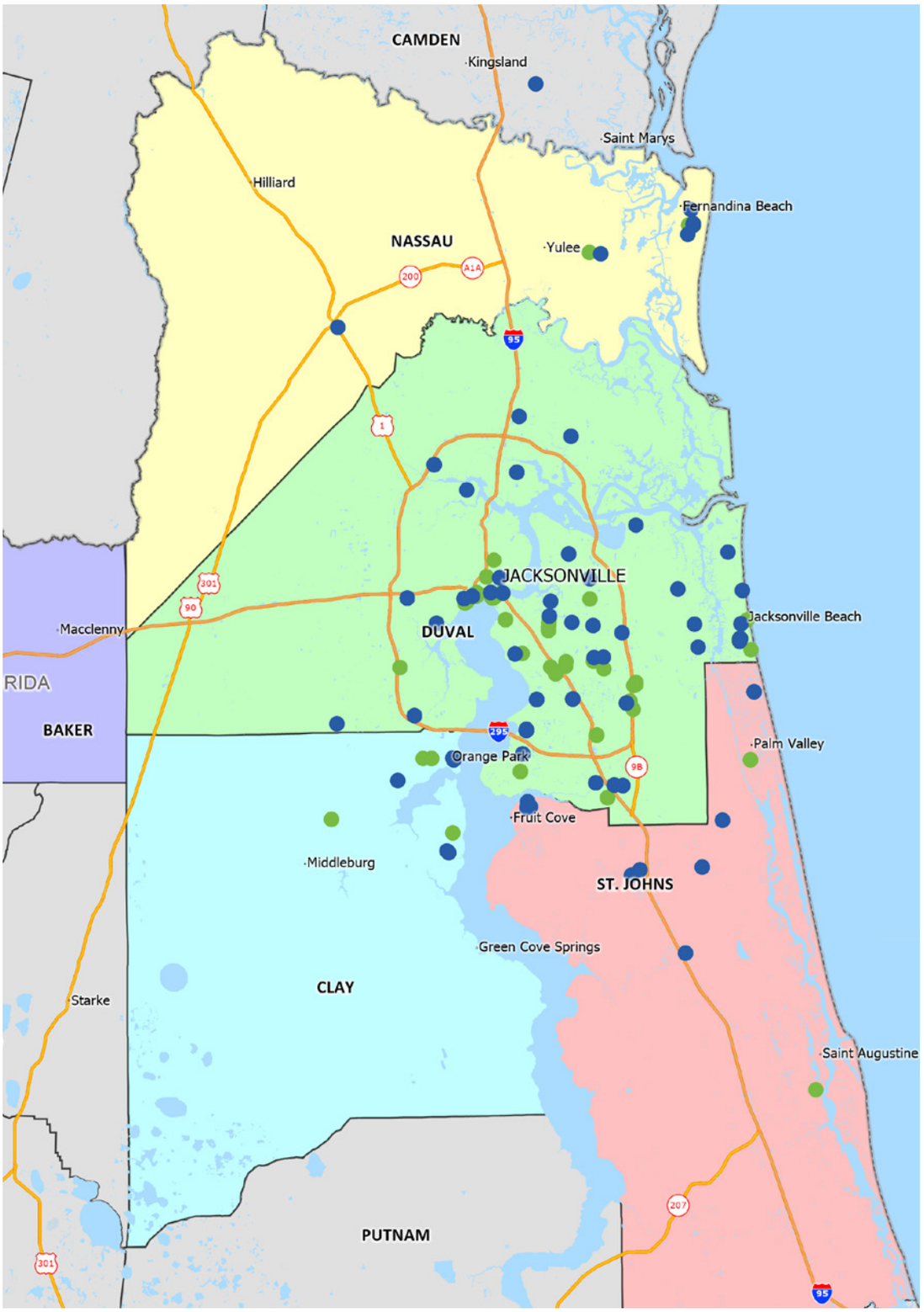
Journey to Population Health

2018 – 2020 Value Report

BAPTIST
Physician Partners

Physician office locations (end of FY20)



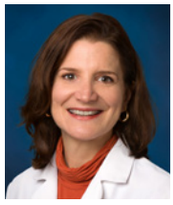
- **194** Primary Care Physicians in **67** locations*
- **889** Specialist Physicians in **144** locations*

**Some dot may be representative of multiple offices at the same location.*

Journey to population health

Brett S. McClung, FACHE
President and CEO
Baptist Health

Timothy Groover, MD
Sr. Vice President and CMO
Baptist Physician Partners



Ilene Levenson, MD
Chairman, Board of Managers
Baptist Physician Partners

The United States spends nearly twice as much as the average developed country on health care, yet has a comparatively lower life expectancy, a higher infant mortality rate, and a higher prevalence of unmanaged diabetes. Conversely, government and private payers are demanding greater value with respect to lower costs, higher quality, and better outcomes for their insured populations.

Since 2014, our clinically integrated network of more than 1,000 physicians, Baptist Physician Partners (BPP), has focused on an evolutionary approach to deliver care in a manner that exceeds payer expectations. We have implemented and matured programs to coordinate care delivery, reduce unwarranted variations in care, encourage appropriate sites of care, improve care transitions, manage chronic conditions, and decrease unnecessary utilization.

Timely access to accurate data has served a critical role in our journey to population health management. Today, our Population Health Analytics team shares pertinent data across the care continuum, allowing for care gap closure and identification of suspect conditions. The ability to utilize Meaningful Use Data Exchange and Alternative Submission Methods for sharing of information with payers has significantly enhanced our ability to demonstrate compliance with metric benchmarks.

In this 2018 – 2020 report, BPP celebrates the successful management of our contracted lives in tandem with Baptist Health, the largest health system in Northeast Florida, a robust care coordination team, and a dedicated administration team.

Recently, we have achieved shared savings in both commercial and governmental contracts, and have entered into a new realm of value-based care by taking on downside risk. BPP began participation in the Centers for Medicare & Medicaid Services Bundled Payments for Care Improvement Advanced Model on January 1, 2020.

Our journey to population health has been accelerated and enhanced by input from physicians, care team members, and most importantly, our patients, as we seek to foster a lifetime of health, together.

Timeline and milestones 2014 – 2020

2014 – 2015 EVALUATION, PREPARATION AND DEMONSTRATION

- Care Coordination program established
- LLC operating agreement effective; Clinically Integrated Network (CIN) formed
- First value-based agreement signed for Employee Health Program (EHP)
- Data analytics platform launches

***700 physician members in network**

2016 DEMONSTRATION

- Clinical Transformation Council (CTC) formed to reduce unwarranted clinical variation
- AvMed and Aetna Whole Health agreements signed
- First BPP Value Report published
- Physician dashboard rolled out to Baptist Primary Care (BPC)
- Care coordination documentation tool implemented and efforts aligned across the continuum

***870 physician members in network; 17,000 covered lives; 3,000+ patients engaged by care coordination**

2017 ENHANCED DEMONSTRATION

- Accountable Care Organization (ACO) formed within CIN
- Nemours pediatric specialists joined (100+ providers)
- Clinical transformation workgroups (CTW) convened to address clinical variation
- United Medicare Advantage agreement signed
- Network adequacy software adopted

