Value-Based Care Management

A Population Health Approach for High-Risk Patients

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Presentation: Care Management in Value-Based Primary Care

1. Defining Value-Based Care in Community Health Centers
2. The Spectrum of Care Management
3. Evolving a Model for Care Management in Value-Based Care
4. The Role of Population Health Tools
5. Re-engineering Care Management: Breakout and Sharing

The U.S. healthcare system rewards disease, not prevention.

How can we solve this at scale?

CMS estimate of 2022 Healthcare spend; 2019 JAMA “Waste in the US Health Care System”

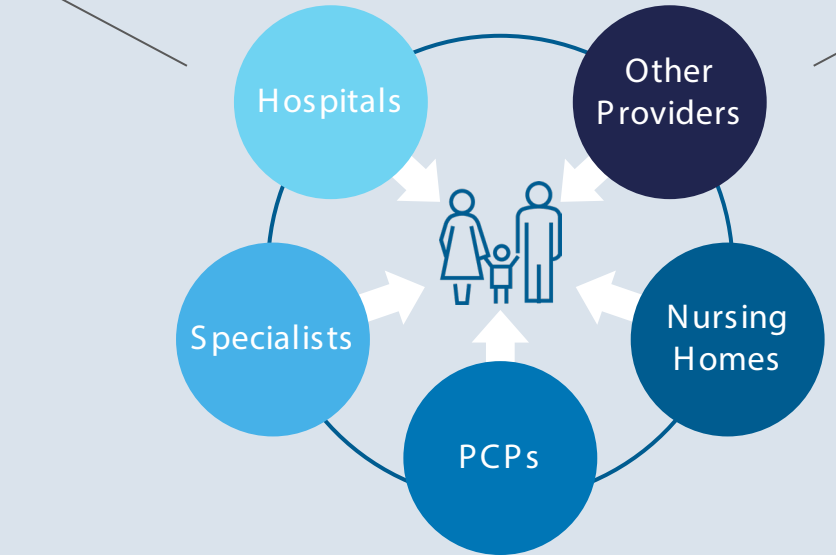
ACOs represent both long- and short-term opportunities to reduce costs and improve health.

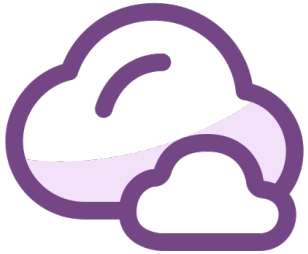
An ACO is a group of health care providers who work to deliver coordinated care and are collectively accountable for the cost and quality of care.

ACOs have the potential to **improve the quality of care** and **lower costs**.

To show success, ACOs must **report on specific quality measures**.

Report levels of performance + Meet benchmark levels of performance + Keep total costs for designated patients below a target level





What does Care Management mean to you?

