

Managing Risk Across Populations That Include Other Risk-based Models



Ascension

NAACOS Fall 2020 Conference
September 22, 2020

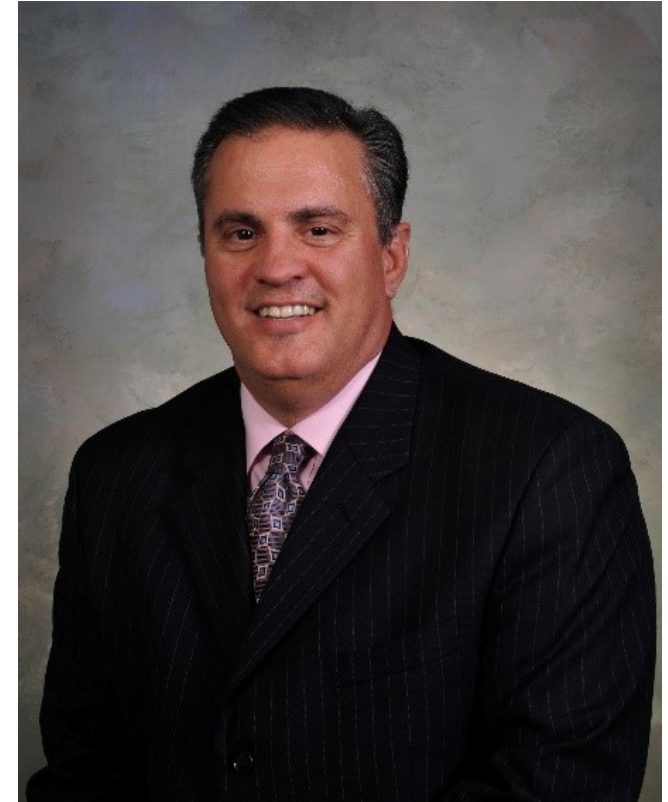
In today's competitive healthcare environment an organization that has the scale to build infrastructure and spread the cost over a wide patient base can generate significant returns on investment. This session explores what industry leaders in value-based care are doing to provide seamless care to their patients across multiple risk models and contracts.

Managing Risk Across Populations that Include Other Risk-based Models

— Moderator

Anthony “Tony” Reed, Vice President of Population Health Strategic Solutions, CNS, Ascension Medical Group

- Vice president of population health strategic solutions, clinical and network services at Ascension Medical Group (AMG) and has responsibility for all value-based health care programs and contracts for AMG. He also represents Ascension by serving as a speaker and member for several national organizations dedicated to accountable care and alternate-care payment models. Mr. Reed is on the board of directors for NAACOS and has presented at many conferences including the leaders board for population health management, NAACOS conferences, The Hospital and Health System Association of Pennsylvania, xG Health Solutions, Inc and for the Marcus Evans Group. He is in his 23rd year of work in health care industry and his previous roles include, chief administrative officer for the Keystone Accountable Care Organization and AVP of accountable care initiatives at Geisinger Health.



Speaker Introductions

**Nick Bassett, Vice President of Population Health Services
Castell / President – Intermountain Accountable Care**

- Nick began his career in 2008 at Intermountain Healthcare doing hospital operating and capital budgets. Since that time Nick has held instrumental roles influencing change both within Intermountain Healthcare and across the country in the journey towards value-based care. As a founding member of Castell (Intermountains' value-based platform company) he was asked to lead the Population Health strategy with accountability for the following areas: commercial and government value-based contracting, physician compensation, network operations, post acute care operations and home-based services. Nick earned his BS degree in business finance from Brigham Young University and an MBA from Southern Utah University



Speaker Introductions

Sidney H. “Beau” Raymond, MD FACP
Medical Director, Ochsner Health Network
Medical Director and President, Ochsner Physician Partner

- Dr. Raymond is the Medical Director of Ochsner Health Network and Medical Director/President of Ochsner Physician Partners.
- He was previously Vice President, Physician Practice Administrator and CMIO at East Jefferson General Hospital. He served on the Steering Committee and as a Board Member for Gulf South Quality Network. He was also involved with Medical Staff committees and served as Chief of Staff. He is a Past President of Jefferson Parish Medical Society.
- Dr. Raymond earned a Bachelor of Science in Biology from Loyola University, Medical Degree from Louisiana State University School of Medicine, and completed Internal Medicine residency at LSU-New Orleans



Speaker Introductions

Jennifer Pereur

Vice President of Solutions at Apixio

- Jennifer Pereur is VP of solutions at Apixio, where she leads the development of new provider-focused products. She brings 20 years of expertise in creating and managing government programs and analytic programs for risk-bearing provider groups. Most recently, she served as director of government programs at Hill Physicians Medical Group, a large IPA with over 4,000 physicians.



Speaker Introductions

Richard Martin, MD FACP

Assoc. Chief Medical Officer for Population Health at Geisinger

Chief Medical Officer for the Keystone Accountable Care Organization

Dr. Martin is family physician and primary care doctor with more than 30 years of experience. Dr. Martin received his medical degree from Jefferson Medical College in Philadelphia. He completed his residency in Family Medicine at Geisinger Medical Center, is certified by the American Board of Family Medicine and is a Fellow of the American Academy of Family Practice. He has also served as Geisinger's systemwide Chief Medical Officer for the Care Continuum and as Department Director for the Community Practice Service Line. In these roles, he has been responsible for initiatives in value re-engineering of the Care Continuum and other population health initiatives at Geisinger, including primary care delivery transformation and post-acute efficiencies. Additionally, he partners with the leadership of Geisinger Health Plan on systemwide population health delivery, with a primary focus on improving service and value and increasing the connectivity between payor and provider in the continuum of care. Dr. Martin has coordinated population health activities across 22 counties in central and northeast Pennsylvania for Geisinger. He also serves as a subject matter expert for patient-centered medical homes, practice transformation and analytical redesign strategies for xG Health Solutions. He is nationally recognized for his expertise on the topics of patient-centered medical homes and primary care practice redesign.



Format

- 90 Minute Session
- Each Speaker will present for 20 minutes
- Questions will be taken after the last speakers finishes

Presentation Order

Nick Bassett

Beau Raymond

Jennifer Pereur

Richard Martin



Population Health Update

*Nick Bassett VP Population Health Services
President Intermountain Accountable Care*



Intermountain Scope & Stewardship



160

Intermountain Clinics
+55 Nevada Clinics



6 States, 40+ sites
~**620,000** Virtual
Interactions



23 Hospitals
+1 Virtual Hospital



39,800 Caregivers
(includes Nevada)

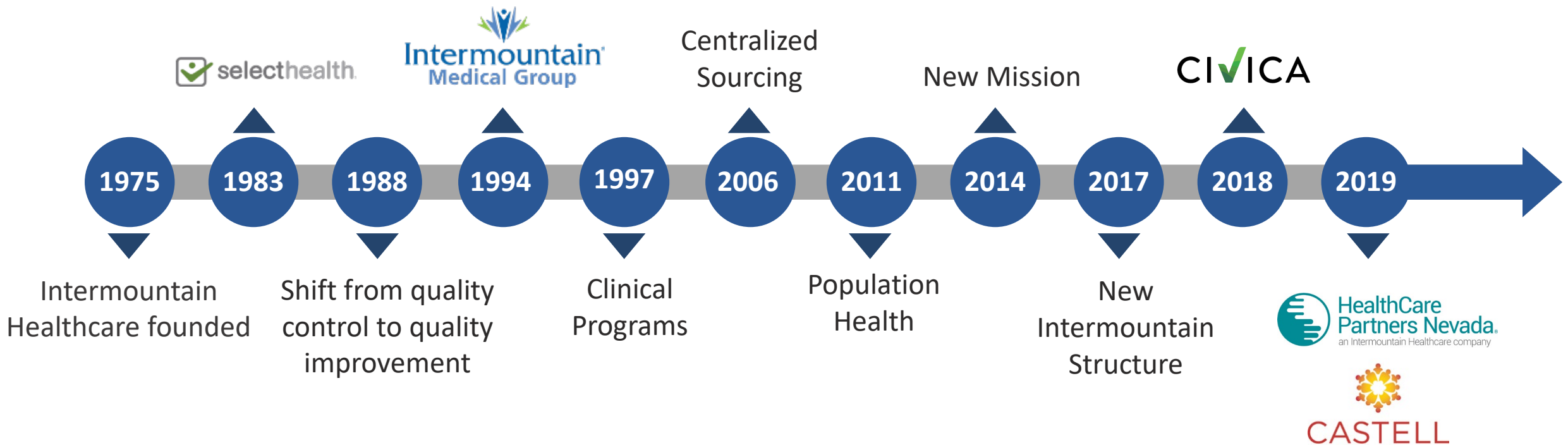


900,000+
SelectHealth Members

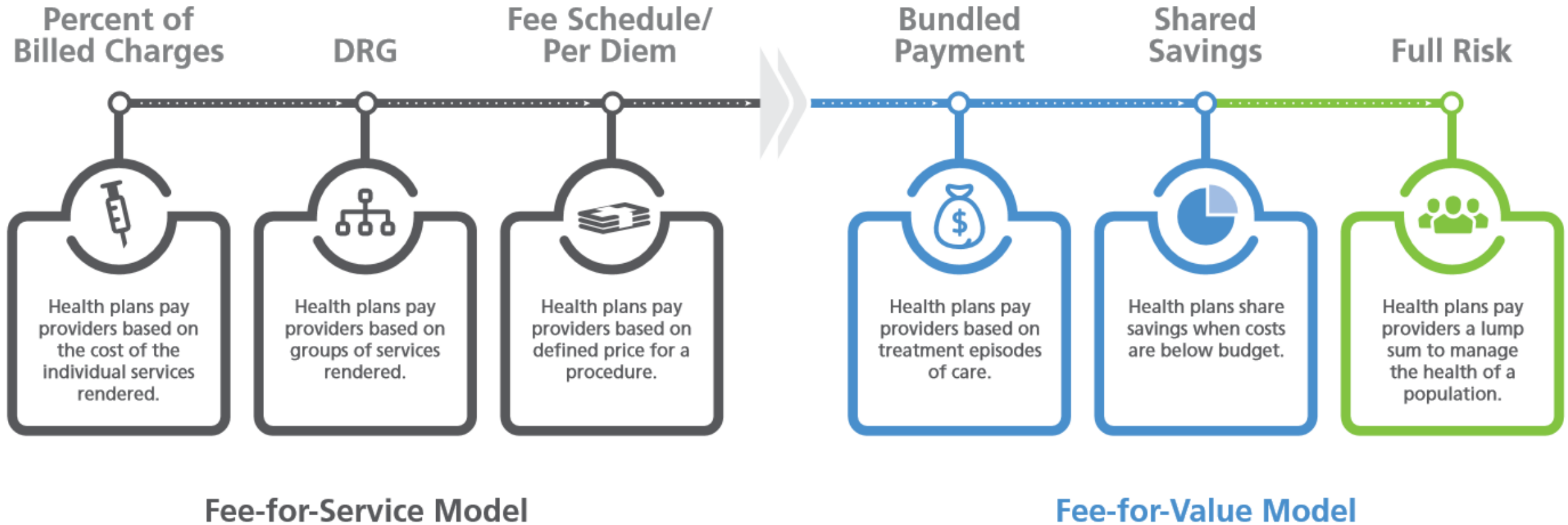


\$250M
Financial Assistance

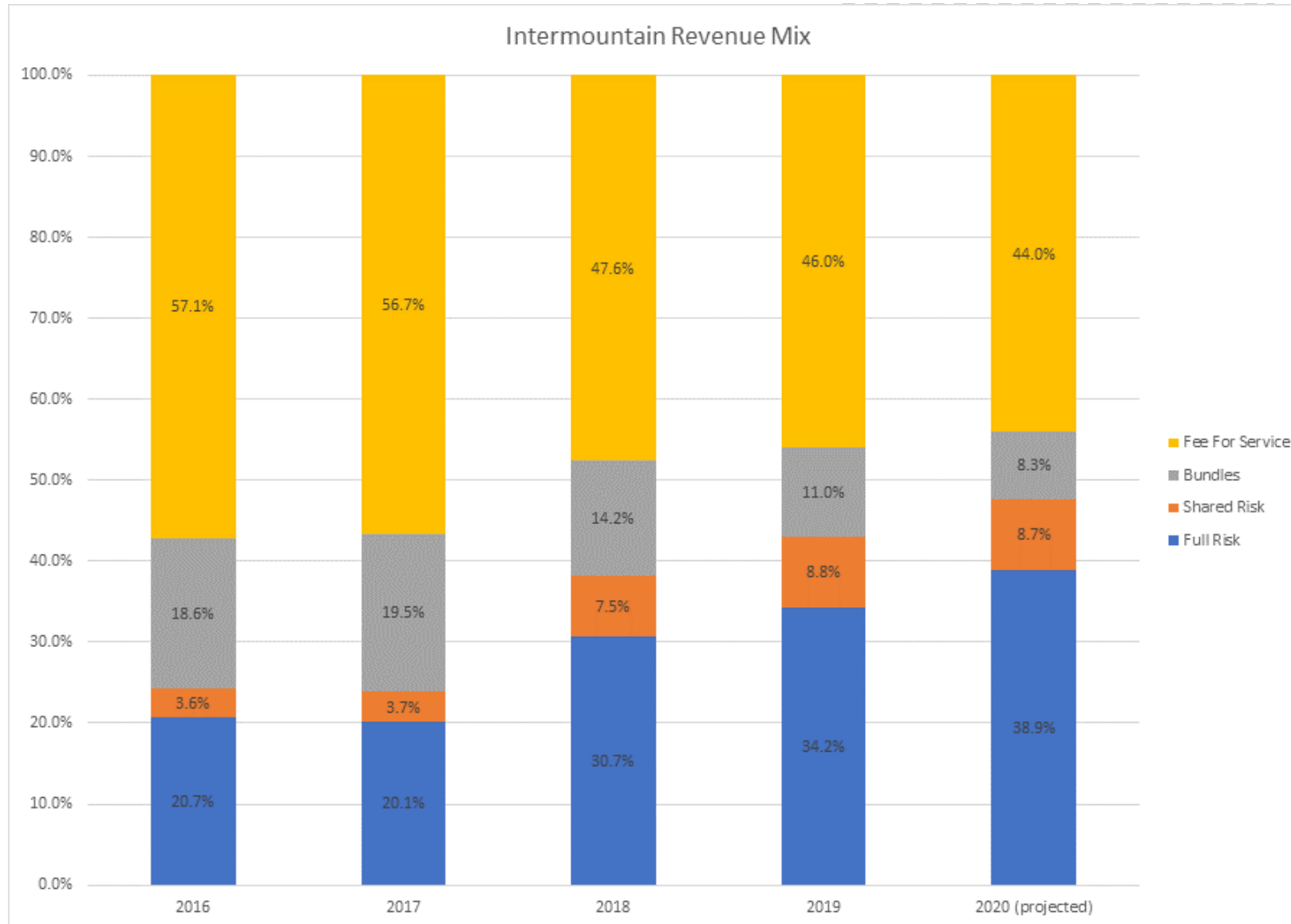
A Tradition of Innovation and Growth



Spectrum of Payment Models



2016-2021 Estimation of Intermountain Revenue Mix





CASTELL

Value-based Contracting

Other Value-based Contracting Strategies

- Ongoing evaluation of models emerging from CMS (direct contracting, enhanced track ACOs, etc.)
- Active work around global cap deals in Medicare Advantage
- Developing strategies around direct to employer value-based contracts (in alignment with SelectHealth)
- Evaluating COE strategy for tourism
- Self-funded Population Health Arrangements



2018 A Good Start for the ACO

\$49

PMPY savings
in 2018

\$1.2M

Our 50% share
of savings

\$577K

Shared with
PCPs

2018 Savings Distribution

- 50% of savings paid to IMG PCPs (MDs and APPs)
- Allocated based on ACO member attribution
- Minimum 15 patients for eligibility
- Payments range from \$247 to \$8,437; median \$1,266

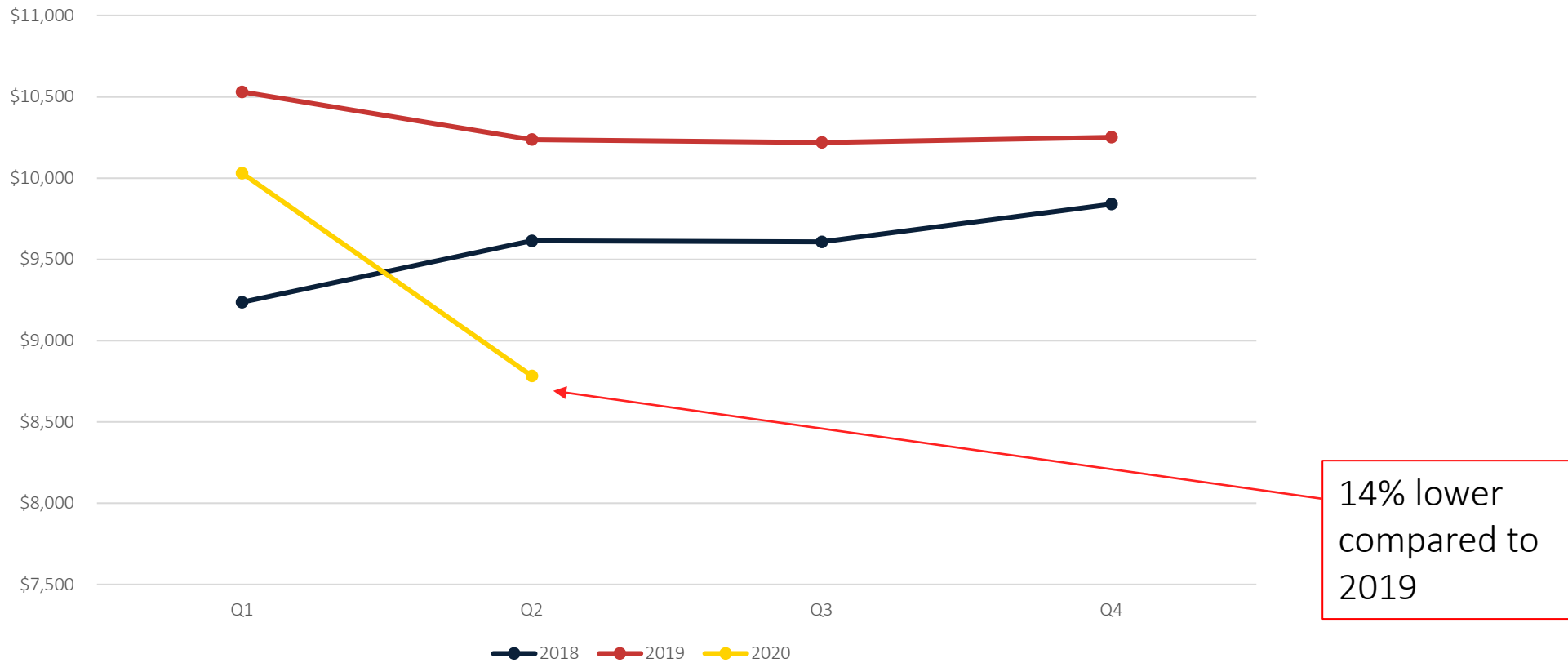


Financial Gains in 2019

ACO Earned \$4.95M in Savings for 2019 Performance

- 4x our 2018 savings
- 98.88% quality score
- 49.4% sharing rate (really close to 50% max)

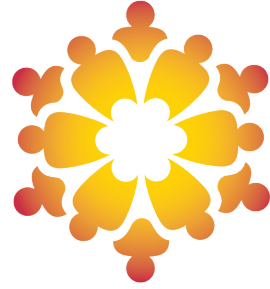
Average Expenditures per Beneficiary



SOURCE: Q2 2020 Expenditures Report.

