Journey of a Winning Collaboration between an ACO and IT Vendor

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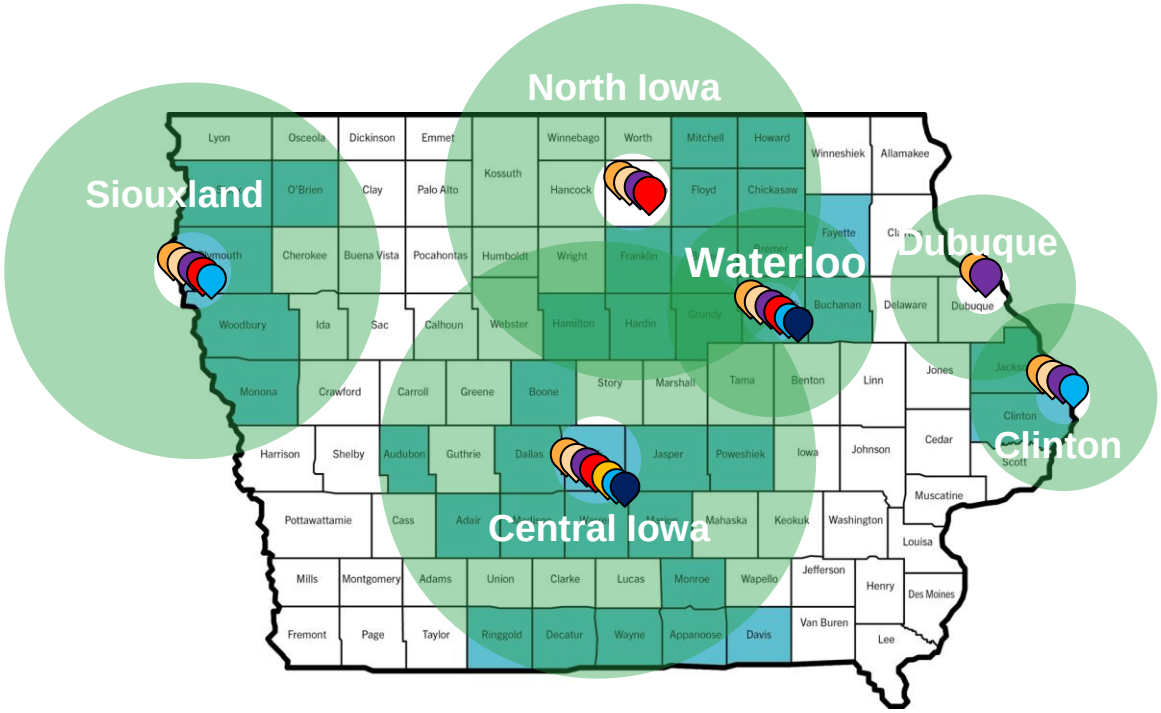
Progression of Healthcare in US

1990s	All-at-once shift to full provider capitation
2003	Bonus payment for submitting quality data
2004	Bonus payment based on quality
2009	Payment based on episode of care
2010	Greater push towards value-based care
2011	Shared Savings based on total cost of care
2012	Accountable Care Organizations (ACOs) formed to meet the triple aim of healthcare (population health, patient experience, reduce costs)
2015	New forms of partial capitation

Mercy ACO



- Medicare Shared Savings Program
- Commercial Shared Savings
- Direct to Employer
- Medicaid
- Medicare Advantage
- Bundled Payments
- MHN Value

2017 - YTD

- MHN moved to 'downside risk'
  - (1) Track 3 MSSP (up-/down-side risk)
  - (2) Track 1 MSSPs (Jan 2017)
  - (5) Commercial Shared Savings Agreements
- Mercy Health Network (MHN) provides foundation for Mercy ACO
  - 6 ACO Chapters
  - 67 of 99 Iowa Counties
- Independent & Specialty Groups
  - 190+ Patient Organizations
  - 3,000+ Providers

History & Overview

2012
Mercy ACO founded by Mercy Des Moines Leadership and Board of Directors as an "all-in" strategy for transition to care

2013
Realized significant Participant/Provider growth in the Des Moines Metro and surrounding area

2014
Separated Des Moines (Chapter) operations to support Mercy North IA (Chapter) and program expansion

2015
Expanded to include 3 additional Chapters (Sioux City, Clinton, and Dubuque) and 28 Rural Affiliates statewide

Mercy begins collaboration with InnovAccer

2016
Mercy ACO formalized as the statewide structure to support six regional Chapter value based programs and MHN's transition to value based care

2017
MHN launches 3 Medicare Shared Savings Programs in preparation of MACRA; Mercy ACO serves as the management company

Care Delivery is *rapidly changing* in the U.S.