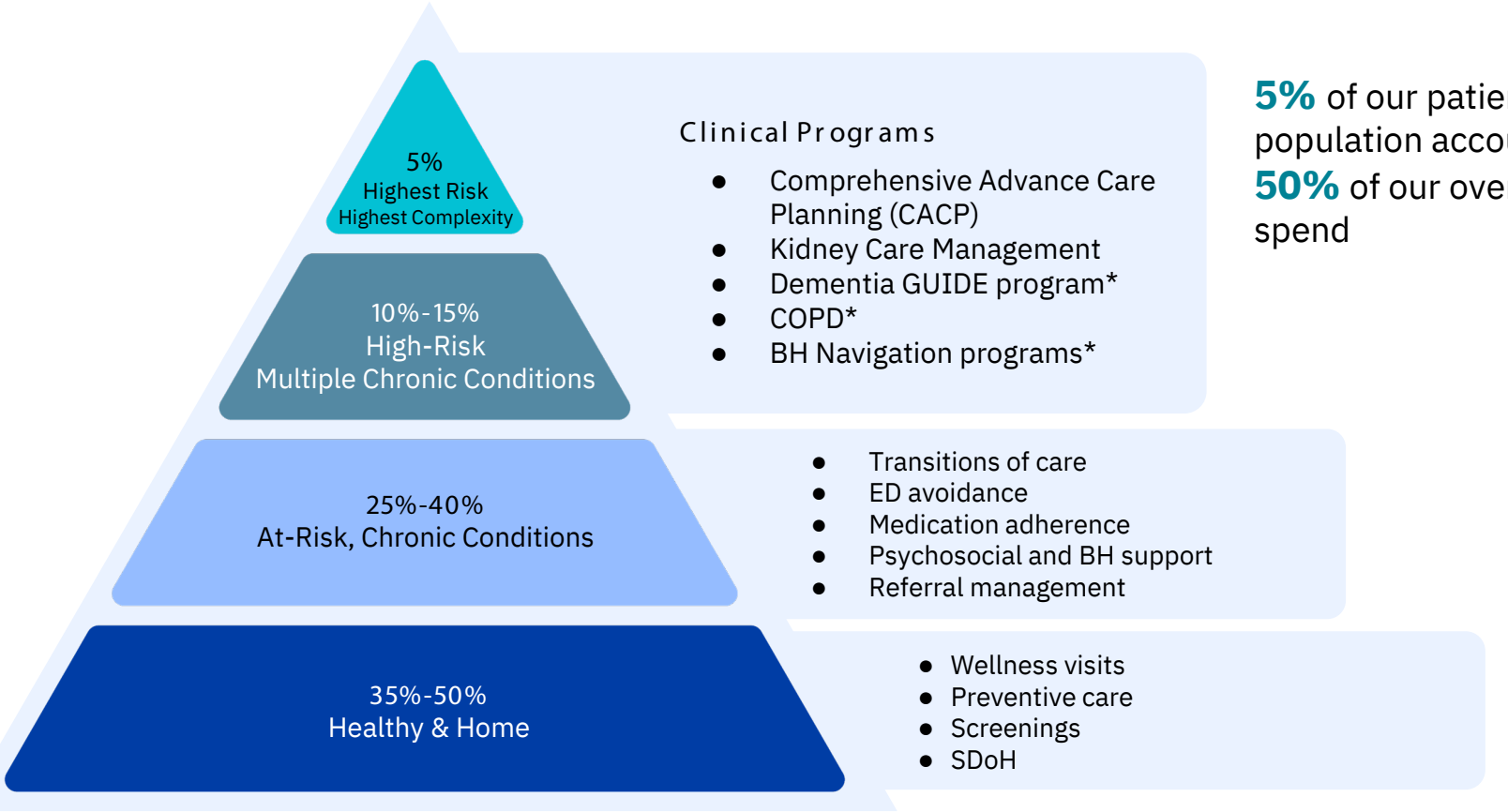
Defining Care Management

The confusing world of care management terminology

- Care Management (CM) vs. Care Coordination (CC)
- Chronic Care Management (CCM)
- Advanced Primary Care Management (APCM)
- Complex Chronic Care Management (CCCM)
- Principle Care Management (PCM)
- Disease Management (DM)
- Utilization Management (UM)

Population health management - understanding your "flock"

Tailoring care through data, tools and timing to reach the right patients, address root causes and prioritize wellness



