Building Effective Value-Based Partnerships

Arizona Care Network

March 2019
The Quadruple Aim

- Improve population health with quality care
- Enhance the patient experience
- Reduce costs
- Improve provider satisfaction

The missing focus in the traditional Triple Aim.
Keys to ACN Success

ACN is a provider network that improves healthcare and reduces costs by actively managing care for our patients.
Engaging Providers

Empowering providers with tools that meet their needs
Provider Satisfaction Survey

To Know – You Have to Ask

- How are we performing against expectations and aspirations
- Perceived clarity of, and concurrence with, our clinical protocols
- Potential improvements
- Communication preferences
- Overall satisfaction and engagement
And The Survey Says…

- Fulfilling our **mission** improved from 64% to 80% between 2017 and 2018

- **Guides** and **education** rated as “most important”

- Most interesting communication topics included **ACN tools/resources** and **payer contract information**

- Nearly two-thirds found their network consultants **trustworthy** and **informative** (highest increase)
ACN Care.Wallet

Blockchain innovation empowers ACN providers with:

- Anytime access to targeted performance metrics
- Timely self-assessment
- Transparent, actionable data
- Convenient notification – info in one location, always at hand
Equitable Relationship with Payers

A proactive, balanced approach
From “Them” to “Us”

It’s a journey we must take *together*

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2019</th>
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<tbody>
<tr>
<td># of Value-Based Contracts</td>
<td>11</td>
<td>15</td>
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<tr>
<td># of Value-Based Lives</td>
<td>150,000</td>
<td>310,000</td>
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<tr>
<td># of Contract Metrics</td>
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<td>50</td>
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<td>Agenda Owner</td>
<td>Payor</td>
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<td>Cadence</td>
<td>Monthly</td>
<td>Quarterly</td>
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ACN Population Health Strategy

Population Stratification via Strong Analytic Platform

Primary Condition/Rising Risk
Self Management techniques; Primary Care Provider connection

3 or more Chronic Conditions
Disease Management, Care Planning, Specialists or Primary Care Provide connection

High Risk + BH
Specialized clinics and care team

Catastrophic Acute Needs
Stabilize, Transition, reconnect

ACN Program Support for Population Needs

N Compass Care Coordination

- Chronic Disease Management & Preventive Medicine
  - Identify patient gaps in care, such as preventive screenings or chronic disease management (i.e. rising HgA1c) via a centralized referral management support structure

N Compass Better at Home
- Hospital to home
- SNF to home

N Compass Comprehensive Care Clinics
- Dedicated staff embedded in specialized clinics to care for complex care needs
Programmatic Approach
Built for scalability across our relationships

Surrounding our providers with ACN’s ancillary care team

Surrounding our providers with ACN information & resources

**Navigators**
Experts to help you find a provider, identify gaps in care, find resources or resolve roadblocks and promote health literacy.

**Social Workers**
Help identify things in your life that impact your health, plan for discharge, handle complex dynamics, connect you to the right community resources for transportation or healthy meals.

**Registered Nurses**
Licensed clinical professionals who offer education, case and disease management, help during discharge and other transitions of care, medication education, collaborative care planning and cost and barrier analysis.

**Behavioral Health Coaches**
Specialize in the integration of medical and psychosocial needs to better manage your complete health.

**Concierge & Transition Navigators**
Centralized referral resources.

**Chronic Disease Management**
Registered Nurses and Social Workers whom surround targeted populations around preventive services and chronic disease management.

**Complex Care Clinics**
Care of complex patients in targeted clinic locations where ACN provides onsite staffing resources, such as health coaches, navigators, registered nurses and social workers.

**Clinical Performance Representatives**
Subject matter experts in Practice Transformation; empowering providers with data and tools.
Other Success Factors

- Relationship management
  - Key Accounts Manager – single point of contact for most issues
  - Executive Sponsor – ELT –
  - Joint Operating Committee
  - Workgroups
- Standardize clinical metrics/programs across ACN relationships
- Leverage payers national brand and resources with ACN’s local reputation and relationships
Thank you