BPCI-A Participation Continues But With Fewer Bundles

	2019	2020
Total Episodes	122 episodes	56 episodes
Hospitals	12	13 (added Park City)
Annual Patient Volume	6,802 patients	3,585 patients
Clinical Programs	<ul style="list-style-type: none"> • Cardiovascular (5 bundles) • Digestive Health (3 bundles) • General Medicine (7 bundles) • Musculoskeletal (5 bundles) • Neurosciences (4 bundles) 	<ul style="list-style-type: none"> • Cardiovascular (4 bundles) • Digestive Health (3 bundles) • General Medicine (5 bundles) • Musculoskeletal (3 bundles) • Neurosciences (2 bundles)



CASTELL



Advantages of an integrated system: PMPM targets

2020 Medical Group Target PMPM Summary

	ACO		INTERMOUNTAIN EMPLOYEES		SH CHIP		SH FEHB		SH INDIVIDUAL		SH LARGE EMPLOYER		SH MEDICAID		SH MEDICARE		SH SMALL EMPLOYER	
Cache Valley	\$737.47	1.1%	\$365.21	5.0%	\$210.43	6.1%	\$328.53	2.6%	\$349.39	4.8%	\$348.43	2.6%	\$235.26	9.8%	\$797.39	1.1%	\$339.85	2.6%
	\$728.12	19.0%	\$345.00	-0.2%	\$187.41	11.1%	\$304.69	15.4%	\$340.44	14.3%	\$342.30	-9.5%	\$211.35	5.0%	\$801.26	40.8%	\$313.94	-27.1%
Central Salt Lake	\$739.70	1.1%	\$471.81	5.0%	\$181.13	6.1%	\$420.50	2.6%	\$502.32	4.8%	\$446.60	2.6%	\$411.57	9.8%	\$710.57	1.1%	\$453.72	2.6%
	\$730.32	4.9%	\$445.70	2.0%	\$190.70	39.6%	\$403.64	39.4%	\$480.78	32.2%	\$432.53	-0.3%	\$361.58	4.5%	\$697.90	6.5%	\$441.11	-3.2%
North Salt Lake	\$714.89	1.1%	\$404.72	5.0%	\$144.59	6.1%	\$455.90	2.6%	\$324.40	4.8%	\$394.31	2.6%	\$302.56	9.8%	\$698.74	1.1%	\$348.21	2.6%
	\$705.82	2.2%	\$382.32	5.8%	\$121.18	-47.9%	\$420.19	-14.0%	\$306.81	-2.5%	\$381.90	-9.9%	\$275.32	-5.1%	\$684.98	3.5%	\$340.11	3.1%
Rural	\$730.24	1.1%	\$385.41	5.0%	\$124.96	6.1%	\$246.30	2.6%	\$519.31	4.8%	\$293.50	2.6%	\$261.04	9.8%	\$834.67	1.1%	\$305.68	2.6%
	\$720.98	1.4%	\$364.09	9.7%	\$122.39	5.5%	\$263.35	60.7%	\$484.79	-6.1%	\$279.70	-12.2%	\$252.09	36.5%	\$831.76	1.7%	\$298.37	-28.3%
South Salt Lake	\$691.08	1.1%	\$370.07	5.0%	\$149.50	6.1%	\$296.68	2.6%	\$276.33	4.8%	\$353.23	2.6%	\$266.31	9.8%	\$631.38	1.1%	\$296.83	2.6%
	\$682.31	5.1%	\$349.59	4.1%	\$146.13	-12.6%	\$273.87	-9.1%	\$260.61	14.2%	\$341.05	1.8%	\$233.05	-9.3%	\$631.21	4.9%	\$288.97	4.3%
Southwest	\$688.22	1.1%	\$391.34	5.0%	\$142.57	6.1%	\$502.38	2.6%	\$420.56	4.8%	\$325.66	2.6%	\$296.31	9.8%	\$739.29	1.1%	\$392.88	2.6%
	\$679.49	0.7%	\$369.69	30.6%	\$134.66	-0.8%	\$477.29	61.2%	\$397.49	7.0%	\$314.20	-20.2%	\$272.54	4.9%	\$722.79	8.6%	\$374.53	-1.1%
Utah Valley	\$661.76	1.1%	\$444.88	5.0%	\$88.49	6.1%	\$545.90	2.6%	\$357.81	4.8%	\$370.32	2.6%	\$341.21	9.8%	\$704.74	1.1%	\$309.39	2.6%
	\$653.37	5.1%	\$420.26	12.0%	\$89.50	-40.6%	\$529.91	7.5%	\$336.62	0.7%	\$356.22	-5.7%	\$297.76	-9.1%	\$701.18	4.1%	\$297.32	-13.3%
Weber	\$686.02	1.1%	\$397.89	5.0%	\$282.46	6.1%	\$520.66	2.6%	\$346.15	4.8%	\$419.52	2.6%	\$344.79	9.8%	\$664.37	1.1%	\$303.06	2.6%
	\$677.32	2.9%	\$375.87	22.1%	\$277.58	128.4%	\$502.62	7.9%	\$329.77	14.6%	\$406.02	17.8%	\$307.06	-1.6%	\$664.60	2.7%	\$286.77	-11.1%
Total	\$700.20	1.1%	\$401.54	5.0%	\$177.06	6.1%	\$466.13	2.6%	\$365.88	4.8%	\$386.86	2.6%	\$317.32	9.8%	\$696.42	1.1%	\$337.29	2.6%
	\$691.32	3.5%	\$379.32	10.8%	\$168.59	11.8%	\$445.45	7.6%	\$347.39	10.1%	\$374.07	0.8%	\$282.93	-2.0%	\$688.67	5.1%	\$325.17	-4.5%

Reimagined Primary Care Results

-\$159
PMPM*

Reduction for MA
costs in RPC clinics vs.
control

-\$54
PMPM*

Reduction for all
product costs in RPC
clinics vs. control

90%

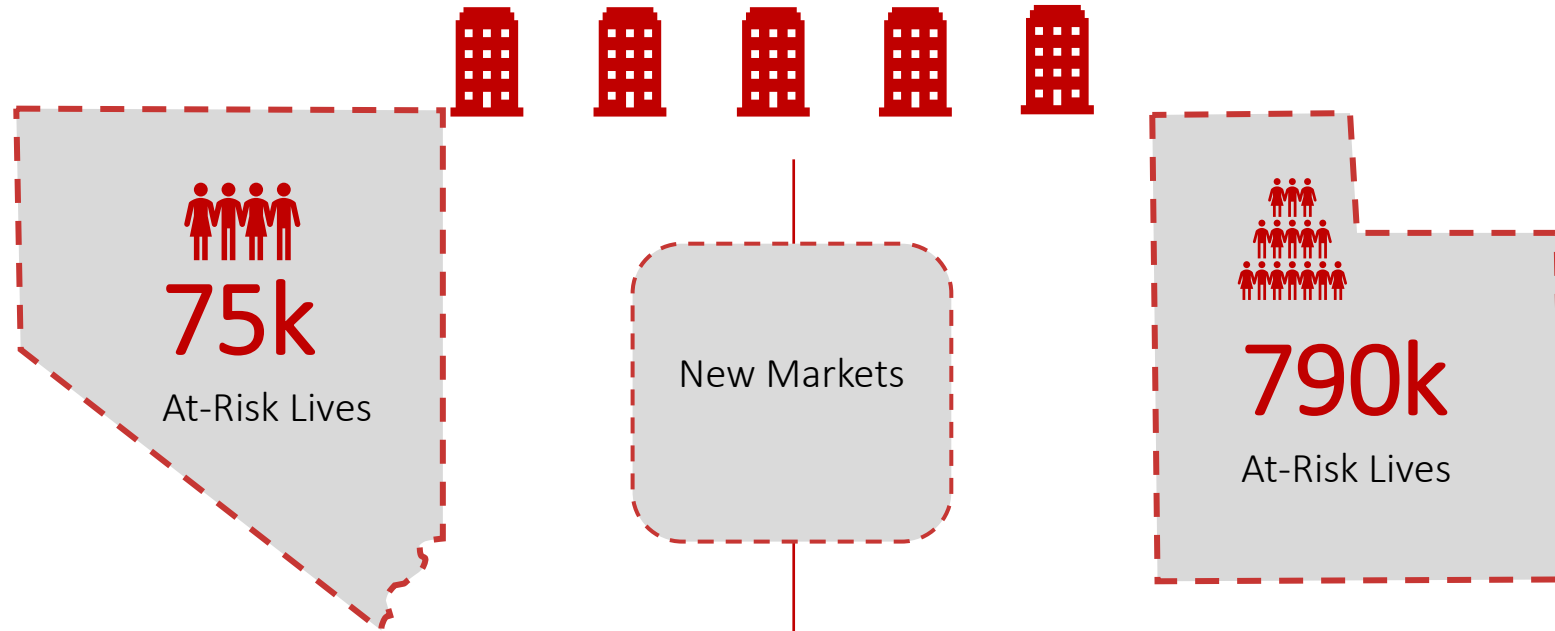
Patients rate overall
clinic experience as a
9 or a 10

*January 2017 through June 31, 2019

*Results compared to a risk adjusted propensity score matched population

The Challenge: Scaling Key Capabilities

Multiple Payers



Managed by...



80 Employed Providers
23 HCP MyGen Clinics



700 Employed Physicians
180 Medical Group Clinics



30+ Affiliated Clinics
87 Affiliated Providers



750 Affiliated Physicians
250 Affiliated Clinics

Why Castell?



Develop and scale population health and value-based care capabilities



Increase pace of innovation and compete with market disruptors

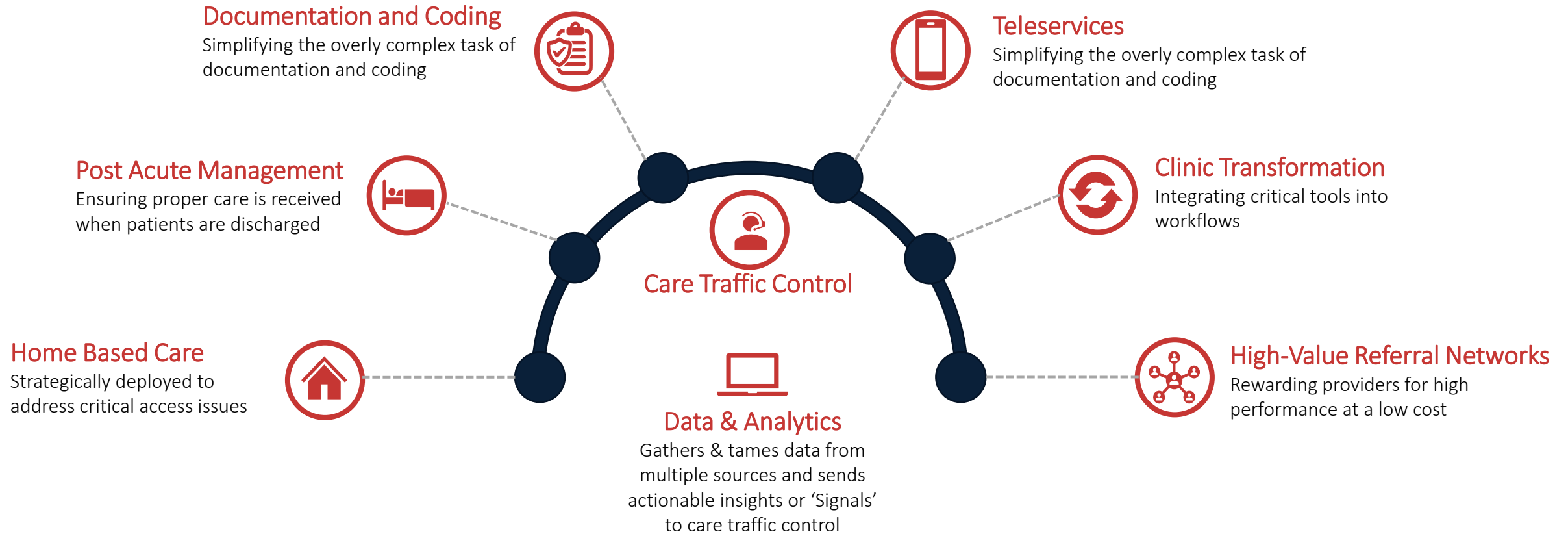


Support growth in new and existing markets



Manage multi-payer arrangements across multiple products and in multiple markets

Castell Operating Model



Partners we serve



For Clinics

Removing the administrative overhead of population health to focus on patient care









For Communities

Aligning provider incentives to make care easier to access, higher quality, and more affordable

Supporting Functions



Care Traffic Control coordinates members and clinics across key supporting functions

-  **Home-based care** provides services to high-risk patients unable to leave their home to receive care
-  **High-value network referral** tools ensure members receive high-value care from value-aligned providers
-  **Centralized documentation and coding** resources provide tools and support that enable accurate coding
-  Clinic Transformation teams provide **education and at-the-elbow support** of care teams to redesign processes and workflows
-  **Tele-services** allow care teams to connect with patients without an in-person visit and give members convenient access for all their needs, 24-7
-  **Post-acute care** teams ensure patients are discharged to right site of care and are cared appropriately if post-acute care is required



Thank you

Managing Risk Across Populations

Sidney H. “Beau” Raymond, MD FACP

Medical Director

Ochsner Health Network

Ochsner Health

Our Mission is to Serve, Heal, Lead, Educate and Innovate

IMPACTING LIVES ACROSS LOUISIANA, THE NATION & THE WORLD



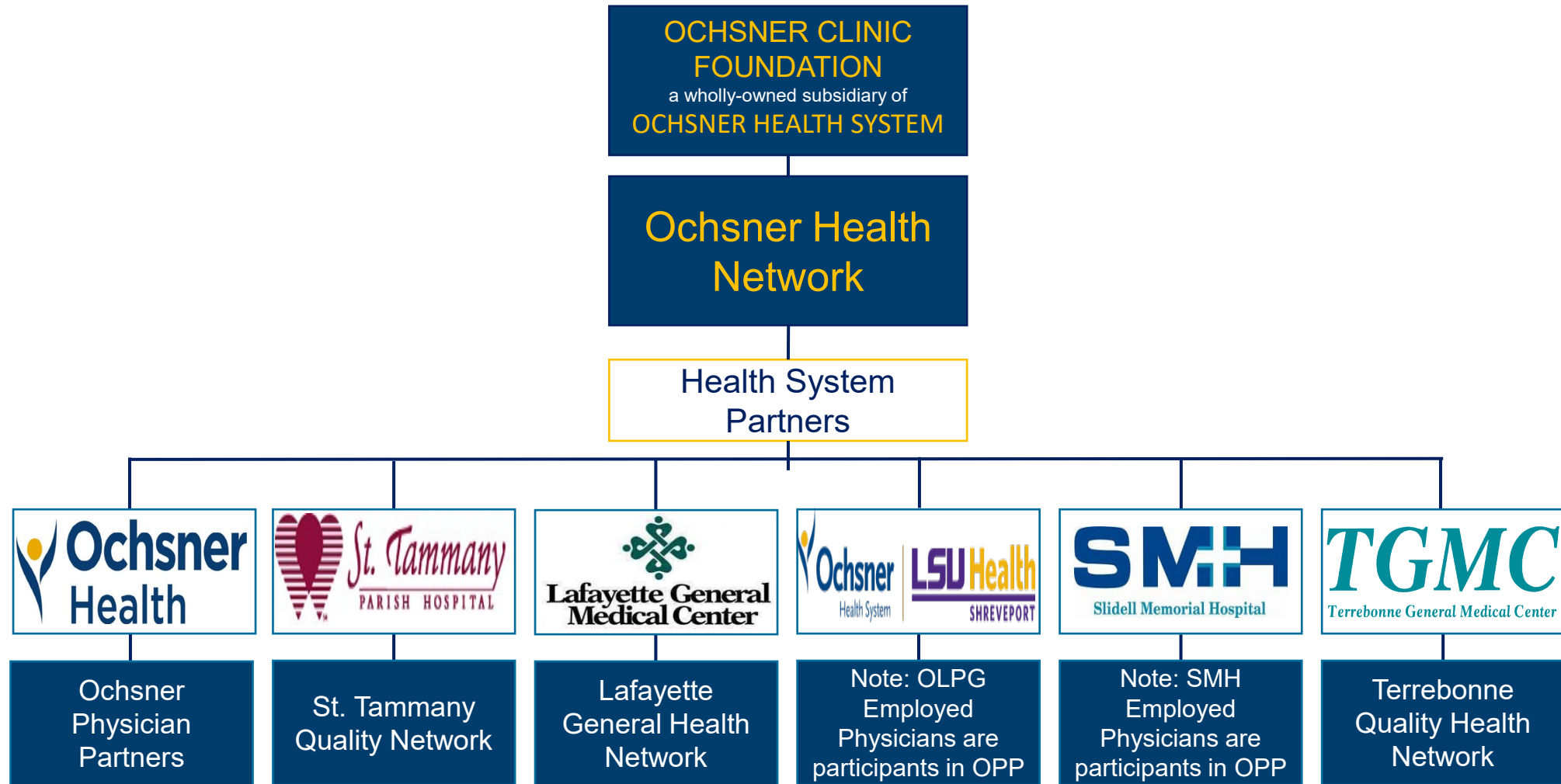
Our Vision

Ochsner will be a global medical and academic leader who will save and change lives. We will shape the future of healthcare through our integrated health system, fueled by the passion and strength of our diversified team of physicians and employees.

