OneCare

THIRD EDITION • 2018 • NEWSLETTER

Letter from the Medical Director

Fredrick Wallisch, MD,
OCC Market Medical Director

Unfortunately, I start this letter with sad news. Recently, Dr. Mark Conway of Deaconess Clinic passed away suddenly. Dr. Conway was a fantastic physician and an even better man. He will be missed by all who knew him but especially by his patients. We thank him for his dedication and commitment to caring for the Evansville community. Our thoughts and prayers are with his family.

There have been so many big initiatives going on in the OneCare network, from successful work of the Care Advisors to continued success in the NGACO program and Medicare Advantage lines of business. I want to take a couple of minutes to call special attention to two initiatives in particular: EPIC RAF integration and our CHF program.

Everyone in the network is familiar with the Risk Adjustment work that has been going on since the fall of 2015. Accurately capturing the burden of illness of our patient population assists in getting them into the right care programs and helps set realistic financial targets with CMS. Since the beginning, this has been mainly a process done on paper (actually continues that way for those physicians and providers not on the EPIC EMR). For the last 2 years, the Deaconess EPIC team, led by Greg Stevens, has been piloting an electronic solution for RAF within EPIC. Late last fall, after consultation with members of the PAC and the central Evolent teams as well as the incredible EPIC team of programmers and trainers, the decision was made to turn on EPIC RAF for all EPIC users. Thus far, this has been a great success. I also want to point out that no other health system in the country has a solution this sophisticated and developed. A big thank you to all to took part and continue to support this effort!!

The other program started almost 2 years ago. This is the CHF program. We recently received an analysis of the first group of patients in that program and saw a significant decrease in ED utilization and hospitalization for those patients enrolled in the program. Our plan is to continue to expand this and begin work with some of the other health systems in the network to move this work forward.

There is always a new program or initiative in progress with our team. We thank all of you for continued care of the patients that entrust their lives to all of us. Enjoy the rest of your summer.

Thanks,
Fred

Success Story: Kim Beghdoud

The Care Advising team received a referral for Complex Care for a patient living with multiple health conditions including COPD, Chronic Pain Syndrome, Depression and anxiety. Through the initial assessment and discussion, the patient revealed that the depression and anxiety symptoms were affecting his/her health, functioning and relationships. In addition, the patient didn't feel like the medication for depression was helping. The patient demonstrated significant difficulty with concentration and focusing on the topic of discussion.

