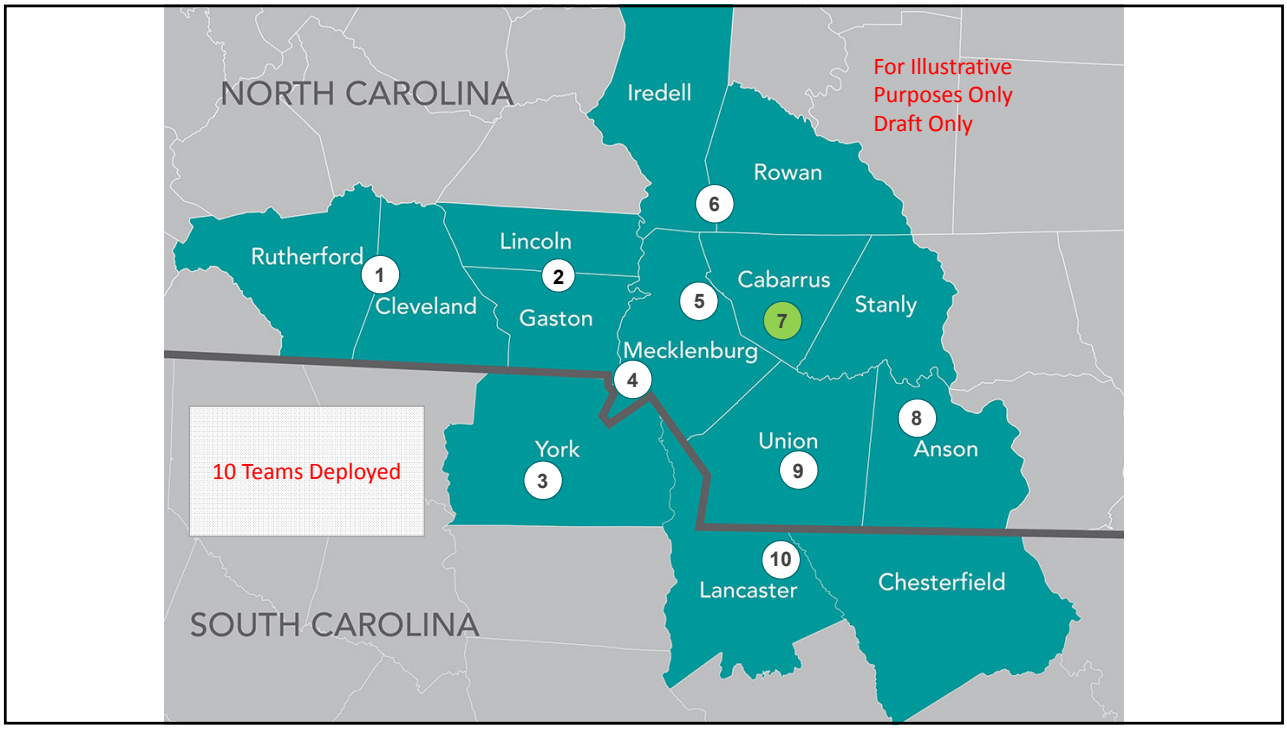
Community Resource Hub



1,455
Programs

339
Activated Community Service Providers

15 organizations are partnering with Atrium Health's Community Resource Hub, bringing nearly 1,000 engaged programs to serve the greater Charlotte area.



Atrium Health's Pledge

GOAL I
Collection, Stratification & Use of Data

- ✓ Demographic Data Platform
- ✓ For All Health Equity Goal

GOAL II
Cultural Competency Training

- ✓ Physicians & ACPS
- ✓ RNs
- ✓ Other Clinical Professionals
- ✓ Non-Clinical, Patient-Facing Teammates