***1,000 physician members in network; 27,00 covered lives**

2018 TRANSFORMATION (LEVEL 1)

- Medicare Risk Adjustment program initiated
- Shared savings for 2017 EHP agreement achieved
- Ongoing CTW efforts: Four initiatives total
- BPC regional site leads engaged
- Social Responsibility partnership established to address social determinants of health
- Data Analytics team expanded to support population health initiatives
- Center for Medicare and Medicaid Services (CMS) Medicare Shared Savings Program (MSSP) agreement commenced (Track 1)
- Population Health Analytics team generated routine reports for physicians

***1,100 physician members in network; 62,000 covered lives; 7,000+ patients engaged by care coordination**

2019 TRANSFORMATION (LEVEL 2)

- Ongoing CTW initiatives: Six total
- End of life added to care coordination strategy
- Senior population health strategy evaluation
- Online application process and content management system launched for provider applicants and members
- BPP Bulletin launched: monthly e-mail update to providers
- Interactive BPP web page designed
- Data analytics platform optimized to produce more robust physician dashboards

***1,055 physician members in network; 69,000 covered lives**

2020 TWO-SIDED RISK

- Ongoing CTW initiatives: Nine total to date
- Governance structure of CTC leveraged by Baptist Health to address COVID-19
- Accurate documentation and diagnostic coding initiatives began
- CMS Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model participation commenced
- Commenced partnership with Alivia Care
- Transition of population health platform initiated; migration from IBM Explorys to Cerner HealtheIntent
- Data analytics capabilities enhanced to provide Care Coordination dashboards

***1,078 physician members in network; 75,000 covered lives**

People Process Technology

250,000+ Patients

74,876 are BPP Contracted Lives

1,078 Active Providers

5 Hospitals

6 Value-Based Contracts (28 bundles)

4.05 Medicare STARS*

Preferred Partners

12 Skilled Nursing Facilities (SNFs)

8 Home Health Agencies (HHAs)

Total amount of savings from all value-based contracts** (2017 – 2019)

$50.69M

4,295 Patients receiving Care Coordination

200+ Locations in 4 counties (Duval, Clay, St. Johns, Nassau)

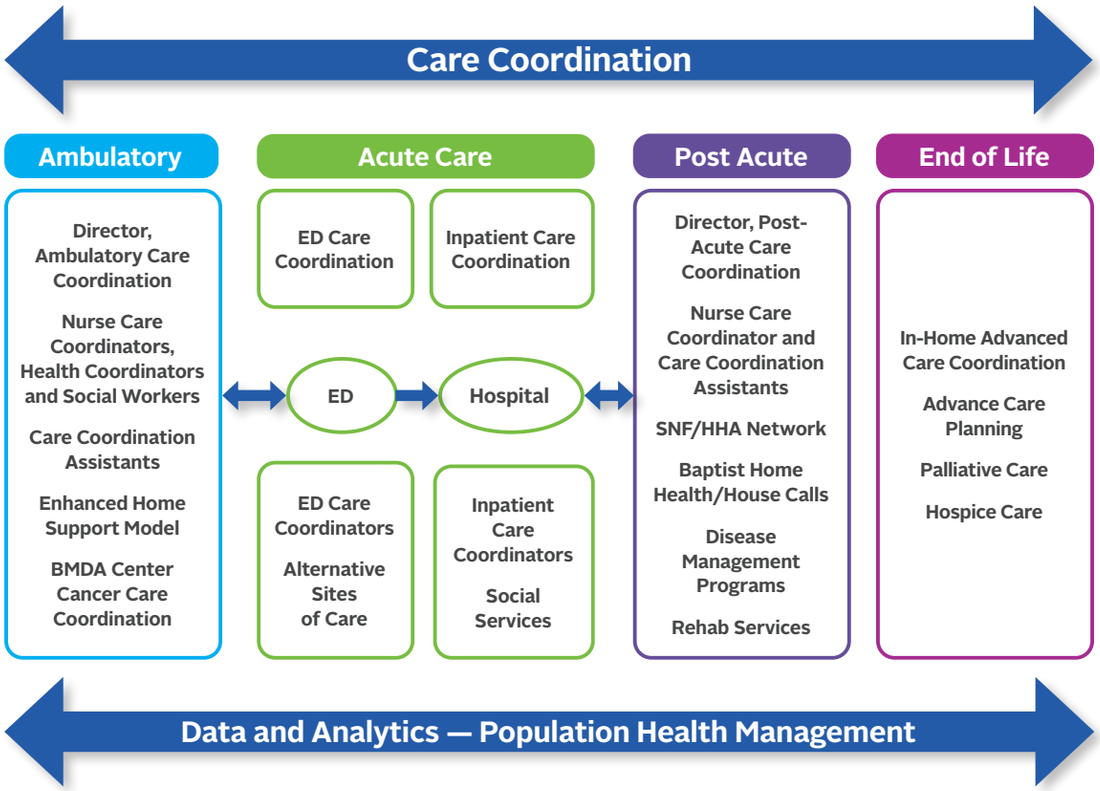
Total Shared Savings** (2017 – 2019)

$24.02M

**Medicare STARS 2019 final reporting.*

***Total Savings is the overall amount saved by the payer and BPP. Shared Savings is the amount of savings that is dispersed to BPP prior to any distribution to the health system, physicians, or administration fees. Exception: Florida Blue Employee Health Plan (distribution to the health system has already occurred in reported number).*

Care coordination model overview



Care coordination across the continuum

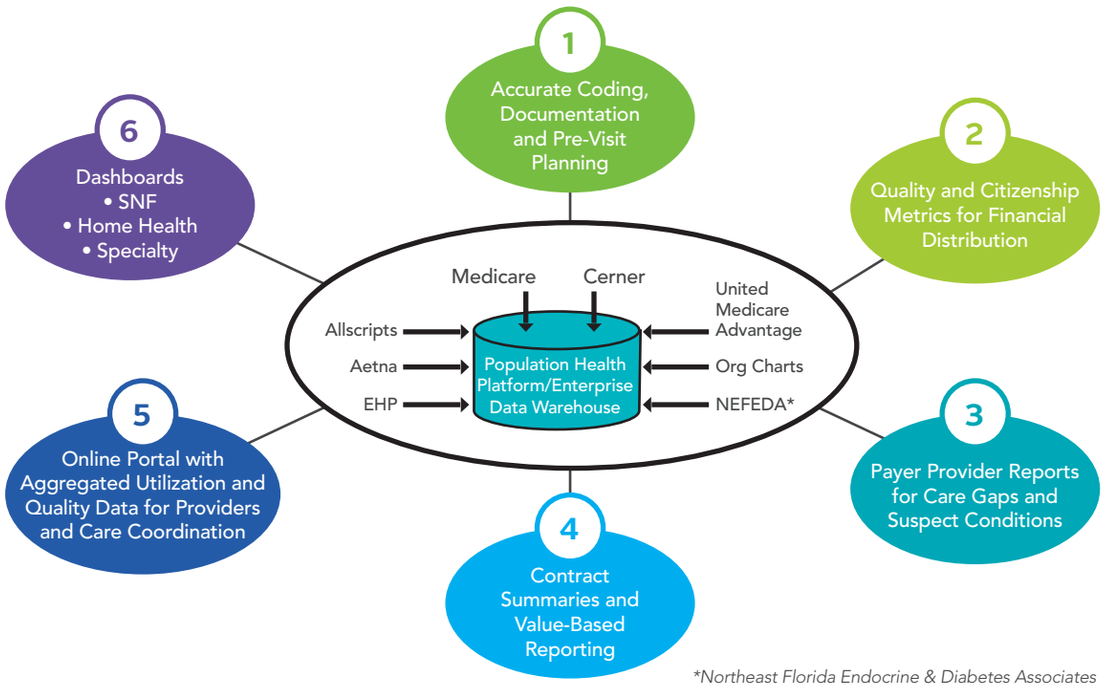
Within recent years, BPP Care Coordination team composition has evolved in response to the addition of value-based contracts. Major program updates include the pivot to an inpatient care coordination model, and the addition of ambulatory social work and end-of-life models.

