5-PART AIM IMPACT PORTFOLIO

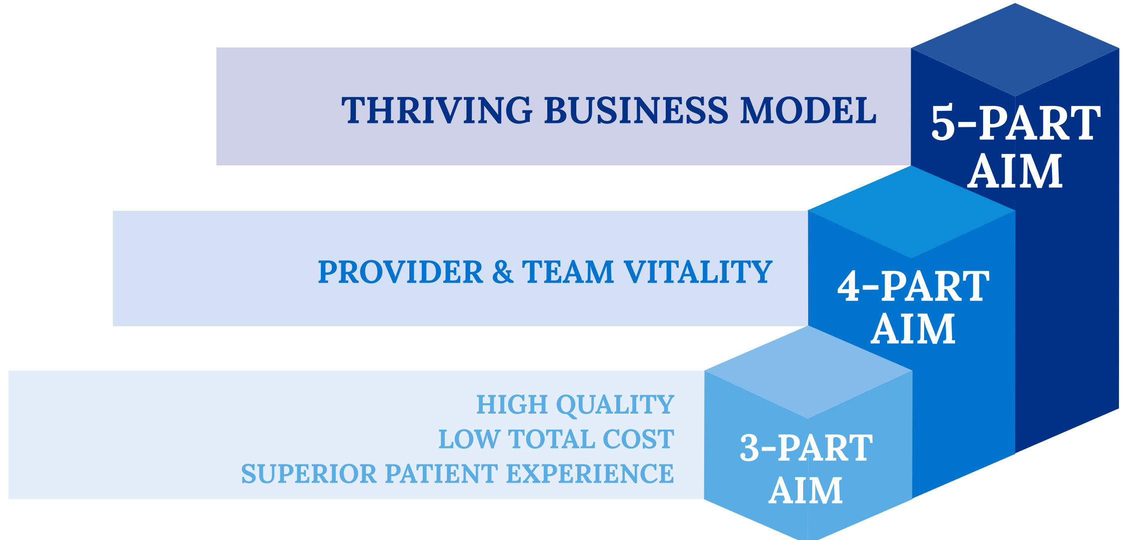
DRIVING CLINICAL AND BUSINESS SUCCESS

Through Practice Transformation and Network Performance Improvement

With more than 20 years of experience in patient-centered practice and system transformation, *HealthTeamWorks* applies proven best-practices to our network client engagements. This **5-Part Aim IMPACT Portfolio** focuses on the DNA of high-performing networks and on *HealthTeamWorks*' **impact data which demonstrates the breadth and depth of our team's subject matter expertise.** We meet our network clients where they are on the journey from volume-to-value and empower delivery system changes, provider collaboration and market leading improvements to achieve **the 5-Part Aim: improved clinical care and patient experience, lowered costs, workplace satisfaction, and thriving healthcare businesses.**

HealthTeamWorks' Helping to Optimize Your Network: Achieving the 5-Part Aim

Engaged and thriving providers – and their teams – are foundational to creating high value, patient-centered care in our communities. *HealthTeamWorks*' approach to practice and network transformation leads with a 5-*Part Aim*; explicitly designed to promote meaningful work and optimize business practices in the delivery of care.



High-value population health management requires a foundation of high-performing, team-based primary care powered by essential medical neighborhood services, including: clinically-relevant data analytics, practice transformation and performance improvement coaching, health information technology (HIT) training and support, community-based care management services, and links to key community-based social support services.

4TH AIM

Physician and provider team engagement follows meaningful workplace vitality. Network leadership must understand *burnout* and prioritize the antidotes, such as advanced team-based care, efficient clinical documentation strategies, and parity in remuneration.

A successful clinically integrated network business model requires the success of its members' micro-businesses. Success means establishing expectations and support for owned and private practices to optimize management and financial performance and ensure funds flows from value-based contracts that both support network services and reward practice-level 3-*Part Aim* performance.

Connecting the Strategic Plan to 5-Part Aim Performance: Designing an Operational Roadmap

“Doing well by doing good.” This summarizes *HealthTeamWorks*’ outcome successes when we partner with delivery organizations and networks to create population-level value.

Our client engagement begins with an understanding of a network’s strategic plan and market opportunities. Our discovery process includes key informant interviews and explores critical dimensions of high-performing delivery networks:

- How will your organization’s business model adapt to create ongoing sustainability on the journey from volume-to-value? How will it manage defined populations and, in particular, high -need, high-cost patients?
- How are effective partnerships being built with your physician community to include true engagement, collaboration and inclusive governance?
- What is your network doing to help independent practices find value in the tradeoff from autonomy to interdependence?
- Is your network building a clear value proposition for payers and employers?

A current-state assessment of network capabilities is then developed and cross-walked against *HealthTeamWorks* Network Evaluation Matrix:

DRIVERS OF HIGH PERFORMING DELIVERY NETWORKS

	Delivery Network Domains	Domain Pillars: 5-Part Aim Drivers
1.	Organization, Leadership, Vision, Strategic Development	• Integrated Delivery Network (IDN): Organization & Governance • IDN: Practice Support Services • IDN: Performance Improvement • Care Team & Provider Vitality
2.	Advanced Network Integration	• Network Collaboration & Care Transition • Advanced Systems of Primary & Specialty Care • Integrated Care & Social Determinants
3.	Value-Based Performance Payer Contracts & Funds Flow	• Value-Based Contracting & Business Models • Total Cost of Care Efficiency
4.	Network HIT System	• HIT Optimization • Transformative Analytics

HealthTeamWorks’ approach matches pace and priorities to mapout and support operational plans and tactics for 5-Part Aim success and revenue performance.

HealthTeamWorks Impact Data

The following Table of Contents outlines *HealthTeamWorks*' 5-*Part Aim* **results** over the past 10 years. The data reflects our impact, including that of our strategic partners, leading and supporting transformation work across 4 Domains and 11 Drivers of high performing care networks. Our clients and engagements, regionally and nationally, have ranged from clinical practices and integrated delivery networks to state- and federally-sponsored demonstration projects and grant-funded transformation initiatives.

1. Practice Transformation & Population Health Performance **p5**

2. Network Integration of Primary & Specialty Care **p11**

3. HIT Optimization & Clinical Analytics **p15**

4. Provider Team Vitality, Engagement & Leadership **p17**

5. Business Best Practices Support for Network Member Offices **p19**

6. Value-Based Contracting, Utilization & Business Models **p21**

7. Integrated Delivery Network – Operations & Governance **p25**

1. Practice Transformation & Performance Improvement

The imperatives of dramatic and comprehensive change – required to deliver population-based value – begin in the community setting where most of chronic care, screening and prevention are delivered. We have demonstrated expertise in practice transformation and effective population health management including advanced teamwork, proactive outreach and care for at-risk patients, improved access, patient engagement, health navigation, and the ongoing capacity for iterative learning, adaptation and change.

HealthTeamWorks' **model of primary care transformation** is built upon *what works* to deliver 5-*Part Aim* results. The model's drivers of high performing advanced primary care draws on the learnings of national demonstration projects, best practice models such as *Bodenheimer's Building Blocks* and our experience leading medical home design and implementation.

