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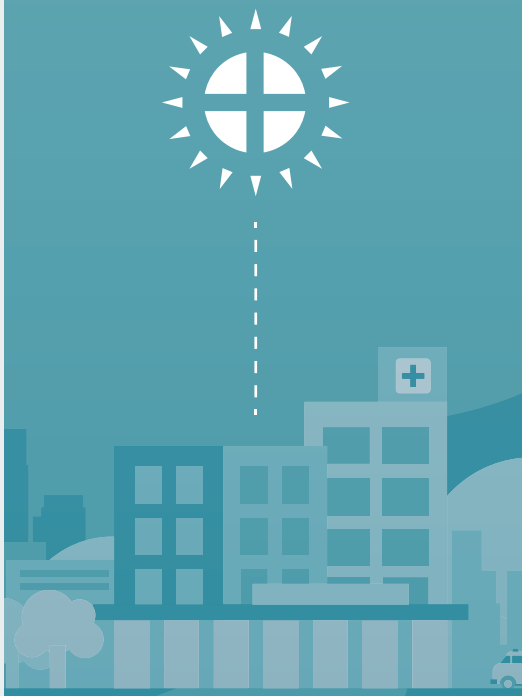
ACO Playbook: Spotlighting Successful Strategies

A compilation of success stories and strategies from Caravan Health clients



Q4 2021

INTRODUCTION

Each week, Caravan Health highlights a partner success story. These spotlights range in topics such as lessons learned, best practices, and others related to population health, value-based care, and 340B.

The ACO Playbook: Spotlighting Successful Strategies is an on-going compilation of these success stories. Throughout this book, you will have opportunities to learn how Caravan-supported providers from across the nation, both urban and rural, small independent hospitals to large health systems, are using sustainable, value-based strategies to overcome challenges and improve quality of care for the communities they serve.

We hope the ACO Playbook: Spotlighting Successful Strategies serves as inspiration and regardless of your experience in the value-based care process, this model will be successful for your organization.

With Caravan Health, now the numbers work.

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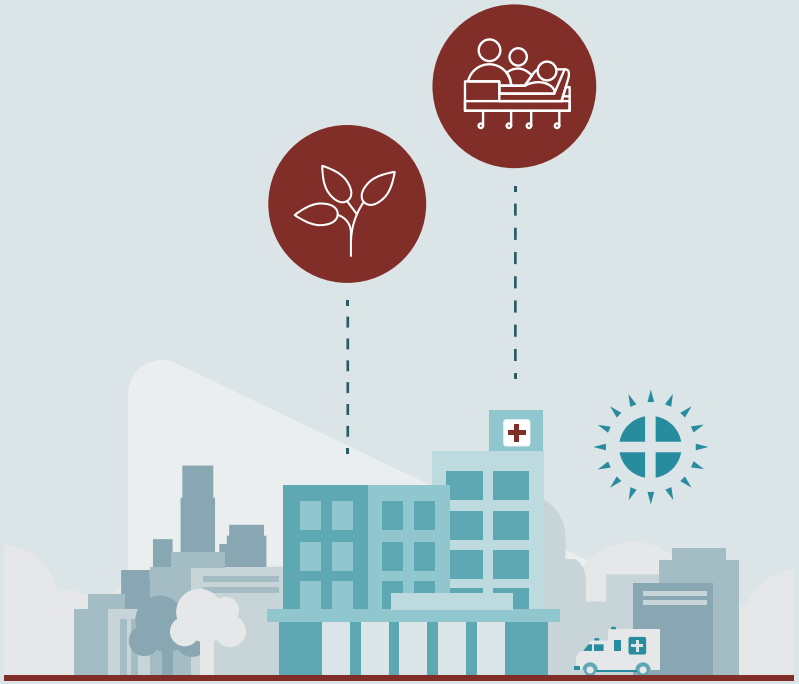
ADVANCE CARE PLANNING



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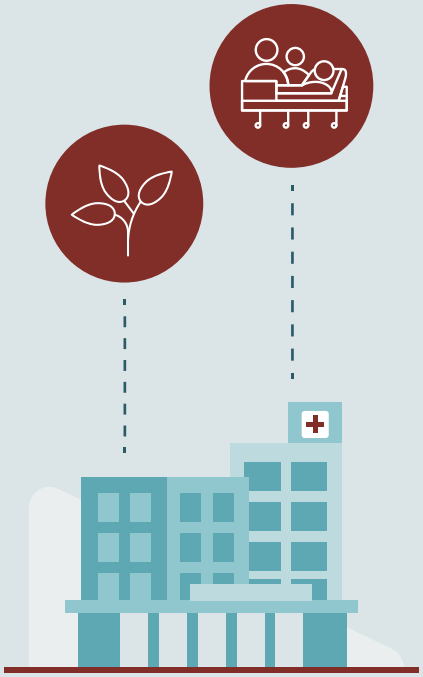

Coal Country Community Health Center Focuses on the Patient with ACP

2020

Based in Beulah, North Dakota, Coal Country Community Health Center (CCCHC), operates four FQHCs and are active members of Caravan's Collaborative ACO. CCCHC has set themselves apart by far exceeding an ambitious goal to provide Advance Care Planning (ACP) to 15% of their Medicare patients. Currently, more than 30% of CCCHC's Medicare patients receive ACP.

CCCHC staff established workflows and a care coordination committee was established to ensure the continuity of their messaging and services. The committee brought providers and clinics together which has led to nurses and social workers becoming certified in, 'Honoring Choices', to help promote more meaningful conversations where patients can express their values and wishes for their end-of-life care. Staff from the local critical access hospital, long-term care facility, ambulance services, and the public health unit have been trained to guide these conversations. Today, 75% of nurses and social workers have been certified and behavioral health care coordinators are currently being trained.

As staff worked to enhance their focus on patients, they also identified other essential components that helped embolden the strength of their ACP program including:

- Accurate coding & billing ensures proper documentation and makes transitions to new EMRs and other technologies more efficient
- Follow-up & scheduling helps to keep conversations open and fluid between provider, patient, and family and loved ones
- Understanding that AWVs & ACPs visits are not separately reimbursable when performed the same day meant that CCCHC opted to forgo a second visit requirement in order to see the patient and have the ACP conversation
- Monthly meetings provide an opportunity to discuss obstacles, help to engage providers, and ensure that the entire team, including billers and coders, care coordinators, nurses, behavioral health providers and C-suite executives are included in the over-arching plan

"When you look at how nursing has evolved, it's really a whole person approach and Advance Care Planning is a huge component. ACP is what's right for the patient. It's what's right for our care teams—being able to have the conversation prior to it becoming a critical situation."

Chastity Dolbec, RN
Coal Country Community Health Center

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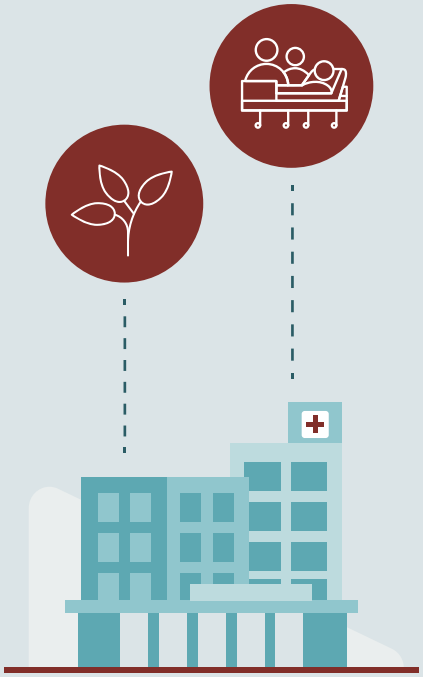

Olmsted Medical Center Focuses on Advance Care Planning to Improve Patient Care

June 8, 2021

Olmsted Medical Center (OMC), serves the community of Rochester, MN and has participated in a Caravan Health ACO since 2016. Staff and providers at OMC have implemented Advance Care Planning (ACP) into their daily workflows as a way to carry out their mission to deliver exceptional patient care by focusing on caring, quality, safety, and service. ACP is also a way to approach population health management.

OMC's successful ACP has been a gateway to improved patient outcomes and has also enhanced financial outcomes. How did they do it? Below are some highlights:

- OMC developed a Multidisciplinary Workgroup comprised of nursing & social services who meet weekly to discuss shared goals & patient progress
- They increased the awareness & importance of ACP by educating clinicians & support staff with consistent all-staff emails, grand rounds, departmental meetings, intranet communications & internal campaign letters
- Staff partnered with IT teams to standardize documentation processes around ACP conversations with patients in their EMR
- They also partnered with their health information management department to develop a process that flags some documents for further review & contact with the patient
- OMC enhanced its rooming standards within the ambulatory care departments to include an introduction to ACP
- They developed a robust audit process which allows them to provide one-on-one education when gaps are identified with certain care teams
- Their social services department has actively engaged with community stakeholders to gather information on how ACP is presented in their facilities
- OMC set a specific goal to increase the number of advanced healthcare directives on-file by 50% over the baseline number by the end of 2021

As the staff and providers work in concert on their ACP goals, they are continuing to strengthen the addition of a follow-up procedure with patients who submitted invalid ACP documents. At nearly the mid-point of the year, OCP is on track to meet their goal.

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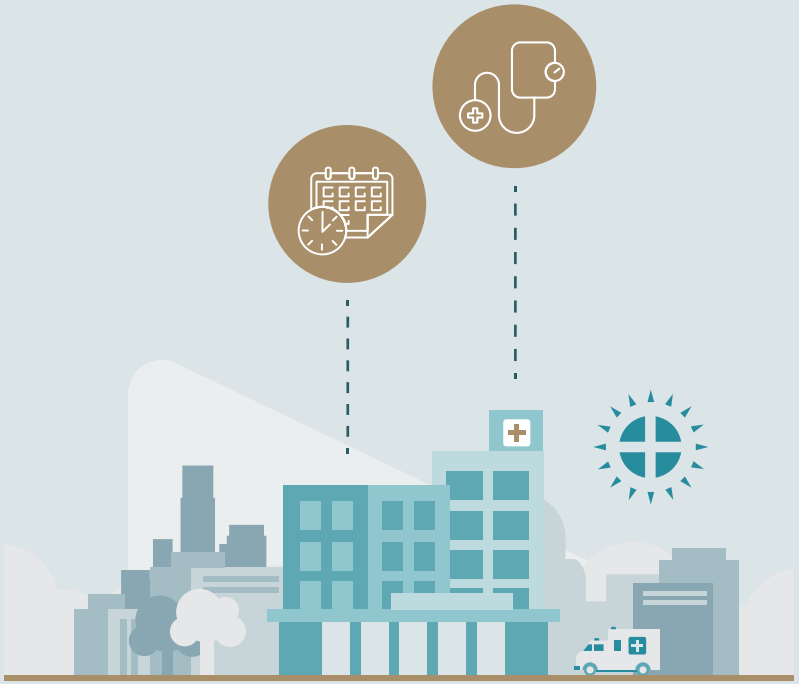
ANNUAL WELLNESS VISIT



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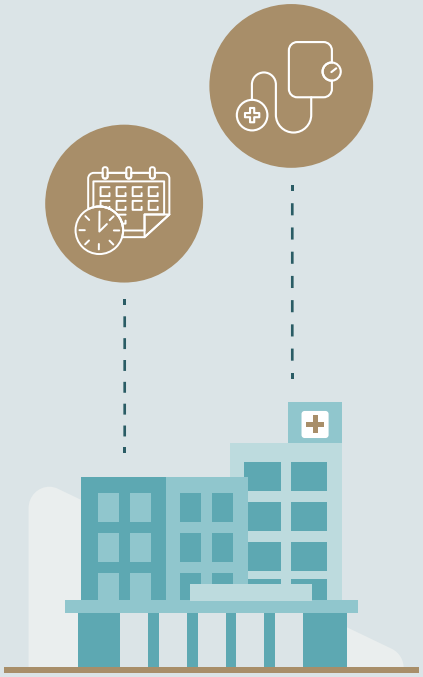
Opelousas General Health Systems Increases Rates of AWVs Using Caravan Health Resources

September 28, 2021



Opelousas General Health System (Opelousas) is based in Opelousas, LA, and has partnered with Caravan Health since 2019. When Opelousas began emphasizing the importance of the Annual Wellness Visit (AWV) to improve workflow efficiencies and identify potential gaps in care, they used one of the more popular resources at Caravan Health: The Annual Wellness Visit Guidebook.

From the onset, Opelousas staff found the Guidebook to be helpful. The Table of Contents showcased the topics listed in each chapter and were detailed enough to allow them to 'search and find' the exact subjects and steps they wanted. But, as the staff quickly realized, this resource was able to supplement their AWV trainings and aligned with their increasing knowledge base.

Rather than be overwhelmed with new population health methodologies, clinic staff were empowered to launch their AWV approaches according to their particular patient demographic yet complying with the standardized workflows that had been proven to be effective with other Caravan Health clients. Clinic managers and staff offered feedback during the trainings which led to a successful and smooth implementation. The Opelousas staff appreciated that each section was written and presented to the varying team members, was specific to each role and did not include more information than necessary which could lead to confusion or misunderstanding.

As they completed the Caravan Health training, the Medical Assistant and Population Health Nurses appreciated the instructions for visit prep and completion and were presented with useful, strategic steps. The reception staff benefited from the overarching introduction to team-based care and learning why the AWV is essential to population health. Providers relied on the Guidebook to learn more about diagnosis reconciliation, advance care planning (ACP) and HCC coding and billing for preventive care.

Having successfully completed rounds of training and implementation, Opelousas has moved forward and beginning to see results. Since January 2021, Opelousas has increased their rate of AWVs from 39.1% to 47.3% and increased their rate of ACP from 24.1% to 29.7%.

"We are on a continuous mission to improve our quality of care with our team-based approaches. Caravan's Annual Wellness Visit Guidebook has proven to be an essential resource to us. The content effectively showcases the information necessary for our staff to absorb and put into action."

Andrea Philippi, BSN, RN, CCM
Population Health Nurse
Opelousas General Health System

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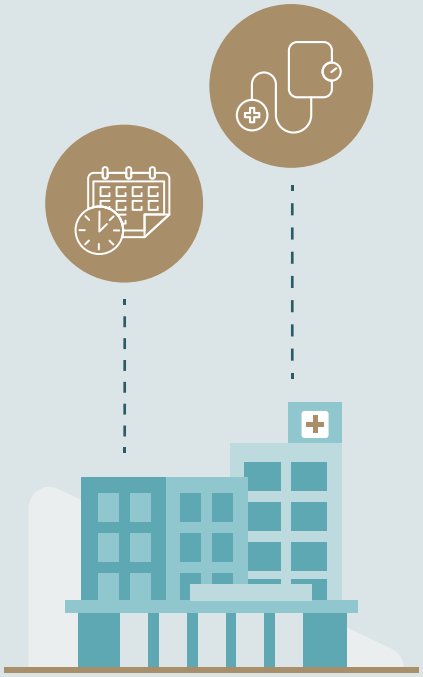
Carteret Medical Group Uses AWV to Solve Social Determinants of Health for Patient in Need

2020



Carteret Medical Group (CMG) has been an active member of the Myriad Health Alliance since 2018. At CMG, population health nurses routinely use the Annual Wellness Visit (AWV) to screen patients and encourage open conversations about their health care and access to health.

When a patient with a history of Type 2 Diabetes presented with comorbidities, Carteret nurses explained, and recommended, Chronic Care Management (CCM) and the patient agreed to be enrolled. Nurses quickly identified concerning factors including the patient's inability to pay for an expensive new-generation medication to treat her diabetes. A consult was arranged with an Endocrinologist who prescribed an equally-effective but more affordable medication and the patient began taking the medication immediately.

In addition, the patient had an above-the-knee amputation and had relied on her long-standing roommate for groceries and help with errands and transportation. Her roommate, however, had recently died unexpectedly and the patient's access to groceries and other necessities was severely compromised.

Relying on population health strategies, nursing staff spent time with the patient, helped to educate her on her health care needs and also helped to resolve some socioeconomic needs that had begun to affect her health. The patient learned how to read food labels, prepare healthy meals, and identify portion size. The patient became motivated to learn and help herself and expressed goals to lose weight, eat better, and lower her HbA1c.

Twelve months later, the patient was active in the CCM program and requested to continue in CCM. She maintained consistent communication with her health care providers and was continuing to take advantage of community resources to help her with transportation and food delivery. She is now scheduled to receive 12 hours of in-home assistance each week. Additionally, the patient has lost more than 20 pounds and her HbA1c has decreased from 6.6 to 4.9. She continues to be motivated and is an active participant in her health care.

"The population health nurse training modules from Caravan stressed the importance of addressing all the aspects of a patient's life that can impact their ability to manage their disease. The patient recently had a positive biopsy result at the site of her original cancer. She will be undergoing surgery and further treatment. The patient will need continued emotional support as she goes through this process."

Anne Kypraios, RN
Carteret Medical Group

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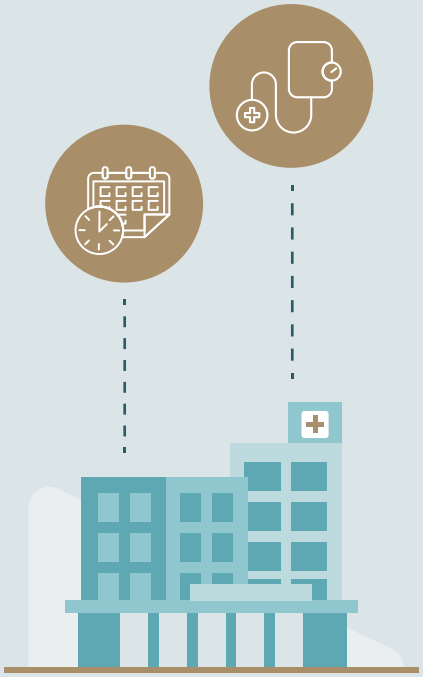
Memorial Community Health Joins ACO and Focuses on Preventive Care

2020



Memorial Community Health Inc., (MCH), has served residents of rural counties in eastern Nebraska for more than 60 years. In 2016, MCH joined Caravan's Collaborative ACO with the goals to improve the quality of patient care and increase revenue for the hospital. By working closely with Caravan experts who provided support, education and resources MCH staff established new population health workflows with emphasis on the Annual Wellness Visit (AWV).

As MCH embraced population health, more emphasis was placed on preventive care and population health nurses Lisa Friesen and Cindy McDaniels worked with staff to schedule AWVs. Their process evolved to perform AWVs in conjunction with provider visits for two reasons, (1) to prevent their patients from coming in for an extra visit in their rural area and, (2) to encourage patient participation and engagement. Staff and providers prefer this back-to-back visit to ensure that patient problems are addressed based on the results of the screenings.

Once example of this successful model involved a patient with a history of tobacco use who typically did not see a doctor unless he felt ill. Encouraged by nurses to have an AWV with an upcoming checkup, the patient agreed to his first-ever AWV. During the screenings, the patient agreed to an AAA screening and a chest x-ray due to his advanced age and smoking history. Staff performed those tests while he was on site for his appointments.

The AAA screening was positive for an 8 cm aortic aneurysm and nurses were quick to refer him to a vascular surgeon - the repair was scheduled within a week of the screening. A low dose chest CT was also completed which showed a small nodule which has been addressed and is now under the watchful eyes of a pulmonologist.

Today, the patient is doing well and recovering from his AAA repair. He plans to return to work once his post-op restrictions are lifted. He has also agreed to have a colonoscopy once he has fully recovered.

"We set a goal to increase our Annual Wellness Visits and place more emphasis on screenings. This has improved our ability to intervene when necessary and help to prevent more serious situations. Our patients have responded well, and we are continuing to add more AWVs to our schedule."

Lisa Friesen, RN
Memorial Community Health, Inc.

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BEST PRACTICES

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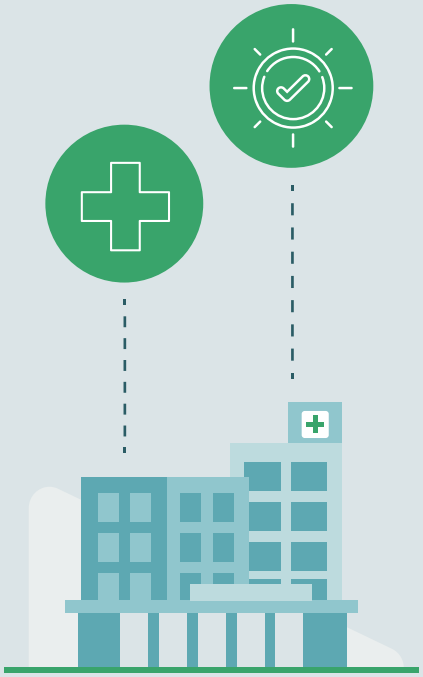
Confluence Health Emphasizes Proactive Outreach During COVID-19 Pandemic

2020



Confluence Health serves 12 rural communities throughout North Central Washington. Located in Wenatchee Valley, the health system joined the Stratum Med ACO in July 2019 and began implementing value-based care and holistic practices.

The first confirmed case of the coronavirus in the United States was in the state of Washington, and providers at Confluence Health were quick to respond. As COVID-19 became a national reality, clinicians at Confluence took a wide-angled approach to preparing for the virus and preparing for its anticipated ripple effect.

Social distancing and quarantine measures disrupt lives and carry the potential to trigger mental illness or behavioral health vulnerabilities. Given their rural population and older demographic, the Confluence team was concerned about surges in the rates of depression and anxiety in their patients. They began making proactive outreach calls to patients who had depression and/or anxiety prior to the public health emergency. Nurses spoke with patients to uncover potential concerns and needs that may had otherwise gone unnoticed. Leaders communicated the heightened importance of population health practices with all clinical teams.

During an ED visit regarding a possible positive COVID-19 patient, the physician was concerned about the patient's severe dementia and requested a CCM consult. The population health nurse made a house-call to assess the patient and her circumstances. The nurse discovered that the discharge medications had been sent to the wrong pharmacy – located in another city – and the patient was still waiting for them to be delivered. If not for the nurse's intervention, the patient would likely have returned to the ED possibly increasing her exposure as well as others to the coronavirus.

