Section 1: How is your organization achieving the Quadruple Aim?

Introduction

The Quadruple Aim's framework acknowledges the role patients, providers and care team members play in the delivery and transformation of healthcare. In the wake of a pandemic, the importance of a holistic lens in strengthening delivery system integrity and outcomes has never been more critically needed. The NOMINEE'S approach to implementing the Quadruple Aim is steeped in its evidence-based approach to transformation.

Quadruple aim: Workplace wellness or joy of work

The alarming rise in provider burnout affects attitudes, behaviors, clinical performance and patient outcomes. Its causes are many and vary by health system. With the NOMINEE'S Mission to improve the well-being of all individuals—including its own—it was purposeful in its current state analysis in identifying pain points. Unsurprisingly, the analysis showed that issues with its Epic electronic health record (EHR) topped the list. In-house analysis reinforced the findings, showing when and how long providers (physicians and advanced practice providers) were logged into the EHR and what sections they primarily interacted with. Collectively, *reducing the documentation burden*—both quantity and quality—became a North Star for improving provider well-being.

The details. In a typical install, Epic's In Basket is where all patient-related messaging is triaged. A surge in messaging occurred during the pandemic, with the onslaught of patient-crafted, EHR-generated and staff messages overwhelming providers and leading to challenges in identifying and acting on what's truly important. The predictable result—longer workdays and increased stress.

The approach. Multiple workstreams led by practicing physicians—all using Agile's iterative continuous improvement methodology—tackled pain points. For each workstream, forming a consensus on a clearly defined problem statement before setting the roadmap for resolution was key.

One illustrative workstream, "In Basket 360," targeted iterative solutions for Epic's In Basket—the analysis' most frequently named pain point. The approach revolved around three "rights:"

- **Right message** – Removing the low value or high cognitive burden messages that were flooding the In Basket.
- **Right person** – Is the best individual (functioning at the top of his or her role/license) responding to the message; could another member of the care team respond?

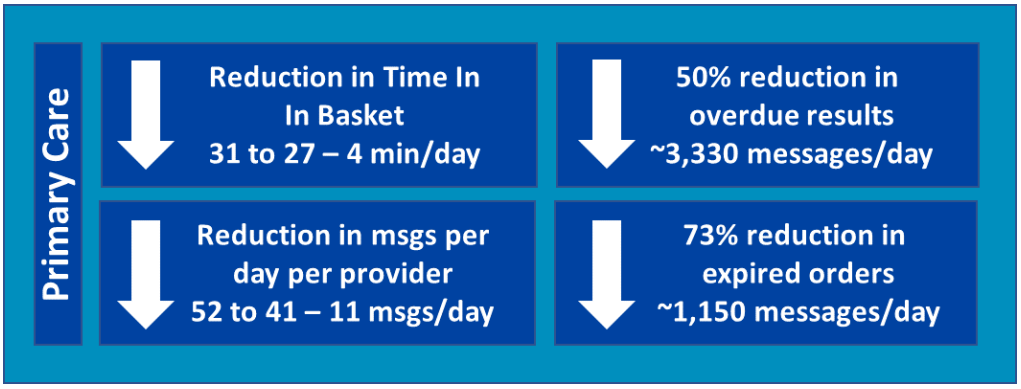
- **Right information** – Are care team members asking the right questions to mature the message before forwarding it on?

In addition, a physician-led team explored ways to reduce the documentation burden by aggressively addressing bloat. Aligning with Centers for Medicare & Medicaid Services recommendations, the intervention looked for ways to avoid copying and forwarding information already available in the chart. The desired narrative focuses on decision making and the actions of the provider.

Interventions. The goal was to reduce message volume and the time spent in the In Basket. Addressing excessive system, staff and patient-generated messages from a technical, workflow and behavioral lens, interventions included:

- Implementing a message retention policy
- Cleaning In Baskets, removing aged messages
- Applying new rules and filters in Epic to reduce low-value messages
- Upskilling care team members, allowing them to work at the top of their roles and reduce the burden on providers
- Retraining support personnel on how to mature messages so the person to whom the message is handed can take appropriate action
- Exploring scribing solutions (AI, voice-to-text, others) to assist providers in writing notes

Preliminary findings are significant. To date, 26.5 million aged messages have been removed from the In Basket. Modifying admission, discharge and transfer message generation eliminated another 400 messages a day. For primary care alone, 2 million overdue results and expired order messages were suppressed. Additional findings:



In Basket 360 is reducing the documentation burden, resulting in providers spending less time on computers and more time in direct patient care.

Quadruple aim: Improving patient experience of care

Poor patient experiences impact satisfaction, loyalty and reputation. They are correlated with poor outcomes, affecting preventive care and disease management.

In response, health systems hire consultants and invest in culture and engagement strategies and countless "Lunch & Learns." Yet despite efforts, improvements are usually short-lived. Like driving without a map, reaching the desired destination is problematic.

NOMINEE has developed a holistic approach to improve and personalize the patient experience. An exceptional patient experience is the sum of all interactions shaped by organizational culture. Exceptional patient experience is no longer merely a gauge of patient happiness but rather a well-rounded assessment of how well we are meeting patients' needs for safety, quality, convenience and compassionate care.

The goal. NOMINEE strives to be a top performer on established experience surveys for patient experience. Sustained quality/safety outcomes and consumer loyalty cannot be achieved without robust, patient-centered methods and behaviors across the care continuum, including all platforms and touchpoints. The perspective expands the concept of "experience" in recognition of the interdependency of the numerous touchpoints. Understanding the basic wants and needs of those we serve is essential, even as NOMINEE'S sheer number of clinics and their unique regional populations pose a challenge.

The intervention. Based on extensive research, NOMINEE developed a service bundle and composite score that embraces non-negotiable, evidence-based, national best practices for all clinics. The bundle is composed of five key metrics affecting patient experience, with survey data contrasted to Press Ganey benchmarks.