DRIVERS OF HIGH PERFORMING ADVANCED PRIMARY CARE (APC)

	APC Domains	Domain Pillars: 5-Part Aim Drivers
1.	Practice Leadership & Advanced Teamwork	Advanced Primary Care Leadership | Advanced Primary Care (APC) Policies | Formalized APC Committees & Meetings | Advanced Team Work (ATW) Structure & Processes
2.	HIT Optimization & Population Health Analytics	Structure, Functionality & Support | Primary Source Clinical Data | Data Quality
3.	Learning Organization	Performance Measurement | Learning Organization Structure & Processes | Provider & Team Vitality
4.	Patient & Family Engagement	Patient & Family Activation
5.	Practice Population Management	Access & Continuity | Empanelment | Risk Stratification | Behavioral Health Integration | Social Determinants of Health | Care Transitions & Referral Coordination | Panel Management & Outreach
6.	Community & Network Integration	Community Clinical Linkages | Integrated Delivery Network | Speciality Care Provider Performance
7.	Value-Based Business Model	Value-Based & Alternative Payment Contracting | Value-Based Contract Funds Flows

Where is your organization on the journey from volume-to-value?
Do your practices have the systems and support to deliver on high quality and lower total cost of care? How will you know if they are prepared for payment based on performance? How will you determine readiness for risk? What is the appropriate pace for your organization to transition and invest in value-based delivery?

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NATIONAL PRACTICE TRANSFORMATION INITIATIVES

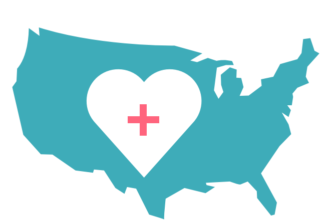
HealthTeamWorks has been awarded numerous competitive contracts at the national and regional levels for our work to support practice transformation and innovation.

PROGRAM	# PRACTICES
Comprehensive Primary Care (CPC)	69
Comprehensive Primary Care Plus (CPC+)	99
Colorado State Innovation Model (SIM) Cohort 1	19
Colorado SIM Cohort 2	27
EvidenceNOW Southwest (ENSW)	22
Transforming Clinical Practice Initiative (TCPi)	40
Colorado SIM Cohort 3	22

of participating physicians of **EvidenceNOW Southwest (ENSW)** likely to **RECOMMEND** *HealthTeamWorks'* Practices Transformation services to a colleague

Source: ENSW, 2015-2018

NATIONAL COMPREHENSIVE PRIMARY CARE LEADERSHIP



HealthTeamWorks' **National Faculty** guides and supports learning and program development **ACROSS ALL 18 CPC+REGIONS** for **2,900** practices nationally

ADVANCED PRIMARY CARE INNOVATION AND LEADERSHIP

HealthTeamWorks led the Colorado Patient Centered Medical Home (PCMH) Multi-Payer Multi-Stakeholder Pilot from 2008-2012 and continues to support medical home transformation efforts both in-state and nationally

WORKFORCE DEVELOPMENT TRAINING: PERFORMANCE IMPROVEMENT

Facilitating Quality Improvement [formally Practice Facilitation (PF) 101] training was the nuts and bolts and how-to's, and Facilitating Organizational Change [PF 201] was looking at the big picture and applying critical thinking to our healthcare system. The experience of Facilitating Organizational Change was a paradigm shift in how we think about and measure value. Prior to Facilitating Organizational Change, I was much more dogmatic in my approach – and now, I have more flexibility in my thinking as a Practice Facilitator.

— QUALITY LEAD FROM A COLORADO FAMILY PRACTICE

MAKING ADVANCED PRIMARY CARE HAPPEN

HealthTeamWorks' impact on Family Medicine Residency training:

Percent **improvement** in Advanced Primary Care Systems

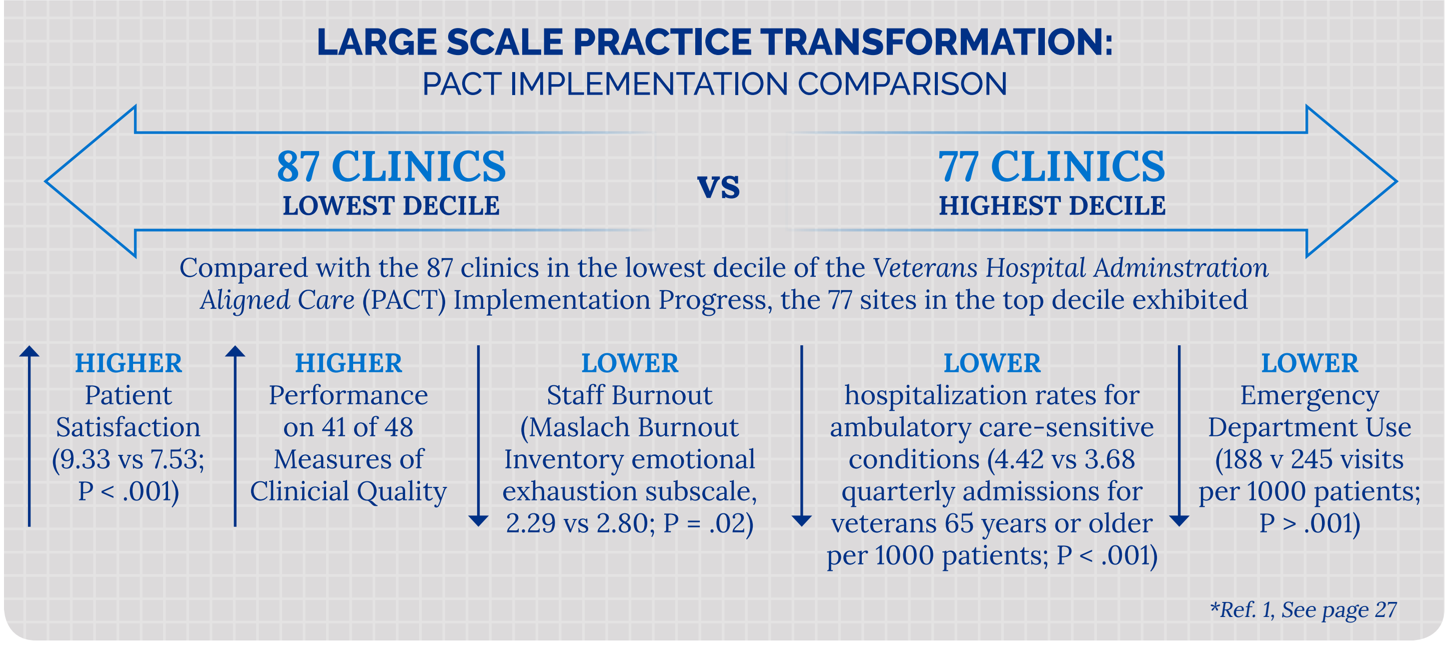
Team-based Care	+49%	Continuity of Care	+31%	Information Systems	+11%
Data & Population Health Management	+42%	Change & Improvement Culture	+10%	Patient-centered Care	+13%
Quality Improvement Process	+23%	Self-Management Support	+11%	Quality of Working Relationships	+5%

Source: Colorado Residency PCMH Program, 2009-2014

ALL PRACTICES ACROSS 10 RESIDENCIES
Achieved NCQA PCMH Level III Recognition

Source: Colorado Patient-Centered Medical Home (PCMH) Residency Program, 2009-2014

of **88 PRACTICES** supported by *HealthTeamWorks* NCQA PCMH Certified Content Experts (CCE) attained Level III Recognition



PERFORMANCE IMPROVEMENT

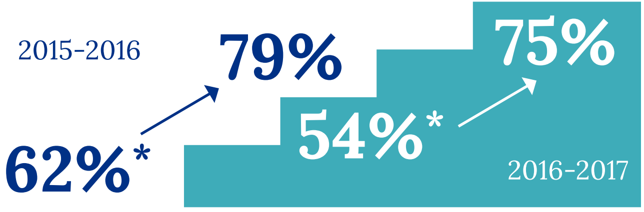
The transformation of community-based, patient-centered practice is critical to the implementation of evidence-based systems, such as PCMH – as well as **the cultural changes and tools of performance improvement**. The new world of healthcare demands this dynamic flexibility to use data, understand population need study and learn as teams, and then to work collaboratively to improve patient-centered performance across defined populations.

