Population Health

2023 ANNUAL REPORT

CommonSpirit

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Welcome

Focus Areas

Meet the Team

We aspire to be on the forefront of that transition [to value], requiring strengthened Population Health infrastructure that can support divisions in selecting and succeeding in value-based contracts.

—CommonSpirit 2026
Our Future Priority

Welcome

Welcome to the first Annual Report of CommonSpirit Population Health. Inside these pages we provide you with an in-depth look at the transformative work happening across the CommonSpirit Health enterprise to support and expand value-based care.

Our work over the past year has centered on increasing the length and quality of life for our populations, while reducing the overall total cost of care. Rather than waiting for sick patients to come to us for care, the CommonSpirit Population Health approach leverages data to prioritize prevention, wellness, and partnerships across the continuum of care, with an emphasis on the most vulnerable patients. This is done through heavy collaboration between our national team, the local Value Hub leaders and providers, Payer Strategy & Relationships, Clinical Standards and Variation Reduction, Quality, and countless others across the enterprise committed to ensuring our most vulnerable patients receive the quality care that they deserve.

As the CommonSpirit ministry continues to evolve, so does Population Health. As one of the nation's largest providers in value-based care with 2.6 million attributed lives, we are uniquely positioned to make a high impact difference and lead in Population Health. Over the past year the team has supported Value Hubs by providing education, evaluating models, standardizing best practice guidelines, and decreasing costs by purchasing necessities like quality benchmarks as a system, among other things.

One of our large accomplishments this past year is launching the Population Health Services Organization (PHSO), designed to support providers as they transition to value-based care and risk. As we continue down the road of creating One CommonSpirit, the PHSO is a major step forward in our ability to leverage our size and scale to provide services that will support value-based care performance, strengthen our networks, and help us keep pace with the evolving reimbursement landscape.

As we look to the future, we're excited for the many initiatives planned for the upcoming year. Our success this past year is directly attributable to the hard work and collaboration of our Population Health team, Value Hub leaders, and partnering teams across the organization. We look forward to what we can accomplish together in 2024.

Thomas McGinn, MD
Executive Vice President,
Physician Enterprise
CommonSpirit Health

Nicholas Stine, MD
System Senior Vice President,
Population Health
CommonSpirit Health

Derek Novak
System Vice President, Population Health Services,
CommonSpirit Health

Understanding Population Health

Definitions

Population Health

The delivery of care and services to improve health outcomes while reducing excess costs for a defined population.

Population Health Management (PHM)

How a health care system operationalizes Population Health principles to manage costs and quality as well as accountability to succeed in value-based payment models.

PHM is how we operationalize Population Health principles and best practices.

Value-Based Care (VBC)

A health care delivery model emphasizing holistic and coordinated care across the continuum to improve health status, outcomes, quality and equity for a designated population.

Value-Based Agreements (VBA)

Contractual arrangements that reimburse providers for successfully managing the health care outcomes, quality and patient experience for a defined group of attributed people, while maintaining or lowering the total cost of care.

Value-Based Agreements introduce a financial model to sustain Value-Based Care.

All Medicare fee-for-service beneficiaries and the vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030. – CMS Ten-Year Strategy

POPULATION HEALTH APPROACH

Population Health is the delivery of care and services to improve health outcomes while reducing excess costs for a defined population. Rather than waiting for sick patients to come to us for care, a Population Health approach leverages data to prioritize prevention, wellness, and partnerships across the continuum of care, with an emphasis on the most vulnerable patients.

WHAT IT STRIVES TO ACCOMPLISH:

- ↑ More preventive care, chronic disease management, length and quality of life
- ↓ Less fragmented episodic care, avoidable ER visits and hospitalizations, total cost of care

The national team delivers Population Health specific clinical strategies, advisory services, global insights, thought leadership, and advocacy to Value Hubs, local markets, national leadership, and the PHSO.

POPULATION HEALTH INSIGHTS

Focus: Value-Based strategic insights

Key Initiatives:

- All payer VBA Claims (AVS)
- Global insights informing total cost of care, clinical initiatives
- Hepatitis C National Initiative

Jesse Singer, DO, System VP
Population Health Insights

VALUE-BASED CLINICAL STRATEGY

Focus: Value-Based clinical program best practices and support

Key Initiatives:

- Annual Wellness Visits
- VBA Quality Metric and HCC Task Force
- 4C's Workgroup

Melissa Gerdes, MD, System VP
VB Clinical Strategy

How We Are Advancing Population Health

Why a PHSO?

CommonSpirit Health serves 2.6 million attributed lives through Value-Based Agreements.

Streamlined and integrated service delivery is needed to align and share best practices and address gaps efficiently.

The rapid increase of value-based agreements creates a need to support providers in delivering Population Health.

Center of Expertise (COE)

- Sources Population Health **best practices**, monitors **market trends**, & evaluates **new care & payment models**
- **Convenes stakeholders** to inform clinical innovation in Population Health
- Supports **policy and advocacy** initiatives for Population Health federal and state opportunities
- **Evaluates & publishes** on successes, industry trends, & positions CSH as a **national thought leader** in Population Health
- Aggregates VBA claims data to **develop insights** (AVS)

COE & PHSO Together

- **Enables** & **accelerates** transformation to value-based care models
- Responds to strategic Population Health **opportunities** & demonstrates **efficacy** of innovative programs
- **Convenes stakeholders** to inform innovation in Population Health
- Establishes **One CommonSpirit strategy** for Population Health

Population Health Services Organization (PHSO)

- Provides a **portfolio of Population Health services** that are deployed nationally, regionally, and locally to provide economies of scale to improve performance (eg. Analytics, Care Coordination, Administration and Technical Services).
- Manages **core infrastructure** for health plan capitation & delegation (e.g. claims, CM/UM, enrollment, network management)
- Leverages actionable data and a standardized approach through the **national Population Health Platform**
- Facilitates governance and structure to drive **improved performance** under value- and risk-based agreements
- Leads growth and participation under VBAs

Results: Improved Population Health

Informed Insights
- Network performance/needs
- Improvement strategies

Clinical Outcomes
- Reduced chronic disease burden
- Improved Health Equity

Operational Outcomes
- Reduced readmissions

Competitive Positioning
- Improved provider recruitment
- Visibility as progressive thought leader

Financial Outcomes
- Increased VBA revenue
- Reduced total cost of care

Value Hubs

An umbrella term for a market-based team that oversees VBA performance and opportunity, mapped to the Integrated Delivery Network (IDN) geography.

COMPONENTS OF A VALUE HUB INCLUDE

Aligned Incentives
Determines pre-requisites for Provider Network participation and Provider Incentive Methodology

Infrastructure and Governance
Organizes network and resources to support care coordination and performance improvement

Data & Analytics
Runs Population Health platform to aggregate data, measure performance and enable coordination of care

VBA Contracting
Develops or implements appropriate VBAs with payers in collaboration with PSR

Performance Management
Determines measurable outcomes of network and engages providers in performance improvement