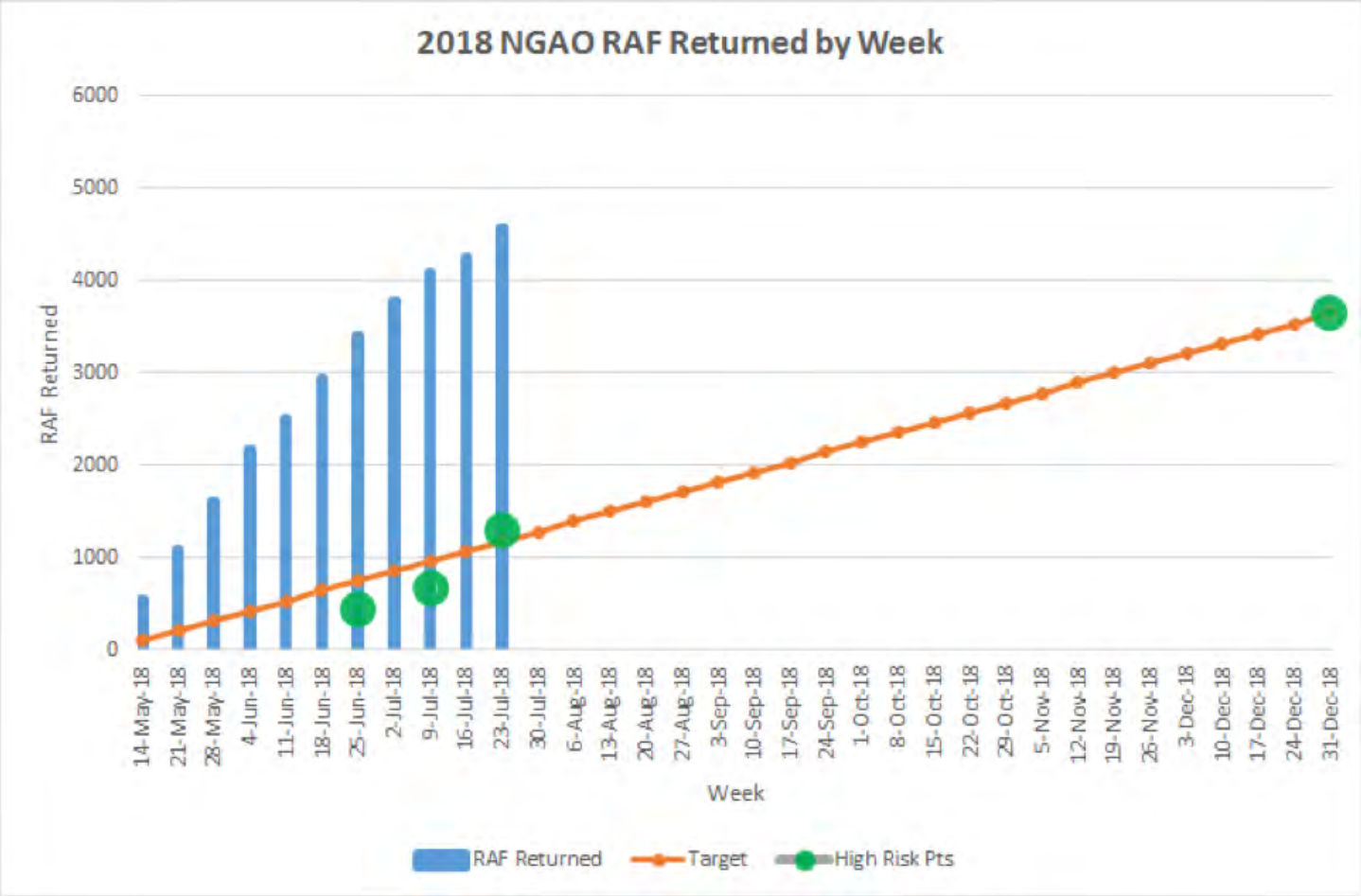
Throughout the course of the program, the Care Advisor supported the patient with meeting his/her goals. The Care Advisor referred the patient to a Social Worker to address depression and anxiety. Together, the patient and social worker discussed healthy coping skills to improve relationships with others. The Social Worker encouraged the patient to continue counseling services with a therapist. The social worker reinforced the importance of taking medication as prescribed and waiting until the medication reached its full efficacy before deciding to discontinue. The social worked continued to monitor the patient's depression and anxiety symptoms through the use of the PHQ9 and GAD7 assessments.

As a result of the interventions of the Care Advising team, the patient was able to make progress towards his/her goals. The patient continues to see a therapist on a routine basis. The social worker noted that the patient's concentration and coping ability has increased while depression symptoms have decreased. The patient also saw improvement in their PHQ9 score. The patient continued to take their medication for depression; which helped him/her to stop smoking.

2018 Initiative Updates: TEAM

EPIC RISK ADJUSTMENT UPDATE

Our RAF efforts are underway and making incredible progress! In the graph below you can see that our RAF completion rate is well above our target and exceeding even our highest expectations. The orange line represents our high-risk patient target (similar to last year's total target). This continues to ensure our patients are accurately coded and getting into the right care advising programs. Thank you to all the physicians and providers for your continued RAF efforts!



PARTICIPANT LIST THANK YOU: NICK DUS

On Friday, June 29, the ACO submitted our provider participant list for performance year 2019. As simple as this task sounds, it is a big effort that involved all of our health system and independent practice partners pulling and validating TINs, Individual NPIs (and organizational NPIs and CCNs where applicable) for all applicable primary care providers. While we will still be able to add providers for 2019 at later dates, the Friday, June 29 date was our deadline to ensure those submitted providers will have their eligible attribution for performance year 2019. Again, thank you for all the work in helping us turn this around and validate information prior to submission!

NGACO QUALITY MEASURE CHANGES: KELLY BANNING

The One Care Collaborative participates in the Next Generation model for Accountable Care Organizations. Each year we do a deep dive chart review and analyze 33 quality measures on a set number of patients. We then report those quality findings to CMS for all the providers within One Care. CMS then shares with us any changes from the previous calendar year. Below are the changes for the 2018 reporting year:

- **CARE-2:** *Falls: Screening for Future Fall Risk*
  Changes: Removed the medical reason denominator exception and added a denominator exclusion for patients who are non-ambulatory.