Payment models are evolving

With an increased focus on capitation and value-based care payment models, it has become paramount to improve quality to succeed.

Population is aging and more prone to risk

The increasing demands of aging population involve a steep rise in cost of care, which calls for a more patient-centric approach.

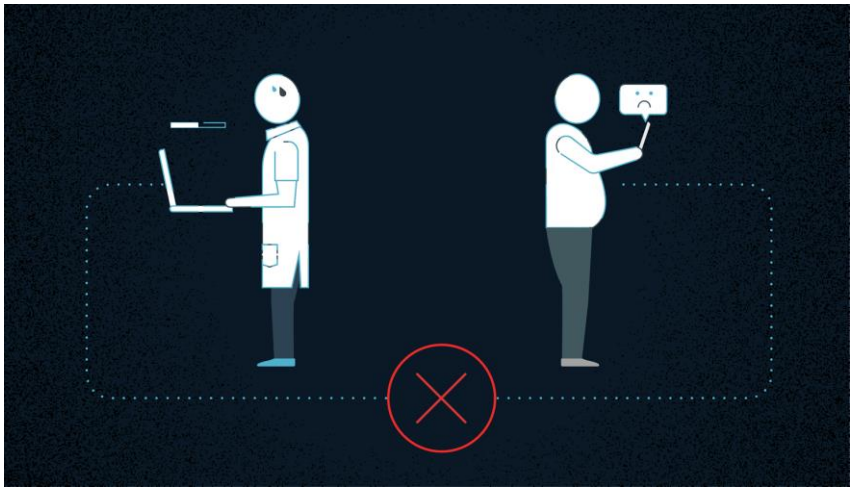
Administrative burdens are high

Along with the policy and socio-economic push there is a strong pressure created because of increasingly competitive landscape.

Non-interoperable technology is a hinderance to this change

Healthcare networks are reeling with distributed information across tens of distributed systems

Health Information systems are distributed with interoperability challenges creating an information gap



Distributed information creates roadblocks in understanding the patient holistically and managing care and risk

The problem of distributed systems is being magnified by massive consolidation that is happening at the level of healthcare networks

Mercy ACO

INNOVACCER

Mercy ACO Mission

- **Improve the health of the patients we serve**

  Manage population segments, not just individuals

- **Lower cost of care**

  Healthier patients will use less healthcare

- **Capture payment for the value we create**

  Shift payment from Volume to Value

Hurdles to overcome

Healthcare Data Integration

For a seamless data exchange, Mercy ACO was looking for connections over different systems (Tier 1, 2 & 3 EMRs).

Separate Platforms

A better visibility of the network's performance was required by having data management, reporting and Care Management on the same platform.

Daily Updated ADT Feeds

Daily update on ADT feeds was crucial for Care Management. A procedure for every site to absorb these feeds on a daily basis was needed.

The right IT engagement model

Build, Operate and Reiterate

It is crucial to realize the fact that the needs of healthcare organizations change every ~1.5 years, and optioning for a “ship and deliver” model will not provide the needed innovation and adaptability

Single Source of Truth

For greater visibility in healthcare and non-care operations, it is better to have care management embedded in the same data platform for optimal tracking and reporting

Automated Workflows for the Staff

Automated and intelligent work queues that can set priorities for staff and match patients on various parameters are helpful in optimizing ROI

Real-time

Data is essential for population health

- Track population of patients and their health status
- Facilitate list of patients overdue for care or not meeting goals
- Perform risk segmentation of the patient population
- Create reports at the organization, clinic, and provider levels
- Measure the effectiveness of interventions
- Analyze the gaps at the point of care
- Discover new opportunities in risk-based models