Strategic Partnership
Facilitates VBA growth in the IDN

WHO IT MAY INCLUDE

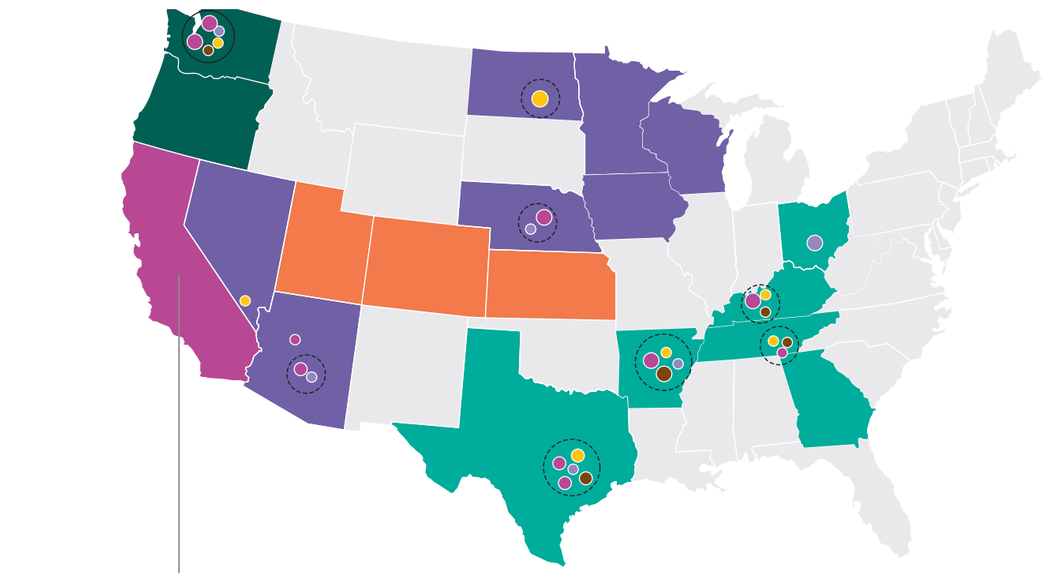
- **ACOs*** | Example: MSSP
- **CINs*** | Example: Medicaid/ Medicare/Commercial/Employer
- **Facilities** | Example: Institutional CAP, BPCI-A
- **Medical Groups** | Example: Professional CAP, MA, PCF
- **Owned IPAs** | Example: Professional CAP
- **External IPAs** » Financially integrated for facility capitation

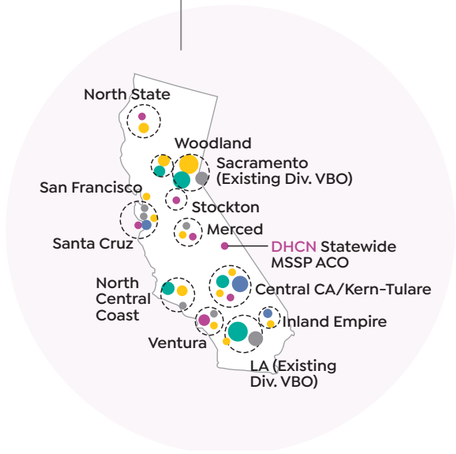
*denotes regulated legal entity to govern collaboration with external parties

WHY IT IS IMPORTANT

The construct of Value Hub is an integrated, cohesive strategy that expands beyond a single CIN silo to ensure there is consistent Population Health infrastructure and value-based readiness across all contracts in an IDN.

Value Hubs: Intended to Oversee All VBAs in Markets





Contracting/Entity Legend

- CINs (Commercial & MSSP)
- Facility Capitation
- DHMN-Owned IPAs
- External IPAs in risk share
- Employed Medical Group(s)
- Bundled Payments
- Other VBAs held at Market

Insights

Overview

Population Health has been building the capability to help deliver insights nationally and to our Value Hubs. Current capabilities include providing insights on current programs and future opportunities such as national CMS program analytics (supporting MSSP), Population Health data science/ advanced analytics (quality gap analysis), program evaluation (Concert/collaborative care, FOCUS grant), as well as clinical analytics (hepatitis C screening/diagnosis/treatment and macular degeneration cost analyses).

WHY

As one of the largest Medicaid providers in the country, with more than 2.6 million attributed lives, CommonSpirit Health has the ability to deliver clinical insights, Population Health insights, and VBA analytics to our Value Hubs to improve patient care and health system performance.

RESULTS

The team has built numerous dashboards and data visualizations for end users as well as for internal use for monitoring and opportunity assessments.

ON THE HORIZON

Looking to the future, we anticipate additional clinical and ROI analyses on high-cost conditions, market-specific dynamics and opportunities, contract-specific analyses and recommendations. Future directions include benchmarking and risk adjustment across VBA types and populations, Value Hub VBA decision support such as new CMMI model discernment processes, Population Health Data Science/ Advanced Analytics such as Total Cost of Care analyses, and sharing clinical insights with PSR, PHSO, CS/VR, and others for action.

ACKNOWLEDGMENTS

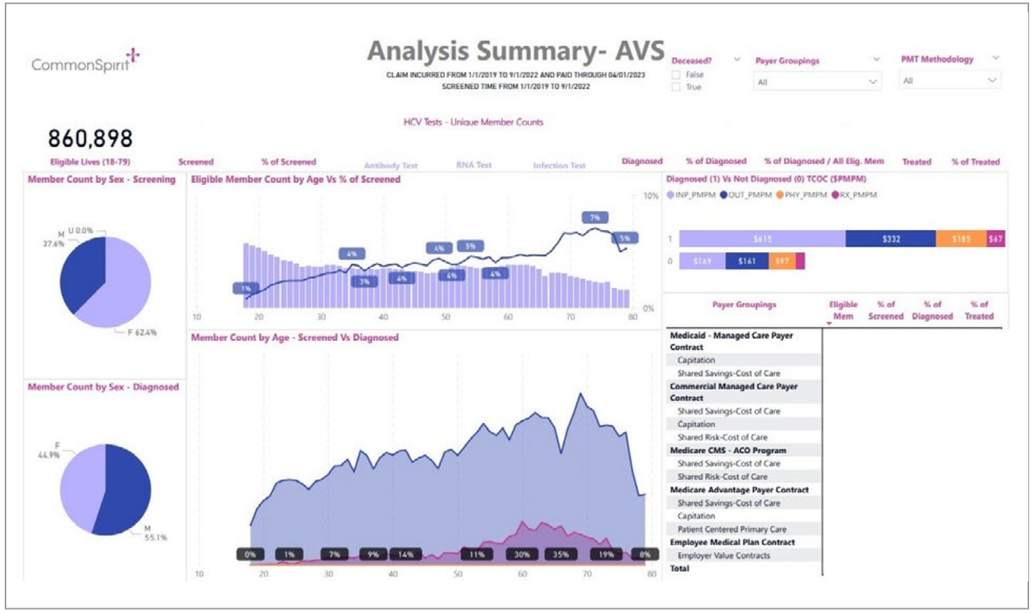
This work is made possible through collaboration with IT, PSR, EBI, and Clinical Standards and Variation Reduction.

PUBLICATION ON THE USE CASE OF BIOLOGICS FOR AGE-RELATED MACULAR DEGENERATION

The team examined part B drug spending and the treatment of age-related macular degeneration (AMD). If untreated, AMD can result in significant morbidity, vision loss, and loss of function affecting millions of Americans, mostly elderly and Medicare-eligible. The team discovered that off-label use of bevacizumab as a vascular endothelial growth factor inhibitor for retinal disease is effective and less expensive than other drugs, but utilization rates remain at about 38%, while its cost represents less than 3% of the total. Working toward change can promote stewardship of cost saving and value-based care that is evidence-based.

Delivering data to our Population Health teams enables them to make real time changes and drive metrics that matter.

Here is an example of a dashboard from All-Payer Value-Based Claims (AVS):



All-Payer Value-Based Claims Solution

Overview

The Insights team uses Innovaccer (IA) to aggregate and normalize claims data, directly from payers and from market IA instances to create the All-Payer Value-Based Claims Solution (AVS). CommonSpirit Health will use this platform to deliver actionable clinical, operational, and financial insights to our Value Hubs. These insights will provide benchmarking and highlight clinical and financial opportunities at the system and market level.

WHY

Population Health data is isolated at the market level and non-standard, inhibiting a global view of our population. Centralized analytics will enable comparison across Value Hubs and enhance performance with support from a broad and standardized data set.

