Medicare Shared Savings Program ACO Learning System

Leveraging Community Resources and Addressing Beneficiaries’ Social Needs

Wednesday, September 14, 2016
2:30 – 4:00 PM ET

Audio for this session can be streamed through your computer, or accessed by phone by dialing 1-857-232-0156; access code: 271840
The comments made on this call are offered only for general informational and educational purposes. As always, the agency’s positions on matters may be subject to change. CMS’s comments are not offered as and do not constitute legal advice or legal opinions, and no statement made on this call will preclude the agency and/or its law enforcement partners from enforcing any and all applicable laws, rules and regulations. ACOs are responsible for ensuring that their actions fully comply with applicable laws, rules and regulations, and we encourage you to consult with your own legal counsel to ensure such compliance.

Furthermore, to the extent that we may seek to gather facts and information from you during this call, we intend to gather your individual input. CMS is not seeking group advice.
Past Webinar Materials

- Interested in past Learning System events? Go to https://portal.cms.gov to access recordings and summaries of past webinars, including:
  - Advancing Primary Care – 11/14/14
  - Beneficiary Engagement – 10/22/14
  - Beneficiary Engagement and Annual Wellness Visits – 8/19/15
  - Care Coordinator Roundtable – Session 1 – 9/30/15
  - Care Coordinator Roundtable – Session 2 – 10/14/15
  - Coordinating Care for Beneficiaries with Complex Care Needs – 6/24/15
  - Coordinating with Hospitals and Specialists – 12/15/14
  - Coordinating with Post-Acute Care Providers – 11/21/14, 11/19/15
  - Engaging Office Managers in ACOs – 12/10/15
  - Engaging Pharmacists in Accountable Care – 7/19/16
Past Webinar Materials (cont.)

- **Evidence-Based Medicine** – 1/7/14, 1/24/14
- **Internal Cost and Quality Reporting** – 4/17/14, 5/22/14
- **Lessons from GPRO Reporting** – 1/17/14, 10/28/14, 10/28/15
- **Lessons Learned from the Million Hearts Initiative** – 7/29/15
- **Provider Engagement** – 9/9/14, 10/1/14
- **Strategies of SSP ACOs Achieving Interim Savings** – 4/4/14, 4/11/14, 5/2/14, 5/16/14
- **Strategies of SSP ACOs Achieving Shared Savings** – 4/15/15, 4/29/15, 5/12/15, 5/19/15, 1/7/16
- **Using Data to Drive Performance** – 6/8/15, 5/19/16

In the ACO portal, materials for these and other webinars are located in the Events Calendar, and Program Announcements section, under “Learning System Webinar Materials”
Webinar Agenda

- Housekeeping items
- Welcome from CMS
- Presentations:
  - Broward Guardian
  - Mission Health Partners
  - Chautauqua Region Associated Medical Partners
- Questions and answers
- Wrap-up
The widget menu located at the bottom of the event console contains various resources for the webcast. You can resize a widget by clicking on the maximize icon on the top right of the widget or dragging the bottom right corner of the widget panel.

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Welcome from CMS

- Featured topic
- Upcoming events
- Polling questions
- Thank you!
Broward Guardian

John Harkins
Executive Director
“A Holistic Approach to Improving Beneficiary Health”
ACO Background

- Start Date: January 2014
- Track 1 Model
- No Advance Payment
- Memorial Healthcare System (MHS) is Participating Provider
- 75 Participating Providers
- 9,000 Attributed Beneficiaries
- 95% EHR Penetration with 15 different platforms (most common EHR is “eClinicalWorks” promoted by MHS)
Broward Guardian Culture

- Collaboration between Memorial Healthcare System (MHS) and Community based Primary Care Physicians.
- MHS is the 4th largest public health system in the country and the only hospital provider in the market.
- Located in Southern Broward County, boarding Miami-Dade County.
- Geographically small, but diverse population mix.
- Extremely high benchmark.
- MA (Medicare Advantage) Risk penetration is high (preferred method of contracting for providers and payers).
Focusing on the Three-Part Aim (Quality/Access/Costs)

- Strategy Driven by Limited Access to Capital
- Reality: Generate Savings or “Close up Shop”
- Focus on Short Term Savings Strategies
  - Cost verses Benefit
  - Short Term verses Long Term
- Physicians understand the relationship between Quality and Savings
  - More Primary Care Utilization
  - Avoid Unnecessary/Avoidable Utilization
Overall Performance

2014*
- Attributed Lives: 5,800
- Benchmark: $17,038***
- Actual Performance: $16,619*** ($16,436 before adjustment)

2015
- Attributed Lives: 9,788**
- Benchmark: $15,540***
- Actual Performance: $14,402***
- Savings per Beneficiary: $1,138 ($11 million)

*Because of delays, the Broward Guardian Care Coordination program did not begin until October 1, 2014.

