ACOs: The Next Generation

Pam Halvorson
Lead Executive of Next Generation ACO Operations

Bryan Sanders
Director of Network Development

Brett Asay
Manager of Network Services, Post-Acute Care

Today’s Objectives

- Understand why Post-Acute Care matters and connection to Next Gen ACO work
- Recognize the importance of partnership and position yourself to be great partners
- Understand the importance of Next Gen ACO to UnityPoint Health and our partners
- Identify key areas of focus for success
UnityPoint Health Partners, L.C.*

- Multi-state ACO
- 5000+ Providers (Facilities and Clinicians)
  - ~1500 employed and 3500 independent providers
- Commercial and CMS Value-Based contracts
  - ~360,000 lives in value-based agreements
  - Over half with downside risk
- ~$1B medical spend in agreements with downside risk

*UnityPoint Health Partners, L.C. is a wholly-owned subsidiary of UnityPoint Health.

Why Post-Acute Care Matters?

Bryan Sanders, RN, BSN
Director of Network Development
UnityPoint Health Partners
Why Post-Acute Care Matters?

- 33,294 PAC Facilities
- 6.8 Million Beneficiaries
- $74.5 Billion Spending
- 13% of Total Medicare Spending

Source: MedPAC, 2015 Data Book (Charts 8-2 & 11-7)

Payment Reforms are Changing the Rules

- Continuous cost and quality improvements are needed to remain viable.
SNFs and the UPHP Network

• More than ever before, skilled nursing facilities (SNF) are becoming a focal point for hospitals and Centers for Medicare and Medicaid Services (CMS).

• As patients are spending fewer days in the hospital, SNF’s will continue to see their acuity levels rise and will be challenged to meet these emerging needs on their own.

• It will be critical for hospitals to partner with SNF’s with multiple disciplines and strategies to achieve desired outcomes in the areas of patient experience, quality, and cost of care.

Opportunities to Impact Current Landscape

• High variability of post-acute care cost is found in SNF’s

• SNF’s are paid a daily rate with limited downside and no current payment penalties for ED utilization or 30-day hospital re-admissions

• No current incentives for SNF’s to shorten length of stay or lower cost of care at this time, or to accept high cost, complex referrals
ACOs: The Next Generation

Goals:
- Develop and operationalize intentional strategies to improve quality and cost in the skilled nursing facility care environment
  - Consistent way of identifying network partners
  - Establish minimal network requirements and capabilities
  - Partner on triple aim initiatives
- Achieve network adequacy/access for skilled nursing facilities across all regions
- Improve transitions, increase efforts in managing LOS, improve discharge home with care

How PAC Partners Position Themselves to be Great Partners?

Brett Asay, NHA
Manager of Network Services, Post-Acute Care
UnityPoint Health Partners
Prepare to Partner

• “The hips and knees are walking out of the hospital”

• Physical Design
  – Consumer prefers separate area and gym
  – Private rooms/baths
  – Hotel/spa like accommodations
  – Warm water pool for therapy
  – Connection to campus amenities

Prepare to Partner

• Communication:
  – Interact tools: SBAR Fax tool, UTI, Pain, CHF, Respiratory care paths
  – Electronic health record
  – Electronic signing capability & remote access
  – Integration capability
  – Rounding at hospital/connection to LTC liaison
  – Electronic forms
  – Lab forms, transfer forms
  – Meetings: Nursing Home & ACO
  – Epic Care link
  – 5 star rating
Prepare to Partner

- **Services/Amenities:**
  - Portable X-ray
  - IV therapy services
  - Bladder scanner
  - Palliative care
  - Wound care rounds
  - 24-hour admissions
  - Therapy services: In-house
  - Education: Position, rehab certification & training

- **Speak with one voice:**
  - Adaptive Design
  - ICCDM

Collaboration

- **Triple Aim is **OUR** Aim!**
Minimum Network Criteria SNF’s

1. Capability to admit 7 days/week, with after hours options ................................................. (Access)
2. 30-day hospital re-admissions at 20% or less ...................................................................(Cost)
3. Average length of stay at 30 days or less ............................................................................. (Cost)
4. CMS 5 star overall rating of 3 or better .................................................................................. (Quality)
5. Participates in on-going quality initiative led by regional OSC ............................................. (Quality)
6. Medical director aligned with UPHP values and focus on triple aim .................................... (Alignment)
7. Agrees to self-report data that is not publicly available ....................................................... (Collaboration)
8. Formalized patient experience program ............................................................................... (Patient experience)
9. Actively using INTERACT or comparable tools ................................................................. (Care Coordination)
10. Utilize EpicCare Link ........................................................................................................... (Care Coordination)
11. 24 hours RN coverage (staffing on site or on call) ............................................................. (Capabilities, Quality)
12. Establishes utilization of provider on site by 2017 .............................................................. (Capabilities, Quality)

Great Partners Add Value!