By communicating their proactive and preventive practices, Confluence clinicians are effectively treating their patients while protecting them and their colleagues from unnecessary risk.

"Social distancing and extreme changes in daily life all have the potential to lead to a surge in clinical depression or anxiety in our rural community. We recognized this as we began preparing our staff for the pandemic and put proactive plans in place to make sure we're monitoring all aspects of our patient's health. This is what value-based care is all about."

Edwin Carmack, M.D.
Medical Director of Value Based Care
Confluence Health

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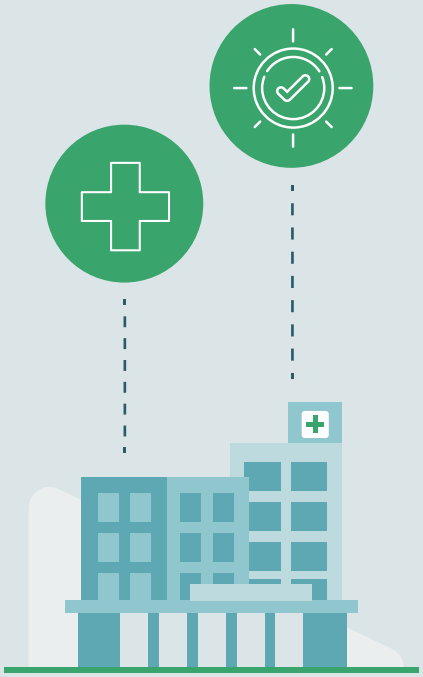
Barrett Hospital & Healthcare Quickly Implemented Proactive Protocols during COVID-19 Pandemic

2020



Barrett Hospital & Healthcare (BHH), is a critical access hospital located in rural Dillon, Montana and has participated in a Caravan ACO since 2016. The hospital serves an area greater than Rhode Island and Connecticut combined. When notified of the first COVID-19 case in their county, they responded quickly.

The hospital took a strategic approach to prepare for a potential outbreak in their expansive rural area and implemented steps to protect their clinicians, hospital staff, and community. Whenever possible, all staff meetings were immediately transitioned to Zoom calls to protect employees. The hospital immediately set incident command in place with their county which, coupled with the Zoom calls, resulted in successful actions that have helped keep the community, and those caring for them, safe. Today the staff is implementing new virtual care workflows. Below are some of the key steps BHH took:

- Each provider highlighted their at-risk patients and chronic care managers provided scripts for all available staff to place calls to every person to make sure needs were met
- Designated a 'COVID-area' to the hospital including triage, hot & cold areas
- Developed a plan with surgeons & OB-GYN providers for COVID-positive patients
- Established morning check-ins for all staff prior to beginning their shifts
- 'No Visitor' policies extended to the assisted living & nursing facilities where all staff are screened twice a day for symptoms & temperature
- Initiated virtual care & telehealth visits
- Engaged community resources including a resident with Ebola experience to assist in PPE equipment, set up volunteers to deliver groceries & developed a payment process. Community outreach resulted in local grocers designating specific shopping hours for high-risk individuals & pharmacy delivery.
- They are implementing plans for a secondary impact on the mental health of staff & community while the BHI team contacts at-risk patients using virtual care

"This was a community effort that relied on all the members of our community to actively participate in the recommendations for isolation. From those in business, those in the church communities, volunteers in the community; to those in the medical arena everyone stepped forward to keep our community safe."

Anna Loge, M.D.
Barrett Hospital & Healthcare

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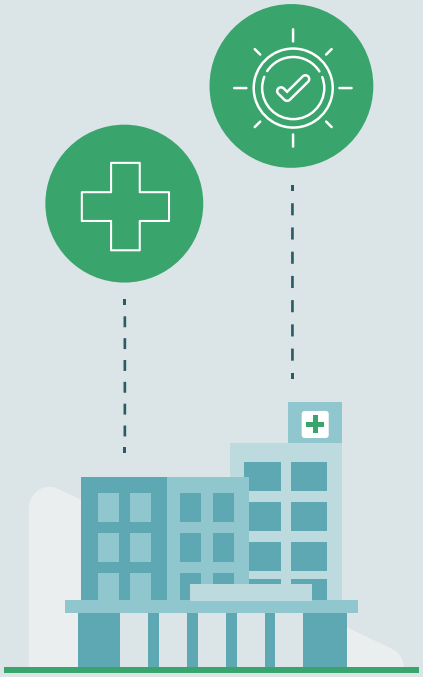

Springhill Medical Services Host Weekly Town Hall Forums to Improve Care

2020

Springhill Medical Services (SMS) is a rural health system located in Springhill, LA. Consisting of a 58-bed community hospital, five rural health clinics, and outpatient physical therapy. They have participated in a Caravan ACO for two years and serve a community of limited resources.

At the onset of the public health emergency, Michael Patronis, CEO, recognized the key to limiting the spread of the coronavirus in their community was communication. SMS providers felt a great responsibility to provide as much insight and education as possible to help educate and safeguard their community. Together, the SMS staff developed a weekly Town Hall forum in order to maintain a pathway for communication and care.

The Town Hall forums are broadcast via Facebook Live, YouTube, and can also be accessed via telephone dial in capability. Each week, the CEO and providers share new information and connect residents to resources and available services such as telemedicine, COVID-19 testing and diagnostics, and access to health care during the pandemic. The sessions are interactive and community members have the opportunity to ask questions.

The forums have been a great success and staff and providers have commented that it has brought them closer to their patients and community.

"The COVID-19 pandemic was a game-changer for us. We knew we needed to rise to the occasion to not only be prepared to treat and care for our patients, but we also needed to be proactive in accurately informing and helping to educate our community. Our weekly Town Hall forum on Facebook and YouTube has been a safe and easy way for us to communicate with our patients and provide them with resources and support. Their questions have helped us understand and meet their needs."

Mindy McConnell, RN
Population Health Nurse
Springhill Medical Services

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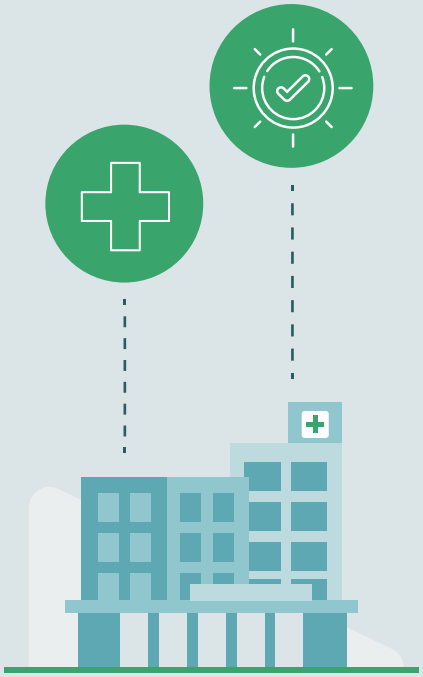

Margaret Mary Health Prepares its Rural Community for COVID-19

2020

Located in rural Batesville, Indiana, Margaret Mary Health serves a rural community with its critical access hospital that provides inpatient and outpatient services. Tim Putnam, CEO, participated in the first of Caravan Health's ongoing educational COVID-19 webinar series and shared his hospital's experience with a patient who tested positive for the novel coronavirus, having staff under quarantine, and planning for worse-case scenarios.

Staff quarantines are a concerning situation for every health system and particularly so for smaller rural-based hospitals with fewer staff. At Margaret Mary, one patient with shortness of breath who came in for a chest x-ray, tested positive which resulted in three staff members being placed in quarantine. Regarding the quarantine concern he stated, "If I lose a surgeon or a couple of anesthesiologists... an ER physician...we lose the ability to provide care to our cardiac patients and the patients who were in accidents."

Tim described the measures he has taken including recording a daily video message for staff and releasing video messages with the Mayor which has helped to inform their community. He has set up a COVID-19 24-hour Hotline for concerned citizens to call with questions and receive information.

His preparation also includes:

- Re-directing & cross-training staff
- Staging for different levels of triage & care
- Segregating the organization to a clinical and non-clinical side

He added, "We are taking a lot of extra precautions which is putting a lot of pressure on our supplies – we're beginning to ask staff to store their used masks with a silicone gel in case we have to reuse them. We've implemented visitor limitations."

To hear more from Tim Putnam and how his hospital is preparing, along with a Q&A, you can watch the webinar **here**.

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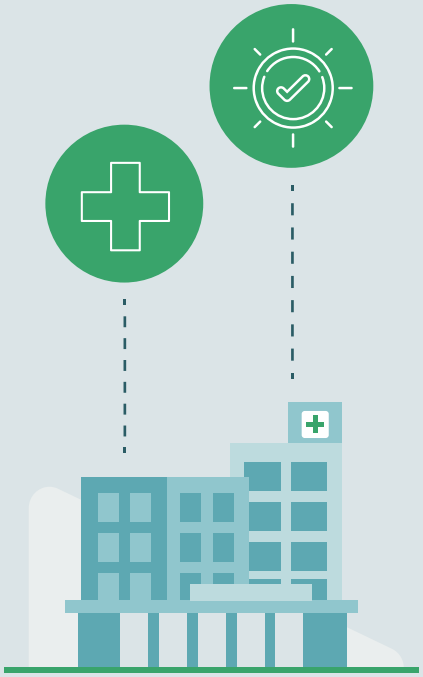

Accountable Care Case Management Leads to Life-Saving Experience

February 2, 2021

Confluence Health | Wenatchee Valley Hospital and Clinics (Confluence) have been members of the Stratum ACO since 2019 – long enough to have established value-based models of care. Confluence serves an expansive rural area in the state of Washington, an area hit hard by COVID-19.

Confluence quickly recognized that with many in-person services being shut down that their patients, and specifically their vulnerable populations, had the potential to be very isolated during the quarantine and social distancing mandates. As they transitioned to virtual care, they also noted that their Medicare population was not as technologically savvy and therefore less likely to access telehealth. With this knowledge, the case management staff placed a high emphasis on personal outreach in hopes to help patients feel supported and connect them with the care, services, or resources when indicated.

In one example, a outpatient had been diagnosed with COVID-19 and lived alone. The case manager called each day and deployed COVID-19 case management workflows overnight. As the case manager continued to call, she noted that the patient had become extremely sick and unable to get out of bed and was no longer returning calls. The Confluence team stepped in and had the patient admitted to the hospital. As the patient slowly began to improve, she thanked the case manager for her persistent outreach. When asked about her case manager the patient commented, "I would have died in bed had she not left multiple messages that day checking in – the case manager saved my life."

"The organization as a whole recognized how specifically case management services and staff have the capacity and skill sets to connect with individuals in the community to engage them in this type of support. We as case managers, have a very specific niche for reaching out and collaborating with patients in the community setting, which is unlike any other service our clinic provides. Due to this, patients are very welcoming and grateful to receive this outreach and feel that we care for them as an individual, making them eager to enroll in this service."

Tabitha Miller, RN
Confluence

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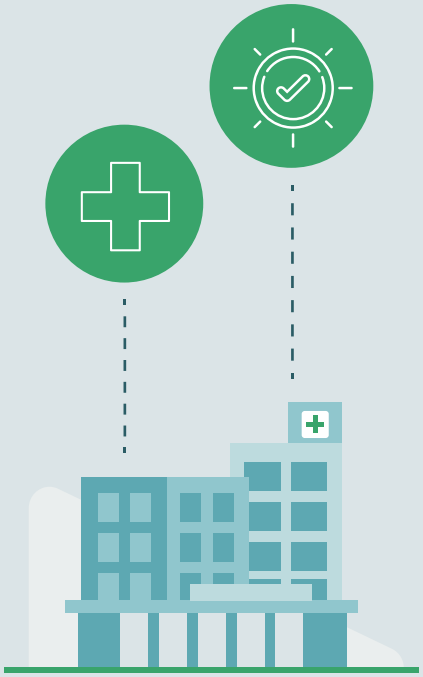
Bingham Memorial Hospital Successfully Reduces Controlled Prescription Use by 50%

March 9, 2021



One of the single most difficult challenges for prescribers is to distinguish between the legitimate use of controlled substances versus overuse or reliance on the medication which can lead to hindering, rather than helping address the core problem. After reviewing patient prescription monitoring data, Dr. Brian Carrigan at Bingham Memorial Hospital (BMH), in Blackfoot, Idaho was concerned when he saw that his patient's usage of sedatives exceeded their state average. BMH has participated in Caravan's Health Collaborative ACO since 2019 and has embraced the team-based approach of population health.

Together, the BMH staff began to identify patients through chart reviews and monthly prescription refills to implement a pharmacy management program. Using a team-based care approach, Melissa Mercado, RN, confirmed prescription usage in the identified patients and explained that they needed to have an appointment to discuss the continued use of the medication. Each patient was scheduled to meet with Dr. Carrigan and Jenilee Johnson, the office pharmacy delegate who developed the program to aid patients in tapering and ultimately discontinuing use of both narcotic sleep aids and benzodiazepines.

Collectively, the team educated patients to the harmful effects of continuing the medication long-term and began to taper their prescription use safely and slowly. Full medication assessments were completed which included a comprehensive intake of their social and past medical history. Patients were assured that their anxiety and sleep needs would be treated with safer alternatives and the team monitored each patient's progress. In the true spirit of team-based care, other members were often involved including the Chronic Care Management team and pharmacy department.

Due to the communication and education they received, patients understood the concern of long-term usage and were motivated to comply with the program. Upon completion of the program, patients often had the same number of prescriptions, but they no longer required narcotics to help them sleep or deal with their anxiety.

"The pharmacy program has been a tremendous success. Use of benzodiazepines and sleep aids in my practice have decreased by half and are now significantly below the state average. Plus, the patients are very appreciative of the care and consideration shown by our practice and the team approach taken to aid in their care."

Brian W. Carrigan, MD, FAAFP
Bingham Memorial Hospital

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BEHAVIORAL HEALTH INTEGRATION

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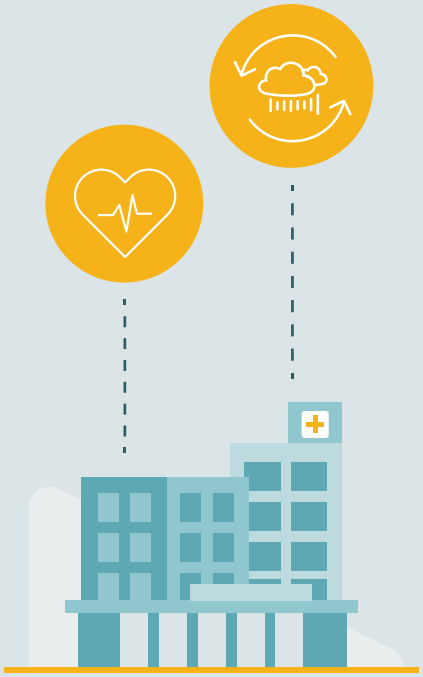
Reid Health Implements Successful Behavioral Health Integration Plan

2020



Serving the extended communities of Richmond, IN, Reid Health (Reid), has been with Caravan Health since 2015, and is currently part of the Crouse/Pathways Collaborative ACO. Reid's Behavioral Health Integration (BHI) program has been recognized for its success and patient engagement. Britany Swallow serves as Reid's Behavioral Health Coordinator, and with April Coffin, Director of Outpatient Behavioral Health, together they have collaborated to ensure patients have access to everything they need while they work with staff to achieve their goals. In Reid's case, seven may be their lucky number.

7 Keys to Reid's BHI Success:

1. **Patient Identification and Outreach:** Each week, Britany creates patient eligibility lists and provides them to the practices for potential enrollment in the BHI program. She visits and communicates with each site on a rotating basis to establish relationships with their care coordinators and providers. Provider referrals are one of the most successful routes of patient enrollment.
2. **Overcoming Contract Disputes:** Britany established a relationship with coding and billing departments and ensured time tracking was completed accurately. This has helped make the billing process smoother resulting in more admin buy-in and leveraging additional resources for patients with financial hardships.
3. **Marketing & Advertising:** A Reid BHI website, brochures with care coordinators information and pictures, and sharing patient testimonials has helped with patient buy-in and referrals.
4. **Enrollment process:** If a patient is seen by the provider, and the provider referred them to the BHI program, they bring in Britany to meet with the patient for a warm hand-off which includes an introduction, consent, and an overview of the program. Similar to their CCM program, she uses a complexity grid to assess how frequently she meets with the patient and has scheduled acuity reviews. If the patient scores 0-5 they meet every month, a score of 5-10 they meet every two weeks, and 10 or more – they meet once a week.
5. **Care Plans:** Britany documents each visit and has the provider signs off on the note in the EHR. They also have a standard follow-up protocol. If they are unable to reach a patient after three attempts, a letter is sent to the patient stating that Britany has been trying to reach them and asks the patient to contact Reid Health.
6. **Billing:** Britany tracks time with each patient, collects out of pocket payments (what? copays? payment) and bills for her services each month. Having a centralized person in place has help to standardize the billing process along with the documentation in their EMR.
7. **Graduation Process:** Britany uses the GAD-7 and the PHQ-9 to check progress over time for patients with depression each month to every three months. Interacting regularly with the behavioral health coordinator has resulted in significant improvements in PHQ-9 scores. These tools also help to identify clients who may be able to graduate from the BHI Program.

"Our behavioral health coordination program is absolutely outstanding. As a provider, it has enabled me to address my patient's mental health in a more comprehensive manner. Every patient who has made contact with this program has had a greatly improved mental health outcome. This community is blessed to have this program."

JoAnna Reisert, FNP-C
Reid Health

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CHRONIC CARE MANAGEMENT

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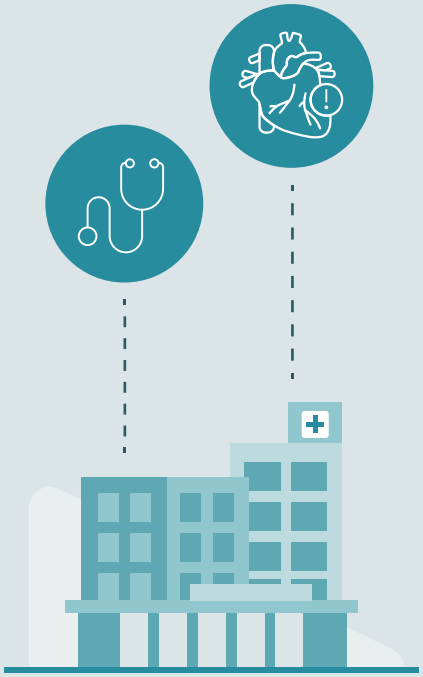
Patient-Provider Relationships at the Heart of Ridgecrest Regional's Chronic Care Management Success

2020



Ridgecrest Regional Hospital (RRH), is a full-service, acute care hospital located in Ridgecrest, CA. The hospital has been a member of Caravan's Collaborative ACO since 2016 and is firmly established in delivering value-based care. Their Chronic Care Management (CCM) program includes 150 patients and between 40-60 patients are seen each month.

The program's success is founded in the levels of trust that have been established between the patients and providers, including nurses who are highly skilled in population health. The nurses, who are enmeshed in the community, know their patients by name and have a well-developed camaraderie. The patients are receptive to the nurse's suggestions and the patient-provider relationship has been the catalyst for the success of their CCM program.

'Only a phone call or hallway away.'

When RRH providers are meeting with patients the CCM nurses are available whether it is a phone call during a virtual visit or on-call nearby for in-office visits.

RRH's nurse-led program includes successful steps such as:

- Providing nurses with dedicated phone lines that allow patients the ability to contact them with immediate concerns or questions
- Giving the nurses the ability to refer patients to a health coach or Behavioral Health team when indicated
- Tracking all relevant information with a spreadsheet that displays the patient's enrollment date, frequency of contact, most recent AWV, secondary payor source, etc
- Accessing a variety of customized reports created to help identify potential CCM patients
- Receiving alerts when their CCM patients are in the ER, Urgent Care, or are hospitalized

CCM nurses work closely with community resources provided by RRH including senior services, support groups, and exercise programs that help patients with chronic conditions maintain their independence at the highest possible level of wellness.

Despite the challenges of the Public Health Emergency, RRH has maintained a continuity of care due to their successful CCM program and the well-established relationships with patients. Many of the community resources that were once offered in-person are now offered virtually. This virtual support has helped their CCM patients maintain their wellness during the pandemic.

"We have a well-established rapport with our patients and throughout the pandemic that foundation of trust has served everyone well. We've been able to maintain our communication and make sure our patients with chronic conditions are maintaining their health. This experience has proven to us how important these patient-provider relationships are."

Celia Mills
Administrator of Care Coordination & Community Health
Ridgecrest Regional Hospital

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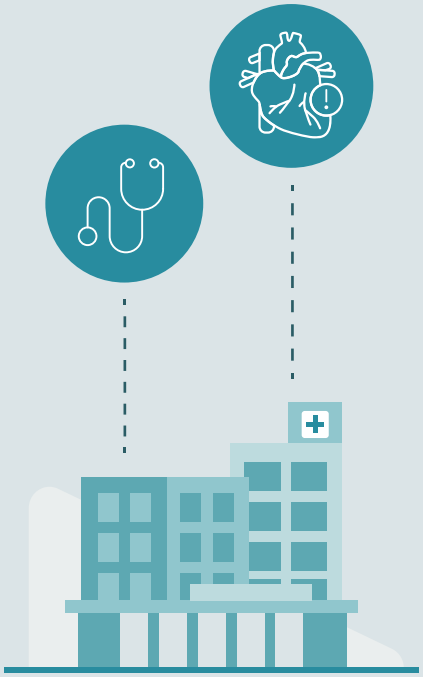

Tri-State Memorial Hospital Uses Quality Data to Build Successful Chronic Care Management Program

2020

Tri-State Memorial Hospital (TSMH) is a critical access hospital with primary care and specialty clinics serving residents in Clarkson, Washington and Lewiston, Idaho. In 2018, physicians and staff worked with Caravan Health to build a chronic care management (CCM) program. With new goals to increase preventive services, improve disease management and better engage patients they recruited Nicole Louchart, RN, to further develop the program. She joined TSMH and brought with her a unique approach to enhancing the program.

