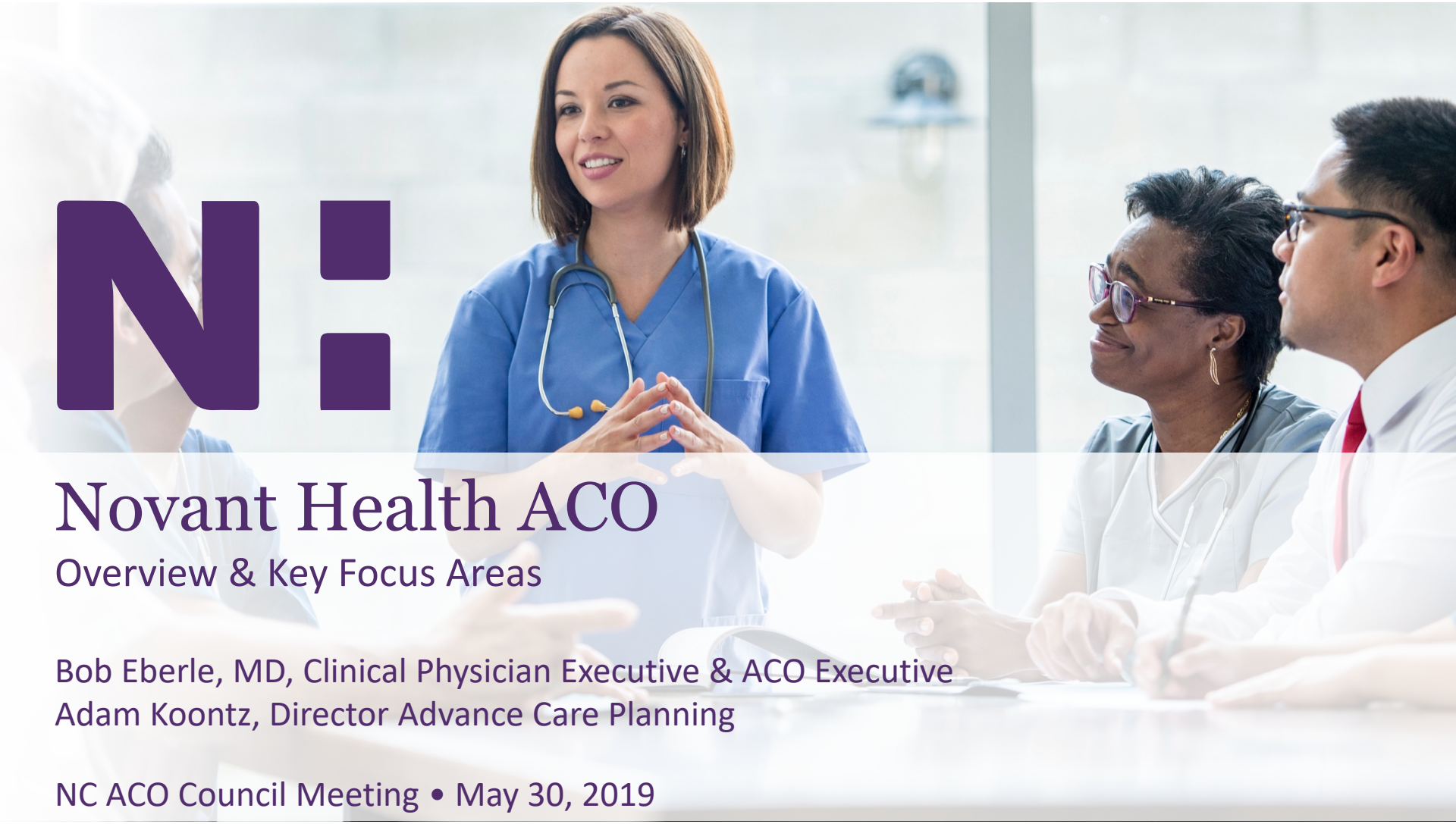

Novant Health ACO

Overview & Key Focus Areas

Bob Eberle, MD, Clinical Physician Executive & ACO Executive
Adam Koontz, Director Advance Care Planning

NC ACO Council Meeting • May 30, 2019

NOVANT HEALTH

Agenda

1. **Novant Health & ACO Overview**
2. **2017 & 2018 Performance**
3. **Successes**
4. **Choices and Champions**
5. **2019 Priorities**
6. **Questions**

NOVANT HEALTH

The mission that drives us and the values that guide us

Mission

Novant Health exists to improve the health of communities, one person at a time.

Vision

We, the Novant Health team, will deliver the most remarkable patient experience in every dimension, every time.

Safety ▪ Quality
Authentic personalized relationships
Voice & choice ▪ Easy for me
Affordability

Values

Diversity and Inclusion
Teamwork
Personal excellence
Courage
Compassion

Our people

We are an inclusive team of purpose-driven people inspired and united by our passion to care for each other, our patients and our communities.

Our promise

We are making your healthcare experience remarkable. We will bring you world-class clinicians, care and technology — when and where you need them. We are reinventing the healthcare experience to be simpler, more convenient and more affordable, so that you can focus on getting better and staying healthy.

NOVANT® HEALTH

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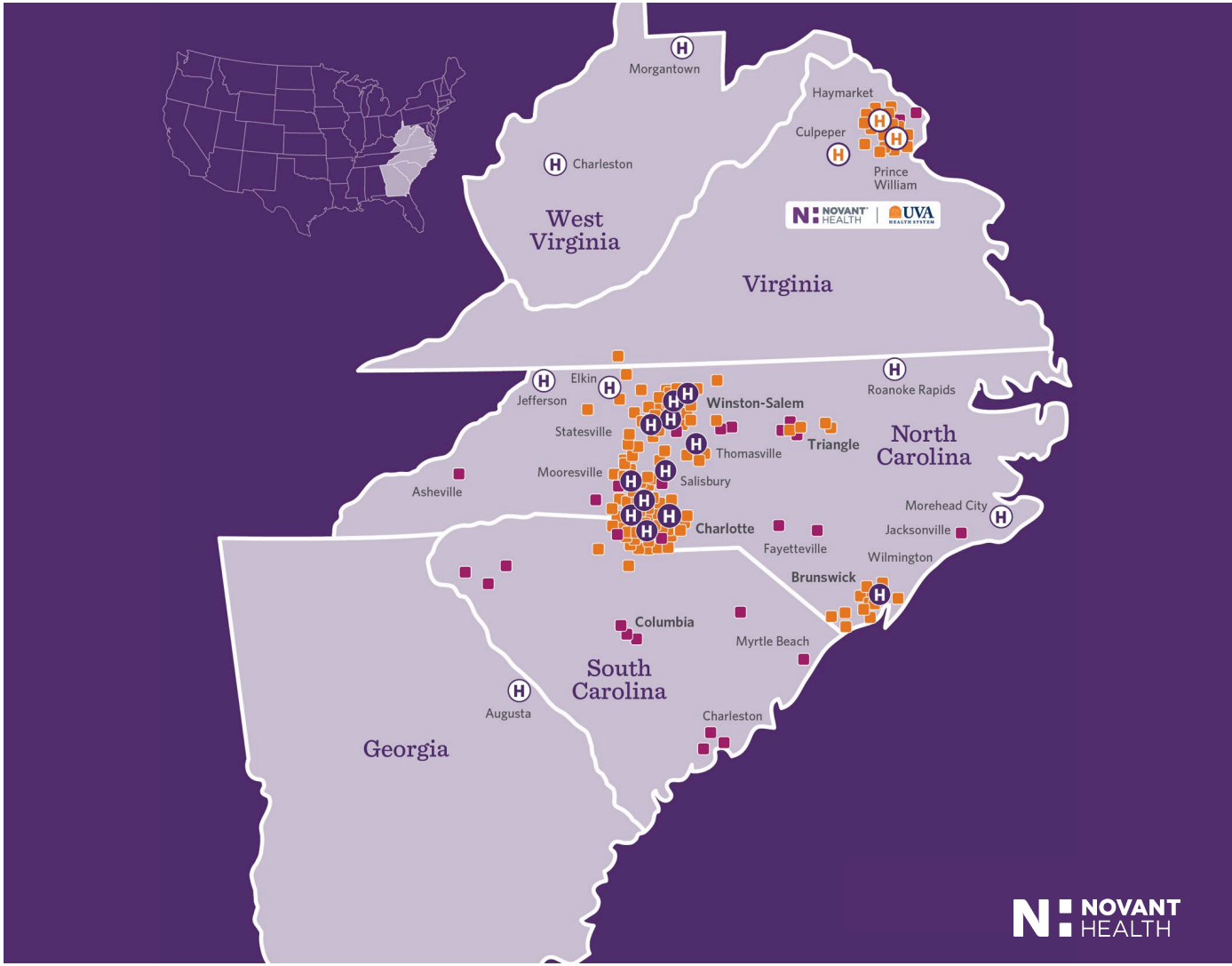
Novant Health medical centers

Novant Health UVA Health System medical centers

Hospitals with an Adept Health agreement

Physician offices

Imaging centers



Note: Markers are for geographic illustration only and do not necessarily represent individual clinics.

