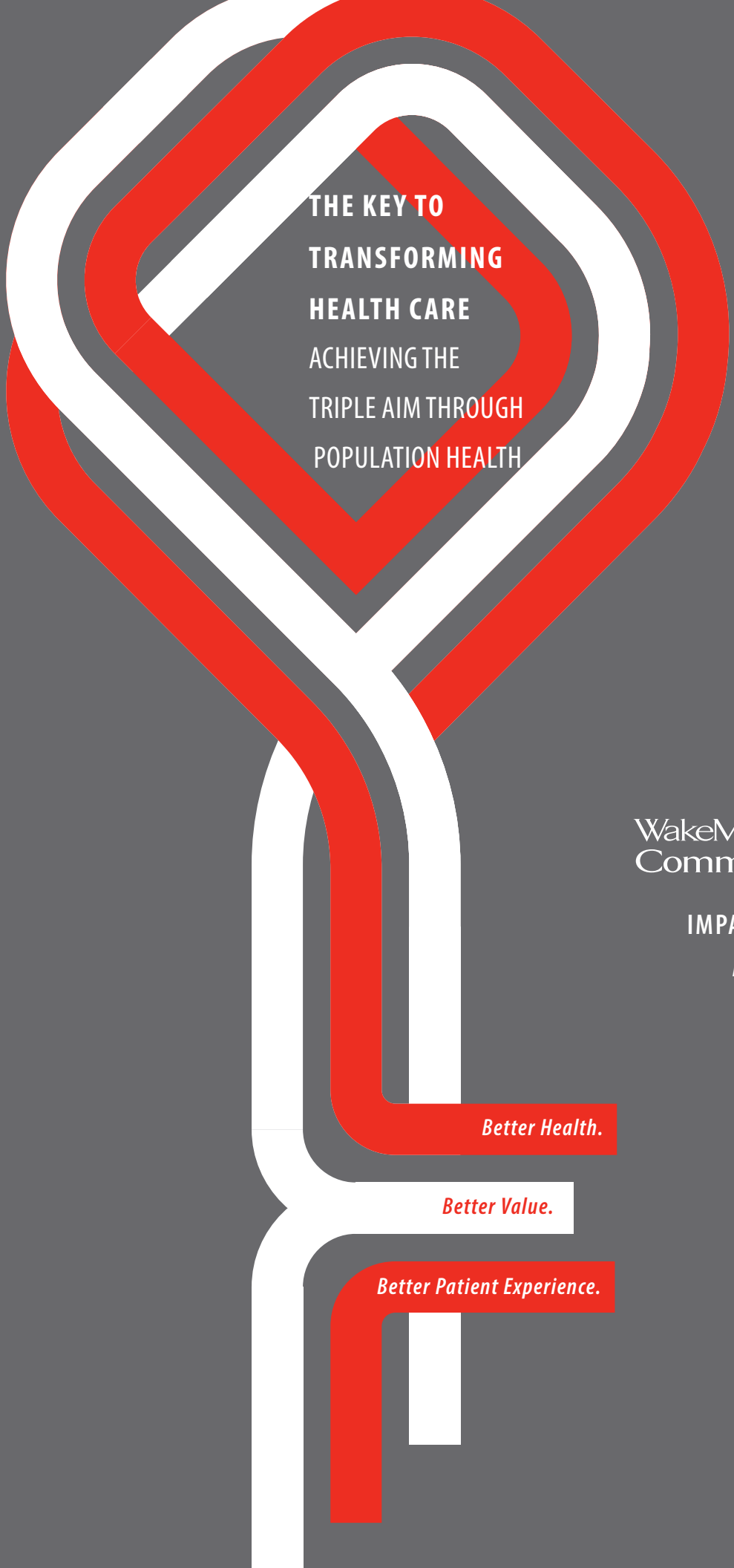
THE KEY TO TRANSFORMING HEALTH CARE

ACHIEVING THE TRIPLE AIM THROUGH POPULATION HEALTH



WakeMed Key Community Care

IMPACT REPORT

Fall 2019

"Sharing risk between insurers and providers is a proven approach to achieving better outcomes, lower costs and an improved patient experience. WakeMed Key Community Care has demonstrated their commitment to improving the delivery of care through population health, and after saving more than $60 million in less than six years, their progress is very promising. Models like this need to be the norm, not the exception."

Rahul Rajkumar, MD, Senior Vice President and Chief Medical Officer
BlueCross NC

To Our Physician Partners, Supporters, Patients and Community,

As Board Chair and physician member of WakeMed Key Community Care, it has been an incredible honor to witness the successes we've achieved together over the past year in the delivery of high-quality, high-value care as one of the highest-performing accountable care organizations (ACOs) in the country. By all measures, this year has been exceptional for WKCC, its patients and its partners. Not only did we make significant strides in improving the health of the 220,000 patients for whom we care, we have also significantly reduced health care costs by doing the right things for the right reasons on behalf of our patients.

As our Medical Director Dr. Brian Klausner always says – population health is easy in theory. It's a matter of going back to the basics and adhering to evidence-based guidelines, communicating with one another and with our patients. While it sounds simple, as primary care providers, we know that medical guidelines are always changing and staying on top of them for the hundreds of conditions we treat isn't easy. The WKCC partnership allows us to use data to identify where we have opportunities to do better, improve quality, deliver greater value and make a difference in the lives of our patients by managing their health in a more collaborative, proactive and well-coordinated manner.

This past year, we've done just that – and better than nearly any other ACO in the country. Our payer partners are amazed by what we've been able to achieve in such a short time. I credit this success to the dedication and compassion of our exceptional providers who have come together and are committed to WKCC's shared values. While the strides we make may feel tedious or small at times, the combined result of all our efforts are truly paying off to improve the health and well-being of our community.

This report features some highlights of our efforts to improve care delivery. You'll see real, tangible results from many of our key initiatives, including improving care for patients with low back pain, enhancing the co-management of patients with congestive heart failure, ensuring the appropriate use of specialist referrals and much more.