Nicole started by completing Caravan's Health Coaching Program and Population Health Orientation to develop her skillsets. She also relocated her workspace to be in close proximity to the providers who served Medicare beneficiaries. In hindsight, it was the seemingly simple change in location that helped her establish the essential relationships needed to enhance the program. By working in the same area with the providers who treated the patients who would benefit the most by CCM, Nicole increased transparency and communication and has led TSMH to success. Today, TSMH's CCM program emphasizes communication between patient and collective care teams.

Five key steps that helped TSMH enhance their CCM program:

1. Involving the entire team with consistent meetings helps everyone state on top of policy changes
2. Billing staff & accurate coding are essential, including follow-through on secondary insurances
3. Reviewing data and goals each quarter ensures that patients and/or opportunities do not fall through the cracks
4. Identifying & engaging patients by cohorts help staff maintain continuity of care
5. Communicating with providers, staff, and patients help with introductions and enrollments which sets the foundation for success

"Sometimes people will say, 'Oh, they're not compliant,' and write them off. Well, in chronic care management, those are the patients you're looking for. It's not that people don't want to be compliant, they can't. They might be choosing between buying medications and paying rent."

Nicole Louchart, RN
Tri-State Memorial Hospital

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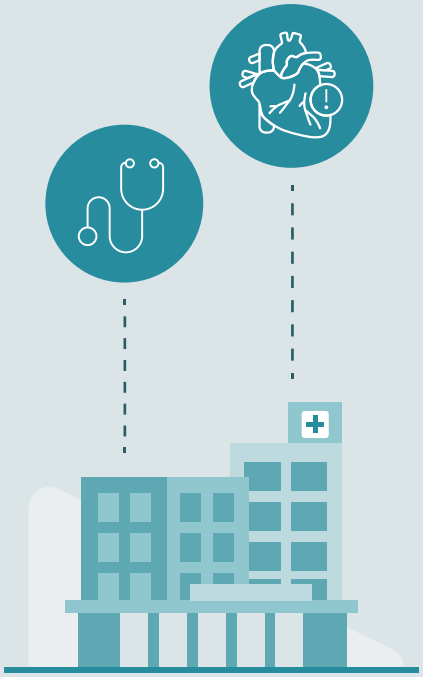

First Care Health Center's Outreach Included Mailing Masks to Patients

2020

First Care Health Center (First Care) is a comprehensive medical center consisting of a critical access hospital and a rural health clinic serving the Park River community in North Dakota. First Care has participated in the Caravan Collaborative ACO since 2016.

Care Coordinator, Shelle Berg, recognized the need for community outreach as First Care began to implement preventive COVID-19 measures. She was concerned that their patients, particularly those who were Medicare-aged, would be hesitant to use telehealth and not want to 'bother' their providers during the public health emergency. The staff created a flyer describing the benefits of Chronic Care Management (CCM) and mailed the flyer, which included a mask, to patients identified as high risk, emotionally challenged, and high utilizers. They also sent the flyer and mask to caregivers of fragile patients. The overall goal for this outreach was to connect with their patients and let them know that they were still available to them during the public health emergency and that the patients could continue to receive care, safely from their homes. The flyer outlined their contact-free CCM program and also described additional available services including:

- Personalized assistance developing a care plan
- Nurse phone calls in-between and necessary clinic visits
- Coordination of care, including referrals
- Connecting with resources and other services
- Medication and self-care support

"Our patients were extremely grateful to hear from us while they were staying at home, and we had patients calling in to express their thanks for the masks and interest in the program. They commented that they felt taken care of and in turn, we have enrolled more patients into our CCM program. I would like for us to be able to continue this level of outreach - after the public health emergency."

Shelle Berg, RN
Care Coordinator
First Care Health Center

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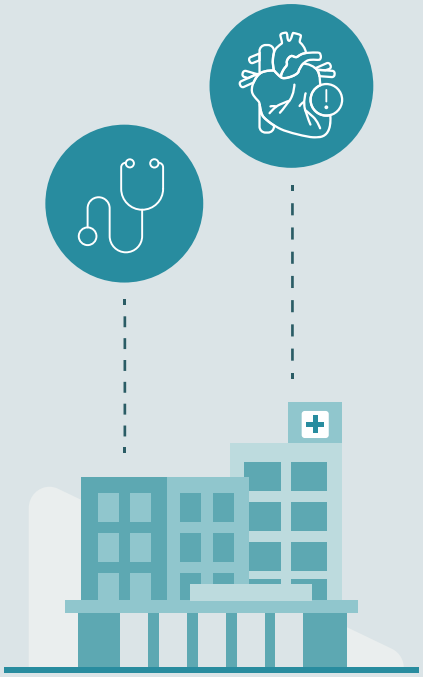
Lost Rivers Population Health Nurse Empowers Patients to Improve Outcomes

2020



Lost Rivers Medical Center (LRMC) is a Critical Access Hospital that provides primary and preventive health care and emergency services to the surrounding communities of rural Argo, Idaho. LRMC is new to accountable care having joined the Eastern Idaho Care Partners ACO this year. The hospital has embraced the nurse-led model of population health and patient outcomes have already improved.

Robin Mangan, LPN, emphasizes patient care and works closely with those who are willing and able to take on a more proactive role in their health. As Robin spent time getting to know a patient with higher-than-acceptable blood pressure, she was prepared to discuss a newly prescribed medication along with the benefits of diet and exercise. She was concerned at the fluctuations in the pressures and taught the patient how to use a loaner cuff to measure his pressures from home. She noticed, however, that as they practiced with the cuff, his pressure was close to normal. Rather than start the meds, Robin consulted with the provider and they opted to delay the prescription for concern that his pressures could go too low. She sent her patient home with the loaner cuff to use during a trial phase and suggestions for improving his diet and exercise.

Within a short period of time the patient discovered his pressure was only high when he was anxious and feeling stressed. As he became more engaged in his health, he learned that if he took care of himself when stressed and purposefully did something to relax, he could manage his blood pressure and keep it under control without medication. Ultimately, the patient achieved target blood pressure values and did not require medication.

Meanwhile, a patient with multiple chronic conditions and a learning deficit was feeling fearful of a recent Type 2 Diabetes diagnosis. Robin taught her patient how to use a glucometer and spent time explaining how to control his diet and maintain his blood glucose levels to avoid the fluctuations of highs and lows. She explained that he didn't need to check his levels six times a day as he was doing out of fear. And, she taught him how to prepare for days when he would be ill with a just-in-case 'sick-day kit'.

Today, the patient is actively engaged in his health, has confidence checking his blood glucose, and has learned to manage his diabetes. This summer he is healthy enough to have a lawn-care job. This type of patient care exemplifies the benefits of population health – care that improves patient outcomes and, in some cases, avoids unnecessary prescription medication.

"As a PHN, it is very gratifying to see my patients take what they have learned and act upon it to manage their chronic illnesses and improve their quality of life. It especially makes me happy to see the joy patients have when they realize they have the control and the disease needn't control them."

Robin Mangan, LPN
Care Manager
Lost Rivers Medical Center

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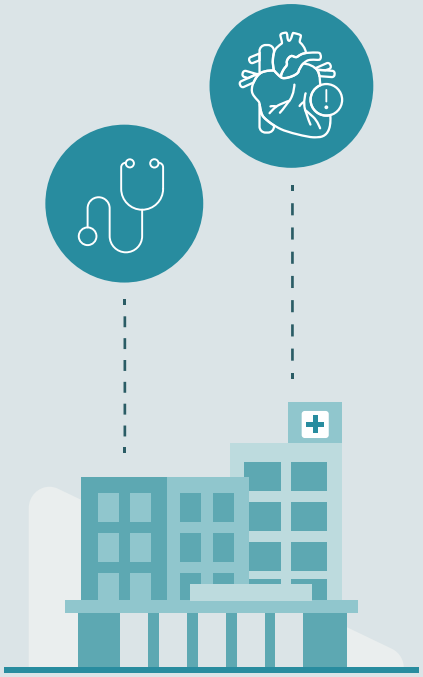

Nurse-led Outreach at Lane Regional Medical Center Prevented ED Visits

2020

Lane Regional Medical Center (LRMC) is a 139-bed hospital located in Zachary, LA. As members of a Caravan ACO since 2018, the hospital staff were highly skilled in population health and routinely screened patients for chronic conditions - including behavioral health concerns. When the risk of COVID-19 began to impact the nation, the hospital proactively contacted their CCM patients who were already identified as high-risk and/or struggled with depression. As the hospital implemented best practices to minimize the spread of the coronavirus, their patients were kept up to date with changes and new information. The staff also took steps to identify available community resources and shared the information with physicians and patients.

The increased communication and outreach from nurses and staff during the pandemic resulted in zero ED visits or admissions from patients enrolled in CCM! The outreach effectively prevented all CCM patients and their families from unnecessary visits to the ED which would have increased the risk of infection and spread.

The outreach has been so successful that LRMC and Lane Family Practice are in the process of developing plans for a strategic re-opening. The nurses and staff continue to reach out to patients to ensure they are informed and educated on precautions and safety policies.

"Our approach has been to increase our outreach to our patients and make sure they understood our new protocols and why we were implementing them. This experience has demonstrated just how effective we can be with outreach. As we move toward a phased re-opening, we will continue to keep our patients informed and they've learned that they can call us any time they have a question or concern. We've made sure they understand the phone works both ways – we are encouraging them to call us as well."

Amy Rome, RN
Population Health Nurse
Lane Regional Medical Center

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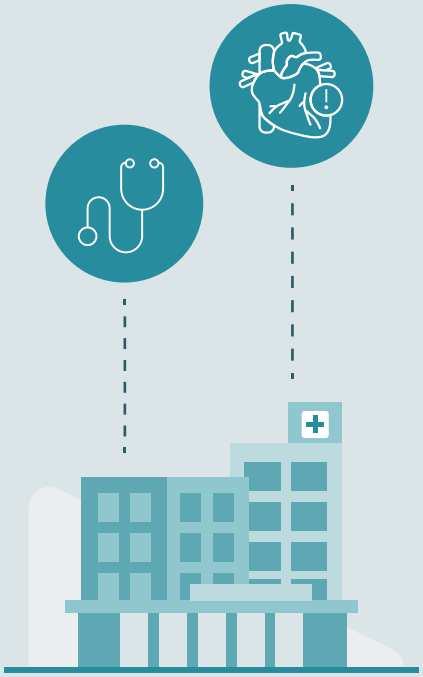

Crawford County Memorial Hospital Staff Successfully Emphasizes Diabetes Control

March 2, 2021

Crawford County Memorial Hospital (Crawford), located in Denison, Iowa has participated in the Caravan Collaborative ACO for three years. Prior to joining the ACO, staff at Crawford had been devoting extra time and resources to their diabetes management program. They hired a clinical health coach and developed a diabetes registry that they used to send care alerts to providers regarding patients who were due or overdue for lab work.

Shortly after joining the Caravan ACO, they accelerated their focus on the Hemoglobin A1c Poor Control Measure and emphasized the measure in their Chronic Care Management program. While Crawford staff and some providers trained and learned how to transition to value-based care they were met with some challenges. Some providers were hesitant to adopt the new methods but soon saw the value in the program. Most recently, COVID-19 has presented obstacles due to patients not being able to have in-person visits and lab testing but they are successfully overcoming those obstacles.

It isn't uncommon for patients to resist more testing or appointments but that has not been the case at Crawford. The program initiatives have been well-received by patients and they have adapted well. One of the biggest catalysts in Crawford's success has been the use of continuous glucose monitoring (CGM). They use CGM to assist in insulin titration, identify hypoglycemia and show patients the effects of food and activity on their blood sugars. Crawford reports that CGM has had a significant impact on improving diabetes control in patients struggling with hyper and/or hypoglycemia.

Of 68 patients who had a professional CGM device placed between Jan 2019 - Sept 2020, 77% showed a drop in A1C with their next check. Of the patients with an initial A1C of > 9%, 76% had an A1C of <9% with subsequent check. 55% of patients dropped their A1C to <8%.

"(The) Diabetes Management Program has been a tremendous help with patients. The close follow up with CCM has very likely helped avoid ER visits and hospital admissions in a few of my patients. The dedicated case management with reinforcement of education has improved overall satisfaction and confidence in the management of diabetes as well as related health issues like heart failure and hypertension."

Julie Graeve, ARNP
Crawford County Memorial Hospital

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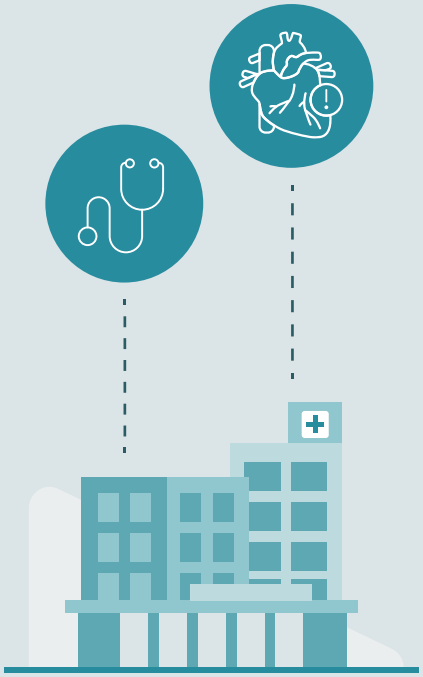
The Iowa Clinic Integrates Chronic Care Management with Behavioral Health to Benefit Patients

June 22, 2021



The Iowa Clinic (TIC) offers comprehensive medical care to the community of Des Moines, with 250 providers who represent 40 specialties. TIC has participated in the Caravan Health Stratum Med ACO since July 2019.

According to the Center for Infectious Disease Research & Policy, (CIDRAP), rates of depression have tripled in U.S. adults during the pandemic amid COVID-19 stressors. In fact, one study reports the rise in depression to be much higher than after previous major traumatic events. Prior to the pandemic, 8.5% of adults reported depression symptoms and in stark contrast, 27.8% reported depression symptoms during the pandemic. CIDRAP also demonstrates that the burdens of depression have increased significantly. Historically, American females experience higher rates of depression than American males, 10% compared to 7%. However, during the pandemic, the rates of females who reported depression symptoms increased to 22.2% and symptoms in males jumped to 21.9%.

Staff and providers at TIC actively enroll qualifying patients in their chronic care management (CCM) program for chronic condition care, including depression. In a recent case, a 65-year-old female was enrolled in CCM for management support of diabetes and depression. The patient had been experiencing depression since her lifestyle was dramatically changed during the pandemic. She was also struggling with debilitating anxiety.

This patient expressed to her care manager how frightened she was to be in public and afraid to go out and get the vaccine which was being offered in a community pharmacy. She had high anxiety about getting sick by being in close proximity to others who were receiving the shot in the small pharmacy. In her evaluation of the concomitant levels of depression and anxiety in the patient, the TIC nurse not only scheduled her for a vaccination appointment at TIC where there would be fewer people, but she also accompanied the patient on her visit to help ease her anxiety. The nurse was on hand to explain the patient's situation to the professional who was administering the shot and therefore he was well-informed and helped to further ease her anxiety and make her as comfortable as possible.

The nurse also provided the patient with educational resources on relaxation and grounding techniques to help manage her anxiety. These population health techniques helped the patient to be more at ease and comfortable returning for her second dose.

"Our chronic care management program is comprehensive. It crosses into behavioral health management and overall health and well-being whenever indicated. This program is successful because we meet the patient where they are and help them learn to better manage illnesses and whatever they may be dealing with."

Christine Taets, RN
Care Manager
The Iowa Clinic

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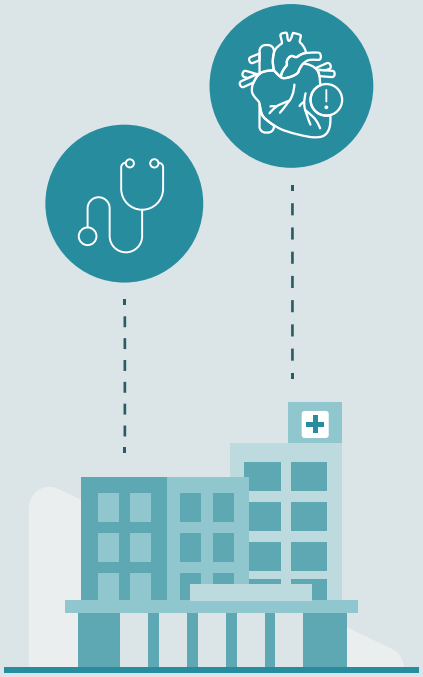
Henry County Memorial Hospital Utilizes Caravan Coach to Identify At-Risk Patients

July 13, 2021



Henry County Memorial Hospital (Henry County) delivers comprehensive health care services to residents of New Castle, Indiana. Members of the SHO ACO, Henry County has participated in a Caravan Health ACO since 2015.

Health care staff and providers at Henry County set a goal to increase their CCM program and enroll more patients who would benefit from chronic care management. With the introduction of Caravan Coach, the comprehensive platform for patient care, the collective team at Henry County learned through training sessions they could generate patient reports based on disease cohorts.

"We decided to start with our COPD population," commented Ashley Reno, RN, Care Coordinator. Indeed, Coach data indicates if patients are at low, medium, or high risk. "We decided that our low to medium risk COPD population would be most appropriate for outreach and CCM services. We have found that most of the high risk patients in this COPD population are currently engaged with us or do not qualify for services."

Ashley began reviewing their low-to-medium risk COPD patient population and immediately identified a patient who was appropriate for outreach. The patient had recently suffered from a Cerebral Vascular Accident (CVA) and during a chart review, it was noted she had been hospitalized at an outside facility. The discharging hospital sent this patient's PCP a fax cover sheet stating to schedule a follow up appointment with this patient for hospital release. The discharging facility, however, did not send a discharge summary. This patient was not scheduled for hospital release, the request was not added into the EHR and was unfortunately missed.

After piecing the bits of information together, Ashley contacted the patient for hospital release follow up call and offered her CCM services. As they talked, Ashley discovered the patient had multiple specialty appointments, and had difficulty tracking her appointments. She suffered from some vision loss in relation to the stroke, so she has a barrier with reading and managing her medications.

"Thankfully, I was able to obtain the patient's discharge summary in the care web portal. I discussed the hospitalization and the patient's barriers with her PCP and collaborated with staff to schedule the patient an appointment for her hospital release. It was then I was able to meet this patient face-to-face," added Ashley.

The Henry County staff has been engaged with the patient for a few months and the patient is improving. She has learned how to track appointments and is understanding the importance of taking her medications. With the help of her health care providers, she is managing her chronic conditions. The patient is also learning the importance of following up with her specialty providers.

Today the patient is extremely engaged and motivated to stay well and healthy. "If this cohort wasn't utilized in the way we are using it, this patient could have potentially suffered from further complications," concluded Ashley.

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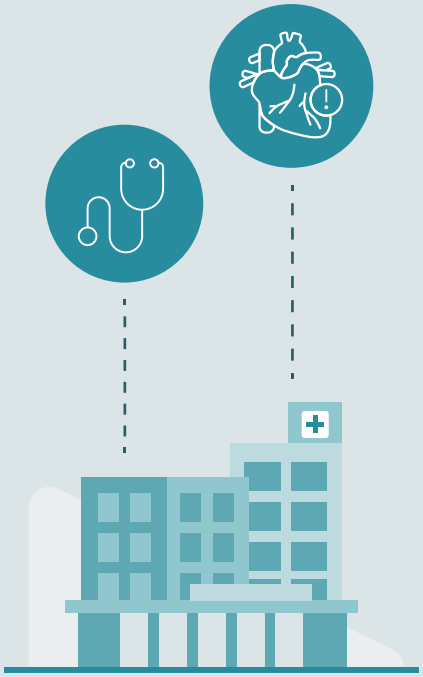

Communication is Key to Madison Healthcare Services CCM Success

August 3, 2021

Madison Healthcare Services (Madison) is a Rural Health Clinic located in Madison, Minnesota and has been with Caravan Health since 2016. As part of the Caravan Health Collaborative ACO, staff and providers at Madison were quick to transition to a holistic care model and implemented a team-based approach to caring for and treating their patients.

Recognizing that one component to improved patient outcomes is through a successful Chronic Care Management (CCM) program, Madison emphasized increasing the numbers of patients enrolled in CCM. Madison's team-based approach includes having LPNs and CNAs complete AWV forms to help identify key points for the providers on CCM eligible patients. These points are reviewed by the provider with the patient and not only helps to maintain a continuity of care but also a continuity of communication between the staff, patient, and provider.

These seemingly simple steps have resulted in better physician engagement. Physicians are able to spend more time with the patient and able to discuss the importance of CCM which effectively creates a warm hand-off to the population health nurses. This step sets everyone up for success.

As Madison continues to improve its CCM program,. population health nurses work closely with patients who are mostly elderly. These patients now feel so supported and engaged that they proactively call the nurse each month, taking ownership of their health and care plan. The population health nurses have given these patients the confidence to take the initiative with their care.

One factor that has proven to be crucial to Madison's CCM team-based success is communication. Gone are the ineffective silos that prevent providers and health care professionals from accessing patient information and in turn, patients have easy access to their health care team. The staff tracks readmission rates and gleans data from Coach to further identify patients who quality for CCM.

"Since implementing team-based care at Madison, we've seen an improvement in communicative care. It's as if the nurses are the arms of the providers – everyone is working together, and our patients comment on how supported they feel."