ACO Overview

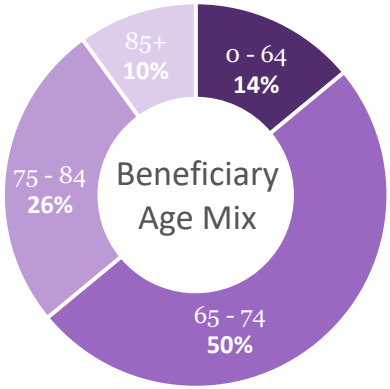
Track 1
Medicare Shared Savings Program (MSSP) ACO

79,174
Assigned Beneficiaries

2,709
Providers

2017
1st Performance Year

Year 3
of 1st Agreement Period



NOVANT HEALTH

2017 Performance

2017 by the numbers

Savings

1.83%
Savings Rate

$12.5 million
Generated Savings

Utilization
2016 to 2017

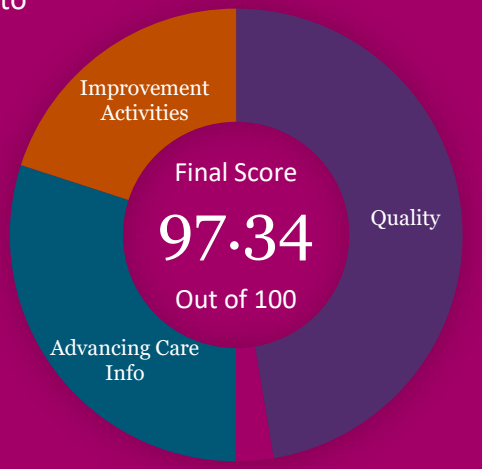
↓ 15%
Decrease in SNF Expenditures

↓ 17%
Decrease in SNF Discharges/1,000

↓ 3%
Decrease in ED Visits/1,000

MIPS/Quality

1.73%
Positive Adjustment to Medicare Part B Payments in 2019



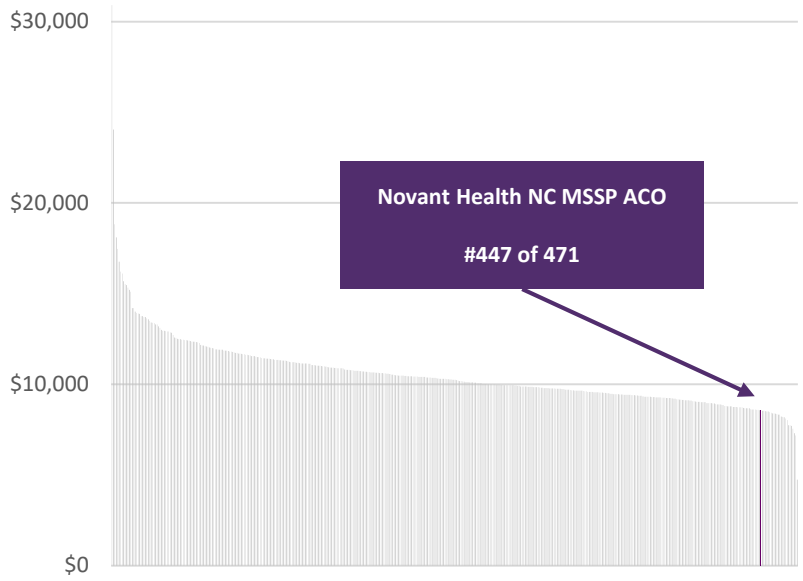
Cost

$8,797
PMPY Expenditures

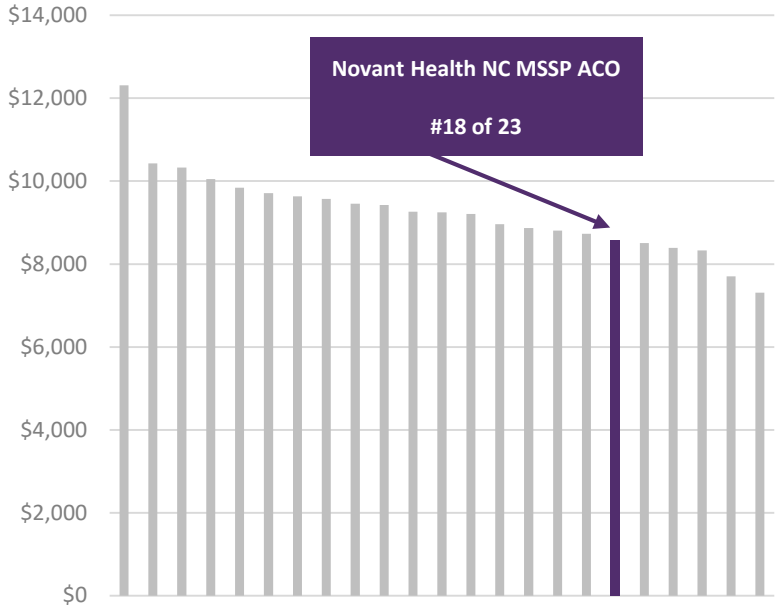
$673 million
Total Cost of Care

Novant Health ACO PMPY Expenditures

National Comparison



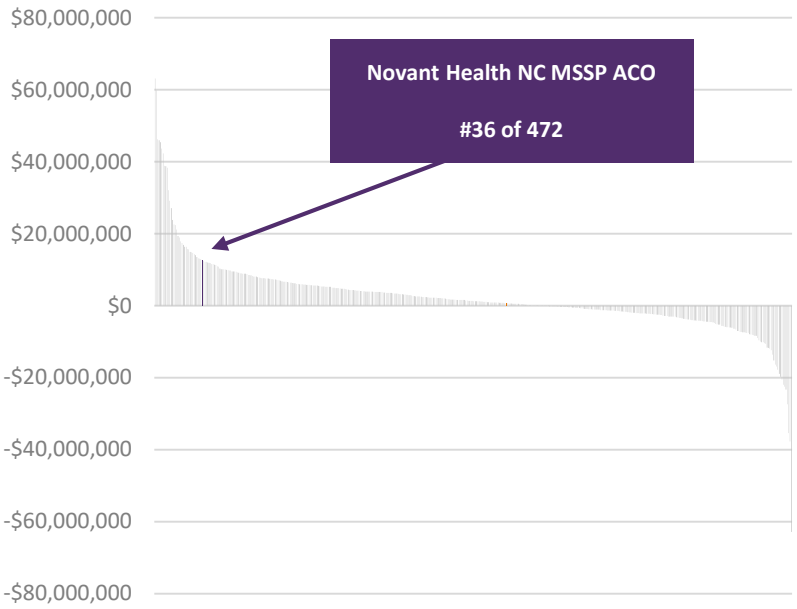
State Comparison



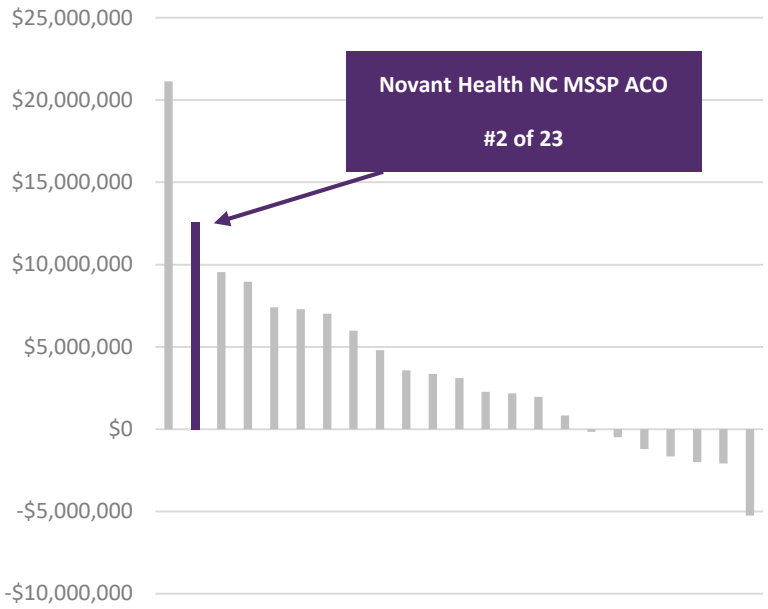
Source: 2017 CMS ACO Public Use File
Based on number of Assigned Beneficiaries

Novant Health ACO Performance Against Benchmark

National Comparison



State Comparison



Source: 2017 CMS ACO Public Use File

2018 Performance

2018 by the numbers

Savings

% Savings Rate

?

$ Generated Savings

MIPS/Quality

?

% Positive Adjustment to Medicare Part B Payments in 2020

Utilization

2017 to 2018

↓ 12.9% Decrease in SNF Expenditures

↓ 5.9% Decrease in SNF Discharges/1,000

↓ 2.9% Decrease in ED Visits/1,000

Cost

$9,173* PMPY Expenditures

$ 709 million* Total Cost of Care

*Estimate based on Q4 2018 CMS Reports

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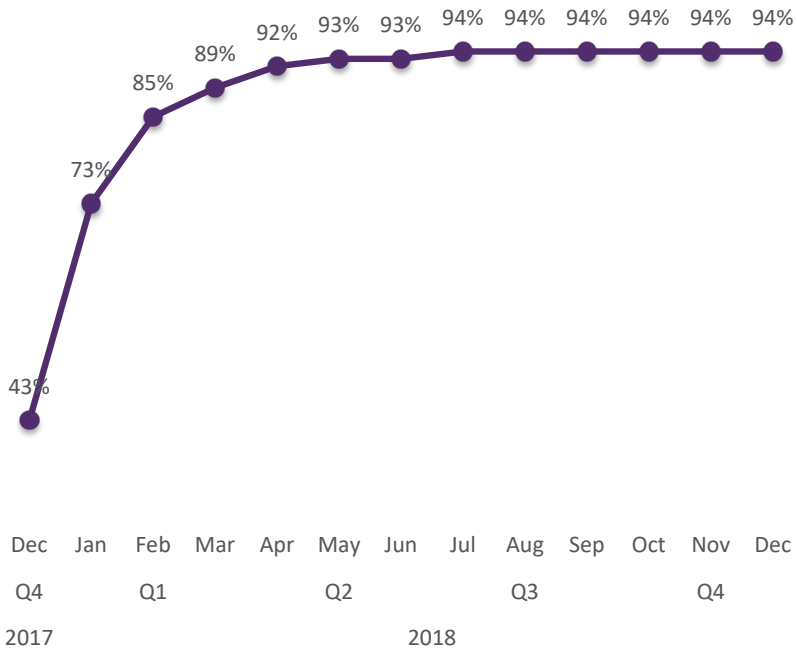
ACO Successes

