

# Strategic Positioning for Healthcare Reform

70D | Thursday, May 2 | 8:30 - 10:00am | Continued at 11:00am – 12:00pm

advocate educate innovate

# Presenters



Jeff Vrieze  
Partner  
CliftonLarsonAllen



Rebecca Neth Townsend  
Senior Vice President  
Ziegler



Kevin Rymanowski  
Chief Financial Officer  
Benedictine Health System

# Agenda



- Introduction
- Overview: National & State Health Reform Activity & Approaches
- Case Studies: How Reform Activities Are Playing Out
- Lessons Learned from ACOs & Other Pilots
- Closing: Thoughts on Opportunity
- Q & A

# Introduction

advocate educate innovate

# Learning Objectives

- Outline accomplishments and trends in the 2010 PPACA since the 2012 elections
- Discuss areas you should be focusing on in order to strategically position your organization in the evolving health care market
- Realize how aging service providers have the leverage and ability to plan an important role in this new and challenging environment
- Review specific case studies of what communities are doing to position themselves

# Overview: National & State Health Reform Activity & Approaches

advocate educate innovate

# The ACA... Three Years Following Passage

- The U.S. Supreme Court has ruled; the 2012 Elections have been decided... the ACA is the law of the land
- Congressional composition requires broad bi-partisan support to make any changes.
- New regulations, guidance, and FAQ documents from IRS, HHS, DOL continue to fill in the implementation picture
- 2014 is the year of expanding access to coverage
- Several CMS pilots, demos are well underway



# Timeline Overview

## 2010

- Affordable Care Act passes and becomes law
- Insurance Market Reforms Phase I
- Patient Centered Outcomes Research Institute established
- Federal Coordinated Health Office established (Dual's office)

## 2011

- Established Center for Medicare and Medicaid Innovation
- Medicaid Health Homes launched
- State Balancing Incentive Program (more HCBS options)
- Multi-Payer Advanced Primary Care Practice Demonstration

## 2012

- Accountable Care Organizations begin
- Health Care Innovation Grants awarded (through 2015)
- Hospital Value-based Purchasing Program
- Hospital Readmission Reduction program
- Comprehensive Primary Care Initiative begins, runs through at least 2016

## 2013

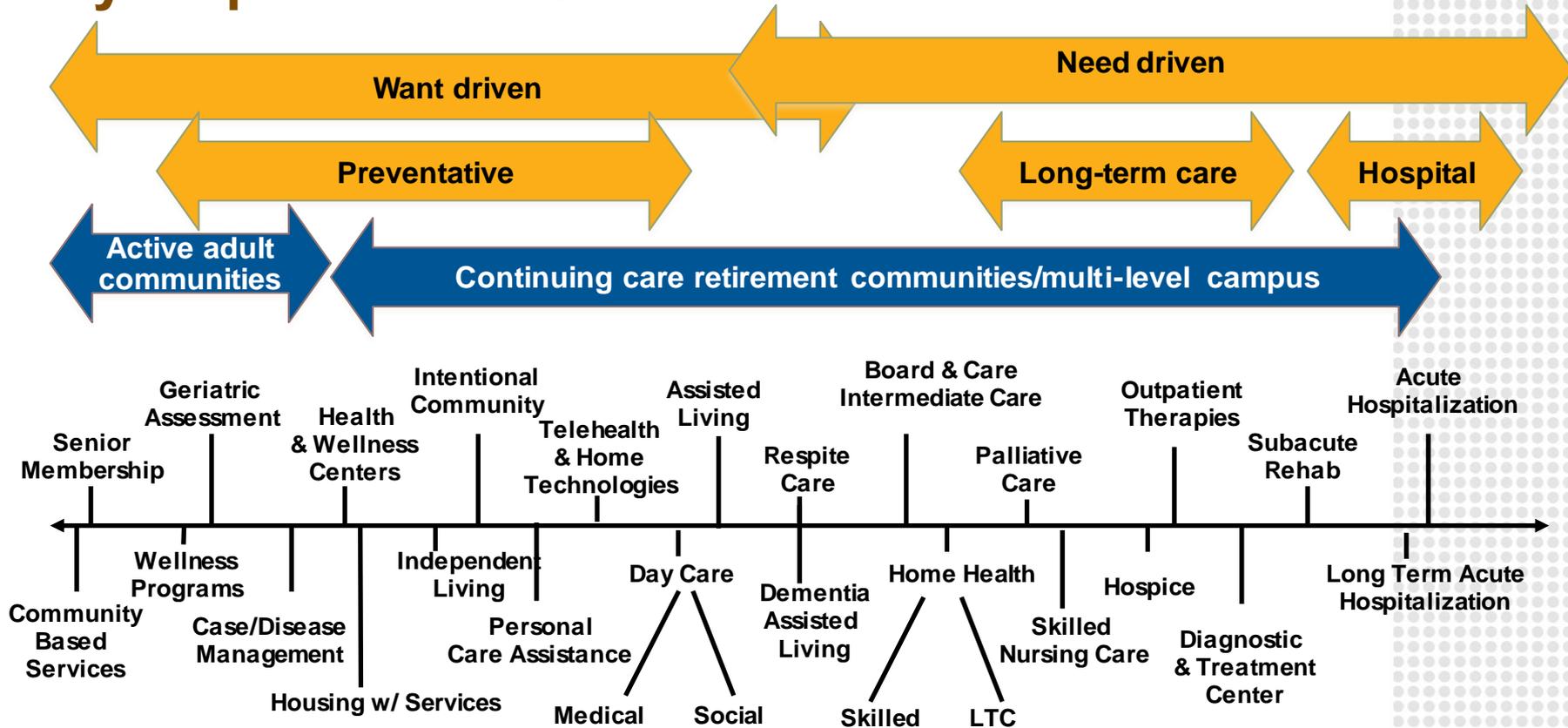
- Financial Alignment Initiative – program for duals (OK)
- Bundled Payment for Care Improvement demo (PA, OK)

## 2014

- Comprehensive Primary Care Initiative (first year of shared savings eligibility)
- First Independent Payment Advisory Board recommendations
- Medicaid expansion
- Individual Mandate
- Health Insurance Exchanges
- Additional Insurance market reforms II
- Employer pay or play penalty