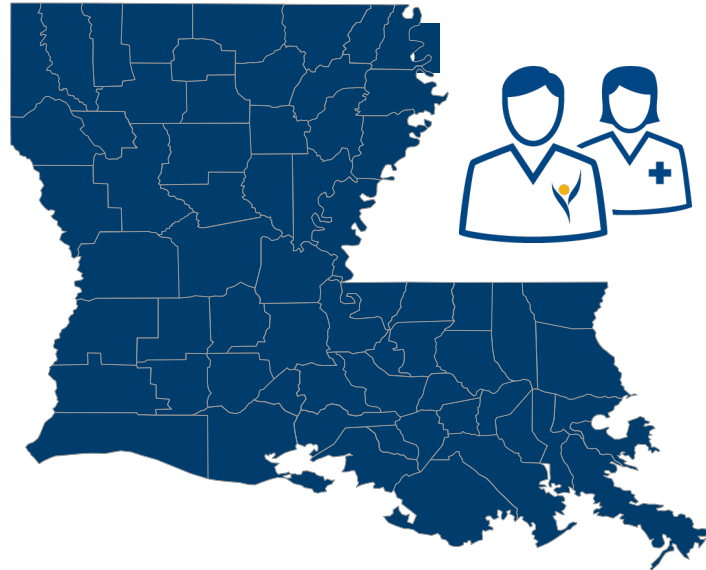
- ✓ Ochsner is Louisiana's Largest Not-For-Profit Health System
- ✓ In 2019, Served 876,621 Patients From Across Louisiana, Every State, and More 70+ Countries
- ✓ 16 Owned & Managed Hospitals, 20 Affiliated Hospitals and 5 Specialty Hospitals
- ✓ 115+ Health Centers and 14 Urgent Care Centers
- ✓ 2 U.S. News & World Report "Best Hospital" Specialty Category Rankings & 2 U.S. News & World Report "Best Children's Hospital" Specialty Category Rankings 2019-20
- ✓ 1,495 employed and over 3,000 affiliated physicians in over 90 specialties & subspecialties
- ✓ Largest Private Employer in the State with 26,000+ Employees
- ✓ More than 291 medical residents and fellows work in 30 different Ochsner-sponsored ACGME accredited residency training programs
- ✓ 750+ Active Clinical Trials
- ✓ \$3.8B in Total Operating Revenue; \$5.9B With Financially Integrated Partners



Ochsner Health Network Participation



Ochsner Health Network (OHN) & Ochsner Accountable Care Network (OACN)



Offering providers best in class EMR and digital population health tools



Provider well-being is at the core of everything we do



62,000+

Serving the **most** Louisianans in exclusive accountable care OHN products



370,000+

The **most** Medicare and Commercial lives under management in Louisiana



\$85M+

Value-based revenue earned by participating practices since 2017, the **most** in Louisiana



2,500

Largest physician network in Louisiana driving collaboration, performance, and influence



OACN 2019 Performance (two tracks)

Track 1+

- Beneficiaries: **28,059**
- Total Savings: **\$24.8M**
- Savings Rate: **7.25%**
- Earned FY Savings: **\$11.4M**
- Prorated Savings: **\$5.7M**

Enhanced

- Beneficiaries: **31,535**
- Total Savings: **\$21.8**
- Savings Rate: **5.77%**
- Earned FY Savings: **\$15.1M**
- Prorated Savings: **\$7.5M**

Total Savings: \$13.26M

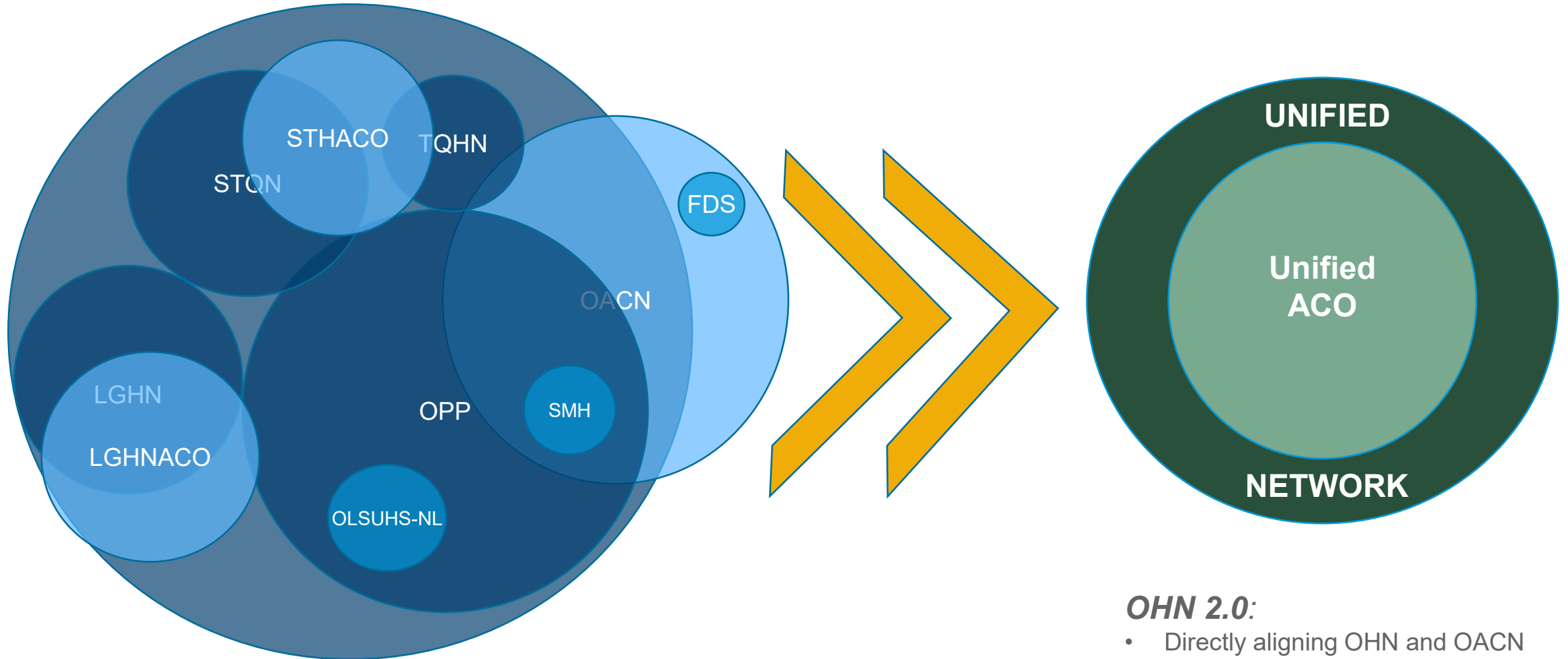


Incentives Increasingly Aligned with Value

Collaboration Models
Increasing Provider Risk →



Network Unification



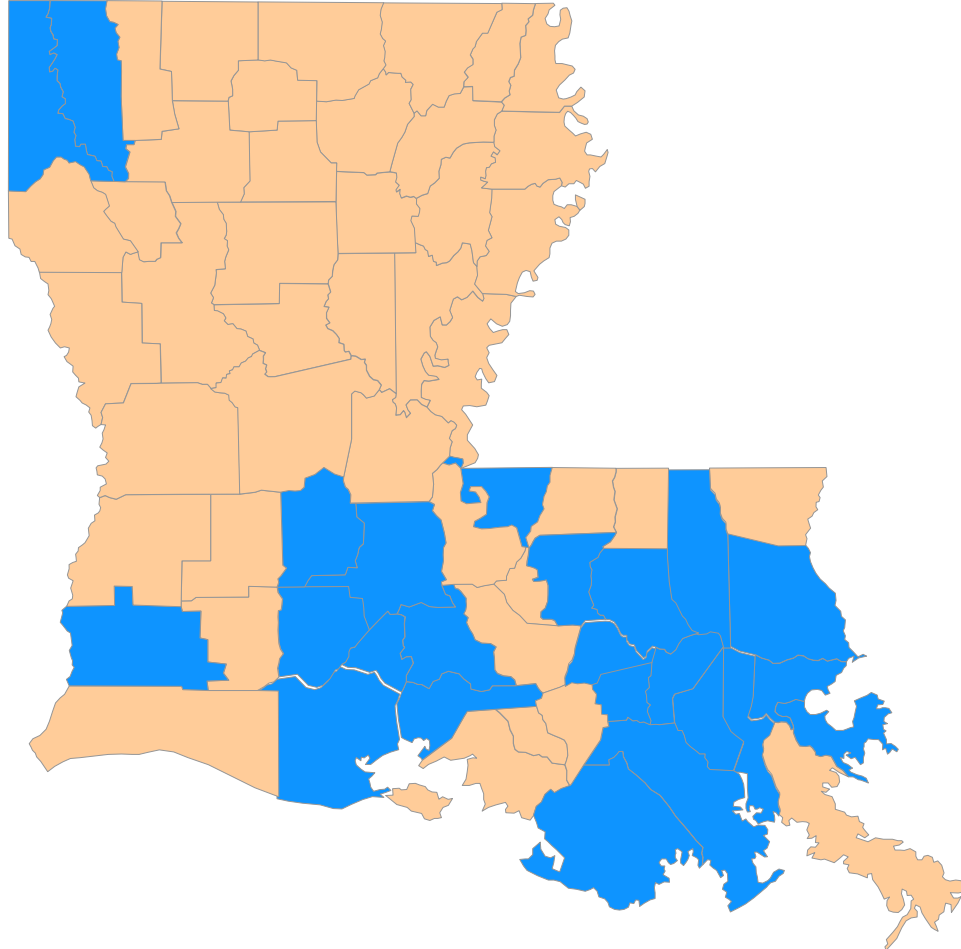
OHN 1.0: 6 Partner Hospitals + 4 CINS + 3 MSSP ACOs =
30+ committees + 7 distribution methodologies

OHN 2.0:

- Directly aligning OHN and OACN
- Ochsner led and funded
- Partner engagement and participation with a primary care focus



Ochsner Accountable Care Network (OACN) Projected 2021 Composition



Ochsner Accountable Care Network (OACN) Stats

Beneficiaries	~40,000
Providers	>3,000

- Expected growth of over 10k beneficiaries in 2021
- Adding several large TINs expanding our reach throughout Louisiana
- Small presence along the MS Gulf



Keys to Success in Value-Based Care



Quality Improvement

Better outcomes and improved patient satisfaction drive stronger patient engagement and increased patient acquisition



Risk Optimization

Optimal reflection of population's care needs facilitates improved care coordination and increased revenue



Cost and Utilization

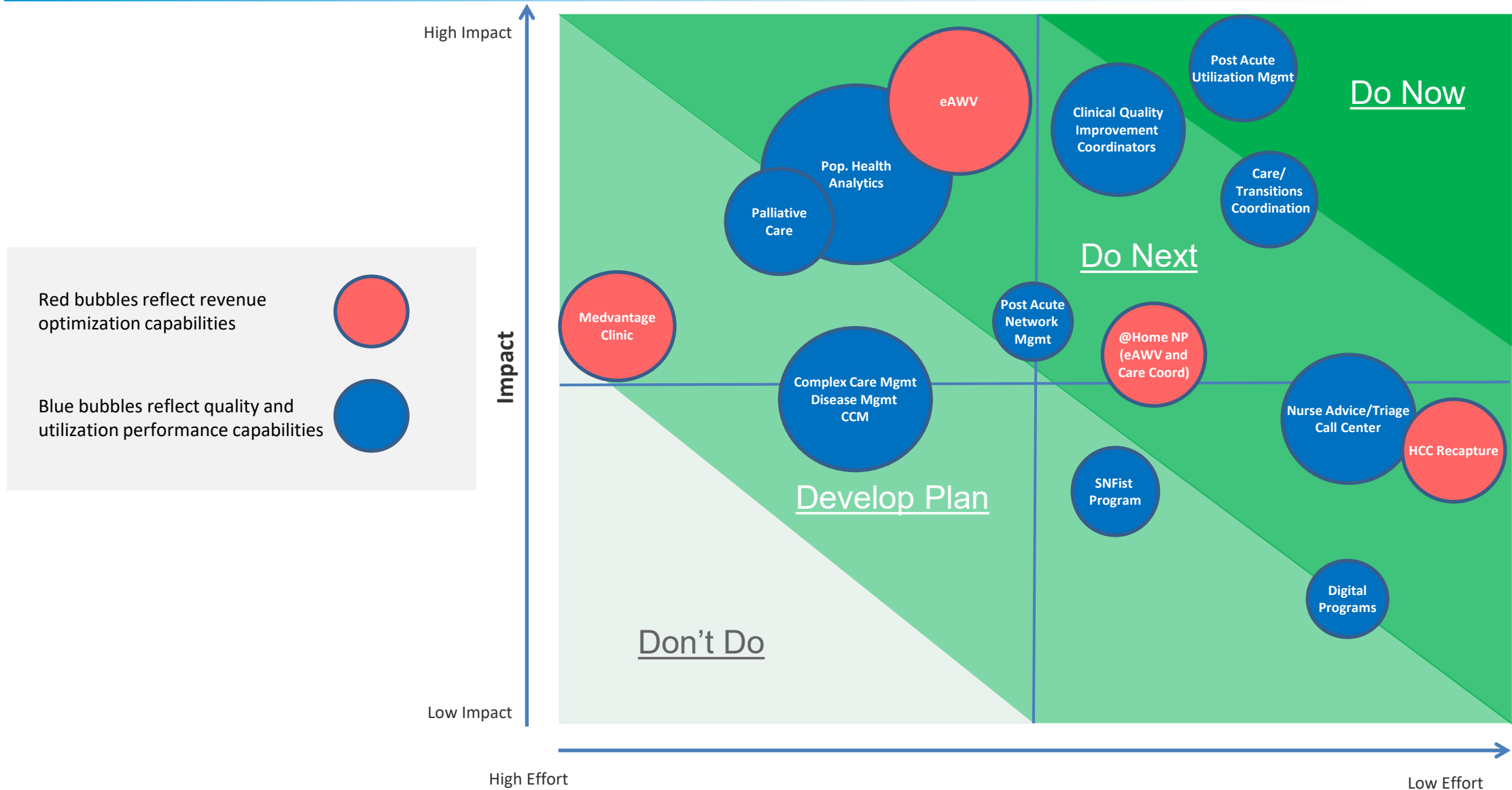
Eliminating unnecessary care and reducing total costs results in shared savings for patients, employers, health plans, and providers



OHN Population Health Services



Prioritization



Topics for Today

- Annual Wellness Visits
- Home Interventions
 - Home Health Network
 - Post D/C Home Visits
 - ED Avoidance Activities



2020: The Year of Virtual Health

Pandemic Conditions Ripe for Telehealth Adoption



Emergent
hospital & clinic Telemed
operations to prevent
exposures



Urgent
community screening,
testing, triage &
convalescence



Chronic Disease
patient protection &
virtual clinic access

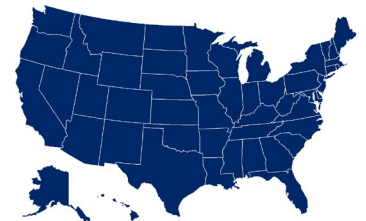


Governmental Response

Expansion
of allowable technology
with broad use of
audio-video apps & chats



Expansion
of interstate practices
with emergency licensure



Expansion
of allowable & reimbursable
CMS codes



Telemedicine Coverage Expansion - CMS



- Added 80 service codes
- Expanded provider eligibility
- Permitted waiving of copays
- Permitted audio-only encounters to qualify as meeting criteria
- Specified (95) modifier during crisis for full face-to-face value
- Created flexibility in vitals documentation for MA – risk-adjusted AWW's



eAWV Visit Options

Virtual



Clinic

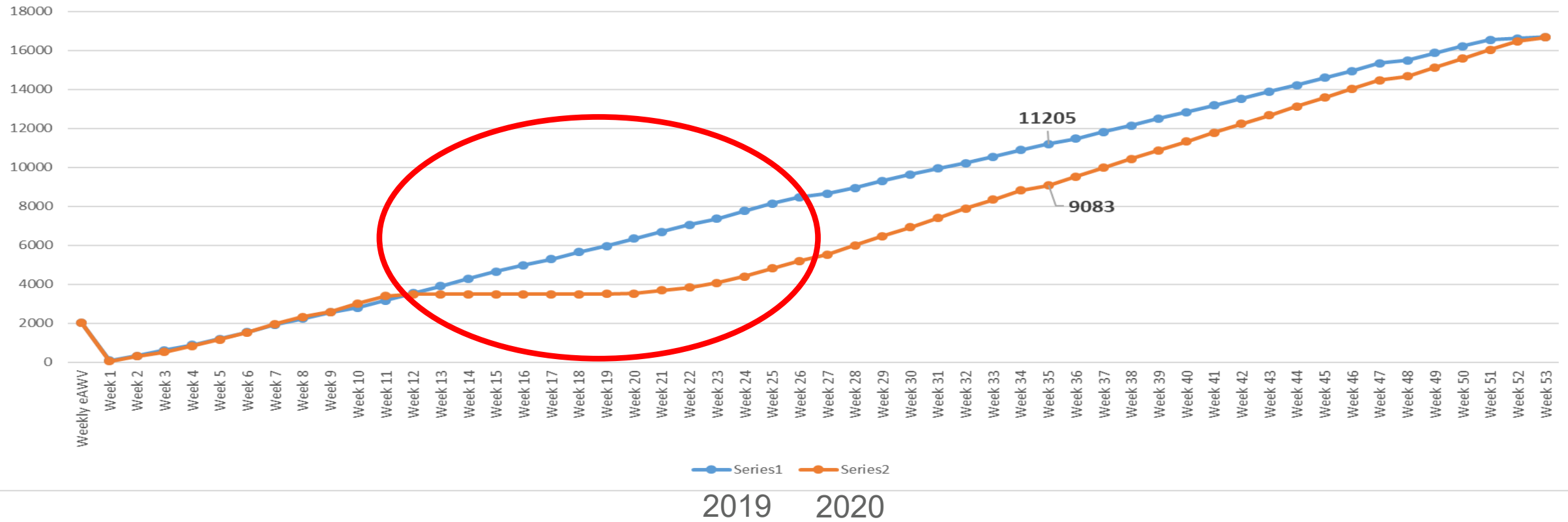


Home



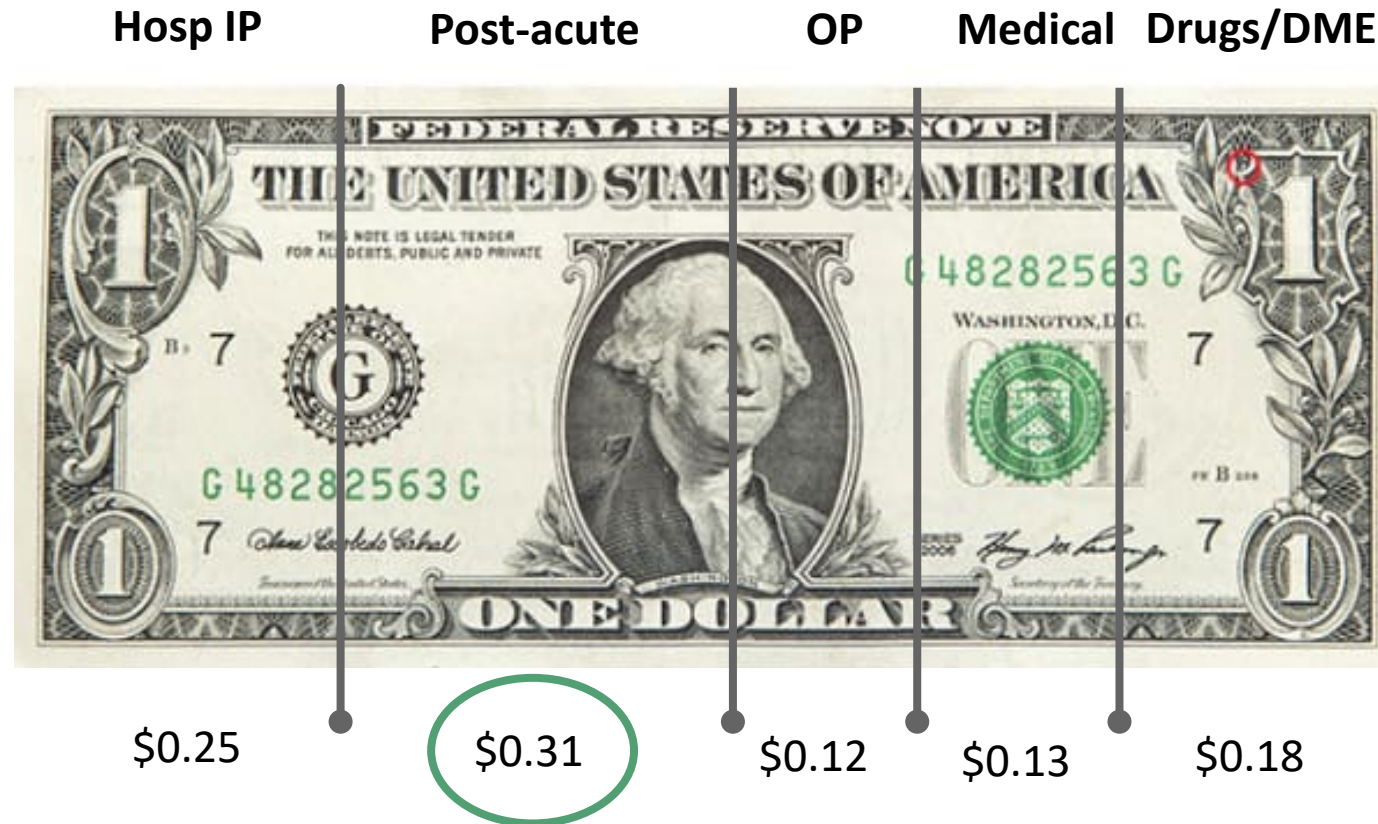
2020 vs 2019 Accumulative eAWV by Week

2019 vs 2020 Accumulative Total Including Trended Projections



Why Focus on Post-Acute?