5% of our patient population accounts for **50%** of our overall health spend

Aledade Figure Adapted from amatihealth.com

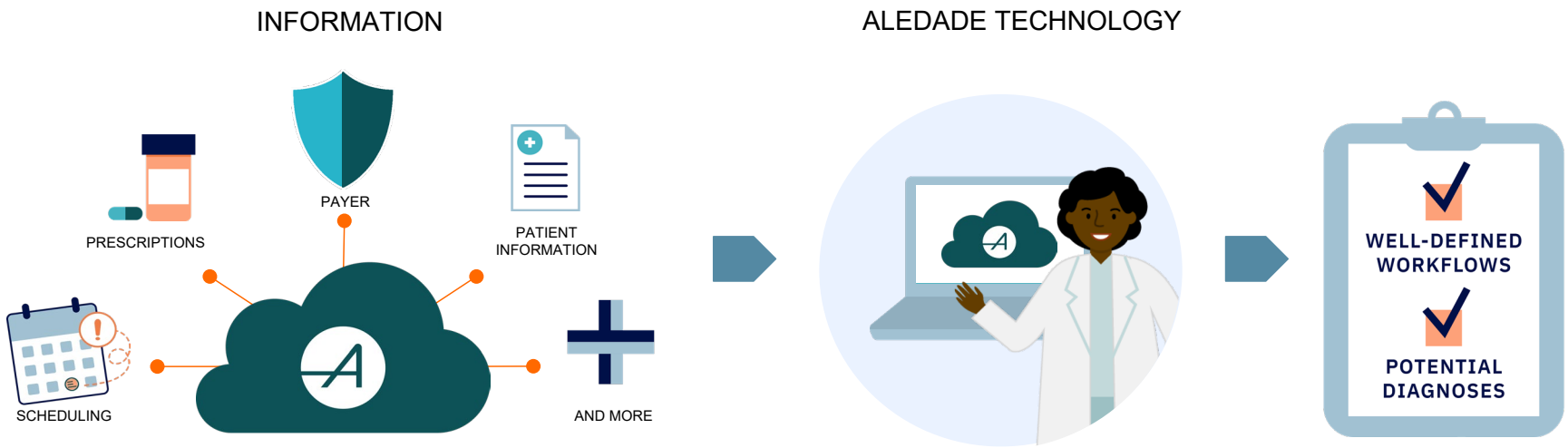
How Do Health Expenditures Vary Across the Population?. 2021. Kaiser Family Foundation

* Limited proof of concept projects

What is the “job” of a population health tool?

Data technology and insights

Aledade delivers the data, insights, and workflows that help primary care teams thrive in value-based care. By unifying multi-source data into a single, intuitive experience, Aledade empowers care teams to act earlier, coordinate smarter and generate revenue tied to high-quality, low-cost outcomes.

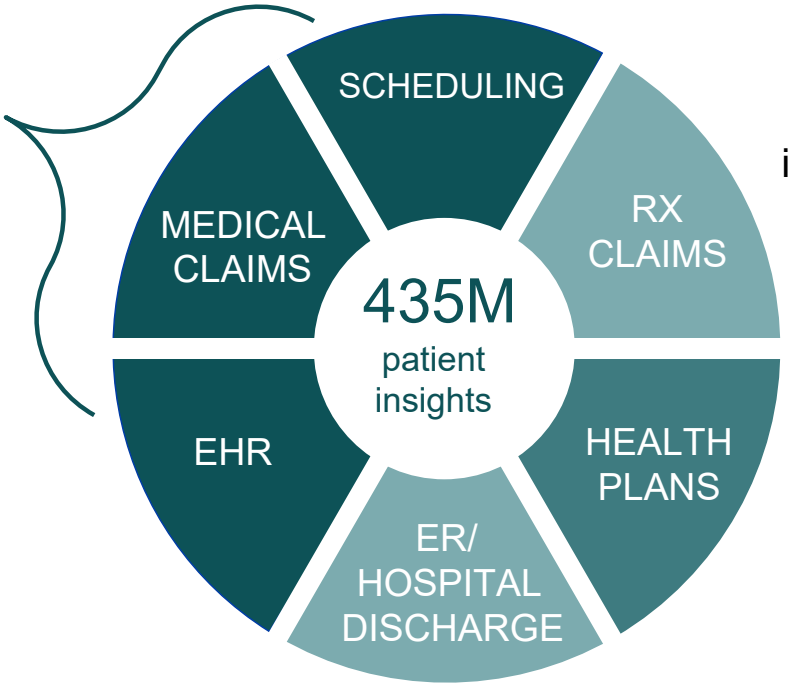


August 2024. 1088-23

Data Source Integrations

Our technology platform integrates with 100+ EHRs and practice management softwares (PMSs), putting external data sources, such as hospital, lab, pharmacy and claims all in one place, equipping you with knowledge to improve health outcomes.