RESULTS

By January 2024, 1.87 million value-based lives served by CommonSpirit will be fully loaded to Innovaccer. Currently, 1.5 million lives have been ingested with the remainder in the acquisition and validation phase. In parallel, data cleansing efforts and initial projects are underway.

KEY GOALS

- Centralized Source of Truth: All value-based claims data from all payers/employers across Value Hubs will be in the Enterprise Data Platform Data Lake and available for analytics
- Unified Patient Records: Full picture of value-based contracts across CommonSpirit
- Performance Benchmarking: Benchmarking performance across Value Hubs, assessing overall performance and network integrity
- Drive Best Practices: Develop targeted interventions and improve performance of care delivery through population level insights
- Payer Contract Negotiation: Market intelligence through historical and recent data to understand payment models and to support payer contracting initiatives

ACKNOWLEDGMENTS

Thank you to IT, PSR, Decision Support, and EBI.

Current and Future Programs

PARTNERS/CUSTOMERS

- IT
- Enterprise Business Intelligence
- PSR
- Decision Support
- Business Intelligence Decision Support Team
- Innovaccer
- PHSO

FOUNDATIONAL WORK

- Loading Data
- Validation and User Acceptance Testing
- Centralize process for provider roster maintenance
- Data retention/destruction policy and procedures
- Methods Determination
- Data Completeness Assessment
- Innovaccer functionality and documentation

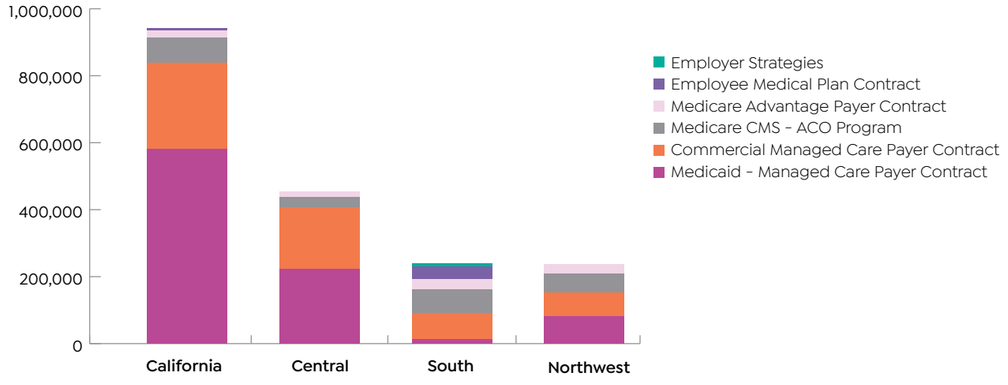
CURRENT PROJECTS

- Core Analytics: Understanding the makeup and risk of CSH's value-based lives
- Hepatitis C
- Macular Degeneration

ANTICIPATED USE CASES

- Capitation Analysis
- HCC Risk Adjustment
- Annual Wellness Visits
- Heart Failure
- Network Integrity / Employed vs. Independent Provider Performance
- Capitation
- National value-based program participation strategy

AVS Lives by Geography and VBC Type



Hepatitis C

Overview

Population Health is working in conjunction with Physician Enterprise leaders to develop, implement, and monitor a systems approach to improving screening and treatment for Hepatitis C. Our focus is on establishing system infrastructure to support facilities in implementing best practices and partnering with the Clinical Standards and Variation Reduction team to support implementation of the Hepatitis C (HCV) clinical guidelines in clinical workflows.

WHY

Roughly 1% of the US population (approximately three million people) are infected with HCV, many of whom will progress to severe illness and/or death. Access to care and treatment are highly inequitable; race, ethnicity and socioeconomic status are associated with substantially less access to treatment and worse outcomes (including mortality). CommonSpirit Health has not had a standardized approach to identify and combat acute infection and prevent long-term poor health outcomes.

HEPATITIS C FACTS

- Most common chronic blood-borne pathogen in the US, affecting 1% of US population (3 million people)
- Most don't know they have it
- Untreated, 5%-25% develop cirrhosis—4% of these develop liver cancer each year
- Incidence has doubled since 2013

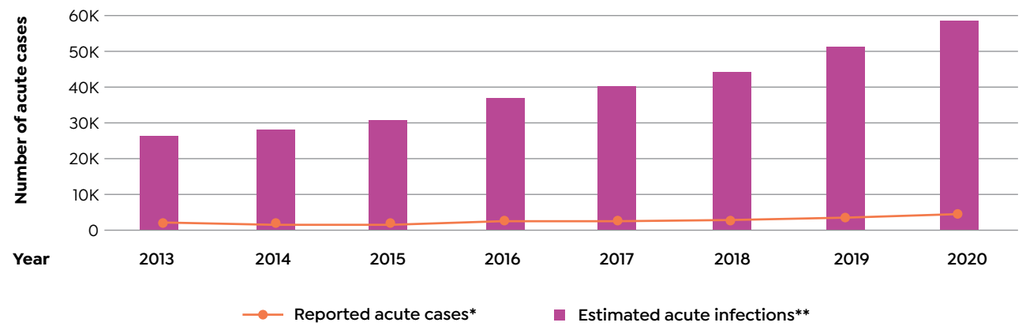
CommonSpirit Health: What We Are Doing

Universal screening integrated into clinical workflows

Connection to primary care-aligned treatment pathways

Removing structural barriers to care

Number of reported cases* of acute hepatitis C virus infection and estimated infections** — United States, 2013 - 2020



ACKNOWLEDGMENTS

Many thanks to the Clinical Standards and Variation Reduction team, Pharmacy, St. Joseph's Medical Center (Stockton) team, the CommonSpirit Health Research Institute, and Barbara Martin, among others.

Quality Inventory

Overview

Quality Measure and Risk Adjustment Methodology Inventory

Population Health inventoried all the quality metrics and risk adjustment methodologies in our active value-based agreements (VBAs) to help understand what risk adjustment and quality parameters we are contractually accountable for and to work toward a smaller number of metrics in future VBAs.

The system's 412 VBAs include Commercial products, Medicare Advantage, Medicare Shared Savings Program, Medicaid Managed Care, and Employee Benefits contracts.

WHY

The quality measurement burden has grown exponentially over the years for physicians and APPs, particularly primary care providers, taking time away from patient care for a largely administrative activity. By quantifying the burden, we aim to persuade health plans that a smaller number of required measures is beneficial to patient care and to both the health plans' and our total cost of care.

RESULTS

Population Health inventoried 93% of active VBAs in 2023 and found 618 unique quality measures, 77% of which are non-standard (i.e., custom) metrics, predominantly in commercial VBAs. With System Quality, we developed short lists of clinically relevant, widely used standard metrics for inclusion in commercial contract negotiations (13 measures for ambulatory and 15 measures for inpatient VBAs) that align with CMS' Universal Measures Set.

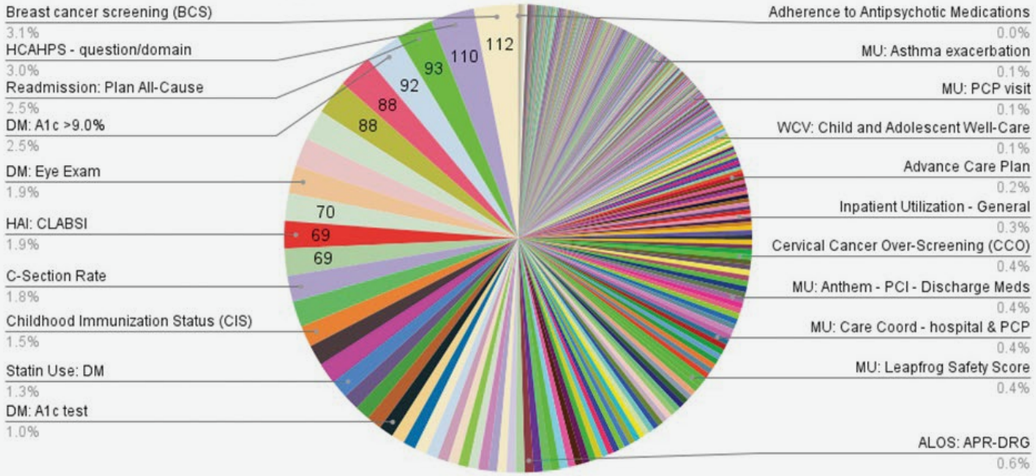
POPULATION HEALTH COLLABORATES WIDELY WITH:

- Payer Strategy to streamline the inventory process and to develop a contracting playbook aiming to negotiate more equitable quality improvement terms for CommonSpirit entities.
- System Quality to identify a smaller number of measures to include in contracts and for the inventory to serve as the basis for a System Quality Measure Repository.