Care coordination teams have broken down silos to facilitate appropriate transitions, safe recoveries, and ongoing patient coordination for high-risk and rising-risk patients in our value-based agreements. Program goals remain steadfast on improving quality, patient experience, and reducing total cost of care.

Seamless communication and standardized workflows among care coordination teams along the continuum have led to recent successes with strong support of information provided by the BPP Population Health Analytics team.

Data analytics and population health

In late 2018, BPP Population Health Analytics assumed an elevated role to assist with population health management and successful strategies within contracts. Composed of six team members, this department supports BPP Care Coordination, BPP Physicians, and multiple health system departments by creating actionable data and dashboards in six key areas (below). From analytics around social determinants of health, to accurate diagnosis coding, SNF dashboards, and population health platform administration, the work of this team is integral to BPP's value-based program.



**Northeast Florida Endocrine & Diabetes Associates*

BPP Population Health Analytics	Receiving Entity				
Type of Information Shared	Care Coordination	BPP Providers	BPC Office Staff	BPP Board of Managers	BPC Coding & Education Department
Population Health Platform	X	X	X		
Coding Education		X			X
Finance, Utilization, and Network Adequacy Reviews		X		X	
SNF Preferred Network Dashboard	X				
Payer Provider Reports	X	X	X		X
Inpatient and ED Notifications: Daily and Weekly	X	X			
Bundle Notifications: Daily	X				
Aetna, Bundle, and EHP Quality and Utilization Reports	X				
Citizenship Metric Reports		X		X	
Financial Modeling/Distribution Reports		X		X	

Bundled Payments for Care Improvement Advanced

The Bundled Payment for Care Improvement (BPCI) Advanced Model is BPP's first down-sided risk contract, expanding the size and scope of our population health strategy.

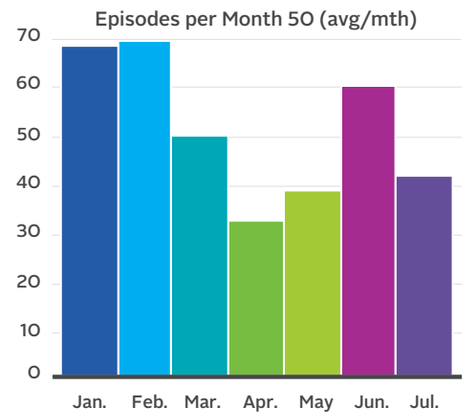
Through a risk-sharing partnership with Signify Health, BPP is paving the way to success through the Committee to Operationalize Medicare Value-Based Programs (COMVP). This expansion of the former Readmissions Committee focuses on three key strategies:

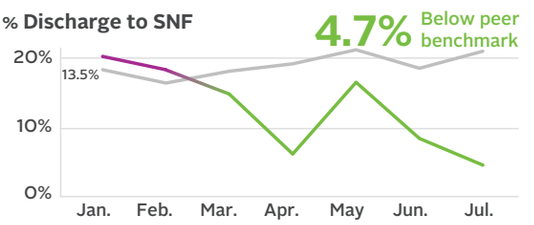
1. Reducing hospital readmissions,
2. Decreasing SNF utilization, and
3. Optimizing care for patients who are at end of life.

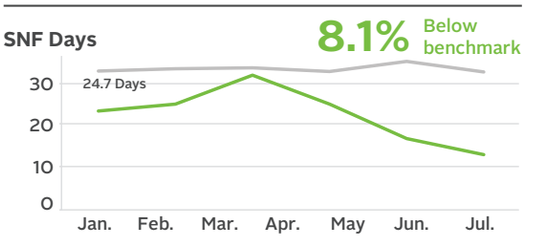
Three Baptist Health hospitals began participation in the CMS at-risk bundled payment program on January 1, 2020.

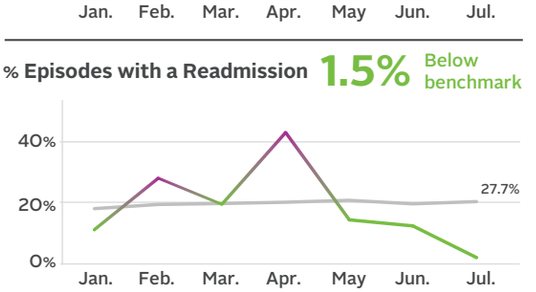
Baptist Beaches 2020

8 Bundles • 347 Episodes • 9 90-Day Readmissions



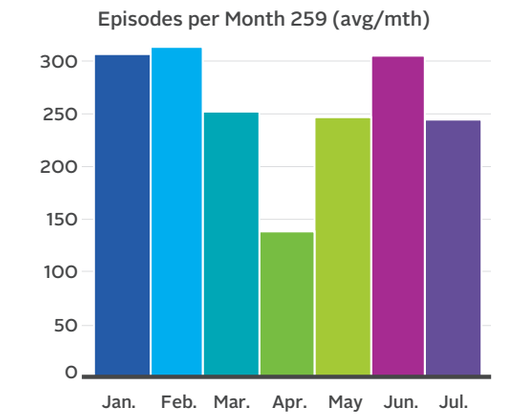


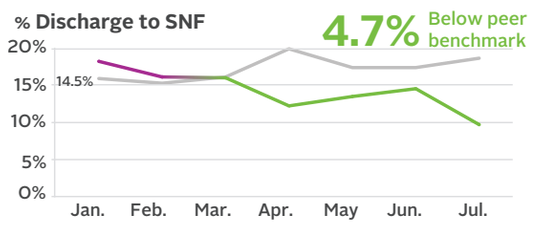


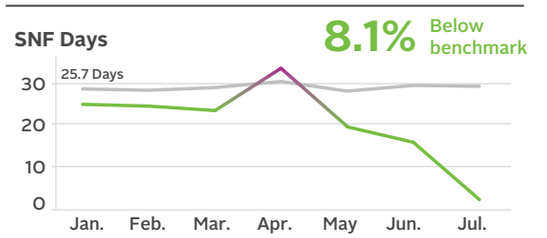


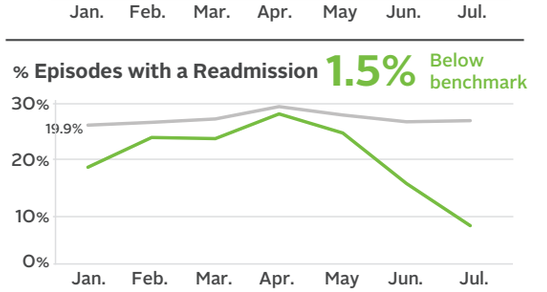
Baptist Jacksonville/South 2020

20 Bundles • 1,811 Episodes • 65 90-Day Readmissions









Data Sources: Episoce Connect Refreshed 7/29/2020

Performing Underperforming Benchmark Neutral

Bundled Payments for Care Improvement Advanced

BPCI Advanced beneficiary flow

Day of hospital admission
- Identify BPCI Advanced Medicare fee-for-service beneficiaries
- Confirm working DRG and presence in Episode Connect