6,000+
practice interfaces



225+
interfaces

600+
interfaces

2.5 M patient alerts received

97.3%
overall performance score

Why payer claims data matter

Attribution

Who they (the health plan) think are your patients may not be who you think they are

Who are my sickest patients?

Diagnosis codes that are left behind do not contribute to the complexity (potential cost) of your patient

Quality Measures

So that's when and where they got that screening!

Medication Adherence

My patient is taking their meds about 1 in 5 days?

Taking Care of Our Sickest of the Sick: A Case Study

Meet Our Care Programs Navigators Team

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Care Programs Navigators

Give seriously ill patients even more support by partnering with our Care Programs Navigators. These licensed and experienced health care professionals enhance chronic care management by streamlining care coordination and helping your staff effectively refer eligible patients for Comprehensive Advance Care Planning (CACP) and other available services.

How it works

Set up meeting cadence that works for your practice

Receive additional training on using the Care Programs Worklist in the Aledade App

Learn how to make effective“warm introductions” to Care Programs

Work together to follow patients from referral through care to ensure continuity and an enhanced health care experience

Participation

This program is available to select Aledade member practices. For more information, contact your field team.

Benefits

- **Strengthen care coordination** and services for high-need patients
- Support in **identifying potential care gaps** and addressing barriers to treatment
- **Reduce the risk of fragmentation** of services
- **Enhance patient outcomes** and experience

What is Comprehensive Advance Care Planning with Iris?

Iris guides patients and families in creating personalized care plans that align with their future health goals.

Guided, personalized conversations with trained health care planning experts

Honor and document patient goals and wishes

Goes above and beyond standard ACP discussion and documentation

For MA & MSSP patients with advanced illness

Optional auto-referral for quick service delivery

No cost to patients or practices

Determining patient eligibility

Patients are selected using an algorithm that is applied to MSSP and Medicare Advantage claims data

Mortality

Probability of mortality in the following 12 months

+

Impactability

Examining outcomes near end of life over entire population

+

Attribution

Patients most likely to remain attributed to an Aledade primary care practice throughout the year

Collaborating With Care Managers

A Case Study: Eastern Shore Rural Health Center

Be Well Block Party

- 500 participants on August 2, 2025 in Parksley, VA
- 60+ Community Partners
- 200+ health screenings

Aledade Care Programs Navigators

- 108 patients
- 63 Five Wishes shared
- Workable Referrals
  - 17% to 56%
- Warm Referrals
  - 0% to 26%