# Health Care and The Field Of Aging Services Is Evolving

## Today's Spectrum of Services



Source: Adapted from previous Greystone and LarsonAllen LLP presentations

# Threads of Reform

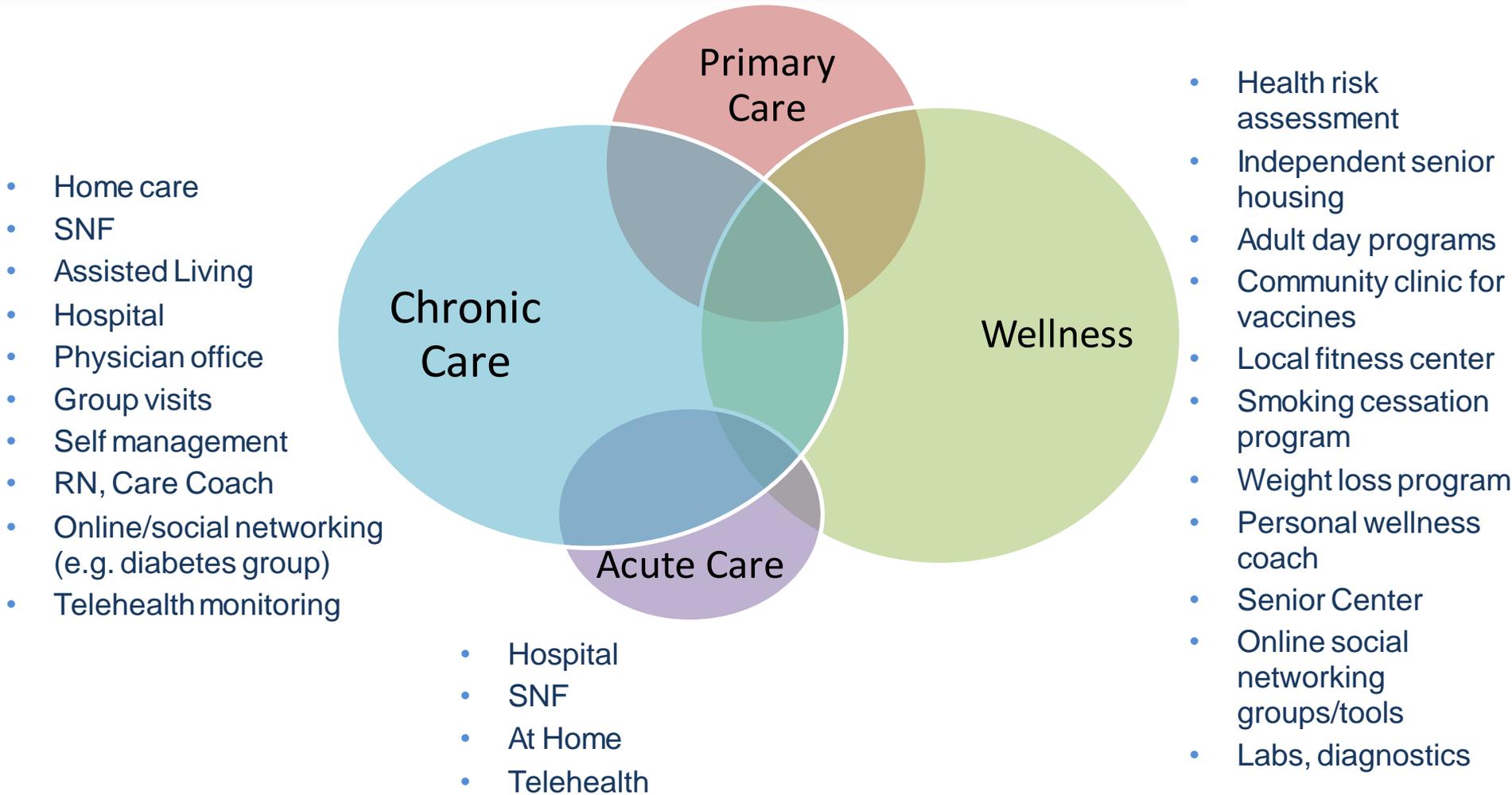
- Reduce hospital readmissions
- Patient-centered care/experience
- Improved care transitions
- Health information sharing/exchange
- Prevention/wellness
- Chronic care management
- Total cost of care
- Integrated, coordinated, seamless care
- Higher quality, cost effective care
- Value-based payment to replace FFS
- Targeting high-cost, high-risk patients



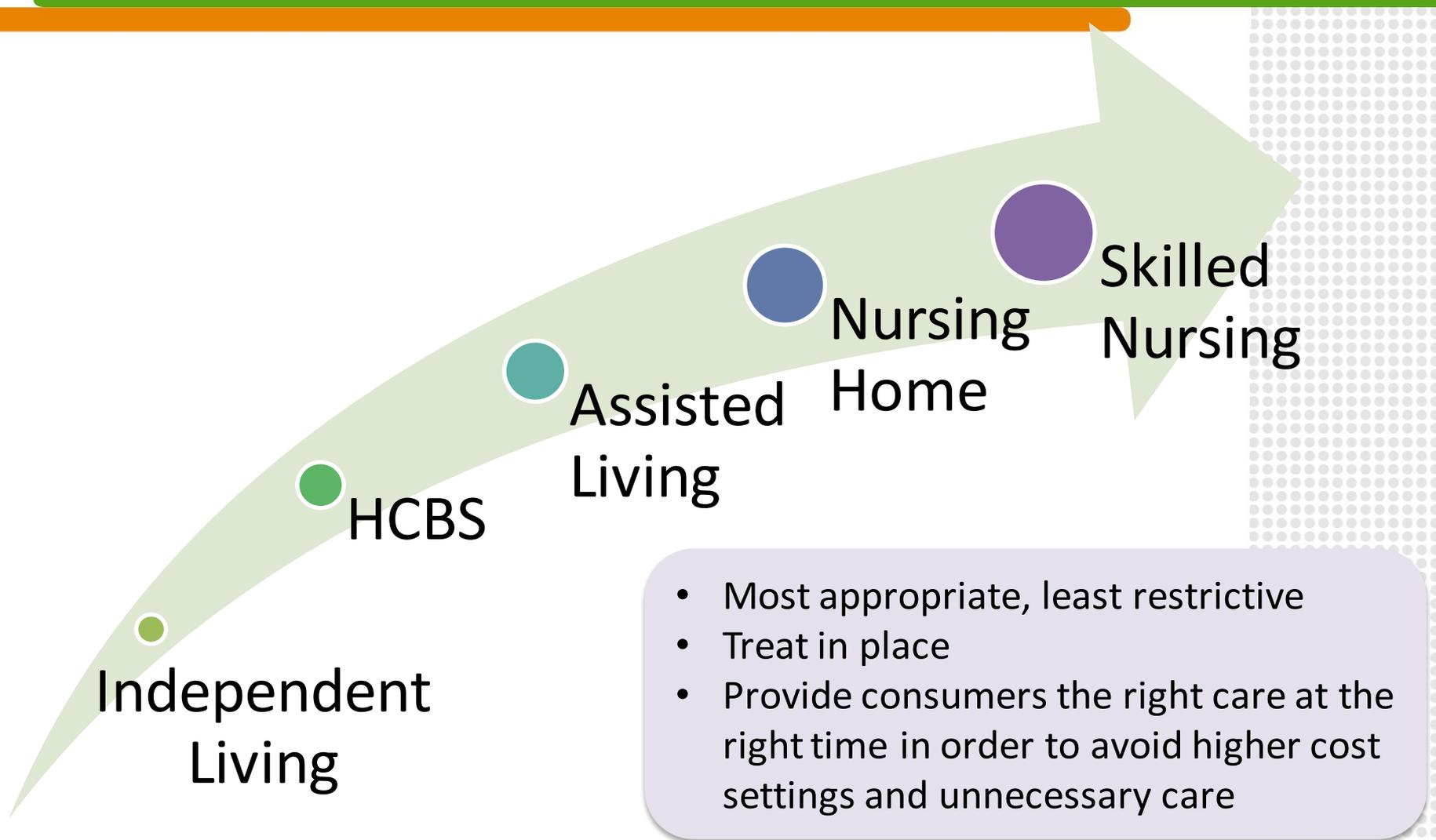
# The Triple Aim Goals

- **Better Care**
  - Improve/maintain quality and patient outcomes
  - Eliminate avoidable re/admissions
  - Eliminate potentially preventable conditions (e.g., never events)
- **Better Health**
  - Primary Care Driven
  - Focus on Prevention & Wellness
- **Reduce Cost**
  - Reduce/eliminate duplication
  - Improved coordination

# Reformed Health System – Service Delivery



# Right Care, Right Time, Right Place



# Key ACA Initiatives: Illinois

## Value Based Payment

- Foundation of all programs
- Will Impact all Markets

## Medical Home

- 25 FQHCs receive care management fee to manage Medicare FFS enrollees with chronic conditions

## Bundled Payment

- Illinois has 24 health systems, SNF, Home Care and/or physician collaborations participating in the bundled payment demo.

## Accountable Care Organizations

- One Pioneer ACO (1/1/12)
- Three MSSPs (4/1/12, 7/1/12, 1/1/13)

## Financial Alignment Initiatives

- Focus is on dual eligibles
- Illinois is one of five states with CMS approval

# Illinois ACA Demonstrations

- **State Innovation Model grant:** \$2M grant for State to transform Medicaid health care delivery by developing and integrating three models: a Provider-Driven Model; a Plan-Provider Partnership Model; and a Plan-Provider-Payer Model. Models will enhance care management and expand payer base.
- **Health Care Innovation Awards for 7 different demos:**
  - Two **University of Chicago** projects - link electronic health records of local safety net providers & integrate inpatient/outpatient care for high-risk hospitalization patients
  - **Imaging Advantage LLC** - manage imaging services
  - **Mt. Sinai School of Medicine** - integrate geriatric care with ER care
  - **The National Health Care for the Homeless Council** - partner with FQHCs to coordinate care for homeless individuals
  - **Univ. of North Texas Health Center** - implement Interact II at the Brookdale SNF and AL centers nationally
  - **TransforMed** technology grant. (TransForMed is a electronic health solution designed to support the Medical Home.)