24-48 Hours of hospital admission
- Initiate assessments and begin next site of care planning
- Collaboration among physicians, inpatient care coordination, and rehabilitation services

72 Hours of hospital admission
- Align on next site of care recommendation
- Discuss challenges to "why not home" (caregiver responsibilities, home environment, clinical, and functional status just prior to hospitalization)

Mid stay
- Assess status of care and transition plan
- Align care and transition plan

Prior to transition
- Assess clinical readiness for transition and confirm next site of care
- Carry out discharge plan

Transition of care
- Warm handoff to next site of care

signifyhealth®

Real-time patient identification
Early patient identification supports early interventions

Patient tracking
Track patients throughout the continuum of care

Transition planning decision support
Complete intervention steps at every crucial stage in the episode

Connecting the acute and post-acute
Enabling seamless communication and data transfer between acute and post-acute care providers

Care coordination strategy

The Inpatient Care Coordination team partners with physicians and rehabilitation services to reduce rehospitalizations and ED visits among patients who have medically complex conditions, including BPCI Advanced Medicare fee-for-service beneficiaries. The team facilitates seamless communication between patient settings while leveraging disparate medical record and documentation systems.

Once a beneficiary has transitioned to a post-acute care provider, the BPP Post-Acute Care Coordination team, in collaboration with Signify Health, follows the patient for 90 days. A solution called Episode Connect allows seamless communication until the patient arrives home.

Medicare Shared Savings Program ACO

MSSP ACO Quality Score

2019

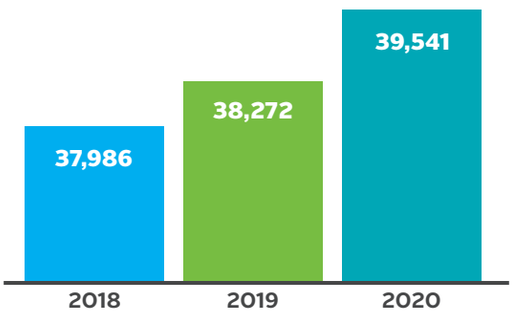
98.50%

Shared Savings*

2019

$11.37M

MSSP Membership Trend



Success to Date

Q1 2018 vs Q1 2020

-15.88%
SNF utilization days/1k

-10.02%
Beneficiaries with a SNF stay

-12.83%
Ambulance cost

-5.38%
Inpatient utilization/1k

-4.86%
ED visits that led to hospitalization

Total Savings** Achieved

2018 **$4.47M**

2019 **$23.09M**

**Shared Savings is the amount of savings that is dispersed to BPP prior to any distribution to the health system, physicians, or administration fees.*

***Total Savings is the overall amount saved by the payer and BPP.*

Medicare Shared Savings Program ACO

Since Baptist Physician Partners' contract agreement for the Medicare Shared Savings Program originated, we have seen a 12.65% membership increase (Q1 2018 to Q1 2020).

In 2018, we achieved savings for CMS, but did not meet the minimum savings threshold to share in savings.

In 2019, we achieved a total savings of $23.09M, of which BPP will receive $11.37M as shared savings!

Multiple strategies created a synergistic effect that led to this accomplishment, including:

1. Ambulatory Care Coordination team contact with over 1,400 Medicare fee-for-service beneficiaries from October 2019 to September 2020.
2. Reports provided by Population Health Analytics to physicians and care coordination teams detailing beneficiary risk scores, utilization, and cost of care.
3. Development of consensus-based guidelines to reduce unwarranted clinical variation of care provided to beneficiaries with chronic conditions such as congestive heart failure, chronic obstructive pulmonary disease, and end-stage renal disease.
4. Decrease SNF utilization secondary to work in refining our post-acute network.

In addition to care coordination, analytics, and care guidelines, other aspects of performance include quality, promoting interoperability, and improvement activities.

The quality performance category includes four key domains: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk population. Measures were calculated using Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, Medicare claims data, and data submitted through the CMS Web Interface.

MSSP ACO Quality Scores for BPP

Domain	Domain Score %	
	PY 2018	PY 2019
Patient/Caregiver Experience	100.00	94.00
Care Coordination/Patient Safety	100.00	100.00
Preventive Health	100.00	100.00
At-Risk Population	100.00	100.00
Final Score	**100.00%**	**98.50%**

BPP demonstrated improvement in six of ten measures submitted through the CMS Web Interface for PY2019. Some barriers and areas of opportunity include absence of chart documentation, depression screening, clinical follow-up plans (e.g., depression and tobacco), and records for colonoscopies and mammograms.

MIPS Alternative Payment Model

Under the Merit-Based Incentive Payment System (MIPS) Alternative Payment Model (APM) Scoring Standard, results are calculated at the entity level based on the overall performance and threshold score for a given performance year. BPP Physicians receive the same MIPS final score and MIPS adjustment.

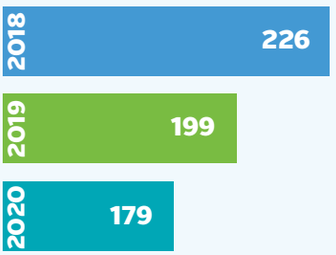
APM Scoring Standard Results for BPP

Domain	Measures	
	PY2018	PY2019
Quality	44.25 of 50	50 of 50
Promoting Interoperability	30 of 30	24.44 of 30
Improvement Activities	20 of 20	20 of 20
Additional Bonus Points	3.00	2.42
Final Score	**97.25**	**96.86**
Total MIPS Adjustment	**+1.55%**	**+1.58%**