Kris Monson, RN
Clinic Manager
Madison Healthcare Services

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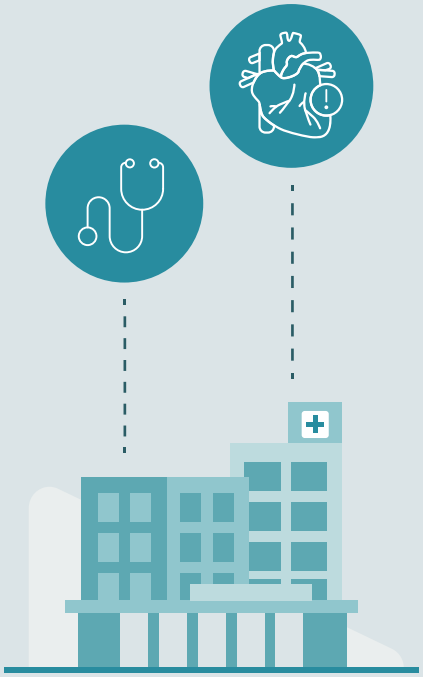
Logan Health Prepares to Transition from CPC+ to Chronic Care Management

December 7, 2021



Located in the Kalispell, Montana, Logan Health is moving full speed ahead with a formal Chronic Care Management Program (CCM). When their CPC+ program ends on January 1, Logan Health will transition to CCM. The rural health care facility participates in the Caravan Health Collaborative ACO.

With CPC+ ending and Logan Health's integration into the Caravan ACO, Audra Saranto, Nursing Executive Director at Logan Health, worked with their Caravan team to identify needs. They recognized the importance of a structured care coordination program to ensure patients had the ability to communicate and self-refer whenever they needed.

The outpatient care managers will provide care management for all patient populations and the inpatient care managers will focus on improving the continuity of care through discharge planning, including TCM to close the loop for the patient transition, ensure that all services have been initiated, and confirm patients understand their discharge instructions and have picked up their discharge medications.

In addition, Logan Health staff, including IT, collaborated as they built templates and created standards for documentation. The intent of the standard documentation is consistency, transparency, and to effectively deliver a continuity of care. They have also developed a registry to maintain an interactive list of patients who have been enrolled in the CCM program. The registry will allow care navigators to document directly from the patient list, keep track of time spent on care coordination for each patient, and will be the location to input the CCM and PCM codes.

Logan Health offered trainings on templates, registry, TCM, billing and consent to properly prepare staff. As a work in progress, Logan Health is aware of a knowledge gap on which payers cover certain codes and who among their patients will or will not be eligible. However, the team has worked diligently to prepare for the transition and set the stage for success.

"We recognized an untapped opportunity to provide better quality care with Chronic Care Management. Our patient demographic is ideally suited for this type of care management. It's been a work in progress so far with emphasis on progress."

Audra Saranto
Nursing Executive Director, Care Coordination & Ambulatory Clinical Operations, Logan Health

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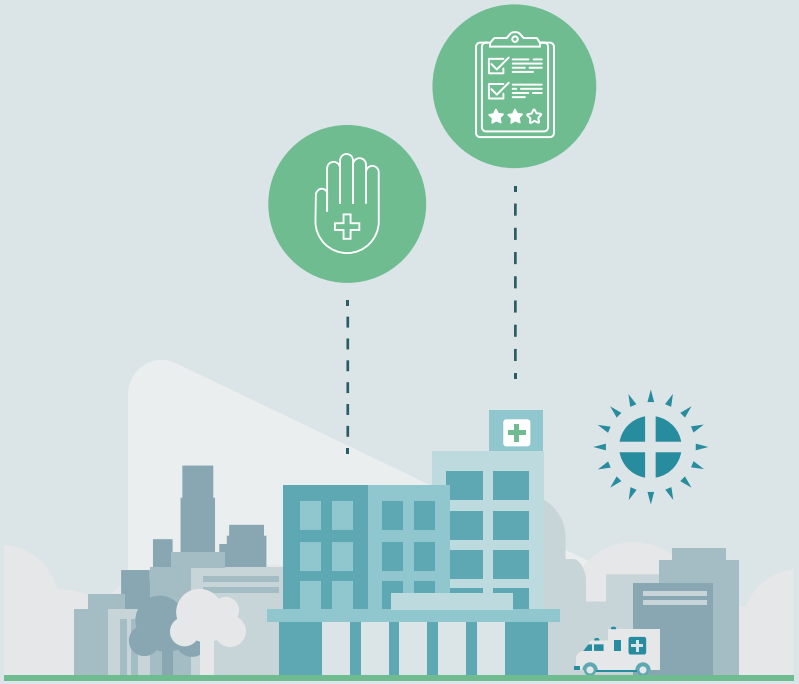
CARAVAN COACH



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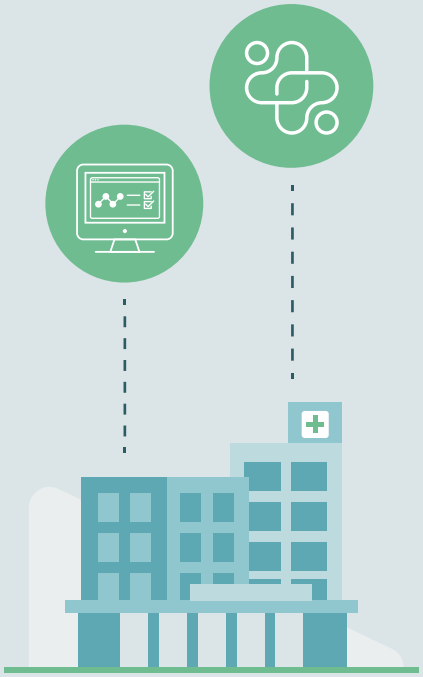
Caravan Coach: Award-winning Technology Helping Clients Improve Health Care

October 19, 2021



As Caravan Health clients know, Caravan Coach was launched earlier this year. The comprehensive platform positions all of the tools, data, and processes needed to run a successful ACO in one easy-to-access place. The cutting-edge, yet user-friendly, technology caught on quickly with clients who learned that Coach not only made their jobs easier but also enhanced their capabilities.

The Care, Track, Improve, and Submit modules helps professionals takes the guesswork out of effectively managing an evolving patient population. Clients use Coach to improve their 340B program and improve their capture rates and increase savings.

We decided to talk with clients who are using Coach to learn what they have to say about some of the benefits:

User-friendly and Improves Efficiencies

"Caravan Coach has improved our efficiencies at Morris Hospital tremendously. We're a small organization and Caravan Coach is so much easier to use. It's kind of the in-between the provider and the patient because it makes it easier for us to identify those patients needs and improve the care of our patients. I think Caravan Health has done a great job."

John Roundtree, Manager of Strategic Planning, Morris Hospital

Optimize 340B Program

"340B has helped Winona Health be able to be strategic about the projects and the programs that we're able to offer to our community. Because of our 340B savings, we are able to offer non-revenue producing programs that benefit our community members. One such program is our Community Care Network, and it is in place due to our success with 340B. Investing time and effort into the 340B program has been well worth it for Winona Health. It is a program that helps us care for our community and our organization."

Robin Hoeg, Chief Operating Officer, Winona Health

"When HRSA does come and if they would like to audit a prescription, that's just one more benefit of the Caravan Coach. We can take documents directly from that software and put them in our EMR for quick record receiving for when those audits do happen."

Levi Hattervig, Informatics Pharmacist, Winona Health

Modules Make Your Job Easier

"In Caravan Coach there is a module where the face sheet is there in a tool called timeline. I love that feature in the sense that, for my chronic care management patients, I can actually give the name of the physician or the facility that they go to outside of Morris Hospital. So that has been more efficient, so now, I know who it is that is also working with the patient and helps with the cohesiveness of the care that is provided."

Jennifer Wallenberg, Nurse Care Coordinator, Morris Hospital

Improves Care Coordination

"Caravan Coach has been a cornerstone in our care coordination program. The customer service and resources Caravan Coach provides have helped our care coordination program grow, deliver excellent patient care, and meet our ACO goals. With Caravan Coach, questions are answered timely, and our processes are effective with a team of care providers patients can trust and rely on."

Kara Redenius, RN, Care Coordinator, Iowa Specialty Hospital

The Wellpepper Patient Engagement App is an Added Benefit

"Wellpepper is a game-changer in patient care. It has opened the door to treating the conditions patients live with, as opposed to merely treating the symptoms as they present during an office visit."

Melissa Hayse, RN, Wellness Nurse, Ohio County Healthcare

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HIERARCHICAL CONDITION CATEGORY CODING
(HCC CODING)

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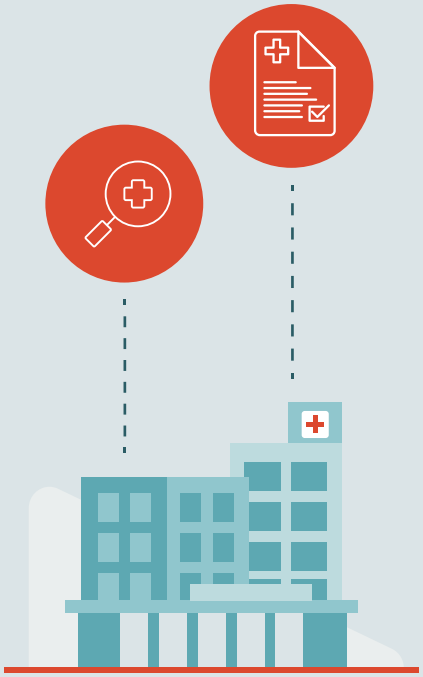
Chambers Health Improves Patient Outcomes by Focusing on HCC Coding

2020



Chambers Health runs a critical access hospital and two FQHC's in Anahuac and Belview, Texas. With the acknowledgment of the constant and unpredictable change in health care and the goal to improve patient care, staff and providers set out to focus on the patient as a whole person – not just symptoms or one area of care.

As comprehensive patient outcomes became a priority, they analyzed key performance indicators, reviewed Caravan Compass reports, and worked closely with their Caravan partners to identify gaps in care. It became apparent there was potential to place more emphasis on HCC coding to assuage gaps between medical teams and coders and further embrace value-based care. As the Chambers staff continued to work closely with Caravan Health, they were able to successfully transition to a level of care that placed improved HCC coding at the top of their list of patient care priorities.

Their successful strategies included:

- Taking the FQHC approach of comprehensive patient care and treating the whole patient rather than one area of symptomology
- Gaining commitment from leadership with transparent and open communication to pursue HCC coding improvements
- Utilizing an external audit for objective analyses that would be fair to all providers
- One-on-one provider education based on the results of their specific audit
- Using HCC face sheets for AWVs to ensure diagnosis reconciliation and preventive screenings

The results of their efforts has been profound. Patient outcomes have improved, staff and providers are not only more informed about the opportunities of HCC coding, but have also identified cancer in patients early on, communication between primary care providers and specialists has improved, and the previously identified gaps in care have substantially narrowed.

Today, the collective Chambers team has made a new commitment to pursuing patient centered care and are working to receive the Patient Centered Medical Home designation through NCQA, with plans to align those goals with their ACO goals. They are continuing to use Caravan Compass to identify highest costs and outliers within their referral system, discussing the use of crosswalks to streamline processes, and are on track to have a PCMH designation by this time next year.

"We've made it a priority to improve patient care. We feel like it's not only an improvement for them and their care and their future wellbeing, but it's also an improvement for us to show that we're able to work comprehensively and try to address their health care needs."

Nellie Lunsford
Director of Compliance
Chambers Health

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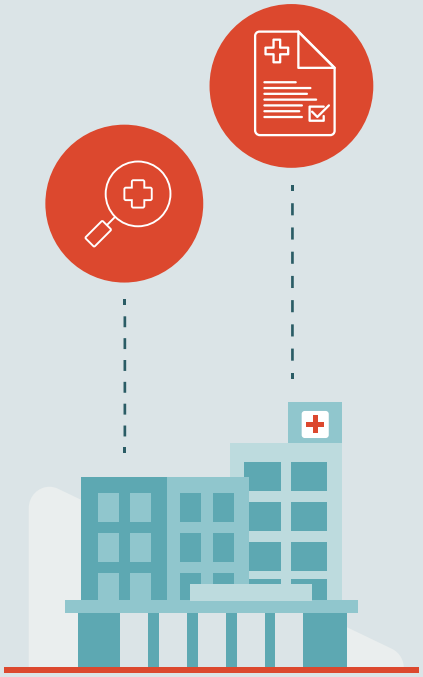

McFarland Clinic Leads Caravan Clients in HCC Recapture Two Years in a Row

February 16, 2021

McFarland Clinic (McFarland) joined Caravan's Stratum Med ACO as founding members in 2019. Comprised of 65 Adult Med and Family Med PCP's, McFarland serves a rural community in Ames, Iowa. When they transitioned to value-based care the McFarland staff worked closely with their Caravan team to place more emphasis on HCC coding. As staff learned to use their new data, they began to recognize opportunities and gaps in care.

McFarland made the decision to hire Lisa Nelson, a CMA who trained to become an AAPC Certified Risk Adjustment Coder. Lisa's prospective chart review and prep gives McFarland's providers the confidence that the ICD-10 codes are not only accurate, but also an understanding of the codes that are most important to refresh. With a Risk Adjustment Coder on staff, patient charts accurately reflect known conditions which improves care coordination between the clinic, hospital, and external facilities. Having a more accurate risk score for their population helped increase their benchmarks which lead to more shared savings opportunities. McFarland consistently sees increases in their population HCC risk scores across both Medicare and Medicare Advantage and for the past two years, has led all Caravan Health clients with their HCC recapture rates.

In 2020, 88% of McFarland's patients were coded with one or more of the following: CHF, Diabetes with or without complications, Specified Heart Arrhythmias, COPD and Vascular Disease.

Learn from the leaders: McFarland's HCC Process

1. Employ a AAPC Certified Risk-Adjustment Coder in population health.
2. Provide a daily list of patients with upcoming PCP visits for coder to review.
3. The patient list is prioritized by highest outstanding HCC value including both known HCC's in Epic and HCC's found in Medicare claims history but not in Epic.
4. Coder edits the problem list where appropriate and flags HCC's for provider review and documentation during the visit.
5. HCC's are auto-flagged for providers by Epic when due for refresh based on past billing or problem list.
6. Coder selects a number of past visits to audit every day to check for adequate documentation and periodically provides results to the provider documentation/coding education team.

"At McFarland Clinic, providers are responsible for their own coding, both CPT and ICD-10. The automated HCC alerts in Epic helped improve our HCC recapture."

Austin Lepper
Director of Population Health
McFarland Clinic

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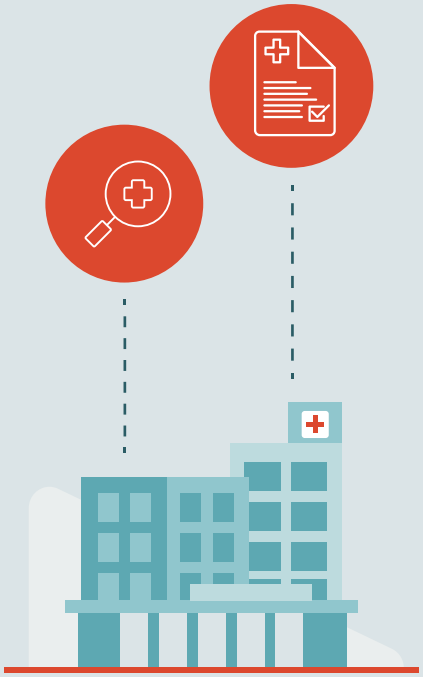

Sidney Health Center Utilizes Billers and Coders to Improve HCC Capture Rates

April 20, 2021

Sidney Health Center (SHC) serves a vast and rural community in Sidney, Montana. Having participated in a Caravan ACO since 2016, they are current members of the Caravan Health Collaborative. The staff has worked diligently to improve their HCC capture rates. At the beginning of 2020, SHC set a goal to achieve an 80% year end HCC capture rate. Despite the disruptions caused by the pandemic, by the end of 2020, SHC reached a rate of 77%.

One of the first steps SHC took was to begin educating and training their billers and coders on HCC process improvement. This turned out to be the catalyst in improving their capture rates. The staff used Caravan's EPIC alerts to identify gaps and opportunities. The billers and coders used Relias and Caravan's portal and have now been trained on Coach facesheets to help further close HCC gaps.

When SHC set their goal of 80% HCC capture, the staff scheduled quarterly staff 'Lunch & Learns' to maintain an open level of communication and to review their progress. The SHC also worked closely with the providers and encouraged them to ensure they were coding to the highest specificity. Because the staff are committed to team-based care, it was only natural that the billers and coders communicated with providers whenever they saw an opportunity for a more precise level of coding.

One of the most recent process improvements involved including the billers and coders on the calls with the Caravan Health team calls, the Relias training, and in learning how to use the HCC facesheets. The billers and coders have become valued members of the clinical nursing team. SHC has continued the quarterly 'Lunch & Learns' and these have been well-received by both staff and providers.

Sidney Health Center HCC Best Practice Results

1. Utilize EMR HCC alerts
2. Billers & Coders are educated and trained on HCC
3. Team-based approach progression toward collective goals
4. Ranked in the top 20% for HCC recapture in their ACO
5. End of 2020: 77% HCC capture

"Our team has learned that accurate HCC coding will lead to better patient outcomes. We've set ambitious goals for our HCC capture and based on the data and our engagement in team-based care, we are optimistic that we will achieve our goals. Improving the patient experience leads us to better patient outcomes and ultimately better financial outcomes."

Beth Mindt, BSN, RN-BC
Sidney Health Center

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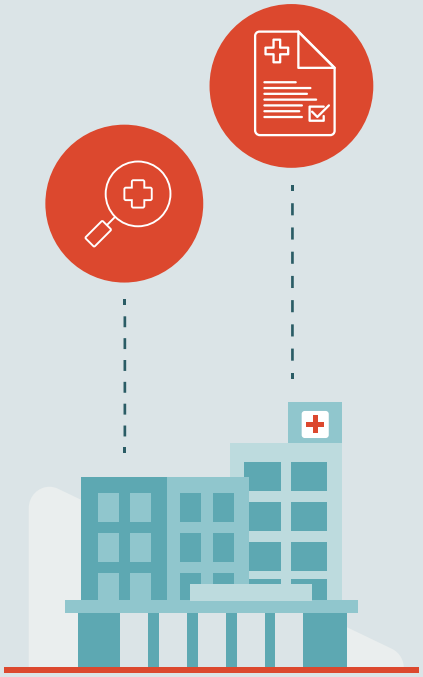

A Day in the Life of a Facesheet at Hendricks Regional Health

May 25, 2021

Hendricks Regional Health (Hendricks), a Magnet Certified Hospital serves suburban Indianapolis, Indiana. Since 2015, Hendricks has participated in a Caravan Health ACO. At Hendricks, bulk printing facesheets has become a daily part of the patient-provider experience.

The medical facesheet is a summary of important information about a patient. It includes patient identification, medical history, medications, allergies, upcoming appointments, insurance status and other relevant information. At Caravan Health, clients use the facesheet to ensure all pertinent patient information is noted and combined in one easy-to-access resource.

The daily journey of a medical facesheet

A facesheet is brought to life by a Hendricks office staff member two days prior to the patient's visit. First thing in the morning, a staff member prints the facesheet based on a daily primary care schedule and places it in a dated folder specifically for the provider. Hendricks typically uses the HCC sheets, but some providers also use the quality sheets in addition to using the patient EMR.

Prior to seeing the patient, the provider reviews the facesheet and local EMR to flag specific conditions and issues they are unaware of and/or need to discuss with the patient. The essential role of the facesheet is to help elevate awareness of chronic conditions, care history, and care gaps. Some patients have multiple chronic conditions and visits to different providers or even hospital admissions, keeping track of everything can be a challenge.

More than a printed piece of paper or the addition of a few diagnoses to a claim, the facesheet helps the providers monitor risk-adjustment and document anticipated changes with the patient. Without continued review and feedback, the provider's job is compromised; the facesheet helps to connect the myriad of moving parts. The staff and providers at Hendricks include maintaining a problem list which further helps to increase the quality of patient care and preventive care. Problem list management and ongoing communication is a key point of focus for the Hendricks staff and providers.

As the provider uses pertinent information from the facesheet, discussion points and conditions are documented in the EMR and used to determine the treatment plan. Following the patient visit the facesheet, having done its job, is placed in the shred bin.

"Risk-adjustment is not intuitive. Our consistent review and feedback are all part of our plan and we make sure our workflows include a problem list and a system of checks and balances that has open, transparent communication. This is a work in progress for us and we're realizing the benefits of facesheets and incorporating them into our best practice, team-based approach."

Linda Gaul, RN, CCS
ACO Quality Operations Manager & Champion
Hendricks Regional Health

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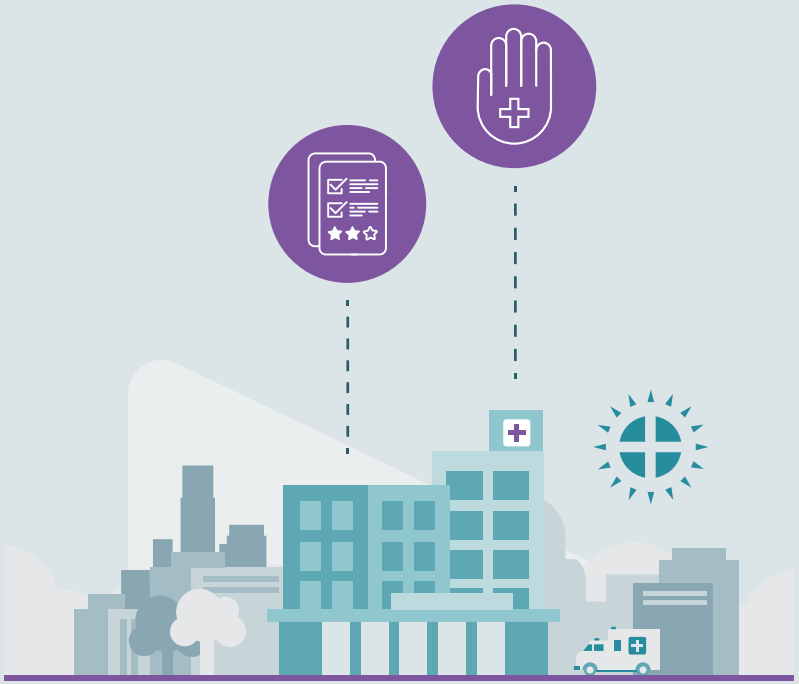
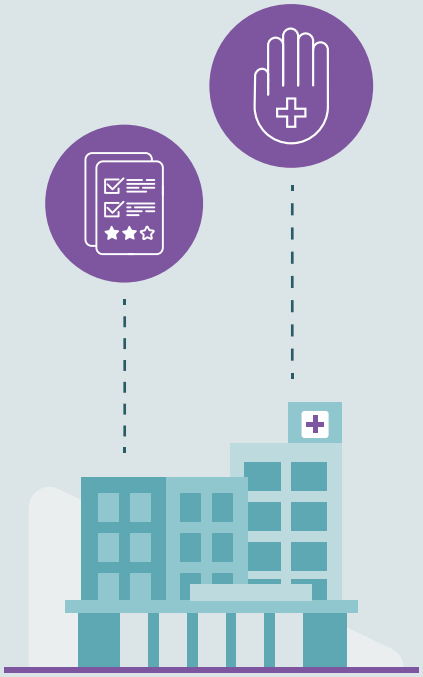
QUALITY MEASURES/PREVENTIVE SCREENING



Hancock Regional Hospital Highlights the Importance of Preventive Care

2020



Since 2015, Hancock Regional Hospital (Hancock), has participated in the Suburban Health Network ACO. Hospital providers and staff are well-versed in population health models of care and when the COVID-19 pandemic hit the nation the Indiana-based, health care facility focused on a core component of value-based care: preventive health care and proactive screenings.