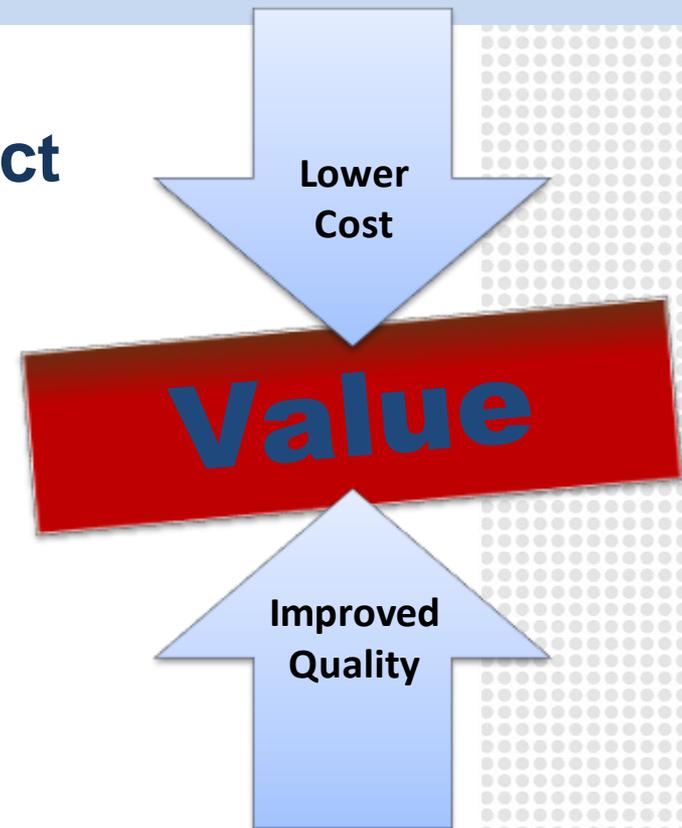
# The Foundation: Value-Based Payment

**Value Based Payment:** *“a reform initiative whereby health care providers will receive payment for service based on their performance or the potential outcomes of the service”*

**Tying payment to performance is perhaps the most significant aspect of health care reform.**

*The de facto definition of “value” in health care reform is the intersection of lower cost and improved quality.*

**Providers who can lower costs and deliver quality will be measured as “value-based providers”**



# Value-Based Performance Payment

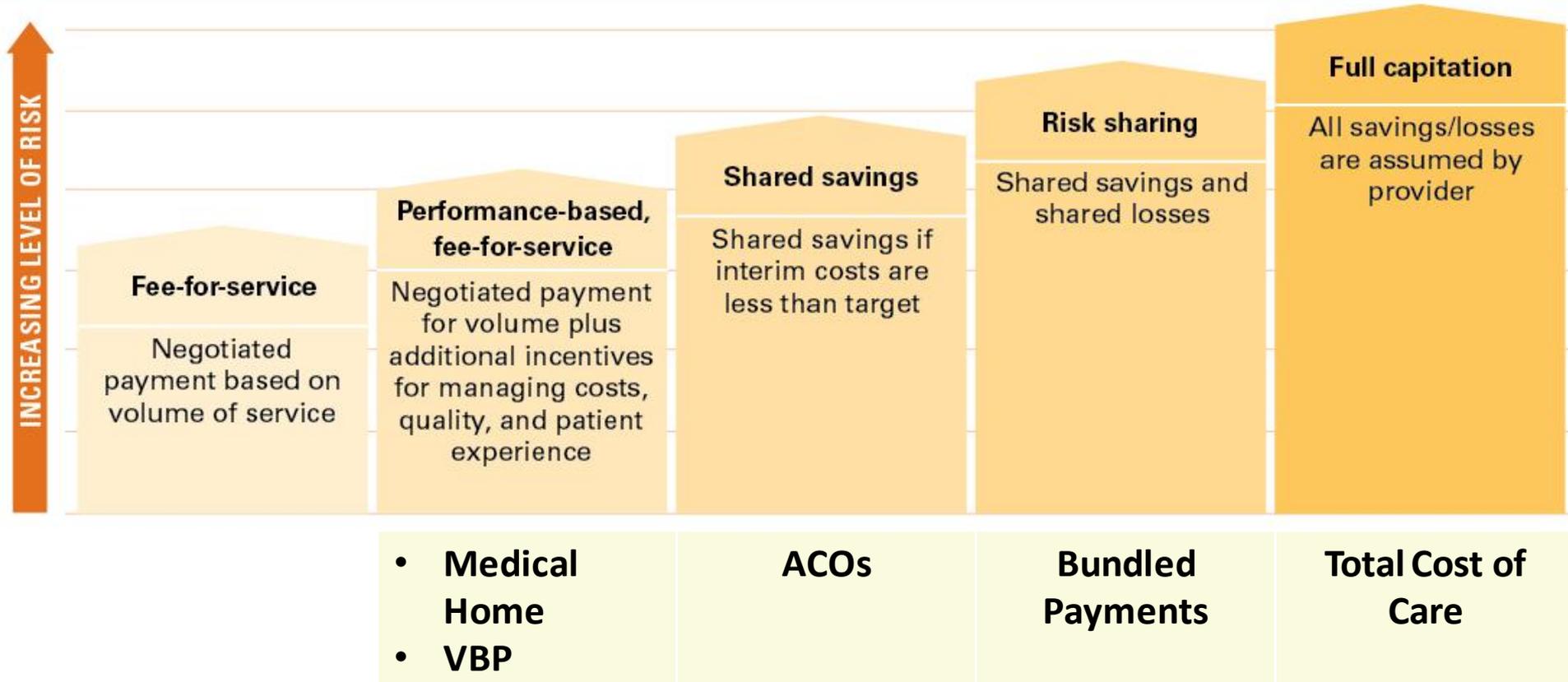
## ***Key objectives:***

1. Encourage use of evidence-based medicine
2. Reduce fragmentation, duplication and inappropriate use of services
3. Encourage effective management of chronic disease
4. Accelerate the adoption of health information exchange
5. Empower and engage consumers

Source: *Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physicians and Other Professionals, Issue Paper*, Public Listening Session, December 9, 2008; CMS

# Array of Payment Options

## Spectrum of Payment Models for Health Plans and Providers



# Medical Home Initiatives

## Key Components

- Whole person orientation to care
- Focus on physician/patient relationship
- Patient-centered care
- Accessible, comprehensive and continuous care
- Quality & Safety
- Health information

## Three initiatives testing model:

- **Comprehensive Primary Care Initiative**
- **FQHC Advanced Primary Care Practice: Illinois participating**
- **Multi-Payer Advanced Primary Care**

# Four Bundled Payment Models

## Timeline

- January – July 2013:  
No-risk prep period.
- July 2013:  
Risk Bearing  
Implementation  
Period

- **Model 1 – Acute Care Hospital Stay Only (Retrospective):** 3 participants representing 32 organizations
- **Model 2 – Acute Care Hospital Stay + Post Acute Care Episode (Retrospective):** 55 participants representing 192 organizations.
- **Model 3 – Post Acute Care Only (Retrospective):** 14 participants representing 165 organizations
- **Model 4 – Acute Care Hospital Stay Only (Prospective):** 37 participants representing 75 organizations

# Accountable Care Organizations

A group of health care providers working together to manage and coordinate care for a defined population, that share in the risk and reward relative to the total cost of care and patient outcomes.

## Medicare ACO Programs

- **Medicare Shared Savings Program**
- **Pioneer ACOs**
- **Advanced Payment Initiative**

# Medicare ACO Programs

## **Pioneer ACO Program (32); started 1/1/12**

- Eligible organizations had prior ACO-like experience
- 15,000 Medicare beneficiaries minimum
- Must enter into outcomes-based contracts with multiple payers.
- Model transitions to greater financial accountability(risk) faster.

