OneCare
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Letter from the Medical Director

Fredrick Wallisch, MD,
OCC Market Medical Director

Happy Spring! Seems like we have had a long winter and cold spring, but perhaps we have finally turned the corner. The hot summer weather will be here before we know it.

While the most obvious example of the work that occurs with our team is visible in the Care Advising programs (Transition, Complex and Advanced Illness Care), there is a significant amount of "behind the scenes" activity that helps make those programs successful. Monitoring and developing new approaches happens before any new initiatives or programs are launched. I wanted to take a little bit of time to share some of that work with you.

We are in the midst of launching two new programs now. The first is around Behavioral Health. Many of you have mentioned patients that you think would benefit from additional services, but they do not seem to stratify into Complex Care programs. Many of those patients do not have chronic medical conditions, but rather have issues around behavioral health. This program identifies those individuals and, after your approval of the rosters, utilizes an LCSW to reach out to the patients to help identify issues and get them into local services. While these LCSWs are not located locally, our team is working with them to help arrange those services here.

The second new program centers around Chronic Kidney Disease (CKD). As you know, CKD stage 4-5 patients are at significant risk of moving into dialysis in the near future. This initiative uses claims data from CMS as well as lab data from EPIC to identify patients in stage 4-5 CKD who also have not seen a nephrologist in the last 9-12 months. While many of these patients are managed by their PCPs, our intent is to identify those who are not receiving any follow up and bring those to your attention. An early intervention can prevent a "crash" into dialysis and save the patient pain, suffering and significant expense.

I also want to give a huge "THANK YOU" to our EPIC team that has worked tirelessly to get the long awaited EPIC RAF solution up and running. Without the great collaboration of the Deaconess EPIC team and the Evolent IT team, this would still be a pipedream waiting to be enacted. This is truly groundbreaking work! No other health system in the country is doing this type of integration.

Also in the background, our local team works with our central Evolent team of actuaries, analysts and quality folks to help monitor our existing programs and review data to innovate on new ones. We have access to other programs throughout the country and have regular contact with other health systems to share best practices as health care continues its journey toward value based care.

I hope that you are able to enjoy some well-deserved time off with family and friends and wish you a safe and happy late spring and early summer.

Thanks,
Fred

Success Story

Recently, the Care Advising team at OneCare Collaborative received a referral for a patient for Complex Care from Transition Care. The patient was living with multiple medical conditions including cirrhosis and hepatic encephalopathy. Kim Goldbach, a nurse Care Advisor at OneCare Collaborative was assigned to this patient. Upon completion of the initial assessment and medication reconciliation, Kim found out that the patient presented to the emergency room two days prior with high ammonia levels. During the patient's visit to the ER, her ammonia levels were drawn. Due to the elevated ammonia levels, her medication (Medication A) dosage was changed from twice daily to three times daily. The patient also informed Kim, that during a recent visit with her GI specialist she was taken off of another medication (Medication B).

Success Story - *continued*

Kim went into action. She reviewed notes from the patient's specialty appointment and found out that the specialist did not stop her medication. Kim contacted the specialist's office and it was confirmed that the patient should be taking this medication (Medication B) once daily and that the dosage of the other medication (Medication A) needs to be changed back to twice daily. Kim contacted the patient and educated her on the new instructions for her medications. The patient was grateful for the clarification. To close the loop, Kim contacted the patient's primary care physician's office and informed them of the updates so that they could be aware and update the patient's EMR.

The care coordination efforts of the Care Advisor played an important role in helping this patient get back on track. When Kim met this patient, the patient wasn't taking medication correctly which caused her an ER visit. Kim quickly worked with the specialist and PCP offices to verify medications and dosage. This intervention by Kim most certainly prevented an additional ER visit and possible admission as the patient's next appointment with the specialist is not for another two months. The patient is still actively engaged in the Complex Care program working towards graduation.