Population health care emphasizes the importance of screenings in order to improve patient health. Population health nurses at Hancock stayed alert to not only their high-risk patients, but also to patients who may not present as high-risk but due to anxiety or apprehension were at increased risk for depression or other behavioral health illnesses.

As health care delivery was disrupted across the nation, Hancock nurses remained steadfast to preventive screenings. With concern for the ripple effect of anxiety, depression and isolation due to the pandemic restrictions, nurses proactively reached out to their patients with questions to facilitate open conversations.

One result of a proactive outreach call had an almost immediate effect on a house-bound patient. The patient's heightened fears about catching the virus resulted in her wearing a face covering inside her house. Despite it being summertime in Indiana, she was afraid to open her windows and the patient had grown increasingly isolated and hesitant to leave her home. Nurses were not only concerned for her mental well-being but also for her decreasing supply of food, medications, and other essentials.

On that call a population health nurse took the time to listen to the patient as she voiced her concerns and then explained specific steps for her to take to ensure that she was using best practices while not succumbing further to depression and isolation. In a follow up call a few days later, the patient's quality of life had improved, her fears had been alleviated, and while she was still concerned about the virus – her response fell into the normative range.

"We know that preventive care and screenings are important and our focus on these have been particularly useful for patients experiencing depression and anxiety during the public health emergency. It's always better to plan ahead and prevent a potential event than to have a reactive approach. Our proactive methods have helped improve outpatient care."

Tish Morris, RN
Hancock Regional Hospital

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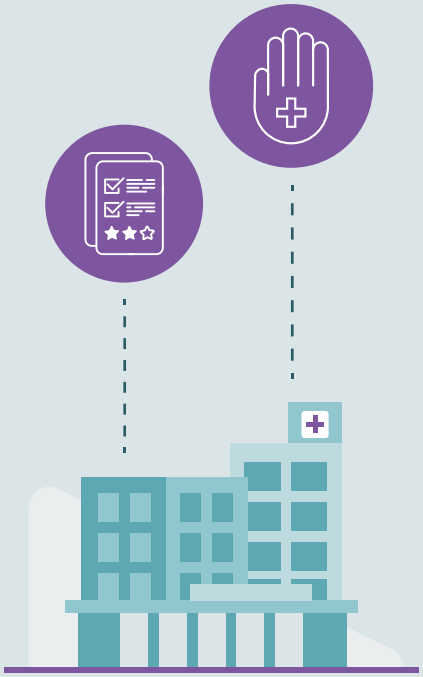
Hutchinson Clinic Removes Barriers So Patients Have Easy Access to Preventive Care

September 1, 2021



The Centers for Disease Control and Prevention (CDC) recommends that people get a flu vaccine by the end of October. However, they state that by getting the vaccination early, in July or August, is likely to be associated with reduced protection against flu infection later in the flu season – particularly among older adults.

Based in Hutchinson, Kansas, the Hutchinson Clinic (Hutchinson), joined Caravan Health's Stratum Med ACO in 2019. Staff and providers at Hutchinson are proactive with educating their patients about the merits of preventive care and one of those initiatives is encouraging their patients to get the flu vaccine.

Hutchinson's Flu Vaccine 7 Best Practices

Education & Marketing: Hutchinson commits to promoting their flu shot clinics and flu vaccine availability. They engage in social media, radio, flyers, posters, outdoor banners, and lawn signs to promote the flu vaccine.

Flu Shot Clinics: Hutchinson offers multiple flu vaccine clinics at convenient times and locations including walk-up and drive thru. One pediatric flu clinic is scheduled during evening hours with extra pediatric nurses available.

Immunization Registry: Through the Kansas Health Information Network, Hutchinson can import vaccine records from other facilities. Any time a patient has an encounter, the registry is queried, and vaccine data is automatically imported to the EHR.

On-Site Flu Vaccine Clinics for Corporate Partners: Hutchinson partners with employers in surrounding communities and makes on-site visits to administer flu vaccine to their employees – all which are documented in the EHR.

Pharmacy: An onsite pharmacy at one location offers flu vaccines. Hutchinson's pharmacy staff administers vaccines and documents in the EHR.

QIS Reminder: A current year flu metric has been added to Hutchinson's EHR to identify care gaps and mark reminders. Staff communicate to ensure the patient is reminded to get the vaccine.

Walk-in Care: Hours at Hutchinson's primary walk-in care clinic are extended, and patients can receive the vaccine anytime the clinic is open.

"At Hutchinson, we make a concerted effort to remove barriers and offer easy access for patients to receive the influenza vaccine. This requires cooperation and communication across many clinic departments and results in more of our patients receiving preventive care."

Lisa Jensen RN, BSN
Clinical Quality Coord
Hutchinson Clinic

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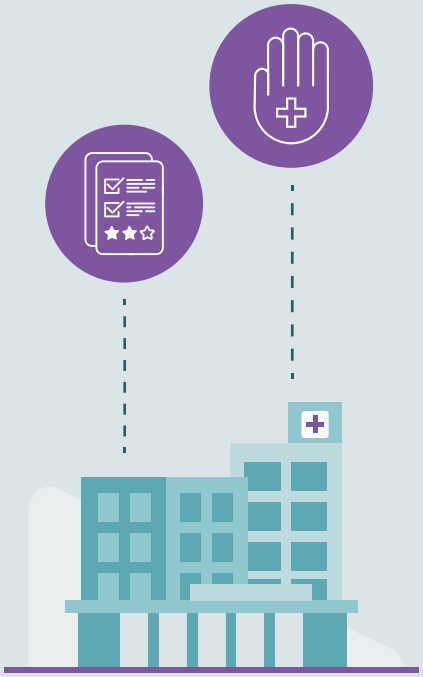
Mammoth Hospital Uses Patient Engagement Techniques to Help Patients with Depression

January 13, 2021



Since 2016, Mammoth Hospital ("Mammoth"), which serves the largely dispersed, rural communities of Mammoth Lakes, has been a part of a Caravan ACO. Rural residency is commonly cited as a risk factor for depression and providers at Mammoth, well-versed in population health practices, routinely take proactive measures to screen, prevent, and treat depression in their rural area.

Recently, during the COVID-19 pandemic and in the midst of social distancing and quarantining measures, a patient presented with a PHQ-9 score of 20 and a GAD-7 score of 3. He was diagnosed with a Major Depressive Disorder, single episode, severe with noted relationship problems and nicotine dependence. Mammoth providers initiated treatment that included a combination of in-person and telehealth visits. After four visits his symptoms had notably decreased and his PHQ9 score was a 6 – in the mild depression range.

The symptoms of depression including low motivation and energy often preclude patients from continuing treatment. As is common, this patient stopped attending visits. Mammoth staff, however, using best practice methodologies, re-engaged the patient and noted his scores had fallen to the moderately severe range with a score of 18. Mammoth staff continued to engage the patient, this time with a psychiatric consultation and medication assessment. Staff also encouraged the patient to attend in-person visits to help offset the isolation.

In a relatively short period of time with consistent visits and enhanced engagement, the patient's PHQ-9 scores returned to the mild range and he was effectively weaned from medication. Population health nurses have worked with the patient to identify his goals to help him find more meaning in his life. The staff have helped him improve his communication style, increase self-compassion, decrease his nicotine use, and establish healthy habits and behaviors. His depression score continues to improve and today is near the normal range.

The Top 3 Takeaways from this Patient Success Story

1. Continue to contact a patient with depression, engage and re-engage as much as necessary
2. Despite the health and safety benefits of telehealth, patients with depression may require more in-person visits to help keep them engaged and motivated to get better
3. Population health best practices such as helping a person with depression set goals and find meaning will help create new patterns of behavior and thinking

"When a patient has depression, it is important to understand that the symptoms of their illness often prevent them from returning calls and/or engaging in appointments. We knew his depression impacted his motivation and we took steps to reach out to him and worked to encourage him to attend virtual appointments. Eventually the appointments transitioned to in-person. Our efforts helped keep him be more engaged, especially through his lowest points."

Dr. Jacob Eide
Behavioral Health Clinical Supervisor
Mammoth Hospital

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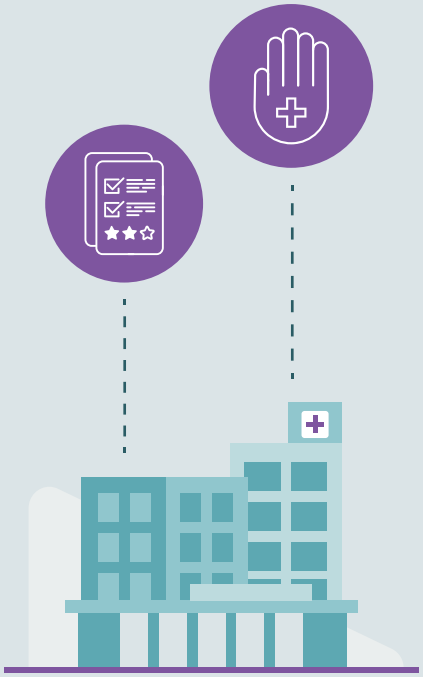

In a Community with Higher-than-Average Smoking Rates, Allen Parish Healthcare is Committed to Smoking Cessation Measures

January 25, 2021

Allen Parish Healthcare, part of the Caravan Health Crouse ACO, serves a rural community in Louisiana, a state with the third highest smoking rate in the nation. Only West Virginia and Kentucky report higher rates of smoking. According to the CDC, tobacco smoking remains the leading cause of preventable death and disease in the U.S. Cigarette smoking kills nearly 500,000 Americans every year.

In Louisiana, 22% of adults smoke. Aware of their higher-than-average rates, staff and providers at Allen Parish are committed to the Tobacco Screening and Cessation Intervention quality measure to help reduce smoking rates in their patients and community.

As part of an ongoing quality improvement effort, Meaningful Use incentive, the staff communicates with patients and asks about their smoking status and informs them of tobacco cessation counseling, educational resources, and enhanced wellness visits to help encourage them to stop smoking or to reduce their usage. With the goal of having fewer active smoking patients, the staff implemented a way to capture each patient's status in order to flag their provider to discuss the merits of tobacco counseling. They rely on their EMR to track their visits and increase the productivity and efficiency of their conversations – continuing to convey the importance of smoking cessation. With the EMR, each team member is able to see prompts to follow up and include specific measures as part of their workflows. Together, staff, providers and patients work toward achieving the collective goal of reducing or stopping smoking.

Despite being in an area with a high rate of smokers, Allen Parish patients have been cooperative and open to utilizing the resources to help them stop or reduce their smoking and have expressed an openness to screenings and cessation interventions. Today, Allen Parish reports that 92.9% of their patients have been screened and received intervention materials.

"Tobacco cessation and counseling reduces risk for many adverse health effects, including poor reproductive health outcomes, cardiovascular diseases, COPD, and cancer. Our clinic and providers have adopted a new vision for our clinic to promote wellness and educate our patients on the importance of being healthy in all aspects. It truly is a team effort in providing wellness care and promoting healthy living to our patients, and our team at Allen Parish Community Healthcare continues to strive to keep our patients healthy."

Alex Courville, M.D.
ACO Provider Champion
Allen Parish Community Healthcare

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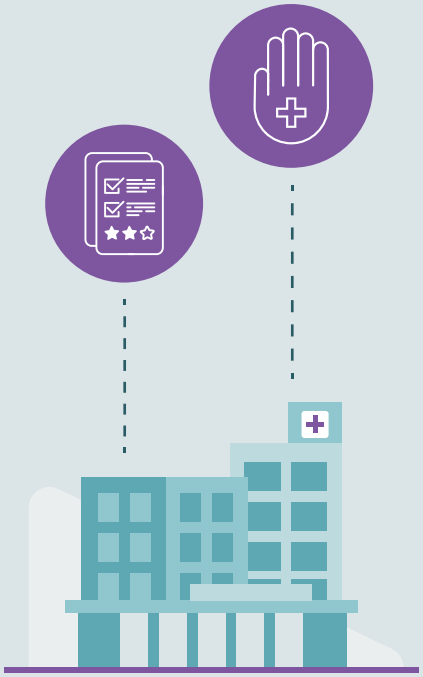
Marcus Daly Memorial Hospital Increases Depression Screenings by 60% in 12 Months

January 26, 2021



Located in Montana, the state with the unfortunate distinction of often having the highest suicide rate in the nation, Marcus Daly Memorial Hospital (Marcus Daly), serves a community that was weighed down by a recent teenage suicide. Members of the Caravan Collaborative ACO since 2016, staff and providers at Marcus Daly collectively agreed, "enough already."

Marcus Daly had established a team to focus on improving certain quality measures as part of their ACO goals. Working in concert with Caravan Health, they began to identify gaps in care, and it was clear that there was room for improvement on the Depression Screening and Follow-up Measure. The team immediately went to work to identify patients who had exhibited signs and symptoms of depression. They quickly learned that to make meaningful change in someone's life who is battling depression, their approach needed to encompass more than treating the symptom.

Using best practice population health techniques staff worked to overcome the stigma of talking about depression, including, at times, their own hesitancy to ask patients the PHQ-2 and PHQ-9 screening questions. It is a common challenge as staff often have to balance asking uncomfortable questions with keeping patients engaged. Staff, however, embraced the screenings, made the conversations more comfortable and included resources and printed materials when appropriate. They did not stop there. They implemented depression screenings in the ED, inpatient, swingbed, specialty and rural health clinics.

By the end of 2019, Marcus Daly reported a 60% increase in the Depression Screening and improved their rates of follow-up for those patients who tested positive. As the COVID-19 pandemic disrupted health care delivery everywhere, Marcus Daly staff continued their screenings resulting in positive change in their community. Today, Marcus Daly is working toward implementing a Behavioral Health Integration Program as they continue to emphasize the importance of mental health.

Marcus Daly Tips to Improve Depression Screening & Follow-up Quality Measures

- Create a committed interdisciplinary team that will meet regularly with a clear scope of the project
- A change in facility culture may be required regarding mental health
- The facts on depression are sobering and you need buy-in from front line staff by educating them on the importance of the screening measures
- Reach out to your state public health or national organizations for additional information and resources if needed
- Take care of your employees and co-workers. Remember, your employees and providers represent your community, and your own employees may have depression or may even be contemplating suicide. If you don't take care of your own, they can't take care of the community.
- Select a provider champion to talk to the other providers to roll out the plan, gain feedback on what is and is not working, and provide support
- Do not make Depression Screening the 'Flavor of the Month'. Create a plan that will continue to monitor that screenings are occurring, and providers have the resources to help the patients.

"We've gleaned information from our state resources and depression is one of the most treatable of all psychiatric disorders. Even more sobering is that up to 45% of individuals who die by suicide visit their primary care provider within a month of their death, with 20% of those having visited their primary care provider within 24 hours of their death. We were determined to improve our Depression Screening and Follow up Measures."

Mira McMasters, CPHQ
Quality Director, Marcus Daly Memorial Hospital

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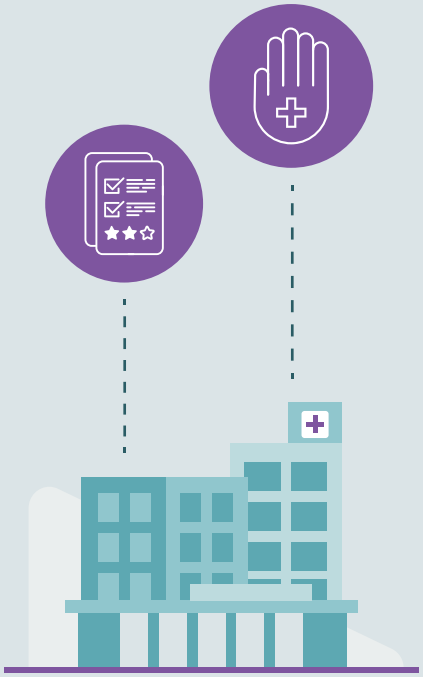
Fisher Titus Medical Center Reports 88% of Patients Have Completed Colorectal Screenings

March 16, 2021



Prior to Dec. 2018, Larry, a 73-year old patient had never had a colonoscopy screening. During his annual wellness visit, his population health nurse discussed the importance of the screening. He denied concerns of his family history with colon cancer but reviewed the risk factors as well as common misconceptions about the screening with his nurse. Larry was resistant to having the screening but agreed to completing a Cologuard Kit. He agreed that if the test was negative, he would repeat it again in three years but if the test was positive, he would consider the colonoscopy. Much to Larry's surprise, the test was positive, "I was really surprised; I was not having any problems." He agreed to have the colonoscopy which resulted in the removal of 10 polyps, including four tubular adenomas and one tubulovillous adenoma.

Larry's experience is typical of patients who aren't concerned with or educated to the importance of preventive screenings. Population health methodologies are founded in preventive care that lead to early detection. Larry expressed his appreciation to the nursing staff for taking the time to demonstrate how to complete the Cologuard testing. Their willingness to explain the steps and answer his questions helped to encourage him to complete a screening that ultimately led to early detection.

Since 2016, Fisher Titus Medical Center (Fisher Titus) has participated in the Caravan Collaborative Pathways ACO. When data demonstrated that Fisher Titus was not meeting the measures for recommended colonoscopy screenings, they began to emphasize the importance of the screenings. One of the biggest challenges was overcoming patient resistance. They expressed concern about the prep, the bad-tasting liquid they were required to drink and a painful procedure.

Trayce Hanlon, LPN, the Population Health Facilitator at Fisher Titus could relate to her patient's concerns. She was overdue for her first colonoscopy screening and decided to use this a catalyst to not only complete her personal screening but to also be able to describe, first-hand, the prep and procedure to her patients. She learned that not all prep kits were the same – some had tastier drinks than others. She also began offering Cologuard kits and provided additional information and visual education aids to help her patients better understand the procedure.

To her delight, the patients have responded well. Providers have noted the increase in the numbers of patients completing the screenings. At mid-year, 2020, during the pandemic, Fisher Titus reported that 88% of their attributed patients had completed their colorectal screenings."

"Having additional educational pieces available that can either be reviewed with your patients during their office visit or on display in your waiting room helps them to better understand. Our patients have responded well when we've taken the time to review and discuss the available options."

Trayce Hanlon
Population Health Facilitator
Fisher Titus Medical Center

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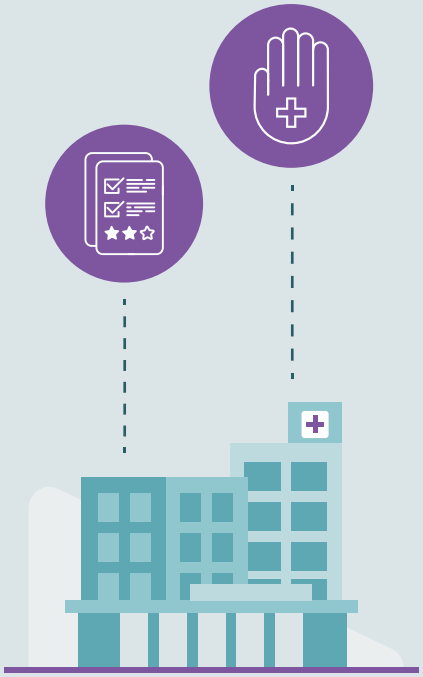
Dorminy Medical Center Initiates Pilot Program to Increase Depression Screenings & Improve Outcomes

March 30, 2021



Rural populations experience more adverse living circumstances than urban populations and tellingly, the prevalence of depression is slightly, but statistically significantly, higher in residents of rural areas compared to urban areas. The COVID-19 pandemic and the resulting economic recession has negatively affected many people's mental health and created new barriers for those already suffering from mental health disorders, including depression.

Many rural providers have placed more emphasis on depression screenings in order to successfully intervene when necessary. Dorminy Medical Center (DMC) serves the rural community of Fitzgerald, Georgia and has been a participant in the Caravan Collaborative ACO since 2016. Staff and providers have been trained in value-based care methodologies which place emphasis on preventive screenings.

Population Health Nurse, Michelle Seagroves, noticed that they were only capturing quality measures for patients who had an Annual Wellness Visit (AWV) – patients who had not yet had an AWV did not have these important measures captured. As staff continued to increase their AWV performance, they decided to initiate a pilot program in one primary care practice to expand the depression screening to visits other than the AWV.

The pilot program was implemented to determine any differentials in patient outcomes. Led by Connie Spires, they verify whether or not a PHQ-9 screen has been performed with every non-AWV Medicare visit or every three months. If there is not a preventive screen on record the patient is screened, the results are documented, and a follow up plan is recorded. Staff and providers participating in this pilot program communicate daily to ensure that patients who meet the criteria are properly screened and follow-up support is provided to patients.

The expectation is that the pilot program will be a success and staff and providers will demonstrate an improved rate of screenings and interventions when indicated. The long-term plan is to deploy this process in all six DMC primary care practices with the goal to increase measure performance and improve patient outcomes.

"Depression can have long-term, detrimental effects on a patient's health and well-being. It can also negatively impact their family members. Our goal is to continue to increase our rates of depression screenings – if we can intervene, we will increase our quality of care and our patients will experience better outcomes."