**We added 25 participating providers in 2015.

***Benchmark and Actual Performance numbers are presented as per beneficiary numbers.
Broward Guardian Care Coordination Model

- Engage High-Risk Patients
  - High Cost and High Risk
- Develop Individual Care Plans
  - Beneficiary/Caregiver/Provider
  - Include Personal Goals
- Frequent Interaction and Contact
- Right service, Right Time, Right Place
- Reduce Avoidable Readmissions
- Reduce Unnecessary ED Utilization
- Eyes and Ears of the PCP
The Care Team

- Director of Nursing(1) - Clinician and Manager
- Inpatient Care Coordinators(2) (Navigators)
  - Visit every patient that present at the 2 main Memorial Hospitals.
  - Critical Strength is ability to effectively communicate
- Care Coordinators(3)
  - LPNs or MAs
  - 1 Coordinator to Every 150 Active ‘High-Risk’ Beneficiaries
  - Telephonic Follow-Ups on ALL Hospital Patients
  - Telephonic Chronic Case Management (CCM Program)
  - Ongoing Coordination for Long-Term High-Risk Beneficiaries
  - Assessments and Care Plan Development
What is a “High-Risk” patient?

- High-Cost
- Multiple Admissions/Readmissions
- Multiple Co-Morbidities
- Poly-Pharmacy
- High ED Utilization
- Low Encounters
- Demographics (age, socio-economics)

WHAT ABOUT THE NON-CLINICAL FACTORS?
Borrowing from the Managed Care Community

- Chronic SNP (Special Needs Plans) Management
  - Comprehensive Assessment
  - Risk Stratification
  - Individualized Care Plans
  - Manage/Evaluate/Reassess

- Managed Long Term Care (MLTC)
  - Home and Community Based Services
  - Caregiver Engagement
  - Holistic Approach
Traditional “Data-Driven” Risk Models

- Generate Quarterly Reports Identifying High-Risk Beneficiaries and Distribute to Each Practice
- High, Medium and Low Risk differentiated by Red, Yellow and Green
- Based Only on Claims Data - No Subjective Input

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<th># of Re-admissions</th>
<th># of ER Visits</th>
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<td>Musculoskeletal Disorders</td>
<td>$ 13,569.09</td>
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Please schedule an appointment with the following Medicare beneficiaries immediately and every month thereafter:

- Doe, John (DOB: 01/01/1900, Gender: M, Risk Score: 3.57)
- Doe, John (DOB: 01/01/1900, Gender: F, Risk Score: 1.15)
- Doe, John (DOB: 01/01/1900, Gender: F, Risk Score: 1.05)

Please schedule an appointment with the following Medicare beneficiaries as soon as possible and every 3 months thereafter:

- Doe, John (DOB: 01/01/1901, Gender: F, Risk Score: 2.15)
- Doe, John (DOB: 01/01/1901, Gender: M, Risk Score: 2.10)
- Doe, John (DOB: 01/01/1901, Gender: F, Risk Score: 1.90)

Please schedule an appointment with the following Medicare beneficiaries every 6 months:

- Doe, John (DOB: 01/01/1901, Gender: F, Risk Score: 1.57)
- Doe, John (DOB: 01/01/1901, Gender: F, Risk Score: 1.47)
- Doe, John (DOB: 01/01/1901, Gender: F, Risk Score: 1.46)
- Doe, John (DOB: 01/01/1901, Gender: F, Risk Score: 1.41)
- Doe, John (DOB: 01/01/1901, Gender: F, Risk Score: 1.20)
Comprehensive Assessment “Looking Beyond the Clinical”

Florida 701B Assessment Tool

- Medicaid Qualification
- Managed Long-Term Care
- Holistic Approach
  - Mental Health/Behavioral/Cognition
  - Nutrition
  - Health Conditions
  - Specialized Services
  - Medications
  - Caregiver Information
The Hidden Risk - A Real Life Example

- Patient Smith - age 70 - Diabetic/CHF (non-compliant)
  - Patient Constantly Rescheduling Visits
  - Does not get lab work when ordered
  - Inconsistent Medication administration
  - No glucose records
  - Reports poor eating decisions
- The “REAL” Risk Factors
  - Patient is primary caregiver for disabled spouse
  - No extended family
  - Struggles to put food on the table
  - No air conditioning
  - Only available transportation is neighbor
Empower the Coordinators to Think Outside of the Box!!!

Success in any Disease Management or Care Management model is dependent on Patient Engagement and Self-Management.