Majority of Measures Are Non-Standard

Nearly 77% of all unique measures are custom: 235 from 2 TN Medicaid agreements and 244 others.

Frequency of All 618 Unique Quality Measures in 286 Agreements, 2003



Population Health produced 2 chapters within the Payer Strategy contract negotiation playbook. The Quality Measure chapter supports negotiation for a small number of standard measures and for reasonable incentive and reporting detail. The Risk Adjustment chapter details the risk adjustment methodology used in a contract and defines clear parameters, helping to reduce the audit risk for CommonSpirit.

In addition, Population Health spearheaded a group purchase of national benchmarks and quality measurement specifications, working with Quality leaders across the ministry. By purchasing in bulk, we saved $30,500.

ON THE HORIZON

Population Health will conduct annual inventories to track reduction in measure count over time and to ensure accurate updates and enhancements to the Payer Strategy contract negotiation playbook and the quality measure repository.

ACKNOWLEDGMENTS

We appreciate the invaluable collaboration and expertise of Payer Strategy and System Quality, including Kristyn Ulrich, Annemarie Hartwig, Kyle Holley, Andrew Galley, Brittany Willis, Dave Mohr, Pattie Fishback, Tammy Wilcox, Debra Rockman, Janet Holdych, and Tracy Sklar.

Hierarchical Condition Category Risk Adjustment

Overview

Population Health convened a task force to develop a national framework for hierarchical condition category (HCC) risk adjustment, which is applied across value-based contracts. The framework supports the development of risk adjustment programs in each Value Hub, accurate and complete documentation of illness by physicians and APPs, and guardrails to reduce risk of audit. The task force identifies best practices, measures, and resources, and tracks performance to drive improvement.

WHY

As described by the American Academy of Family Physicians, "The risk-adjustment model is used to estimate future health care costs for patients by calculating a risk adjustment factor (RAF) score for each patient. The purpose is to pay for the additional care that sicker patients need."

HCC risk adjustment is ubiquitous in CMS Programs and is used increasingly by commercial health plans. Risk adjustment is clinically important in identifying and addressing health conditions. Accurate and complete documentation by providers is the hallmark of risk adjustment; without documentation clearly supporting what is billed, additional payments for needed care are withheld. In both the 2020 and 2022 Value Hub Capability Assessments, Value Hub leaders across CommonSpirit indicated 'documentation and coding' were their weakest areas. A national strategy to support accurate and complete documentation is critical to the success of risk adjustment.

RESULTS

The task force developed a national risk adjustment framework defining a coordinated approach to risk adjustment, accurate and complete documentation, and coding. It published an HCC Risk Adjustment Process playbook, which details creating a risk adjustment process, including supporting resources and metrics to track progress. The task force designed a high-level dashboard to track MSSP risk adjustment recapture, risk and AWV scores. It has also vetted and chosen software to support data aggregation, normalization, and recapture as well as highlight gaps in coding.

CMS HCC Risk Adjustment Deliverables

COMPLETED

- Develop national risk adjustment framework
- Choose software (Innovaccer) for data aggregation, normalization, recapture
- Publish HCC Risk Adjustment Process playbook
- Draft language for inclusion in future VBAs

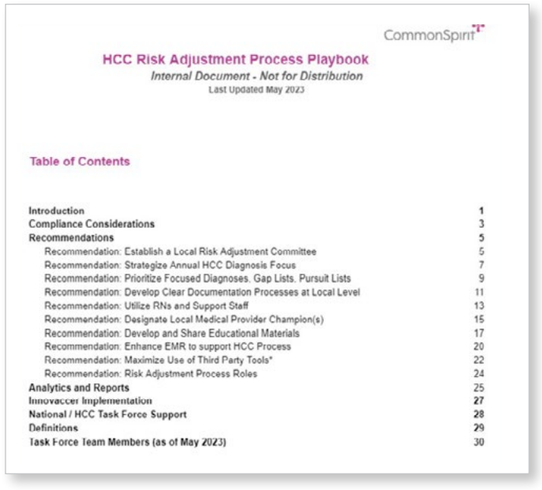
IN PROCESS

- Dashboards to track risk adjustment metrics and score
- Electronic tool for coding assistance (e.g., embed tool in EMR)
- Guidance for rule out conditions in ambulatory settings
- Value Hub functionality and resources (RN/Coding)

FUTURE

- Add MA to the dashboard and review in early 2024
- With Compliance, develop self-audit process
- Strategies to standardize coding messaging for independent/ non-employed providers
- Assess risk adjustment program progress across system

Risk Adjustment Process Playbook


CommonSpirit

HCC Risk Adjustment Process Playbook

Internal Document - Not for Distribution

Last Updated May 2023

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Access Playbook here.

ON THE HORIZON

The Task Force plans to add Medicare Advantage to the dashboard when MA data are available in the all payer claims database, and to assess progress in risk adjustment programs across Value Hubs. The task force will also support better documentation and coding of suspect conditions in the ambulatory care space, which increases the completeness and accuracy of overall risk adjustment.

ACKNOWLEDGMENTS

We appreciate the dedication, expertise, and guidance of Joyce Davis, Katie Froelich, David Walsh, Ranae Forbes, and Dr. Melissa Gerdes, without whose acumen this work could not have been completed. We also appreciate the knowledge and insights of the other members of the HCC Task Force: Angela Franceschi, Brenda Smith, Camille Wilson, Candace Lozano, Casey Hilbun, Danielle Vandergriff, Dave Mohr, David Mayo, Dr. David Mescher, Dominic Staeheli, Dr. Hank Sakowski, John Chan, Joella Russell, Dr. Kamal Sumar, Dr. Kia Parsi, Kristen Brown, Kristin Pappas-Buri, Lindsey Haner, Lisa Icard, Lori Allison PhD, Megan Harkey, Natasha Jivani, Pamela Burgoyne, Pam Thompson, Rosa Vicente-Soito, Russelyn Cruse, Tracy Maddox, Tyler Peavy, Yesenia Gurka.

Medicaid Best Practices and Cal-AIM

Overview

Population Health is building a workgroup to promote greater communication and coordination related to serving Medicaid populations, including sharing best practices, facilitating ways to close gaps in care, and leveraging innovative opportunities including capacity-building and funding.

WHY

While the Affordable Care Act (2014) greatly expanded coverage for the Medicaid population, in recent years, there has been an uptick in policy actions to truly improve access to care. These efforts are largely rooted in a shared vision to connect health care with social needs and mental/behavioral health. CMS has also committed to ensuring the majority of Medicaid beneficiaries are in value-based care by 2030. CommonSpirit Health is one of the largest providers of Medicaid services in the country. While there are robust market-level efforts across the CommonSpirit footprint, these are largely operating in silos and there is opportunity to build a more cohesive, system-wide approach to serving this population.

RESULTS

The Medicaid workgroup launched this year and is building an inventory of best practices and Medicaid-related state policy actions. The workgroup will build from early learnings around California Advancing and Innovating Medi-Cal (Cal-AIM), a transformative state policy reform effort, which CommonSpirit has participated in since early 2022.