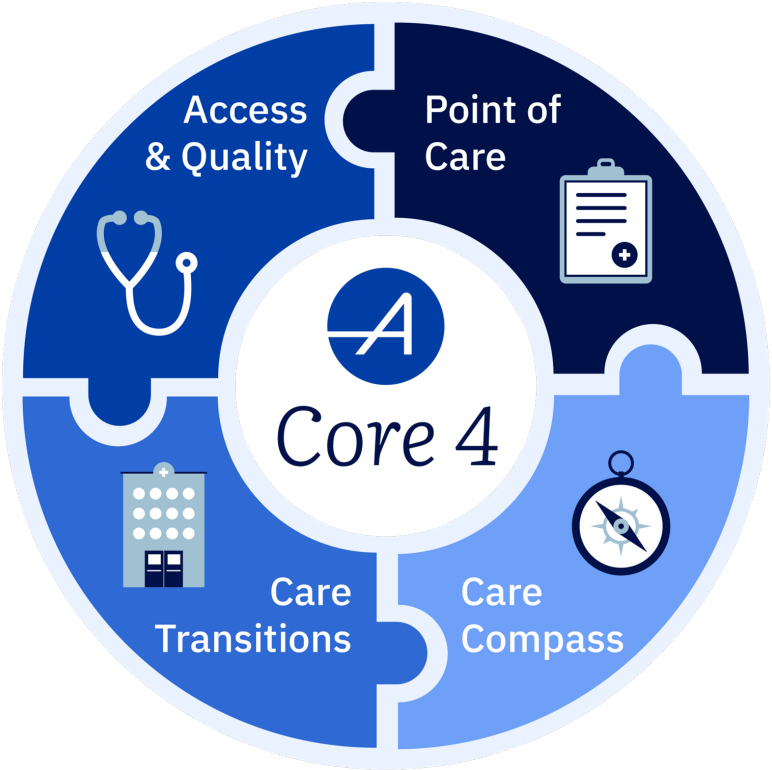
Re-imagining Care Management in Value-Based Primary Care

Incorporating Value-Based Care in Care Management

Key considerations and questions to ask

Leadership	Staffing	Competencies	Tools	Culture	Data
Do our leaders see VBC as a strategic priority, not just an initiative?	Do we have the right mix of roles and enough capacity to succeed in VBC?	Have we equipped our workforce with the skills to succeed?	Are our clinical and admin tools enabling smarter decisions or slowing us down?	Do we have a culture where frontline teams are empowered to test, learn and adapt in real time?	Are we turning data into actionable insights that enhance our ability to care for patients?

The Essentials of Value-Based Care and the Role of Care Managers



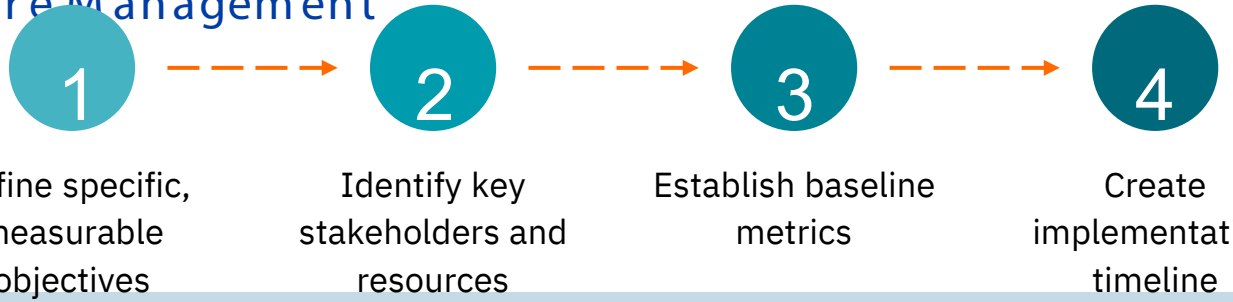
For Discussion

Optimizing Care Management: The Why and How

1. Describe your program (how did it begin and why, how many staff, how are they deployed, patient enrollment criteria?)
2. What do you like?
3. Based on your current organizational priorities, (and maybe what you've heard today), what would you improve?
4. Why?
5. What does success look like for your program? How would you know?
6. Next steps

Quality Improvement Framework: Continuous Enhancement - PDSA Cycle Implementation for Care Management

Plan Phase - Setting Up for Success



Example PDSA Cycle: Reducing 30 -Day Readmissions

Plan:

- Objective: Reduce 30-day readmissions by 25% over 6 months
- Intervention: Systematic 48-72 hour post-discharge phone calls
- Metrics: Readmission rates, patient satisfaction, staff time per call
- Timeline: 3-month pilot with 2 high-volume diagnoses

Do:

- Train 2 staff members on structured call protocols
- Implement call tracking system
- Document patient responses and identified issues
- Track time investment per call