GOAL III
Diversity in Leadership & Governance

- ✓ Men's Diversity Leadership Program
- ✓ Women's Executive Leadership Program

GOAL IV
Community Partnerships

- ✓ ONE Charlotte Health Alliance

Scale Focused Programs to Measure Impact

Mental Health First Aid

QUIT SMART

Tobacco Cessation

5210 LEAGUE

Obesity

Access

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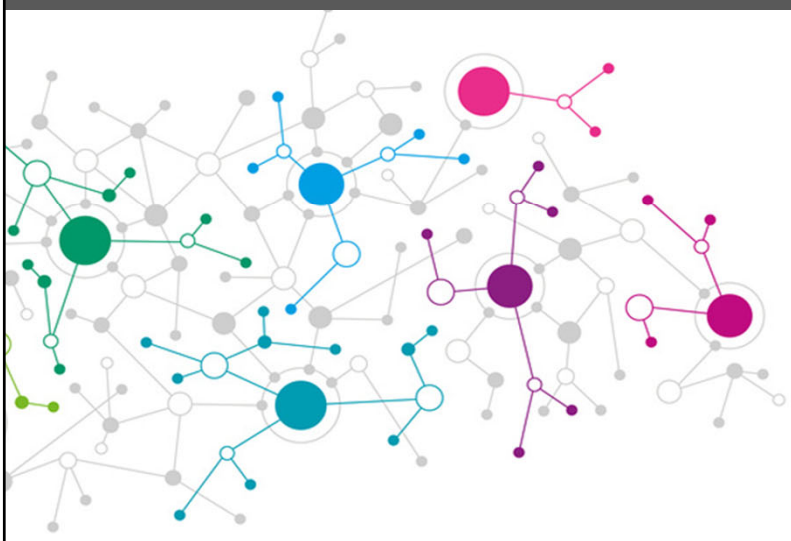
Connecting the Dots by Capturing New Data



Standardized Social Determinants of Health Screening for Physician Workflows

1. In the past 12 months, were you worried that your food would run out before you got money to buy more?
2. In the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non medical meetings/appointments or getting things that you need?
3. Are you worried or concerned that in the next two months, you may not have stable housing?

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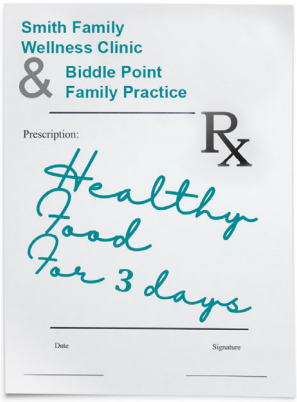
Mobile Health Units

Mobile Food Pharmacies



Healthy Communities Scscorecard

ONE CHARLOTTE HEALTH ALLIANCE

What do we need to do differently to successfully manage the populations we are at risk for today?

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Focus on 'At-Risk' Population

Why Focus on 'At-Risk' Populations?

- No Regret Strategy
- Access to comprehensive data sets
- Tracking and monitoring of performance across defined measures
- Focused direction for initial deployment of limited system resources (i.e. care managers & coders)
- Foundation from which to Scale

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Investing in new IT capabilities

To support our population health priorities

To effectively manage a population requires more than interoperable data. It requires

- **Data -> Insight**
- **Insight -> Action**
- **Action -> Outcomes**

across the continuum.