## **Medicare Shared Savings Program (MSSP) (221)**

- Program requires the participating providers to form an ACO
- 5,000 Medicare beneficiary minimum for participation
- Two approaches: Savings only, Savings/Losses
- MSSP start dates: 4/1/2012, 7/1/2012 , 1/1/2013

## **Advanced Payment Initiative (35)**

- Must apply to be an MSSP ACO first
- Only smaller physician only practices OR rural health clinics or CAHs are eligible to participate
- Receive advance payment on their projected shared savings

# Managed Care and the Dual Eligibles

## Who are the “duals”?

9 million low-income seniors and disabled covered by both Medicare and Medicaid.

Characteristics include:

- **High cost:** Represent 20% of Medicare population but 31% of costs.
- **Poorer health status**
- **Low income:** 86% of them have incomes below 150% FPL (\$17,235 for individual)

- **Renewed federal and state focus on Managed Care for dual eligibles**
  - Federal Coordinated Health Care Office created
  - The Financial Alignment Initiative
- **Types of Managed Care:**
  - Medicare Advantage
  - Medicaid Managed Long Term Care
  - Managed Care for Duals/Financial Alignment Initiative

# Financial Alignment Initiative

## Capitated Integration Model

- Three-way contract between state, CMS and health plans
- Plans paid prospective blended rate for all primary, AC, behavioral, and LTSS
- CMS and state share savings
- Passive enrollment of duals with opt out
- Simple, unified rules

## Managed FFS Model

- State eligible for retrospective performance payment for achieving estimated level of Medicare savings
- Providers continue to get paid FFS by CMS & State
- Other state flexibility may be granted around benefits and to target duals in certain geographies.

26 States submitted proposals ; As of 3/27/2013,CMS has approved five states : CA, WA, MA, IL, OH in these demonstrations

# Illinois Integrated Care Program (ICP)

Started in 2011

**Population:** Non-duals Medicaid Managed Care for seniors and disabled

**Geography:** Suburban Cook, DuPage, Kane, Kankakee, Lake, and Will counties only.

**Services:** all Medicaid - acute care, behavioral health and long term services and supports (LTSS) ; Care coordination

**Plans:** Aetna and IlliniCare

Foundation for Medicare-Medicaid Alignment Initiative (MMAI)

# Illinois Medicare-Medicaid Alignment Initiative (MMAI)

- **Population:** Full benefit duals, not DD
  - **Passive enrollment with opt out – assigned plan if none selected but can change plans or opt out**
- **Services:** Full array of Medicare and Medicaid services including pharmacy – medical, behavioral, pharmacy, and long term services and supports (both institutional and community-based)
- **Plans:** State reviewing plan responses to RFP now
  - October plan selection anticipated
- Blended capitation payment for MCOs with P4P incentive
- **Implementation date:** 4/1/2013

# MMAI - Geography

- Phase I:
  - **Greater Chicago:** Cook, Lake, Kane, DuPage, Will, Kankakee counties
  - **Central Illinois:** Knox, Peoria, Tazewell, McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion, Ford, Menard, Stark counties
- Phase II: Year 2 of Demo
  - Rockford: Winnebago, Boone, and McHenry counties
  - East St. Louis: Madison, Clinton, and St. Clair counties
  - Quad Cities: Rock Island, Mercer, and Henry counties

# MMAI State Expectations

- More care coordination for duals
- Increased health risk and behavioral health assessments
- More duals with care plans
- Greater access to HCBS waiver and support services
- Reduced hospital readmissions, inappropriate ER use, and non-emergent transportation costs (esp. for NH residents).
- Improved beneficiary satisfaction

# Case Studies: How Reform Activities Are Playing Out

advocate educate innovate



**BENEDICTINE**  
Health System

*justice*

SERVING WITH TRUTH AND ACTION



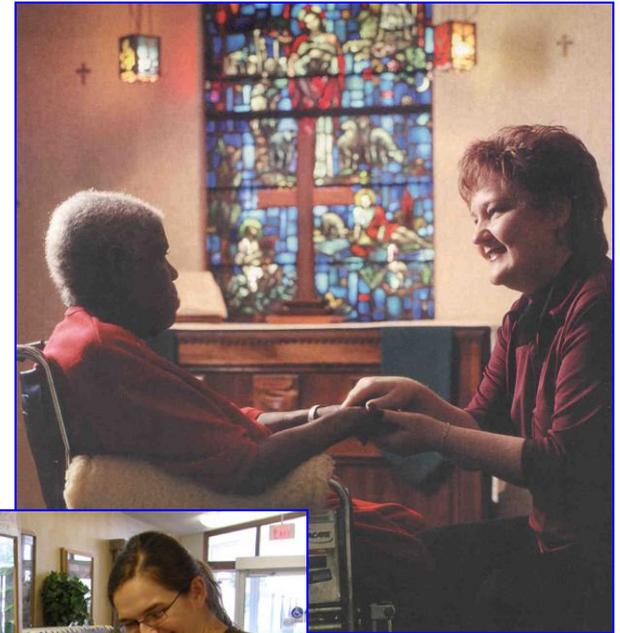
# Post-Acute/ACO Strategy Development

Kevin J. Rymanowski, SVP-Finance/CFO  
Benedictine Health System



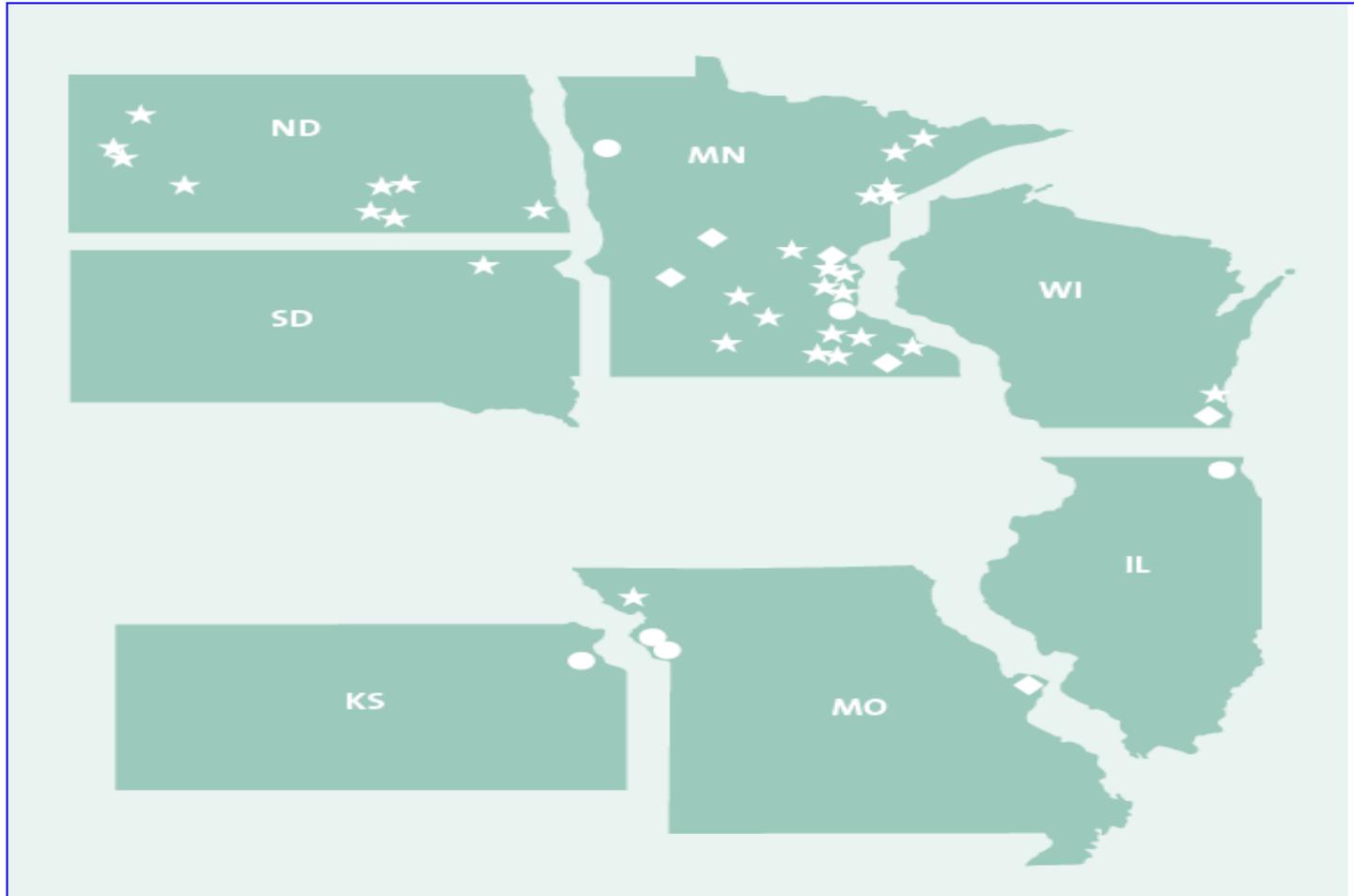
## BHS

- 40 Senior Communities across 6 states
- Bed complement
  - 3,300+ Long-Term Care
  - 2,200+ Housing with Services/ Assisted Living Facilities
- Staff
  - 7,000+ total employees