United Medicare Advantage

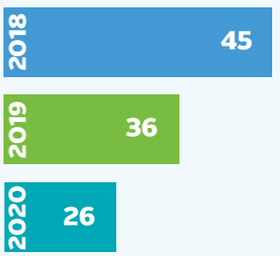
Member Utilization

Net Inpatient Admits per K*

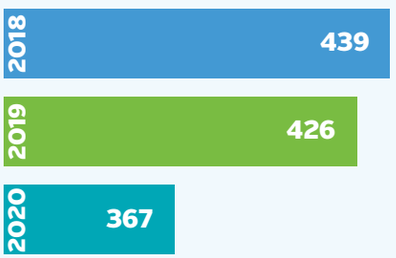


**Monthly averages from Jan-July for each year*

Total SNF Admits per K

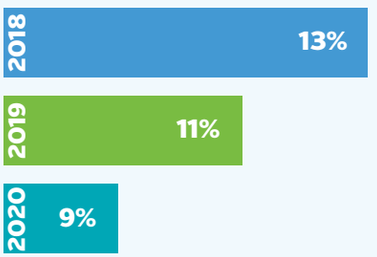


ED Visits Per K**



***Monthly averages from Jan-April each year*

Percent of Avoidable ED Visits**



Success to Date

2018 vs 2019

5.25%
Risk Score Increase

.75
STARS Increase

-3.62%
Inpatient Spend Decrease

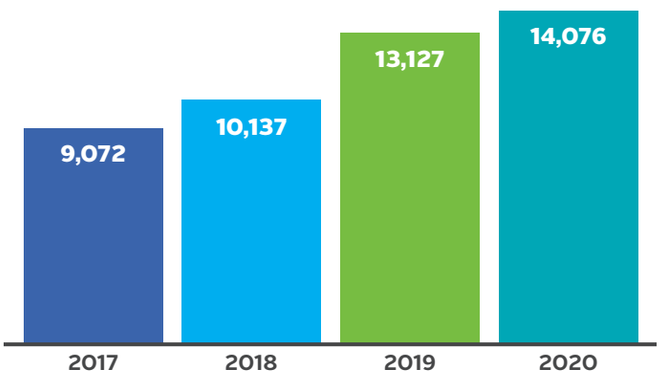
Total Savings* Achieved

2019

$7.66M

**Total Savings is the overall amount saved by the payer and BPP.*

UMA Membership Growth



United Medicare Advantage

BPP and UnitedHealthcare entered into an ACO agreement for the management of United Medicare Advantage (UMA) members in April 2017.

The agreement focused on four core eligibility metrics that serve as a gateway to achieving financial savings: 1) Basic Metabolic Panel (BMP), Comprehensive Metabolic Panel (CMP), or Renal Panel; 2) HbA1c Determination; 3) Nephropathy Screening; and 4) PCP Visit. BPP exceeded core eligibility metric targets in 2017, 2018, and 2019. In addition to meeting these metrics, shared savings eligibility requires BPP to manage medical expenditures at a Per Member Per Month (PMPM) rate of less than 89% of the benchmark.

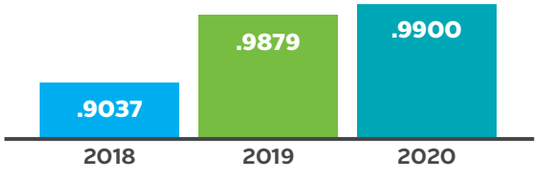
In PY 2019, BPP exceeded quality targets and managed costs well below the benefit cost ratio (BCR) target. Consequently, the network generated $7.66M, with $3.83M of that as shared savings. Additionally, successful BPP performance under two amendments for Healthcare Effectiveness Data and Information Set (HEDIS) metrics and meaningful use data exchange earned an additional $1.12M, increasing the BPP's total shared savings revenue to $4.95M.

Tactics that contributed to the overall success with this agreement include:

1. **Enrolling members in care coordination**
   - Developed data-driven definitions for high-cost, high-risk, and high-utilization.
   - Streamlined workflow and outreach efforts for ambulatory care coordination team.
2. **Improving physician documentation, coding, and care gap closure**
   - Initiated pre-visit planning pilot that focused on capturing accurate diagnoses.
   - Created and disseminated payer-provider reports including patient-level details of care gaps and possible coding opportunities.
   - Submitted monthly reports to UnitedHealthcare to close out care gaps (Meaningful Use Data Agreement) and alternative submission method (ASM) reports to capture additional diagnoses to reflect a more accurate risk score. The graph below demonstrates year-over-year RAF improvement.

Risk Adjustment Factor (RAF)

Year-Over-Year Comparison for the month of May



3. **Reducing unwarranted clinical variation**
   - Enhanced primary care electronic medical record workflow to align with consensus-based clinical guidelines.
4. **Decreasing costs in the post-acute setting**
   - Further developed the post-acute care coordination department and enhanced the post-acute preferred provider network (PPN) to facilitate appropriate site of care transitions.
   - Created SNF dashboard to monitor utilization and cost data.

Employee Health Plan

EHP Quality Measures

Measure Description	Results	
	2018	2019
Potentially Preventable ED Visits (Inverted)	37.40%	36.90%
Biometric Screening Critical Value Improvement	88.00%	100.00%
% Generic 30-Day Supply Prescribed	82.10%	81.40%
Breast Cancer Screening	77.60%	80.08%
Childhood Immunizations, Combination #3	68.50%	81.72%
Colorectal Cancer Screening	58.90%	55.18%
Controlling Blood Pressure, Explorys	63.30%	69.97%
Diabetes Care, HbA1c Control <8%, Explorys	70.90%	71.61%
Diabetes Care, HbA1c Screening	90.40%	90.96%
Diabetes Care, Monitoring for Nephropathy	89.50%	88.24%
Statin Therapy for Patients with CVD, Received Therapy, Total	83.60%	82.17%
Well Care Visits, 3-6 years	81.70%	86.42%

As the first value-based agreement BPP signed, the Florida Blue-administered Employee Health Plan demonstrated success by achieving shared savings of $1.80M in 2018 and $3.54M in 2019. Our Certified Diabetes Educator, Lynn Howard, RN, built relationships with Baptist Health team members, guiding them and their family members toward health goals. In addition, our health coordinators have focused on preventative screenings and rising risk members, achieving continuous improvement in critical values.

Total Savings* Achieved

2018 **$3.60M** → 2019 **$7.09M**

**Total Savings is the overall amount saved by the payer and BPP.*

Care coordination: Michael's journey with Lisa

Retired airline pilot Michael Oakey of Jacksonville flew the friendly skies for more than 30 years before his aviation career was cut short due to health reasons. Since retiring in 2001, he has survived three different types of cancer, including leukemia, and been treated for heart disease. Prior to that, the decorated U.S. Air Force veteran logged very few sick days. "I flew 200 combat missions during the Vietnam War and many of places I flew into were defoliated with the cancer-causing chemical Agent Orange," said Michael, a former C-130 and B-52 jet pilot. "In all probability, that's what caused my cancers." Today, Michael, 74, relies on

Aetna Whole Health

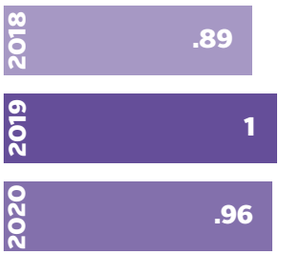
BPP's partnership with Aetna continues to mature, with an increase in Whole Health product member panel size and an upward shift in risk factor scores as a result of Aetna's proprietary risk methodology. Due to inadequate panel size, we did not qualify for shared savings in 2018. Although we achieved a 100% quality score in 2019, we did not meet our financial target to achieve shared savings. Member panel size has contributed to volatile outcomes, creating a challenging environment for population health management activities.

Expanding upon learnings in our flagship commercial contract (EHP), Health Coordinators use BPP's robust data analytics platform to conduct campaigns for preventative screenings. They also provide health coaching for rising risk members and connect them to the appropriate level of care.

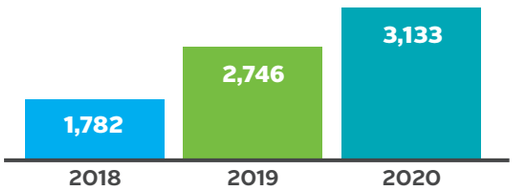
Working as one team, BPP and Aetna have formed a strong alliance to identify and address utilization and cost opportunities in monthly meetings. Disease management, social determinants of health, and barriers to care are prioritized to ensure members continue to receive the highest quality care in the most appropriate setting.