COLORADO PCMH PILOT: IMPACT ON CLINICAL QUALITY IMPACT MEASURES

- **9%** REDUCED HGBA1C>9
- **14%** IMPROVED LDL CONTROL
- **7%** IMPROVED TOBACCO CESSATION INTERVENTION
- **43%** IMPROVED SUBSTANCE ABUSE SCREENING
- **23%** IMPROVED DEPRESSION SCREENING

Source: Colorado Multi-Payer Multi-Stakeholder PCMH Pilot, 2009-2012

AGGREGATE IMPROVEMENT IN QUALITY IMPROVEMENT PROCESSES



*Baseline aggregate for participating practices (different groups each year)

Source: Better Care, Better Costs, Better Colorado Program (BC3), 2015-2017

IMPROVEMENT IN CARDIOVASCULAR HEALTH IN COLORADO & NEW MEXICO

IMPROVEMENT in **BP CONTROL** **48%**

HGBA1C >9 REDUCTION by **28%**

TOBACCO USE SCREENING INCREASE by **15%**

Source: EvidenceNOW Southwest (ENSW), 2015-2017

POPULATION HEALTH IMPROVEMENT: CANCER SCREENING & CHRONIC CONDITIONS

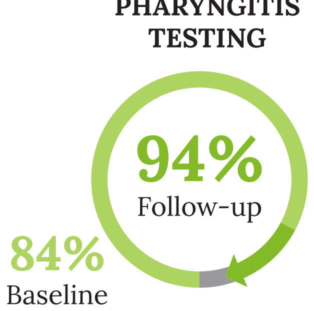
Provides a comprehensive approach that focuses on prevention, early detection and treatment

- **17%** IMPROVEMENTS **IN BREAST CANCER SCREENING**
- **14%** INCREASE **IN BP CONTROL**
- **3%** REDUCTION **IN HGBA1C>9**

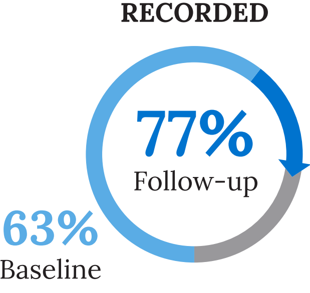
Source: Cancer Cardiovascular Pulmonary Disease (CCPD) Program

PEDIATRIC MEASURES IMPROVEMENT

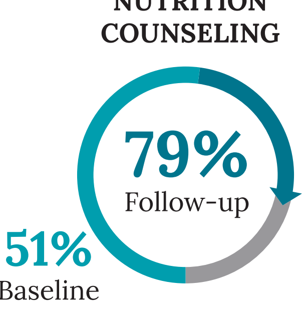
PHARYNGITIS TESTING



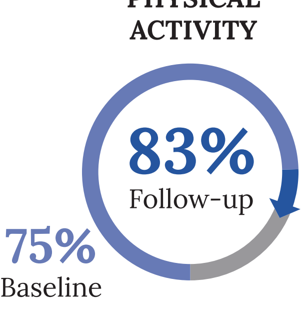
BMI RECORDED



NUTRITION COUNSELING



PHYSICAL ACTIVITY



Source: Colorado Children's Healthcare Access Program (CCHAP), 2015-2016

WORKFORCE DEVELOPMENT FOR ADVANCED PRIMARY CARE

17

MEDICAL ASSISTANTS **COMPLETED** ADVANCED MEDICAL ASSISTANT TRAINING

Source: BC3, 2015-2017

28

PERFORMANCE IMPROVEMENT TRAINING SESSIONS **COMPLETED**

Source: BC3 2016-2017; HealthTeamWorks Workforce Development Program

263

PRACTICE FACILITATORS **TRAINED**

Source: BC3 2016-2017; HealthTeamWorks Workforce Development Program

33

CARE MANAGERS **TRAINED**

Source: HealthTeamWorks

WORKFORCE DEVELOPMENT TRAINING: TEAM-BUILDING COURSE USING STRENGTHFINDER

*"I can't even explain how much of a game changer it is. Now we have our team speaking the same language, and really using each person so much better. We always talk about **working to the top of your license**, but this training is about taking it to the top level for each individual.*

—BC3 Participant, Family Practice Manager

BURNING PLATFORM: BUILDING A COMMUNITY OF PHYSICIAN PARTNERS

How is your organization building an effective partnership with the physician community? Is navigating beyond decades of distrust and siloed practice the foremost challenge of leadership? Are physicians in community practices at the table, but not quite ready to stake both their and the organization's performance against clinical quality measures and the total cost of care?

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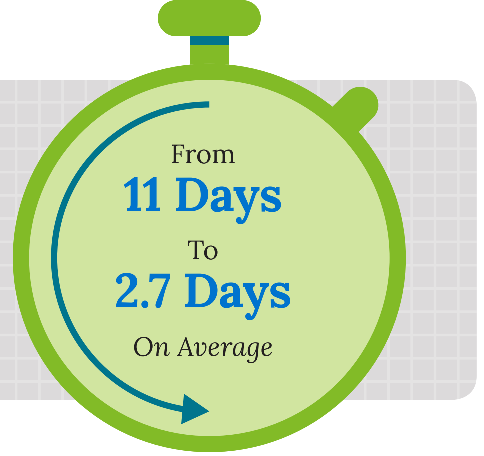
2. Network Integration of Primary and Specialty Care

A framework of advanced primary care is essential, yet insufficient, for the success of independent delivery networks (IDN). Key network services are required to create systems of high-performing, team-based care in both primary and specialty practices and across the network. Examples include process improvement, care coordination and care management, practice coaching, health information technology (HIT) integration, and clinically-relevant data analytics.

REDUCED Time to a Third Next Available Appointment

increasing patient access at Critical Access Hospital Clinic

**Ref. 2, See page 27*



ACCESS AND CONTINUITY

BC3 Better Care. Better Costs. Better Colorado.