Physician Compensation, Annual Wellness Visits, Complex & Transitional Care Management Pilots, Choices and Champions

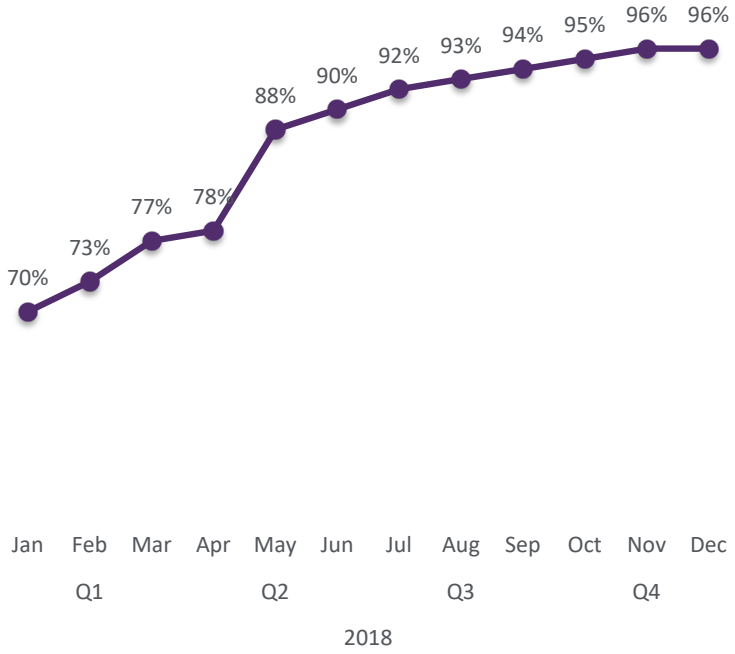
2018 Physician Compensation

Non-productivity Metric Results

Choices and Champions



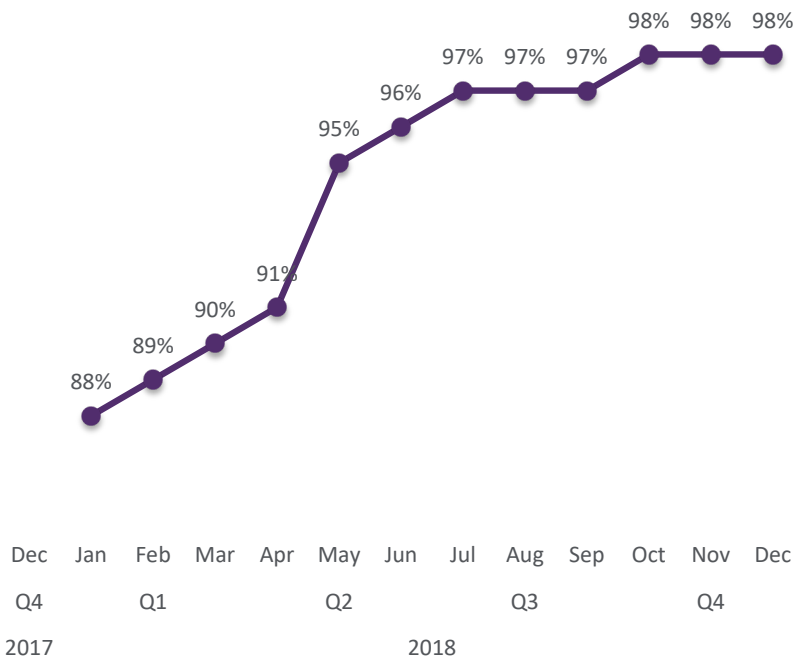
BMI Screening and Follow Up Plan



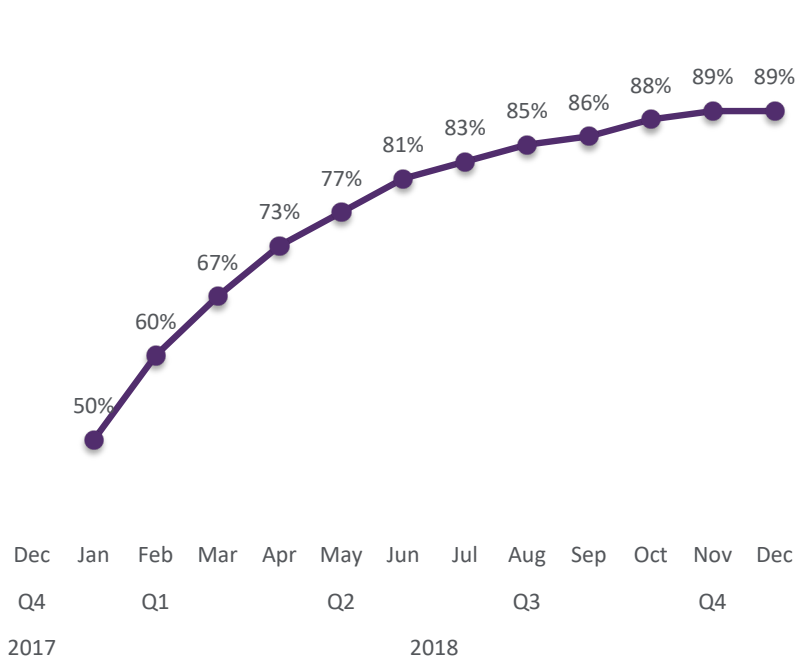
2018 Physician Compensation

Non-productivity Metric Results

Tobacco Screening and Follow Up Plan



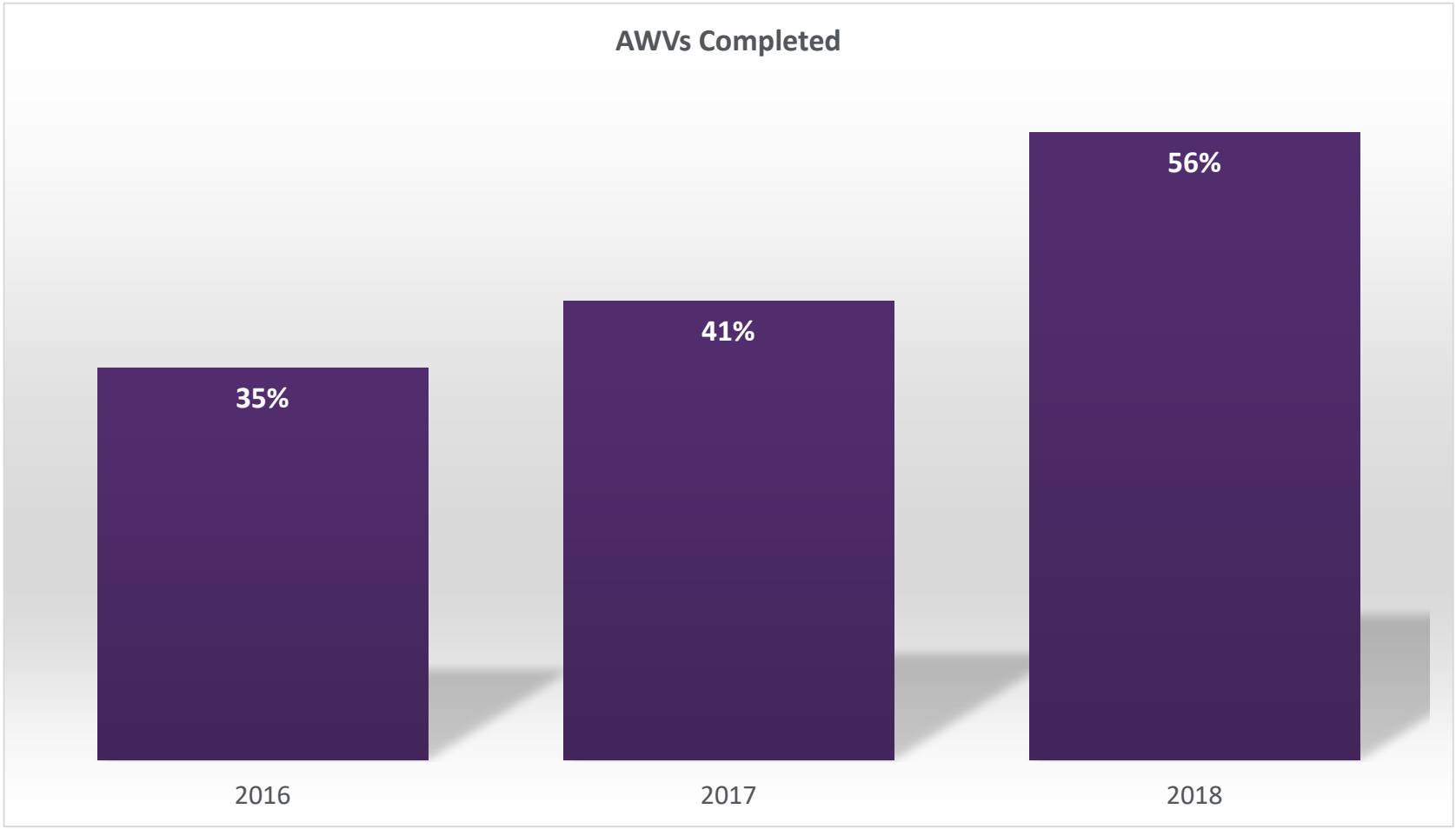
Depression Screening and Follow Up Plan



Medicare Annual Wellness Visits (AWVs)