Aetna PMPM Trend

Aetna Risk Score



Aetna Membership Trend



several physicians within the Baptist Physician Enterprise (Baptist Primary Care, Baptist MD Anderson Cancer Center, and Baptist Heart Specialists).

An ambulatory nurse care coordinator with Baptist Physician Partners (BPP) helps him coordinate his appointments, tests, and medications from all of his physicians. "I have BPP nurse, Lisa, on speed dial. She gets back to me right away," Michael said. "She not only answers my questions, but interprets what my doctor is saying."

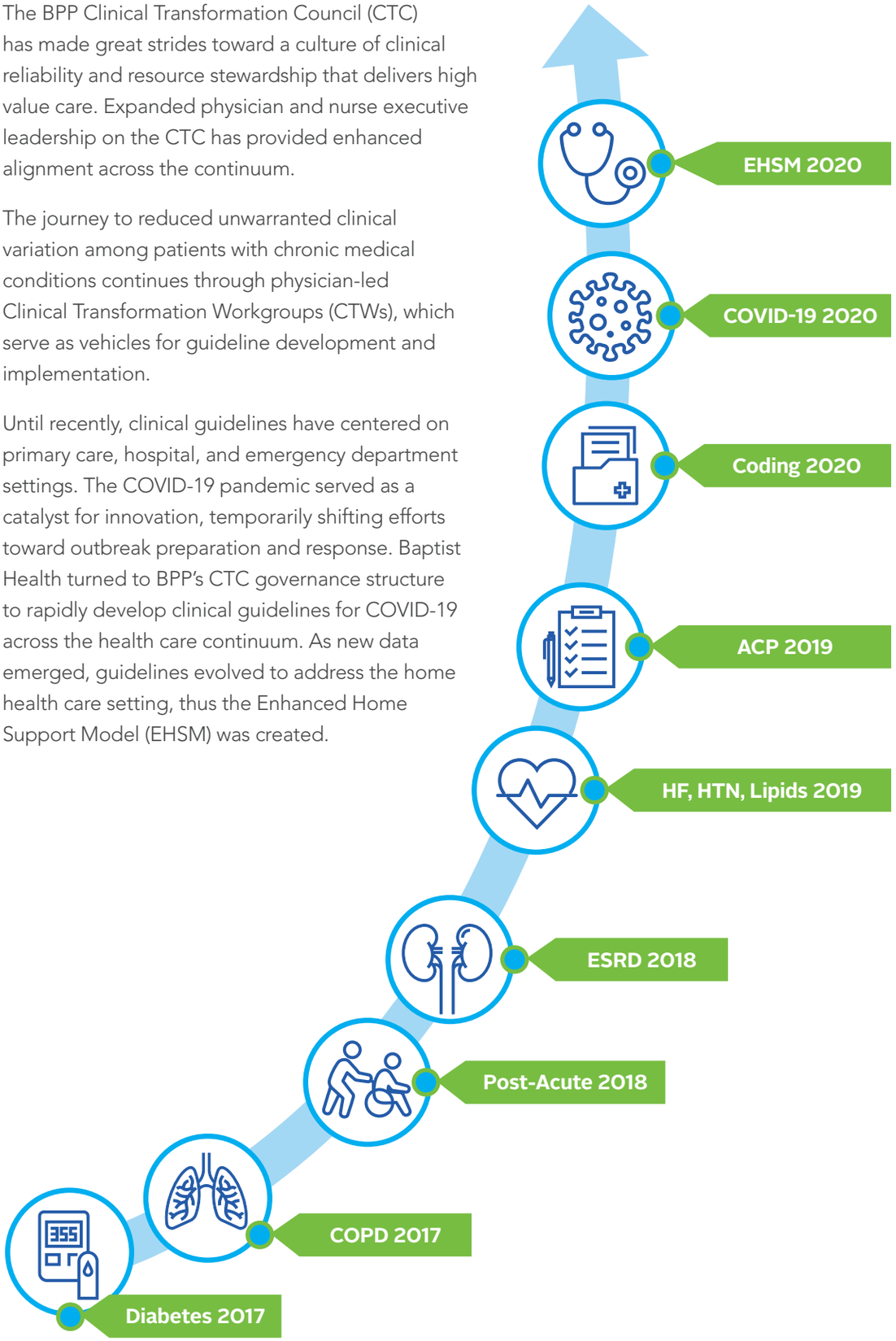
Michael recently battled a case of gout and couldn't walk for months. He also had a pacemaker put in about a year ago. Now, he's planning a return to the gym and the golf course. "To have this kind of care coordination is excellent. It makes my life a lot easier," he added. "I can't say enough good things about this program."

Reducing unwarranted clinical variation

The BPP Clinical Transformation Council (CTC) has made great strides toward a culture of clinical reliability and resource stewardship that delivers high value care. Expanded physician and nurse executive leadership on the CTC has provided enhanced alignment across the continuum.

The journey to reduced unwarranted clinical variation among patients with chronic medical conditions continues through physician-led Clinical Transformation Workgroups (CTWs), which serve as vehicles for guideline development and implementation.

Until recently, clinical guidelines have centered on primary care, hospital, and emergency department settings. The COVID-19 pandemic served as a catalyst for innovation, temporarily shifting efforts toward outbreak preparation and response. Baptist Health turned to BPP's CTC governance structure to rapidly develop clinical guidelines for COVID-19 across the health care continuum. As new data emerged, guidelines evolved to address the home health care setting, thus the Enhanced Home Support Model (EHSM) was created.



COVID-19: Enhanced home support model

The goal of the EHSM is to reduce utilization of hospital and emergency department services among patients with COVID-19 and persons under investigation by leveraging home health care and virtual visits. Patients with mild symptoms such as myalgia, upper respiratory symptoms, and low-grade fever qualify for this model of care. Additionally, the EHSM can support low flow oxygen up to five liters per minute if appropriate.

Baptist Home Health Care, along with nine home health agencies in our preferred provider network, have implemented the EHSM, with a total of 509 patients being cared for as of September 28, 2020.

The EHSM physician order set allows the home health nurse to perform lab work and start the patient on oxygen. In addition to BPC physicians, hospitalists and emergency medicine physicians working with Baptist Health can refer patients to this new service through the electronic medical record system. Telemonitoring, oxygen support, and lab testing allows for high-quality care in the home setting.

Meghan Debbie, a Jacksonville resident, can attest to this unique delivery of clinical care in her home. A 30 year-old single mom, Meghan experienced ongoing health challenges after contracting COVID-19 in the spring and self-isolated in her home for nearly two months. She received regular visits from a Baptist Home Health nurse and daily virtual visits from both a Baptist Home Health case manager and a Baptist Primary Care (BPC) physician.

Meghan was provided an oximeter to measure oxygen saturation during her initial home visit. When her oxygen saturation started to decline, the Baptist Home Health nurse notified Dr. Schlotzer, Meghan's BPC physician. Per protocol, Meghan started oxygen therapy and an oxygen concentrator was promptly delivered to her home to ensure continued support.

A Baptist Home Health case manager kept in constant contact with Meghan through virtual visits and text messaging. "I was having trouble breathing and Amy calmed me down and then got Dr. Schlotzer on the phone." Meghan recalled. "They were super attentive to my care and really in touch with one another."