In the coming year, our goal is to continue our mission of delivering high-quality, high-value care, ensuring high patient satisfaction and supporting our patients in improving their health. To accomplish this, our areas of focus include: behavioral health; restructuring and enhancing how we track, report and evaluate data; and going back to the basics that got WKCC off the ground and running just a few years ago. This includes strengthening our focus on communication, coordination and the co-management of patients, as well as focusing on those high-risk patients who stand to benefit the most from our efforts.

I am humbled to be in the company of such an incredible, innovative group of providers supported by an experienced and talented team of health care professionals. I look forward to seeing what we can accomplish together in another year as we continue enhancing the value we deliver to our patients and this community.

Sincerely,

JOHN HOLLY, MD

Chair, WakeMed Key Community Care Board of Directors

WakeMed Key Community Care

About WKCC

WKCC MISSION

To deliver high-quality, high-value care, ensure high patient satisfaction, and support our patients in improving their health.

WKCC VISION

To be leaders in value-based care by improving the health and well-being of our community through physician-led primary care teams, innovative patient engagement and experienced leadership. We will care for all populations with compassion using data-driven decision making and ensuring high patient and provider satisfaction and outcomes.

WakeMed Key Community Care is an Accountable Care Organization (ACO) established to enhance the quality and coordination of health care, and reduce the costs of care by providing more value for beneficiaries. A collaboration between WakeMed Health & Hospitals and Key Physicians, WakeMed Key Community Care brings together more than 420 primary care providers with a leading health system and an additional 750 specialty care providers. The partnership is designed to ensure that patients, especially the chronically ill, get the right care at the right time at the right level, while avoiding unnecessary duplication of services and preventing medical errors.

Accountable Care Organizations enable medical providers to work closer together to create healthier communities and help patients coordinate their health more effectively.

WakeMed Health & Hospitals

WakeMed is the only private, not-for-profit health care organization based in Raleigh, N.C. The 941-bed system comprises a network of health care facilities throughout Wake and Johnston counties. Locally based and community owned, WakeMed exists for the health of the community and is committed to a variety of health and wellness improvement programs.

Key Physicians

Key Physicians is a community-based group of primary care medical professionals dedicated to high-quality care delivered at optimum value. Based on the concepts of Patient Centered Medical Home, Key brings together more than 365 primary care providers to deliver a coordinated and collaborative experience for its patients.

WakeMed Primary Care

WakeMed Primary Care is a network of internal and family medicine providers committed to delivering quality, compassionate and innovative care to its patients. Operating as part of the WakeMed Health & Hospitals system, the group features nearly a dozen locations throughout the Triangle area - all dedicated to WakeMed's mission of improving the health and wellbeing of the community.

The Patient-Centered Medical Home Model

WakeMed Physician Practices and Key Physicians practices have each earned the highly-regarded designation as a Patient-Centered Medical Home (PCMH) as recognized by the Agency for Health care Research and Quality. This medical home model puts the patient at the center of health care, and defines a medical home not simply as a place, but as a model of primary care designed to improve health care in America.

Encompassing five key elements, the PCMH model ensures that the care delivered is: comprehensive, easy to access, well-coordinated, patient-centered and of the highest quality and safety. This three-year designation is earned only by practices that demonstrate adherence to these values.

WKCC TEAM

Debi Hueter

Brian Klausner, MD

John Holly, MD

John Burkard, MD

Our Leadership

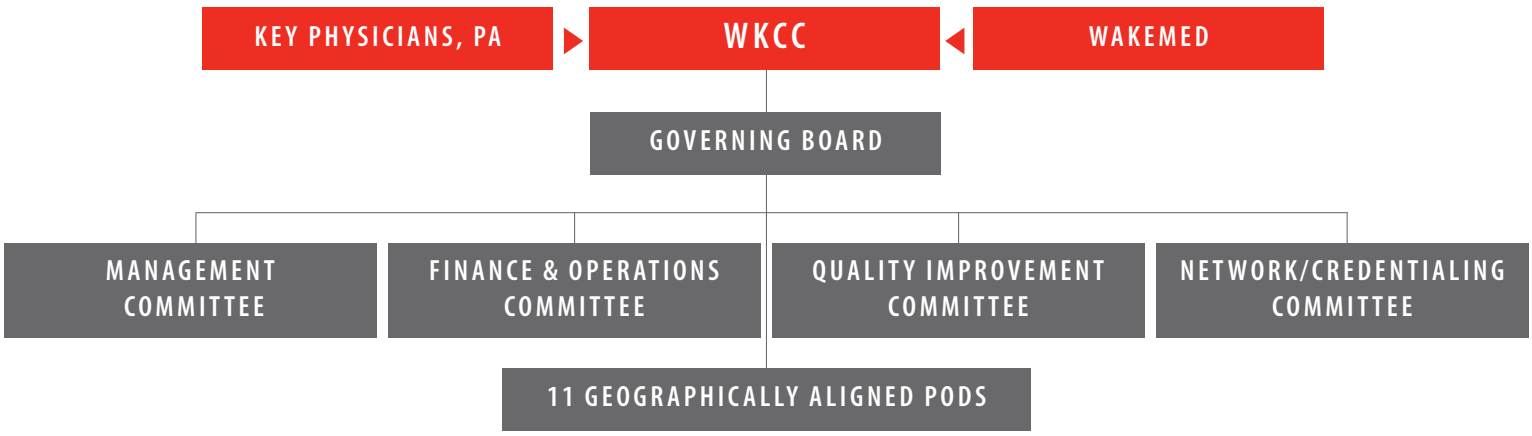
Debi Hueter,
Executive Director

Brian Klausner, MD,
Medical Director

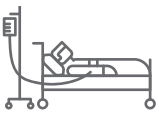
2018 Board of Managers

John Holly, MD, *Chair*
John Burkard, MD, *Vice Chair*
John Meier, MD, *Treasurer*
William (Tres) Pittman, MD, *Secretary*
Donald Gintzig
John Rubino, MD
Matt Nathan, MD
Conrad Flick, MD
Peter Chauncey
Allen Hewett, MD
Larry Mann, MD
Theresa Amerson, MD
Stephen Leinenweber, MD
West Paul, MD
Robert Bilbro, MD (Medicare Beneficiary)
Thomas Oxholm (Community Stakeholder)