- Do you know what your specialties are?
- What makes you different and a valued partner?
- Do you know where you can improve?
- What feedback/information can you provide?
- Do you have a collaborative approach for aligned home health, hospice, DME, palliative care, infusion, tele-health, and wound care specialists?
- Have you communicated your strategy to Health System Partner? Have you engaged Health System Partner in planning, education, implementation of the strategy?
Collaboration

• Get Comfortable with Being Uncomfortable
• More than just a “token collaboration”
• Fear is a part of the process.
• There is never an END point, you have never “arrived”
• Our world is constantly changing and evolving.
• Don’t catch up – get ahead and keep pushing further!

What Next Generation ACO Means to UPH and PAC Partners?

Pam Halvorson
Lead Executive of Next Generation ACO Operations
UnityPoint Health Partners
What is Next Generation ACO Model?

- 21 Participating ACOs
- 14 States
- Higher Financial Risk and Reward
- Goal: Better Patient Engagement and Care Management

Source: Centers for Medicare & Medicaid Services

Next Generation ACO

<table>
<thead>
<tr>
<th>REGION</th>
<th>TOTAL COVERED LIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cedar Rapids</td>
<td>10,732</td>
</tr>
<tr>
<td>Central Iowa</td>
<td>25,450</td>
</tr>
<tr>
<td>Fort Dodge</td>
<td>10,688</td>
</tr>
<tr>
<td>Peoria</td>
<td>12,383</td>
</tr>
<tr>
<td>Quincy</td>
<td>10,887</td>
</tr>
<tr>
<td>Waterloo</td>
<td>15,917</td>
</tr>
<tr>
<td>Unmarked</td>
<td>126</td>
</tr>
</tbody>
</table>

As of January 1, 2016. Initial counts will be issued in April.
Next Generation ACO Model

• A new opportunity in accountable care:
  – More predictable financial targets;
  – Greater opportunities to coordinate care;
  – High quality standards consistent with other Medicare programs and models

• The Model seeks to test how strong financial incentives for ACOs can improve health outcomes and reduce growth in expenditures for Original Medicare fee-for-service (FFS) beneficiaries.

Model Principles

• Protect Medicare FFS beneficiaries’ freedom of choice;
  – Create a financial model with long-term sustainability;
  – Use a prospectively-set benchmark that:
    • Rewards quality;
    • Rewards both attainment of and improvement in efficiency; and
    • Ultimately transitions away from updating benchmarks based on ACOs recent expenditures;
  – Offer benefit enhancements that directly improve the patient experience and support coordinated care;
  – Allow beneficiaries a choice to remain aligned to the ACO;
    • Mitigates fluctuations in aligned beneficiary populations
    • Respects beneficiary preferences;
  – Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms.
UnityPoint Health Partners Next Gen ACO

**Objective:**
- Patient-Centered, Provider Aligned, Care Coordinated Systems
  Designed to Improve Quality and Reduce Cost

**Primary Drivers:**
- Patient-Centered
- Care Coordinated
- Provider-Aligned
- Commitment to Increasing Quality and Reducing Unnecessary Cost

**Secondary Drivers:**

<table>
<thead>
<tr>
<th>Patient-Centered</th>
<th>Care-Coordinated</th>
<th>Provider-Aligned</th>
<th>Commitment to Increase Quality and Reducing Unnecessary Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience</td>
<td>Transitions of Care or Continuum of Care</td>
<td>Practice Standards</td>
<td>Prevention</td>
</tr>
<tr>
<td>Targeted Interventions</td>
<td>Integrated Information Exchange</td>
<td>Value Emphasis Through Performance Metrics</td>
<td>Quality Performance</td>
</tr>
<tr>
<td>Community Presence</td>
<td>Staffing Model and Specified Roles</td>
<td></td>
<td>Operational Efficiency</td>
</tr>
</tbody>
</table>
Benefit Enhancements

- Medicare payment rule waivers designed to improve care coordination and cost saving capabilities:
  - Telehealth expansion
  - Post-discharge home visits
  - SNF 3-Day Rule Waiver
- ACO may decide which, if any, to implement.
- For each, ACOs must submit an implementation plan describing how the ACO will utilize, monitor, and report on the benefit enhancement.

Focus Areas for ACO and PAC Partner Success

- Improve Care Coordination Across the Continuum
- Committing to appropriate post-acute setting and reductions in overall LOS
- Post Discharge Referral Management - Home Care, DME, Other
- Early Identification of Need For Palliative Care or Hospice
- Prevent Unplanned ED Visits and Hospital Admissions – improved assessments, communication, staff education and training
- Readmission Reduction – especially for COPD, CHF, Diabetes
- Patient Experience – integrating “whole person” culture on every encounter
Next Steps:

• Make a connection with your regional/local Health System Partner.
  – For UnityPoint Health, this is your Organized System of Care (OSC) Director

• Share your innovative ideas/best practices with your Health System ACO Partner(s).
  – Industry best practices
  – Organization/Campus specific

Questions or comments?