Study:

- Analyze readmission data monthly
- Review call documentation for patterns
- Survey patients about call helpfulness
- Calculate staff time costs

Act:

- Standardize successful call elements
- Address identified system gaps
- Scale to additional diagnoses
- Integrate findings into broader care management

Measurement Strategy Framework

Outcome Measures (The What)

- Clinical outcomes (A1c, blood pressure control, depression scores)
- Utilization outcomes (ED visits, hospitalizations, readmissions)
- Financial outcomes (total cost of care, shared savings)
- Patient experience (satisfaction scores, engagement levels)

Process Measures (The How)

- Care plan completion rates
- Patient contact frequency and methods
- Screening completion rates (SDOH, depression, etc.)
- Care coordination activities (referrals, communications)

Balancing Measures (Unintended Consequences)

- Staff burnout indicators
- Patient complaint rates
- Time to routine appointment availability
- Provider satisfaction with care management support

Planning for Sustainability

Embedding Improvements

- Policy and procedure updates
- Staff training curriculum modifications
- Performance evaluation integration
- Reward and recognition systems

Continuous Learning Culture

- Regular case study reviews
- Peer practice learning exchanges
- Conference attendance and knowledge sharing
- Innovation time for staff ideas

The Power of Relational Connectivity

Building Therapeutic Relationships

- Trust-building in rural communities
- Continuity of care provider models
- Family and caregiver engagement

Community Partnerships

- Hospital system collaboration
- Behavioral health networks
- Social service organizations

Peer Support Networks

- Diabetes support groups
- Mental health peer counseling
- Chronic disease self-management programs

Thank you!

Additional Resources

App Video


Get to know the
Aledade App
Aledade
Your Practice
Upcoming Patients

Resources for Advance Care Planning

Caring for Those Who Care

Cross Cultural Medicine Microlectures

Cultural Relevance in End of Life Care:

Avoiding Cultural Assumptions in Palliative Care

The Conversation Project-starter kits for families interested in advance care planning

Serious Illness Conversation Guide - a guide for clinicians

Prepare for Your Care - educational videos for patients and their families

National Hospice and Palliative Care Organization - advance directives legal forms by state

Peace of mind for you and your circle of care

> Health care planning helped me understand what I want out of my healthcare. It also opened my eyes to things I never knew I should think about before these decisions."
>
> *- Patient*

> The final result provides clarity for the patient, family, and clinician, helping to avoid that foggy treatment limbo that can occur when no one, including the patient, is certain about their preferred care options."
>
> *- Physician Partner*

> Planning for my medical care in the future lifted a big burden off my kids. I could see the relief in their faces after we finished the process."
>
> *- Patient*

Ready to get started?

A member of the Iris team will contact you soon to schedule your health care planning appointment.

If you have any questions:

Visit the webpage below, or

Call Iris at 800-845-2081

Prepare for your appointment at irishealthcare.com/whyiris

irishealthcare

Rooted in what matters, ready for whatever comes

In every season of life, your values can guide your care. **Complete your complimentary health care planning appointment with Iris.**

ALE-10124
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Iris partners with your doctor's office to provide complimentary health care planning services to eligible patients.

What is health care planning?

Life can be unpredictable. Even if you feel healthy, unexpected emergencies can happen.

Health care planning lets you decide what you want for your medical care before you need it. Your choices are then put in writing. This creates a clear guide for you, your family and your doctors.

How does it work?

In your appointment, we help you think about the kind of care you want in the future - especially if you ever get sick and can't speak for yourself.

An expert from Iris will guide you through:

- What matters most to you in different health situations
- How and where you want future care to take place
- Who you want to make decisions if you can't
- What happens if your health changes over time

This service is offered at no cost to patients who meet required criteria and are approved by their primary care physician. Contact Iris to confirm eligibility.

How is Iris different?