WKCC GOVERNANCE STRUCTURE



Impact at A Glance



220,000
Patients We Serve
(Covered Lives)

430
Committed
WKCC Providers

750
High-Value Specialist
Collaboration Members

57
Number of
Participating Practices

12%
Year-Over-Year Growth
in Provider Base

16th largest
ACO in
the Nation

IMPROVING QUALITY, VALUE

$61.7M
Shared Savings
to Date

17,000
Care Gaps
Closed

14%
Reduction in
Unnecessary
Specialist Visits

28%
Reduction in
Opioid
Prescriptions

~2,000
Patients Engaged
in Care Advising
Programs

120
Performance
Improvement Projects
(PDSAs) Completed

15%
Decreased Length of Stay
for Skilled Nursing
Facility Patients

100%
Medicare Shared Savings
Program Quality Score

100%*
UnitedHealth care
Quality Score

** 2017-2018 year*

ACO STRUCTURE PROMOTES ENGAGEMENT & PERFORMANCE

With 57 practices and 70 locations throughout the region, engaging the full WKCC team and facilitating rounds needed to be as efficient as possible. To optimize provider engagement and leadership, facilitate bi-directional communication and develop/expand leadership within the ACO, a new Pod Structure was implemented in 2018. WKCC's team of 430 providers was divided into 11 pods based on geographic proximity for convenience. Pods meet before or after clinic hours once per quarter, and attendance at three out of four meetings per year is required.

POD STRUCTURE OVERVIEW

11 PODS
8 Adult & 3 Pediatric

1 MEDICAL DIRECTOR
Elected by Members

~ 38 PROVIDERS PER POD

Supported by Population Health Manager & Care Adviser

Pod Medical Directors report to WKCC Medical Director and meet monthly

Function of the Pod

- Meet Quarterly (Attendance at 75% of Meetings Required)
- Focus on pod-specific goals that align with WKCC mission
- Share and discuss evidence-based protocols
- Review data and discuss continued improvement
- Pods "cross-pollinate" to share best practices

Benefits of Pod Structure

- Optimize provider engagement and leadership
- Facilitate bi-directional communication
- Develop/expand leadership within ACO
- Further WKCC goal of increasing quality and reducing costs

Team in Action

Effectively managing a population of 220,000 patients is no easy feat – it requires constant collaboration, review and evaluation of data, ongoing performance improvement, engagement and much more. WKCC's team of Care Advisors, Population Health Managers and Community Health Workers work closely with WKCC leadership, its 50+ primary care practices and patients to focus on core initiatives, improve quality and value for all our patients – and especially those at the highest risk.

WKCC is supported by a full local operations team, as well as extended team members in IT, analytics and research & development, as part of their population health partnership with Evolent Health.

CARE ADVISING PROGRAMS

In 2018, more than 2,000 attributed WKCC patients were enrolled in one or more Care Advising Program(s). These programs, developed by Evolent, provide patients with an added level of personal support from the Care Advising Team. Patients are chosen for enrollment in Care Advising Programs based on predictive modeling – identifying those patients who are at the greatest risk for having an avoidable inpatient event.

- **Advanced Illness Care Program** – A proactive approach to chronic, life-limiting conditions that improves patients' experiences with care. It honors their preferences for care while reducing costs of care.
- **Complex Care Program** – Helps patients with one or more chronic conditions such as congestive heart failure, asthma, diabetes, COPD, among numerous others. It is designed to support patients whose risk for hospitalization in the next 12 months is increasing based on health indicators.
- **Transition Care Program** – Supports patients who are discharged from the hospital and are at high risk for readmission to the hospital. The focus is on execution of the discharge plan of care, adherence to and understanding of prescribed medications, and timely post-discharge follow-up with the primary care provider and specialist(s).
- **Skilled Nursing Facility (SNF) Program** – Offers assistance for patients who are being discharged from a SNF to home. This program is designed to reduce SNF length of stay when clinically appropriate, reduce readmissions and improve patient quality of life during and after a SNF stay.
- **Pediatric Complex Care Program** – Provides ongoing assistance for pediatric patients (and their families) who are diagnosed with chronic conditions or have ongoing medical needs due to catastrophic events or congenital problems.
- **Care Coordination Program** – Based on social determinants of health, enrollment in this program means patients can get support accessing resources for non-clinical needs such as housing, transportation, food, financial assistance and more.

The Role of the Care Advisor

Care Advisors (CA) play a critical role in the success of WakeMed Key Community Care. Each CA is a registered nurse whose role is to work with patients participating in Care Advising Programs to help them improve and manage their health. These exceptional nurses are an extension of the WKCC practices, and they collaborate closely with providers to develop customized care plans for each patient. One of the most significant elements of their role is education – Care Advisors spend a great deal of time educating patients about their conditions and medications, ensuring follow-up with providers, providing guidance on where to seek care, coordinating resources and helping identify strategies they can use to better manage their own health.

The Role of the Community Health Worker

Community Health Workers support the CA team to align resources for patients who may struggle with transportation, food security, access to housing, language barriers or other social determinants of health. Their role is incredibly important for helping patients adhere to their plans of care and supporting non-clinical needs that can have a significant impact on their health.

The Role of the Population Health Manager

Experts in quality and process improvement, WKCC's Population Health Managers work closely with providers and practice staff to identify opportunities for improvement – all based on data that is monitored regularly. They help practices identify and implement performance improvement projects (known as PDSA for Plan/Do/Study/Act) and serve as the practice's conduit to reviewing and understanding the immense amount of data generated by each practice and provider – all in an effort to improve the quality and value of care delivered.

Population Health Managers contribute to practice transformation through the following levers

Provider Partnerships + Education & Training + Tools & Resources + Process Improvement

Care Advising

PATIENT CASE STUDIES

THE PATIENT

58-year-old male patient with Type II diabetes, obesity and hyperlipidemia. Patient's A1C was 10.4 and had a BMI of 30.