ACCESS & CONTINUTY MEASURE IMPROVED FROM

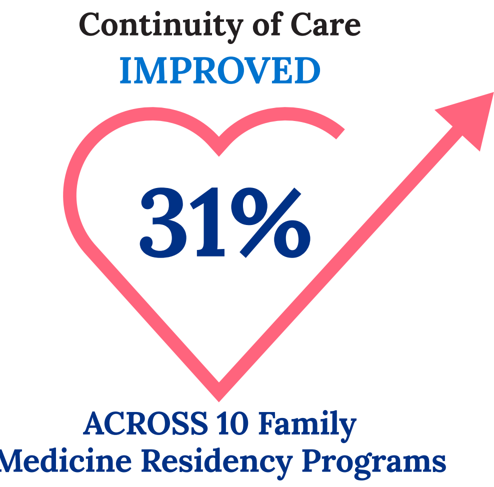
83 → 91%

The Better Care, Better Costs, Better Colorado (BC3) initiative was a collective impact effort to change the way Colorado communities deliver and pay for healthcare. HealthTeamWorks provided practice transformation services to healthcare providers in support of evidence-based, coordinated care supported by payment systems that reward positive outcomes.

Source: BC3, 2016-2017

Continuity of Care

IMPROVED



ACROSS 10 Family Medicine Residency Programs

Source: Colorado Residency PCMH Program, 2009-2014

Measures Of Team-Based Care

INCREASED

48*→63% 2015-2016

66*→70% 2016-2017

**Baseline Aggregate (different practice cohorts)*

Source: BC3, 2015-2017

PROGRAM IMPROVEMENT ACROSS PRACTICES IN CLINICALLY INTEGRATED NETWORKS (CIN)

Based on more than 10 years of executive experience leading and developing clinically integrated networks (CIN), *HealthTeamWorks*' staff brings deep expertise to organizational best practices including performance improvement infrastructure and services, clinical analytics development and implementation, practice transformation coaching, and physician governance.

Over a 12-month period of time and across 200+ providers*, *HealthTeamWorks* noted marked improvement achieved in the following quality measures:

Dilated Eye Exam – patients 18-75 with diabetes

100%
50%
20%
0%
Apr 2016
Oct 2016
Feb 2017

Top Provider **149**
Overall **3,619**
QPP Benchmark Decile 7 **96.67%**
Other Practices (8)

Diabetes Poor Control: A1c > 9%

DECREASED

25% → 18%

Breast Cancer Screenings (ages 50-75)

INCREASED

61% → 66%

Depression Screening and Follow Up

INCREASED

37% → 49%

Self Management Goal Setting

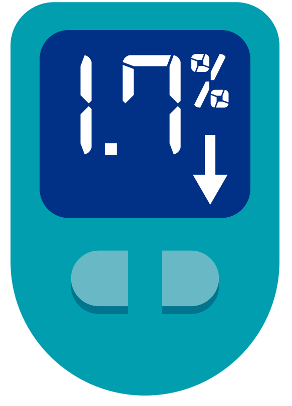
INCREASED

8% → 17%

**Integrated Physician Network, Louisville, Colorado*

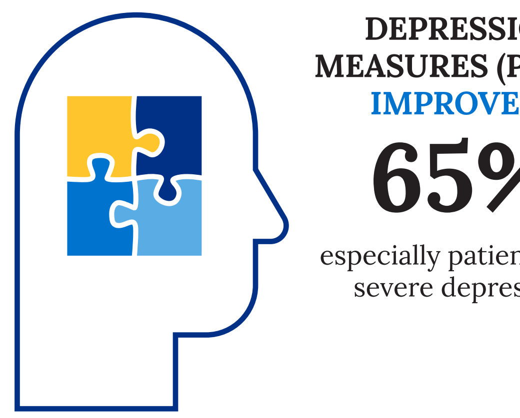
INTEGRATED CARE PHARMACIST INTEGRATION

Pharmacist-Integrated Team-Based Care Improvement
DIABETES A1C
LOWERED



Source: Comprehensive Primary Care (CPC), Colorado, 2015

IMPROVED BEHAVIORAL HEALTH SCREENING & FOLLOW-UP



DEPRESSION MEASURES (PHQ-9)
IMPROVED*
65%
especially patients with severe depression

Source: Pharmacist Integration Strategy (Colorado), Comprehensive Primary Care Classic, 2015

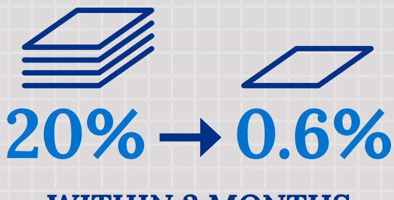
PRACTICE-BASED RAPID IMPROVEMENT TRAINING

White Mountain Regional Medical Center 1-day Rapid Improvement Training event focused on Lean Methodology resulting in a marked reduction in post-admission delays in care.

DEFECTS IN TIMELY COMPLETION OF ADMISSION ORDERS

DROPPED **75%** **TO** **SUSTAINED** **0%**

Yuma District Hospital and Clinics (CO)
DECREASED
ORDERS REQUIRING REWORK



20% → 0.6%
WITHIN 3 MONTHS

Kahuku Medical Center (HI)
ELIMINATED
OVER 1,000
MINUTES PER MONTH
IN EFFICIENCY AND WASTE AT THE FRONT DESK

**Ref. 3, 4, 5, 6, See page 27*

TRANSITIONS OF CARE

Efficient, patient-centered Transitions of Care management is built upon systems of collaboration and accountability across an integrated network of providers. While timely and coordinated follow-up is essential to caring for high-risk, high-cost patients, it is insufficent. Care transitions management also requires a team-based approach to understanding patients' "lived environment" - it is here that the social determinants of health are to be found and effectively addressed. *HealthTeamWorks* has reflected these needs in our advanced primary care model to include new team members, such as Community Health Workers and Health Navigators.

CANCER CARDIOVASCULAR PULMONARY DISEASE PROGRAM (CCPD)

75%

of **PATIENT DISCHARGES** from the hospital or ED received **TIMELY FOLLOW UP** from participating practices

100%

of participating practices implemented **CARE MANAGEMENT** for **HIGH RISK PATIENTS**

The Colorado Department of Public Health and Education's CCPD program is a state-wide initiative to promote more effective coordination of care for patients with chronic disease and especially for those in underserved communities. Our Impact: practice transformation and program leadership.

Source: CCPD Program

COMPREHENSIVE PRIMARY CARE INITIATIVE

89%

of hospitalized patients received **FOLLOW-UP** within **TWO BUSINESS DAYS** of **DISCHARGE**

Source: Comprehensive Primary Care (CPC), 2015

BETTER CARE, BETTER COSTS, BETTER COLORADO (BC3) PROGRAM

Behavioral Health Screening AND Follow-up Improvement		Behavioral Health - Primary Care Integration
INCREASED 36% to 49%g	INCREASED Urban Adults 64% to 68% Rural Adults 47% to 56% Rural & Urban Kids 13% to 30%	INCREASED 48% to 63%
YEAR 1 (2015-2016)	**YEAR 2** (2016-2017)	**YEAR 1** (2015-2016)