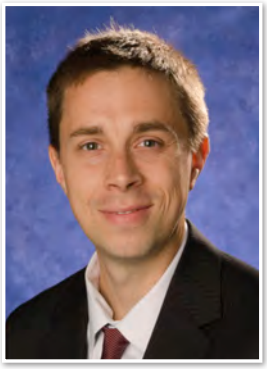
2018 Initiative Updates: TEAM - *continued*

- **PREV-7:** *Preventive Care and Screening: Influenza Immunization*
  The patient's medical record must contain: Indication the patient received an influenza immunization between August 1, 2017 and March 31, 2018 (not required if pre-filled with "Yes" in the Web Interface) or documentation of the reason why the Quality Action is not performed due to an exception.

- **PREV-8:** *Pneumococcal Vaccination Status for Older Adults*
  The patient's medical record must contain: The year (up through the last day of the measurement period) and type of pneumococcal vaccine provided. If the patient was reported prior to 2015, documentation indicating receipt of a pneumococcal vaccine is sufficient. If the patient was reported between 2015 and 2018, documentation indicating the year of the vaccination and confirmation of the type as PPSV23 or PCV13 is required.

- **PREV-9:** *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Pla*
  Changes: The BMI look back period from the most recent visit in the measurement period changed from six months to twelve months (for BMI and follow-up plan).
- **PREV-10:** *Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*
  Changes: Three measure rates reported for this measure. Medical reason exceptions vary by rate.

  1. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months.
  2. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention*.
  3. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.



Get to know your OneCare Team: Nick Dus

OCC: Tell us about your background and how you came to be a General Manager?
I have a Bachelor and Master degree in Health Administration from Indiana University. I worked in Quality Improvement/Lean Six Sigma at Deaconess Health System for 6 years- prior to moving to Vectren to work in Energy Delivery Performance Management for 2 years. In 2015 I came back to Deaconess to work at OneCare as Manager of Quality Improvement. Throughout my time in OneCare I have gone on to work in Clinical Operations and Market Operations before obtaining my current role as General Manager.

OCC: How long have you been in this role?
I have been in my current role since January 2018. It has been a learning experience, but I have appreciated being a new role that has allowed me to work more in depth with CMS and Payer Partnerships.

OCC: How would you describe your role and responsibilities as a General Manager?
The role of the General Manager is to help execute our population health objectives to transform the way healthcare is delivered for the OneCare Collaborative via overseeing the delivery of services and the ongoing management of the population health infrastructure. I am also responsible for achieving our client business cases for each line of business under management, P&L accountability for internal budget, managing the partner relationships, leading staff within the Population Health Services Organization (PHSO), and representing OneCare at Board meetings and executive committees. A few of the committees/teams I regular lead include weekly team Leadership Meeting, monthly Payer Contracting/Partnership meeting, weekly Market Initiative/Medical Economics Committee, monthly Market Operations Reviews, Analytics/Actuary Review Committee, etc.

OCC: How do you like to spend your free time outside of work?
I have 3 kids (ages 8, 5, and 10 months). They are very active in the summer with basketball classes, swim teams, etc. Therefore, most of my team is spent trying to keep up with them! I do enjoy running and annually train for the Evansville Half Marathon.

The 2018 OneCare Collaborative Population Health Team

Julie Anderson, RN
Care Advisor

Kelly Banning
Market Operations Director

Alescia Bradshaw, RN, BSN
Care Advisor

Lynn Brower, RN
Care Advising Manager

Crystal Chaney, RN
Care Advisor

Kim Childers, MSW
Social Worker

Jessica Cooper, RN
Care Advisor

Nick Dus
Market General Manager

Rachael Farmer, RN
Care Advisor

Kristina Gentil, RN
Care Advisor

Kimberlee Goldbach, RN, BSN
Care Advisor

Sharon Goodman, RN, BSN
Care Advisor

Amy Kennedy
Population Health Manager

Krista Kiefer, RN
Population Health Manager

Simone LaGrone
Outreach Specialist

Stacey Morris
Market Operations Manager

Tami Muncy, RN
Care Advisor

Melissa Norman, RN
Senior Director, Clinical Operations

Heather Orth, RN, MBA
Regional Market President

Amy Pritchett, RN
Population Health Manager

Michelle Reising, RN
Care Advisor

Paige Rowe, RN, BSN
Care Advising Manager

Christine Sides
Coordinator, Market Operations

Kristina Tate, RN, CCM
Care Advisor

Fred Wallisch, MD
Market Medical Director

Megan Wathen, RN
Care Advisor

Brian Whitman, RN
Care Advisor