Care Advising Program: Complex Care

Care Advising Support Provided:

- Evaluated patient's diet and lifestyle habits that were contributing to declining health indicators. Patient had limited understanding of diabetic diet, ate out frequently, ate high carbohydrate foods and did not engage in physical exercise.
- Provided printed and verbal education about diabetes management with a focus on diet. Evaluated the restaurants he eats at regularly and examined their menus to help him find the healthiest options.The patient made significant diet changes (decreased portion sizes and carbs, gave up sugary drinks).
- Stressed importance of exercise and helped him find the best activity and how to set small, attainable goals. He began exercising once on the weekends and then added 1-2 times during the week and bega n to lose weight.
- Assisted him in accessing his eye care benefits and making an appointment for eye exam (identified care gap), which is critical for diabetes patients.
- The patient's A1C came down from 10.4 to 8.2 in three months, and he continues on a path to better health.

THE PATIENT

89-year-old female diagnosed with ALS, but not interested in hospice care. Patient was suffering from significant pain and lacking critical resources needed to manage her condition at home, including wheelchair and cough assist machine.

Care Advising Program: Advanced Illness Care

Care Advising Support Provided:

- WKCC's Care Advising Team made home visits along with the primary care provider.
- Held group meeting with patient's entire family support system (some in person, some via telephone) to discuss patient's wishes and plan of care.
- WKCC facilitated referrals for end-of-life planning.
- Care Advising Team coordinated with ALS Association to secure wheelchair, cough assist machine and massage therapy for pain.
- Patient is receiving only the care she wants.
- Hospitalization for pneumonia avoided when WKCC provider made home visit and prescribed antibiotic treatment.

THE PATIENT

14-year old female with celiac disease and recurrent episodes of fainting over a six-month period. With three emergency department and hospital visits, and numerous pediatric specialists (cardiology, GI, behavioral health and neurology) involved in her care, she was missing school and needed some additional support to get back on track.

Care Advising Program: Pediatric Complex Care

Care Advising Support Provided:

- WKCC's Care Advisor established a relationship with patient's mother.
- Worked together to develop a plan for adherence to care plan developed by primary care provider.
- Offered nutrition education to help with celiac disease. Dietary changes were made according to recommendations.
- Provided comprehensive education on medication and supplementation.
- Assisted in finding an in-network psychiatrist and scheduled patient's initial visit. Prozac was discontinued due to negative side effects.
- Helped coordinate specialist care to assist with complex diagnoses.
- Worked with family to move forward with an esophagogastroduodenoscopy (EGD) as suggested by pediatric gastroenterologist.
- Patient is no longer suffering from fainting episodes or side effects and hasn't been to the hospital or emergency department in more than three months.
- Mother is appreciative of the support navigating between specialists and insurance coverage.
- Patient is on track to return to school in the near future.

PATIENT PROFILE

Carolyn McLean is a 72-year-old woman who has struggled with her health on and off for many years. With diagnoses of asthma and chronic heart disease, Carolyn, like many women her age, has also recently been battling depression. In the two years leading up to Carolyn's enrollment in WKCC's Complex Care – Care Advising Program, she had been either hospitalized or visited the emergency department a total of 14 times.

That's why in July 2018, Carolyn was identified by WKCC's high-risk stratification model as someone who would benefit from a helping hand in the form of additional support and health care resources designed to enhance and streamline her care.

WKCC's Jessica Hauser, RN, was named as Carolyn's Care Adviser and in July 2018, the two began a beautiful journey and partnership that would span nine months of working together to meet a series of health-related goals. In tandem with Dr. Laura Ekka, Carolyn's primary care doctor, the team set off to enhance Carolyn's care.

"When I received the first call from Jessica, I was unsure of why she was calling or how she could help me. When she explained that she was calling on behalf of my primary care provider and wanted to support me in coordinating my health care – I was so relieved to know I would have someone to help me navigate between all of my doctors."

Closing Gaps in Care

Jessica quickly got up to speed on Carolyn's health history, current diagnoses and medications – as well as her opportunities for better health and higher value health care. Immediately, Jessica noted a care gap. Carolyn had a history of cardiovascular disease but wasn't on a statin – even though evidence-based guidelines recommended it based on her condition. Jessica made the patient and her primary care provider aware, and Carolyn was promptly put on 40 mg of Crestor daily.

Supporting Carolyn's Health Changes

While in WKCC's Care Advising Program, Carolyn encountered numerous new diagnoses and treatments – for which she was incredibly grateful to have Jessica's continued support.

In May 2018, Carolyn suffered from unstable angina which required a heart catheterization and some procedural work to reduce stent stenosis. She was discharged with a blood pressure monitor, which Jessica was able to educate her on and explain the importance of routine monitoring – as well as what symptoms to look out for.

Later that year, Carolyn was experiencing significant shoulder pain due to rotator cuff problems and underwent an elective orthopedic procedure shoulder replacement. Before surgery, Jessica helped coordinate resources, facilitate communication among her care team and assist with scheduling. Following surgery, Jessica provided

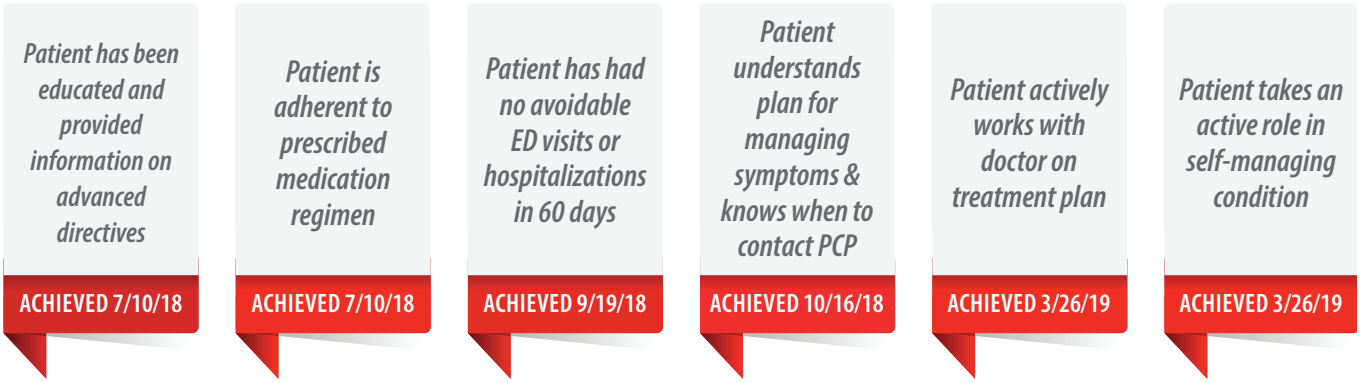
discharge education, pain management and helped coordinate resources such as physical therapy, occupational therapy and ongoing counseling. She also connected Carolyn with community resources including Resources for Seniors and Volunteers for Caregiving to coordinate transportation and other important services.