Michelle Seagroves
Population Health Nurse
Dorminy Medical Center

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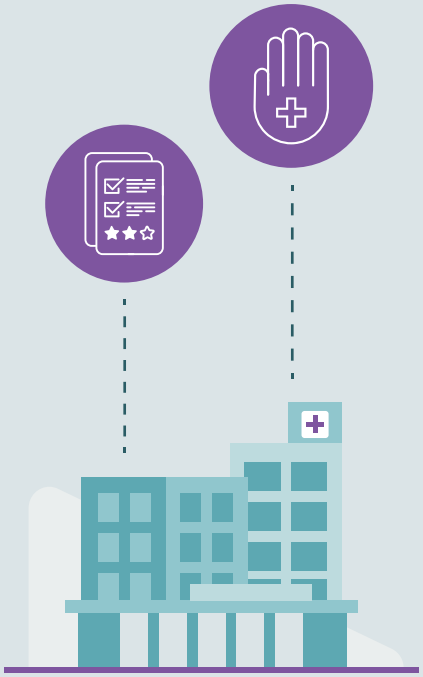
Sullivan Community Hospital's Increase in Depression Screenings is Benefiting Their Community

April 13, 2021



Since 2016, Sullivan Community Hospital (SCH) has participated in Caravan's Collaborative Pathways ACO. SCH serves a rural community in Indiana and in the past year placed more emphasis on depression screenings with the goal to intervene when necessary to either treat patients who are experiencing depression or prevent symptoms from escalating.

SCH staff began increasing their rates of screening by incorporating their screening efforts with every Medicare AWV and CCM care plan. These efforts have led the staff to identify multiple patients in need of mental health services. The dedicated population health staff did not stop there. They have not only focused on their Medicare patients, but they have also expanded their PHQ-9 screenings clinic wide to all appropriate patients. Their goal is to ensure they are asking the right questions and initiating follow up for those patients in need.

It's ok to not be ok.

The enhanced efforts have paid off. The staff has been able to successfully identify multiple at-risk patients and have collaborated with their primary care clinics, their outpatient behavioral health program (Turning Leaf), and their local counseling centers. Every patient with a positive screen (>5) receives a follow up call from staff to probe further and identify specific patient needs for intervention. The staff are dedicated to working to eliminate the stigma attached to mental health and are consistent with their message that "it's ok not to be ok". The staff meets patients where they are – meaning, they provide assurance that they are there to help and that judgments and concerns about what other people might think are neither reasonable nor welcome.

This team-based approach focuses on holistic, whole person health care which doesn't limit their care to medical needs but incorporates multiple areas that contribute to someone's overall wellness including, but not limited to, emotional, social, financial needs and intellectual capabilities. SCH patients understand that they have an advocate and someone they can call in a time of need. By asking the right questions, suggesting referrals, and offering follow up support the SCH staff is committed to the overall health of their community so that their patients are ultimately healthier, happier and safer.

"With an emphasis placed on incorporating the PHQ-9 routinely, we have engaged our patients and our staff. Depression is on the rise across our country, and we are taking a proactive approach to intervene and treat whenever possible. It is incredibly important to ask patients how they are feeling. People are at risk of feeling more isolated than they ever have been so asking the right questions is imperative."

Ashley Kilpatrick, RN
Director of Care Coordination
Sullivan Community Hospital

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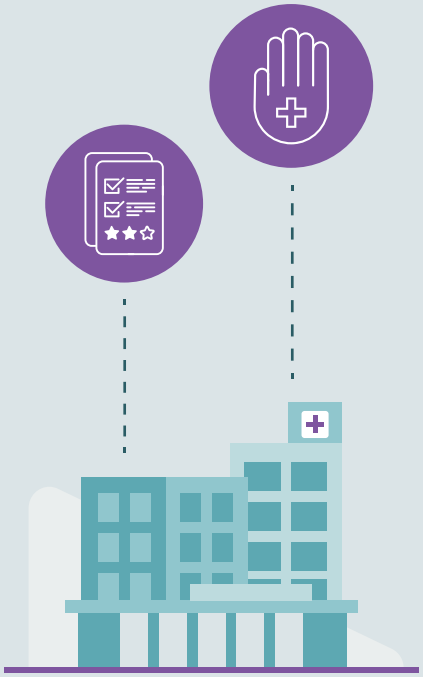
Helen Newberry Joy Hospital Increases HTN2 Measure to Lower Overall Hypertension Rates

April 27, 2021



Helen Newberry Joy Hospital (HNJH), has participated in a Caravan Health ACO since 2016 and serves a rural patient population in the northern-most reaches of Michigan. Aware that hypertension increases the risk of heart disease and stroke, two of the leading causes of death in the U.S., staff and providers at HNJH wanted to be more proactive with their preventive HTN2 measures. This measure helps screen for high blood pressure and the staff initiated a program to improve their preventive measures across their patient base.

The hospital has reported a successful increase in preventive screenings. To learn more, we recently talked with Allison Blakely, Clinic Quality Supervisor at HNJH.

What was the catalyst behind the decision to place more emphasis on HTN2?

"Hypertension is something that HNJH had focused on in 2019 and will continue to concentrate on this measure due to the high rate of hypertension diagnosis within our community. Understanding how hypertension is the starting point for many disease processes made this focus all the more important."

What were some of the biggest challenges you experienced and how did you overcome them?

"I believe two of the biggest challenges that HNJH faced was documentation of more than one blood pressure during a visit and also having patients return to have a blood pressure check at another time. To combat these issues we brought up case examples of how taking an additional blood pressure reading and documenting this in the chart helped to see whether the patient was well controlled and if further intervention was needed. Many examples brought up had a lower blood pressure reading during the visit that may not have been documented. If it had been we would see that the patient was on the correct therapy and did not need further interventions to help control their blood pressure. The second issue regarding getting patients back in for a return visit was tackled by making sure that patients were educated on what the return visit would consist of. The patient would be informed by staff that when they were to return for a blood pressure check it could be a nurse visit and something that would be quick and not billed. This improved numbers as well since patients knew what to expect and eliminated the assumption that it would be a long and costly visit."

How have your patients responded?

"Patient responses have improved! We will continue to track and encourage patients to return for blood pressure checks as needed."

Can you share any data or outcome results?

"Our patient return rates have improved."

What advice do you have for other practices interested improving performance on this measure?

"Explaining the process to staff and encouraging all staff to educate the patient on what is expected is one great way to start. Many times patients do not what to voice their concerns about time and money. With education, patients do not have to ask these questions and we can help reassure that this will not be a major disruption to their day or their bank account."

Any patient success stories?

Andrea Marsh, Care Coordinator added, "We had one patient who did not want to come in due to the time they thought it would take to have a blood pressure check. The patient was a CCM patient and expressed to the Care Coordinator that they did not have the time to devote to coming back in for a visit. The Care Coordinator explained the process for a blood pressure check and that it would only take a short amount of time. This education provided by the Care Coordinator helped ease the patient's concerns and increased their blood pressure follow ups."

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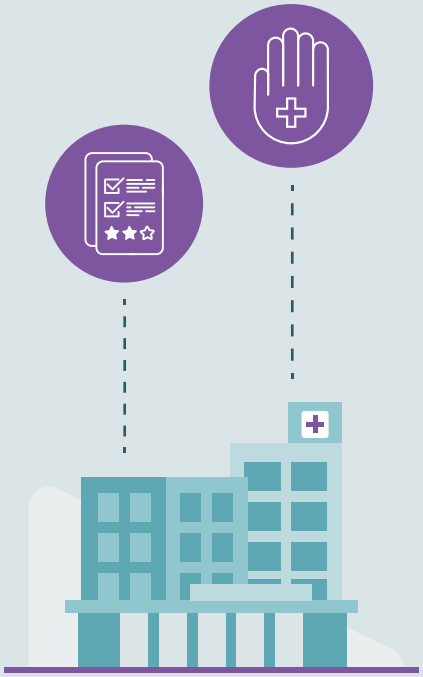
Schoolcraft Memorial Hospital Takes a Proactive Approach with Depression Screenings

October 5, 2021



Located in Manistique, Michigan, Schoolcraft Memorial Hospital (SMH) joined Caravan Health in 2016. As active participants in the Caravan Health Collaborative ACO, staff and providers have become experts at value-based care using population health methodologies.

When the Quality Team at the SMH clinic started their Behavioral Health Program they began placing more emphasis on depression measures by increasing depression screens. SMH's behavioral health team consists of two therapists, a psychiatric nurse practitioner, and a care coordinator who focuses on this patient population.

SMH set a goal to perform an annual depression screen on all patients aged 12 and older and more often if indicated. The care coordinator conducts a depression and anxiety screen on her patients every time she speaks with them. Follow-up guidelines and codes are shared with providers and the numbers of screens are monitored by staff each week. If the numbers of screens decrease, a reminder is sent to the clinical teams in their daily huddles and weekly emails.

Regular updates and reminders to the clinic teams are vital, and the consistency of screening helps staff maintain a continuity of patient care. At SMH, preventive screenings are a routine part of the patient experience – purposefully built into the culture.

Becky, SMH's Care Coordinator, employs motivational interviewing skills with her patients. Recently an elderly patient was having a particularly bad day. When asked what would make things better, the patient replied simply that she loves cream pie. Later that day, Becky baked her patient a cream pie and delivered it to her house.

While pie-baking and delivery is clearly a step above and beyond holistic care, SMH's improved scores on the PHQ9 and GAD 7 indicates overarching success. Over the course of three years, SMH has tracked 25 behavioral health patients with chronic conditions and some patient scores for both depression and anxiety have decreased.

"Our team at Schoolcraft Memorial recognizes the relevance of depression screening and how it can help to provide overall quality patient care – especially during this extended public health emergency. The screening has become part of the integration of behavioral and mental health and contributes to the patient's overall health outcomes."

Kimberly Shiner
Director of Compliance and Quality
Schoolcraft Memorial Hospital

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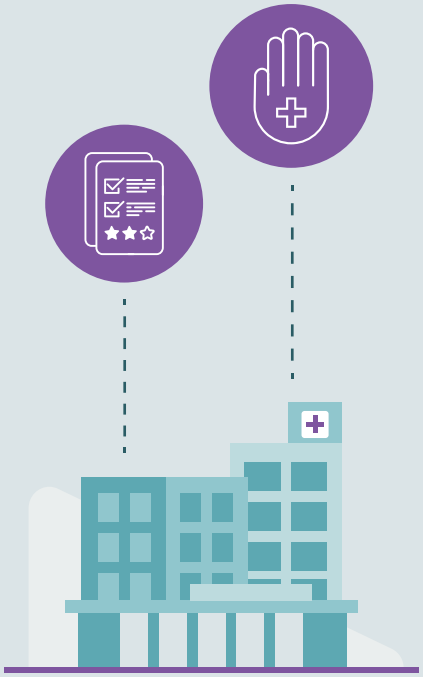
Reid Health Implements Preventive Measures to Improve Patient Care

October 12, 2021



Serving an expansive patient base in Richmond, Indiana, Reid Health has participated in a Caravan Health ACO since 2015. Staff and providers rely on Epic for their EMR and are realizing population health success in the Caravan Collaborative Pathways ACO.

Reid Health strives to provide the highest quality care while ensuring the safety of their patients, employees, and providers. In order to achieve their goals and continue improving the quality of care, the organization identified four key preventive care initiatives to implement in 2021.

FluFOBT Program

During the month of October, Reid Health has implemented a program to increase their numbers of colorectal cancer screenings. When patients come in for their influenza vaccine staff take the initiative to talk with them and screen for appropriateness to receive a take home colorectal cancer screening kit with instructions.

Controlling High Blood Pressure

Reid Health utilizes Vivify Health, a mobile remote care management platform. This program allows providers to order remote patient monitoring for up to 90 days. With this service, patients can monitor their blood pressures from home and upload their readings from their blood pressures cuffs to their assigned iPads via Bluetooth capabilities. Reid Health has a process of notifying providers if a patient has two consecutive blood pressures out of range (>140/90) and provides a query form to place an order for Remote Patient Monitoring (RPM). Within the first month, staff and providers realized an increase in our RPM orders.

Breast Cancer Screenings

Reid Health's quality team implemented a process to review a list of women due for mammograms. Each patient is contacted if they are not already scheduled for an appointment.

By generating a monthly report from their EHR, Reid Health staff reviews patients who have not had an AWV and follows a schedule of proactive outreach calls to encourage them to have the preventive screening. The initiative has proven to be a success and the staff has seen an increase in mammograms. Any patient who declines or postpones is added to an outreach contact list and staff continues to communicate and educate them to the benefits.

Depression Remission Screening

Similar to Reid's mammogram outreach protocols, patients who are due for their follow-up PHQ9 screening are contacted if they do not have an appointment scheduled. For those who don't have an upcoming appointment within the specified timeframe, three attempts are made to reach the patient by phone and the PHQ9 screening questions are completed and documented as a telephone encounter. The PHQ9 score is relayed to the provider. This initiative also been a successful – Reid Health staff have effectively closed care gaps.

"One of Reid Health's guiding principles is to provide an excellent patient experience by exceeding industry standards and stakeholder expectations. In order to help reach our goals, we identified opportunities for improvement with our quality measures and implemented improvement strategies this year which has proven to be successful."

Heather McDaniel, RN
Reid Health

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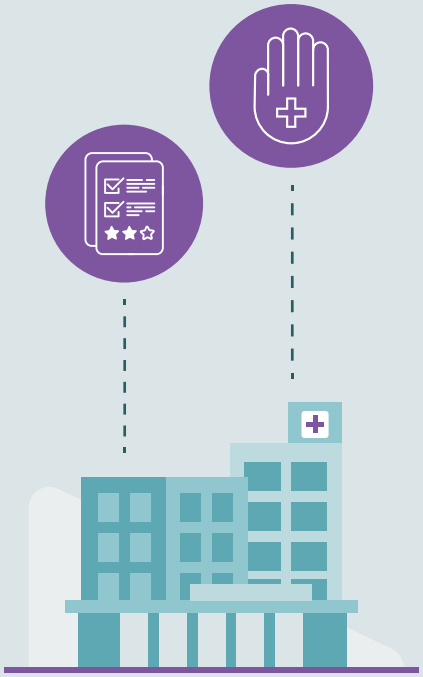
Patient Quality Alliance Emphasizes Diabetes Screening to Better Manage Patients

November 2, 2021



November is American Diabetes Month. Diabetes is a recognized epidemic that has no cure, yet more than 35 million Americans are living with diabetes, representing 10% of the U.S. population. Between 1990 and 2010, the number of people living with diabetes tripled and predictive analyses suggest the total number of Americans with diabetes will reach 54.9 million in 2030.

At Caravan Health we recognize the challenge our clients face in effectively managing patients with diabetes. We are currently developing analytic tools and reports that allow clients to better identify impactable diabetic patients. Additionally we will be showcasing technology-enabled clinical programs that allow clients to better track their patients and provide evidence-based interventions when appropriate. These interventions will empower Caravan clients to improve the quality of life for diabetic patients. Patient Quality Alliance is one example.

The staff and providers at Patient Quality Alliance (PQA) in Pocatello, ID participate in the Caravan Health Collaborative ACO and use the Epic EMR. PQA's Chief Medical Officer and care management and data analytics teams have increased their focus on the Diabetes Mellitus: Hemoglobin A1c Poor Control (DM-2) which has resulted in improved A1c's for their patients and better management of their diabetes through diet, exercise, and other lifestyle improvements. In 2019, PQA's measure rate was 21.83% and by mid-year of 2021, the rate had improved to 16.56%.

We talked with Valerie Yv. Woolsey, MBA, Executive Director at PQA to learn more.

What motivated you to focus on this Diabetes measure?

PQA really dove into chronic condition follow-up in 2021. We know when chronic conditions are not well managed it can lead to other chronic conditions. Diabetes is the perfect example. PQA care managers, Abby Wilson, RN and Katelyn Chandler, RN, provided education and 1:1 rounding with clinic care managers across the network. They focused on the value and importance of scheduling patients according to best practice recommendations. This included evaluating and educating them to quality improvements in everyday processes. It has helped PQA ensure patients aren't falling through the cracks. Abby and Katelyn are the backbone of our PQA care management team, staying consistent, maintaining touchpoints, and providing support.

What steps did you take to engage your staff and patients?

With clinical staff throughout the network, PQA's care management team developed education on implementing successful workflows for getting patients on the schedule. Successful diabetes management cannot happen without actually seeing patients. This couldn't have been done without the influence of PQA Chief Medical Officer, Dr. Kelli Christensen, who supported the providers with provider-specific education and support. For our network care management monthly education, she implemented the concept of 'Chronic Condition Spotlight'. After teaching the core concepts of chronic condition follow up, she put the spotlight on diabetes to connect to purpose. This meant discussing a case study example and walking through steps to providing excellent care management, coordination of care, including what the follow-up for a person living with diabetes would look like from a clinic perspective. This gave us a chance to highlight the positive impact these steps would make in the life of someone living with a chronic condition.

What lessons have you learned that can be shared with your Caravan Health peers?

Consistency is key. The greatest athletes excel because they can power through the tedious routine of consistently showing up to train every day. PQA takes pride in helping our clinics stay consistent. Everyone is working toward the same goal: taking great care of patients and helping them live the healthiest lives possible. PQA is heavily invested in doing what is best for the patient. Sometimes this means taking a time out, focusing on a chronic condition such as diabetes, and reconnecting the value of everyday processes with 'why' showing up and staying consistent helps the patient.

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SOCIAL DETERMINANTS OF HEALTH

Helen Newberry Joy Hospital Nurses Impact Social Determinants of Health & Improve Care

2020

Population Health nurses at Helen Newberry Joy Hospital (HNJH) serve a rural community in the eastern Upper Peninsula of Michigan. HNJH has been part of Caravan's collaborative ACO since 2016. In addition to delivering value-based care, the nurses are dedicated to taking advantage of continuing education and training opportunities that help to enhance their skills.

Following the first week of a Caravan Health PHN training on communication styles, Population Health Nurse Andrea Marsh, had the opportunity to use her new skills in a challenging patient situation. She had been working with an underserved, disadvantaged family with a Chronic Care Management (CCM) patient who lived with some complex medical challenges. Throughout their entire care history, it was assumed the daughter was the most competent person to receive and disseminate written instructions. While the daughter was amenable, Andrea noted inconsistent follow through. In time, with more conversations with the extended family using her new communication skills, Andrea discovered that the family spokesperson could not read.

Today, the nursing staff intervenes as necessary to ensure that whenever written instructions are provided, they invest more time talking with the daughter, using visual aids with symbols and drawings to ensure she understands. The nurses are continuing their collaborative efforts with the family to ensure that care, instructions, and communication works for them. Communication has been significantly improved and customized which has resulted in better care for the entire family's health and well-being.

"Population health relies on good communication skills. I wanted to enhance my patient care and to improve our team dynamic with higher quality skills. We are continuing our focus on efficiency and team-based care and with each new experience our team learns and shares best practice techniques."

Allison Blakely, RN
Helen Newberry Joy Hospital

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First Care Uses Population Health to Improve the Patient Experience

April 6, 2021

Population health methodologies are founded in nurse-led care with an emphasis on preventive measures. Value-based care results in improved patient outcomes by opening doors to better access to health, enhanced collaboration, and improved communication. First Care has participated in a Caravan ACO since 2016 and are currently active members in the Caravan Collaborative. First Care staff and providers have been trained in population health and had a successful transition to value-based care.

In one recent example of a successful population health experience, First Care staff was working with a patient who had experienced three hospital admissions and four ED visits in a recent three-month period. The patient, a 64-year old woman with a history of CHF and COPD, has also battled alcoholism. She lives alone and relies on her son for transportation and other aspects of her care, but his job frequently requires him to be away for a week at a time. There are times when she is in need and he is not available.

Solving the social determinants of health for patients typically requires a variety of solutions, particularly when there are family members who are willing to help. It is important to include family members who want to be involved while making sure the patient's best interests are the priority.

Due to her son's schedule, there were times the patient delayed care because he wasn't available. This resulted in repeated calls to 911 and ED visits that could have otherwise been prevented. Following a hospital admission in November, during a COVID-19 surge, her son wanted to admit her to a long-term nursing facility. However, when the nurses followed up with the patient, they learned that she did not understand the nursing facility would be long-term and wanted to live at home.

The staff at First Care employed population health techniques and worked with both son and patient to find an outcome that was in her best interest. Despite his hesitancy, the son worked with the staff as he understood that her mental health and well-being was essential.

Today, the patient is living at home with a strategic schedule of PT and OT and home health visits that are ensuring her needs are met. Her son was involved and found a metered alarm that reminds her to take her medication. He also fills her medication dispenser each week before he leaves for the workweek – this device unlocks each day at the time she needs to take the medication and sends her an alert. The new plans have been a success and today, she is working virtually with a counselor to address her alcohol dependency and she has also begun to exercise. Her physical and mental health is remarkably improved. Both patient and her son are strong advocates for the First Care team and has recommended their primary care services and CCM to friends and family.

"Population health connects the dots in so many ways. Our focus on this patient resulted in improved chronic care management which resulted in improved patient outcomes. Our team-based approach is successful for our providers, our staff and our patients."

Shelle Berg
First Care

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Bay Clinic Addresses Food Insecurity with a Veggie Rx 'Farmacy'

June 15, 2021

Since July 2019, the Bay Clinic has participated in a Caravan Health ACO, and staff and providers place an emphasis on improving population health. When their Social Health Department Director, Sarah Cornelison, read about a neighboring community health improvement plan she wanted to learn more about implementing a Veggie Rx program for their patients experiencing food insecurity.

Working with the local food bank to provide fresh foods, they partnered with a non-profit corporation that provides assessment, training, and employment of people with disabilities in various capacities. They worked together to secure refrigerators and food sources. Staff and providers started using a SDOH screening tool and chronic disease diagnoses as criteria to qualify patients for fresh veggie assistance.