Through a joint effort with Baptist Home Health and BPC, Meghan was able to be treated for COVID-19 on an outpatient basis, saving her from making multiple trips to the ED or being admitted to the hospital.

Advance care planning

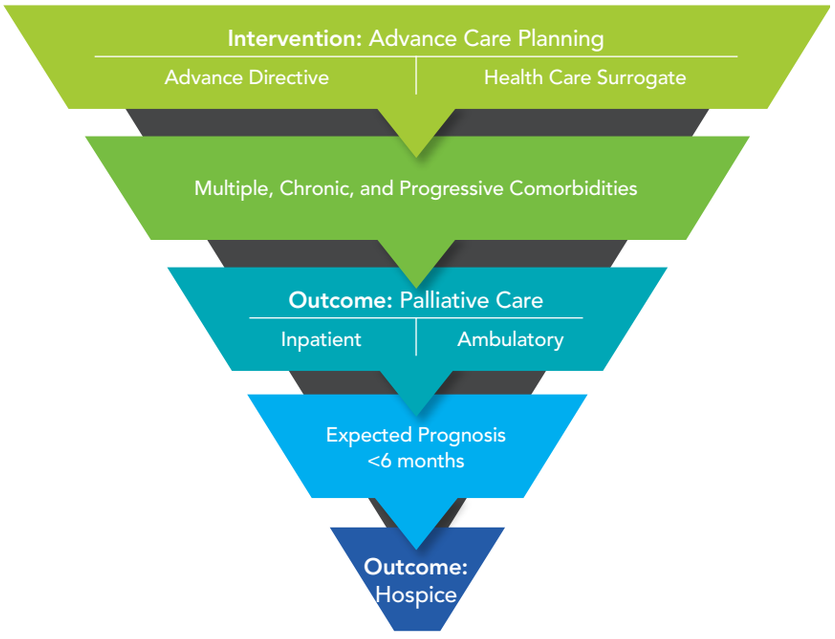
Advance care planning (ACP) promotes the understanding and sharing of a person's values, life goals, and preferences regarding future medical care. To reduce widespread variation in quality and associated costs that occur during end of life (EOL) care, BPP convened a CTW to normalize ACP discussions and to develop a standardized model for Baptist Health. Advance directives allow for continuity of care, respect for a person's wishes, decreased caregiver anxiety, and reduced unwarranted medical treatments.

ACP is included in BPCI Advanced quality metrics, requiring CPT/CPT II codes to be appropriately documented on submitted claims. Additionally, as a participant in Track 1 of the Medicare Shared Savings Program (MSSP), BPP is responsible for EOL expenditures, including hospice, when calculating the total cost of care for each beneficiary assigned to the ACO.

The 2018 MSSP per beneficiary per year benchmark for BPP was $9,743. For the period January – December 2018, there were 836 deaths among BPP's assigned beneficiary population (2.2% mortality rate). The total paid for this population was just over $32 million, equal to 9.0% of total expenditures ($366 million). The average amount paid in the 30 days preceding death was $17,253. Among those who expired, 21.1% of deaths occurred in the hospital, 40.3% were never admitted to hospice, and 15.2% spent less than three days in hospice.

End of Life Measure	2018 Jan. – Dec.	2019 Jan. – Dec.
Assigned Beneficiary Deaths	836	887
Annual Mortality Rate	2.2%	2.2%
% of Total Expenditure	9.0%	8.8%
Average Paid in 30 Days Preceding Death	$17,253	$16,832
% of Deaths Occurred in Hospitals	21.1%	17.4%

ACP on the care continuum



As of January 2020, BPP has partnered with **Alivia Care** to provide advanced care coordination in the home. This patient-centered care coordination model identifies goals of care and facilitates advance care planning in order to improve quality of life and satisfaction among patients with medically complex conditions. Patients who receive this service are more likely to choose palliative care and hospice services.

Advanced Care Coordination Model Overview

Care team members
- Nurse and social worker-driven model
- Palliative care physician
- Access to a care team member 24/7
- Paramedicine

Settings
- Home visits
- Virtual visits, including video and telephonic calls

Core interventions
- Care coordination and transitions
- Patient engagement and coaching
- Advance care planning

Eligibility criteria
- Life expectancy ≤12 months
- Individuals with two or more clinical complexities

Data Jan. – Sept. 2020

93
Patients enrolled

66.0%
Referrals to enrollment rate

56
Discharges

1,320
Total visits
(In-person and virtual)

41.9%
Patients
Completed an advance directive while enrolled in advanced care coordination

Program Savings Analysis*

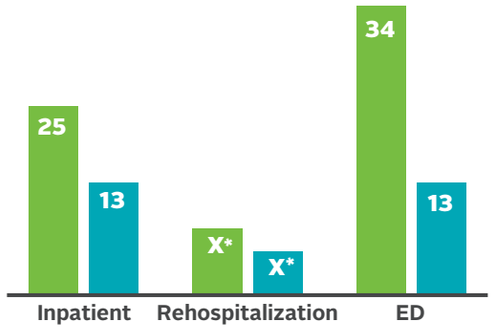
$1,106,006
Pre-Enrollment Cost
(Total cost three months before enrollment)

$865,308
Post-Enrollment Cost
(Total cost three months after enrollment)

$240,697
Savings
(Difference before and after program enrollment)

**Based on claims data received through June 26, 2020 and reported as of August 24. Data can change if additional claims are received at a later date for dates of service in the Jan-June 2020 time period.*

Utilization Before and After Advanced Care Coordination Enrollment



- Number of visits three months before program enrollment
- Number of visits three months after program enrollment

**Results below 10 are redacted per MSSP Data Use Agreement*

Social determinants of health

Every three years, Baptist Health conducts a Community Health Needs Assessment (CHNA) to identify community health needs for each hospital's patient population and to develop strategies to address significant findings. In 2015, the CHNA uncovered an overall lack of health education, inability to access available resources, poverty, lack of mental health resources, poor lifestyle choices, and minority health needs and disparities as major contributors to health issues in the surrounding community.

BPP collaborated with the Baptist Health office of Social Responsibility in July 2018 to develop a sustainable and scalable framework to identify and address the social determinants of health (SDOH) for patients accessing the Baptist Health system. After careful exploration and review of a wide variety of internal and community-based SDOH activities, a focused approach was developed in order drive meaningful results for patients (see below).

Strengthened partnerships with CBOs (2018)

- Collaborated with 11 Community-based organizations (CBO) in Duval County.
- Held focus groups and 1:1 meetings.

Built ambulatory social work model (2019)

- Embedded three social workers within existing ambulatory care coordination model.
- Model serves as gateway between medical and social interventions.

Formal partnership with United Way and Aging True (2019 – 2020)

- Established pilot program with Lyft to address lack of transportation.
- Initiated non-skilled services pilot with Aging True to reduce utilization.

Partnered with Buxton Analytics to ascertain SDOH data on covered lives (2019 – 2020)

- Provided detailed insight on who, what, and where to focus SDOH efforts to fully understand patient population.

Alice's social support system

Alice Jones, a resident of Twin Towers in Jacksonville, struggles with the management of her pulmonary hypertension, congestive heart failure, diabetes, and chronic kidney disease. Her low vision doesn't help ease her daily burdens. As a dual-eligible Medicare Advantage member with UnitedHealthcare, Alice receives transportation benefits; however, she had no additional assistance for her daily needs.