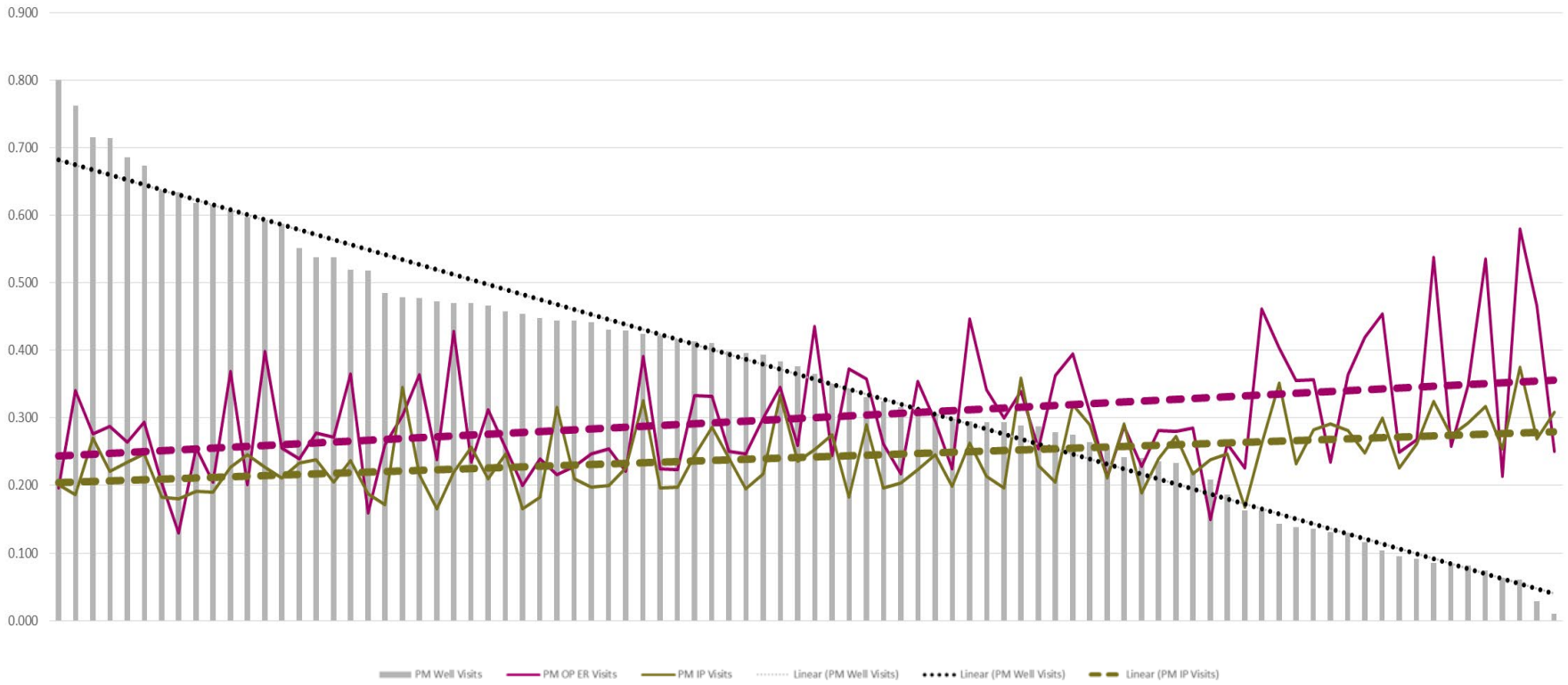
- Opportunity to improve health and welfare of patients
- It affords time for a clinician or team member to have crucial conversations
  - Identify and act on outstanding health maintenance items
  - Shared goal setting
  - Prevention, detection and slowing progression of chronic conditions
  - Opportunity to update Hierarchical Condition Categories (HCC) annually
- Enhance patient and provider experience
- New revenue stream
- Gain valuable experience in providing patient-centered, team-based care; aligns with value-based models of reimbursement
- Highly successful organizations have adapted AWVs as a focus area to drive outcomes
- Lowering healthcare costs while meeting performance standards on quality of care through MSSP

Annual Wellness Visit Success



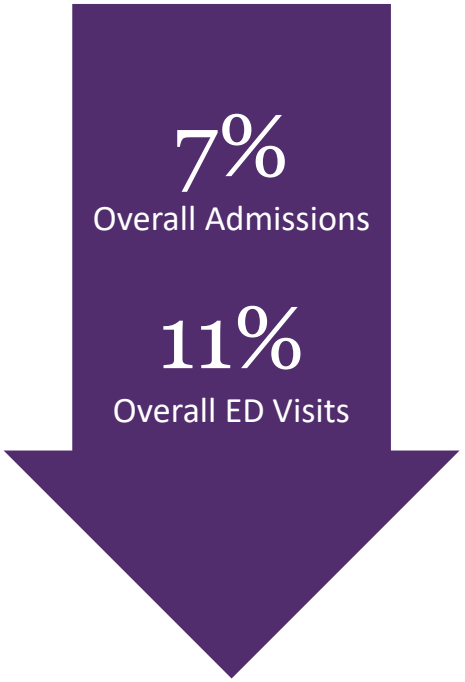
2017 Results Demonstrate Correlation

AWV Completion, ED Utilization, and IP Admissions



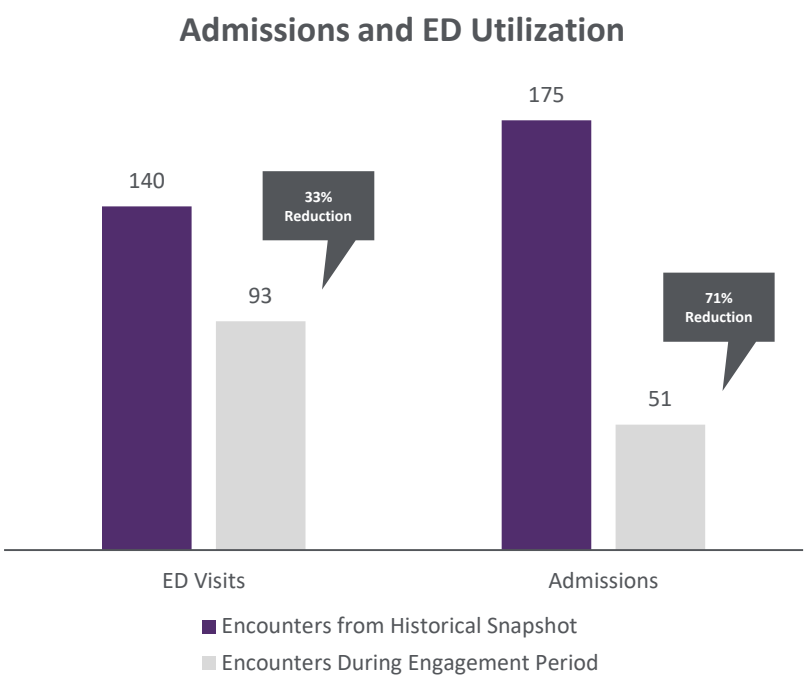
Complex Care Management & Intervention Pilot

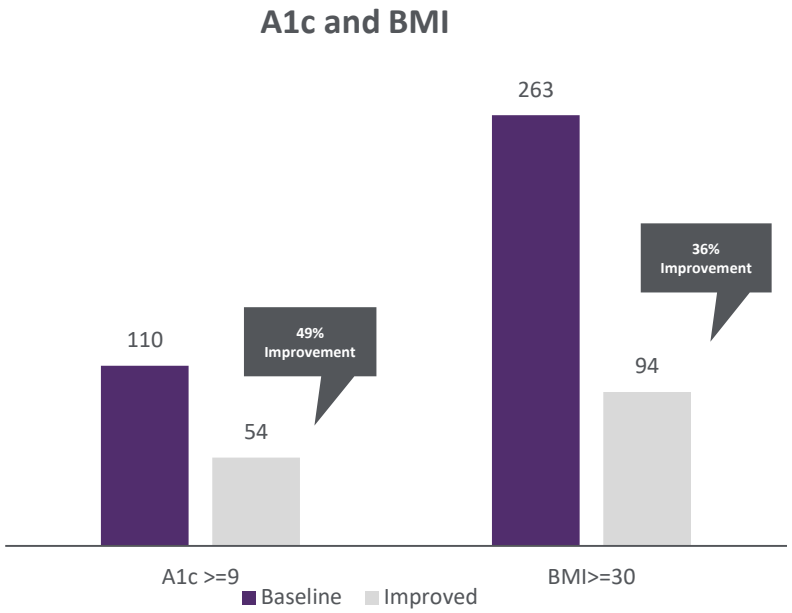
- **Primary Goal**: Facilitate complex care management and intervention for high risk, high acuity patients
- **Initial Population**: MSSP patients identified with frequent admissions/readmissions and chronic condition including COPD, diabetes, and heart failure across all markets
- **Dates**: October 2017 to April 2018
- **Process**: Embedded nurses in 6 clinics to:
  - Identify barriers
  - Reduce care variation
  - Reinforce understanding of disease process
  - Provide self-management education
  - Facilitate medication review
  - Produce new revenue stream



Complex Care Management & Intervention Pilot

Outcome data from a subset of pilot population where specific data prior to the pilot identified need for targeted interventions*





*Patients with 2 or more ED visits or Admissions during the 12-month baseline period

Complex Transitional Care Management (TCM) Pilot

- **Primary Goal**: Facilitate safe transition of care for high-risk, high-acuity patients
- **Initial Population**: MSSP patients living in the Coastal Market with NHMG Coastal Market PCP with frequent admissions/readmissions, disease focus includes COPD, diabetes, and heart failure
- **Launch Date**: August 1, 2018

Patient Touch Points

- Hospital visit prior to discharge
- Documented initial TCM outreach within 2 days
- Home visit(s) as indicated and appropriate
- Ongoing complex care management during transitional care period

Pilot Features

- Communication plan to PCP prior to post-hospital visit
- Referrals as appropriate to Care Connections and partner with PCP for specialty referrals as needed
- Addressing SDOH by engaging family members, community resources, etc.