## Service Area





## **BHS ACO Partnering and Strategies**

- **“The Three Aims”**
  - **Better Health (of the Population)**
  - **Better Health Care (health care delivery/patient experience)**
  - **Lower Costs/Rate of Cost Increase**



## Acute and Post-Acute: What is an effective Partnership?

- Complex Patients are driving Medicare costs
  - By 2017 researchers are projecting that patients with 4 or more chronic conditions will account for 96% of Medicare expenditures
- Public Payors are experimenting with innovative approaches to “bend the cost curve”
  - P4P: Pay for Performance
  - Bundling payments to providers for specific conditions
  - Bundling payments by specific “episodes of care”
  - Capitation/Shared-Savings models: Can you say “HMO?”



## Acute and Post-Acute: What is an effective Partnership?

- P4P: by 2017 roughly 3,100 hospitals who qualify for “Value Based Purchasing” may experience a “withhold” of up to 2% of the base DRG payment if Quality Performance Metrics aren’t achieved
  - 12 process of care measures and 8 patient experience measures
  - Scored relative to national benchmarks and improvement compared to their own baseline
  - Payment will be based on meeting metrics and because of budget neutrality roughly half of the health systems will be “winners” – the others “losers”<sup>6</sup>



## **Acute and Post-Acute: What is an effective Partnership?**

- The Affordable Care Act has provisions to change how care is organized and delivered:
  - Section 3025: lower reimbursement (withholds) for readmissions of AMI, Heart Failure and Pneumonia within 30 days of discharge from acute care
  - Section 399KK: CMS will require a Quality Improvement Program for hospitals experiencing high re-admission rates
  - Section 3026: Community-Based Care Transitions Program will provide \$500MM over 5 years for care transition services for “high risk” Medicare beneficiaries



## Acute and Post-Acute: What is an effective Partnership?

- The Affordable Care Act has provisions to change how care is organized and delivered:
  - Bundled payments by episode will force the new ACOs to set up systems that provide high quality care across the whole continuum, but at a much lower total cost of care.
- Health Systems with ACOs will be looking for post-acute partners who are willing to “share risk”



## **BHS' Perspective and “Lessons Learned” so far...**

- Regardless of whether ACOs become the organizing paradigm for healthcare services, reform is inevitable
- There is no ‘single model’ for health care integration
- A commitment to quality processes and quality improvement is imperative
- IT will be a major component of any acute/post-acute partnership, and will require significant investment of both people and technology.



## Lessons Learned

- Not all hospitals or LTC providers understand the implications; have the same readiness or ability to innovate; or share a common vision for an effective strategy of post-acute care in the context of a continuum of care at an affordable rate
- A new wave of consolidation will change motivation and interest overnight
- Management of chronic conditions over the long term with seamless transitions is key



## Acute Care System “A”

- Senior transitions approach is well defined and being widely implemented
- Aggressive integration with existing marketplace SNFs
- Aggressively pursuing capitation on multiple fronts: Medicaid, dual eligible, Medicare, Private Insurance, eldercare
- Aggressive long term strategy: “new” post-acute product offering including ownership with select post-acute providers



## Acute Care System “B”

- Development of Critical Access Hospital assets into regional post-acute/rehab centers
- Not seeking ACO certification; longer term strategy around cost, chronic disease management and research based quality outcomes
- Interest in long-term care/post-acute partnerships still a bit “unclear”



## Acute Care System “C”

- Certified ACO but still developing strategies
- Committed to strong post-acute, short stay/rehab, but focused on moving patients aggressively to “home”
- Committed to existing LTC partnership and enhancements to services/facilities



# Acute Care System “D”

- Developing Senior Partners care management systems and approach in geographically defined area
- Aggressive use of existing providers (SNFs) focused on distinguishing them through quality outcome metrics & processes
- Aggressively pursuing capitation on multiple fronts: Medicaid, dual eligible, Medicare, Private Insurance, eldercare



# Road Map for an effective Acute and Post-Acute Partnership

## 1. Determine Market Position

- Identify strong, fully integrated potential health system partners in the market
- Establish complementary post-acute care partnerships focused on the needs of the health system and the patients (the initial focus may be to reduce re-admissions...but there are also clinical, satisfaction and financial measures that are equally important)



# **Road Map for an effective Acute and Post-Acute Partnership**

## **2. Differentiate on Quality and Service**

- Organize services by disease state
- Track metrics in a way that is consistent with ACO requirements
- Commit to a quality agenda across the whole organization
- Integrate the post acute care organization in transition-of-care planning and processes



## Road Map for an effective Acute and Post-Acute Partnership

3. Provide “hardwired” connections
  - Create a shared quality improvement structure
  - Enhance communication across the continuum’s providers
  - Make the necessary IT investments to allow for seamless sharing of information
  - Establish shared care pathways and protocols



## Road Map for an effective Acute and Post-Acute Partnership

### 4. “Capitation is not a dirty word...”

- BHS has been active in advocating for provider-based risk arrangements with Public/Private Payors
  - Dual-Eligible Plans
    - MSHO (Minnesota)
    - PACE (North Dakota)
  - Medicare Plans



## Acute and Post-Acute: What is an effective Partnership?

- Partnerships for Profit: Structuring and Managing Strategic Alliances by Jordan D. Lewis, 2002 identified 3 components of effective partnerships:
  - Mutual Needs
  - Common Objectives
  - Shared Risk
- BHS desires to be an effective partner in an ACO/Bundled Payment arrangement, and is willing and able to share financial risk (managed through appropriate processes of care and systems for monitoring performance against agreed upon measures of performance)



## **Road Map for an effective Acute and Post-Acute Partnership**

### **5. “On the Road with BHS”**

- Working with a Major Health System to establish 6 metro area “Transitional Care Units” on hospital campuses – first TCU’s to come on line in 2014
- Development of “branded” approach to post-acute services
- Partnership between Acute Health System and two Senior Living systems



## Framework

- Change the paradigm of what a TCU concept includes and what its role is in the health care system.
- Create a brand that connotes something “radically different” from today’s TCU model.
- Optimize referrals from discharges from our TCU’s that benefits Hospital System’s HCBS.
- Integrate spaces into our TCU’s that house HCBS staff like Case Managers to help optimize referral potential.



## Framework

- Position our “new TCU” to provide ER type support and direct admissions without an initial hospitalization.
- Achieve fewer hospitalizations, fewer re-hospitalizations, and fewer transitions.
- Optimize the use of and effectiveness of the informal care giving network and community resources that are not traditionally part of the health care system.



## **Some Infrastructure Perspective**

- Focus on increasing value to the overall system by collaborating on development of care coordination protocols – i.e., think fully capitated.
- Manage post-acute experience in less costly and more desirable locations.
- Locate our TCUs where possible to be in close proximity to the hospital, convenient for MDs, but distinct enough to preserve cost structure advantages.



## **Infrastructure Network Development**

- Collaborative process used for clinical and care protocol development.
- Emphasize Primary Care, and Sr. Transitions.
- Integration of electronic health record.
- Build collaborative relationships with nursing homes, physicians and community vendors
- Measure and improve customer satisfaction.