What can we do to help enable the patient to be more engaged?
Community Partnership

- Area Agency on Aging (AAA) and the Aging and Disability Resource Center (ADRC)
- Provide and Coordinate Services
- Free to the Beneficiary
- Free to the ACO
- Added Resource
Integrating and Coordinating

- Comprehensive Care Plan
  - Clinical Interventions
  - Non-Clinical Interventions

- Direct Referrals to Community Agencies
  - Assistance with locating, qualifying, applying for services
    - Meals on Wheels
    - Transportation
    - Social Programs

- Self-Management Training Programs
  - Diabetes Self-Management
  - Chronic Disease Self-Management
  - Falls Prevention Program

“More Eyes On The Beneficiary”
Key Areas of Focus - Summary

- Reducing Unnecessary and Avoidable Hospital Utilization
  - Reduce ER/ED Utilization
  - Reduce Readmission Rate (24%)
  - Promote Primary Care Utilization
  - Identify Gaps in Care
  - Facilitate the Flow of Information

- Remove Barriers
  - Identify Risk Factors
  - Develop Comprehensive Care Plan
  - Utilize Community Resources
  - Become a Beneficiary Advocate
Contact Information

John Harkins
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Broward Guardian
jharkins@bguardian.org
(954)544-4065

Thank You!
Questions & Answers

• Please submit questions through the Q&A panel/widget
Mission Health Partners

Robert Fields
Medical Director
It Takes a Village: Community Resource Use by a Medicare Shared Savings Program ACO

Rob Fields, MD
Medical Director
Mission Health Partners
Asheville, NC
Mission Health Partners

- Track and Start date: Track 1, 2015
- State(s): North Carolina
- Advance Payment or ACO Investment Model? No
- Are any of the ACO participants hospitals? Yes
- Number of practitioners: 1,100
- Number of assigned beneficiaries: 47,000 MSSP; 75,000 total
- 100% EHR penetration; 15 platforms within primary care alone
ACO Formation, Culture and Background

• Our formation was a collaboration between independent primary care physicians and our largest hospital system, Mission Health.

• Provider-led with a majority of our Board seats held by independent physicians.

• Semi-Urban
  – Total population 800,000 in 18-county service area
  – Total population 250,000 in Buncombe County (largest)
Formation and Collaboration

- Community interest in partnership with Mission Health
- Mission recognized the need for partnership outside of ownership
- Shared perspective and mutual respect within our governance structure
Care Coordination

• The foundation of population health

• Typically condition focused

• MHP motivated by an “upstream” approach

• Pathways Community HUB approach as the foundational model*

*More information on the HUB model can be found in the AHRQ manual: https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf
Pod 1
- Registered Nurse
- Certified Pharmacy Technician

Pod 2
- RN
- CPhT

Pod 3
- RN
- CPhT

Pod 4
- RN
- CPhT
Pathways & ACO Care Management

• Accountability model

• Begins with an assessment of needs during intake process

• Marry a social determinant need with a community agency that does the work
  – E.g. Legal aid organizations
Pathways & ACO Care Management

- Agencies “assigned” one or more social determinant pathway(s)

- Tool tracks completion of those pathways

- Collected data could lead to development of advocacy efforts
  - e.g. transportation, housing, nutrition, med access
Community Partner Motivation

• Interest in ACO/health system alignment

• Data collection

• ??Shared savings??
Barriers to Success

- “Buy in” using the tool
- Appropriate agreements need to be in place to allow access
- Long-term incentives for community partners
Contact Information

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Medical Director, Mission Health Partners
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(828) 213-6108
Questions & Answers

• Please submit questions through the Q&A panel/widget
Chautauqua Region Associated Medical Partners

Ann Morse Abdella
Executive Director
Chautauqua Region
Associated Medical Partners (AMP)

ACO Learning System:
Leveraging Community Resources and Addressing Beneficiaries’ Social Needs

Wednesday, September 14, 2016
AMP Profile

- MSSP participation only, July 2012 cohort; renewed contract 2016-18, Track 1
- Rural upstate New York
- 6,600 beneficiaries
- Physician-Hospital Partnership
  - 11 Independent PCPs (5 different EHRs)
  - 4 Independent Hospital Organizations (3 different EHRs)
  - 2 Independent SNF Organizations – 3 facilities (2 different EHRs)
- No advance payment
- Shared Savings in 2014; saved 6.4%, 92% quality score
Differing Approaches to Integration

Conventional Wisdom

Chautauqua Health Connects
Our Plan

Build Patient Centered Medical Homes and
Centralize the Medical Neighborhood (Community) to Support Them

Focus: Medicare Beneficiaries
Strengthening the local Health Care and Wellness Delivery System

Our Strategies:
Clinical Integration and Collective Impact

“Systemness” and Relationships
Accountable Care Communities

• Coordinate health care inside AND outside the doctor’s office

• Improve care and promote healthier choices in people’s daily lives

Policy ~ System ~ Environment
Some Things We Think We Are Doing Right

• Accountable Care Communities taking Geographic and Public Health Approach to design and delivery
• Patient Centered Medical Home and Neighborhood
• Continuum of Care and Community Collaborations
• Performance Targets and Plans: Citizenship + Quality
• Data Driven-reporting, structured data, and transparency
• Social Determinants of Health
• Collective Impact Framework
• Alignment with Other Public Health Initiatives
• Patient Engagement
• Building Care Management Capacity
Roles for NY Connects (ADRC) in an ACO