Mercy ACO Care Delivery Vision

- **Manage patients as populations and individuals**
  Planned patient visits and measure population based outcomes
- **Continuous quality improvement**
  Measurement and reduction in variation for Diabetes and HTN
- **Engage patients with Health Coaches**
  Identify high risk patients most likely to benefit
- **Coordinate care**
  Communicate and share information on care plans
- **Develop models to be reimbursed for value, not just volume**
  P4P, Shared Savings, Capitation
- **IT systems**
  Disease registries and data warehouse

How this reduces the cost of care

Relatively low cost care delivery system changes can improve the health of patients

- Health coaching
- Coordination of care
- Reduction in variation

Improving the health of patients will reduce

- Hospitalizations
- Emergency department usage
- Drug costs

Mercy ACO Implementation – Data Strategies

Claims-based Insights

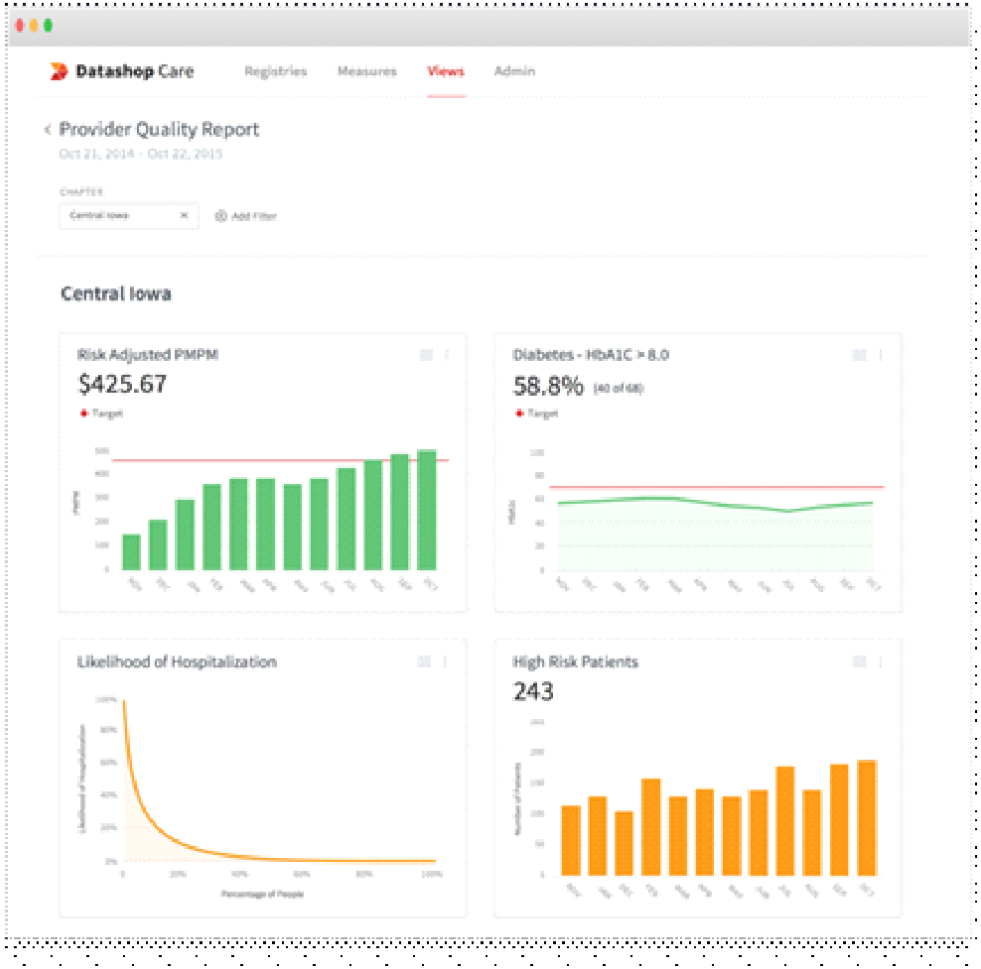
Separate report cards with clinical, operational, and financial measure performance