We are thrilled to introduce our Community Healthcare Workers (CHWs). This is a new non-clinical role that will provide focus on Enhanced Care Management (ECM) solely and will be the true heart of the program. The CHW will be the conduit for patient engagement and represent the culture and language of the population we serve.

– Sue Bartkowski, Vice President of Clinical Services

ACKNOWLEDGMENTS

Advocacy & Public Policy; Acute & Post-Acute Care Coordination; Behavioral Health; Community Health; Continuing Care; Dignity Health Medical Foundation; Dignity Health Managed Services Organization; National Philanthropy; Payer Strategy & Relationships Physician Enterprise West; Population Health (Local & National); Value Hub Leaders

Next Steps

Medicaid

- Expand the CommonSpirit Medicaid Inventory, including state-by-state policy actions
- Convene Medicaid Stakeholders and Share Best Practices
- Identify key strategic workgroup priorities for 2024

Cal-AIM

- Continued support for implementation of the new Medi-Cal benefit Enhanced Care Management in five CommonSpirit markets
- Monitor and apply for capacity building support for existing and exploring Cal-AIM-participating markets

	A. Medicaid VB Lives	B. % of all Medicaid VB Lives	C. Medicaid Expansion State**
1. California	611,026*	62.9%	Y
2. Arizona	162,613	16.7%	Waiver
3. Washington	86,650	8.9%	Y
4. Nebraska	78,675	8.1%	Y
5. Arkansas	14,468	1.5%	Waiver
6. Kentucky	12.255	1.3%	Y
7. Texas	2,898	0.3%	No
8. No. Dakota	1,607	0.2%	Y
9. Tennessee	1,052	0.1%	No
Total* **	**971,244**	**100%**	**N/A**

1 million Medicaid VB lives across 9 CommonSpirit states (41% of all VB lives)

- 6 states comprise 99% of all Medicaid VB lives (in pink)
- Medicaid Expansion: Nationally, 41 states have adopted expansion

Notes
*In CA, ~70% of Medi-Cal VB lives are facility risk, 30% are professional.
**Medicaid expansion per the Affordable Care Act (2014). Includes DC (a/o 2/23).
***Excludes OR & Nevada Medicaid VB.

Lifesaving. Team Members are always available for concerns between medical appointments.

– [Cal-AIM ECM Patient Feedback, in reference to CommonSpirit Care Team's support]

After being enrolled in our Enhanced Care Management program for just over a year, one of our patients had the appropriate support system in place to have a surgery she had needed. After completing the surgery, she is very happy with the results with no reports of pain, and her PHQ-9 went from a score of 17 prior to surgery, to 0 following the surgery. She is interested in establishing a major for college and thankful for the [Care Coordination] team's wrap-around support.

– Kanika Kisero, Supervisor, Continuing Care Coordination DHMSO-Inland Empire

Medicare Shared Savings Program

Overview

CommonSpirit Health has been participating in the Medicare Shared Savings Program (MSSP) since 2013 and is continuing to deliver high quality performance. Participating in programs that prioritize innovative high-quality care is a priority for our ministry.

WHY

Medicare Shared Savings Program accountable care organizations (ACOs) are groups of health care providers who collaborate to give coordinated high-quality care to people with Medicare, focusing on delivering the right care at the right time, while avoiding unnecessary services and medical errors. The program was designed by the Centers for Medicare and Medicaid Services (CMS) to improve care for patients, while making health care more affordable.

RESULTS

CommonSpirit delivered improved quality and $68 million in savings to Medicare for the 2022 performance year of the MSSP. Through its nine ACOs, CommonSpirit improved care outcomes for over 233,000 Medicare patients, with higher quality scores than the national ACO average. Over the past five years of participation in the MSSP, CommonSpirit has saved Medicare more than $474 million by prioritizing proactive outreach and addressing not only medical, but also behavioral and social needs.

Core to our mission is improving the health and well-being of the communities we serve, including the most vulnerable populations. We are one of the nation's largest providers of value-based care, and we are focused on growing those programs and delivering quality, affordable care to more communities across America. These results demonstrate that we are making a meaningful impact and driving large scale change.

–Thomas McGinn, MD, System Executive Vice President, Physician Enterprise, CommonSpirit Health

MSSP at CommonSpirit Health

For the 2022 performance year, CommonSpirit Health ACOs:

Delivered improved quality to over **233K** beneficiaries, with an average quality score of **83%**

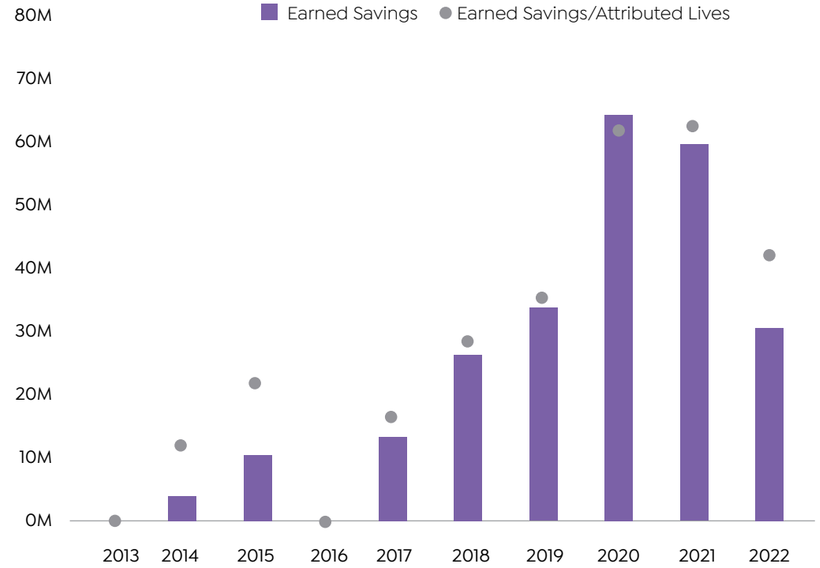
Reduced costs by **$68M**

Earned incentive shared savings worth **$33M**

On average, saved Medicare **$7.6M**

Over the past 5 years, CommonSpirit Medicare Shared Savings Program ACOs have saved Medicare more than **$474M** and earned over **$231M** in shared savings

2022 MSSP Earned Shared Savings



ACKNOWLEDGMENTS

ACO Leaders, Post Acute Care Coordination, Home Health, System Quality Teams, PSR-AI

Collaborative Care Models for Behavioral Health Treatment

Overview

CommonSpirit Health has partnered with a vendor to provide virtual, integrated behavioral health care via the Collaborative Care Model across our health ministry since 2020. In the future, the ministry will use a system metric to measure and foster improving rates of depression screening and follow-up, with a comprehensive toolkit to ensure providers can successfully address all patient needs identified.

WHY

Collaborative Care is an evidence-based model that integrates behavioral health into a patient's primary medical setting by providing both psychosocial treatments and medication management for mild to moderate behavioral health conditions, such as anxiety and depression. Collaborative care has been shown to increase patient access to behavioral health care and significantly improve clinical outcomes. Simultaneously, our providers were asking for help in providing behavioral care and our patients were having difficulty accessing behavioral health care (time/financial barriers, stigma, limited provider availability).

RESULTS

The Quality Committee has approved the system metric and, to date, 3,000+ CommonSpirit patients have been served by Concert Health. Ninety-day remission rate is 41.91% and 120-day remission rate is 44.36%, consistently positive net promoter score by participant patients.

WHY COLLABORATIVE CARE?

More than 90 randomized controlled trials (RCTs) demonstrate that Collaborative Care is more effective than usual care for patients with depression, anxiety and other behavioral health conditions. Published in 2002, the IMPACT study (Improving Mood — Promoting Access to Collaborative Treatment) is the seminal RCT demonstrating that Collaborative Care more than doubled the effectiveness of depression treatment for older adults in primary care.