Most recently, Carolyn was diagnosed with sleep apnea. She was having trouble sleeping and breathing – and was feeling tired all the time. After numerous sleep studies, discussions with her primary care physician and loads of paperwork, Carolyn was still unable to secure her CPAP machine. Fortunately, her Care Adviser and primary care physician were able to connect all the dots, finalize the paperwork and get her the much-needed equipment. Today, Carolyn is feeling better than ever and breathing so much better – all thanks to a few helping hands to navigate a challenging process.

"Before working with Jessica, my Care Advisor, there were so many times I would get discouraged about ever feeling better. If I had questions for my doctors or needed help coordinating appointments, I didn't know where to turn. She helped me line up transportation, learn more about how to monitor my own health and avoid numerous emergency department visits. I don't think I would have ever been able to make the progress I've made in the past year without her support."

Achieving Care Advising Program Goals

Patients enrolled in the Complex Care Program have to meet critical goals before they can "graduate" back to self-management. For Carolyn, most of the goals were achieved through regular and ongoing communication with her Care Advisor and her primary care physician. Through routine phone calls with Jessica every two weeks (or more often as needed), Carolyn learned a great deal about her health conditions such as how to better manage blood pressure, when to contact her primary care physician, the importance of adhering to medications, heart healthy diet strategies and much more. The graphic below demonstrates Carolyn's achievement of all goals of her Care Advising Program.



On March 26, 2019, Carolyn "graduated" from the Complex Care Program.

"I have appreciated my Care Advisor's support so much – I'll miss hearing from her regularly, but I'm glad to be on a path to better health."

QUALITY & PATIENT SATISFACTION

Quality is at the core of any ACO – in essence, it's the primary reason they exist at all. As such, WKCC's payer partners – on both the government and private side-hold WKCC accountable to achieving certain quality measures. As one of the highest performing ACOs in the country based on national benchmarking data, WKCC has made great strides in achieving (and exceeding) quality goals across all payer scorecards.

Similarly, improving the patient experience is also at the core of WKCC's mission. Patient satisfaction data is tracked at the physician practice and payer level and is based on the CG-CAHPS standardized approach to measuring patients' perceptions of care provided by physicians in an office setting.

Quality at a Glance

- Through 2018, WKCC has surpassed all quality targets across all payer partnerships.
- On average, WKCC has demonstrated improvement year over year on 65% of measures across all payer partnerships.
- On average, WKCC has 51% of contracted measures exceeding the HEDIS 2017 National 90th Percentile Benchmark.

Highlight of ACO Quality Measures

There are over 50 different quality measures that vary across all payer partnerships. While they vary by payer, below is an overview of the most common quality measures. Compliance with these measures is evaluated on an ongoing basis by WKCC's quality and data analytics team and each payer partner – based on claims data and electronic medical record documentation.

- Colorectal Cancer Screening (Colonoscopy)
- Breast Cancer Screening (Mammogram)
- Diabetes Hemoglobin A1c Control
- Diabetes Care: Medical Attention for Medical Nephropathy
- Control of High Blood Pressure
- Adult BMI Assessment
- Appropriate Use/Avoidance of Antibiotics (for Adult Bronchitis)
- Hospital Readmission Rates
- Referral for Diabetic Eye Exam
- Among others, which vary by payer

"Cigna's partnership with WKCC represents one of the highest performing ACOs in the country. Working together, the physicians, leadership, data sharing and cooperation represents one of the most innovative and creative partnerships I've encountered. Cigna individuals who choose to be part of the WKCC ACO consistently receive higher quality care at a lower cost. This is a real success story for patients, WakeMed, Key Physicians, Cigna and employers in the Triangle."

Ed Hunsinger, MD, Senior Medical Executive
Cigna Health care

AREAS OF EXCEPTIONAL PERFORMANCE (AS RECOGNIZED BY PAYERS)

While WKCC met quality standards in many of the aforementioned measures, below are those that represent the highest performance.