Implemented in 2021, the bundle critically focused on those areas that are of utmost importance to NOMINEE'S customers. Equally important, scores could be directly impacted by the actions of members of the care team. Clinic-level tactics included:

- Adding **Patient Experience Advisors** to provide clinics with a single point of leadership accountable for implementing and driving exceptional patient experiences.
- Conducting **weekly reviews of patient experience composite scores** at each clinic.
- Implementing **behavioral-based training for front-line teams** targeting "back to basics," communication fundamentals, relationship-centered communication, clinic shadowing and coaching, conflict resolution, and empathy curricula.
- **Leveraging huddles** so the patient experience remains front of mind, with metrics shared to promote transparency and continuous improvement.
- Iterating on a **toolkit that compiles best practices** across clinics.
- Refining, implementing and measuring **new service standards** that allow the NOMINEE to act in the moment to observe the "must-have" behaviors of an exceptional patient

experience, identify service issues, collect real-time feedback, solve problems before they surface online or in surveys, and track progress.

- Based on practice experience composite mean scores, **use external observers**—at least twice yearly (weekly, if needed) to drive change.

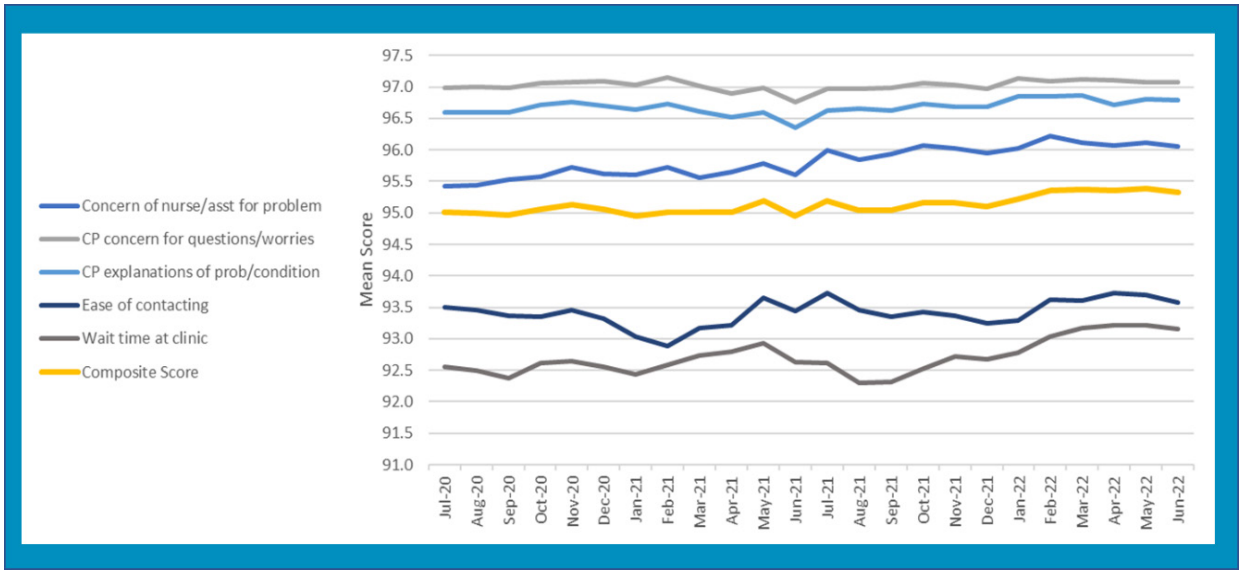
Results

The NOMINEE shows how a focused effort, centered on the customer experience, can drive behavioral change at the clinic level:

Medical Practice FY22 Performance

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	FYTD	Goal	%tile Rank	Gap to Goal
# of surveys received	48406	51529	46873	47262	44167	41785	49730	43806	53412	48909	47116	50139	573134			
Concern of nurse/asst for problem	96.00	95.84	95.93	96.07	96.03	95.95	96.02	96.22	96.11	96.07	96.12	96.05	96.03	95.64	80	0.39
CP concern for questions/worries	96.97	96.97	96.98	97.06	97.03	96.97	97.14	97.09	97.12	97.10	97.08	97.08	97.05	97.04	74	0.01
CP explanations of prob/condition	96.62	96.65	96.63	96.73	96.68	96.68	96.85	96.85	96.86	96.71	96.80	96.78	96.74	96.64	72	0.10
Ease of contacting	93.73	93.46	93.35	93.42	93.36	93.25	93.29	93.62	93.60	93.72	93.70	93.57	93.51	93.34	71	0.17
Wait time at clinic	92.61	93.20	92.32	92.53	92.72	92.68	92.78	93.04	93.17	93.21	93.21	93.16	92.81	92.64	75	0.17
COMPOSITE	**95.19**	95.04	95.04	95.16	95.16	95.11	96.22	95.36	95.37	95.36	95.38	95.33	95.23	95.05		0.18

Through NOMINEE'S efforts, it is performing above the 70th percentile for all five Press Ganey metrics. In FY 22, using NOMINEE'S five-question clinic composite, 12-month clinic performance was both strong and trending positive:



Quadruple aim: Reducing the per capita cost of healthcare

Gallup tells us that 40% of households are cutting spending thanks to rising healthcare costs. NOMINEE'S accountable care organization (ACO) is one of the true success stories when it comes to simultaneously lowering healthcare costs and improving quality of care.