The Medicare healthcare dollar in Louisiana

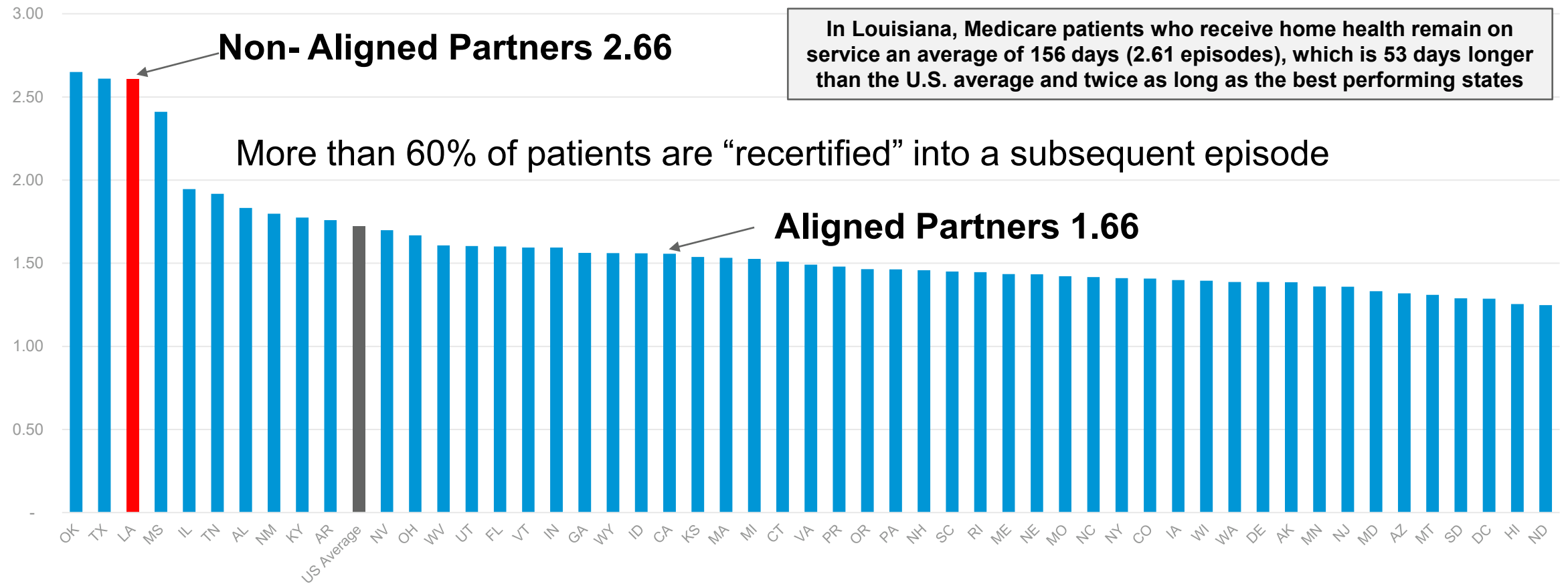


Louisiana is the **ONLY** state where Medicare pays more for Post-acute care than Hospital IP care!



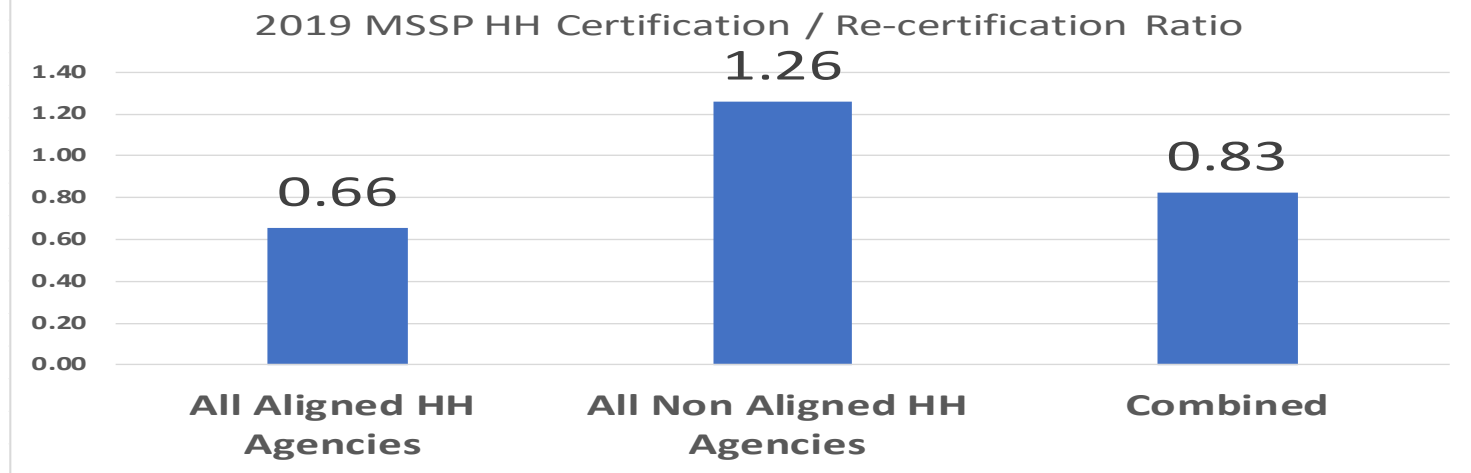
2019 MSSP Home Health Network Average Number of Episodes

Medicare Home Health Episodes per Patient



Recertification Rates Aligned vs Non-aligned

MSSP HomeHealth Certification / Re-Certification Activity 2019				
Home Health Name	Sum of re_cert	Sum of new_cert	Certification / Re-certification Ratio	Aligned Y/N
All Aligned HH Agencies	1925	2937	0.66	Yes
All Non Aligned HH Agencies	1450	1151	1.26	No
Combined	3375	4088	0.83	Combined



2019 MSSP Home Health Cost Per Patient Average	
Average Cost Per Patient (Aligned Partner 1.66)	\$4,880
Average Cost Per Patient (Non-aligned Partner 2.26)	\$6,780
Difference	(\$1,900)

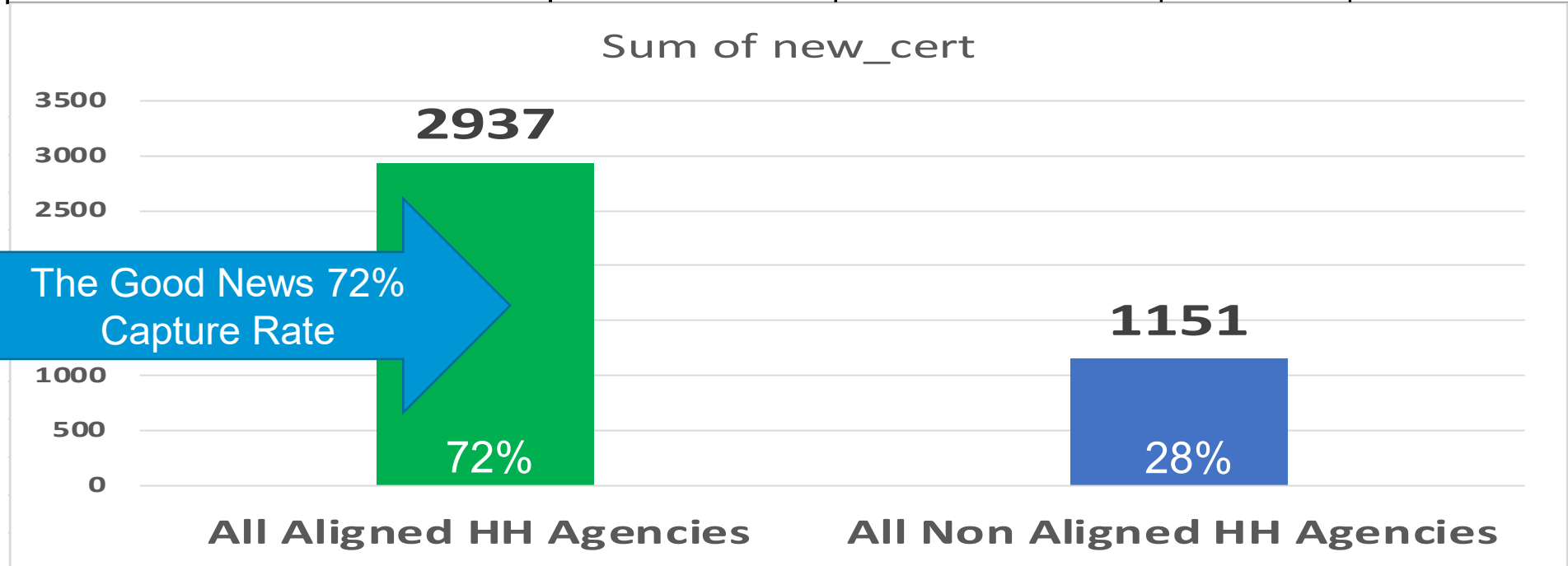
Average Medicare Cost:

OP Therapy	\$ 1,000
HHA	\$ 3,000
SNF	\$12,000
IRF	\$20,000
LTAC	\$32,000



Over-Utilization of PAC Services

MSSP HomeHealth Certification / Re-Certification Activity 2019				
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At Home Priority Clinic: Nurse Practitioner Visits to Prevent Readmissions

- Patients at high risk of readmission are identified during post-discharge transitions call and a home visit is scheduled
- Home visit includes:
 - Clinical assessment
 - Medication reconciliation
 - Home environment assessment
 - Nutritional education
 - Social barriers assessment
- May be a single visit or a 30-day longitudinal care plan

Comparison with Traditional Priority Clinic

	Traditional Priority Clinic	NP Home Visits
% of patients who accept appointment	50%	95%
% of Appointments that are canceled/no-show	20%	< 1%
30-day hospital readmission rate	10%	5%



Ready Partnership



Medical Visits



On Demand Urgent Care



Coordination and Management



Ochsner's 24/7 Nurse Advice Line

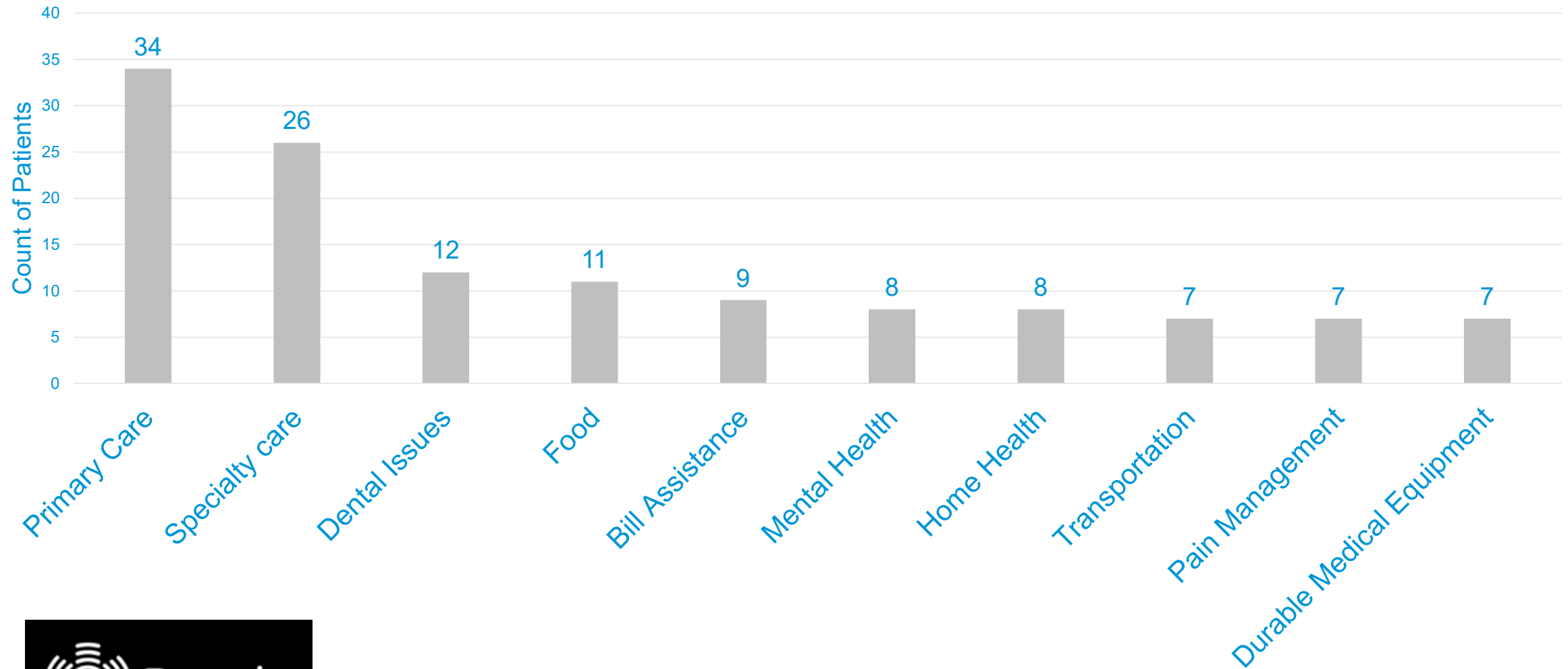


Ochsner
On Call

After Hours Care Line
1-800-231-5257



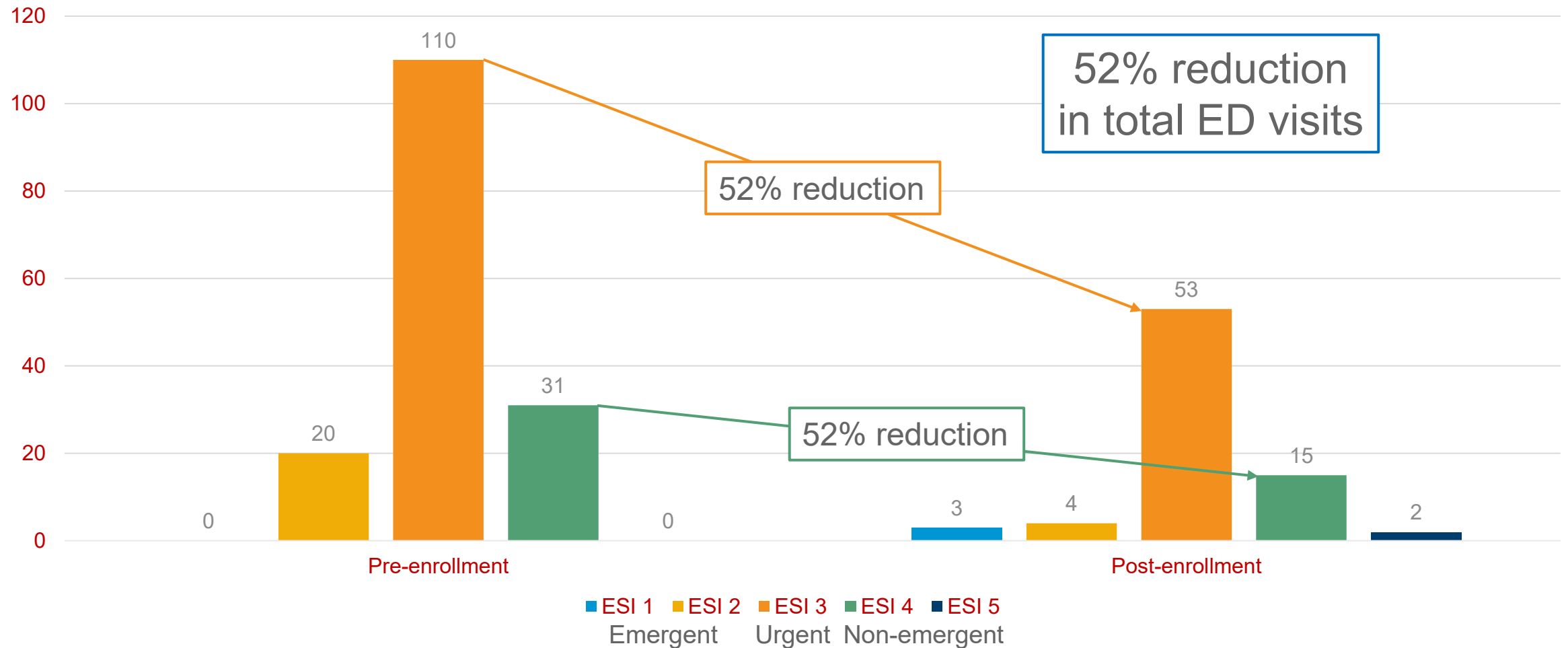
Identified Needs of the MSSP Beneficiaries



Urgent Needs Uncovered

Community Care Results - MSSSP

*64 patients (47% 0-90 days post-enrollment; 53% 90-180 days; 0% >180 days)



What Patients Would've Done

If Not For Ready House Call Program

<i>Where Patient Would've Sought Care If Not For Ready Responders</i>	<i>% of Outcome – Patients 65+</i>	<i>% of Outcome – All Patients</i>
<i>Called 911</i>	11%	3%
<i>Doctor's Office/Urgent Care</i>	37%	44%
<i>Gone to the ER</i>	42%	38%
<i>Stayed at Home/Done Nothing</i>	11%	16%



Steps to Success

- **Grow** the populations that partner with Ochsner on health and well-being
- Make it very **convenient** for them to get appropriate care and advice
- **Manage** the Total Cost of Care

- Assure patients have **access** to high quality post acute providers
- **Manage** the expenditures within the post acute environment
- **Coordinate** movement from post acute to home and/or palliative care when appropriate

- **Design** and **execute** programs across the system to:
 - Anticipate needs of patients
 - Improve the care experience
 - Improve clinical outcomes
 - Drive value-based financial performance



Enhancing and Expanding OHN and OACN Success



Enable HCC recapture tool and deliver training for all current and 2021 OACN practices on Epic



Develop and deliver monthly practice-level performance reports with quality, cost, utilization, and risk management measures



Develop statewide post-acute preferred network and statewide SNFist program



Educate and engage providers and expand outpatient case management program enrollment



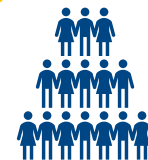
Implement post-acute mobile patient tracker for readmission avoidance for all MSSP and MA patients



Educate and engage providers and expand digital medicine program enrollment



Scale MA Clinical Care Coordinator outreach to all clinics on Epic for QBPC and MSSP patients



Expand eAWV prioritization, outreach, and in-home visit program





The Role of AI in Value Based Contracting



Who is Apixio?