2018 Initiatives

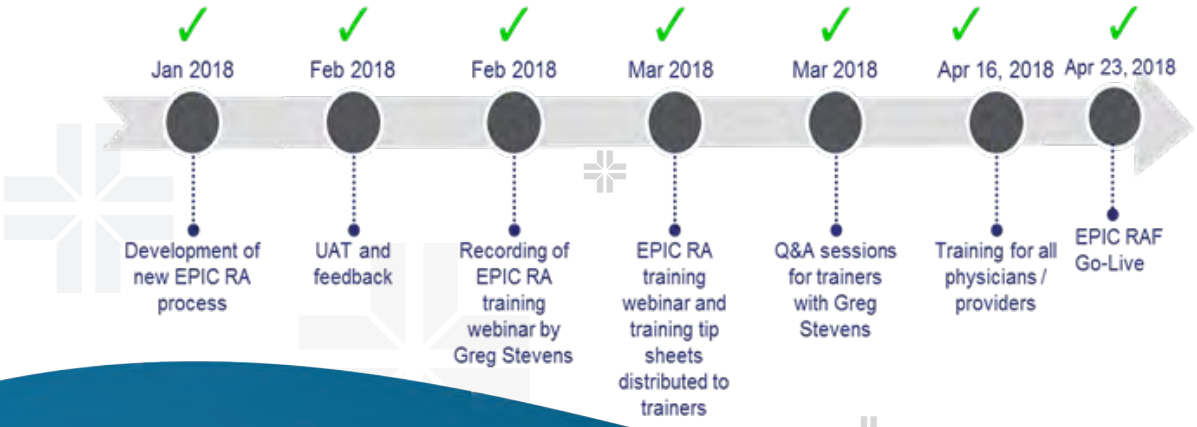
EPIC RISK ADJUSTMENT UPDATE
In 2018, all risk adjustment work previously completed using paper by EPIC offices will be available in EPIC through a new risk adjustment (RA) opportunity tab.

From last year's EPIC RA solution pilot, in which several Deaconess Clinic sites participated, we found that more risk adjustment work was completed and there was a higher claims confirmation rate. This helps ensure that the burden of illness is appropriately documented for our patients. It also helps us achieve an accurate benchmark and better identify patients for stratification into appropriate care management programs. Much was learned from last year's pilot and we are excited to extend the reach of our new solution this year. Education and training efforts are ongoing and training materials include:

1. Tip sheets; **2.** Webinar e-learning;
3. EPIC playground environment

Practice managers, credentialed trainers, scribes, population health managers and other OneCare RA team members are trained and available as a resource. One-on-one training is available by request.

Timeline:



2018 Initiatives - *continued*

For those offices not on EPIC, the paper risk adjustment forms will be available in May 2018. We also have a potential electronic solution for non-EPIC offices that may be trialed in late 2018.

The following are risk adjustment incentive model changes:

- Turned on all members with suspect conditions in EPIC
- $38 per RAF "closed" in EPIC (paid in same cadence as in 2017)
- $1 PMPM BONUS paid at end of year to provider for all completed RAF patients if provider completes RAF for 60% or higher of their available RAF patients

The following is an example that shows a hypothetical provider in the old RAF incentive model vs the new RAF incentive model.

	Previous RAF Incentive	New RAF Incentive
Attributed Pts	200	200
Bursted RAF	50 (high risk subset avg)	200 (all pts with suspects)
Completed RAF	30 (assumes 60% completed)	120 (assumes 60% completed)
Incentive	$3,000	$4,560
RAF Completion Target	NA	60% Goal
Bonus	NA	$1,440
TOTAL COMP	$3,000	$6,000

To achieve the 60% threshold RAF completion target and obtain the $1 PMPM bonus, a RAF form can be completed by any provider- physician, nurse practitioner, physician assistant.

ED AVOIDANCE INCENTIVE UPDATE

In 2017 the One Care Collaborative rolled out a new initiative that focused on keeping PCP treatable visits out of the Emergency Departments. Between March and December of 2017 the Population Health Managers met with a majority of the offices rolled out staff education with specific action items. There was a total of 214 providers who attested to Tier 1, 2 or 3 in this initiative with 656 distinct individual changes. Some examples of that work are: changing voice mail to include specific urgent care information, having office hours before 8am or after 5pm and keeping same day and next day appointment open for acute visits. Preliminary results show a ED Visit per 1,000 rate of 9.1 visits per 1000 prior to initiative and a reduction to 6.9 visits per 1,000 4 months post launch. Very exciting work that far exceeded our goals.

This calendar year the Population Health Managers will be working with the offices and providers to attest to the same 3 Tiers as last year, minus the practice education. We are hopeful to see that the offices are doing the same great work they implemented in 2017. The second part of the ED Initiative this year is outcome based. We will be reviewing the year over year ED data at the practice level. This information will go out to the providers at the quarterly Pod meetings. If you have any additional questions feel free to reach out to your Population Health Manager.