NOMINEE'S integrated care model enhances the quality of care and life and improves consumer satisfaction and efficiency. The NOMINEE believes success in delivering low-cost, high-quality care is achieved when:

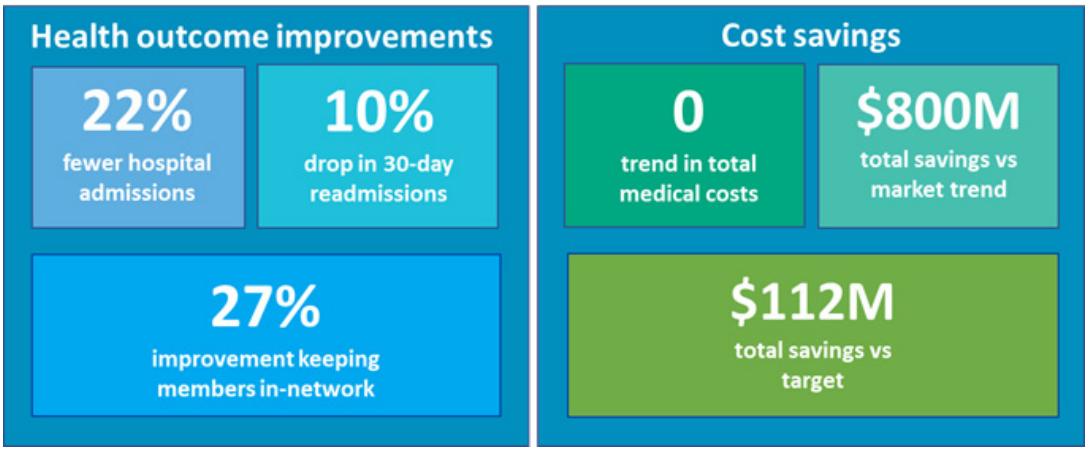
- Clinical processes are aligned as closely to the provider and patient as possible.
- Barriers to care caused by administrative hurdles and red tape are reduced.
- Care is managed across all sites of care.
- Standardized best practices are identified and shared.
- Accountability for improving quality and efficiencies is monitored and reported.

NOMINEE works directly with employers to focus on cost. By managing the population to increase member engagement, foster appropriate utilization and reduce risk, the total cost of care for NOMINEE'S providers is 16% below market competitors. Factors that contribute include:

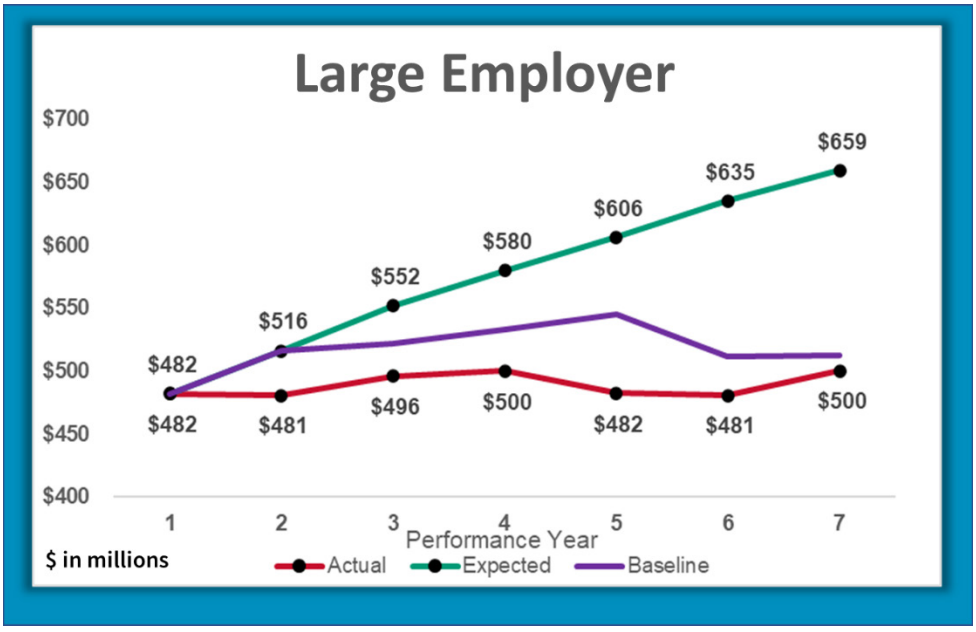
- Convenient access to quality primary and specialty care physicians, retail clinics, urgent care centers, and select practices offering "after-hours" care.
- Integrated care teams where care managers, health coordinators and licensed social workers proactively reach out to members and assist them in navigating the healthcare system and maintaining compliance with doctor-driven treatment plans.
- Chronic disease management to help those with chronic illness manage their condition, maximize the impact of their doctor's treatment plan, improve quality of life and reduce the need for costly healthcare.
- Preventive health services focused on wellness, early detection, gaps in care and prevention of chronic disease.
- Aligned incentives so that doctors are rewarded for improving healthcare quality and efficiencies.
- App-based telehealth and remote offerings to avoid delays in both preventive care and treatment while increasing access.

Proven results

Employer benefits. Putting NOMINEE'S integrated care model to work has resulted in significant improvements in health outcomes and medical cost savings.



Cost savings. Cost savings for one large employer is representative. The green line depicts how the plan would have performed based on the medical cost trends in our markets, while the purple baseline is based on trends using the prior year's actuals and forecasting the next year's target. (Baseline is reset every year.)



Medicare benefits and cost savings. NOMINEE'S organization saved over $322 million dollars over four years in a Medicare Shared Savings Program (MSSP) while maintaining quality scores above 97%. The results demonstrate that even when faced with an unforeseen and

unprecedented health crisis, NOMINEE remained committed to making healthcare better and more affordable through provider-led care coordination and design. Within the MSSP population, the organization saw notable improvements in performance, including increased primary care visits and a 17% increase in care management engagement—helping drive lower avoidable admissions and emergency department utilization despite the challenges posed by the pandemic.

Increasing provider and care team engagement, collaboration and alignment and providing "at-the-elbow" support are inherent to the NOMINEE'S integrated care model that is delivering low-cost, high-quality care across its service area.

Quadruple aim: Improving population health with focus on quality

Fundamental to improving community health outcomes is a commitment to fostering health equity. Organizations that are truly transformative must move beyond talk or theory.

NOMINEE is leveraging data to improve patient outcomes and cut costs. It is purposeful in its approach, with a bias toward tightly tailored, actionable, evidence-based solutions. It begins by analyzing the population based on:

- Race and ethnicity
- Age and gender
- Language
- Risk
- Social determinants of health
- Income
- Chronic condition cohorts

The strategy allows the NOMINEE to segment populations by cohort to inform care, improve workflow decisions and promote action. By embracing these groupings as part of its risk model, NOMINEE supports data-driven decisions.