ACKNOWLEDGMENTS

Thank you to Christine Brocato, Ankita Sagar, Debra Rockman, Paul Rains, and Alisahah Jackson.

The shortage of mental health care providers in my area is significantly greater than other areas of the state. Concert Health staff provide up to date mental health care to our patients. Counselors have alerted me to patients who require extra care or are not responding appropriately to treatments. The notes from the psychiatrists have broadened my knowledge of medication management or mental health conditions.

— Primary Care Physician, Santa Cruz

SYSTEM AMBULATORY QUALITY GOALS

FY24

- Improve rates of depression screening and equitable application across demographic groups
- Report rates of provider follow-up for positive screen results as available
- Develop toolkit and resources

Learn About the Impact to Date

Collaborative Care Model (CoCM) with Concert Health is live in 4 CommonSpirit Health markets.

3,000+
patients served

190+
providers enrolled

60.5%
of patients complete care with subclinical scores on anxiety and depression screening tools

83+%
of surveyed patients reported their CoCM provider has helped them feel better

2%
positive operating margin based on initial financial reporting

Annual Wellness Visits

Overview

Annual Wellness Visits have been a core priority for CommonSpirit Health Quality and Population Health for the past three years. A multidisciplinary workgroup meets regularly to share best practices, update on results, and standardize care. We've seen steady improvement across the ministry since the start of the initiative.

WHY

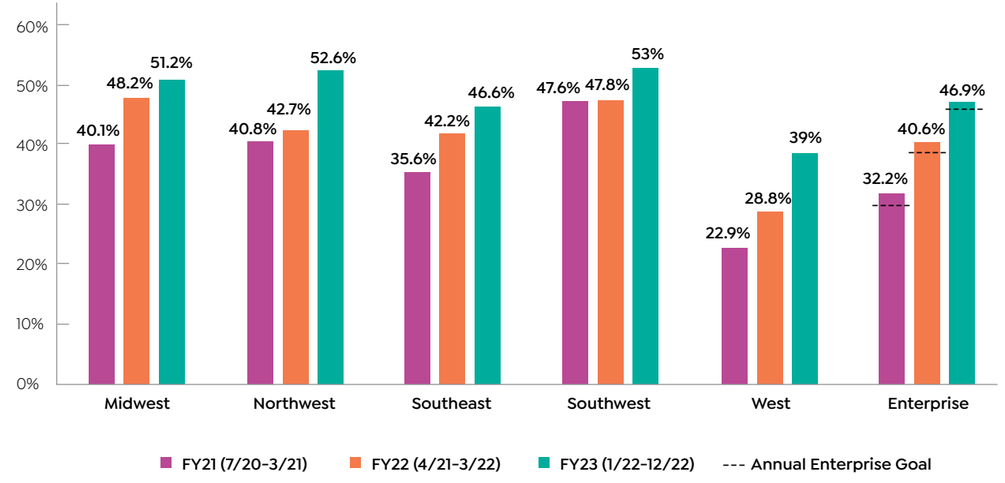
Annual Wellness Visits provide a vital opportunity for the patient and the primary care provider to assess future risk, close quality gaps, and establish a care plan.

RESULTS

An additional 28,000 Annual Wellness Visits were performed last year compared to the prior year, resulting in $17 million in direct Medicare revenue to CommonSpirit. These visits are also associated with higher quality and lower total cost of care.

Annual wellness visits (AWVs) are a critical pathway in identifying high risk patients and helping them to develop personalized prevention plans to prevent illnesses, including immunizations, medication review, and advance care planning. They can be a valuable tool to ensure appropriate quality gaps are closed.

Annual Wellness Visit Goal Performance



Advance Care Planning

Overview

Advance care planning (ACP) is a voluntary, face-to-face service between a provider, a patient, and sometimes their loved ones to discuss the patient's health care wishes if they become unable to make their own medical decisions or to provide the opportunity for the loved ones to hear what the patient's wishes are.

WHY

ACP discussions have multiple benefits for patients, providers, and the health care system. ACP respects the patient's choice and preserves the patient's dignity by providing clarity to loved ones and providers about what the patient wants if they become unable to make their own medical decisions.

ACP discussions and documentations can help providers understand the patient's wishes. A team approach to ACP can reduce the burden on primary care providers. ACP also helps reduce wasteful utilization and cost for the health care system. Multiple efforts surrounding ACP are happening across different regions in silos. We strive to bring different groups together for increased collaboration, awareness, engagement, coordination, and education while aligning with national clinical strategies.

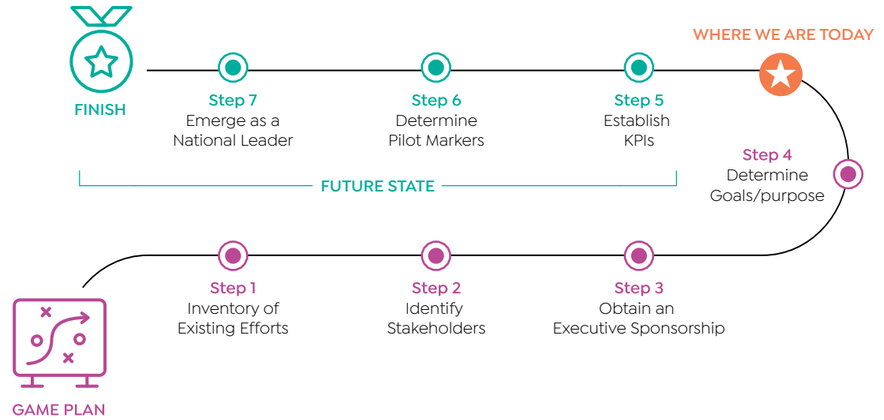
RESULTS

The Population Health ACP team created an inventory of ACP efforts in various markets within CommonSpirit Health, gathering the stakeholders and collecting feedback on ACP strategy. Leaders from Population Health, Ethics, and Age-Friendly Healthcare System are cosponsors for this project. Numerous robust discussions with various regions and entities are in progress, supporting the value and the potential impact of this work.