Silicon Valley-based healthcare analytics company that helps payers and risk-bearing entities drive value-based care using our patented AI platform and associated applications that analyze and derive insights from structured and unstructured data at scale

The Problem

Healthcare data is increasingly digital, and it holds insights for better, affordable care. Current systems and solutions for clinical, operational, and reimbursement initiatives are not able to effectively use billions of documents created each year

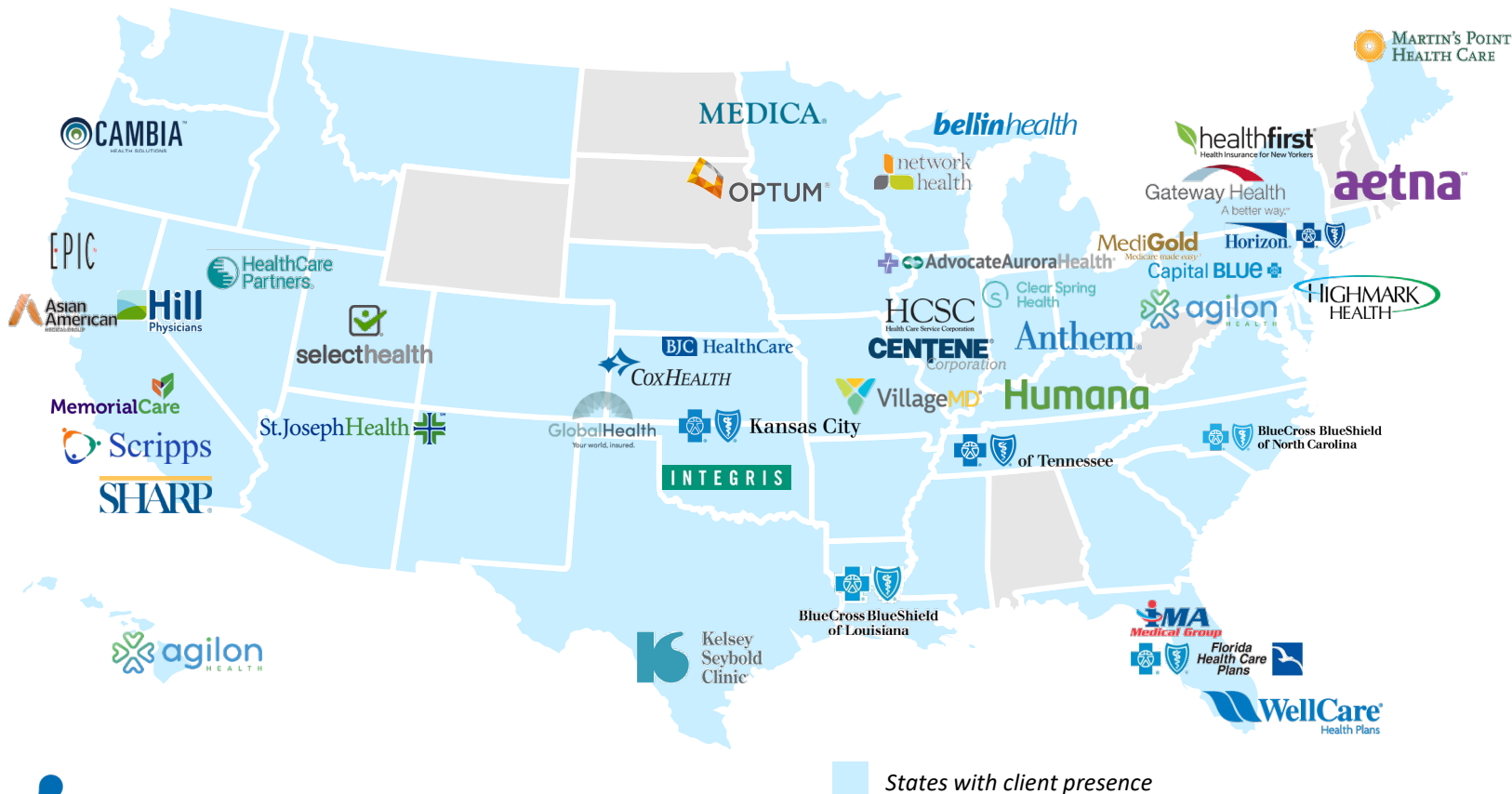


The Solution

Develop technology that can ingest unstructured information and apply AI/ ML algorithms to reveal deep clinical, operational, and reimbursement insights for user-friendly applications

Large and Diverse Set of Brand Name Payer and Provider Clients

Leading National & Regional Payers and Risk-Bearing Providers Spanning Patients and Members Nationwide



47
Total Clients

40
States Covered

6 of 10
Top MA Plans

12
Blues Plans

21
Risk-Bearing Providers

94
KLAS Score
Risk Adj Analytics

Client Count – Payer vs. Provider



Artificial Intelligence → Machine Learning

Artificial Intelligence (AI) is any device that mimics “cognitive” functions, such as:

- Vision
- Speech recognition
- Natural language processing
- Knowledge representation
- Planning

Machine Learning is a subset of AI that uses statistical techniques to “learn” from data to accomplish a task

Machine Learning in Common Use Today

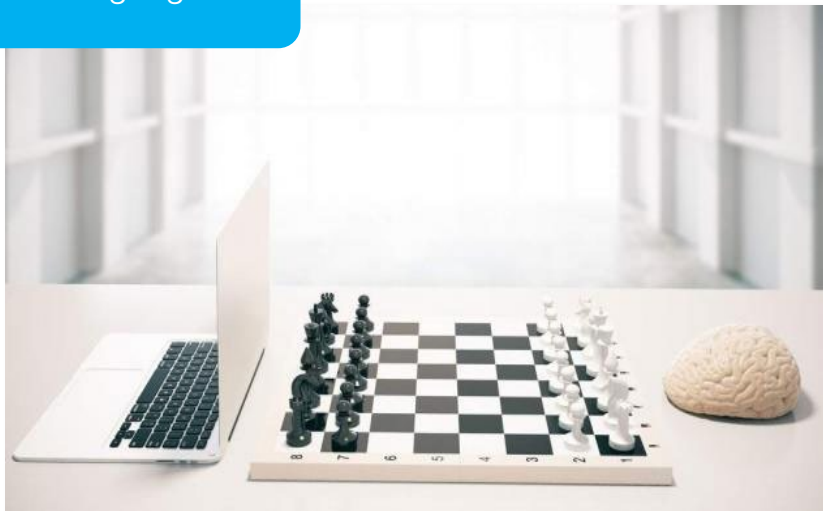
Semi-autonomous driving



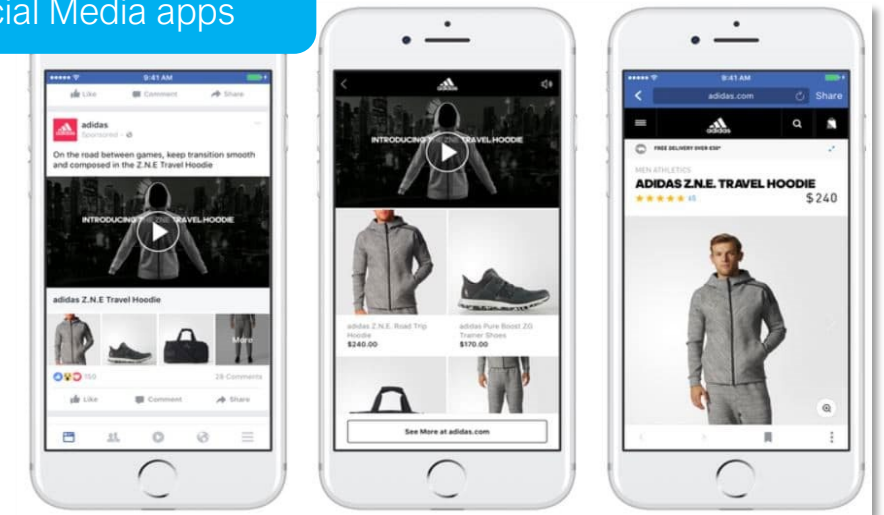
Voice recognition in smart devices



Master at strategic games

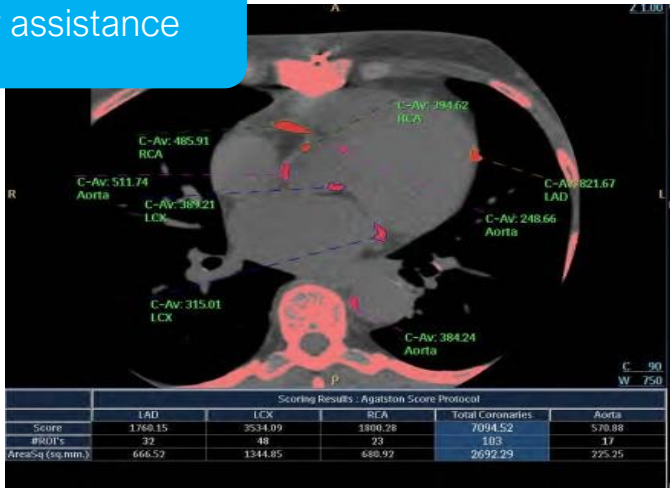


Advertisements on Social Media apps



Early Uses of Machine Learning in Healthcare

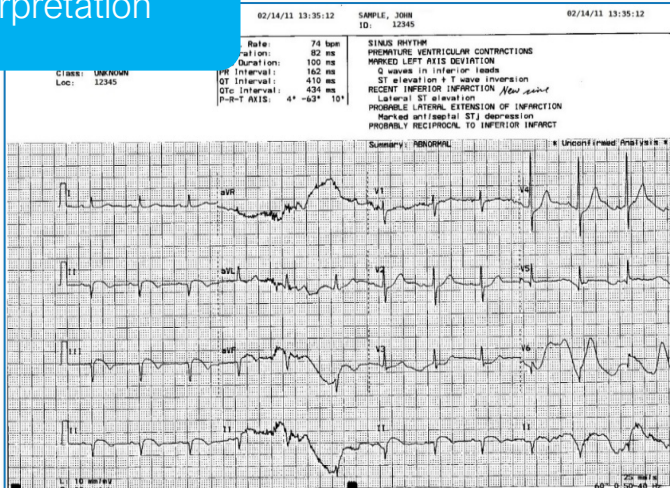
Radiology assistance



Pathology assistance



EKG interpretation



Patient profiling

PATIENT: SAMPLE, JOHN
DOB: 10/12/1943
MRN: 12345
DOS: 11/26/2011

Chris Cardio, M.D.

Consult - Congestive Heart Failure

Description: Congestive heart failure (CHF). The patient is a 68-year-old gentleman presented through the emergency room. Symptoms are of shortness of breath, fatigue, and tiredness. Main complaints are right-sided and abdominal pain. Initial blood test in the emergency room showed elevated BNP suggestive of congestive heart failure. Given history and his multiple risk factors and workup recently, which has been as mentioned below, the patient was admitted for further evaluation. Incidentally, his x-ray confirms pneumonia.

REASON FOR CONSULTATION: Congestive heart failure.

HISTORY OF PRESENT ILLNESS: The patient is a 68-year-old gentleman presented through the emergency room. Symptoms are of shortness of breath, fatigue, and tiredness. Main complaints are right-sided and abdominal pain. Initial blood test in the emergency room showed elevated BNP suggestive of congestive heart failure. Given history and his multiple risk factors and workup recently, which has been as mentioned below, the patient was admitted for further evaluation. Incidentally, his x-ray confirms pneumonia.

CORONARY RISK FACTORS: History of hypertension, no history of diabetes mellitus, active smoker, cholesterol elevated, questionable history of coronary artery disease, and family history is positive.

FAMILY HISTORY: Positive for coronary artery disease.

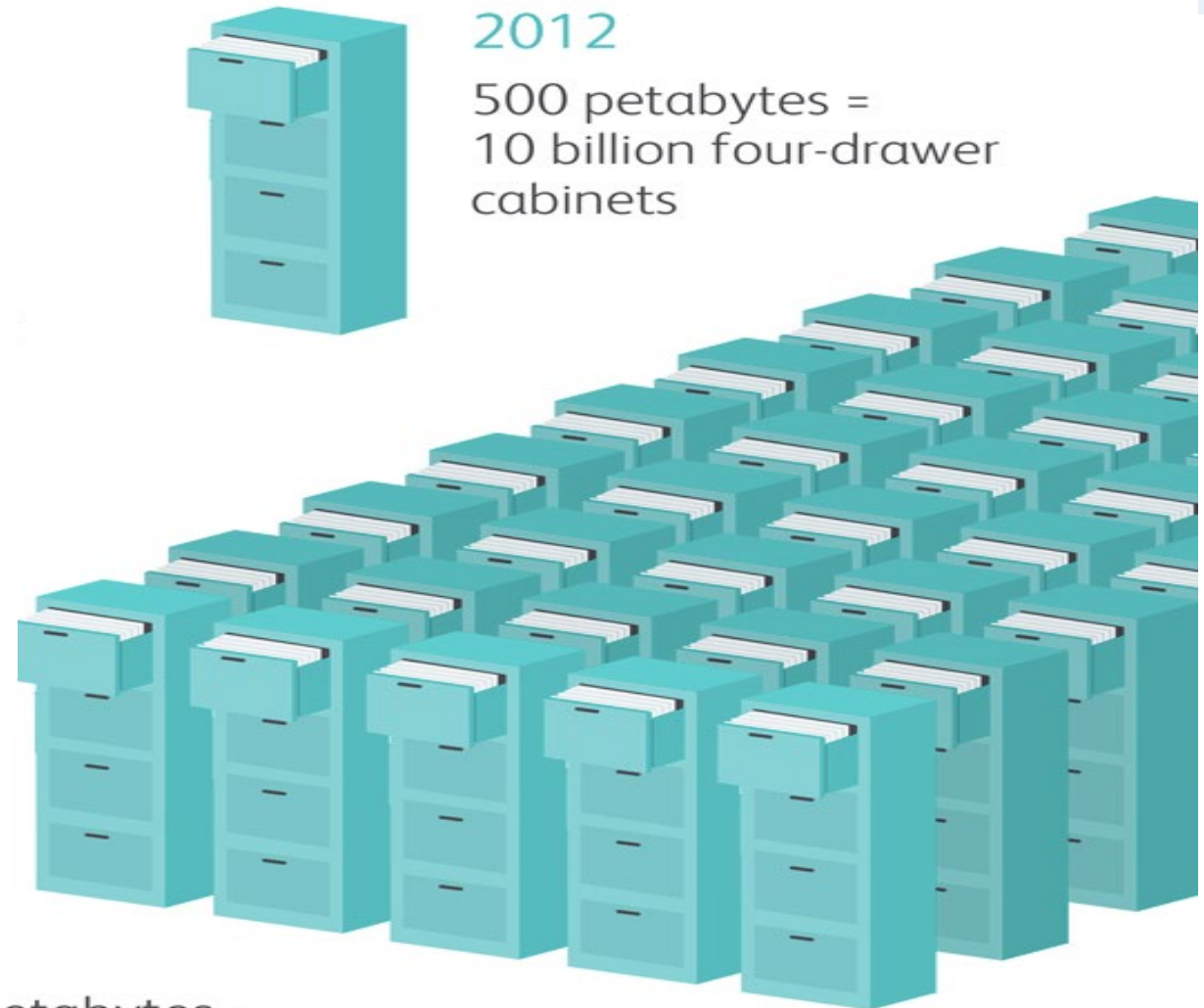
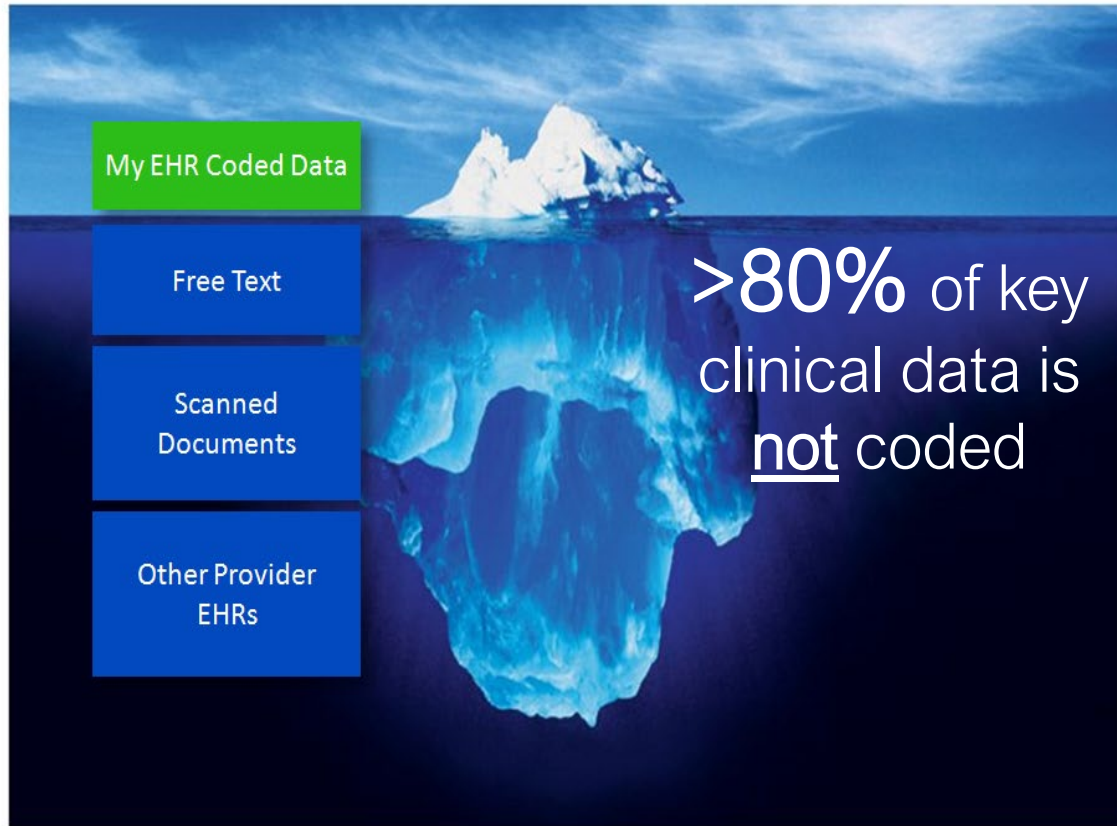
PAST SURGICAL HISTORY: The patient denies any major surgeries.

MEDICATIONS: Aspirin, Coumadin adjusted dose, digoxin, isosorbide mononitrate 120 mg daily, Lasix, potassium supplementation, gemfibrozil 600 mg b.i.d., and metoprolol 100 mg b.i.d.

ALLERGIES: None reported.

PERSONAL HISTORY: Married, active smoker, does not consume alcohol. No history of recreational drug use.

Healthcare Data Explosion



Scanned Charts Need to Be Made Machine Readable

Page 2 of 13

MAY, ANGELA
75 year old Female, DOB 12/12/1940
Account Number: 8231
123 Mango Park Lane, Youngstown ME - 59001
Home: 406-925-3725
Guarantor: MAY, ANGELA Insurance: MEDICAS
MEDICARE Payer ID: 54320
Referring: Ben nett Gayle
Appointment Facility: Youngston Smart Care LLC.