The power of informed decision making. Exploring cohorts by chronic condition offers insights. Data shows that the top seven chronic conditions overlap across races/ethnicities:

Top 10 Chronic Condition Cohort	Number of Members	Percentage
Hypertension	198,660	12.32%
Hyperlipidemia	174,789	10.84%
Obesity	124,725	7.74%
Fibromyalgia, Chronic Pain and Fatigue	100,936	6.26%
Rheumatoid Arthritis/ Osteoarthritis	87,638	5.44%
Anxiety Disorders	86,944	5.39%
Diabetes	81,296	5.04%

In managing population health, four actions stand out:

1. **Resource guide build-out.** The NOMINEE'S findings from its population health analysis led to the development of a resource guide. A short sample is shown below:

Findings/ Cohort	Programs/ Activities Available	Resources Needed	Action Needed	Priority
Social Determinants of Health (SDoH)	• Provide patients with community resources directly from Epic (searchable by name, city and zip) • Community resource referrals – Community Health Department will update directories quarterly and as needed • Referral to care management	• SDoH Dashboard in the EHR • If resources need to be added to or deleted from community directory, staff can email • Identify staff to outreach if needed	• Review SDoH dashboard • All primary care staff can and should document SDoH • Care management social work, and care managers will also document SDoH • Everyone in the care team will have access and can update as needed • Capture SDoH during visits or as information is received or provided over-the-phone	High
Hypertension (HTN)	• Hypertension standard delegated order • Hypertension Management Plan • Hypertension tip sheet	• Specialty RN • Sufficient staff	• Provide patient with education and engage patients on management plan • Use the standard delegated order, pharmacy and care management staff	High

The resource guide promotes consistency and clinical performance excellence for the care of those with chronic conditions.

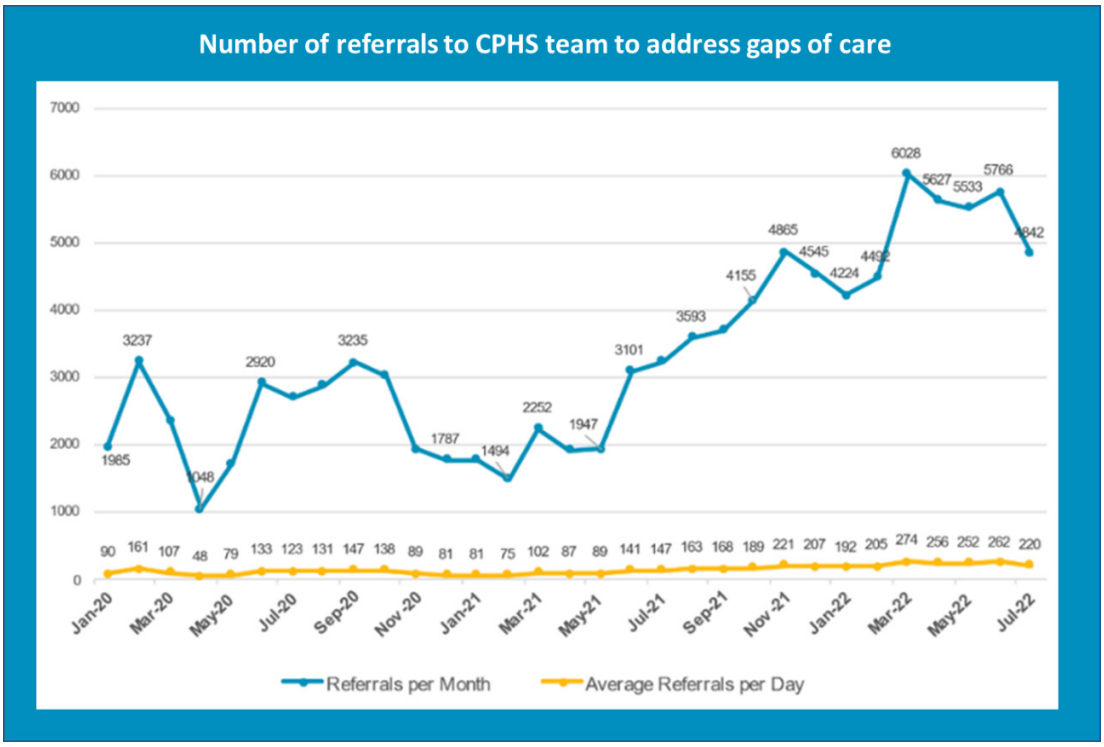
2. **Standardize processes.** The NOMINEE standardized processes as its clinics managed these patient populations:

    - Reports from Epic's Healthy Planet population health application identified overdue patients to contact.
    - Pre-visit planning identified overdue health maintenance topics.
    - A “gaps” team reached out via the NOMINEE’S digital health app and by phone.
    - Case managers working with high-risk patients, pharmacy and social workers had access to standardized delegated orders for health maintenance topics. By design, these orders empowered staff to place internal referrals for social determinants of health and other services.

3. **Promote gap closure.** The NOMINEE launched **Centralized Population Health Services (CPHS)** to help primary practices ensure that gaps are closed and that reports are correctly scanned into charts. CPHS reduced the documentation burden for clinics while simultaneously ensuring attestation documentation is readily available for risk contracts. Collectively, they created a safer environment for patients and providers.

4. **Centralizing workflows.** This change resulted in streamlined processes for obtaining external records and improved accuracy for entering results/scans. Most importantly, it increased the time available for the care team to focus on providing high-quality and coordinated patient care to drive positive change.

Results. The NOMINEE’S impact can be measured in increased referrals to CPHS to promote closing gaps in care:



The impact can also be seen at the cohort level, with hypertension control a representative example:

Blood Pressure Control (JNC8)

Payor	Current Performance	Target	Data Trends Data Range: July 2021 – May 2022
CMCL	**80.4%**	64.1%	*Scale: 79.4% - 80.7%*
MCAID	**69.4%**	59.7%	*Scale: 69.2% - 71.8%*
MCCARE	**85.8%**	78.5%	*Scale: 84.5% - 86.6%*

Ongoing tactics:

- Outreach to non-adherent members by CCM and clinics
- Document patient reported blood pressure in Epic Remote Vitals
- NOMINEE'S ACO Pharmacy Team outreaches MA members non-adherent to medications

Moving beyond talk and theory. The NOMINEE is moving beyond talk and theory to systematically improve the health of underserved populations in alignment with its Mission.