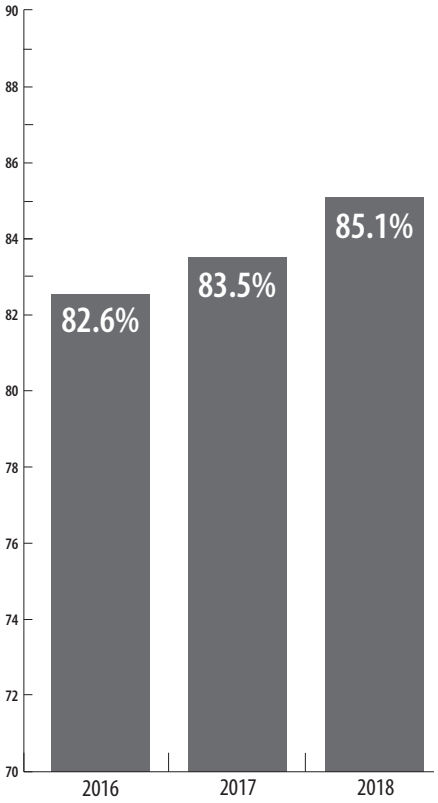
Areas of Exceptional Performance

QUALITY

- Breast Cancer Screening
- Colorectal Cancer Screening

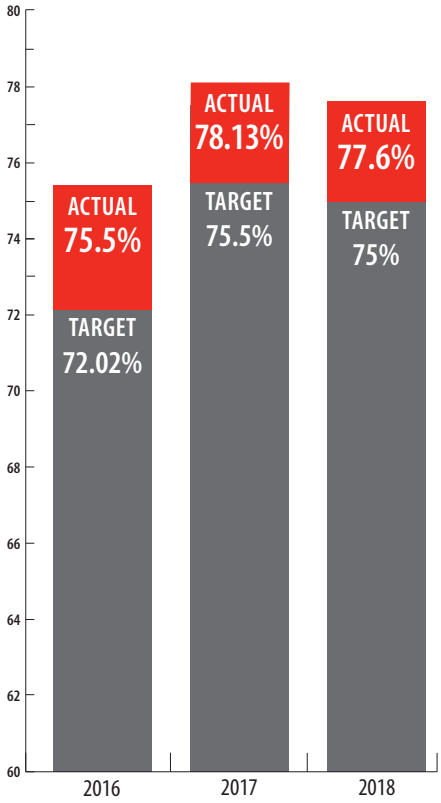
PATIENT SATISFACTION

Overall, the WKCC patient satisfaction rate is currently 85%. This is a 5% improvement since the inception of the ACO. Every year, WKCC has consistently satisfied its patients across all survey categories greater than the peer norm.



Breast Cancer Screening Rates

Average for all contracted payers



Colorectal Cancer Screening Rates

Based on BCBSNC data

AREAS OF GREATEST OPPORTUNITY

The continuous evaluation of data helps the ACO determine key priorities for each year. Based on both internal and payer data, below are WKCC's areas of opportunity for the coming years.

Areas of Opportunity

QUALITY

- Diabetes Hemoglobin A1c Control
- Referral for Diabetic Eye Exam

PATIENT SATISFACTION

- Health care teams discussing:
  - Prescription Medication Costs
  - Mental Health Status (i.e., items that may worry, stress or depress the patient)

COLLABORATING WITH HIGH-VALUE SPECIALISTS

WKCC has developed a collaboration with hundreds of like-minded, value-driven specialists to help achieve its goals and expand its delivery of value beyond primary care. The high-value specialist collaboration has grown to 700 providers at more than 100 locations, covering a broad range of specialty areas. This collaboration allows WKCC to ensure patients continue to receive quality, value-based care when referred out for specialty care.

High-value specialist practices and providers were chosen based on their performance against certain quality and value-based metrics. All practices and providers have agreed to WKCC's shared values, which include:

- Providing timely access to care
- Ensuring the primary care provider stays at the center of the patient's care
- Facilitating excellent communication between specialists and primary care
- Participating in performance improvement initiatives that support ACO goals
- Playing an active role by attending meetings and networking events

These values each support WKCC's goal of improving patient care, and reducing unnecessary delays in care or overutilization/duplication in services.

THE EFFECTIVE USE OF DATA AND TECHNOLOGY

Data-Driven Decision-Making

WKCC uses numerous sources of data in order to make strategic decisions about where to focus its efforts. Data sources include predictive analytics, payer data and comprehensive data stratification models. This allows the ACO to maximize resources by focusing on the areas that make the most impact on WKCC's goals of improving quality and value.

Technology & Innovation Drive Success

Similarly, WKCC uses numerous technology-based tools to track performance, enable better communication and facilitate seamless care across the ACO.

- **RapidConnect** – RapidConnect facilitates secure, provider-to-provider communication – allowing members of the care team to communicate, collaborate and coordinate patient care in real-time.
- **Infina Connect Referral Management Platform** – Infina allows WKCC providers to electronically submit referrals, share patient notes between primary care and specialty providers, and much more.
- **Identifi*** – Identifi is a proprietary data stratification and provider portal care management tool used by WKCC. At the highest level, it allows providers to understand trends and opportunities for improvement. By drilling down to the patient level, a provider can quickly see specific actions they can take today to better care for their patients.

INNOVATION IN ACTION Putting the EMR to Work

When emergency department (ED) physicians are caring for patients, a number of clinical decisions are contingent upon whether or not the patient has a primary care medical home. That's because patients who have a good primary care relationship have access to prompt follow-up care, are more likely to adhere to their plan of care and medication regimen, and are less likely to return to the emergency department.

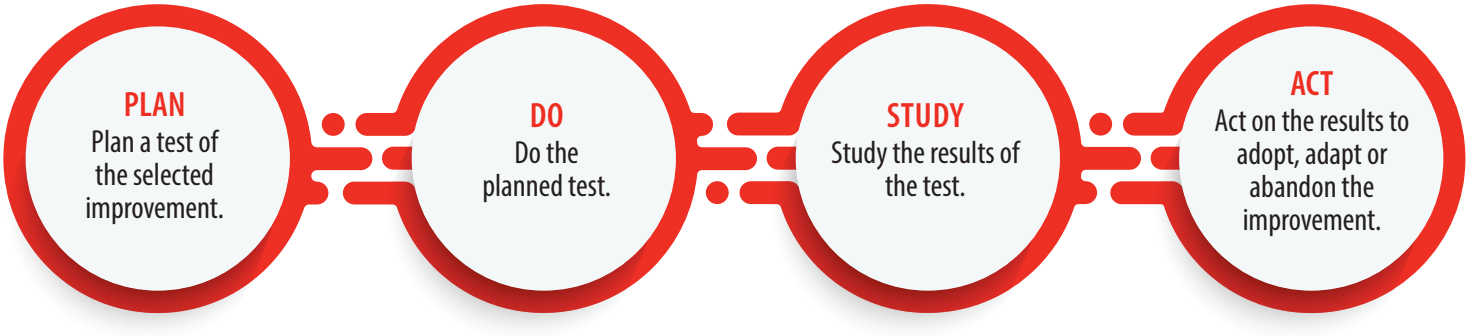
WKCC partnered with Wake Emergency Physicians, PA, (WEPPA) the team of providers who staff WakeMed's seven emergency departments, to develop a way for ED physicians to know when they are treating a WKCC patient.

After some quick brainstorming, the team established a process in WakeMed's medical record system for identifying WKCC patients – along with a built-in workflow that would help ED providers indicate the urgency of needed follow-up care.