Bay Clinic's Veggie Rx Farmacy has been in full operation since mid-January 2021. After a provider identifies an unmet need, a referral is sent to the Social Health Department who works with the patient to establish goals. Any patient who meets the criteria and wants to participate can receive services through the Veggie Rx Farmacy. Each patient receives a portion plate, reusable produce bag, information packets based on the reason for referral and decorated water bottles and pencils and stickers featuring fun vegetables for children.

Since the program began, Bay Clinic has served an average of 60 or more patients and their families every Thursday. Despite having a designated date and schedule for the Farmacy, patients are never turned away regardless of the day when there is a need.

Patients participate for multiple reasons and range in age from pediatrics to adults. Some want to lose weight and need access to fresh vegetables; others need to gain weight but need to avoid items high in sodium due to diagnoses such as congestive heart failure. Families enjoy bringing their children and spouses to select and discuss new and different types of fruits and vegetable available. Patients have sent the staff pictures of the foods they have cooked at home using the produce. The Veggie Rx program has been an overwhelming success.

For anyone interested in starting a Veggie Rx program, the Bay Clinic staff recommends contacting local food share services to learn how your office could set up a pantry or Veggie Rx Farmacy program to fight hunger and help prevent social determinants related to food insecurity. Partnering with a non-profit helps to reach more patients with fresh fruits and vegetables.

"Out of the numerous things I do in care coordination for families, the Veggie Rx program is the most rewarding. I love seeing patient's faces light up when they see all of the new produce we have."

Heather Garrett
Certified Community Health Worker, Bay Clinic

"We identified the need our patients had to access fresh fruits and vegetables. With limited community transportation playing a factor in our rural area, we worked to develop a program that would minimize the transportation problems of our patients and allow them the ability to access a food pantry for those with food insecurity and a Veggie RX 'Farmacy' program for those on a limited budget with health-related determinants within their medical home. We are truly putting population health into action and working to not only screen for social determinants of heath but to also build solutions to the problems".

Sarah Cornelison CCMA, CCHW
Social Health Department Director, Bay Clinic

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Hancock Regional Health Helps Patients Address Medical & Social Challenges to Improve Outcomes

July 20, 2021

In Greenfield, Indiana, Hancock Regional Health (Hancock) delivers high-quality, value-based care to their community. The full-service health care network has participated in a Caravan Health ACO since 2015 and are current members of the SHO ACO.

With staff and providers well-versed in the nuances of population health, Hancock understands that patient compliance may not always be what it seems – sometimes social determinants of health (SDoH) are at play. The health system works in concert with Healthy 365 (H365), their social services department, and their Care Coordination team to make sure patients have the resources to address obstacles that prevent them from accessing health. In some situations, patients who may present as being non-complaint are dealing with challenges that keep them from being compliant and many do not know they can discuss these challenges with their providers.

Population Health Makes a Difference

A patient at Hancock presented as non-compliant with a suggested medical regime. In other, non-population health facilities, the patient would likely have been labeled as non-compliant. However at Hancock, the staff wanted to learn why the patient – who seemed interested in following through with instructions – was not doing so. After a conversation with the patient using population health methodologies, the population heath nurse discovered that the patient was struggling to pay their monthly rent. With money tight, the patient could not justify spending the money on transportation to the office when it could jeopardize her housing.

In this case and many similar, the Care Coordination team communicated with the H365 team. Together, they discussed the challenges the patient was facing. The H365 team stepped in to assist the patient in applying for financial assistance. They also coordinated rental assistance and worked with the patient to identify other social determinant challenges.

Population Health Takes a Team

Hancock recognizes that comprehensive team-based care helps improve outcomes by not only focusing on their patient's medical needs but by also placing emphasis on their patient's social needs. Hancock holds a quarterly meeting with their 50 social service providers to discuss new programs or problems encountered while seeking services. In addition, a care team manager attends a monthly board meeting to ensure a continuity of care through a continuity of communication.

"At Hancock we understand that our patient's health is comprehensive and in some cases that includes addressing social determinants of health. If a patient presents as non-compliant, we learn the core cause of their non-compliance and work to overcome the challenges together."

Susan Neely, RN, MSN
Chief Clinical Officer
Hancock Regional Health

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Community Memorial Health Systems Use Team-based Care to Address Social Determinants

August 10, 2021

Community Memorial Health System (CMHS) joined the Caravan Health Collaborative ACO in 2021. The Ventura, California-based health system includes a 242-bed hospital which also serves as a community-based teaching facility.

Accountable health care incorporates a range of population health methodologies including a team-based care approach. Team-based care involves a variety of health care professionals, including office personnel and CNA's who often help to identify patient needs.

Recently, CMHS's Chronic Care Management team referred a patient in acute need to a Case Manager. The patient, who had cirrhosis of the liver, was extremely ill. He was living in his car and suicidal. He had a history of repeated visits to the ED which is indicative of a chronic issue and can be very costly for a facility.

Research has shown that in some cases, social determinants can be more important than health care or lifestyle choices in influencing health. For example, according to the World Health Organization, numerous studies suggest that social determinants of health account for between 30 and 55% of health outcomes. Providers and staff at CMHS understand that addressing the social determinants of health is fundamental to improving health and reducing longstanding inequities – like experiencing homeless and suicidal ideations.

The CMHS Case Manager immediately went to work for the patient and secured housing for him under a special homeless assistance project. In addition to housing assistance, the Case Manager started the process of helping him to apply for disability benefits, referred him to food pantries and kitchens, and enrolled him into the CMHS Behavioral Health Integration program.

Today the patient's health and housing have been stabilized. He is being treated for his cirrhosis and also seeing a psychiatrist. He is receiving long-term disability which is helping him to maintain his housing. CMHS staff continue to work together in a team-based approach to improving patient outcomes.

"Through our population health methodologies, we identified a patient experiencing homelessness who was repeatedly going to the ED and we intervened. Repeated ED visits are always a sign of a more comprehensive problem. Our High-Risk Case Manager helped get the patient in a stable medical situation and worked with other social service teams to provide resources and support."

Maureen Hodge
Manager High Risk
Community Memorial Health System

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Lake View Memorial Hospital & Medical Clinic Address Patient Health Literacy

November 30, 2021

Lake View Memorial Hospital and Medical Clinic (Lake View) is located in Two Harbors, Minnesota. Since 2015, Lake View staff and providers have collaborated on their Care Coordination Program with the goals to encourage preventive care and assist patients experiencing chronic illnesses.

J.C. has been a patient at the Lake View Medical Clinic for many years. She has a myriad of health problems including 15 chronic conditions. For years she has experienced uncontrolled diabetes which has resulted in a kidney transplant and vision loss.

Living alone on a fixed income, J.C. takes multiple medications each day. Because her medical co-pay expenses are high, she has worked with Robin Glaser, Lake View population health nurse, to obtain the medications from a Canadian mail order program at a reduced price.

Robin had offered her patient the opportunity to enroll in care coordination, but J.C. was hesitant due to concerns about her limited income. J.C.'s health continued to be compromised however, and she was diagnosed with cardiac atrial fibrillation which typically requires patients to take high-priced medication. Despite the added burden of the additional meds, J.C. again dismissed the opportunity to enroll in Lake View's care coordination program.

Robin continued to work closely with J.C. and as her patient developed more trust, Robin explained the benefits of care coordination. When J.C. stopped by Robin's office one afternoon, distraught and overwhelmed with her high-priced medications, Robin took another collective step forward with her patient.

With the understanding that health literacy is a national problem, and the fact that nine out of 10 Americans lack the skills to effectively manage their health and prevent disease, Robin sat with J.C. and listened to her patient's concerns about the cost of medications. Robin talked with J.C. about her social security income and her living expenses. In uncovering more information on her patient, Robin realized she would qualify for financial and patient assistance through some of the drug manufacturer's programs.

After spending more time with Robin, J.C. not only enrolled in three programs designed to deliver medications at no cost to her home but also agreed to participate in the care coordination programs. J.C. has been so pleased with the benefits of care coordination that she referred a friend.

"Patients don't always understand what it means to be in care coordination. I often tell them that I am the go between for them and their physician - the one who will follow up with answers and make sure they understand it. When we meet our patients where they are and recognize that medical jargon doesn't always make sense to them, we help them become active participants in their health care."

Robin Glaser
Care Coordinator
Lake View Memorial Hospital and Medical Clinic

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TEAM-BASED CARE

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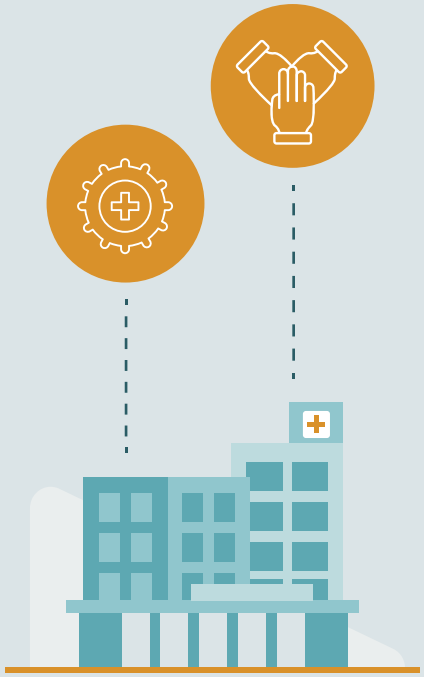
Confluence Health Joins ACO & Successfully Transitions to a Nurse-led Approach to Care

2020



Confluence Health (Confluence), located in Wenatchee, Washington, is the major medical provider between Seattle and Spokane. More than 300 physicians and 150 advance practice clinicians serve patients in the integrated health system that includes two hospitals and more than 40 medical specialties. Confluence joined Caravan's Stratum Med ACO in the summer of 2019.

Patient care had always been a top priority with staff, however, prior to joining the ACO they did not have standard workflows in place to facilitate communication between primary care departments. The Caravan team worked with Confluence staff to restructure the case management team processes. The new workflows enabled the 10 case managers to complete AWV intakes for the 130+ primary care providers in 14 different locations. This gives every patient the opportunity to receive case management services including support for the social determinants of health.

Helping patients "get through the medical maze."

Corinne Loyd, Confluence TCM Nurse Case Manager, recently shared one case – among many – where the restructured case management made a difference in a patient's life. When Corinne contacted the terminally ill patient for TCM, she learned how one particular nurse, Bernie Stanfield, helped him and his wife as he described it, "get through the medical maze. Corrine explained that the patient said he couldn't imagine what people do "if they don't have a Bernie," as he explained the stress of navigating end-of-life decisions with multiple doctors on his care team.

Confluence's Chronic Care Management program was just beginning to be implemented when COVID-19 began to affect their region. Despite redeploying staff to work with COVID-19 assignments and placing a hold on non-essential office visits, they have demonstrated measurable care management program growth based on Caravan's guidance and the commitment to a nurse-led, team-based approach. The staff continue to hear positive feedback from patients as they continue to their expansion of population health care.

"We all have the patient as the center of our focus and through the support of each other, we are able to provide excellence in patient care. This patient's sincere appreciation of Bernie was so heartfelt and moving, and I was so moved by his descriptions of the impact she had on his life; I wish I could have recorded our conversation. She really was his angel on earth."

Corinne Loyd, RN, CCM, CBN
TCM Nurse Case Manager
Confluence Health

"What I did for this gentleman was mostly behavioral health. Yes, I talked to him and his family about advanced care planning, housing options and physical needs but the majority of my 'work' was preparing him for transitions. We discussed her needs and his spirituality and everything in between."

Bernie Stanfield, RN, BSN
CCM Nurse Case Manager
Confluence Health

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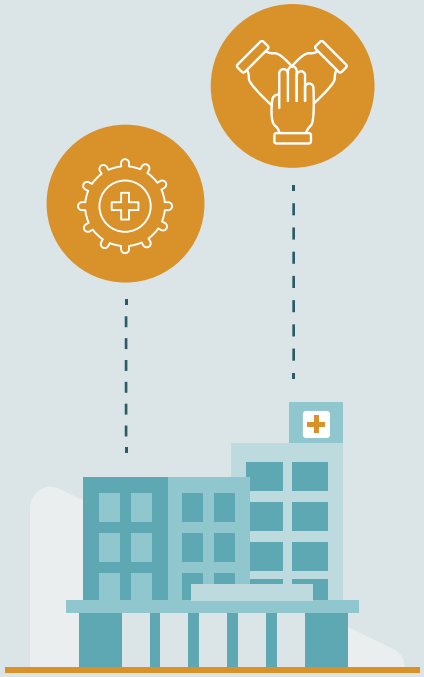
A Before|After Look at Team-based Care at Bibb Medical Center

June 2, 2021



Prior to joining a Caravan Health ACO in 2021, the staff and providers at Bibb Medical Center (BMC) in Centreville, Alabama delivered high quality patient care – but it did not include the comprehensive, team-based care that encompasses population health accountable care. The differences in population health with a team-based approach are not always immediately recognized. And yet sometimes, the differences are noticed quickly.

With new population health nurses trained and implementing new workflows, proactive patient outreach was underway. A call was placed to a patient who was due for her AWV. It was on that call that the patient's son informed the nurse that it had become difficult to physically move her and get her out of the house. She had not been seen by a provider for six months due to COVID-19 risk factors and her new bedbound status. The patient has diet-controlled diabetes but her A1c had increased since her last lab results. Home health had been monitoring her coumadin levels but due to no decline or change in status they planned to stop the visits.

As the conversation progressed, the nurse learned about the anxiety and burdens the son was experiencing due to his mother's declining mobility. In a short time, the BMC population health nurse took command and addressed the patient's current status and social determinants that were resulting in compromised care. The population nurse's action steps, shown below, not only resulted in improved patient care and health status but also the patient's son was able to better manage his anxiety as his mother received more support and resources for his mother. The increased trust between the patient, family, and provider led to better outcomes.

BMC Population Health Nurse's Action Steps:

- The nurse informed the patient of the Provider House Call Program and enrolled her for services including routine visits, labs, ACP and depression screening assessments
- A licensed social worker made an in-home visit to identify and assist with social determinants
- The AWV was completed in the patient's home
- A PT/INR and A1c was obtained with the AWV and ordered by home provider to be obtained in the patient's home in the future
- A Diabetic Education referral was made for services to be provided in the patient's home
- Monthly meetings provide an opportunity to discuss obstacles, help to engage providers, and ensure that the entire team, including billers and coders, care coordinators, nurses, behavioral health providers and C-suite executives are included in the over-arching plan

The patient is currently enrolled in a CCM program and reinforcement was provided on the importance of using these services and communicating about new needs and changes.

"The population health methodologies that we implemented at the beginning of the year provided us an opportunity to connect with more community health resources. Emphasizing a holistic approach to patient care is in everyone's best interests and already we're seeing positive results."

Dawn Jones, RN
Bibb Medical Center

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TRANSITIONAL CARE MANAGEMENT

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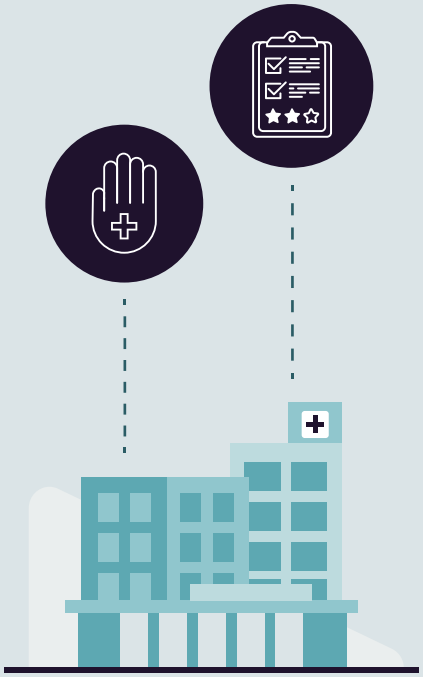
Fisher-Titus Medical Center Emphasizes Transitional Care Management to Improve Outcomes

July 27, 2021



In 2016, Fisher-Titus Medical Center (Fisher-Titus) made the decision to transition to value-based care and joined a Caravan Health ACO. Fisher Titus delivers high quality health care to residents of Norwalk, Ohio, by opening avenues of communication and aligning departmental teams to best serve their patients in transitional care.

The Transitional Care Management (TCM) success at Fisher-Titus is founded in the support system that starts at the executive level. In 2020, Brent Burkey, MD, President and CEO, suggested that staff and providers align their chronic care navigators under the quality division that also oversees inpatient case managers. The alignment successfully removed the siloed experience that was occurring between inpatient and ambulatory offices. The move successfully opened the doors of full transparency and communication between inpatient case managers and chronic care navigators. This resulted in an improved focus on the transition of care and the assurance that chronic care navigators are aware of all inpatient discharges and conditions related to that inpatient stay.

Fisher-Titus has implemented additional initiatives that help set the stage for TCM success including:

- Quarterly meetings are held with all post-acute providers, skilled nursing facilities, and home health organizations. The meetings help to ensure that chronic care navigators are notified of all patient discharges assigned to ambulatory offices within 24 hours. This initiative has proven to be effective with patient follow-up appointments and automatic communication if a notification is missed.
- Health information exchanges are checked daily for outside discharges from tertiary hospitals and post-acute facilities

Results of improved TCM at Fisher-Titus:

- Fisher-Titus' 7 and 30-day Medicare ED utilization has decreased
- Patients enjoy the weekly calls from their navigators which has led to increased enrollment in the Chronic Care Management program

"The most important advice I could give to anyone considering accountable care and a team-based approach is to get your senior leaders on board, along with the Ambulatory Medical Director. They become your biggest champions."

Karen Dickinson
Vice President Quality
Fisher-Titus Medical Center

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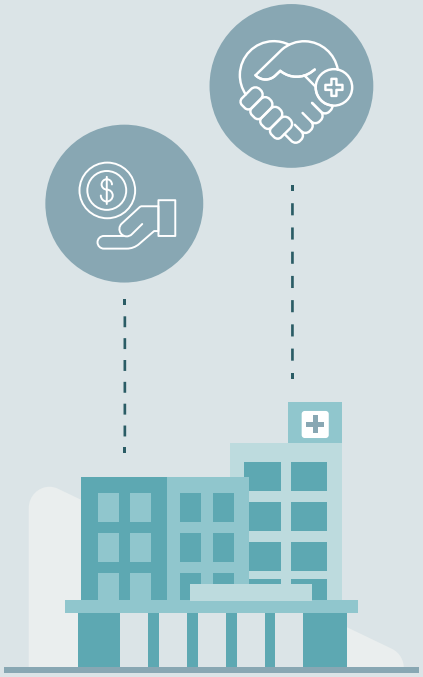
VALUE-BASED CARE



Year of the Nurse

2020

The World Health Organization (WHO), has designated 2020, the 'Year of the Nurse'. In honor of this, each quarter we will highlight a nurse in one of Caravan's collaborative ACOs. This week's Spotlight shines on Nicole Tabert, RN and Clinical Coordinator for Samaritan Healthcare in Moses Lake, Washington.

In 2019, Samaritan joined the Caravan ACO, and assembled their first population health team. Together, they attended trainings, learned best practices, and transitioned to value-based care. Prior to joining the ACO, the staff nurses were not working at the top of their licenses, there was no chronic care management (CCM) program in place, and they had completed a total of 18 annual wellness visits (AWVs).

With benchmarks in place, Nicole worked with her team to increase the numbers of AWVs. She routinely scheduled 2 FTE RNs to perform AWVs and she didn't stop there. Nurses used the AWV to identify patient need for CCM and, the clinical staff worked to engage community health workers.

Nicole's efforts have paid off. They have multiple patient success stories, including one patient who was identified early with congestive heart failure which resulted in intervention that has prolonged his life.

In year one, Samaritan increased their AWV rate by 18%, and went from no CCM program to one that receives daily referrals. Increasing their HCC coding recapture rates by 65% resulted in more than $600,000 in new revenue. Inpatient admissions and emergency department utilization rates have decreased.

Congratulations, Nicole for a job well done – you are an inspiration for nurses everywhere.

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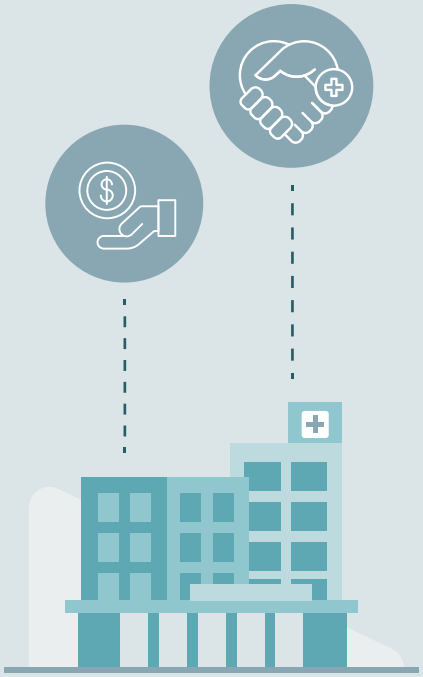
Population Health is Part of the Culture at McKenzie Health

2020



Since 2014, McKenzie Health System (McKenzie), in Sandusky, Michigan, has participated in a Caravan Health ACO. Interested in adopting a wellness model of care, hospital administrators encouraged the transition to value-based care in order to identify illnesses sooner, apply interventions, and improve patient outcomes. The patient-centered approach was the catalyst for staff and providers to focus their attention on preventive measures and well visits.

Fast-forward to 2020 and six years of experience delivering value-based care, population health techniques have become an engrained component of the culture at McKenzie which has had a positive ripple effect on its rural community.

Recognized as a Top Performer – 76% of McKenzie's traditional Medicare patients have had a wellness visit in the last 12 months.

Early on, staff and providers recognized the value of the Annual Wellness Visit (AWV), and they worked with Caravan to create goals, implement workflows, and establish templates to ensure consistency. The AWV has become the key to seeing patients who aren't sick or in need, to maintain their health, and to discuss preventive care. Patients have heard McKenzie's, 'one year and one day' mantra enough to know that one year and one day following their AWV, they will be seeing their providers for another one. This type of communication and education has created opportunities for increased chronic care management and has improved overall outcomes for patients and providers.