Section 2: Tell us your story

Essay #1: A "Star" in the making

Accountable care organizations (ACOs) strive to improve quality, enhance the patient experience and reduce healthcare costs. Change of that magnitude begins with empirical data.

The VBC Star Rating (VBC Star) is an in-house developed composite measure that evaluates clinic and provider performance using a five-star scale. It is a tool that is central to hard-wiring the exceptional experience NOMINEE'S customers deserve.

The design process. VBC Star is a product of a partnership between the NOMINEE'S operations team and its ACO. Together, they designed the analytics, methodology, dashboard and implementation toolkit. The original goal was to tightly align ongoing quality improvement efforts with contract measures, creating a synergy that would feed operational goals.

At its heart, VBC Star reflects how well care is delivered, with a focus on preventive measures and the management of chronic disease conditions. The measures forming the composite allow for comparison to state and national benchmarks.

Critical to the composite's success is its tight integration with what payor contracts identify as important. Those payor preferences are aligned with interventions that can prevent or delay disease progression. To the extent that customer health is positively impacted, plan expenses decline. In turn, VBC Star promotes a consistent patient experience regardless of provider and becomes a key tool in aligning clinic performance across a large and geographically diverse service area.

Implementation. An internal Clinical Excellence team monitors performance and meets monthly with regional leaders to review clinic performance, craft action plans and celebrate successes. At the clinic level, NOMINEE supplements deployment via resources for clinic administrators, providers and the entire care team (reports, training, etc.). Importantly, providers can view their own performance year-over-year and can run reports that identify patients who are past due for preventive procedures and tests or are non-adherent to medication. These reports are opportunities for the care team to reach out to the patient to address access, affordability and related questions. In addition, providers also can review their own performance against other providers in their clinic, region or across the System.

As implemented, VBC Star would:

- Indicate how well care is delivered to its members
- Highlight measures tied to disease prevention and chronic disease management
- Focus providers and the entire care team to "provide the right care at the right time"
- Drive improved contract performance (commercial, Medicare, Medicaid and direct contracts)

Overcoming obstacles. Nationally, many health systems found the transition from fee-for-service to value-based care has been episodic and rocky at best. At the root was a simple question, "What is value-based care?" Star's implementation was an opportunity for the NOMINEE to educate the entire care team from the customer's perspective on how it will improve quality and affordability and, ultimately, create healthier communities.

Important learnings. Two key learnings:

Payor and employer preferences are a moving target. Across the years, payor expectations shift. VBC Star has had to adapt to stay relevant/impactful. FY 23 measures are:

FY23 NOMINEE Quality Measures

Measure	Measure
Well-child visits in the first 30 months of life	Child and adolescent well-care visits ages 3-11
Child and adolescent well-care visits ages 12-17	Appropriate treatment for UTI
Avoidance of antibiotic treatment for acute bronchitis	Blood pressure control (JNC8)
Breast cancer screening	DM: A1c Control (<8%)
Kidney health evaluation for patients with diabetes (KED)	Use of imaging studies for low back pain
Medication adherence for cholesterol (statins)	Medication adherence for diabetes
Colorectal cancer screening	

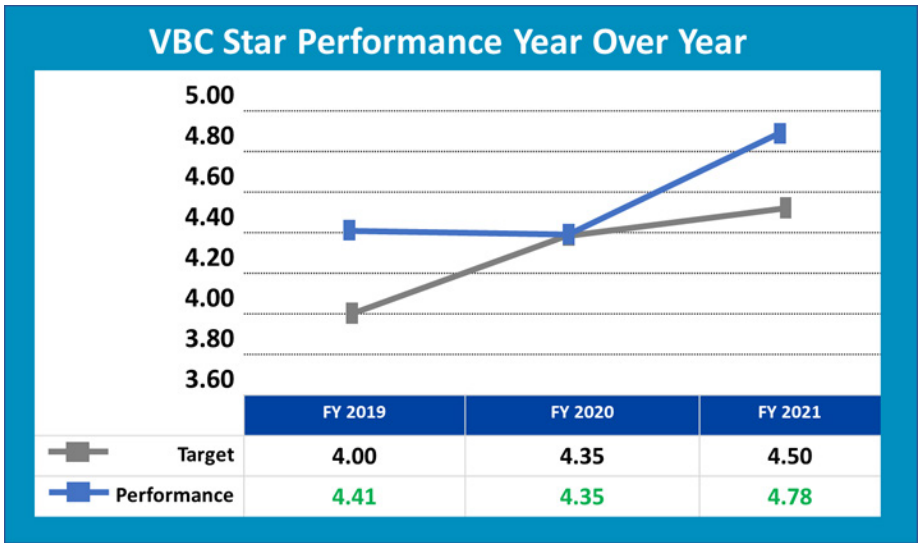
Note: State HEDIS benchmarks and CMS Medicare Advantage (MAPD) Star cut points are used to determine the VBC Star targets.

Iterating is key. Central to the NOMINEE'S adoption of the Agile framework for continuous improvement is embracing iteration. There are always ways to improve processes.

Spreading best practice. What works gets adopted. As of July 2022, VBC Star is deployed across more than 700 primary and specialty care clinics in the NOMINEE'S network.