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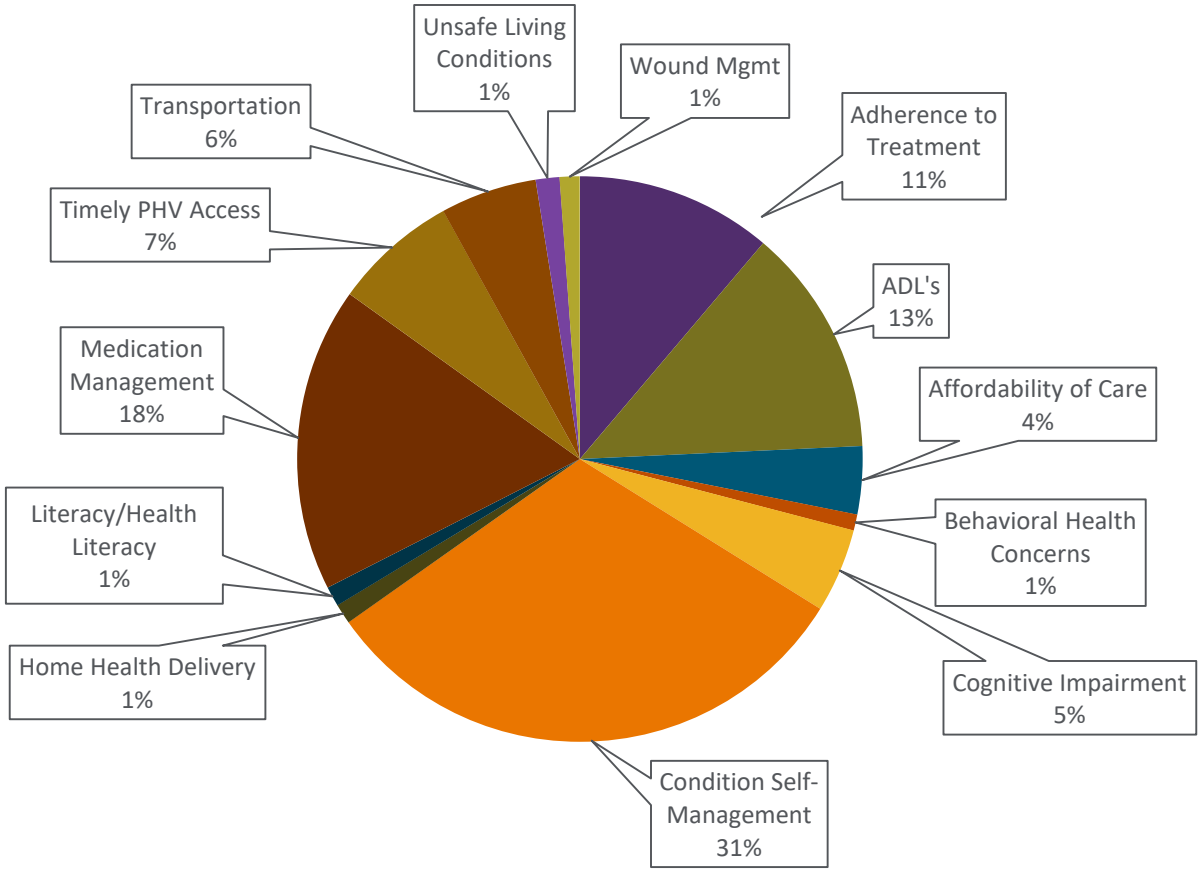
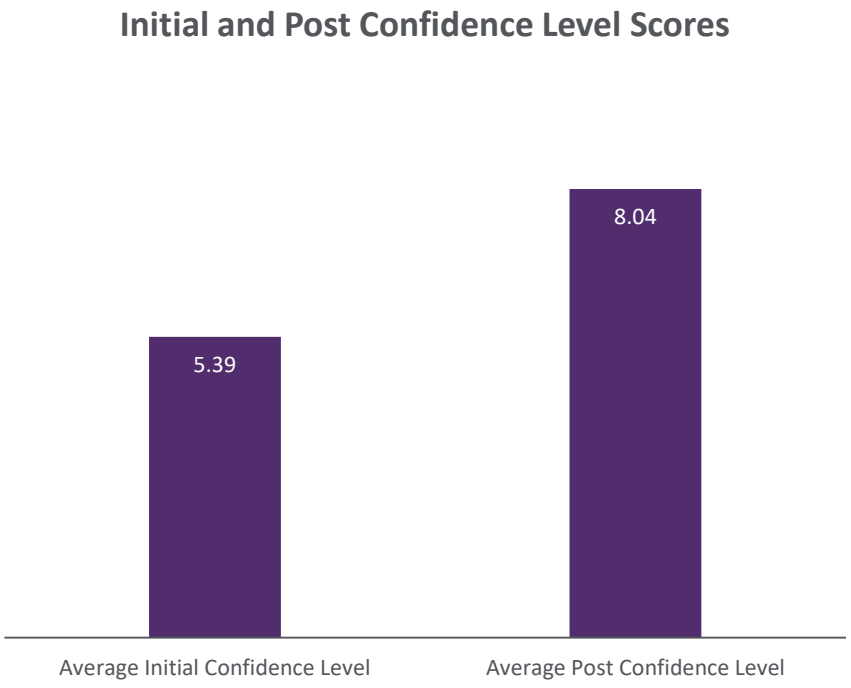
A Community Perspective: TCM Pilot Patient Barriers



TCM Pilot Patient Care Self-Management Confidence Levels

- We recently began collecting data from patients on their confidence to manage their health and conditions at home after discharge on a scale of 0-10*
  - 0 = not at all confidence
  - 10 = very confident
- Initial data was collected at the first contact post-discharge and the final (post) data collected when the patient has completed the 30 day transitional care period.
- Overall, 48 patients had an initial and post- level score reported.



*Data collection implemented beginning 11/1/18

Patient Story: DKB – Moderate Complexity

Clinical Concerns

72 years old

PMH: COPD, CHF, anxiety, diabetes type 2

4 hospitalizations in last 12 months

3 hospitalizations prior to RN engagement

Healthy Opportunities (SDOH)

Admitted with diabetic hypoglycemia

Anxious about blood sugar continually dropping

Timely access to PHV—scheduled for 14 days post discharge (patient did not keep appointment as they were out of town for the holidays)

No glucometer in the home

Interactions

1 hospital visit, 1 home visit, 2 calls

Engagement: 12/18/18-1/18/19

Interventions

Contacted PCP for "Medicare paid" Glucometer prescription including supplies

Educated patient and spouse how to use glucometer

Reviewed COPD and CHF action plans

Reminded patient to reschedule follow-visit with PC

Impacts

Initial Confidence Score: 4

Follow-Up Confidence Score: 9 (after glucose education)

Follow up call on 12/27/18 found them enjoying vacation in Charlotte with an average morning blood glucose of 128

Patient Story: JCB – Moderate Complexity

Clinical Concerns

69 years old

COPD, tobacco use

0 Hospitalizations in the last 12 months

Healthy Opportunities (SDOH)

2 months of worsening COPD and bronchitis problems (frequent PCP visits)

History of tobacco abuse since 18 years old

Decrease in ambulation and activities due to SOB

Lack of medication knowledge

Lack of self-management skills

Anxious

Transportation issues: patient unable to safely operate vehicle

Interactions

2 hospital visits, 3 calls, 1 home visit, 1 PHV in 7 days

Engagement: 12/28/18-1/28/19

Interventions

Active listening and motivational interviewing to help reduce anxiety

Medication management

Education on O2 equipment, COPD—including Krames booklet and Action Plan

Coordinate follow-up care with transportation

Coordinate care with PCP, specialist, and HH

Impacts

Initial Confidence Score: 0

Follow-Up Confidence Score: 7
(after initial home visit)

"Just knowing someone is available to answer questions makes me feel calmer"

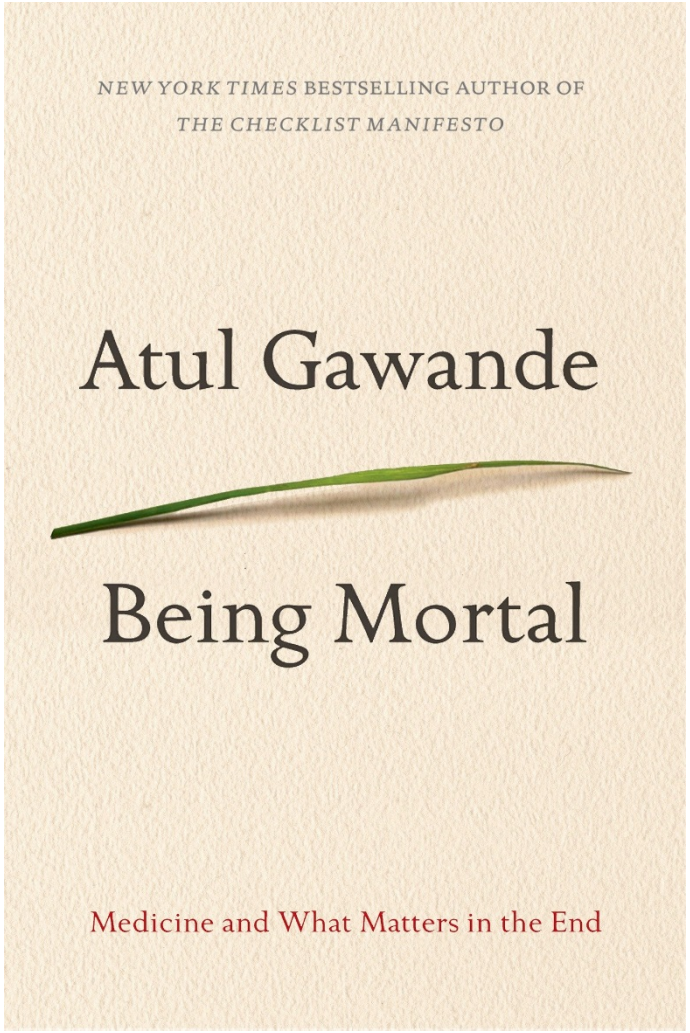
Choices and Champions

Transforming culture to transform care at end of life

From	To
Waiting till the end of life to start planning for end of life	Talking about advance care planning across the care continuum from wellness to death
Focusing on disease	Beginning with goals of care and using these to guide our treatment recommendations
Feeling like a “failure” when we can no longer treat or cure	Treating the whole person and helping our patients finish life’s journey with dignity