Source: BC3, 2015-2017

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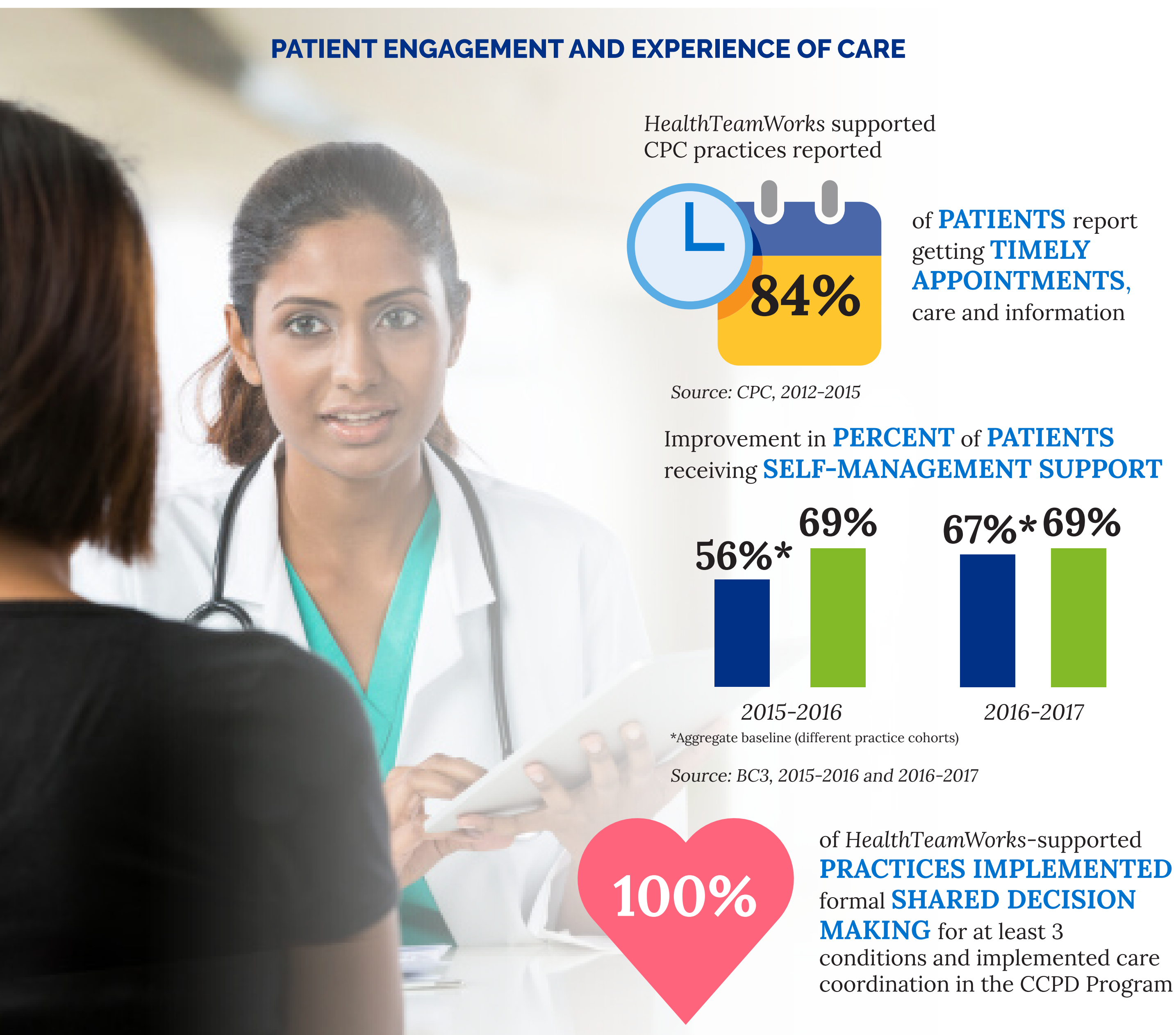
BURNING PLATFORM: NETWORK MEMBERSHIP AS BUSINESS PROPOSITION

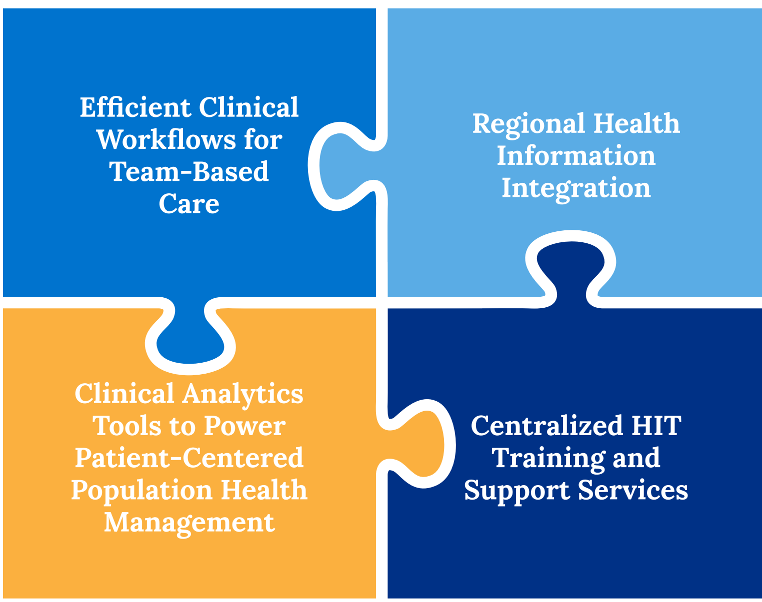
Is there a meaningful value proposition for network membership?
Are your independent practices struggling to find value in the tradeoff from autonomy to network interdependence? Do practices see the value of network membership as providing a roadmap to future economic security? How are networks rewarding advanced primary care for effective population management while also restructuring revenue models to reward high acuity network partners (e.g., hospitals, subspecialist providers) for more efficient care?



3. HIT Optimization & Clinical Analytics

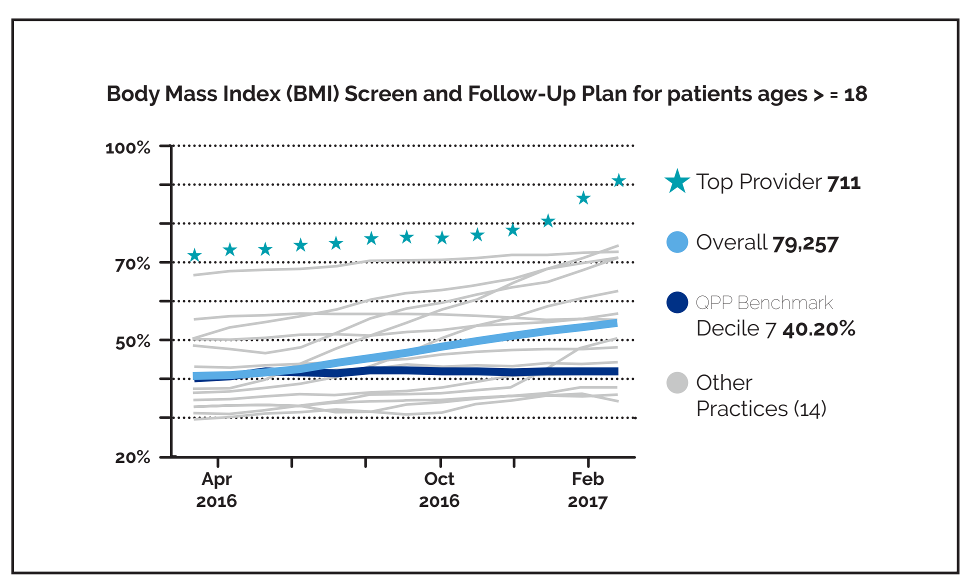
The fundamental power of an independent delivery network (IDN) is the efficiency and effectiveness of collaboraton around common goals. This principle must be applied to the health information technology (HIT) and information security (IS) tools that are critical to clinicians' patient care information access and integration across the network. Key examples include electronic health records (EHR) workflow optimization and design of clinical analytics tools that power patient-centered and advanced teamwork, such as real-time pre-visit planning reports, 2-step risk stratification tools, a universal registry, and performance engagement reports.