Assembling Clinician-Led Workflow Integration

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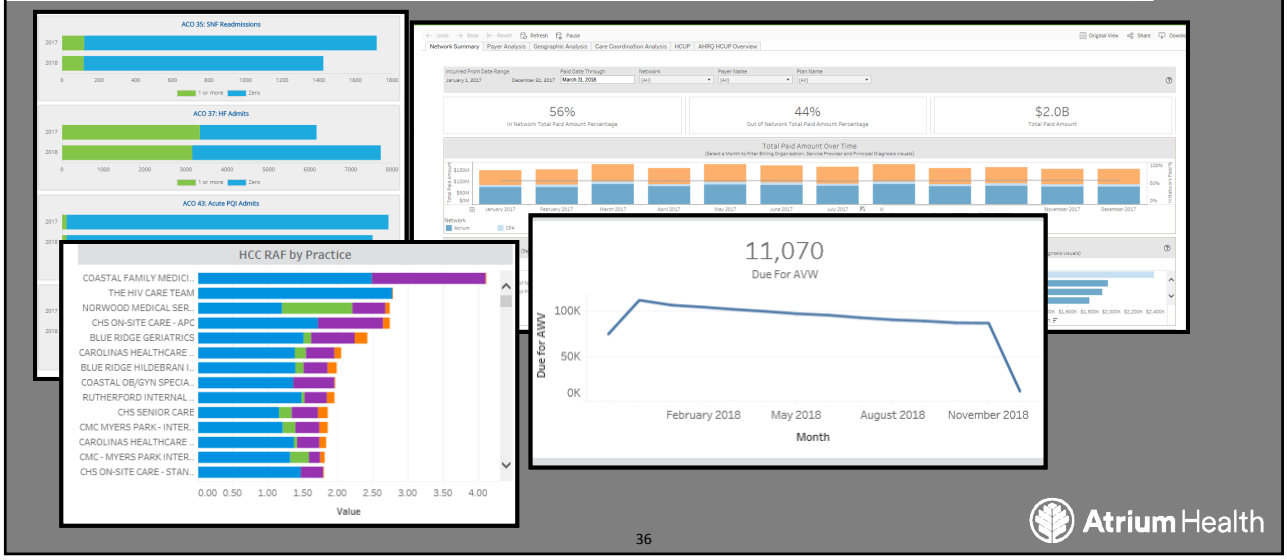
Performance Dashboards



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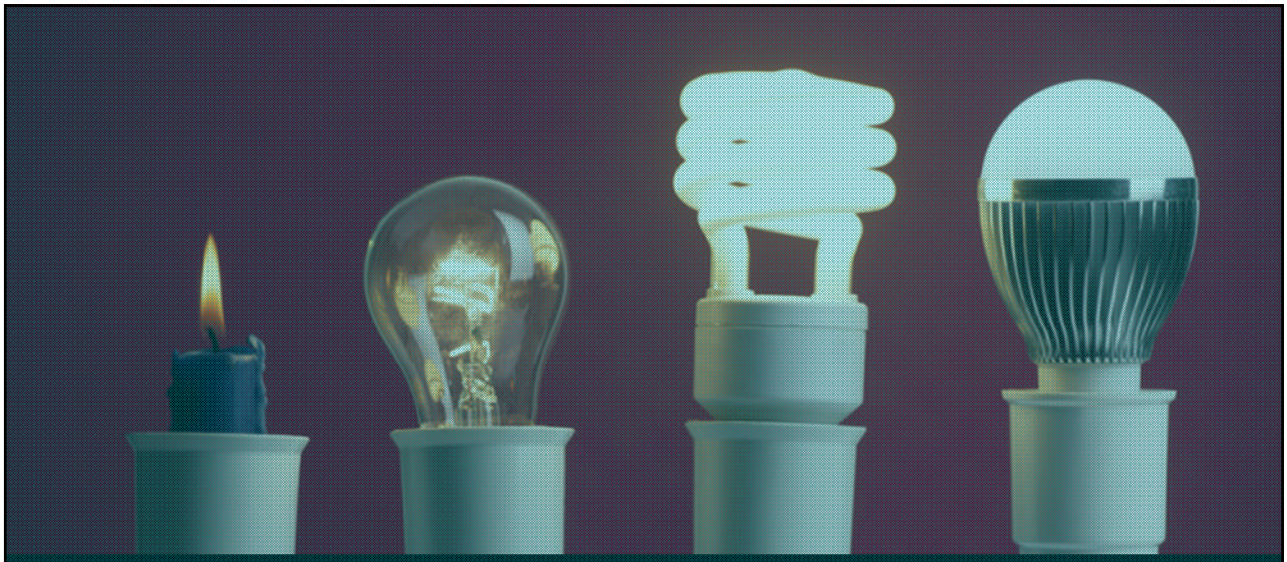
Care Management

