Post-Acute Services in Accountable Care

National Accountable Care Congress
November 11, 2014
Los Angeles, CA

Manoj K Mathew, MD, SFHM
Medical Director
SFV & Acute Care
Agenda

- HCP Infrastructure - Medicare Advantage
- ACO programs
- General Strategies
- Metrics
- Evolutionary program considerations
HCP Current Market Footprint

5 Major Markets: AZ, CA, FL, NM, NV
Senior HMO MAPD Patients: >290,000
Commercial HMO Patients: >390,000
Medicaid HMO Patients: ≈ 110,000
Employed Physicians: >1,000
IPA Primary Care Physicians: >3,000
IPA Network Specialists: >8,000

* Data as of March 31, 2014

Largest Private Medical Group in each of HCP’s Current Markets

Variety of physician and hospital payment arrangements
All employed physicians paid salary with incentives
Contracted Physicians (PCPs & Specialists) paid on percent of Medicare or capitation or combination plus incentives
ACO Programs

HealthCare Partners is involved in three, key ACOs

**MSSP Membership**
Three markets – total 59,400
- Nevada – 17,440
- Florida – 14,560
- California – 27,400
  - 9,700 HealthCare Partners Group patients
  - 17,700 Affiliated Physician patients

**Cigna – PPO**
(Collaborative Accountable Care – CAC)
- Ca – 11,000
  - 53% IPA

**Anthem – PPO**
(Enhanced Personal Health Care – EPHC)
- California – 93,000
**HealthCare Partners ACO Unit**

- Comprised of:
  - 1 Manager, 2 CM, 2 Health Educator, 5 coordinators
- Follows-up with patients post-discharge and provides care coordination and transitions of care
- Conducts Health Risk Assessments as needed
- Identifies high risk patients via Opportunity Patients Listing (OPL)
- Assists with referrals to HealthCare Partners’ high risk and disease management programs
Opportunity Patients Listing

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Risk Stratification

**Primary Care Physician**
Motivate, educate and engage Patients to get involved in their care and self-management with their PCP and Care Team.

**Level 1**
- **Primary Care Physician**
  - Patient Self-Management & Health Education

**Level 2**
- **Complex Care and Disease Management**
  - Intensive one-on-one Physician /Patient care
  - Case management for the highest risk, most complex Patients.
  - When stable, Patient is upgraded to Level 2.
  - Diabetes, COPD, CHF, CKD, Depression, Dementia

**Level 3**
- **Comprehensive Care and Post Discharge Clinics**
  - Intensive one-on-one Physician /Patient care
  - Case management for the highest risk, most complex Patients.
  - When stable, Patient is upgraded to Level 2.

**Level 4**
- **Home Care Program**
  - Provides in-home medical and palliative care management.
  - Physicians, Nurse Practitioners, Care Management, Social Workers
  - Chronically frail Patients
  - Physical, mental, social, financial limitations in accessing outpatient care

**Hospice/Palliative Care**
Chronically frail Patients
Physical, mental, social, financial limitations in accessing outpatient care

**Complex Care Management / Disease Management**
Provide long-term enhanced care oversight. Multidisciplinary team approach for complex, high acuity Patients; Diabetes, COPD, CHF, CKD, Depression, Dementia

**Home Care Program**
Provides in-home medical and palliative care management. Physicians, Nurse Practitioners, Care Management, Social Workers
Chronically frail Patients
Physical, mental, social, financial limitations in accessing outpatient care
Commonly Used Specialists/Services

Commonly Used Specialists Forms:
• Cardiology
• Gastrointestinal
• Neurology
• Orthopedic
• Podiatry

*Forms are for patient reference only, and are not an authorization for treatment or service.

Commonly Used Services Forms:
• Home Health
• Ambulance
• Durable Medical Equipment (DME)
ACO Patient Identification

Allscripts EMR system has a blue and purple “pinwheel” icon under an ACO patient’s name.
MSSP Patient Identification

HCP Medicare ACO ID cards are sent to the patient
- Use is optional but highly encouraged
- This is in addition to their regular Medicare card

My doctor, is part of HealthCare Partners, a Medicare ACO.
Call HealthCare Partners at 855.414.1226, to get and share any needed medical information that helps coordinate my care.