Whether you're starting from scratch or updating previously created documents, the process is easy and focused on you.

We ensure your voice is heard and understood in critical moments by:

- Giving you and your loved ones **as much time as you need** in your appointment
- Creating required legal documentation, along with a Planning Summary that details your wishes **in your own words***
- **Notarizing and distributing your documents** to you, your loved ones and your primary care team
- Providing **ongoing support** for document updates and questions

** Available in multiple languages.*

What's the difference between Advance Care Planning (ACP) and Comprehensive ACP (CACP)?

Aledade

Traditional ACP	vs.	CACP with Iris
• For all patients • Can occur during an AWV or office visit	Overview	• High-impact ACP for high-risk patients • Services delivered virtually by Iris • Complements or replaces in-office ACP
• Potential out-of-pocket expense for the patient • Billable based on length of time spent, using certain codes	Cost / Billing	• No cost to patient or practice • Complementary ACP billable before or after CACP, using certain codes (see CACP Implementation Guide, section 4F)
Qualified health care professional or attorney	Facilitator	Health care planning expert trained in CACP
• Living will • Medical power of attorney	Scope	• Comprehensive discussion and guide to patient's values and medical preferences • Any needed legal documentation (e.g., living will, MPOA, DNR/ POLST)
Typically in person with qualified health care professional or attorney	Format	• Over phone, or video, if requested • No time constraints in order to meet patient's pace and medical needs • Loved ones invited to attend • Tailored to patient's literacy and comfort level
Provided, if with a clinician	Medical education	Explore patient's understanding of their health, including a discussion of life support, potential side effects and expected outcomes and goals for recovery

A0209-25

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A0209-25

My Planning Summary
Onboarding DevPatient

Date of birth 08/23/1954

MY TREATMENT PREFERENCES

I have received care information about my situation and have discussed possible future situations I might experience. These are my preferences:

HEALTHCARE AGENT: Family Member 1234561234

TREATMENT GOALS & VALUES

Recovery Goals: A level of recovery or quality of life that I would be willing to accept must include:
- The ability to spend meaningful time with my loved ones
- The ability to express my needs and communicate with others
- Enough physical independence to manage with some assistance

OVERALL TREATMENT GOAL: If my health reaches a point where I am not likely to get better, or improve to my quality of life and recovery goals, I would want standard medical care but prefer to avoid invasive or burdensome measures, especially long term.

LOCATION OF CARE: If I had a serious condition making it likely that I would need significant help, such as long term 24-hour care support, I would prefer everything done to keep me at home. If my family, caregivers, or doctors tell me it would be too dangerous or difficult to keep me at home, I would agree to go into a nursing home or assisted living.

HOSPITALIZATIONS: If my doctor tells me my condition is not expected to get any better, I want to set up the kind of care that would help keep me out of the emergency room and hospital.

LIFE SUPPORT

Feeding Tubes: I am willing to receive food by feeding tube placement but would not want it to go on for the rest of my life. GOAL: To be used temporarily for recovery purposes (see recovery goals).

Breathing Machine/Ventilator Use: I am willing to try a ventilator if my condition requires it but would not want it to go on for the rest of my life. GOAL: To be used temporarily for recovery purposes (see recovery goals).

CPR: If I had no pulse and wasn't breathing, I would want them to attempt resuscitation/CPR.

I would consider a DNR if:
- I have a recent history of CPR being performed and it is likely to keep occurring OR
- I am no longer able to recognize or meaningfully interact with my surroundings and loved ones

ADDITIONAL PREFERENCES: It is my wish that a ventilator along with my preference listed above, is only used in acute or emergency situations only

Where you can find support for Care Programs

The power to manage complex populations is more possible than ever

- Demo video - Reviews key features of the Care Programs list
- Flyer - Reviews benefits of the Care Programs list
- Job Aid - Reviews features of the Care Programs list
- Care Programs ListFAQs
- CACP Program Information Flyer