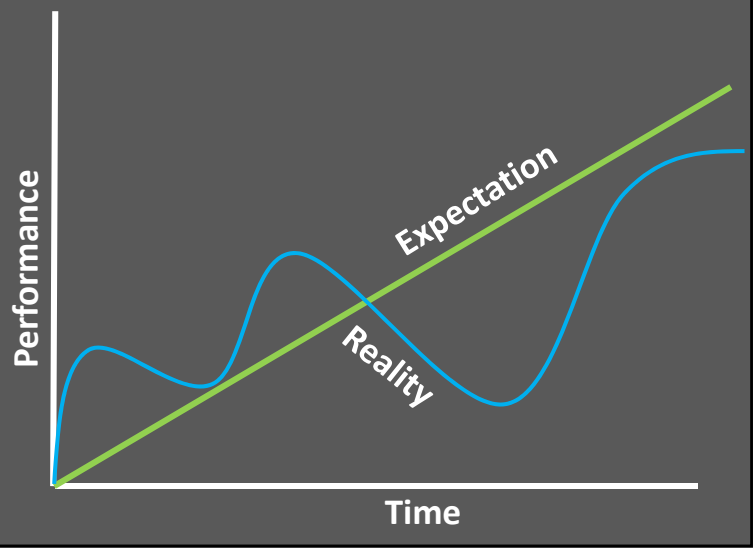


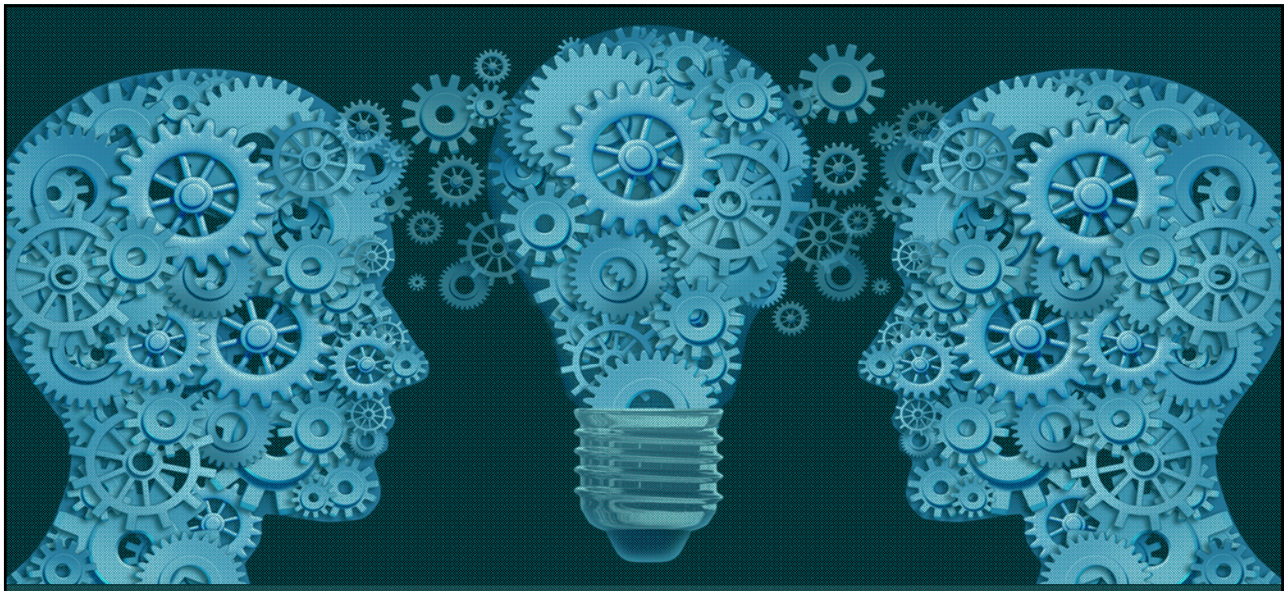
Iterating Current Initiatives

Caring for Large Populations

With over **99,000** assigned Medicare Beneficiaries, the Carolinas HealthCare System ACO, LLC Is one of the ***largest*** ACOs in the country.