Everyone plays an integral role including support staff, billing and coding experts, nursing staff, providers and the schedulers. McKenzie successfully uses centralized scheduling to the benefit of staff, providers, and patients. Schedulers block specific times for providers which helps the daily schedule run as smoothly as possible. Patients are scheduled according to category – sick visits, well visits, med reviews – and during the COVID-19 pandemic, these time blocks have worked well to keep high risk patients safer.

The results of six years of population health are undeniable:

- Significant decreases in unnecessary ER visits
- Improved patient outcomes
- Patients are more engaged and take the initiative for their own health
- There has been an increased in community health screenings
- An increased number of patients enrolled in Chronic Care Management

"We have focused on population health for so long that we see it instilled in others. It's become part of our culture and you see it in the hospital, in outpatient, in the clinics – we see it in our community."

Debbie Ruggles
Director of Healthcare Practices
McKenzie Health System

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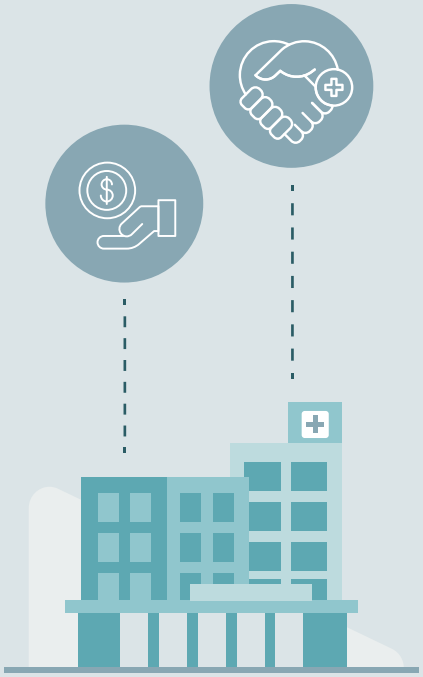

Tampa General Hospital Improves Patient Outcomes with Population Health

September 09, 2020

In 2019, Tampa General Hospital (TGH) made the decision to join the Caravan Health Collaborative ACO. From all accounts, the Florida-based hospital has not looked back. The enhanced focus on patient care using population health methodologies has made a significant difference in overall outcomes in a short amount of time.

One recent example highlights the benefit of the improved patient-provider relationship. A population health nurse discovered that a patient with diabetes had stopped taking her meds due to the high cost of the prescription. In a routine nurse-led screening, the patient opened up to the nurse and explained that she knew she needed to take her meds but there were times that she couldn't afford to refill the script.

The nurse went to work to solve the obstacle and create opportunities for the patient. She spent time with the patient and learned about her lifestyle and began a series of conversations about the importance of healthy living, provided eating tips including healthy snacks and meals, and found an affordable YMCA membership to encourage exercise. Providers worked with the local pharmacy and safely changed her prescription to a less expensive option.

The patient became actively engaged and encouraged by the affordable prescription, took more ownership and began following the advice of her care team. Patient records now show a patient with diabetes who is committed to taking her meds and has adopted a healthier lifestyle.

The numbers speak for themselves: her cholesterol numbers dropped from 144 to 127, triglycerides dropped from 148 to 116 and today, her liver functions are in the normal range. An AIC goal of 7% was set and has been achieved.

"With population health, we're able to dive deeper with patients and get to know them on an all-new level. The extra time spent with them is making a difference. We're improving our outcomes and our patients are taking ownership of their own health. It's a win-win."

Adrienne Holmes BSN, RN
Tampa General Hospital

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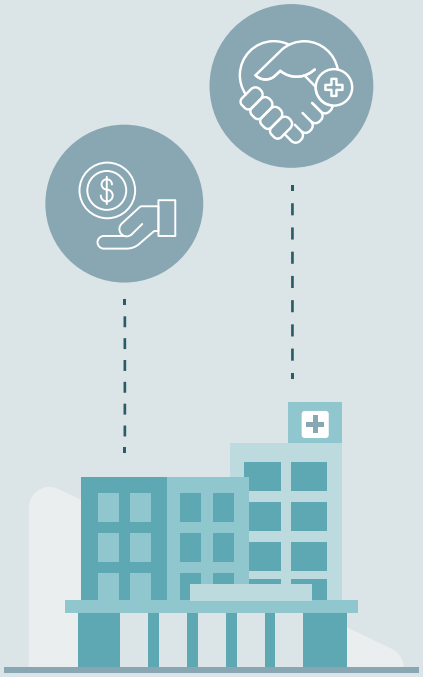
Knox Community Hospital Understands that Quality Health Care Takes a Team

May 18, 2021



Located in Mt. Vernon, Ohio, Knox Community Hospital (Knox) serves its community with a wide range of services through their Joint Commission-accredited hospital. Knox has been with Caravan Health since 2016 and participates in the Collaborative ACO.

A common occurrence when providers make the transition to value-based care is the sharing of patient success stories. Oftentimes these stories involve a social determinant or health literacy issue that was not previously identified with fee-for-service, traditional care approaches. The patient success stories offer pragmatic proof that team-based care helps to improve patient outcomes. Recently, the staff at Knox shared an example of team-based population health at work.

A 66-year old male with an impressive history of chronic illnesses including lymphocytic leukemia, atrial fibrillation, thrombocytopenia, hyperlipidemia, diverticulitis, bilateral hearing loss, sleep apnea, and obesity. The patient had recently been admitted to the hospital with COVID-related pneumonia and treated with broad spectrum antibiotics and a variety of other medications, convalescent plasma, and supplemental oxygen.

Prior to making a call to the patient, the Knox TCM Navigator reviewed the patient's discharge instructions and summary. The Navigator spotted a concern. The discharge summary included instructions to stop a cardiac medication due to infection. The Navigator followed up with a number of members of the collective care team and it was confirmed that the medication was to be halted, however, it was soon understood that the patient had continued to take the medication after being discharged.

Further collaboration and communication resulted in the stoppage of the medication due to heightened risk factors and the patient fully understood and complied. The patient was made aware that he was not to resume taking this cardiac medication until he received further instruction from his care team.

The experience not only resulted in the effective intervention of a patient who was continuing to take a medication that contraindicated his current health status, but it also encouraged the patient to express interest in more nurse-led support. The patient was referred to Knox's Chronic Care Management Program.

"Our team-based approach is a foundation of the thoroughness of our patient care. With our enhanced communication we help patients not only gain access to the highest quality of service, but we also help to prevent them from falling through the cracks. Quality health care truly takes a team."

Beth Tracy, RN
Knox Community Hospital

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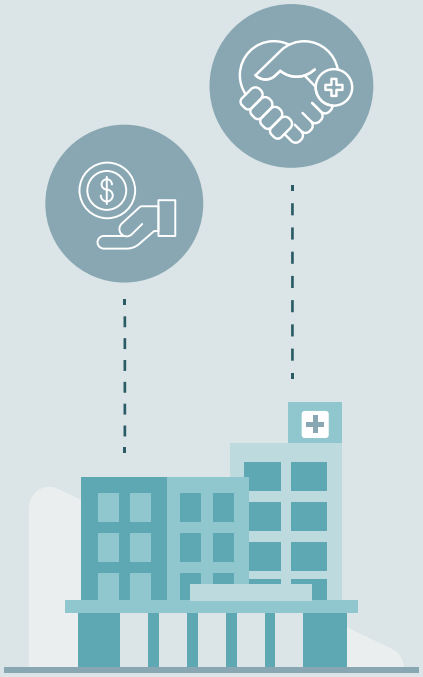

Frances Mahon Deaconess Hospital Uses Preventive Care to Improve Patient Outcomes

September 14, 2021

Serving a patient population in Glasgow, MT, France Mahon Deaconess Hospital (FMDH) has partnered with Caravan Health since 2016. FMDH is a participant in Caravan's Collaborative ACO.

In 2019, FMDH implemented a new EMR and began to capture and report quality measures. For data capture of the fall risk assessment FMDH staff added the required assessment in the intake portion of the progress note near the chief complaint for all visits with patients aged 65 and over. Nursing staff were asked to observe the patient as they were escorted to the exam room and to notice if they require an assistive device or if they noted problems with their gait.

Prior to implementing the workflow and documentation changes, 78% of this cohort of FMDH patients had documentation that a fall risk screen had been completed. Following implementation of the new workflow, 94% of patients had documentation that a fall risk screen had been completed. This is a significant increase in the number of patients screened for fall risk. Screening patients for fall risk is a key element to preventive care and helps FMDH staff identify opportunities to intervene prior to a fall.

Lessons Learned

The biggest challenge for FMDH was to build the required elements and successfully mapping them in the EMR in order for the reports to correctly reflect the denominator and numerator. Nick Dirkes, Director of Planning, ensured that the FMDH documentation and reporting was streamlined and user-friendly which has proven to be an essential component of their success.

The majority of the patients have a negative screen which requires no action. For those with a positive screen, staff make referrals to PT and/or recommend exercises and provide resources so patients can improve their balance and strength at home.

"Falls are the leading cause of fatal and nonfatal injuries for our patients aged 65 and older. Identifying fall risk and preventing falls is a low cost, high-yield strategy for improving health care. This is at the core of our population health workflows."

Nick Dirkes
Director of Planning
Frances Mahon Deaconess Hospital

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VIRTUAL CARE/TELEHEALTH

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Madison Memorial Hospital Expanded Telehealth Services to Offer Consistent Care Delivery

2020

Prior to the COVID-19 pandemic, Madison Memorial Hospital (MMH) had not deployed any telehealth or virtual care to their patients. The rural facility, based in Rexburg, Idaho, had recently joined the Eastern Idaho Care Partners ACO, and had begun the transition to value-based care.

The hospital administrators and staff responded quickly when CMS began to promote telehealth services with fewer restrictions. By recognizing the potential implications of the coronavirus on their community, they designated a core team to understand the components required and set about to launch their first telehealth services.

Working at a fast pace, they researched the availability of reliable internet connections across their community and software that would effectively streamline appointments in a virtual environment. They proceeded to put systems in place for their essential employees including the front office staff, providers, and clinicians to access their new telehealth software.

The team looked at each part of the telehealth visit and analyzed the processes needed to make sure their patients received quality care, despite not being in the office. They understood their community had no experience with telehealth and made efforts to ensure the process would be smooth for patients. The reassurance they provided to their community was particularly important during this pandemic.

As our nation grapples with the coronavirus, MMH has a well-received telehealth care plan in place. In their first month patients, who had begun to acclimate to value-based care, have responded positively with little-to-no resistance. The team invested many hours developing their workplans and today, patients and providers have embraced the technology with the understanding that it is the best way to keep their community safe while ensuring their patients have access to their providers.

"We recognized quickly that telehealth and virtual visits would be the key to keeping our patients and staff protected. Now that CMS has expanded telehealth services, we've embraced this new option and for a small, rural community, our patients have supported our efforts. It's a collective effort that protects everyone."

Heidi Riphenburg
Quality Projects Coordinator
Madison Memorial Hospital

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Alcona Converts 100% of its Clinics to Virtual Care in Two Weeks

2020

Based in Michigan, Alcona Citizens for Health, Inc. (Alcona) is a medical group with offices in nine locations. As one of the founding members of Caravan's Collaborative ACO, Alcona has participated since 2014.

With population health practices well established among staff and providers, Alcona prepared to implement new methods of care in response to the COVID-19 pandemic. One priority was virtual care. Alcona's specialty clinics had already opened their virtual care doors and had been successfully conducting BHI appointments from FQHCs. With one goal, to serve their patients to the best of their abilities, they expanded their virtual care services.

They began by looking at the providers who were already performing telehealth visits and one provider stepped forward to set the stage for the entire health system. Alcona ensured that providers, staff, and patients were equipped with the tools, resources, and information required to be successful by using well-ingrained population health methodologies.

'Drive-up Telehealth'

When challenges presented themselves, each time Alcona successfully course-corrected. When Skype wasn't reliable in their area, they determined Zoom was. When patients didn't have ready access to Wi-Fi, they created 'Hot Spots' in clinic parking lots – areas cordoned off specifically for telehealth appointments. For patients who didn't own a smartphone or laptop, they provided tablets for them to use from the safety of their car – tablets donated by staff and employees, reformatted and prepared by IT teams to make them user-friendly. Every Alcona clinic had a 'telehealth mini-launch' that provided staff the resources and information they needed to develop workflows, use Zoom, ensure proper documentation and troubleshoot issues.

Within two weeks, Alcona had converted 100% of their sites to virtual care practices and were successfully seeing 35-40% of their patients virtually. The majority of patients were seen through telehealth from their homes and each day, between 35-50 patients had appointments from the 'Hot Spot' zone in the designated spaces in the parking lot. The 'drive-up telehealth' gave patients the ability to safely see and be seen despite having no access to smart devices or technology.

Today, Alcona has begun to see more patients in office settings, however they continue to see patients virtually from home and from the 'drive-up telehealth' parking spaces.

"Telehealth has worked out great, we've served so many patients we would not have been able to see if we hadn't put this in place."

Caitlin Schlappi, RN
EMR Coordinator
Alcona Citizens for Health, Inc.

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Nurses at Witham Memorial Hospital Have Made a Difference by Focusing on Virtual Care

2020

Located in rural Indiana, Witham Memorial Hospital (WMH) is a member of the Suburban Health Network ACO. In their five years of active ACO participation, the staff have become experts in population health and adept at identifying at-risk patients and the social determinants that preclude them from accessing health care.

As the COVID-19 pandemic enveloped the nation, WMH providers implemented preventive measures to minimize risk and spread of the coronavirus. The staff collaborated with home health partners who assisted patients with technology and virtual visits which opened the virtual doors of communication for a continuation of CCM visits. The partnership with the home health professionals helped staff identify patients who were likely in need of therapy and services such as injections or other procedures.

Many patients were afraid to leave their homes to seek care and were feeling isolated and alone. Some patients had become weak from sitting too long which could lead to falls. The public health emergency resulted in lowered patient volumes which afforded staff opportunities to call recently discharged patients with a specific focus on patients who had refused post-acute care. Nurses coordinated with their telemedicine team to have labs drawn and EKGs done in patient's homes.

By focusing on virtual care and patient safety, nurses placed nearly 100 more proactive outreach calls in April than in months prior. During one call to an elderly man, it became apparent that he was struggling. His wife was diagnosed with COVID-19 and in a rehab facility. A PHQ-9 indicated that he was experiencing depression and at risk. Acting quickly, a virtual visit with his physician was scheduled, medication was prescribed, and care was coordinated with the home health partners who arranged their schedules to optimize the cadence of visits. In addition, the rehab facility was contacted, and visits were arranged so he and his wife could connect virtually. Today, both have recovered, are at home, and coping well.

"The unexpected isolation and fear produced by the COVID-19 virus restrictions, put an already vulnerable population at risk for collateral problems. The Witham team worked creatively with Home Health Care, telemedicine, and other community resources to break the barriers to healthcare that many of our high-risk patients were experiencing during this time."

Kathy Sawyer, RN
Care Coordinator
Witham Memorial Hospital

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Crouse Health & Family Care Medical Group Maintains Continuity of Care with Telehealth

March 23, 2021

Crouse Health located in Syracuse includes multi-specialty practice Crouse Medical Practice with more than 12 locations and partners with multi-specialty practice Family Care Medical Group with 29 locations. Combined, they have a total of 28 PCP locations to serve an expansive patient base in Central New York. As the COVID-19 pandemic made its impact on New York, both medical communities prepared for what was likely to be a long-term public health emergency. After CMS made telehealth a viable option, the providers successfully transitioned to offering virtual care to their patients – an impressive task given the multiple locations and specialties within these two medical groups.

In what appeared on the surface to be a seamless effort, they overcame technological barriers with their EMR, staff and patients. With only uncertainty as a sure thing, the collective group of staff and providers committed to offering every possible option to their patients and made efforts to ensure those patients who wanted to use telehealth had the tools and resources to do so.

As participants in the Caravan Collaborative Pathways ACO, Crouse Medical Practice and Family Care Medical Group gained distinction for some of the highest rates of telehealth usage across all of Caravan. While providers battled various levels of the pandemic in their communities, they recognized the potential in virtual care in an otherwise shutdown world and quickly and effectively embraced the opportunity.

Despite being embroiled in the pandemic, this group of providers continued to perform their Annual Wellness Visits (AWV), using telehealth. The virtual care implementation was so successful that their rates of AWVs were higher than their original, pre-pandemic goal. Their rates of Advance Care Planning, which is an initiative they prioritize as part of their wellness exams, also exceeded their pre-pandemic goal, increasing more than 10% from the beginning of 2020 through the third quarter. The group's Chronic Care Management program also flourished as a result of their emphasis on virtual care. To date, data has demonstrated an improvement in enrollment rates of more than 2% during the pandemic.

The COVID-19 pandemic has disrupted health care delivery as we once knew it. Yet for Crouse Health and Family Care Medical Group - when offered the opportunity to transition to virtual care – they embraced new technology and effectively maintained continuity of care.

"We understand that the Annual Wellness Visit is the foundation for improving our quality of care. When we were first hit by the pandemic and telehealth became a more viable option, we didn't look back. We adapted to virtual care and expanded our chronic care management program, because we knew it was best for our patients and best for our continuity of care."

Seth Kronenberg, MD
Chief Operating Officer/Chief Medical Officer
Crouse Health

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Cavalier County Memorial Hospital Providers Use Caravan Health Scripting to Promote Telehealth

November 9, 2021

When the first wave of the pandemic began to hit, Cavalier County Memorial Hospital (CCMH), recognized an opportunity. The Langdon, North Dakota-based hospital is a participant in the Caravan Health Collaborative ACO and has been with Caravan since 2018.

Staff and providers were thinking proactively as they considered the ramifications of social distancing in their rural community. When CMS opened the virtual doors to RHCs, CCMH recognized the ability to provide telehealth meant staff and providers could maintain a continuity of care without requiring patients to physically come to the clinic.

The IT team at CCMH was integral to not only finding a platform that would make visits easy for patients new to the technology but also implementing the platform quickly and efficiently. Within one week, staff and providers were being trained on the technology and everyone was enthusiastic about the telehealth opportunity to bill Annual Wellness Visits (AWVs) with a specific G2025 code. CCMH staff contacted high-risk patients and informed of them of their newly implemented telehealth platform.

The biggest obstacle was overcoming resistance from patients and their hesitancy to use the technology. However, the dedicated staff ensured patients understood how to use the system. CCMH emphasized the new opportunity and provided education and resources. A large part of the patient acceptance and CCMH's pivot to telehealth was the essential role the providers played. While patient volumes were low, CCMH providers called their patients, acknowledged that the pandemic was difficult and explained they did not want to lose touch with them. But the providers did not stop there. While on the phone with their patients, the providers discussed the importance of AWVs and with the help of Caravan Health scripting, advocated for wellness visits and preventive care.

Word spread quickly in the small community that providers were encouraging patients to use telehealth which resulted in the new technology being embraced and utilized in a matter of weeks. And, as witnessed across the country, CCMH patients welcomed the convenience of telehealth, and the new form of technology-driven health care was a success. As of August 2021, 26% of CCMH's Medicare patients have had a telehealth AWV.

"We pivoted quickly to performing telehealth AWVs. Our staff and providers took the initiative to reach out to patients and it has been nothing but success. Our providers were comforted being able to continue to care for their patients and the patients were appreciative of the opportunity to have that connection from the safety of their homes."

Darla Roder
Chief Operating Officer
Cavalier County Memorial Hospital

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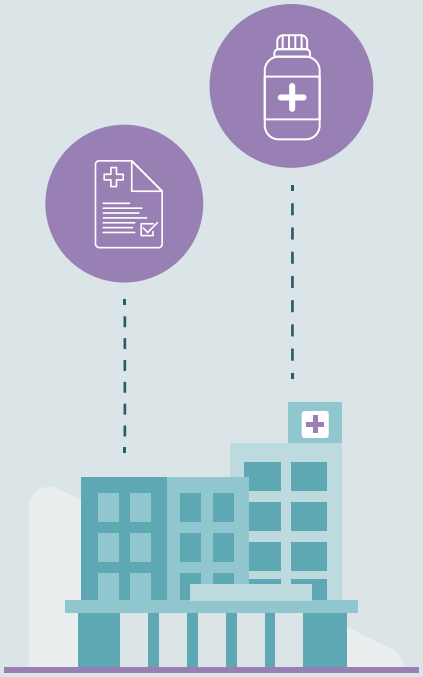

Winona Health Captures 340B Success with Caravan Coach

September 21, 2021

Winona Health (Winona) has served its rural Minnesota community for the past 126 years and are known as an all-inclusive health care organization delivering care from birth to death. Winona has a 49-bed inpatient hospital, a long-term care facility, an offsite memory care home and offsite clinics.

Due to Winona's successful experience participating in the Caravan Collaborative ACO, when the 340B opportunity presented itself, Chief Operating Officer, Robin Hoag made the decision to learn more. She engaged her pharmacy staff and together they worked with their Caravan partners to learn more. They did not have a lot of prior experience or 340B knowledge. They admit to being initial skeptics – it sounded too good to be true that they could claim some of the prescriptions being written by their contract pharmacies by outside providers.

A proven win-win

Prior to becoming involved with Caravan, Winona's 340B program consisted of five contract retail pharmacies located in their town. After learning of the savings potential, they worked closely with Caravan to optimize their opportunities. Today, Winona's 340B program has expanded to 40 different locations including mail order and specialty long-term care pharmacies.

Due to their newfound knowledge and understanding, Winona staff and providers have expanded their professional relationship beyond a medications list. They are able to share more information with their partners and this communication has opened up new treatment options and opportunities for patients – particularly in the realm of behavioral health. They have identified gaps in care and potential medication replication which could have been detrimental.

Winona has used Caravan Coach to increase capture rates by identifying every possible prescription that could potentially be included in the program. Winona evaluates claims and all the documentation to ensure they are maintaining optimal levels of compliance. They have implemented their 340B program and enhanced it with Coach and the combination is proving to be a success.

"Our 340B program has become a completely different program with so much more opportunity. And not just for capturing revenue, but in coordinating care with our patients and providers. It's closing the loop on some patients."

Robin Hoag
Chief Operating Officer
Winona Health

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