Important things to remember:
- If you choose, you may want to share this card with your other doctors or healthcare providers.
- Your doctor’s participation in HealthCare Partners doesn’t change your Medicare benefits.
- HealthCare Partners isn’t a Medicare Advantage plan or an HMO plan.
- You still have the right to use any doctor or hospital who accepts Medicare, at any time.
Employed Hospitalists

- ER Triage
- Remote EMR access
- Advanced care planning focus
- Daily IDT meetings with Leads/Med Dir/CM
- Frequent touch bases, huddles
- D/C summary at time of D/C
  - ADT feed to EMR
- Hand-off (telephonic, VM, secure email)
- SBR (Site Based Review)
- Hospital JOCs
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HealthCare Partners Programs & Strategies

Employed Care Managers & Social Workers

- Patient education & care coordination
- On-site and telephonic
- ACM phone calls
- IVR

Patient Support Center and I-Care

- Triaging calls
- Post D/C appointments
- Sends records to PCPs in IPA

Out-of-Area Department

- MD & CM staffing
- Collects and forwards records

Comprehensive Care Programs
Patient Admission Notification
k2workflow@healthcarepartners.com
To: Deon Smit; Jim Joyce; Chris Malone

HealthCare Partners
MEDICAL GROUP

Inpatient Central Notification

Patient Hospital Admission Notification

Date: 3/14/2007

LIVINGSTON MD, EXPLORER

Your patient SAMPLE, PAT 1 with DOB 09/25/1930
and MRN No: 11-111111 has been admitted
to Methodist on 03/10/2007 01:03:49.
The initial admitting diagnosis was ACUTE SOMETHING

Please feel free to call the Hospitalist with any questions or input at (310) 555-1234.
Following discharge, an appointment may be scheduled with your office to provide continuity of care for your patient.

Sincerely,

Inpatient Central Department

The information contained in this notification may be confidential, proprietary and/or legally privileged
information intended only for the use of the individual or entity named above. If the reader of this
message is not the intended recipient, you are hereby notified that any copying, dissemination or
distribution of confidential, proprietary or privileged information is strictly prohibited. If you have received
this communication in error, please notify the sender at (800) 275-4427 immediately.

This is a system generated notification, please do not reply to this e-mail.
Post Acute Facility Strategies

Preferred Network of SNFs
- Consolidation of both MA and ACO patients

SNFists
- Employed & Contracted
- MDs & NPs
- Daily or Q2-3d visits

Process
- SNF admit order set
- Biweekly IDT meetings with Leads/Med Dir/CM
- SNF Joint Operating Committees (JOC)
- Advanced care planning focus
- D/C summary at time of D/C
- Hand-off (telephonic, VM, secure email)
SNF D/C Process

• HCP CM sends referrals for placement to HCP SW.

• HCP CM sends a discharge planning form to the ACO unit.

  - The ACO unit coordinates post-discharge services with preferred partners and gives details back to SNF CM.

  - The TCM/ACO unit will make 4 post d/c f/u calls to the patient.

• CCP program enrollment
Comprehensive Care Programs

Primary Care Physician

CCP Team: Physician, NP, Care Manager, Social Worker, Medical Assistant

Inpatient Team: Hospitalist & Care Manager

CCCP

CCC – Comp. Care Clinic

Palliative Care Consults

House Calls

ESRD
Comprehensive Care Clinics

Multidisciplinary Team
- Pod = 1 MD, CM, Nurse, 1 SW, 2 MA

Program
- Brick and Mortar
- Referral Source – Hospitalist, SNFist, PCPs
- Post Discharge clinic
- Short duration of “High Touch” care
- Patients: Ambulatory, High Risk
- Centers for CHF/COPD Care Management and Palliative Care Programs
House Calls Program

Multidisciplinary Team
• Pod = 1 MD, 2-4 NPs, 1 SW, 1 MA

Program
• Home Visits
• Referral Source – Hospitalist, SNFist, PCPs
• Patients: Functionally Home-bound, High Risk, EOL
• Key Practices
  • Weekly Team Reviews
  • Standard Care Guidelines
  • Palliative Care Options
  • Access to team 24/7/365
  • Motivational Interviewing, Shared Decision Making, Coaching
HealthCare Partners Programs & Strategies