INTEGRATED DELIVERY NETWORK HIT OPTIMIZATION



CLINICAL ANALYTICS

Changing the behavior of care teams to drive outcomes across an IDN with 240 providers: Demonstrated **impact of 'transformative clinical analytics' tools** on population health performance.



Source: Integrated Physician Network

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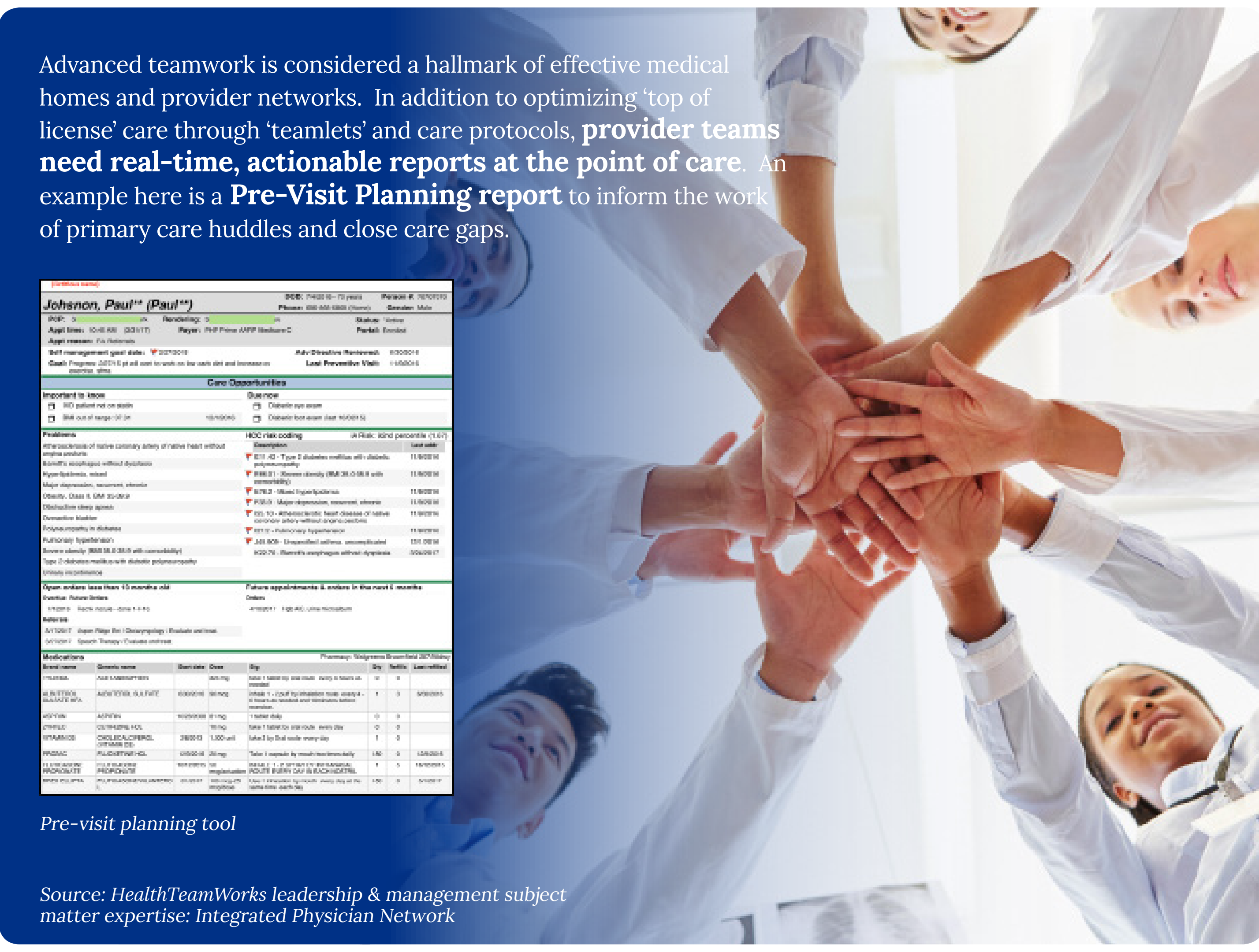
Of all the drivers of high performing healthcare organizations, ***the neural network — or HIT integration and functionality*** *— defines the currency, usefulness and impact value of clinical information across a collaborative community of providers. What matters to healthcare teams and their patients are its usefulness, data tools, efficiency, and standardization. This foundational HIT system-property does not tolerate fragmentation of HIT solutions. It obsesses over and remedies inefficient and duplicative clinical workflows. And it mandates data competency — namely, that primary clinical and utilization source data is mined, presented, and leveraged to power the work of care teams and their patients and families. The HIT neural network is foundational to making accountable and collaborative care work.*

—D. Ehrenberger MD., CMO, HealthTeamWorks



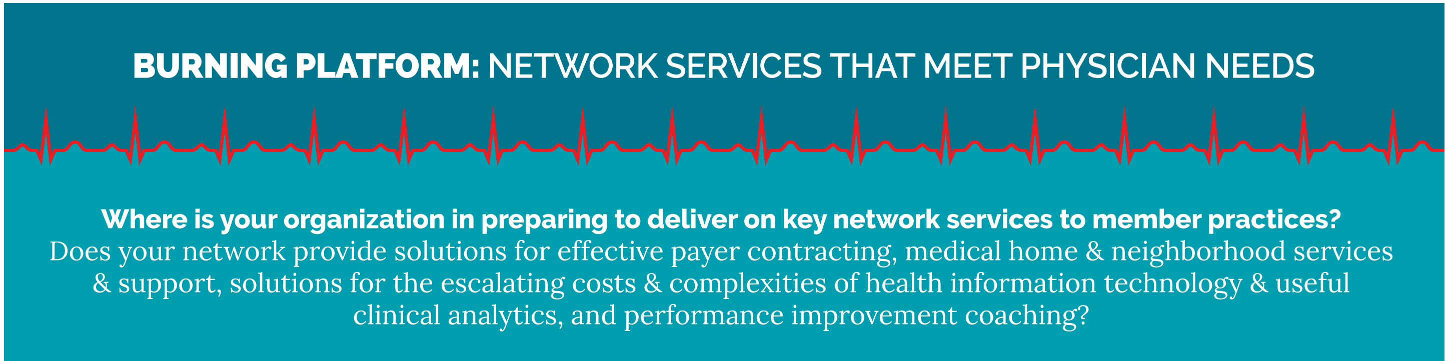
Advanced teamwork is considered a hallmark of effective medical homes and provider networks. In addition to optimizing 'top of license' care through 'teamlets' and care protocols, **provider teams need real-time, actionable reports at the point of care**. An example here is a **Pre-Visit Planning report** to inform the work of primary care huddles and close care gaps.