08/10/2016 Progress Notes: Boyd A. George, MD

Current Medications
Taking
● propranolol 11 mg tablet 1-2 tab(s) once a day
● Gas Relief 128 mg tablet, chewable 1 tab(s) 4 times a day (after meals and at bedtime)
● Prenatal Plus Iron Prenatal Multivitamin with Folic Acid 2 mg tablet 1 tab(s) once a day
● Nexium 45 mg delayed release capsule 1 cap(s) once a day
Discontinued
● Dexam 50 1 tab(s) once a day
● Diliazem Hydrochloride CD 249 mg/24 hours capsule, extended release TAKE ONE CAPSULE EVERY DAY
● Medication List reviewed and reconciled with the patient

Past Medical History
Hypertension
SVT
Atrial fibrillation
echo 9/12/12 EF 62%, normal valves, trace TR
ETT 9/12/12 6:29min, 91% MPPH, 1min ST depression c/w ischemia
exercise nuclear stress 9/19/12, 6:40 min, 91% MPPH, no EKG changes, no infarct or ischemia, EF 72%
echo 10/7/14 EF 55-60%, trace-mild MR and TR, PAP 60mmHg
exmc 10/7/14 7:30min, 9.8% MPPH, no ekc changes, no infarct or ischemia, EF 67%

Surgical History
C section 01/2009
Abilition (non-infectious) 12/19/12
Iron infusion 8/21/15

Family History
Father: abn. Hypertension, Diabetes mellitus, Bypass, depressed with Diabetes, Heart Disease
Mother: deceased, Hypertension, Leukemia
brother(s): 3, sister(s): 1, son(s): 1, daughter(s): healthy.

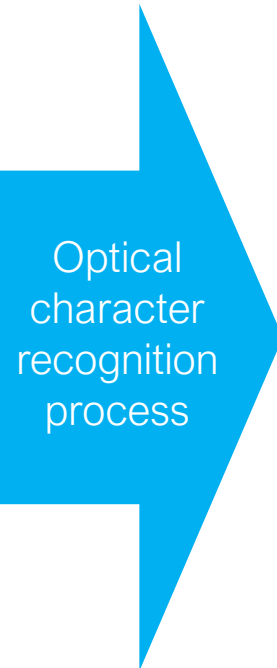
Social History

Reason for Appointment
1.6 MO F/U

History of Present Illness
Cardiology:
75 year old female presents with c/o dizziness, c/o palpitations. Denies: chest pain, shortness of breath, diaphoresis, leg edema, orthopnea, no changes in sleep pattern.
8/10/16 She comes in for follow-up visit for palpitations, SVT, hypertension. She reports she gets a little dizzy when she has her menstrual cycle. She is anemic. She takes a prenatal vitamin. She does not take iron supplements due to constipation. She tries to watch her diet. She walks twice a week for exercise. She has occasional palpitations lasting a few seconds about twice a week. She notes that when she gets cold her toes turning blue. She denies any pain in her legs or her feet. EKG today: Sinus rhythm, heart rate 71.
2/17/16 She comes in for follow up visit for palpitations, SVT, HTN. She has been doing fair since her last visit. She reports feeling a little tired and sluggish today. She denies any CP or SOB. She still has some palpitations about 1 time a week for a few seconds at a time. She has not had any recent illnesses. She saw Dr. Gayle GI and was told to take gas meds and meds to keep her regular. She reports improvement in her chest pressure.
10/10/15 She comes in for follow up visit for palpitations, SVT, HTN. She reports that she has been having some chest discomfort. She reports that it is associated with belching. She also notes it occurs more when she drinks milk products and eats a lot of fatty foods. She reports this chest discomfort occurs about twice a week and last about 2 hours at a time. She reports her dizziness was improved.
9/26/15 She comes in for followup visit for palpitations, SVT, hypertension. She reports that she's been doing fair since her last visit. She occasionally has some sharp chest pains. They occur at rest and with exertion. They resolve on their own. Last for a few seconds or minutes at a time. She has been walking every day other day for about 15 min. She occasionally feels dizzy when she doesn't eat. She reports that she has not had any recent palpitations. EKG today: Sinus rhythm, poor R wave progression, heart rate 71.
3/31/15 She comes in for a followup visit for palpitations, SVT, hypertension. She has been doing fair since her last visit. She reports that she sometimes feels so dizzy and lightheaded. She notes it more

Patient: MAY, ANGELA DOB: 12/12/1940 Progress Note: Boyd A. George, MD
08/10/2016

9/12/2016



History of Present Illness

Cardiology:
75 year old female presents with clo dizziness. clo palpitations. Denies : chest pain, shortness of breath, diaphoresis, leg edema, orthopnea, no changes in sleep pattern.
8/10/16 She comes in for follow-up visit for palpitations, SVT, hypotension. She reports she gets a little dizzy when she has her menstrual cycle. She is anemic. She takes a prenatal vitamin. She does not take iron supplements due to constipation. She tries to watch her diet. She walks twice a week for exercise. She has occasional



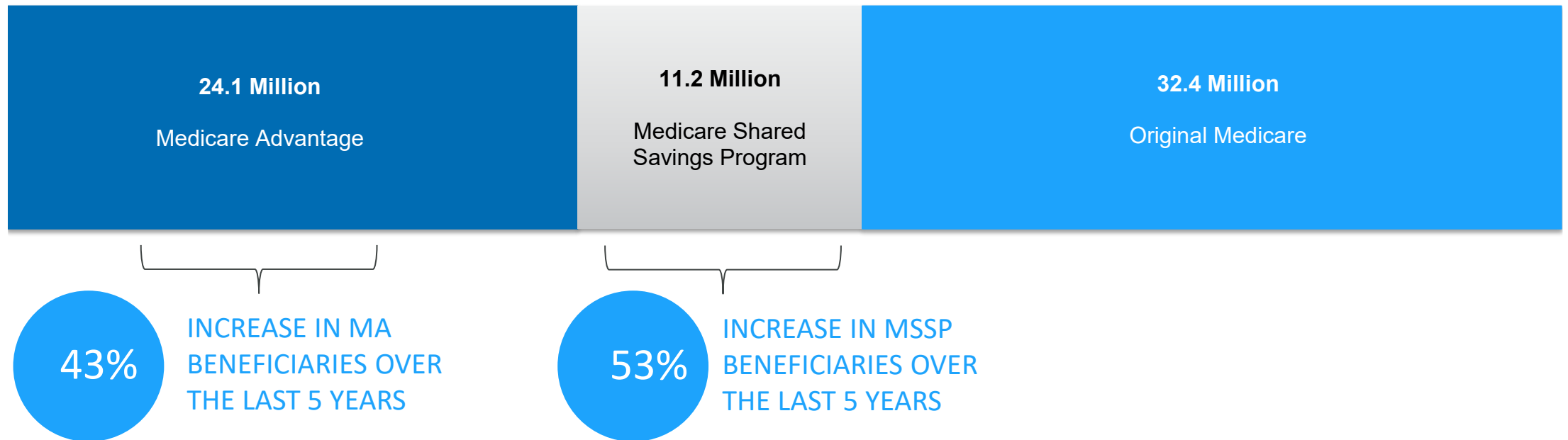
Risk Adjustment and Quality Reporting are Key Components of Value-Based Contracts

- ✓ Medicare Advantage (MA)
- ✓ Medicare ACO Programs (MSSP)
- ✓ Medicaid
- ✓ Marketplace/ACA
- ✓ Commercial
- ✓ PPO



Medicare Beneficiaries by Program - 2020

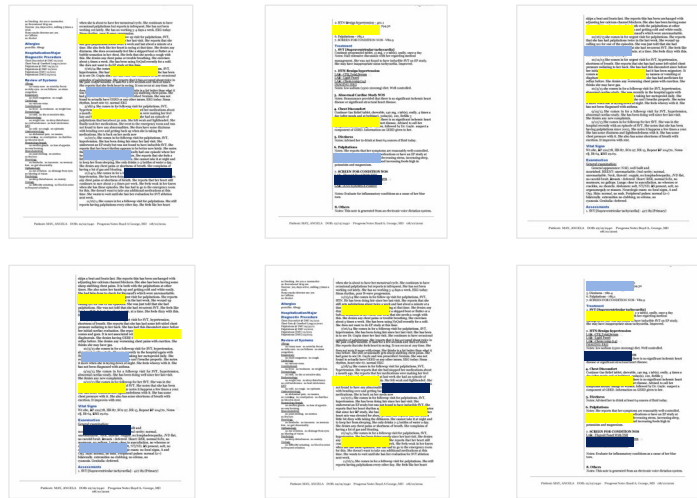
The CMS-HCC risk model has increasingly been used to ensure payment accuracy across the Medicare population.



Enhanced Chart Review Using Machine Learning



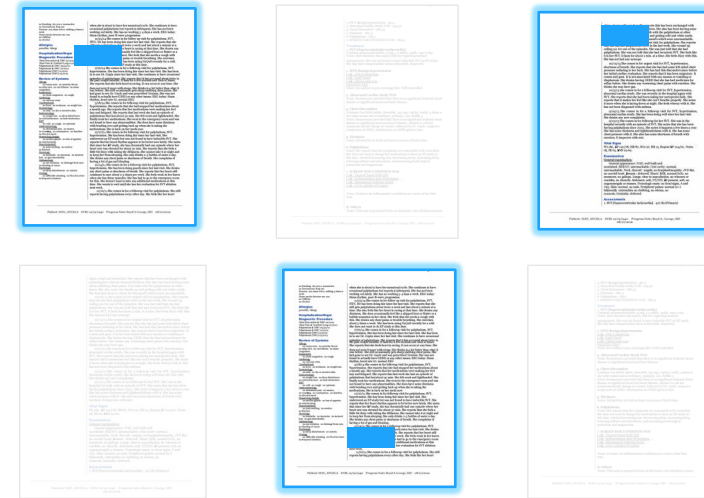
Manual Coding



- ⊗ Requires whole chart review
- ⊗ Coder has every HCC in mind
- ⊗ Process prone to errors



AI-powered Coding



- ✓ Targeted, selective review by coders
- ✓ Focus upon new or audited HCCs, one at a time
- ✓ Better decision making

Large National Plan Case Study of *HCC Identifier*



Apixio technology greatly increased coder accuracy and efficiency

Participants:

Apixio client participated in the largest study ever undertaken using technology assisted risk adjustment coding

Sample:

284,000 charts were included in the study from providers operating in 10 states across the country

Design:

Client coders used the Apixio application; vendor coders reviewed charts using manual (unassisted) methods

Apixio Technology Results:

- ✓ **23.9%** more codes found
- ✓ **80%** less time and effort to code charts
- ✓ **94%** of inappropriate (false) coder rejections recovered



Results: Accuracy (# new, unique HCCs)



30,236

TRADITIONAL VENDOR

24,385

PERFORMANCE
GAP

Results: Productivity (# charts reviewed per hour)



17.0

TRADITIONAL
VENDOR

4.5

PERFORMANCE
GAP

Enhanced Quality Abstraction Using Machine Learning

Manual Abstraction

Currently, staff *locate unstructured data manually* to accurately report key quality measures, or ask physicians to attest to results, both of which are *time-consuming, expensive and ineffective*



Expensive

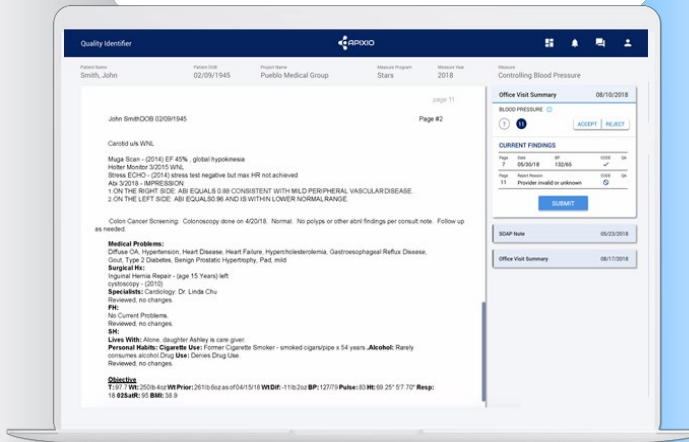


Time Consuming



Administrative Burden on high-skilled staff

Machine learning enabled chart review to locate key facts for measure reporting



AI-Powered Abstraction

AI offers an enhanced path to *find facts in medical charts*, to *accurately report results efficiently*, for optimal *performance-based incentives across all lines of business*



Efficient



Accurate



Gives back time to skilled nurses and doctors

2019 Measurement Year: Pilot Results

Projects

- Partnered with 6 clients
- Supported quality abstraction for 5 HEDIS measures:
 - Body Mass Index (BMI)
 - Comprehensive Diabetes Care - HbA1c
 - Controlling Blood Pressure
 - Colorectal Cancer Screening
 - Breast Cancer Screening

Initial Results

- **Closed Quality Data Gaps**
 - 8% of open quality gaps closed
- **Abstracted More with Less Effort**
 - Over 78% reduction in documents for review by AI-screening
 - 22 gaps reviewed per hour with AI assistance

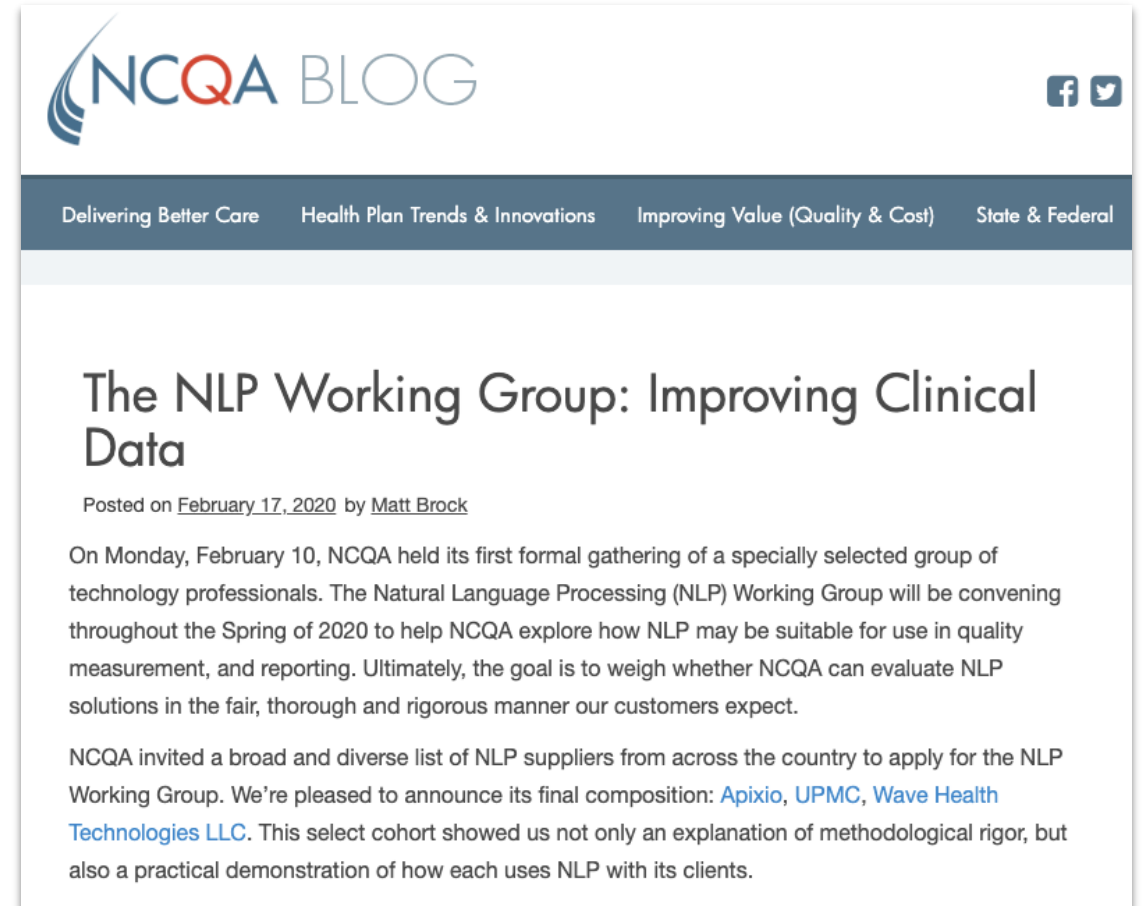
2020 Measurement Year Support

- ABA: Adult BMI Assessment
- BCS: Breast Cancer Screening
- CBP: Controlling Blood Pressure
- CDC: Blood Pressure
- CDC: Eye Exam
- CDC: HbA1c
- CDC: Medical Attention for Nephropathy
- COA: Medication Review
- COL: Colorectal Cancer Screening
- MRP: Medication Reconciliation Post Discharge
- TRC: Medication Reconciliation

NCQA NLP Working Group

Working Group Goals:

- Work with NCQA to determine how to validate the accuracy of NLP outputs as part of an electronic clinical data system (ECDS)
- Help NCQA develop a validation model for NLP-derived quality measurement data
- Share insights with an independent advisory panel of NLP experts including academics, researchers, and industry thought leaders.

A screenshot of a blog post from the NCQA Blog. The header includes the NCQA logo and the word "BLOG" in a large, light blue font. To the right are social media icons for Facebook and Twitter. Below the header is a dark blue navigation bar with white text for "Delivering Better Care", "Health Plan Trends & Innovations", "Improving Value (Quality & Cost)", and "State & Federal". The main content area has a white background with a large, bold title "The NLP Working Group: Improving Clinical Data". Below the title is the author information "Posted on February 17, 2020 by Matt Brock". The body text describes the formation of the NLP Working Group on February 10, 2020, and lists the members: Apixio, UPMC, and Wave Health Technologies LLC. The URL <https://blog.ncqa.org/nlp/> is visible at the bottom of the screenshot.

NCQA BLOG

Delivering Better Care Health Plan Trends & Innovations Improving Value (Quality & Cost) State & Federal

The NLP Working Group: Improving Clinical Data

Posted on [February 17, 2020](#) by [Matt Brock](#)

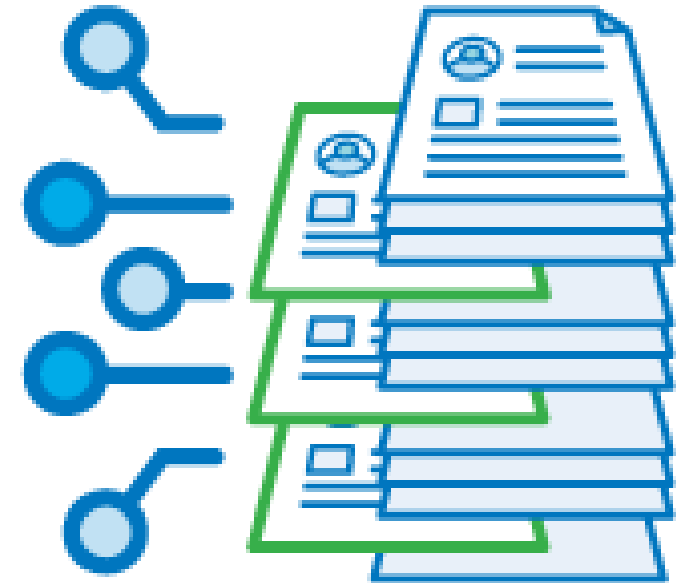
On Monday, February 10, NCQA held its first formal gathering of a specially selected group of technology professionals. The Natural Language Processing (NLP) Working Group will be convening throughout the Spring of 2020 to help NCQA explore how NLP may be suitable for use in quality measurement, and reporting. Ultimately, the goal is to weigh whether NCQA can evaluate NLP solutions in the fair, thorough and rigorous manner our customers expect.