24-Hour Urgent Care

- MD staffing
- Telemetry monitoring
### MSSP Utilization/Expenditure Report

Results include CA, NV, FL

**Skilled Nursing Facility Expenditures per Assigned Beneficiary**

<table>
<thead>
<tr>
<th></th>
<th>2013 HCP Benchmark (Baseline)</th>
<th>Q1 2014</th>
<th>Q2 2014</th>
<th>Difference between 2013 benchmark and Q2</th>
<th>Change between 2013 benchmark and Q2</th>
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</thead>
<tbody>
<tr>
<td>HCP</td>
<td>$565</td>
<td>$539</td>
<td>$539</td>
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<tr>
<td>All MSSP ACOs</td>
<td>$762</td>
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<td>-5.12%</td>
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<tr>
<td>National FFS</td>
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<td>$813</td>
<td>$817</td>
<td>-3.88%</td>
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**Skilled Nursing Facility Discharges (Per 1,000 Person-Years)**

<table>
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<tr>
<th></th>
<th>2013 HCP Benchmark (Baseline)</th>
<th>Q1 2014</th>
<th>Q2 2014</th>
<th>Difference between 2013 benchmark and Q2</th>
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<tbody>
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<td>All MSSP ACOs</td>
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<td>64</td>
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<tr>
<td>National FFS</td>
<td>76</td>
<td>69</td>
<td>69</td>
<td>-9.21%</td>
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</table>
## MSSP Utilization/Expenditure Report

Results include CA, NV, FL

### 30-Day All-Cause Readmissions per 1,000 Discharges

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<th>2013 HCP Benchmark (Baseline)</th>
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<td>All MSSP ACOs</td>
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<td>National FFS</td>
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<td>153</td>
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<td>-1.29%</td>
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### 30-Day Post Discharge Provider Visits Per 1,000 Discharges

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<td>728</td>
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<td>All MSSP ACOs</td>
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<td>752</td>
<td>-1.83%</td>
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<td>National FFS</td>
<td>730</td>
<td>719</td>
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<td>-1.64%</td>
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## MSSP Utilization/Expenditure Report

Results include CA, NV, FL

### Emergency Department Visits (Per 1,000 Person-Years)

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<th>2013 HCP Benchmark (Baseline)</th>
<th>Q1 2014</th>
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<th>Difference between 2013 benchmark and Q2</th>
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<tr>
<td>National FFS</td>
<td>684</td>
<td>651</td>
<td>649</td>
<td>-5.12%</td>
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### Emergency Department Visits that Lead to Hospitalizations (Per 1,000 Person-Years)

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<tr>
<td>National FFS</td>
<td>212</td>
<td>201</td>
<td>199</td>
<td>-6.13%</td>
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# MSSP Utilization/Expenditure Report

Results include CA, NV, FL

## Home Health Expenditures per Assigned Beneficiary

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<td>National FFS</td>
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<td>$574</td>
<td>$566</td>
<td>3.66%</td>
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## Hospice Expenditures per Assigned Beneficiary

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<td>HCP</td>
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<td>-14.96%</td>
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<td>All MSSP ACOs</td>
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<td>$218</td>
<td>-11.02%</td>
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<td>National FFS</td>
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<td>$323</td>
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<td>-6.27%</td>
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HealthCare Continuum - Today

Health care resources:
- Payors: Ins, HMO, IPA's
- Hospital
- Skilled nursing
- Home health
- Hospice

Community based resources:
- Residential facilities for the elderly >60 (RCFE)
- Adult residential facilities (ARF) <59
- Adult day healthcare (ADHC)
- Home care

Hundreds of thousands of available state licensed care beds and after vital care resources.
Biggest challenges

1. Patient identification on the MSSP side
   • Huge problem for large varied areas like LA.
   • Not so much for smaller, geographically aligned systems

2. Physician engagement
   • Influence IPA providers in referral patterns and utilization

3. Patient engagement
   • Inability to influence the patient in utilization
   • Patients lack of insight of or active enrollment into the programs
MSSP Wish List

1. Real time notification with actionable and complete patient utilization data

2. Decreased bureaucracy and restrictions regarding communication to members

3. Resolve disconnect between patients opting out of sharing data but ACO still responsible for patient in the MSSP program.

4. Prospective methodology of attributing patients which would avoid the confusion regarding which patients are truly part of the MSSP program.
thank you