Pre-visit planning tool

Source: HealthTeamWorks leadership & management subject matter expertise: Integrated Physician Network

4. Provider Team Vitality, Engagement & Leadership

Burnout in primary care – reportedly ranging from 50-60% — is getting worse. It reflects both the inherent emotional burdens of empathic clinical work and the growing work-life struggles of modern systems of healthcare. Additionally, the imperative of practice transformation to advanced primary care, represents a further challenge for providers and their teams. To attract and grow healthy advanced primary care, IDNs must make workplace vitality a priority. Improvement in the experience of delivering care requires engagement and leadership of providers and their teams.



CLINICIAN AND STAFF EXPERIENCE OF DELIVERING CARE

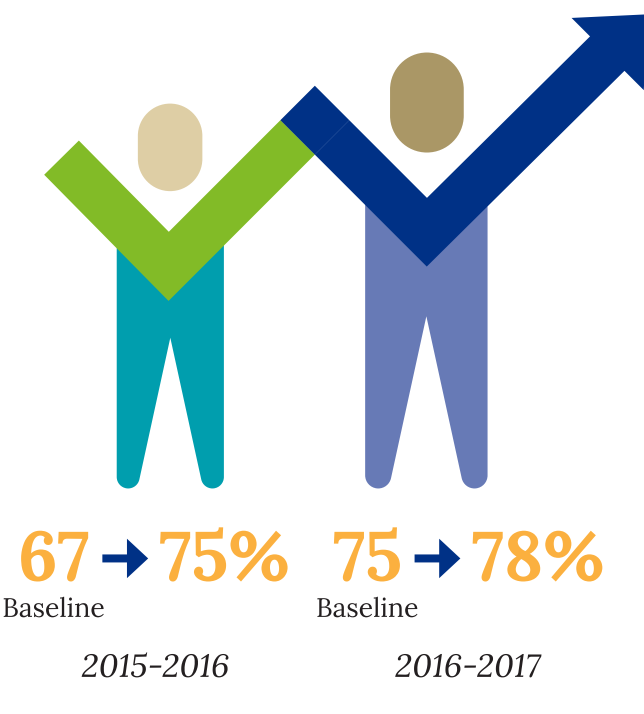
IMPACT ON BURNOUT

OF CLINICIANS AND STAFF REPORTED NO BURNOUT SYMPTOMS

32% less than the national average

Source: BC3, 2016-2017

LEADERSHIP & STAFF ENGAGEMENT MEASURES IMPROVED



Source: BC3, 2015-2016 and 2016-2017 (different practice cohorts)

EXPERIENCE OF PROVIDING CARE:
COLORADO FAMILY MEDICINE PCMH PROGRAM

49%

TEAM-BASED CARE
IMPROVED

10%

CHANGE & IMPROVEMENT CULTURE INDEX
IMPROVED

5%

QUALITY of **WORKING RELATIONSHIPS**
IMPROVED

Source: Colorado Residency PCMH Program, 2009-2014

EXPERIENCE OF PROVIDING CARE:
LARGE SCALE PRACTICE TRANSFORMATION*

87 CLINICS
LOWEST DECILE

VS

77 CLINICS
HIGHEST DECILE

Compared with clinics in the lowest decile of PACT advanced primary care
Veterans Health Administration's 'Patient Aligned Care Teams',
the **HIGHLEST DECILE of PERFORMANCE exhibited**:

↑ **HIGHER PATIENT SATISFACTION**
9.33 vs 7.53,
P < .001**

↓ **LOWER STAFF BURNOUT**
2.29 vs 2.80; P = .02**

*Ref. 7, See page 27

***Maslach Burnout Inventory emotional exhaustion subscale*

5. Business Best Practices Support for Network Member Offices

The small businesses of community-based practice are being profoundly challenged by the shift from fee-for-service and the high expectations by regional accountable care networks. To achieve these goals, **IDNs can provide professional "business of practice" support and collaboration resources** to ensure business management best practices, e.g., business model, financial management, human resources management, A/R billing, and collections.

PRACTICE PRODUCTIVITY

PRACTICE FINANCIAL SERVICES & TRAINING*

Office-based **PROVIDER PRODUCTIVITY** INCREASED **39%**

Colorado Critical Access Hospital

DAILY CASH COLLECTION INCREASED **10 FOLD**

Cheyenne Health and Wellness Center (FQHC)

40% INCREASE in **PATIENT VOLUME** within 6 months

Cheyenne Health and Wellness Center (FQHC)

57% INCREASE in **PATIENT ACCESS** and average **PROVIDER PRODUCTIVITY** (increase in patients per day per provider: **13.4 to 21**)

Kahuku Medical Center

Ref. 8, See page 27

ENCOUNTER CODING & RAF SCORING*

Encounter coding and compliance expertise provided to **2000+** PROVIDERS NATIONALLY

RAF REVIEWS, scoring best practices, coding and/or auditing services for over **300,000** MEDICAL RECORDS PER YEAR

Ref. 9, See page 27

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BUSINESS OF PRACTICE OPTIMIZATION: FINANCIAL SERVICES

REVENUE CYCLE MANAGEMENT IMPROVEMENT
CLAIMS PAID IN

21

DAYS
ON AVERAGE

*Ref. 10, See page 27

SUBMISSION RATE
95.3%
CLEAN CLAIMS
on first pass

TOTAL BILLED
REVENUE COLLECTED
96.8%
after contractual adjustments

*Ref. 10, See page 28

BUSINESS OF PRACTICE OPTIMIZATION: BUSINESS OPERATIONS

"The management consulting team has completely turned around our practice. They developed systems in the office that have made all of our providers more efficient and more organized, allowing better care for more patients. The team helped with our growth strategy, insurance contracting, medical records issues and many other areas has made our office a better, more effective, and more rewarding place to work!

*Ref. 11, See page 27

6. Value-Based Contracting, Utilization & Business Models

Networks that aspire to deliver market-relevant value must develop new business models with funds flows that reward high-value care, support the ongoing work of transformation and provide for effective governance. Central to this value-based healthcare are the Integrated Delivery Network (IDN) services necessary for engaged providers to lower the total cost of care and help lower premiums for patients and employers — while also improving the quality of care, access, patient experience, and provider and staff vitality.

VALUE-BASED CONTRACTING

Payer contracting services show a substantial return on investment for client practices, medical groups, and independent physician associations.

What clients say...

*There are so many complex, intertwined layers to the business of medicine critical to the success of a medical practice. [They] met and exceeded my expectations in contract negotiations. I would recommend them without reservation!**

- Sherry Niccoli M.D., F.A.C.O.G.