CKD PILOT PROGRAM

The objective of the program is to help primary care providers identify their patients that have been diagnosed with CKD4 and CKD5 that have not seen a Nephrologist in the past 12 months. Lab data pull from EPIC identifies and puts patients on a monthly roster and we are printing patient worksheets bi monthly for the primary care providers to assess and make appropriate referrals as needed.

Nephrologist's availability has been assessed in the market and expressed that they are happy to see the appropriate patients in a timely fashion. Hopes are to discuss potential early vascular access and other options they may have to avoid potential crash into dialysis.

2018 Initiatives - *continued*

Education was first done with six providers in the market. As of March 13, 2018, initial outreach was completed. This has resulted in one new referral to Nephrology and seven primary care follow up appointments that have been scheduled. A recent decision was made to add all EPIC providers to the pilot program. Roll out is set to happen at Q2 Pod meetings by OCC Market PHMs. The CKD Pilot has been well received by providers and we are currently exploring the addition of CKD to the OCC banner in EPIC for easier identification.

QUALITY HIGHLIGHTED MEASURES FOR Q2 PODS

Highlighted measures for Q2 2018 are the BMI Assessment and Follow Up and Depression Screening and Follow Plan. Poor performance in 2017 GPro audit by providers to document follow up plans for these measures prompted their selection for Q2 Pods. Our goal for Pay for Performance measures are in the 70th percentile or higher.

The highlighted measures provided by the PHMs at Pod meetings include specific requirements for documentation and tips on how to meet the measure. Epic tip sheets are included with the measures for Epic users and samples of the PHQ9 (Patient Health Questionaire-9) and scoring guidelines were provided to assist non-Epic users in developing a process to meet the measures.

4P or 4R	Measure	2018 Preliminary Performance	2018 Preliminary Percentile	2017 Performance
Performance	Screen for Depression	61.51	60th %tile	63.46
Reporting	Depression Remission	6%	N/A	10.71%
Performance	BMI Screen	57.29	50th %tile	69.96

The highlighted measures are great discussion guides for the PODs. It's always the goal of the PHMs to encourage sharing between providers so others can learn and improve.

OneCare Leadership Change

Get to know your OneCare Team: Kelly Banning

Kelly Banning has recently accepted the role of director of Market Operations for the OneCare team. Kelly brings a wealth of experience with her and has previously served as a Population Health Manager (PHM). Prior to being a PHM, Kelly was a Regional Network Services Coordinator for Deaconess. In her new leadership Position, Kelly has been part of our strong PHM team that has launched Pods, helped implement market initiatives, and foster strong relationships with several of our providers and health systems. Kelly is always willing to lend a helping hand and we are very excited to see Kelly move into this new role and know she will provide great leadership for our team.

In her new role, Kelly will initially be leading our PHM Team, Pod Operations Team, have quality improvement oversight, and play a larger role in our clinical/quality calls with MA payers.

OCC: Tell us about your background and how you came to be a Director of Market Operations.

KB: I received a business administration degree from Taylor University in 2003. I then worked in the health care field for 9 year in various business development roles. Most notably, I served as a regional coordinator for Deaconess Health System and Deaconess Clinic. I worked closely with five regional hospitals and over 300 physicians to develop strategic relationships that would impact growth, physician access and improve quality. Two years ago I started with One Care as a Population Health Manager, working with approximately 85 providers over 30 office locations. I was able to work alongside the primary care providers to drive change to increase quality and work on getting the right patient, to the right place at the right time.

OCC: How long have you been in this role?
I just started at the Director of Market Operations on May 1st. It has been an awesome two years with the One Care team as a Population Health Manager. I loved the PHM role and I am excited to see what is ahead. I truly enjoy being part of a team that works together to improve the health of our community.

OCC: How would you describe your role and responsibilities as a Director of Market Operations?
KB: The Director of Market Operations works closely with the market leadership team on the development and execution of key strategic initiatives. This includes analyzing data to identify trend and conducting root analysis. I will also work with the Population Health Managers to take quality and cost savings initiatives to the practice and provider level.

OCC: How do you like to spend your free time outside of work?
KB: I am a proud mom of two kids, ages four and six. I love spending time with my family. Between dance class and soccer practice, my husband and I are constantly running after the little ones and we love every minute of it! I enjoy reading and playing golf, and in the summer you can find me at the pool. We are trying to teach our kids how to play golf so they can join us on the course!

The 2018 OneCare Collaborative Population Health Team

Julie Anderson, RN
Care Advisor

Kelly Banning
Population Health Manager

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
Care Advisor

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 Advisor

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