Results

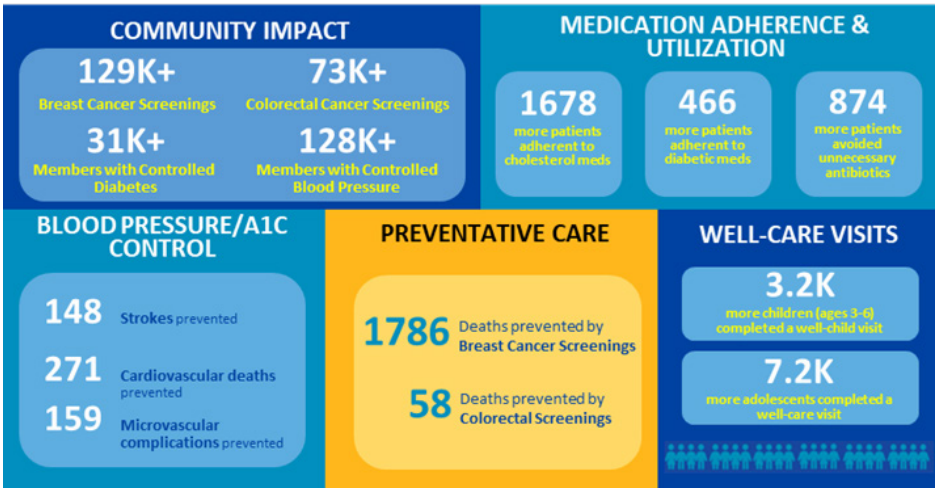
VBC Star is improving clinic performance. While change isn't measured in a day, it is relatively safe to say that after three years, VBC Star Rating is an important indicator of how well the NOMINEE is delivering care to the vast population of patients and members served. The implementation of VBC Star at NOMINEE'S clinics is driving improved performance, as shown below.



In its first three years, VBC Star has seen overall clinic performance above threshold and target—results not expected until year five.

VBC Star is changing lives

Through the systematic implementation of VBC Star, patient health is improving, and the cost of healthcare is decreasing.



Through this easily replicable composite, hundreds of thousands of patients/members are receiving optimum care, their risk of developing preventable disease has been significantly decreased and the right tests have been done to ensure early detection. For patients with chronic conditions, care teams are partnering with patients, providing support and empowering them to better manage their condition.

It is the ultimate goal of any health system—empowering you to live well.

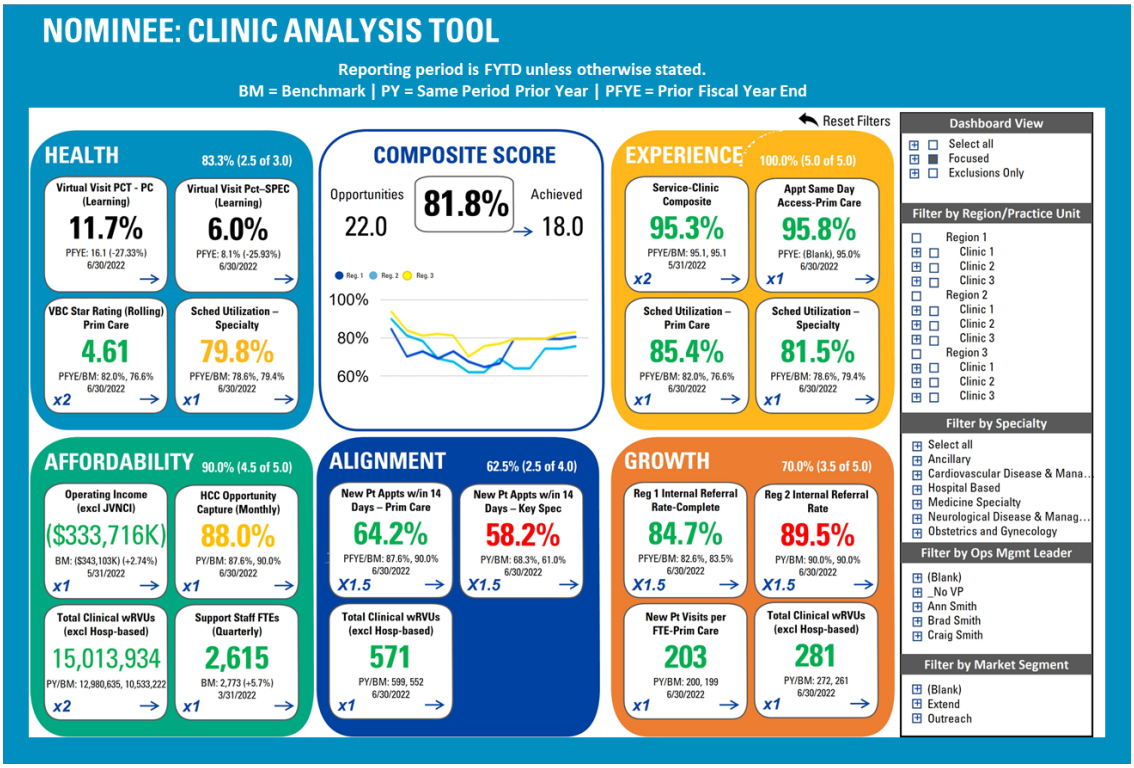
Essay #2: Addressing access issues

Access issues shape customer perceptions about a “broken” healthcare system. Statements like, “It took five weeks to see the oncologist,” impact the patient and the brand.

NOMINEE’S clinics deliver an exceptional individualized experience that is consistent and predictable. With no single, evidence-based, reliable source that showed trends, historical data and the relationship between variables, NOMINEE built its own.

Introducing the Clinic Analysis Tool (CAT)

CAT is an in-house built, dynamic dashboard that displays performance at various levels of detail down to root causes. It provides actionable data for operational improvement and growth, identifies best practices, and aggregates performance metrics at the organization, region, clinic, specialty and provider levels. CAT is the primary tool to advance practice standardization, ensuring that all patients receive the experience they deserve.



Design. Using a 12-month Agile process, NOMINEE united resources from across its organization—analytics, operations, finance and clinic leaders—to build a dashboard to advance understanding of how clinics perform overall, rather than simply financial performance.