This seamless process helps WEPPA facilitate timely discharge and smooth transition of care – all leading to higher quality and value for WKCC and its patients.

WKCC'S PROCESS IMPROVEMENT STRATEGY – PLAN, DO, STUDY, ACT (PDSA)

Performance improvement is how ACOs achieve their goals and WKCC is no exception. WKCC's standardized approach to process improvement is known as the Plan, Do, Study, Act (PDSA) approach. Individual practices routinely select PDSA projects to help achieve smaller goals that, when combined, help drive WKCC's overall goals of quality, value and patient satisfaction.



*Identifi® is a third-party population health management technology platform used by WKCC under license.

Key Initiatives

KEY INITIATIVE Effectively Co-Managing Congestive Heart Failure

Congestive Heart Failure (CHF) impacts more than 5.7 million Americans and leads to more than 1 million hospitalizations annually and many hospital readmissions – many of which are preventable with close monitoring and education – as well as the proper combination of medication therapies, exercise and other interventions.

Data-Driven Decision-Making

A quick look at WKCC's data for patients with CHF revealed that these patients incurred twice as many medical expenses as those without CHF, so it was a clear opportunity for improvement.

Team Approach

The CHF initiative began with a workgroup comprised of primary care providers, representatives from Transitions LifeCare, WakeMed Home Health, WakeMed Heart Failure Program, and cardiologists from the high-value specialists collaboration. The workgroup developed criteria for narrowing down the highest risk CHF patients to ensure they each have access to additional resources to help manage their care – such as a WKCC Care Advising Program, WakeMed's Heart Failure Program or Transitions LifeCare's CHF Program.

The workgroup also developed a new program called "Rush Hour Rounds," which allows primary care providers to call into a monthly Q&A/education session led by heart failure specialists, who are also members of WKCC's high value specialists collaboration. During these sessions, primary care providers are able to bring patient case studies for discussion – allowing them to collaborate with specialists to ensure their CHF patients are getting the highest level of care available.

Results

- Better coordination of care between primary care and advanced heart failure specialty team.
- Enhanced ability to manage advanced CHF at the primary care level, reducing unnecessary specialist visits.
- Patients appreciate the convenience and reduction in out-of-pocket costs associated with fewer specialty visits.
- 62% of WKCC's CHF patients have been enrolled in a CHF management program – either through WakeMed, WKCC or Transitions LifeCare – providing an added level of clinical and logistical support for these patients with complex medical needs.

"The Rush Hour Rounds program is a great way for us as primary care providers to connect with specialists and to further our knowledge about topics in cardiology, particularly Congestive Heart Failure (CHF). Through this program, I have learned about outpatient treatment options for my CHF patients that can help avoid the need for future ER visits and hospitalization. I have also learned some new clinical pearls I can use in my practice going forward."

Anjali Solanki, DO
WakeMed Primary Care - Brier Creek

"As a pediatric practice, one of the top diagnoses we see in our office among teens is acne. While we had historically referred many of these patients out to dermatology, after thoughtful consideration and collaboration with a dermatologist from the high-value specialists team, we developed an acne treatment program in our office. We educated our patients about this offering – highlighting benefits such as the reduction in out-of-pocket costs and convenience. In less than three months, we saw a 45% decrease in the total claims from dermatology for a diagnosis of acne. Our patients were appreciative of the new service and lower costs – and we made a significant contribution to the overall ACO goals of improving cost, quality and access."

Peter Ercolino, MD
Wake Forest Pediatrics

KEY INITIATIVE Ensuring Appropriate Use of Specialist Referrals

One of the most common contributors to rising health care costs is the overuse of specialists – particularly with common conditions that can be managed at the primary care level. Unneeded specialist visits can lead to higher out-of-pocket costs for patients and can also reduce access for patients who really need it – particularly for high-demand specialties such as rheumatology, dermatology and other specialties where there is a shortage of available appointments.

Data-Driven Decision-Making

WKCC data showed that reducing unnecessary specialist visits was a significant area of opportunity. In fact, when compared to similar accountable care organizations across the country, WKCC ranked second highest in terms of overall specialty costs. This data prompted an ACO-wide PDSA around reducing unnecessary specialist visits. To better align with national benchmarks, WKCC set a goal of reducing unnecessary specialist visits by 5-10%.

Team Approach

Fortunately, WKCC had already established a team of experts to help get this critical initiative started. Numerous members of the high-value specialist collaboration joined several WKCC primary care providers to create a panel of providers to tackle the issue. This cooperative panel – including specialists covering a broad range of specialty areas including ENT, dermatology, and cardiology – spent time discussing and brainstorming how to better treat and co-manage patients as a team. All involved providers agreed that ensuring patients who truly need a specialty referral was critical. Each WKCC primary care practice was challenged to develop a PDSA project to reduce unnecessary specialty referrals. Each PDSA project identified was based on data related to the individual practice's greatest areas of opportunity.

Results

In less than 15 months, WKCC reduced overall specialist referrals by 14% – not only reducing the overall cost of care, but also protecting access to specialists for patients who truly require a higher level of care. Other benefits include fostering closer patient relationships at the primary care level and enhanced coordination of care.

Key Initiatives

KEY INITIATIVE Reducing Opioid Prescriptions

WKCC is a leader in reducing opioid prescriptions. WKCC created an opioid toolkit for providers that includes tools and resources about the NC Stop Act, pain management patient contracts, and other resources to help providers appropriately address opioid addiction. WKCC PCP scripts per 1,000 patients have decreased significantly since launching this initiative:

27% decrease 2015 to 2016 ▸ **10%** decrease 2016 to 2017 ▸ **12%** decrease 2017 to 2018 ↓

"WKCC worked to address the critical issue of opioid overuse through analysis of current data and ongoing discussion and education around optimal evidence-based management of patients."

Theresa Amerson, MD
WakeMed Primary Care

KEY INITIATIVE A Coordinated Approach for Treating Low Back Pain

Back pain is one of the most commonly treated health problems in America and is the leading cause of disability. It is estimated that approximately 31 million Americans experience low back pain at any given time and around 80% of adults will experience the condition during their lifetime – impacting patients' quality of life, while also significantly contributing to rising health care costs.