Novant Health Reads

- Distributed >8,000 copies
- Discussion groups held across the system throughout the year
- Dr. Gawande spoke at NHFMC on Tuesday, October 20 2015



3 year Long Term Goal - Readmissions

Retrospective analysis:

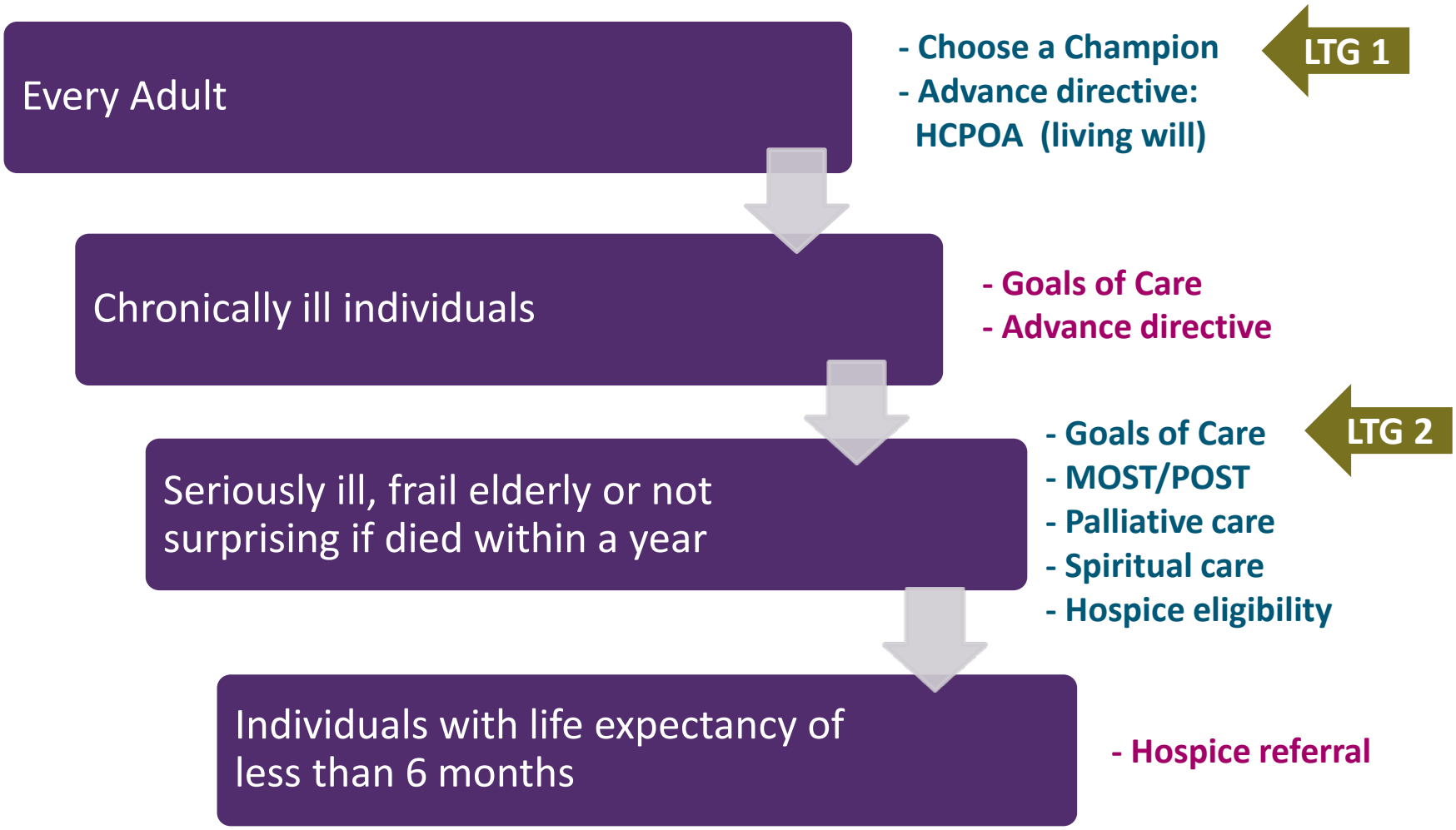
If hospice screening tool was implemented with Case Management and/or Care Coordination

- 13 HF patients were medically appropriate for hospice on index admission
- All 13 patients would have triggered *"Would you be surprised if the patient died within the next year" question*
  - 12 patients would recommend goals of care conversation and hospice consult
  - 1 patient would recommend palliative care consult

Anecdotal comments:

- ***3 patients still under hospice with no subsequent readmissions***
- *9 patients now deceased with average hospice length of stay = 6.2 days (median of 4 days)*

Choices and Champions across the continuum of care



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Choosing a healthcare Champion

At check in, all adult patients are now asked:

"At Novant Health, we ask all our patients to choose a healthcare Champion. Who do you trust to speak for you if you are unable to make your own medical decisions?"

NHMG metric navigator

Metric	Age	When BPA fires
Choices and Champions	18 and over	No documentation of a healthcare “Champion”
Tobacco Use Screening and Cessation Intervention	12 and over	No screening for tobacco use within the last 12 months or no cessation counseling if a user within the last 12 months
Depression Screening	12 and over	No screening for depression in last 12 months without an active diagnosis related to depression
Adult BMI Screening and Follow-up	18 and over	BMI of 30 kg/m2 or over and no follow-up plan documented within 6 months of the current encounter
Pediatric BMI Assessment and Intervention	3 to 18 years	BMI greater than 95th percentile for age

2017-2019 long term goal

Choices and Champions – Metric 1

% of All* patients age ≥ 18 with an Office visit/month who have a Champion Documented														
5/6/2019	Service line	October 2016	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	LTG Target
		**													
Ambulatory	Behavioral Health	1.1%	84.9%	84.5%	84.3%	87.5%	86.4%	90.6%	89.3%	91.3%	92.9%	90.0%	91.5%	92.2%	75.0%
	Cancer***	1.7%	90.6%	90.5%	90.0%	91.7%	91.8%	92.8%	92.9%	91.8%	92.5%	91.2%	90.8%	90.4%	75.0%
	Community Medicine***	N/A	93.7%	94.1%	94.2%	94.5%	94.7%	94.7%	94.8%	95.0%	95.2%	95.2%	95.2%	95.4%	75.0%
	Heart and Vascular	1.6%	92.9%	93.5%	93.6%	94.1%	93.8%	93.0%	93.0%	92.8%	93.4%	93.9%	93.6%	94.1%	75.0%
	Hospital Medicine***	N/A	94.8%	93.7%	93.5%	95.6%	96.3%	96.8%	95.6%	94.3%	95.7%	95.5%	95.3%	95.2%	75.0%
	Neurosciences	1.1%	95.3%	95.5%	95.9%	95.7%	95.2%	94.6%	95.0%	95.4%	96.0%	96.1%	95.5%	95.4%	75.0%
	OB/GYN***	0.21%	93.4%	92.8%	92.5%	92.9%	92.2%	92.9%	94.3%	93.5%	94.6%	95.1%	94.9%	94.7%	75.0%
	Orthopedics	1.1%	88.4%	89.3%	91.0%	91.8%	92.2%	92.2%	92.4%	91.6%	92.2%	92.2%	92.4%	92.9%	75.0%
	Pediatrics***	N/A	88.4%	90.9%	93.3%	93.3%	91.4%	90.7%	91.4%	91.4%	92.2%	93.5%	92.1%	94.9%	75.0%
	Surgery	1.5%	92.0%	93.3%	94.1%	94.7%	94.4%	93.8%	94.4%	93.5%	94.9%	95.4%	95.6%	95.5%	75.0%
	NOVANT	1.1%	93.2%	93.5%	93.7%	94.0%	94.0%	94.1%	94.4%	94.3%	94.8%	94.8%	94.8%	95.0%	75.0%