NCQA invited a broad and diverse list of NLP suppliers from across the country to apply for the NLP Working Group. We're pleased to announce its final composition: [Apixio](#), [UPMC](#), [Wave Health Technologies LLC](#). This select cohort showed us not only an explanation of methodological rigor, but also a practical demonstration of how each uses NLP with its clients.

<https://blog.ncqa.org/nlp/>

Using AI to Mitigate Coder Bias

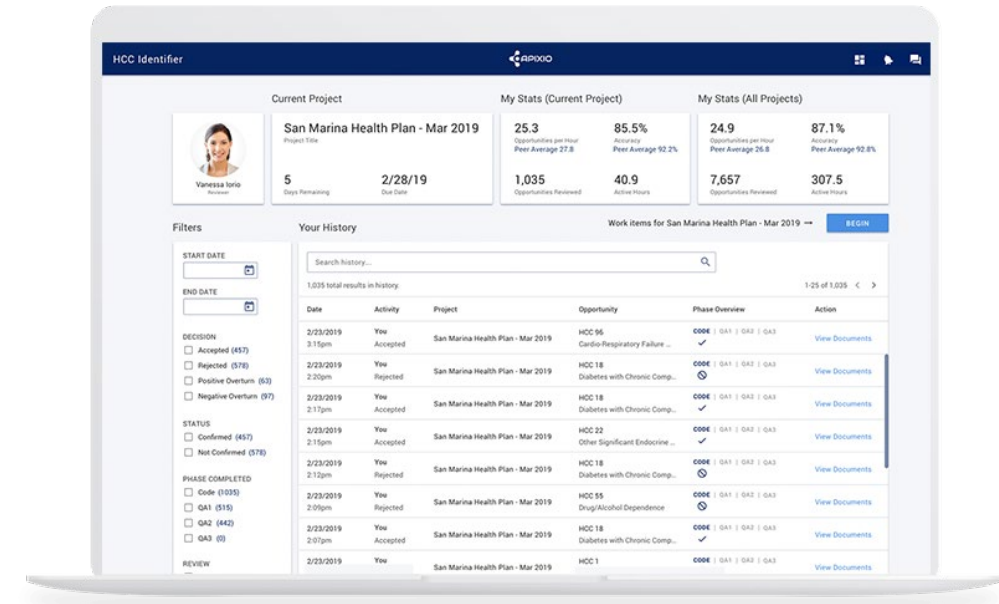
- AI algorithms identify coder behavioral bias due to fatigue and repetition by looking at over 20 data points based on user actions, such as:
 - Time per page view
 - View all highlighted pages in range
 - Streak of coding decisions
- Recover targeted, high-confidence rejected coding opportunities by routing them through an additional blind review
- **5-6% lift** in net-new HCCs



AI as a Compliance & Auditing Solution

An AI-powered audit tool allows you to:

- Analyze retrieved patient charts to identify source encounter notes for reported codes.
- Validate whether encounter notes have the required elements to support HCC codes.
- Report validated and unsupported codes.
- Confirm the integrity of your HCC submissions.



\$20B

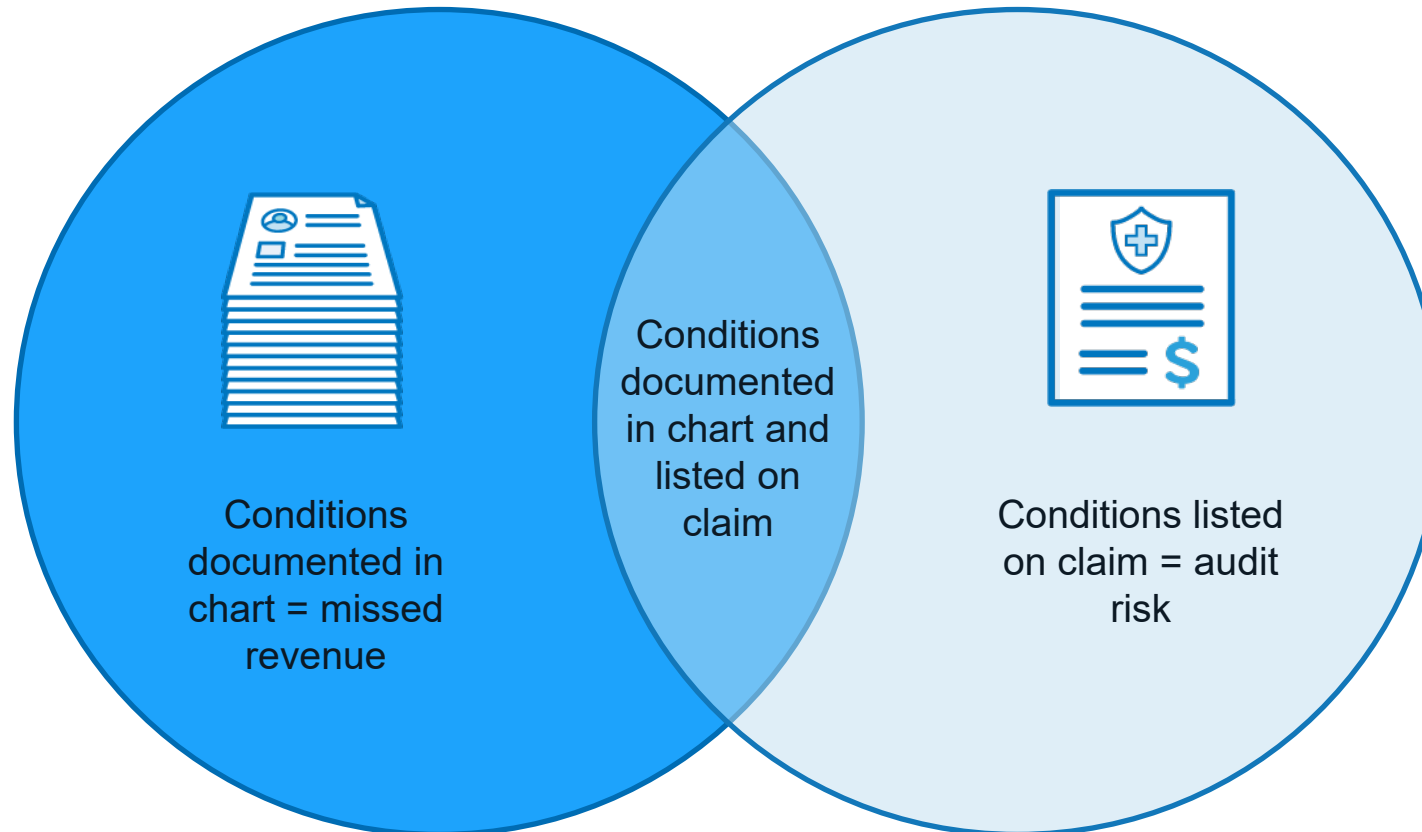
MA RA
PAYMENTS
WITHOUT
SUPPORTING
EVIDENCE

3-18%

CODES ON
CLAIMS
WITHOUT
SUPPORT

Identifying Missing or Wrong Condition Data

The medical chart is the source of truth for risk-adjustment. Unfortunately, the translation of the chart documentation to an appropriate ICD-10 code on a claim is often wrong.



Impact of AI in Healthcare

Applying Intelligence for Optimal Workflows



The use of AI to reduce administrative burden and improve performance is spreading across key functional areas in healthcare.

- 20% increase in coding accuracy
- 4 – 7X increase in coding productivity
- 8% closure of open care gaps



Thank you!

Jennifer Pereur
VP, Solutions
jpereur@apixio.com
[m](#)
(510) 282-0101

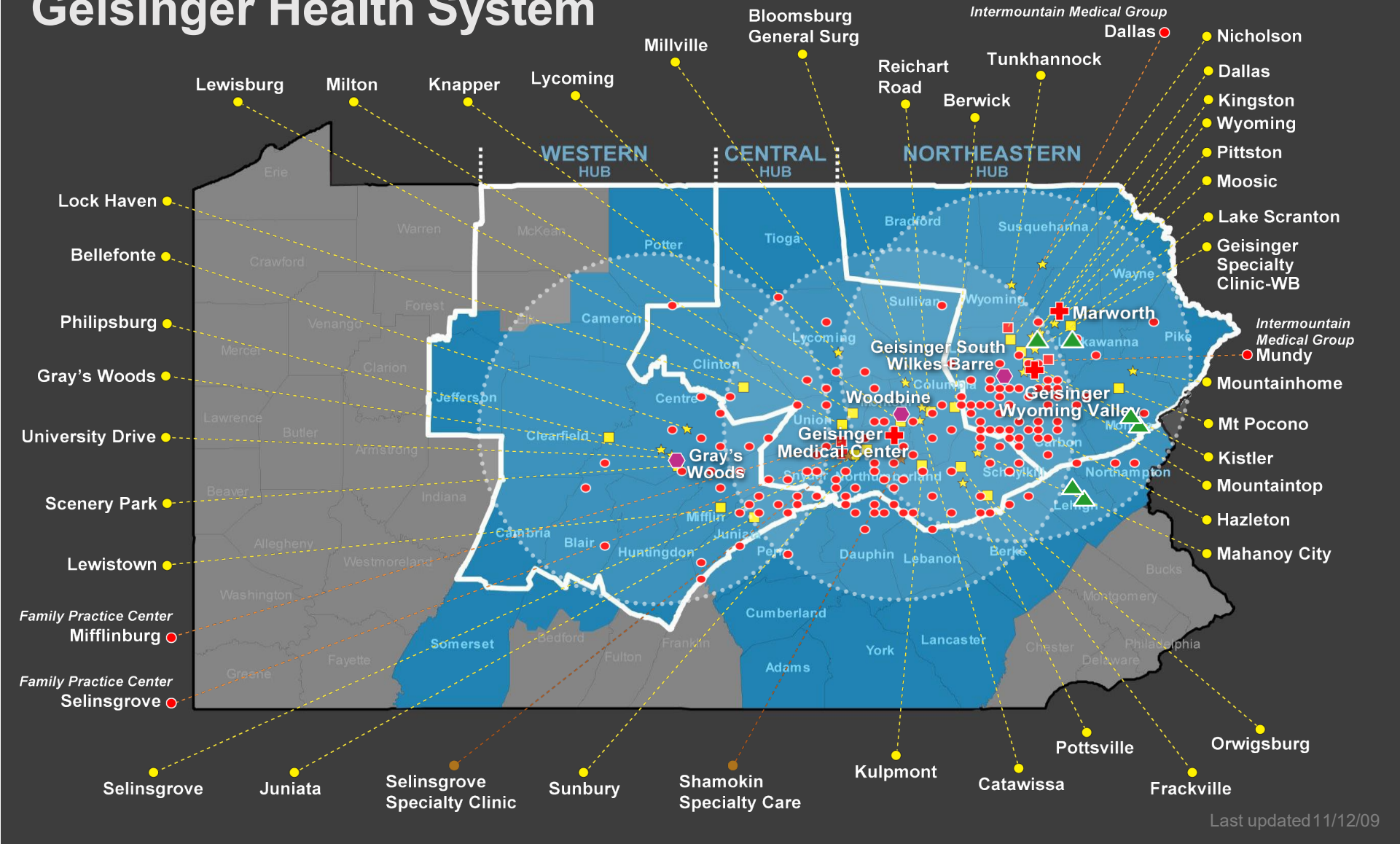
Care Across the Spectrum

Geisinger

NAACOS

September 2020

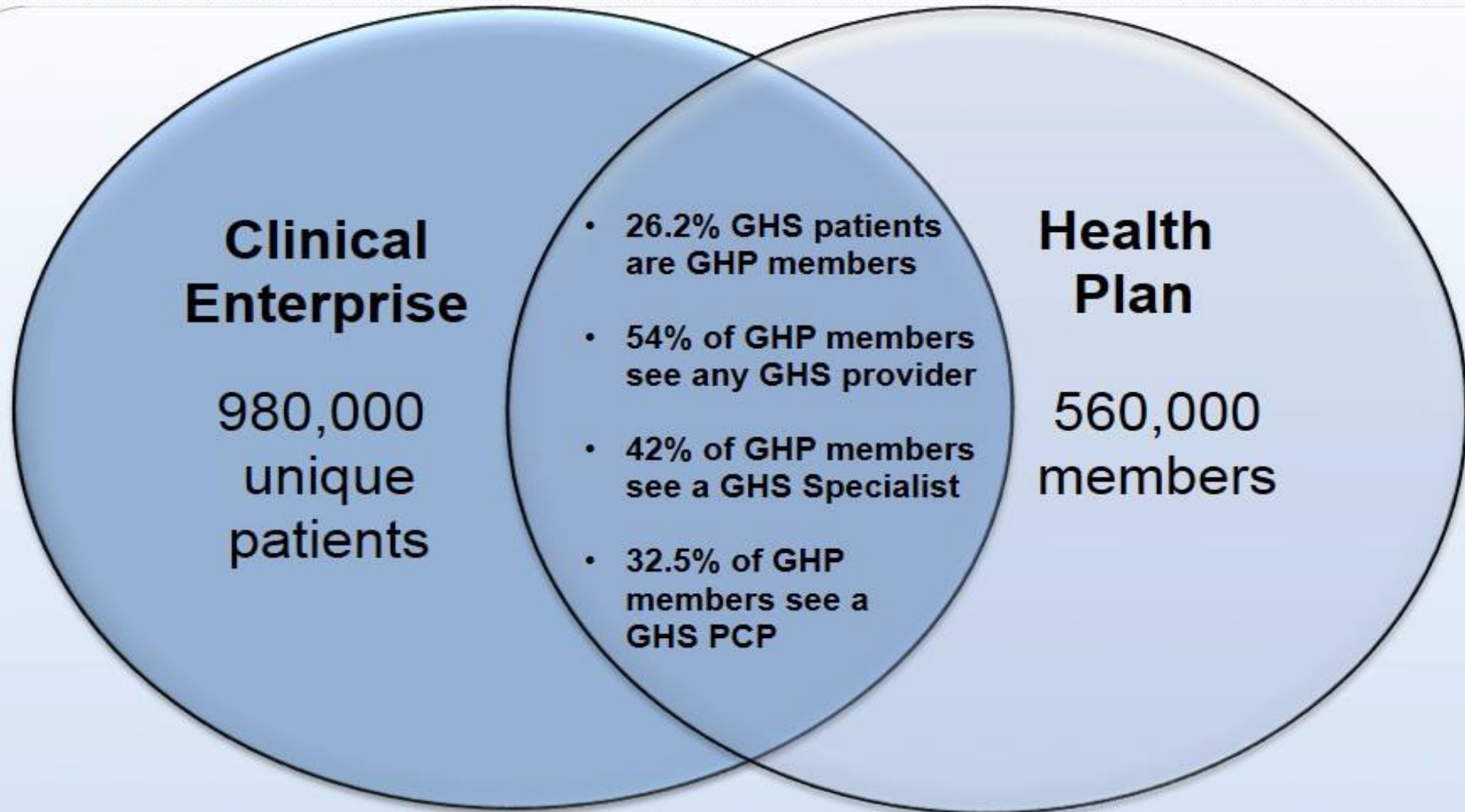
Geisinger Health System



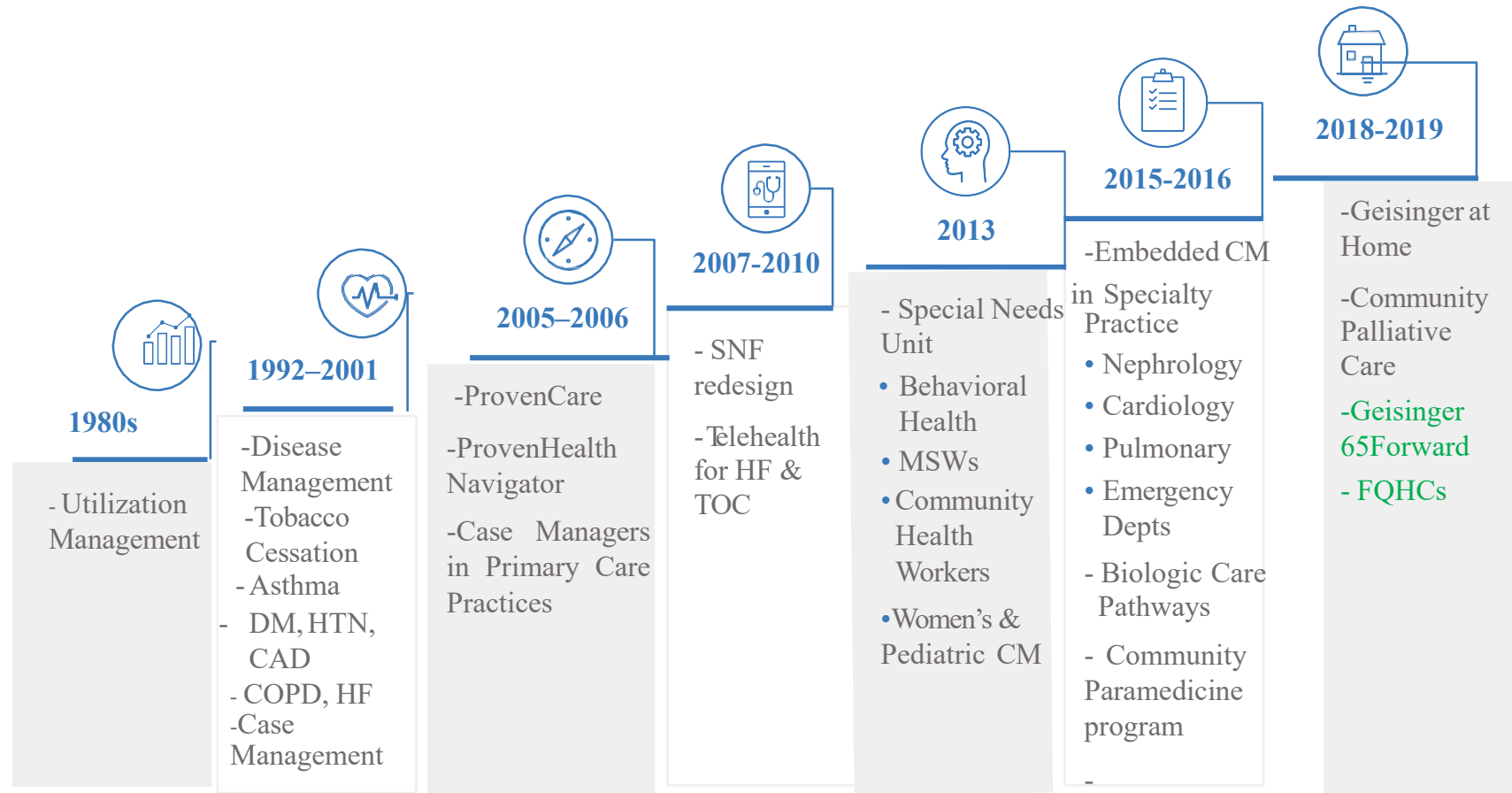
Last updated 11/12/09

- Geisinger ProvenHealth Navigator Sites
- Contracted ProvenHealth Navigator Sites
- ★ Geisinger Medical Groups
- ★ Geisinger Specialty Clinics
- + Geisinger Inpatient Facilities
- ⬡ Ambulatory Care Facility
- Geisinger Health System Hub and Spoke Market Area
- Geisinger Health Plan Service Area
- ▲ Careworks Convenient Healthcare
- Non-Geisinger Physicians With EHR