Data-Driven Decision-Making

For WKCC, low back pain represents more than $22 million in direct costs each year for just 10.5% of all WKCC patients. Not surprisingly, spinal pain was the second most frequent reason for patients to visit their primary care physician, representing 3% of all WKCC primary care visits. After carefully reviewing data on how we were treating patients with uncomplicated low back pain, the data suggested WKCC could enhance the care delivered by adopting a consistent approach to diagnosis, referral pathways and treatment across the ACO.

Team Approach

With help from WKCC's population health partner Evolent Health's research & development and local operations teams, WKCC developed a plan to tackle this issue. When providers work together across the continuum of care to review evidence-based guidelines and agree to standardize how to care for a group of patients – that is population health at its core. As such, WKCC first assembled an interdisciplinary team that included physicians and specialists from primary care, emergency medicine, spine surgery, neurosurgery, pain management and physical therapy. The team's most significant takeaway was that evidence-based guidelines suggest patients with uncomplicated lower back pain most likely don't need imaging studies or surgery, which lead to higher costs but not always better outcomes. With this information in mind, the team worked together to develop a plan to streamline and standardize how to treat and refer uncomplicated low back pain. The data was compiled along with recommended strategies for managing and referring patients and shared across the ACO.

Results

After 12 months, the data suggests that the program enhanced the value of care delivered to patients with uncomplicated low back pain. Program outcomes included:

- Reduction in unnecessary imaging studies as evidenced by a 16% reduction in advanced imaging studies and an overall 20 percent reduction in early imaging studies. 3% increase in performance on Cigna's measure for avoidance of imaging studies for uncomplicated low back pain.
- Better management of uncomplicated lower back pain at the primary care level as evidenced by a 21% reduction in referrals to orthopedic/neurology/pain management. Decreased unnecessary specialist visits as evidenced by an 8% decrease in PCP to orthopedic specialist referrals.
- Enhanced overall quality of care as evidenced by an 11% reduction in ED visits related to primary diagnosis of lower back pain.
- Increase in use of alternative therapies as evidenced by a 20% increase in physical therapy referrals.

"Working together with primary care and other spine-focused specialists to enhance our management of low back pain was a refreshing initiative that had numerous positive effects. Working together, we developed an evidence-based algorithm for managing low back pain that allowed our primary care team to effectively manage these patients in their offices – knowing they were fully supported by a team of specialists when and if a referral was truly needed. The ultimate outcome was reducing out-of-pocket costs for our patients, while providing exceptional, well-coordinated care."

Gurvinder Deol, MD
Wake Orthopaedics

KEY INITIATIVE Reducing Avoidable Emergency Department Visits

Unnecessary emergency department (ED) visits are a leading cause of rising health care costs, with the number of visits increasing dramatically. Contributors include misperception of problem severity – particularly in children, as well as service accessibility and nationwide referrals from primary care.

Data-Driven Decision-Making

WKCC identified avoidable ED visits as an area of opportunity – for both adults and children. Collaborating with providers from primary care, pediatric primary care and emergency medicine, WKCC focused on this key initiative.

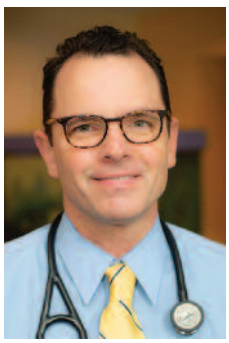
Understanding why patients may be using the incorrect level of care is a critical part of addressing overutilization. Adult challenges include lack of access to primary care or appropriate follow-up care after an initial ED visit. In children, parents often erred of the side of caution and brought kids to the ED when they could have been effectively treated at urgent care or the pediatrician's office. In addition, children with chronic problems such as asthma were identified as high utilizers.

A Team Approach

- On the adult side, emergency medicine providers were engaged to indicate the urgency for patient follow-up so the care coordinator could ensure the patient was connected back to their PCP or a community partner clinic in a timely manner. Electronic orders for follow-up care are created at discharge and patients who need prompt care (within two days) are seen by a transitional health provider.
- For children, one large pediatrics practice worked together to implement a "Should I Go?" PDSA to educate patients on where to go for care and to encourage use of the after-hours advice line before visiting the ED. The group also established a PDSA focused on communication, education and management for asthma patients/families.

Results

Initiatives for both adults and children remain underway, but preliminary data is very promising. In adult patients, the return rate (to ED or as inpatient) went from 48.6% to 19.3% for those connected with a PCP for follow-up. On the pediatric side, a dedicated care coordinator is following up with patients seen in the ED and a Certified Asthma Educator is following up with all asthma children's ED visits to reduce avoidable return visits.



"Using a care coordination model and dedicated staff to follow up on ED visits has helped us look at reducing ED utilization in a new way. We are educating families on when it is appropriate to seek emergency care through one-on-one conversations, education on our after-hours phone services, and through dedicated initiatives targeted at our asthma patients. These care coordination tools have helped us achieve one of the lowest ED rates in the community."

Allen Hewett, MD
Raleigh Pediatric Associates

Looking Ahead

WHAT'S NEXT FOR WKCC?

For WakeMed Key Community Care, the future is incredibly promising. After saving more than $60 million in less than six years, the providers and leadership of WKCC understand how to drive value-based care, while continuing to exceed quality and satisfaction goals. Through ongoing quality improvement efforts and data-driven decision-making, WKCC will continue to make strides in support of its mission.

Key Areas of Focus

- Continue to lead the way in the delivery of value-based care.
- Pursue the development of innovative collaborations with providers and payers to improve how we better manage the health of some of our most vulnerable patients, including those with mental illness.
- Continue to improve the data and analytics that providers can utilize on a day-to-day basis to improve the care they provide their patients.
- Collaborate with community partners to help improve patients' healthy lifestyle patterns.

"Our continued success as an ACO will simply be the summation of the individual successes of our providers at the clinic and patient level."

Dr. John Holly, Chair, WakeMed Key Community Care Board of Directors

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