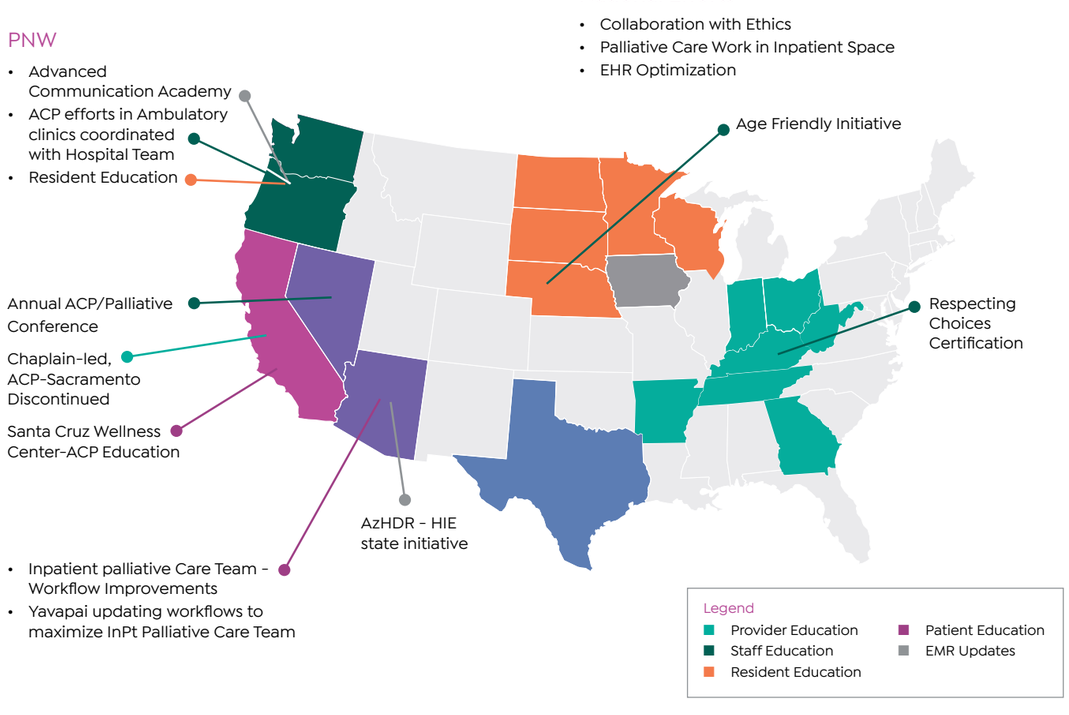
ACKNOWLEDGMENTS

Age Friendly Team, ALz Association, CHA, Advocacy & Government Relations, Clinical Standards & Variation Reduction, Cross Care Continuum Councils, Ethics, IT & EHRs, Mission Integration, Palliative Care (all phases), Physician Enterprise, Pastoral & Spiritual Care, Philanthropy, Population Health, Staff

Proposed Process for ACP Initiative



Inventory of Work at a Glance



Population Health Services Organization (PHSO)

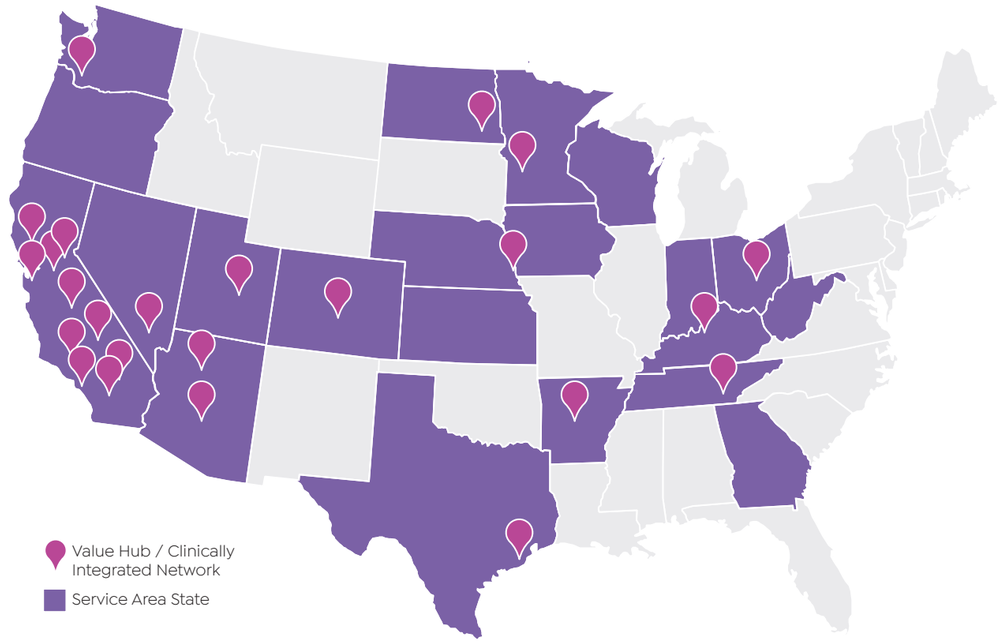
Overview

Our objective is to leverage the best practices, people and systems from three existing California MSOs to build a newly branded PHSO (Population Health Services Organization) that moves CommonSpirit Health toward the future of value-based care. Doing so will also create operating expense synergies, leverage core capabilities and drive network integrity.

WHY

Current VBA revenue is $1.1B or 3% of total system revenue. Managing performance under value-based care contracts is plateaued and disconnected, and negotiating higher rates from health plans is becoming increasingly more difficult. CommonSpirit needs to remove administrative burden from providers of complex and varied payment models.

Our Goal Together as One CommonSpirit



With 2.6 million lives today, we are already one of the largest providers of value-based care.

- Our goal to work as partners to build an industry leading PHSO together; transparency and communication will be key to this partnership.
- CommonSpirit's PHSO centralizes our national value-based capabilities and expertise, establishing a platform to serve value hubs across our footprint.
- Value-Hub leaders will share ownership in decision-making processes to help align on a one system strategy for population health.

ACKNOWLEDGMENTS

Marketing and Communications and the broader Physician Enterprise. The PHSO will offer a portfolio of services that are deployed nationally, regionally, and locally to provide economies of scale, effective plug and play services, and best practice knowledge to improve performance in local markets.

Population Health Platforms

Overview

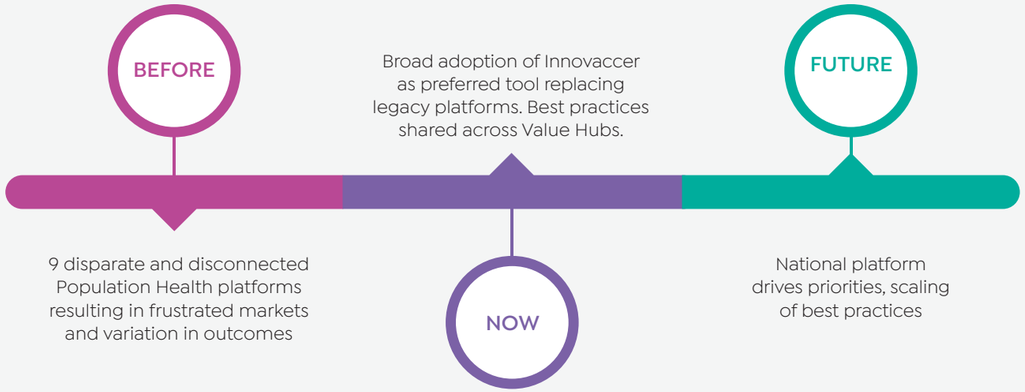
Population Health platforms combine data, analytics, care management services, and quality management in one place to deliver improved finances, clinical outcomes, and patient engagement. Streamlining platforms at CommonSpirit Health allows us to leverage best contract pricing and share best practices.

WHY

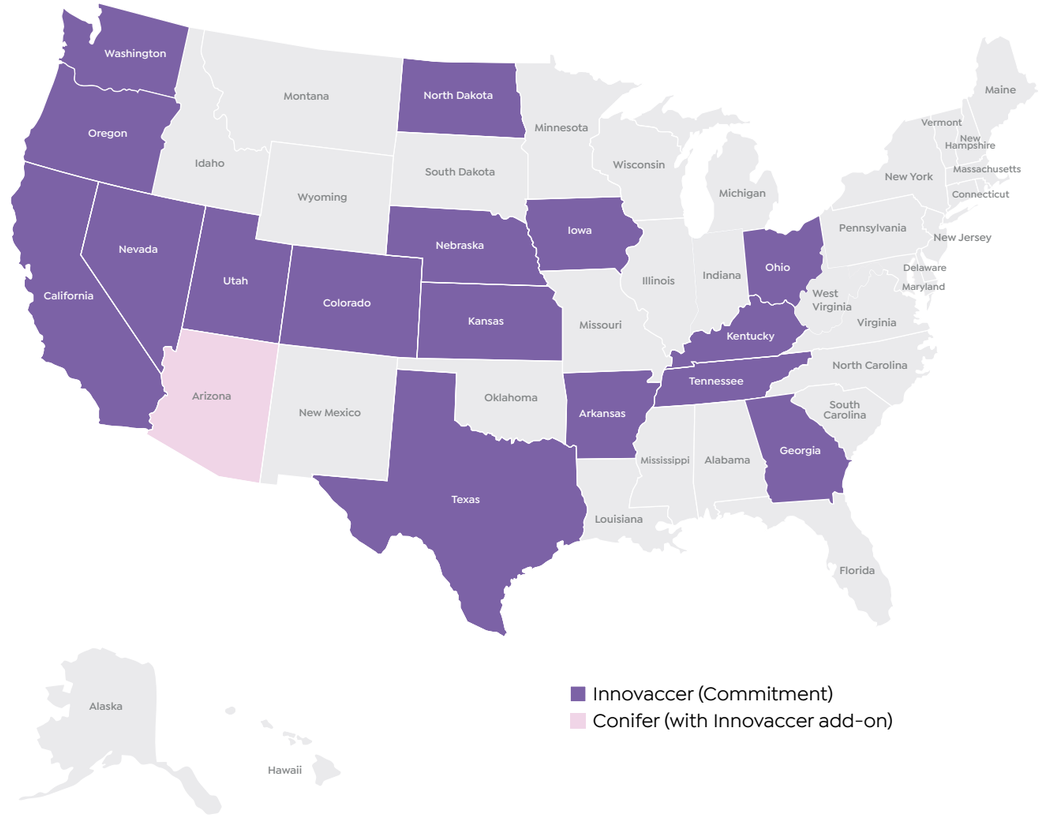
CommonSpirit had nine disparate and disconnected Population Health platforms across the ministry resulting in frustrated markets and variation in outcomes.