**BENEDICTINE**  
Health System

# Approaches to Collaboration Vary

- Four ACO situations
  - Criteria
  - Approaches
  - Expectations
- Boston ACOs PAC Measures
- Other examples from other markets

# Boston ACO Post Acute Care Measures/Expectations

STANDARDS OF POST ACUTE CARE	PERFORMANCE EXPECTATIONS/ASPIRATIONS
<b>GENERAL</b>	
1. Staffing	<ul style="list-style-type: none"> <li>a. Low staff turnover.</li> <li>b. Minimal use of agency nursing/nurse's aides.</li> <li>c. A nursing supervisor on all shifts (for preferably on-site).</li> <li>d. A primary care RN/LPN on-site 24/7 for short-stay units.</li> <li>e. Facility has a primary nursing(RN or LPN) model with consistent assignment for nurses and CNAs.</li> <li>f. Facility has access to adequate interpreter services.</li> </ul>
2. System Continuity	<ul style="list-style-type: none"> <li>a. Facility will offer the group's preferred providers to all of the group's patients at discharge (e.g. DME, VNA, specialists).</li> </ul>
3. Quality Improvement Efforts	<ul style="list-style-type: none"> <li>a. Facility will participate in collaborative QI work with the group (e.g. STAAR Cross-Continuum meetings, monthly case reviews, receive w arm hand-offs, etc.).</li> <li>b. Facility will participate in meetings with the group on an as needed basis to cover related topics (e.g. customer service, etc.).</li> </ul>
<b>PRE-ADMISSION</b>	
1. Screening/ Admission	<ul style="list-style-type: none"> <li>a. Facility will provide patient screens and determination of bed offer within 2 hours of referral.</li> <li>b. Facility is willing to collaborate with group on late evening admissions.</li> <li>c. Facility will both screen and accept patients seven days per week.</li> <li>d. Facility will accept direct admits for qualified patients from home/ER/clinician office.</li> <li>e. Facility will identify the patient's as group patients when bed offer is made, as reported by the ACO to the facility.</li> </ul>
2. Medical Coverage	<ul style="list-style-type: none"> <li>a. Facility will assign patients to the group's selected attending physician at time of bed offer (unless patient expresses alternative request).</li> </ul>
3. Care Transition	<ul style="list-style-type: none"> <li>a. Facility will develop and maintain a process for the nursing staff to receive a "warm hand-off" from any referral site.</li> </ul>

# Boston ACO Post Acute Care Measures/Expectations(Cont.)

<b>DURING STAY</b>	
<b>1. Facility Environment</b>	<p><b>a.</b> The Facility will provide:</p> <ul style="list-style-type: none"> <li>i. An environment (e.g. food, cleanliness, noise, comfort, etc.) that meets patient expectations.</li> <li>ii. Critical medications (e.g. pain, antibiotics, anticoagulation, cardiac, etc.) are available at patient's arrival.</li> <li>iii. DME that is in the patient's room prior to their arrival when appropriate.</li> <li>iv. Suitable work space available for MD and APCs as well as computer/printer access.</li> <li>v. Wireless internet access made available to both patients and to MD/APCs.</li> </ul>
<b>2. Care Systems</b>	<ul style="list-style-type: none"> <li>a. Facility will train staff and implement the INTERACT program. <ul style="list-style-type: none"> <li>• If alternative protocols/tools are in place, facility to make available to group.</li> </ul> </li> <li>b. Facility will provide high quality mental health coverage: <ul style="list-style-type: none"> <li>• At a minimum for emergent needs -continuous 24/7 telephonic coverage until resolution of emergency.</li> <li>• All other -telephonic coverage, as well as face-to-face consultation within 2 to 3 days.</li> </ul> </li> <li>c. Facility will provide high-quality palliative care consultations.</li> <li>d. Facility will assure STAT Radiology, Laboratory obtained and resulted within 4 hours.</li> <li>e. Facility will assure STAT prescriptions delivered within 6 hours.</li> <li>f. Facility will assure PT/OT are provided as ordered at least six days per week; if patient arrives before 2 pm, assessment and initial evaluation will be completed and documented on the day of admission. If admitted after 2 pm, evaluation must be completed and documented by the end of the next day. Therapies are available seven days per week.</li> </ul>

# Boston ACO Post Acute Care Measures/Expectations(Cont.)

<p>3. Care Planning/ Coordination</p>	<ul style="list-style-type: none"><li>a. <b>Facility will implement care planning meetings that occur within three days of admissions.</b> Patients, families, legal representatives and PCP's care manager are to be notified at least 48 hours prior the family meeting and are encouraged to participate.</li><li>b. <b>Outcomes of this first care planning meeting include:</b><ul style="list-style-type: none"><li>i. Establishing and documenting the <u>functional goal</u> required for patient to be transferred safely home.</li><li>ii. Establishing and communicating to patient, care team and group designee the estimated <u>discharge date</u>.</li></ul></li><li>c. Facility will establish a consistent day-of-week and time-of-day (e.g. every Tuesday at 9am) for the <b>interdisciplinary team meetings</b> for the group's patients.</li><li>d. <b>Facility case managers are responsible for:</b><ul style="list-style-type: none"><li>i. Assessment, creation, implementation and documentation of a discharge plan that begins at admission. The discharge plan is revised as appropriate, documents functional status, delivers notification of discharge/termination of benefits letters, etc.</li><li>ii. Timely collaboration with the group's Case/Care Management staff (e.g. Care Coaches, Case Managers) or their designee with any significant change in status or plan, including, discharge date.</li></ul></li><li>e. <b>The facility will identify a "point person" who will be responsible for providing both rehabilitation and clinical updates</b> (could be case manager or alternate with easy availability and access to coordinate with group's staff or SNF provider team) , including tele-rounding with the group case manager.</li></ul>
---	--

# Boston ACO Post Acute Care Measures/Expectations(Cont.)

## AT DISCHARGE AND POST-DISCHARGE

1. Medication Reconciliation and Education	The facility will assure that patients are given a typed list -in large font -of current medications upon discharge from SNF; medication changes are highlighted and explained; the list is fully reconciled with the home and hospital discharge summary medication lists.
2. Advance Directive Documentation	The facility will assure that: <ul style="list-style-type: none"> <li>• If patient does not arrive to facility with advance directives documented, these will be discussed and documented prior to discharge.</li> <li>• Any Advance Care directives, health care proxy or activation form will also be sent with the patient and faxed to the group and/or PCP office.</li> <li>• Of note, if the patient is DNR or a completed MOLST form is available, the form will be sent with the patient upon any transfer and through every area of care (including outpatient appointments).</li> </ul>
3. Communication of Discharge Paperwork to the Group	a. The facility will comply with the standard for completion of page 1, 2, 3 referrals and will include a typed discharge medication list to be faxed to the appropriate group and/or PCP fax number for scanning into electronic medical record. b. Will fax falls assessment to group's designee upon discharge.
4. Standard discharge planning checklist	The facility will use a standard discharge planning checklist that includes at least the following: <ul style="list-style-type: none"> <li>a. Identify family/caregiver availability</li> <li>b. Discharge medication list: <ul style="list-style-type: none"> <li>i. Determine patient's ability to acquire needed medications including cost and transportation.</li> <li>ii. Patient will receive appropriate education on medications.</li> <li>iii. Prescriptions for medications.</li> <li>iv. Technique review for example, for inhaler use.</li> </ul> </li> <li>c. Discharge instructions.</li> <li>d. Ensure patient can "teach back" using consistent teaching tools.</li> </ul>
5. Selection of Transfer Facility	a. If patient requires transfer to acute care facility, patients are to be transferred to original referring acute care facility unless medically contraindicated or due to patient.

# Boston ACO Post Acute Care Measures/Expectations(Cont.)

## REPORTING EXPECTATIONS

During relationship with the group, facilities are expected to have the **following data updated on at least a monthly basis** (or quarterly if specifically noted below) to be made available in regular reports to the group (or on request):

**Bed Screen Outcomes :**

- a. Bed offer made and bed accepted;
- b. Reason why bed not offered.

**INTERACT QI Review Summary**

***Clinical Programs***

- a. Provide list of specific clinical programs (e.g. cardiac, pulmonary, behavioral);

**Patient satisfaction results**

- a. The facility will survey patients regarding their satisfaction (at least two questions in the survey are from the CAHPS surveys and includes at least "willingness to recommend") and share the results quarterly with the group.