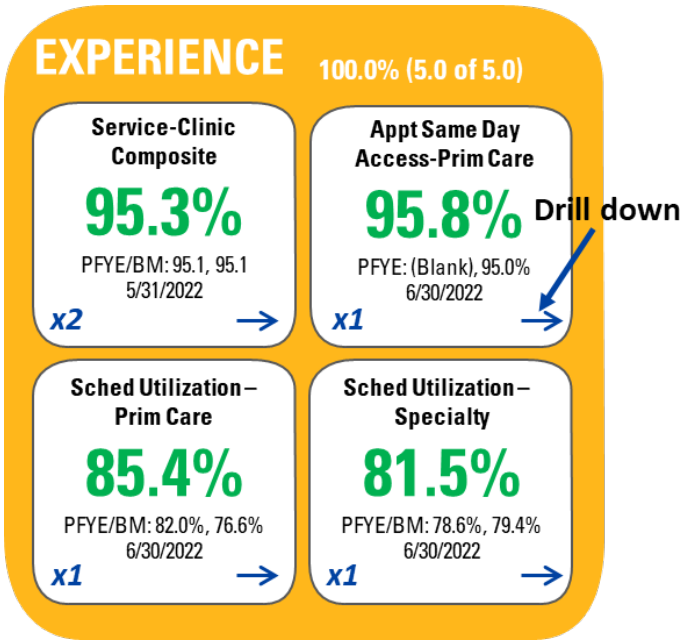
Obstacles. Chief among obstacles was creating and maintaining the myriad of interfaces from the multiple applications that populate CAT. NOMINEE sources data elements from its EHR and

proprietary systems, grouped by weighted category. The five categories—Health, Affordability, Alignment, Experience and Growth—represent key areas of clinic performance and adjust dynamically depending on the filters applied.

NOMINEE takes care of its patients holistically and views its clinics through a similar lens. Within each category, individual metrics can be compared to benchmark, prior year or prior fiscal year. Individual metrics can be drilled down to display underlying data while top-level data shows gap to goal—the strategic areas for improvement. Categories, in turn, are combined to display a composite score. For example, embedded in the Experience category is the Service-Clinic Composite.

CAT in action

Implementation. Clinic and executive leadership meet monthly by region to evaluate each clinic's performance. They look at individual category elements and their potential relationship with elements from other categories. Clicking the right arrow next to an element drills down into the data to the provider level. For example, using CAT, they may discover that quality is improving while access is declining, suggesting a throughput issue.



At the clinic, huddle boards display subsets of CAT data, a central topic of the 20-minute weekly meetings with the entire care team. Subsequent CAT data evaluates effectiveness and encourages iteration. Ultimately, solutions that positively affect the patient experience are spread across NOMINEE'S clinic network.

Example. One of the NOMINEE'S key focus areas this year is access. CAT access-related metrics that help identify best practices and areas of opportunity include Press Ganey—ease of scheduling, schedule utilization, new patient lead days, provider panel size and same-day access. For getting new patients scheduled in a timely manner, the NOMINEE set as its target the 75th percentile from Epic benchmark data—a 14-day scheduling window. In addition, it set a target of 95% for those patients seeking same-day access.

A key attribute of the CAT is its ability to identify best-performing and low-performing clinics. An analysis of identified high-performing clinics suggested a range of interventions, from leveraging the NOMINEE'S digital app for self-scheduling and 24/7 virtual urgent care services to enhancing care team roles and ratios.

For a low-performing clinic, the intervention included:

- Providing more virtual visit options for all patients—new and existing.
- Adapting schedule workflows to meet patient needs.
- Targeting increased facility utilization by extending hours and staffing to reduce the ratio of exam rooms per provider.
- Revising the support staff to provider ratio.
- Optimizing cost control opportunities.

For the low performing clinic, NOMINEE changed its model to include expanded care teams, more virtual care options, new providers and extended hours with minimal added expenses.

Results. The clinic's professional net revenue increased 115%, while operating expense rose only 59%. Schedule utilization increased from 87.7% to 89.8% while same day access remained high and slightly increased from 97.5% to 97.8%. The intervention led to reduced referral delays (while keeping 85% of patients in-network). New patient lag time for primary care outperformed the Patient Access Collaborative 75th percentile benchmark.

Spreading best practice. The intervention's success is resulting in its phased deployment across more than 700 primary and specialty care clinics in the NOMINEE'S network.

Important learnings. *By leveraging "big data," organizations like the NOMINEE have the information readily accessible to supercharge clinics by advancing quality and improving the patient experience.* Solutions like CAT can lead to redesigning processes and empowering customers.

Keeping patients well

Addressing health equity perfectly aligns with NOMINEE'S Mission. Its extensive network of Community Care Clinics (CCC) targets the underserved, united around a single focus—keeping patients well and in the community. CCCs serve a population that is 85% uninsured, with incomes at or more than 200% below the federal poverty line. With an integrated care team embedded in each clinic, treatment plans address multiple social determinants that affect long-term outcomes. Collectively, they target over 13,500 high-risk patients with chronic medical conditions across more than 41,900 encounters annually.

How it works. Primary care providers are a part of multidisciplinary, enhanced care teams with an integrated approach to medical, behavioral and social determinants of health. By targeting the whole patient, they optimize care delivery—advancing patient outcomes and promoting health equity.

Example. A 50-year-old unmanaged patient served by the clinic had multiple morbidities (COPD, obesity, hypertension and hepatitis C). Based on her current health status, she had a one-in-five chance of being alive 10 years from now. Given her current health trajectory, the patient's later years would see a steep decline in quality of life and surely consume significant healthcare resources.

In decades past, the patient, if seen, would be given prescriptions and, perhaps, a lecture about taking care better of herself. Odds are, there would be little follow-up if an appointment was missed—with even fewer checks on prescription compliance. As her health declined, she would be a frequent visitor to the emergency department.

The CCC's approach is remarkably different. It begins with an understanding that the complexities of chronic disease management and addressing social determinants takes a team approach. Behaviorists address social and mental health needs while community social workers solve for food insecurity, transportation and housing barriers. Dietitians help reframe the patient's relationship with food and reinforce a diabetes- and hypertension-friendly meal plan. Physicians, advanced practice providers (APPs, such as nurse practitioners) and pharmacists treat the underlying conditions while promoting behavioral change. Support staff frequently reach out to encourage medication compliance and answer questions. By meeting the needs of patients where they are and crafting unique, multifaceted care plans, the enhanced care teams across the NOMINEE'S several CCC locations are changing lives and changing healthcare for the better.