RESULTS

There is currently broad adoption of Innovaccer as the preferred tool replacing legacy platforms. There are also best practices shared across all Value Hubs.



National Technology Infrastructure



ACKNOWLEDGMENTS

We extend our gratitude to all Value Hubs leaders as well as the CommonSpirit IT team.

Care Coordination Cross Continuum: 4Cs

Overview

The Care Coordination Cross Continuum (4C's) group coordinates work happening across the care continuum to resolve barriers, address gaps, and promote best practices. Clinician and non-clinical support teams assist patients in transitioning smoothly from one site of care to another, such as hospital to home, ensuring that items like transportation, food security, medications, and follow-up appointments are arranged. The vision is to serve and support all patients receiving services at our hospitals, patients under value-based arrangements, and patients cared for by our Physician Enterprise providers.

WHY

Acute Care Coordination, Post Acute Care Coordination (Transitions of Care), and CC (Ambulatory CC) exist in silos and historically have not had a formal platform for market leaders to connect to share best practices and resolve barriers.

RESULTS

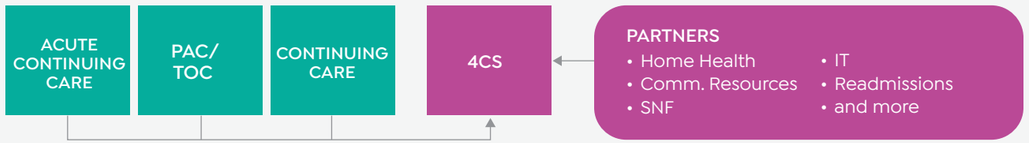
- Market 4C Councils provide quarterly tracking reports to National 4C:
  - Status Summary
  - Accomplishments
  - Priorities (Action Plan w/Dates)
  - Escalations to National with Potential Solutions
- Local Market Tri-Chairs Self-Report Being On-Track

FACTS AND FIGURES

- 18 Local markets have 4C meetings
- Each local market provides quarterly updates to national team
- Two-thirds of latest survey believe Communication and Collaboration has improved
- Top project for savings (s/o Tennessee) has ~$207,000 in cost avoidance FY23

4CS FACILITATE HORIZONTAL TEAMWORK

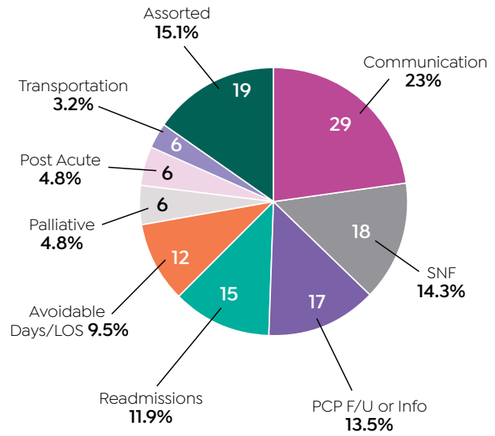
Shared targets of Length of Stay, Readmissions, Patient Satisfaction, etc.



The 4Cs Team

Phase	Acute Care	Post Acute/ Transitions of Care	Continuing Care (formerly Ambulatory Care)
Where	Hospital	As patient returns and settles back home. Sometimes in SNF/IRF/LTAC	Usually home, but anywhere outside of a healthcare setting
When	During hospital stay	From Discharge up to 30 days	~2 days post discharge thru as long as needed
Who	RNs, sometimes SW or CC Asst. Usually a part of UM.	RNs, LVNs, Navigators	RNs, LVNs, SW, Navigators

Local Market 4C Projects by Theme



Goals of Market 4C Councils

GOAL 1

Improve communication & collaboration across the care coordination continuum in order to improve patient care

GOAL 2

Support National, Division, and Local Goals

GOAL 3

Build relationships and alliances both within and outside of our organizations

GOAL 4

Focus on patient interests and experiences to drive improvement

GOAL 5

Use data to uncover insights and motivate change

ACKNOWLEDGMENTS

Thank you to Acute Care Coordination, Post Acute Care Coordination, Community Health, Acute Care Coordination (Gail Moxley), Post Acute Care Coordination (Regina Mudd), Community Resources (Ji Im and Jurema Gobena, Home Health (Rob Plunkett, Adam Hill, Nicole Main), Clinical Operations, and local Continuing Care Leaders.

What We've Accomplished Together

VALUE-BASED CARE AND RISK

Expand cross-disciplinary Population Health Capabilities to leverage existing investments and drive value-based care transformation in markets, ignited by the shifting reimbursement landscape.

- 28,000 Expanded Wellness Visits
- 2.6 million lives: Met VBA Participation and Performance Board Goal
- 1,729 Hypertension CV Events Averted
- Launched Population Health Services Organization
- 66% AVS Implementation Complete
- Developed HCC Risk Adjustment Playbook
- Completed VBA Quality Metric Inventory
- Saved Medicare more than $474M through our MSSP programs over the past 5 years

WHERE WE'RE GOING

As we look to 2024, we look forward to exploring opportunities to further refine and expand the initiatives mentioned in this portfolio and to pursue new topics. This includes:

- Expanding the reach of our newly launched PHSO
- Supporting markets as the new system metric to improve rates of depression screening and follow-up is launched
- Expanding our hepatitis C efforts to positively affect even more patients across our ministry
- Completing our All-Payer Value-Based Claims Source
- Identifying, through value-based claims, ways to impact and improve value-based care
- Provide cross functional spaces across departments and geographies to facilitate collaboration and best practice sharing in support of One CommonSpirit

Who We Are

Meet Our Team

As part of the Physician Enterprise, the Population Health team focuses on supporting value-based care across our enterprise.

We source best practices and disseminate them across our markets. We centralize tools and resources to gain preferred pricing. We digest new care models and advise on participation. We engage clinical leaders on best practices for expanding value-based care. We engage operational leaders on how to sustainably support Population Health practices. We build data sources to deliver insights on high impact ways to improve the health of our populations. We believe that when we succeed in our work, clinicians can provide care more easily and our communities can live longer and happier.

Population Health Leadership

Nicholas Stine, MD
System SVP
Physician Enterprise, Population Health

Melissa Gerdes, MD
System VP
Population Health Clinical Strategy

Jesse Singer, DO
System VP
Population Health Insights

Derek Novak
System VP
Population Health Services

We believe that when we succeed in our work, clinicians can provide care more easily and our communities can live longer and happier.


CommonSpirit