To provide the support system she needs, Alice worked closely with BPP Ambulatory Social Worker Blair Sisisky, who helped enroll her in the Aging True Purchased

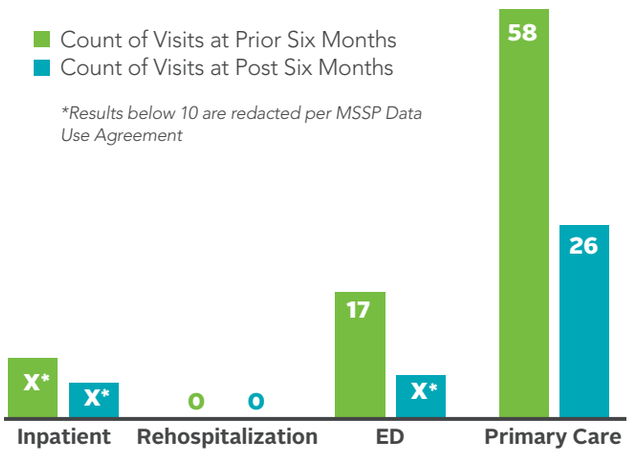
Non-skilled home support

In October 2019, Baptist Health initiated a partnership with **Aging True**, a non-profit organization providing home-based services that enables seniors to live independently in their homes. This collaboration strives to establish a long-term support of non-skilled home and community-based services for dual-eligible Medicare fee-for-service beneficiaries and UMA members. Successful program outcomes are demonstrated by enrollment in one of the following long-term programs: Community Care for the Elderly, Managed Long-Term Care, or the Older Americans Act support program.

Goal: Maintain patient well-being and minimize unnecessary utilization of services among BPP covered lives.

Strategies: Address the social needs of patients with chronic conditions that are not being optimally managed by performing skilled and non-skilled services in the home.

Aging True Comparison between Visits at Six Months Before and After Enrollment



Program statistics

Current Partnership time frame:
Oct. 1, 2019 – Sept. 30, 2021

Reporting Period: Oct. 1, 2019 – June 30, 2020

Total Referrals: 23 total, 5 referrals either refused assistance or could not be served

Total Served: 18 served, 15 graduated

Client Satisfaction: 10 of 15 clients participated in the satisfaction survey: 100% would recommend the program to a friend and found the program to be helpful in maintaining independence

Services Pilot. October 2019 marked a new beginning for Alice; an aide from Aging True started to make weekly home visits to assist her with personal care, cleaning, laundry, and shopping. Companionship care also helped alleviate social isolation. In addition, Alice started receiving hot meals daily. "I wasn't eating very much before, but now I'm eating every day," she exclaimed.

After one month, Alice was pulled from the Medicaid long-term wait list, a relatively short time period as the wait list time usually ranges from several months to years. Blair helped her transition to WellCare Medicaid long-term care where services were initiated in February 2020. Alice will continue receiving support services in her home and unlimited transportation for as long as needed.

"Alice has made remarkable progress despite all the barriers she has faced. She is now in a supported environment that allows her to thrive as best as she can," said Blair.

Documentation, coding, and care gap closure

Accurate physician documentation and coding create a more complete picture and appropriately reflect the severity of a patient's illness. Coding is used in value-based models to illustrate risk, establish benchmarks, and promote patient-centered care. A specific focus on these areas may improve the value of EMR workflows and enable better management of a patient's chronic conditions.

Several efforts have taken place within BPP to ensure that documentation and coding correctly reflect the health status of our patients. Beginning in late 2018 and through September 2020, our areas of focus included:

1. Quality care gaps

Quality data sharing with providers and office managers to address open care gaps.

2. Group performance reports

Collaborated with all Medicare TIN quality team members to report out on quality measures, identify challenges, and develop improvement strategies.

3. Diagnosis and quality data reporting

Submission of retrospective data for United Medicare Advantage members, including diagnoses missing from claims to improve financial outcomes, and labs and other procedures to aid with care gap closure.

4. Pre-visit planning pilot

Collaboration among BPP's Medicare Risk Adjustment Specialist and 11 primary care providers to identify documentation and coding opportunities around chronic conditions prior to patient visits for our United Medicare Advantage member panel.

5. Post-visit coding pilot

Structured coding review process focusing on Medicare fee-for-service beneficiaries where a percentage of charts were reviewed across all primary care offices and claims were audited prior to submission for accurate coding and documentation.

COVID-19 is reshaping BPP's population health strategies

The COVID-19 pandemic has challenged organizations to consider new approaches to managing patient populations, keeping the community healthy while caring for patients in unparalleled conditions. COVID-19 has, in many ways, reshaped our health care delivery system and further improved our value-based strategies. BPP has responded by redeploying team members and designing new processes while leveraging new and existing information technology components.

Care coordination

The BPP Ambulatory Care Coordination team has pivoted to integrate new approaches to managing patient populations:

- The COVID-19 response team was created to provide additional support for patients with COVID-19 as they transition from the ED. These patients benefit from additional follow-up by a nurse care coordinator due to various risk factors. Patients may also receive a home monitoring kit, including a thermometer, a pulse oximeter, a medication organizer, two face masks, disinfectant, and an educational packet.
- Leveraging Zoom, the Ambulatory Care Coordination team can now connect with patients by video calls for disease management, patient education, and advance care planning conversations.
- Patient contact has improved with the addition of virtual and telephonic visits. Through this type of outreach, reinforcing discharge instructions, goal setting, identifying barriers, and communicating and preventative health reminders have been well received by patients.

Enhanced Home Support Model (EHSM)

The EHSM has been a great success. The program focuses on providing home-based skilled services, including oxygen therapy, to patients with COVID-19 and patients under investigation to minimize the spread of disease. This model leverages community partnerships and has been instrumental in decompressing our EDs and creating capacity within our hospitals to treat more patients.

From April 1 to September 28, 2020, the EHSM achieved the following milestones:

- 509 total patients cared for, of which 315 (61.9%) were cared for by Baptist Home Health Care
- A rehospitalization rate of 12.3%
- Cared for 191 (37.5%) patients who were on oxygen support

Looking toward the future

1

Senior strategy

We have initiated a formal search for an executive to lead our proposed senior lives strategy and organize our inaugural senior clinic for patients over age 65. Planned expansion of our Medicare Advantage portfolio will accompany a contracting strategy that will focus on managed Medicare market share growth and all associated wrap-around services.

2

Downside risk

Participating in the BPCI Advanced Model has heightened our focus on care transitions, post-acute utilization, and end-of-life care. We will continue advancing our capabilities and competencies in order to take on additional downside risk and increased value.

3

Population health analytics

Transition from IBM Explorys to Cerner HealtheIntent consolidates data analytics into a single platform creating a more efficient workflow. This allows the team to focus on ingesting data from external sources as well as new initiatives.

4

Reducing unwarranted clinical variation

We will continue to develop consensus-based, clinical guidelines for high-risk, high cost conditions. Guidelines will transcend into the home setting, as the EHSM will be used for patients with heart failure and COPD.

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In Memory of
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BPP Senior Population Health Analyst
March 8, 1963 to May 25, 2019

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