Community Care Coordination:

• Access point for community supports & services (all ages)
• Ensure two-way communication with medical providers
• Support seamless care transitions at discharge
• Partner with Physicians and CBOs in new, collaborative ways, i.e. Community Services Plans (ACA) and Million Lives Initiative
• Non-medical services become part of the medical care plan
• Support for PCMH – Retooling of care management to include community care & behavioral health
• Deploy Chronic Disease Self-Management Education & other EBI
• Support Advance Care Planning and Palliative Care
Projects We are Working on Together

• Increasing data sharing among participants
• Reducing readmissions
• Building Care Management
• Consumer Engagement
• Self-Management
• Aging in Place

Area Agency on Aging (AAA) gradually integrating as part of the PCMH care team
Long Term Care Council Advises
AAA Key Partner
Area Agency on Aging

- Addressing Social Determinants of Health
- Care Transitions beyond CMMI
- Training & Adoption of best practices (falls, LTSS)
- Health Care Proxy Registry
- Collaboration on Complex Clients in Crisis
- Feedback on Community Referrals
- PCP staff involved in EBI
Secure Referrals

• In-service staff and make referrals part of their performance measures
• EHR Referral templates built
• EHR turns referral into a fax
• AAA fax number built-in
• Fax goes to AAA secure mail box
• AAA Acknowledges receipt
• 2 month follow-up report
• Fall screens faxed to PCP
AAA Menu of Services

• Referrals to EBI
  – Stepping On
  – Home falls assessment
  – Tai Chi
  – Powerful Tools for Caregivers
  – CDSMP
• Community based LTSS
• Health Insurance Counseling
  – Medicare & Medicaid
• Health Care Proxy Registry

• Examples of other non-medical services that impact care:
  – Meals on Wheels
  – OFA Home Care Services
  – Transportation
  – Adult Day Care
Sharing Info with PCPs

• LTSS (frequency & provider)
  – Meals
  – PCA I or II
  – PERs
  – Dietician consults
  – Home repairs/access

• Health & wellness classes
  – Fall prevention (TUG scores)
  – Exercise
  – CDSME

• ADLs & IADLs
  – Deficits only

• Caregiver Information
• Clean Medication List
# Sample Clinical Measures Experience

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Source: CMS MSSP Performance Reports
Financial Support

- Leverage existing county services
- AMP subscribes for secure messaging and referral service; Direct may replace
- DUA and BAA with OFA; approved by CMS
- AMP subcontracts for CTI coaching
- AMP sister rural health network assists with staff education and training
Future

AAA

In the Works...

• ADRC expansion under Medicaid (1115 waiver)
  – NY Statewide PeerPlace
  – Direct communication capability is increasing
  – Import/Export automatic reports from service data to healthcare
    • EHRs not set up to capture Caregiver info
  – Exploring a pilot to expand LTSS to a wider group of beneficiaries
  – NYS Alzheimer’s Caregivers Initiative

• Just launched partnership with Hospice and Palliative Care
• Building connections between PCMH and Behavioral Health Homes
• Building Community Health Teams with hospitals
• Just beginning discussions with County Health Department
Acronyms Used

- EHR: Electronic Health Record
- ADRC: Aging and Disabilities Resource Center
- AAA: Area Agency on Aging is the same as Office for the Aging
- EBI: Evidenced based intervention
- LTSS: long term services and supports
- ADL: Activities of Daily Living
- IADL: instrumental Activities of Daily Living
- TUG: timed up and go test. A measure used to assess falls risk
- PCA I: Personal care level one
- PCA II: Personal Care level two
- PERs: Personal Emergency Reporting System
- CDSMP and CDSME: Chronic disease self-management program or education
- CTI: Care Transition Intervention Program
Contact

Ann Morse Abdella
Executive Director AMP

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(716) 338-0010 x1202

Special thanks to:
Mary Ann Spanos

Director Chautauqua County Office for the Aging

spanosm@co.chautauqua.ny.us
(716) 753-4471
Questions & Answers

• Please submit questions through the Q&A panel/widget
Please give us your feedback!

Open the survey widget located in the widget menu at the bottom of your event console.

Don’t forget to press the submit button when finished!
Thank you!

• Slides and a link to the webinar recording will be posted to the ACO portlet. A recording will also be available tomorrow from the audience link that you used to attend.
• Please complete the webinar evaluation.
• Fee free to send questions, comments, and suggestions for future topics to ACOLearningActivities@mathematica-mpr.com