**Staffing**

- a. Staff turn-over rate by staff type (e.g. RN, LPN, CNA etc.);
- b. Nurse staffing ratios by staff type. RN, LPN, CNA etc. for both short- stay and long-term patients;
- c. Flu vaccination rate;

**DPHI Joint Commission Results**

- a. Namely, details of any survey deficiencies.

**QI process measures** (as established w/ group)

- a. For example, number of admissions w/ completed warm hand-offs.

**Functional Improvement Scores**

- a. Use of MDS measures acceptable.

**The following information is expected to be reported to the group in real-time without prompting:**

- 1) Change in Director of Nursing, Administrator or other senior leadership
- 2) Change in any "point person" per above, including admission director, case manager, etc.
- 3) If not already employed by the group, any change in staffing of medical coverage or any concerns regarding the ability of the medical coverage provider team of meeting the needs of existing or new patients.
- 4) If facility is closed for admission(e.g. flu outbreak or other unforeseen event).

# PAC Provider Activity: Realignment / Partnerships

- Sun Health
- Catholic Health Partners
- TCU management for ACO
- Shea Communities
- Health Café

# Strategic Initiative: Champion of Healthy Living

## Sun Health Care Transitions Program



**Sun Health**™  
CARE TRANSITIONS



1107388 [0] © www.istockphoto.com

# Sun Health Care Transitions Program

## Program Description



- RNs and LPNs follow patients for 30 days post discharge
- Medicare beneficiaries with CHF, AMI, PN, COPD, arrhythmias, CABG and other heart surgery, diabetes, stroke, hip fracture or other high risk ortho
- Education and self-management program based on the Coleman Care Transition Intervention® program and CTI's "four pillars"



# Sun Health Care Transitions Program

## Program Description (continued)



### Program Timeline

Each patient has a personalized care plan developed according to their needs. A typical patient would have interactions with Care Transitions staff as indicated below:



# Sun Health Care Transitions Program



- Reinforce patient education, including self-management of chronic condition and “red flags”
- Medication reconciliation, up to date list created using [SunHealthMeds.org](http://SunHealthMeds.org)
- Physician follow up visit
- Personalized plan of care in health record binder
- Referrals for other helpful community services

# Patient Education

 Doctor \_\_\_\_\_ Phone \_\_\_\_\_

## COPD ACTION PLAN

<p><b>GREEN LIGHT</b></p> 	<p><b>Green Light: No problems</b></p> <ul style="list-style-type: none"> <li>• Good, stable breathing</li> <li>• No difficulty doing normal activities, such as walking</li> <li>• Normal appetite, and sleeping without difficulty</li> <li>• No problems thinking clearly</li> <li>• Limited mucus</li> </ul>	<p><b>→ ACTION PLAN</b></p> <ul style="list-style-type: none"> <li>• Continue to take all medications as directed</li> <li>• Know and avoid your triggers</li> <li>• Eat healthy meals</li> <li>• Exercise as directed</li> </ul>
<p><b>YELLOW LIGHT</b></p> 	<p><b>Yellow Light: Caution-Beware of...</b></p> <ul style="list-style-type: none"> <li>• Increased coughing and shortness of breath</li> <li>• Thicker mucus that is yellow or green in color</li> <li>• Decreased appetite and problems sleeping</li> <li>• Some difficulty doing normal activities</li> <li>• Hard time concentrating or thinking clearly</li> <li>• Increased weakness and fatigue</li> <li>• Low grade fever</li> </ul>	<p><b>→ ACTION PLAN</b></p> <ul style="list-style-type: none"> <li>• Call your healthcare provider if your symptoms worsen</li> <li>• Continue to take all medications as directed, and use pursed-lip breathing and relaxation techniques</li> <li>• Check your oxygen system for problems, if you use one</li> </ul>
<p><b>RED LIGHT ALERT!</b></p> 	<p><b>Red Light: Medical Alert!</b></p> <ul style="list-style-type: none"> <li>• Shortness of breath while at rest or not relieved by rescue meds</li> <li>• Blood in mucus or difficulty coughing up mucus</li> <li>• Fever, chest discomfort, or night sweats</li> <li>• Drowsiness, confusion, or slurred speech</li> <li>• Blue lips or fingernails</li> </ul>	<p><b>→ ACTION PLAN</b></p> <ul style="list-style-type: none"> <li>• You need to talk to a doctor immediately if you have any of these symptoms!</li> <li>• Call 911 if you cannot reach your doctor.</li> <li>• Keep using your medications including your rescue medications.</li> </ul>

This information is not intended as a substitute for professional medical care. Always follow your health care provider's instructions. Source: 2011, Kinross Therwell, LLC. Content used for Sun Health, Copyright © 2012.

 Doctor \_\_\_\_\_ Phone \_\_\_\_\_

## HEART FAILURE ACTION PLAN

<p><b>GREEN LIGHT</b></p> 	<p><b>Green Light: No problems</b></p> <ul style="list-style-type: none"> <li>• No weight gain</li> <li>• No swelling in your feet, ankles, legs or stomach area</li> <li>• No shortness of breath or trouble breathing, either at rest or with minimal exercise</li> <li>• No chest pain</li> <li>• Activity: Plan time EVERY DAY for walking or other activity—unless your doctor has given other instructions.</li> </ul>	<p><b>→ ACTION PLAN</b></p> <ul style="list-style-type: none"> <li>• Continue to take all medications as directed.</li> <li>• Continue to weigh yourself every day.</li> <li>• Eat a LOW SODIUM DIET.</li> <li>• Keep the appointments listed on the discharge form given to you.</li> <li>• If you smoke or chew tobacco—you must quit.</li> </ul>
<p><b>YELLOW LIGHT</b></p> 	<p><b>Yellow Light: Caution-Beware of...</b></p> <ul style="list-style-type: none"> <li>• SUDDEN weight gain of 2 to 3 pounds in a day or 5 pounds in a week, or whatever amount you are told to report</li> <li>• Swelling in feet, ankles, legs or stomach area</li> <li>• A decrease in how much you urinate</li> <li>• Shortness of breath or trouble breathing at rest</li> <li>• Trouble sleeping</li> <li>• Having to sleep with more pillows or sitting up</li> <li>• Frequent or worsening cough</li> <li>• Worsening fatigue or constant feeling of tiredness</li> </ul>	<p><b>→ ACTION PLAN</b></p> <ul style="list-style-type: none"> <li>• Call your doctor or health care provider if you have any of the symptoms listed.</li> <li>• Your doctor may need to adjust your medications.</li> </ul>
<p><b>RED LIGHT ALERT!</b></p> 	<p><b>Red Light: Medical Alert!</b></p> <ul style="list-style-type: none"> <li>• Weight gains of more than 5 pounds within a week</li> <li>• Severe swelling in feet, ankles, legs or abdomen</li> <li>• Unrelieved shortness of breath or severe breathing trouble</li> <li>• Chest pain</li> <li>• Need to sleep sitting straight up</li> <li>• Confusion</li> </ul>	<p><b>→ ACTION PLAN</b></p> <ul style="list-style-type: none"> <li>• You need to see a doctor immediately if you have any of these symptoms!</li> <li>• Call 911 if you cannot reach your doctor.</li> </ul>

This information is not intended as a substitute for professional medical care. Always follow your health care provider's instructions. Source: Adapted from The American Heart Association, Inc. © 2008 by Sun Health.

# Medication Profile



Revised: 06/17/11 at 11:06



Jonathan B Doe DOB: 12/21/1950  
Allergies: Penicillin, Sulfa

Family Doctor: Dr. B. Smith  
908-555-5555

Take These Medications	At These Times			
	8am	12N	8pm	10pm
 <b>Crestor®</b> (Rosuvastatin) 10mg Tablet(s) <i>Lowers cholesterol</i>	1 Tablet(s)			
 <b>Cymbalta®</b> (Duloxetine HCL) 20mg Delayed release capsule(s) <i>Treats mood disorders/depression; Treats/Prevents nerve pain</i>	1 Delayed release capsule(s)	1 Delayed release capsule(s)	1 Delayed release capsule(s)	
 <b>Januvia®</b> (Sitagliptin) 25 mg Tablet(s) <i>Lowers blood sugar</i>	1 Tablet(s)			
 <b>Lasix®</b> (Furosemide) 20mg Tablet(s) <i>Water pill</i>	1 Tablet(s)			1 Tablet(s)
 <b>Potassium Chloride</b> 25 mEq Tablet(s) <i>Electrolyte supplement</i>	1 Tablet(s)			1 Tablet(s)
 <b>Nexium®</b> (Esomeprazole) 20mg Capsule(s) <i>Treats/prevents stomach ulcer/heartburn</i>	1 Capsule(s)			
 <b>Zonig®</b> (Zolmitriptan) 2.5 mg Tablet(s) <i>Treats migraine</i>	Take one tablet as needed for migraine headache. If headache returns the dose may be repeated after 2 hours. Do not exceed 10mg total in a 24 hour period.			