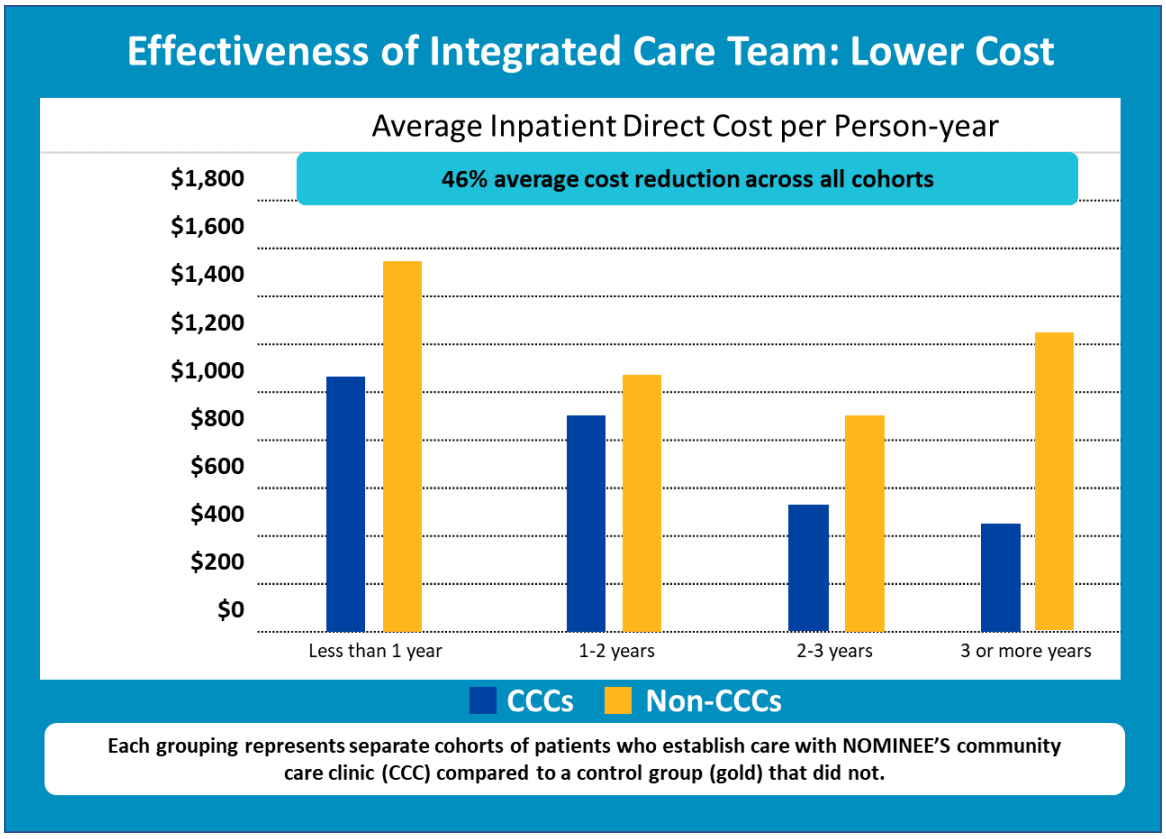
Extraordinary care starts at the NOMINEE'S clinics and extends to the relationships that are built, proactively reaching out to patients. Staff members ask, "How are you doing? Is there anything you need?" Just as importantly, they were intentional, asking, "How is your stress level?" Trained behaviorists and community health workers follow up as needed. Those

conversations served to identify critical care gaps while reminding patients they were not alone and that we are in this together.

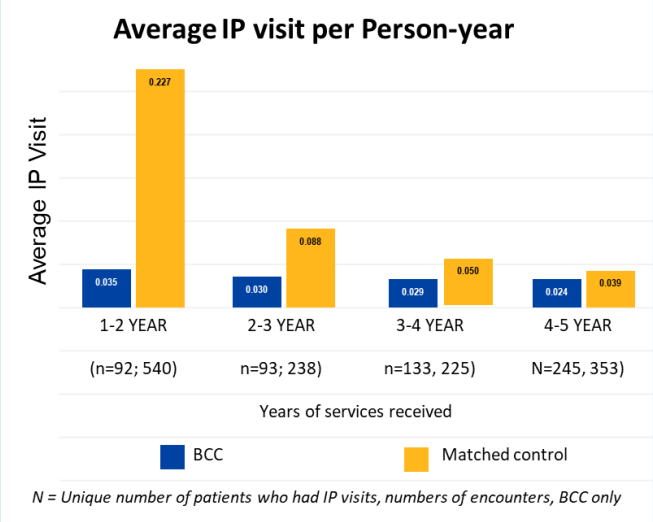
Results. When comparing separate cohorts of patients who established care with the NOMINEE'S CCCs for three-plus years compared to a control group that did not:

- **64% reduction in average inpatient direct costs** compared to non-CCC.
- **73% lower inpatient visit volume** compared to non-CCC, per year.
- For every 1,000 patients, CCC had **21 fewer inpatient admissions** compared to non-CCC.
- During the COVID surge, CCC had **67% lower inpatient COVID volume** compared to non-CCC, per year.
- During the first COVID surge, CCCs had an **84% increase in behavioral health visits**. **80% of them were by telehealth.**

For many, medicine is a calling. The providers and support staff at NOMINEE'S CCCs show the advantages daily of a high-touch, integrated care model that embraces value over volume. It's a future that is better for our patients and better for our providers.



Average IP visits 2020-2021, per person year by duration of services received from NOMINEE'S clinics.



N = Unique number of patients who had IP visits, numbers of encounters, BCC only

For patients who received services 3-4 years:

- CCC had **73%** lower IP volume compared to non-BCC, per year.
- For every 1,000 patients, CCC had **21** fewer IP admissions compared to non-CCC