“One Geisinger”: Managing *all* Patients and Members



Developing our Model to Manage Populations

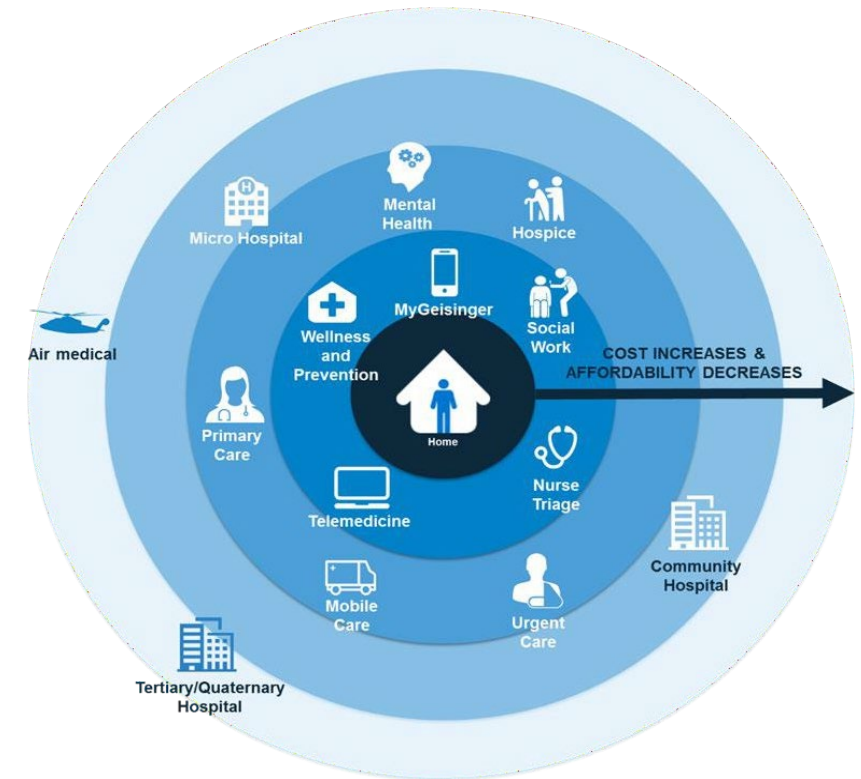


Transforming Primary Care

Primary Care Strategy Guiding Principles

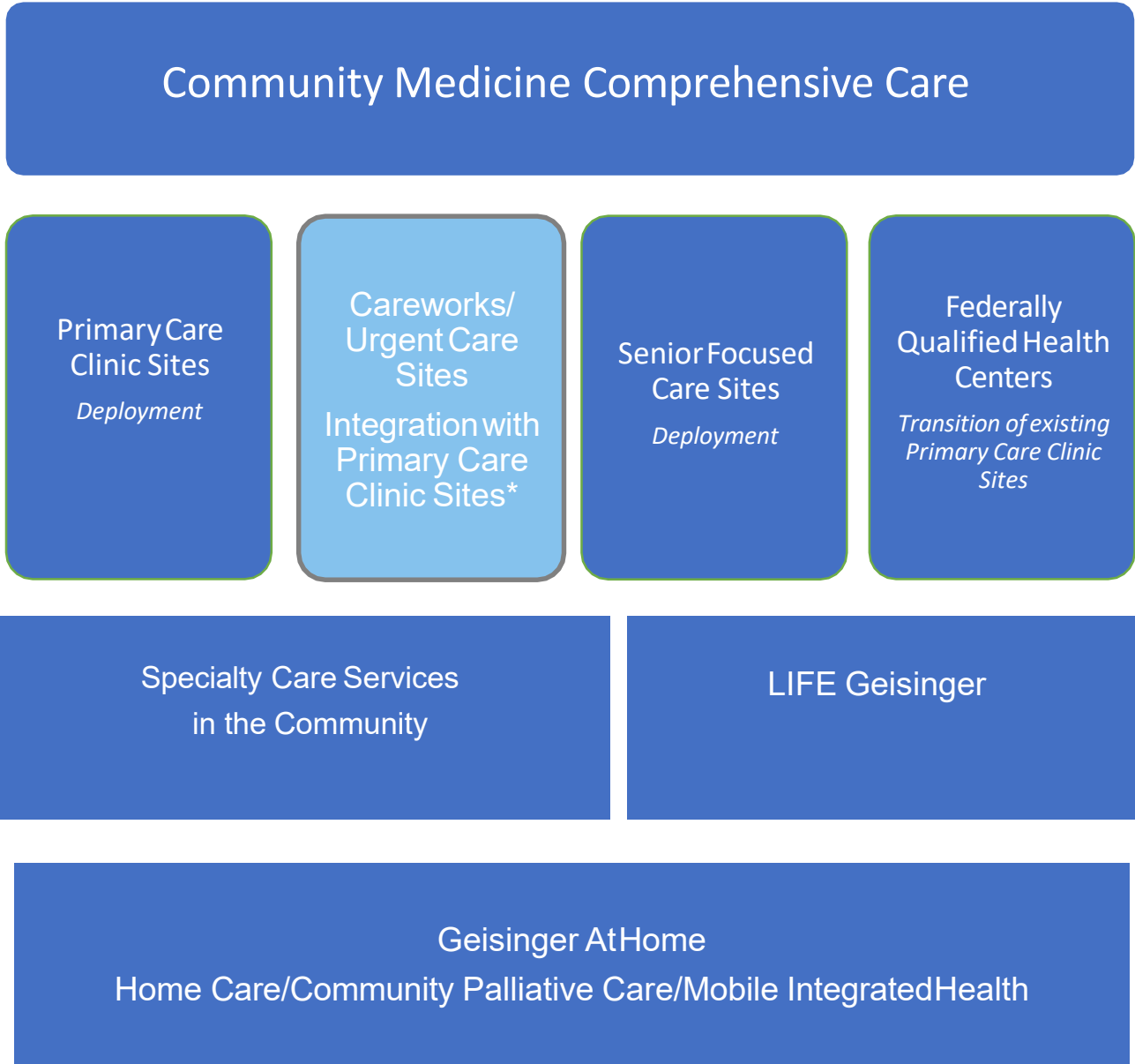
Objective:

- To develop a plan that will **assure access** to primary care services across our market that is commensurate with the health needs of the populations (patients and members) we serve.
- Provide for **low cost, high quality** primary care services
- **Reduce cost** of care trend
- **Be aligned** with patient and member experience needs; drive a **differentiated experience** for our patients/members, being particularly responsive to **an aging population**
- **Improve our position in the market** by delivering better health outcomes to more people
- Incorporate existing care models and introduce **new models of care delivery**
- Accommodate both a **recruitment and retention strategy**
- Leverage **partnership strategies**; move away from dependency relationships toward collaborative and aligned partnerships.



Geisinger is building capabilities to assure that care is delivered in the most effective and efficient setting possible.

Care Models



ACCESS!
ACCESS!
ACCESS!

Availability

Affability

Ability

Patient Time to Be Seen –

Definition: % of new patients seen within 10 days (specialty) or an acute appointment is provided same or next day (primary care).

Target: >75%

Objective: Maximize the value our providers provide while meeting patient needs.

Multiple strategies to meet patient needs

- Alternate delivery mechanisms vs face-to-face
- Close-in release of slots for sooner new patient access
- Reduce high cost and low value interventions
- Evaluate repeat no-show and late cancel re-scheduling practice
- Reduce unwarranted variability in practice patterns, e.g., return visit patterns. “Follow Up Frequency Dashboard” to identify variation.

“One of the key ways a health care system can improve access is by reducing unnecessary demand for various services so that patients who need a particular service can receive it in a timely way.”

- Key Concepts in Understanding Advanced Clinic Access

A large blue arrow pointing from left to right, serving as a background for the text.

Primary Care Strategic Plan

Changing Care Delivery

Project Teams – Care Redesign & Implementation

Care Redesign: Enhancing Primary Care Strategy and Speciality Integration Geisigner Health System

Exec. Committee Sponsors	Dr. Sanjay Doddamani, Dr. Ed Hartle, Dr. Maria Kobylinski, Dr. Jaewon Ryu, Dr. Paul Simonelli, Janet Tomcavage, Tracey Wolfe					
Purpose Statement	<i>Dramatically improve value and outcomes for our patients by enhancing primary care strategy, greater integration with specialty care and access to robust out-of-hospital resources</i>					
Workgroups	Workgroup 1: Care Redesign	Workgroup 2: High Impact Chronic Conditions	Workgroup 3: Command Center	Workgroup 4: Pt. Monitoring and Home Services	Workgroup 5: Transitions of Care	Workgroup 6: Key Performance Indicators
Workgroup Purpose	Panel size and template adjustments. Increased duration of office visits for complex patients.	Model principles, best practices, team functions, acute care management, and data transparency	Determine right site, right place, right team.	Determine IT needs, innovative technologies, monitoring and home based interventions for chronic Hi-6 conditions.	Improve communication and care through transitions and across continuum. Decrease readmissions shift to right-more patients home. Appropriate	Identify key success measures (acute admits/1000, ED/1000, hospital free days, others).
Workgroup Directives	Panel, template, and access	Care team visibility, identification, and functionality in the EMR	Dedicated access line, team composition within GPS and flow of calls	Multi-purpose super chronic telehealth visual and phone communication device (iPad)	Discharge communication	KPI
	Team roles, functions, huddles, visit flow and communication (includes in-basket)	Registries and clinical pathways	Phone-based clinical management pathways based on workgroup 2 recommendations	Mobile response team capabilities for scheduled and urgent at home treatment	Next level of care planning (shift to right - home first)	Scorecard development
	Clinical management strategies based on workgroup 2 pathways and immediate access visit	Bear Hug Care for super-chronic patients including reimmediate communication, access, interventions, technology and at home care)	Direct flow of care based on clinical needs and immediate access	Home health services optimization and alternatives to facility-based treatment	Home-ED-Home process optimization to avoid unplanned readmissions	

ACSC Protocols



Geisinger 65 Forward

Objective

*Develop a care model that delivers a spectrum of clinical services to treat elderly patients with varying degrees of disease burden.

*This leads to better outcomes, reduced admissions and significant cost reductions.



LIFE
Geisinger



Federally Qualified Health Centers

Careworks Convenient Care

- 21 locations
- AP model
- Integrated with traditional primary care sites
- 180,000 annual visits
- Quality standards
 - ✓ Antibiotic stewardship
 - ✓ Communication
 - ✓ Specialty linkage
 - ✓ ER appropriateness
 - ✓ Clinical education
 - ✓ Care gaps
 - ✓ Peer review



Telehealth

E- ICU

Specialty E-consults

ED to Careworks

Geisinger at Home

Care Management

Neurology

Endocrinology

Telehealth Programs

By Service Line

Cancer Institute

Palliative Care

Genomics Institute

Genomics

Heart Institute

Cardiovascular

Surgery Institute

Colorectal Pre-Op
Emergent General Surgery
Transplant
Trauma

Musculoskeletal

Orthopedics
Wound Care

Population Health

Geisinger at Home

Women & Children

Allergy & Immunology
Maternal Fetal Medicine
Neonatology
Pediatric Gastroenterology
Pediatric Genetics
Pediatric Infectious Disease
Pediatric
Neurodevelopment
Pediatric Neurology

Medicine Institute

Careworks - TeleTriage
Clinical Nutrition
Dermatology
eICU
Emergency Medicine
(Peds)
Endocrinology
Gastroenterology
Infectious Disease
Internal Medicine
Nephrology
Occupational Health
Pulmonary
Rheumatology
Sleep Medicine

Neuroscience

Addiction Medicine
Behavioral Health
Neurology
Neurosurgery

BPCI A Participation Summary

TIMELINE:		
Program Start Date:	10/1/2018	
Program End Date:	12/31/2023	
Cohort 2 / Model Year 3 Start Date:	1/1/2020	36 Potential IP EPISODES AVAILABLE: 3 potential OP EPISODES available

EPISODES:	BPID	Participating Hospital
COPD, Bronchitis, Asthma	1102	Geisinger Community Medical Center (GCMC)
(DRGs 190-192; 202, 203)	1103	Geisinger Holy Spirit (GHS)
	1104	Geisinger Lewistown Hospital (GLH)
	1105	Geisinger Medical Center (GMC)
	1106	Geisinger Wyoming Valley (GWV)
Hip & Femur Procedures except Major Joint	1102	Geisinger Community Medical Center (GCMC)
(DRGs 480-482)	1104	Geisinger Lewistown Hospital (GLH)
	1105	Geisinger Medical Center (GMC)
	1106	Geisinger Wyoming Valley (GWV)
Major Joint Replacement, Lower Extremity (DRGs 469, 470)	1104	Geisinger Lewistown Hospital (GLH)
Stroke	1102	Geisinger Community Medical Center (GCMC)
(DRGs 61-66)	1103	Geisinger Holy Spirit (GHS)
	1104	Geisinger Lewistown Hospital (GLH)
	1105	Geisinger Medical Center (GMC)
	1106	Geisinger Wyoming Valley (GWV)

QUALITY MEASURES (+/- 10%)	POPULATION:	
Advance Care Plan	NQF #0326	All IP and OP
All Cause Hospital Readmission	NQF #1789	All IP and OP
Hospital Level Risk Standardized Complication Rate (RSCR) following MJRLE	NQF #1550	DRGs: 461, 462, 469, 470
CMS Patient Safety Indicators	CMS PSI90 NQF #0531	ALL IP and OP
Periop Selection of Prophylactic Antibiotic: 1st/ 2nd Gen Cephalosporin	NQF #0268	Hip & Femur Procedures except Major Joint MJRLE
MODEL YEAR 3 – Choose ADMINISTRATIVE Quality measures (ie. from above) or ALTERNATIVE Quality measures (combo of claims-based and registry-based measures).		

PATIENT POPULATION:

Medicare Fee For Service (Parts A & B)
 Excludes ESRD (As benefit)
 Excludes Managed Care Plans (ie Medicare Advantage)
 Discharged with Episode DRG (No OBS)

EPISODE TRIGGERS & LENGTH

MS DRG on Inpatient claim
 90 days following discharge date of Anchor Stay

TARGET PRICING

Baseline less CMS 3% Discount
 Prelim Target adjusted by patient case mix & Peers
 Final Target Price retrospective at Reconciliation

NON-CONVENER PARTICIPANT

(bearing financial risk)



Geisinger at Home

Moving Care Closer to Home

Community Medicine Care Teams

Core Care Team

- *Senior-Focused Physician*
- *Advanced practitioner*
- *RN*
- *LPN*
- *Multiphasic Tech*

Administrative Team

- *Referral/Scheduling Coordinator*
- *Front Desk Receptionist/Patient Access Rep/Float/Phone*

Extended Care Team

- Behavioral Health/Grief Counselor
- Case Manager
- Community Health Associate
- Specialty Outreach
 - Cardiology
 - Neurology
 - Memory/Cognition Clinic
 - Podiatry

Wellness Team

- Wellness Coordinator

GHP Team

- Customer Service Rep

Ancillary Services

- Radiology – Basic X-ray, Mobile DEXA/Mobile Mammography
- Lab Services (Point of Care Testing/Lab Draws)
- Telemedicine Capabilities
- Audiology
- DME Partnership
- Pharmacy Home Delivery

Advanced Care Planning Strategies

- **Focus on actual patient's EOL wishes (LW, POLST)**
- **Don't ask about wishes but identify *who* will make them at EOL (DPOA-HC)**

Muriel R. Gillick, M.D. 350; 1. NEJM 2004

Innovative Collaboration between Clinical Care and Community-Based Organizations – New

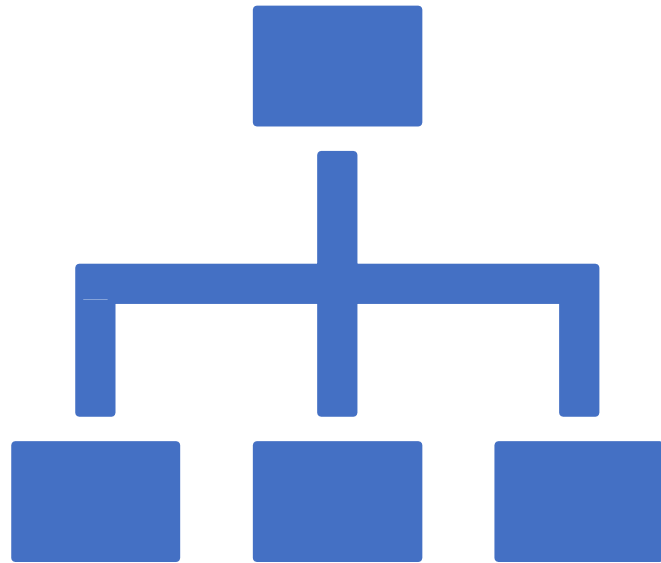


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Fresh Food
Farmacy™



*All Integrated
with Quality*

Medicine Institute Quality Plan



Sets the Strategic Direction



Intra & Inter-Institute Alignment of Initiatives



Fosters Collaboration and Coordination across Teams



Standardization of Metrics and KPIs

Analytical Tools: Primary Care Provider Scorecard

Geisinger

Updated: 5/14/2019 9:08:12 AM

Anthony B
Physician..

Risk Adjusted Panel Size: 728
% Filled= 69.37% (Goal = > 90%)

Patient Satisfaction

Current Score: 97.89

Prior Year: 96.98

Satisfaction Score and Prior Year Score. Date window used for Measures is between April 30, 2018 and April 30, 2019. Sourced from Press Ganey

Access

Fill Rate: 95.50%
Goal: 90%

No Show Rate: 2.7%
Goal: < 5%

Time To Seen: 10.2
Goal: <= 1 Day

Fill Rate, No Show Rate and Time to Seen. Date window used for Measures is between April 1, 2019 and May 1, 2019

Utilization

ED Utilization

Provider Rate: 443.8 / 1000
Site Rate: 444.2 / 1000
Goal: 250 / 1000

InPatient Utilization

Provider Rate: 215.3 / 1000
Site Rate: 226.4 / 1000
Goal: 215 / 1000

ED Utilization and Inpatient Utilization for GHP Gold Population. Data is sourced from CommMed_GIM_MCI_PED Excel Sheet for the month of April, 2019. Site level data is aggregated at the source level and if grouping does not match with dashboard a* may be displayed instead of value.

Quality

Breast Ca: 77.9%
National Benchmark: 79.0%

Colorectal Ca: 78.0%
National Benchmark: 79.0%

DM Eye: 76.1%
National Benchmark: 80.0%

DM Nephropathy: 90.7%
National Benchmark: 97.0%

DM Control A1C>9: 15.4%
National Benchmark: 15.0%

Chlamydia Screening: 76.9%
National Benchmark: 56.00%

Breast Ca, Colorectal CA, DM Eye, DM Nephropathy, DM Control A1C>9 and Chlamydia Screening. Cerner Extract last refreshed on April 30, 2019

Market

Care Gaps Missed Ops:
41.86%
Goal: 0%

Disease Burden Missed Ops:
18.18%
Goal: 0%

Disease Burden Capture:
80.13%
Goal: 100%

*example of single provider

Care Gaps Missed Ops and Disease Burden Missed Ops Date window is April 1, 2019 and April 30, 2019. Disease Burden Capture window is January 1, 2019 and May 12, 2019.

Thank you



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Questions?