Clinical Integration and Analytics

Build data lake from all sources for a reliable analytics platform

Reporting and Network Optimization

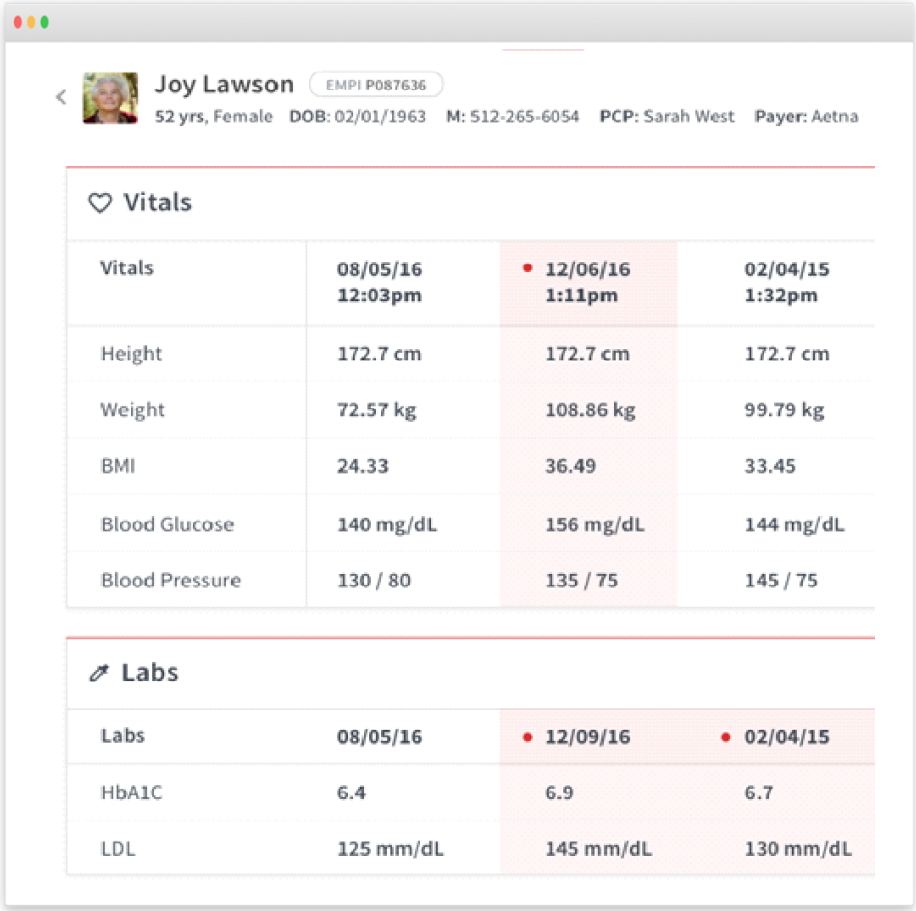
Reporting with “customer” views to provide insights to users for strategic activation



Mercy ACO Implementation – Automated Care Management

Automatic identification of patients through pre-defined triggers for health coaches

- Which patients to work with
- Best approach for care
- Tracking of impacts from care coordination



Joy Lawson EMPI P087636
52 yrs, Female DOB: 02/01/1963 M: 512-265-6054 PCP: Sarah West Payer: Aetna

♡ Vitals

Vitals	08/05/16 12:03pm	12/06/16 1:11pm	02/04/15 1:32pm
Height	172.7 cm	172.7 cm	172.7 cm
Weight	72.57 kg	108.86 kg	99.79 kg
BMI	24.33	36.49	33.45
Blood Glucose	140 mg/dL	156 mg/dL	144 mg/dL
Blood Pressure	130 / 80	135 / 75	145 / 75

Labs

Labs	08/05/16	12/09/16	02/04/15
HbA1C	6.4	6.9	6.7
LDL	125 mm/dL	145 mm/dL	130 mm/dL

Outcomes Achieved

Over **~10 hours saved** per week per staff through automation of ADTs for Care Coordinators

Projected **1.5 - 2x savings** in commercial contracts from last year based on better reporting, accurate risk capture, and care gap closure

Improved accuracy in Risk Stratification via CMS-HCC for Medicare population and HHS-HCC for commercial population

Same platform achieved for data management, reporting, and care management, supporting a full data driven process

Projected Medicare “Total Cost of Care growth” is **lower than national average**

Operational inefficiencies identified and addressed, leading to increased network performance

Recommendations

1. Align data and reimbursement systems with ACO mission and goals
2. Embed care management and data management in the same platform
3. Select a “build, operate and reiterate” model to meet constant changes in healthcare
4. Track the efficiency of all care operations and address the gaps in care
5. Automate clinical workflows as much as possible for higher ROIs
6. Identify and reduce the high-cost drivers and leakages

Questions ?