Success or Luck?

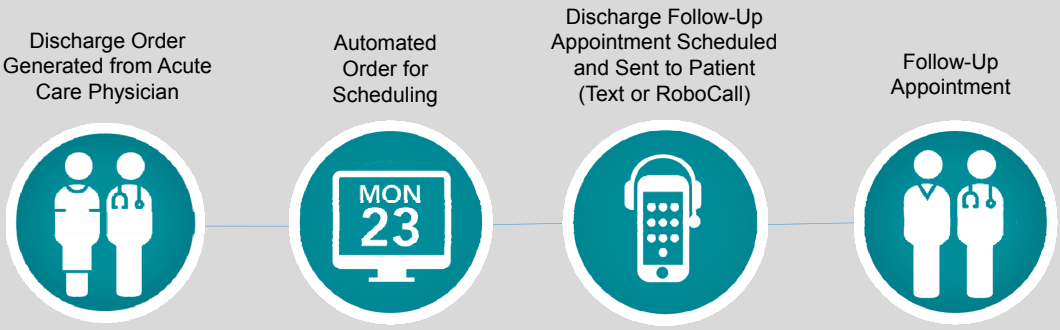




Continuing to Innovate

Focusing on Readmissions

Post Discharge Follow Up



Status Report:
Scheduled Discharge Follow Up with PCP: 70-80%
Arrival Rate within All Risk Bands:
- 81.9% Within 30 Days of Discharge (20% Baseline)

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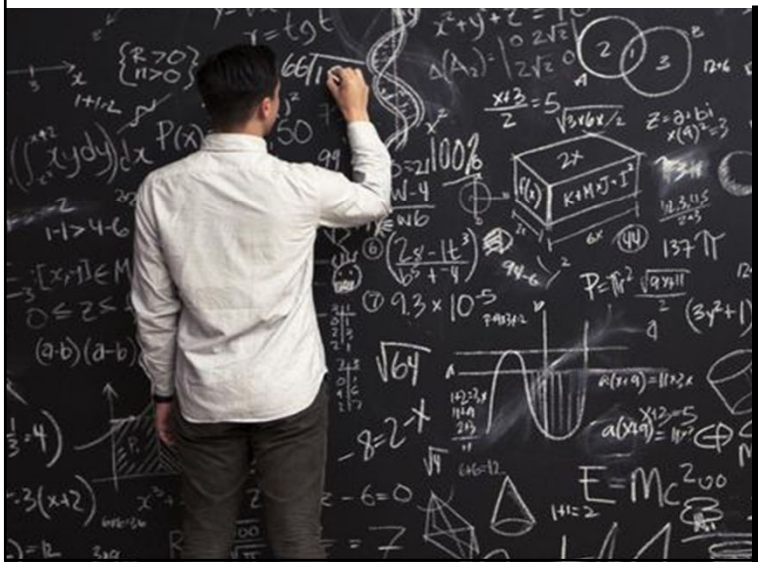
Examining the Post Acute

Skilled Nursing Facility Network



To improve outcomes and overall Medicare spend

To establish the largest, best network

To focus on partnership and shared accountability

To proactively address opportunities for improvement

We want to partner with facilities that share a **Vision** and **Commitment** to **Quality**

Next Steps

- Continued Infrastructure Development
- Care Management Alignment
- Partnerships with Community Organizations

- Enhanced Benchmarking
- Improving Outcomes
- Fostering an Accountable Community

Disruptive Developments

Source: Modern Healthcare

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Keys to Staying Ahead

Sticking to our Strategic Beliefs:

- Value is defined by the **customer** – those who consume care and those who pay for it
- Long-term financial viability requires delivering value through **sustainable** models
- The ability to keep individuals and populations **healthy** is a key determinant of future success

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Destination 2020

Improving Lives within Sustainable Value Based Care Models