The pharmacist may make a generic substitution for the medication shown in your Daily Schedule. The medication name, dosage strength, shape, color, and size may change as a result of this substitution. Please check dosage strength on your prescription bottle against the dosage strength shown on your daily schedule. Call your healthcare professional's office immediately if you receive medication that is different from what was prescribed or if you have questions about your medication.  
1 teaspoon = 5ml, 1 tablespoon = 15ml.

©2001-2011 MedActionPlan.com, LLC. All Rights Reserved.

Revised: 06/17/11 at 11:06



Jonathan B Doe DOB: 12/21/1950  
Allergies: No Known Drug Allergies  
Emergency Contact: Mrs. Jane Doe  
908-555-5555

Medication	8 am	12 N	8 pm	10 pm
<b>Crestor®</b> (Rosuvastatin) 10mg Tablet(s)	1			
<b>Cymbalta®</b> (Duloxetine HCL) 20mg Delayed release capsule(s)	1	1	1	
<b>Januvia®</b> (Sitagliptin) 25 mg Tablet(s)	1			
<b>Lasix®</b> (Furosemide) 20mg Tablet(s)	1			1
<b>Potassium Chloride</b> 25 mEq Tablet(s)	1			1
<b>Nexium®</b> (Esomeprazole) 20mg Capsule(s)	1			
<b>Zonig®</b> (Zolmitriptan) 2.5 mg Tablet(s)	Take one tablet as needed for migraine headache. If headache returns the dose may be repeated after 2 hours. Do not exceed 10mg total in a 24 hour period.			

Primary Care Physician  
B Smith, MD  
Morristown, NJ (973) 555-5555  
Cardiologist  
D. Lipskis, MD  
Morristown, NJ (973) 555-5555

Primary Health Insurance  
Blue Cross/Blue Shield Policy # 1234567890  
Morristown, NJ (973) 555-5555

©2001-2011 MedActionPlan.com, LLC.  
All Rights Reserved.

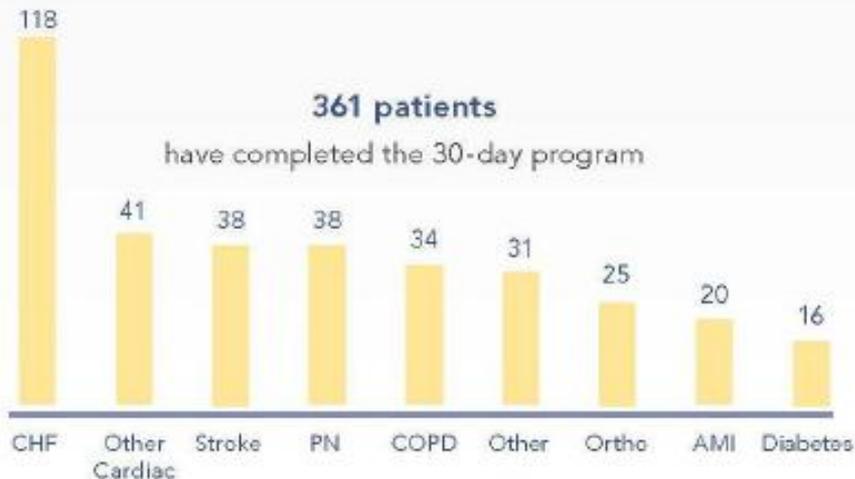
# Sun Health Care Transitions Program

## Outcomes as of 12/31/12



### Encouraging Initial Outcomes

Since the launch of the Care Transitions program in November 2011:



# Sun Health Care Transitions Program

Outcomes as of 12/31/12



527

Of the 361 patients, Care Transitions nurses helped to identify and **correct 527 medication discrepancies**, an average of **1.46 per patient**.



46%

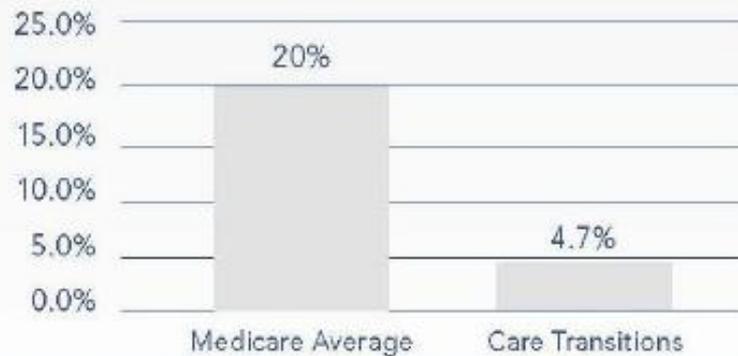
Care Transitions nurses helped to ensure **timely physician follow-up appointments for 46% of patients**.

# Sun Health Care Transitions Program

Outcomes as of 12/31/12



## Reducing Readmissions



Only 17 patients out of 361 have been readmitted within 30 days, a 4.7% readmission rate.

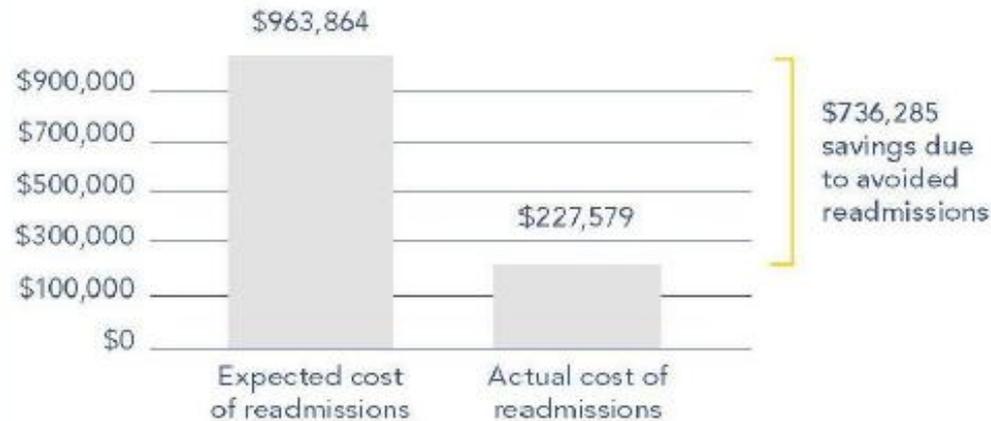


# Sun Health Care Transitions Program

Outcomes as of 12/31/12



## Saving Medicare Dollars



Jennifer Drago, VP Business Development

[Jennifer.drago@sunhealth.org](mailto:Jennifer.drago@sunhealth.org)

1.623.832.5563



# Lessons Learned From ACOs and Other Pilots So Far

advocate educate innovate

# Key Lessons From Early Adopters

1. Health care changes are evolving with significant variances
2. Change is really hard
3. Not all providers like the new organizational designs or the incentives
4. Timing is everything
5. Mergers and realignments are happening
6. Market share growth is essential
7. End of Life care matters...
8. Having fun is critical...

# Reframing the Discussion:

## *Market changes are driving health care reform...*

1. Customers/residents are defining new expectations
  2. Growth in Medicare and Medicaid volumes are redefining state & federal budgets
  3. Government spending limitations & changes in health insurance plans are driving movement to value vs. volume
  4. Payment structures are moving to recognize value
  5. Mergers and restructurings are occurring to manage costs and volume changes
  6. New market entrants are helping redefine care and services
- ... the ACA is a product of market changes and facilitates health care reform***

# Closing: Thoughts on Opportunity

advocate educate innovate

# Q & A

advocate educate innovate