At or above NH Corporate target of 75%

>/= to Baseline

Less than Baseline

*Urgent Care, Express Care, and Ambulatory Surgical Centers are not included

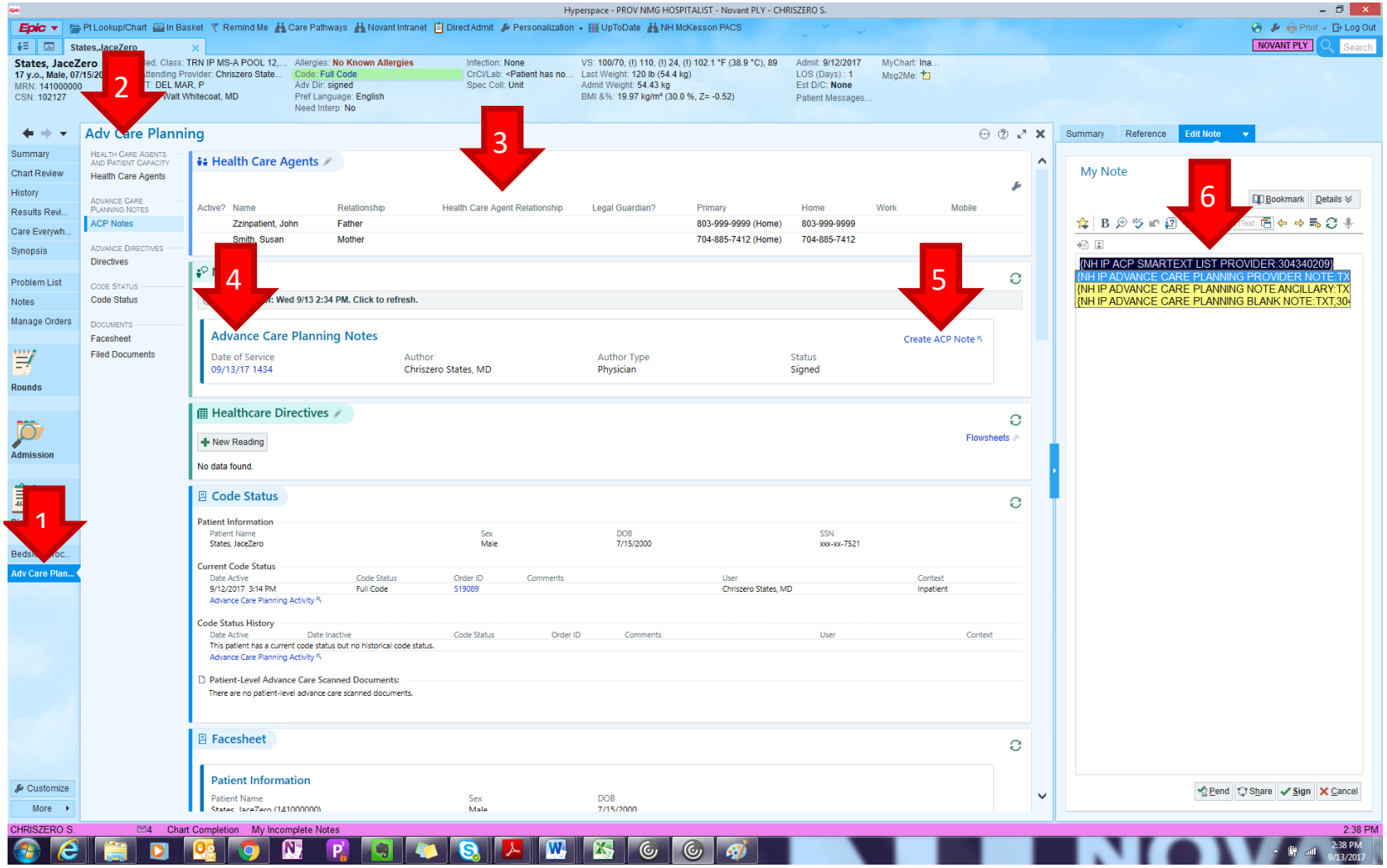
** Data is cumulative based on April changes in scope-dates unavailable for monthly distinction

***Service Line names changed/added/removed to align with current glossary

Jan 2018 forward reflects only those practices "Active" on Jan 1 2017

Analytics and Informatics

Dimensions ACP navigator



Initiating the conversation on goals of care

For anyone: What matters most to you?

For every adult / well patients:

1. What does a good day look like for you?
2. What gives your life meaning?
3. What do you look forward to getting back to after this hospitalization/illness/surgery?
4. What's on your bucket list?

For the chronically/seriously ill:

1. What do you understand about your illness?
2. How has your good day changed since I last saw you?
3. What are your hopes? Fears?
4. Have you thought about what tradeoffs you are willing to make?

2017-2019 long term goal

Choices and Champions – Metric 2

% of All Medicare patients admitted/month who have Advance Care Planning Note Documented																
5/16/2019	Facility	Jul-Dec 2016 Baseline	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	LTG Target
		***														
ACUTE	NHBMC	0.2%	9.0%	14.3%	16.7%	20.6%	18.8%	24.8%	27.5%	31.8%	65.6%	73.6%	87.7%	88.3%	97.1%	75.0%
	NHCOH	1.2%	8.0%	19.1%	16.2%	15.8%	22.2%	55.4%	73.8%	78.3%	78.3%	77.0%	84.7%	83.1%	76.6%	75.0%
	NHFMC	1.7%	38.5%	44.0%	43.5%	47.8%	50.8%	55.4%	58.6%	60.8%	62.3%	65.9%	67.9%	66.8%	67.3%	75.0%
	NHHAMC	0.3%	36.0%	9.7%	22.9%	26.7%	38.2%	58.7%	66.1%	72.7%	72.6%	79.2%	65.3%	78.9%	68.4%	75.0%
	NHHMC	14.0%	47.6%	54.9%	45.9%	51.8%	54.9%	63.0%	64.0%	64.1%	66.8%	76.3%	75.9%	75.2%	79.5%	75.0%
	NHKMC	1.2%	17.9%	12.5%	27.5%	49.0%	45.6%	53.9%	49.6%	50.7%	67.9%	58.7%	54.3%	64.7%	54.8%	75.0%
	NHMMC	9.9%	63.8%	63.5%	70.7%	71.0%	71.9%	73.8%	73.3%	72.9%	80.6%	76.6%	81.7%	83.2%	83.1%	75.0%
	NHMPH*	0.5%	0.0%	44.1%	62.1%	61.8%	91.7%	75.0%	80.0%	79.3%	80.8%	79.4%	76.2%	83.3%	76.2%	75.0%
	NHPMC	6.7%	39.0%	45.0%	39.2%	39.4%	39.7%	49.6%	53.2%	49.3%	52.0%	53.7%	65.2%	65.4%	70.8%	75.0%
	NHPWMC	0.3%	15.1%	9.8%	18.7%	19.0%	18.5%	24.2%	40.9%	45.6%	47.5%	50.9%	63.0%	75.5%	68.4%	75.0%
	NHRMC	0.5%	12.4%	14.6%	11.6%	8.8%	12.3%	27.9%	60.0%	79.2%	72.1%	80.8%	79.0%	71.3%	75.6%	75.0%
	NHTMC	2.5%	25.4%	28.9%	30.8%	46.4%	38.7%	41.8%	43.2%	66.7%	84.7%	75.7%	73.2%	69.2%	65.4%	75.0%
	NOVANT	3.7%	34.1%	38.0%	37.8%	41.6%	43.4%	51.4%	57.2%	60.6%	65.0%	67.3%	71.1%	71.2%	72.3%	75.0%
	Facilities not in scope for final corporate roll-up for LTG															
****	NHCMC	N/A	18.0%	51.0%	81.0%	78.5%	87.0%	78.3%	79.8%	83.5%	84.9%	92.4%	89.0%	87.6%	90.6%	75.0%
*****	NHMHMC	N/A	N/A	N/A	N/A	N/A	N/A	N/A	81.1%	70.9%	73.0%	77.0%	82.4%	87.0%	76.1%	75.0%

At or above NH Corporate target of 75%

>/= Baseline

Less than Baseline

Analytics and Informatics

***Data for Q1 2017 has been changed to reflect the acquisition of the date field for the ACP note.

*Data reflective of OP pre-visit notes as of May 2018

****Monitoring progress.Effective 4-11-2019 nemoved NHCMC from ALL corporate roll-ups. Not IP facility when goal established

*****Monitoring progress but not included in corporate goal. Not in scope when goal established.

NOVANT HEALTH

Playing in the dirt…

Choices and Champions: 'Know Me' across the Care Continuum

Part A
Our well patients
< 15 minutes

1. Explain the roles of providers and the healthcare team in advancing conversations beyond Choose a Champion.
2. Demonstrate how eliciting your patient's goals of care ('know me') can provide clinically relevant information.
3. Illustrate how to document your conversations in the Dimensions ACP navigator (a 'know me note') so other members of the healthcare team can know and honor your patient's wishes.