**Ref. 12, See page 27*

*From accounts receivable and appeals assistance to insurance contracting suggestions to compliance issues, [they have] impacted our business in very positive ways and delivered effective and quality services.**

- Linda Mercer, RN, BSN, RCC Compliance Office

**Ref. 13, See page 27*

UTILIZATION: ADVANCED PRIMARY CARE (PCMH)

Colorado All-Payer Claims Database showed the Total Cost of Care for the 3 largest primary care practices in a Denver Metro independent practice association (IPA):

Source: Colorado All-Payer Claims Database, 2015-2017

IMPACT OF ADVANCED PRIMARY CARE: UTILIZATION AND TOTAL COST OF CARE

Comprehensive Primary Care (CPC) Classic (2015)

REDUCED EMERGENCY DEPARTMENT UTILIZATION costs

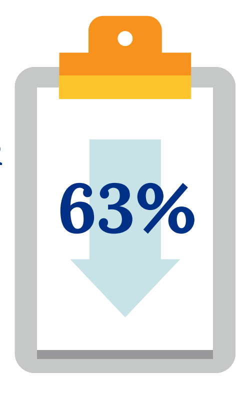
$10 per patient per month

93% Colorado **CPC PRACTICES ELIGIBLE** for **SHARED SAVINGS**

REDUCED HOSPITAL ADMISSIONS **7.6%**

REDUCED RE-ADMISSIONS **3.4%**

CPC practices **CARE MANAGER** integration **REDUCED ADMISSIONS*** by



*Ambulatory care sensitive conditions

Source: CPC, Colorado, 2015

Fresno California Patient Centered Medical Home (PCMH) Initiative

9% **DECREASE** in **TOTAL MEDICAL CLAIMS SPEND** (savings of ~$1 million)

16% **DECREASE** in **COST** among **HIGH RISK PATIENTS**

22% **REDUCTION** in **HOSPITALIZATIONS**

3% **REDUCTION** in **ED VISITS**

Source: PCMH, 2015-2017

BC3 Better Care. Better Costs. Better Colorado.

COST CONTAINMENT during Year 1 **IMPROVED**

58 → 77%
Baseline

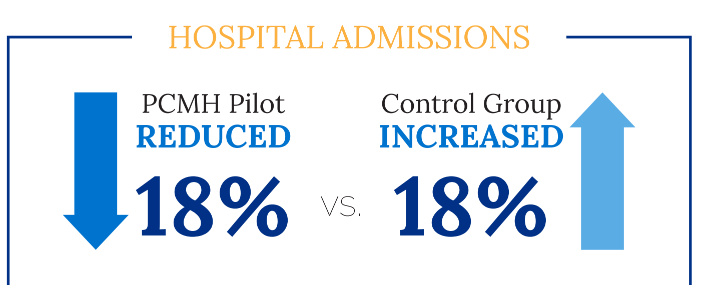
Source: BC3, 2015-2016

BURNING PLATFORM: CREATING MARKET-RELEVANT VALUE

What about the value proposition for payers and employers?
Is there a plan to understand your pain points, e.g., the total cost of care, access or quality of care? What about absenteeism & presenteeism? Do member PCP teams have the tools & community partnerships to assess & impact social determinants of health, especially for high cost, high need patients? Are there sufficient – and effective – centralized & practice-based care management services?

COLORADO MULTI-STAKEHOLDER MULTI-PAYER PCMH PILOT

The 5-year PCMH demonstration pilot, led by *HealthTeamWorks*, improved clinical quality while reducing utilization and the total cost of care.



HOSPITAL ADMISSIONS

PCMH Pilot **REDUCED** **18%** VS. Control Group **INCREASED** **18%**

VISITS TO EMERGENCY DEPARTMENT

PCMH Pilot **REDUCED** **15%** VS. Control Group **INCREASED** **4%**

Source: Colorado Multi-Payer Multi-Stakeholder Pilot 2009-2012

PARTICIPATING PAYERS
in this multi-stakeholder PCMH Pilot demonstrated a **RETURN ON INVESTMENT** ranging from

2.5→4.5:1

Source: Colorado Multi-Stakeholder Multi-Payer PCMH Pilot 2009-2012

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DIRECT-TO-EMPLOYER CONTRACTING SERVICES*

Independent third-party administrator services providing full-service solutions without channel conflict with hospital's current carrier arrangements, i.e., Blues, United, Aetna, etc, and comprehensive health plan solutions necessary to productize the hospital-ACO/CIN directly to self-funded employers in their local market.

Services including:

- Marketing and Selling the CIN product (including responses to employer RFPs)
- Employer Medical Benefits Administration & Account Management
- Employer Monthly Enrollment & Billing
- Customized Benefit Medical (TPA) & Pharmacy (PBM) Coordination
- Population Health Management Coordination (between employer & CIN)
- CIN Cost & Quality Performance Optimization
- Value-based CIN Payment Administration
- Self-funded Employer Reinsurance Coordination

*Ref. 14, See page 27

PAYER CONTRACTING SERVICES*

Payer contracting services on behalf of individual practice, medical groups and IPAs with hundreds of providers

PROVIDERS & **PROVIDER GROUPS** experienced a **RETURN ON INVESTMENT** of at least

50:1

*Ref. 15, See page 27

PAYER CREDENTIALING SERVICES*

Initial & on-going credentialing for commercial health plans, state health plans, Rural Health FQHC's, hospitals & hospital systems, advanced surgical centers (ASCs), durable medical equipment (DME), and physician practices

Storing & actively maintain (and update) credentialing files for thousands of physicians, mid-levels and other provider types

Primary source verification and credentials verification organization (CVO) & management services organization (MSO) services

Primary support of state & CMS mandated credentialing initiatives

*Ref. 16, See page 27

7. Integrated Delivery Network (IDN) – Operations & Governance

5-*Part Aim* organizational competency is built upon a foundation of Integrated Delivery Network (IDN) leadership and governance, organizational infrastructure, and member accountability designed to deliver on short- and long-term market-relevant value. Skilled leadership – by a team of business and physician executives and by an engaged and balanced board – is required to build and implement forward-thinking bylaws, member obligation policies, and key working committees, such as clinical HIT, security, membership, quality, and contracting.

HealthTeamWorks' staff brings decades of experience designing and building physician and network governance structures that work. The result is a culture of *collaborative accountability* that translates patient-centered and integrated care into 5-*Part Aim* performance.

Operations, Leadership & Governance Pillars of High Performing Delivery Networks

IDN Organizational & Governance

Practice Support Services

Performance Improvement

Care Team & Provider Vitality

HealthTeamWorks Subject Matter Expertise: Breadth, Depth and Experience in Network Transformation & 5-Part Aim Performance

Sustainable improvement to achieve healthcare network transformation requires a deep-understanding of the 5-*Part Aim* of **enhanced clinical care, improved patient experience, lowered costs, workplace satisfaction, and thriving healthcare businesses.**

At *HealthTeamWorks*, our staff and strategic partners have demonstrated successes through leadership and impact spanning the major domains of innovation in healthcare delivery. How we work together to provide integrated expertise is unique in the industry.

Our Approach fosters sustainable improvement for organizations providing: advanced primary care thought-leadership and implementation, development of high-performing accountable care networks, and leadership and support of programs that operate on the regional, national, and international levels.

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Our Leadership Team

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Our Strategic Partners

Booz | Allen | Hamilton

Colorado Health Extension System

*Ref. 14**

DCHC Consulting

HealthCare Innovations Consulting Group

Medical Home Primary Care of NY/Primary Care Innovators Network

*Ref. 1, 7**

*Ref. 8, 9, 10, 11, 12, 13, 15, 16**

*Ref. 2, 3, 4, 5, 6**

Subscript numbers reference our strategic partners' successes highlighted throughout this 5-Part Aim Portfolio.

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