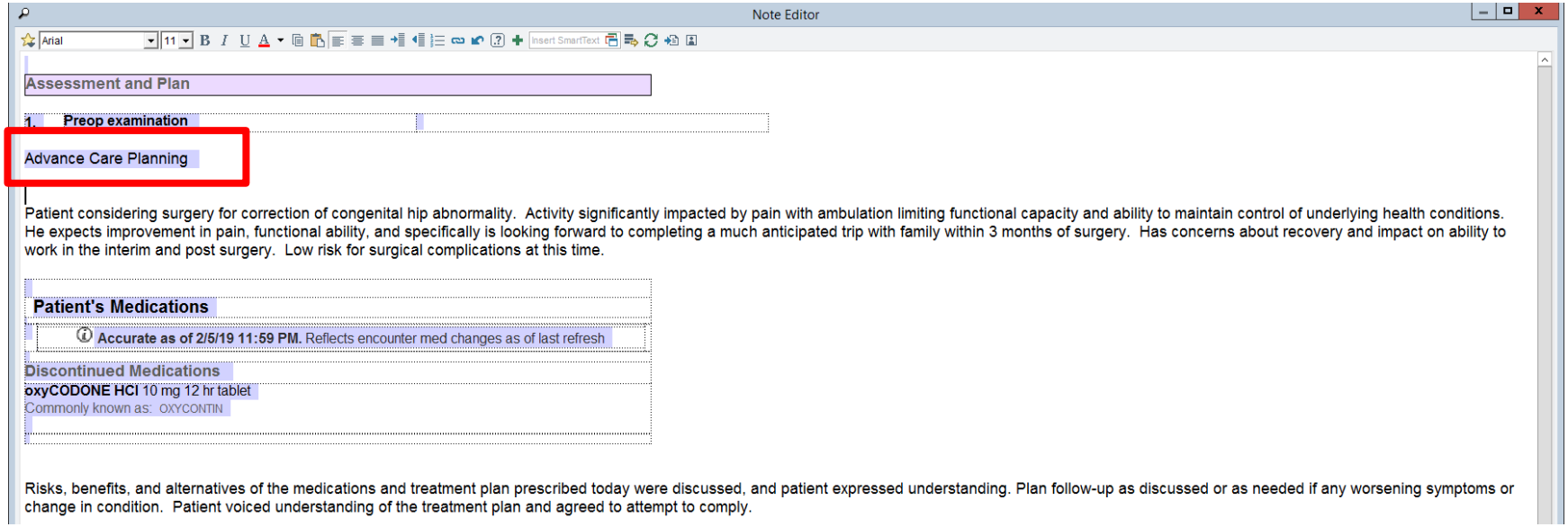
Part B
Our chronically & seriously ill patients
<30 minutes

1. Illustrate the importance of revisiting goals of care ('know me') conversations over time.
2. Explain how to identify patients who may need a more in-depth advance care planning conversation
3. Demonstrate a conversation framework to facilitate serious illness conversations

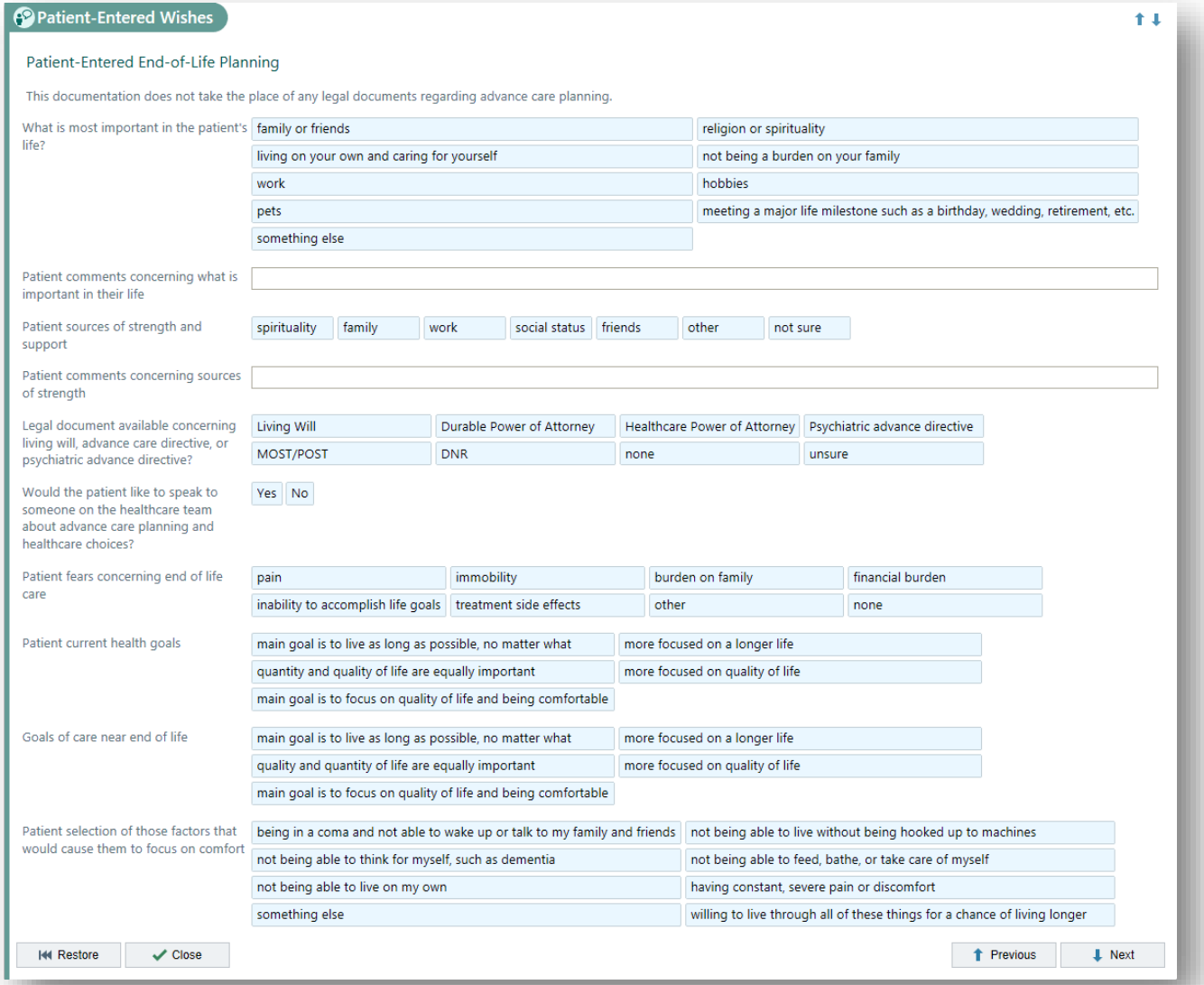
NOVANT HEALTH

ACP Note Bookmarks

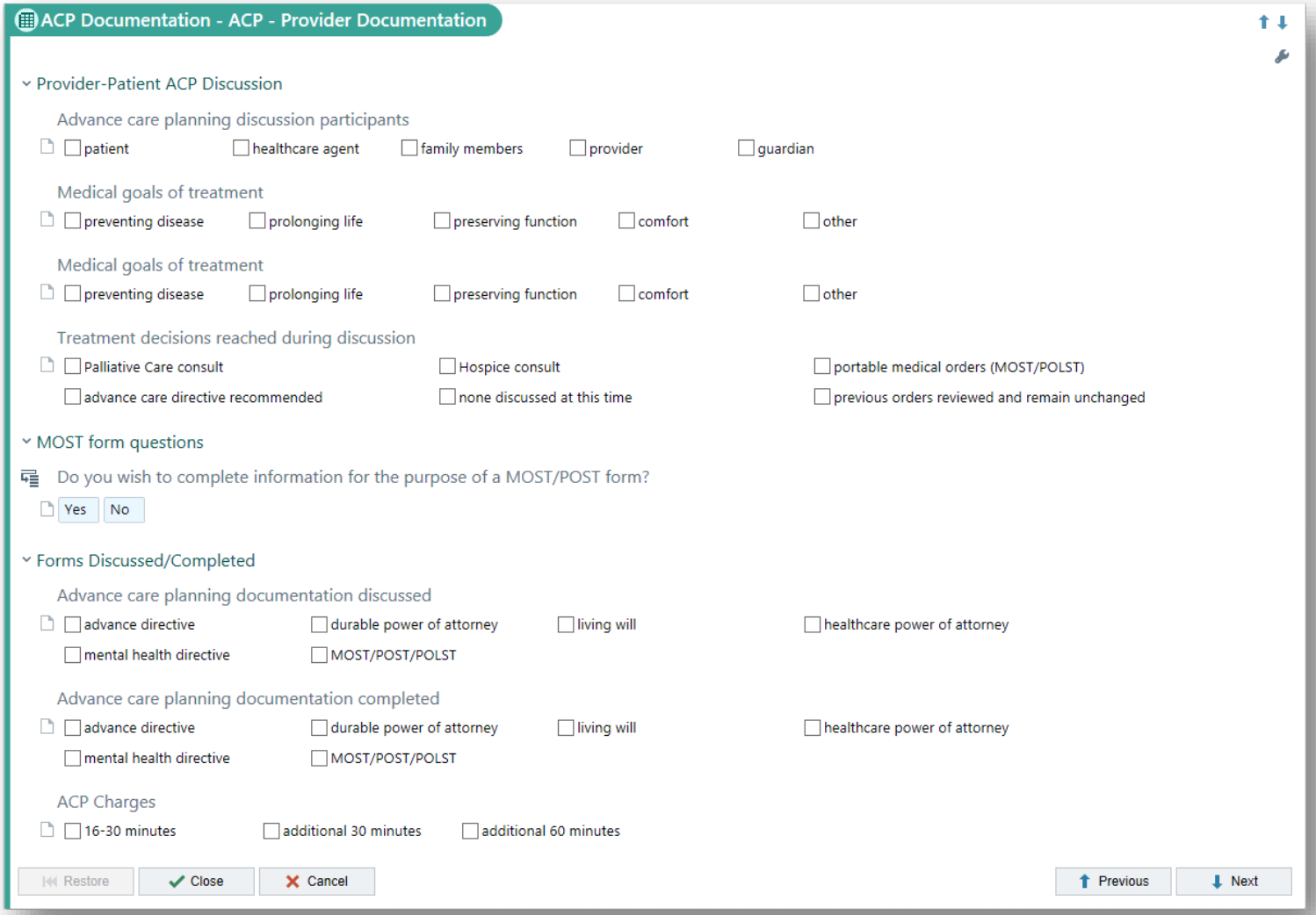
Place cursor in appropriate position and enter the ACPBEGIN SmartLink:



Patient-Entered Wishes



ACP Documentation Provider Flowsheet



Looking Ahead

2019 Priorities

- Provider Engagement and Compensation Plan Redesign
- Complex Care Management and Patient Engagement
- Refine Data and Analytics
- MSSP ACO Modeling for 2020
- Focus on Key Cost Drivers

Questions?