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.
Interested in past Learning System events? Go to http://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
- **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
- **Engaging beneficiaries and annual wellness visits** — 7/22/15
- **Evidence-Based Medicine** — 1/7/14 and 1/24/14
- **Internal Cost and Quality Reporting** — 4/17/14 and 5/22/14
- **Lessons from GPRO Reporting** — 1/17/14 and 10/28/14
- **Lessons Learned from the Million Hearts Initiative** — 7/29/15
- **Provider Engagement** — 9/9/14 and 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
- **Using Data to Drive Performance** — 6/8/15

Materials for these and other webinars are located in the Program Announcements section of the Portal, under “Learning System Webinar Materials”
Webinar Agenda

- Housekeeping items
- ACO Introductions
- Roundtable discussion
  - Using Data for Care Coordination
  - Engaging Beneficiaries and Clinicians
  - Addressing Behavioral Health Needs and Social Factors
  - Lessons Learned and Future Directions
- Q&A
- Wrap-up
The widget menu located at the bottom of your event console provides access to various resources for a webcast. Should you accidentally minimize any of your widgets, you can open them again using the widget menu.

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KCMPA-ACO, LLC

Cindy Campbell, BSN, RN, MBA, CPHQ
Director of Clinical Strategies

Connie Wilkinson
Care Coordinator
Kansas City Metropolitan Physicians Assoc. (KCMPA) ACO

- Track and Start date: Track 1; 2013
- State(s): Kansas & Missouri
- Advance Payment? Yes
- Are any of the ACO participants hospitals? No
- Number of practitioners: 87
- Number of assigned beneficiaries: 13,000
- Percent EHR penetration, and number of EHR platforms used: 100%, 7 different EHRs
ACO Formation, Culture and Background

- Provider-based
- Serve rural, urban, and suburban
- KCMPA began as an IPA in 2011, then formed an ACO in 2013.
- KCMPA leads multiple organizational processes with the purpose of improving care coordination, care transition, chronic care management, population health, patient engagement, and provider engagement.
- This is accomplished through a variety of methods that include structured trainings, meetings, newsletters, information and training videos, technology use, patient education materials, and monthly webinars.
- Knowledge dissemination of PCMH, TCM, CCM, correct coding, care coordination, analytics reporting-claims and quality measures is a high priority throughout the organization.
Care coordination: Staffing and resources

**Staffing:**
- **All Care Coordinators are clinic-based employees**
- **1-3 CCs, RNs – LPNs – SWs – MAs**
- **All embedded in the practice**

**Resources:**
- **HMS– SQI tool for population health of beneficiaries and ACO measures**
- **ServData system which is based on claims and allows for analysis of key reports that can be used to identify where to direct coordination efforts**
Care coordination:
Beneficiaries and beneficiary identification

• Utilize Hospital Discharge lists
• Utilize High cost/ED Frequency use/30-day readmission lists
• Identify diabetic needs and coordinate care with Certified Diabetic Educator (CDE)
• Focus intensely on Medicare beneficiaries but try to establish processes that can be applied to entire practice population.
Care coordination: Identifying and addressing gaps in care

• **Overall Population Based Reports**: Annual Wellness Visit (AWV), Transition of Care (TOC), Preventive care, Diabetic care needs – Reports are provided to the practices showing percentages of needs met compared to unmet.

• **Individual Patient Reports**: Reports are provided to the practice that specifies the patients, this is also done during the chronic care management review. Also, the tool for ACO measures can drill down to the specific patient.
Care coordination: Identifying and addressing gaps in care

- A quarterly report is provided to each ACO practice to assist with care coordination processes in the practice.
Contact Information

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Accountable Care Coalition of Mount Kisco and Accountable Care Coalition of Syracuse

Jumana Sayegh, BSN, RN
Clinical Manager

Cindy Nigolian, RN, CS-Gerontology
Clinical Manager
Care Coordination at the Accountable Care Coalition of Syracuse, Accountable Care Coalition of Mount Kisco, and Collaborative Health Systems

Cindy Nigolian and Jumana Sayegh

September 2015
Accountable Care Coalition of Syracuse

- Track and Start date: Track 1; July 2012
- State(s): Central New York
- Advance Payment? No
- Are any of the ACO participants hospitals? No
- Number of practitioners: 196
- Number of assigned beneficiaries: 17,742
- Percent EHR penetration, and number of EHR platforms used: 3 EHRs, 100% penetration
Accountable Care Coalition of Mount Kisco

- Track and Start date: Track 1; April 2012
- State(s): New York
- Advance Payment? No
- Are any of the ACO participants hospitals? No
- Number of practitioners: 497
- Number of assigned beneficiaries: 24,000
- Percent EHR penetration, and number of EHR platforms used: One platform used, 100%
ACC of Syracuse and MKMG Formation, Culture and Background

- Provider-based, strong collaboration between provider groups and local hospitals
- Includes both rural and urban settings
- Embedded care coordination staff allows for collaborative environment, creates a team-based atmosphere and allows for increased transparency and real time communication
- High levels of provider engagement with care coordinators allows for efficiencies in transitions of care, referrals and triage of patients
Care Coordination Team Goals

Working with the doctor and his/her staff to:

- Engage beneficiaries who are identified as high risk or require transition of care support
- Facilitate coordination of care through timely exchange of information regarding health events and treatments
- Promote access to cost-effective care and social services resources
- Reach beneficiaries with the highest needs who have the highest chance for improving their condition
- Identify and monitor beneficiaries with ongoing chronic and/or complex healthcare needs
- Help to avoid hospital unnecessary re-admissions, emergency room visits, and duplication of services
- Facilitate transition of care to improve outcomes after discharge and enhance beneficiary and caregiver satisfaction
- Collaborate with ACO participants to promote the quality measures established by the Shared Savings Program
Scope of Activities to Support Our Care Coordination Goals

- Reach out to beneficiaries to:
  - Introduce Care Coordination Team and explain the Care Coordination support available.
  - Conduct appropriate assessments to determine their needs from a medical, social, and environmental perspective.
  - Develop care plans to address the beneficiary’s unique needs, chronic conditions, and high-risk factors.
- Communicate and collaborate with providers to promote transition of care coordination, discharge planning, and post-discharge care.
- Support outpatient care coordination activities and collaboration.
Care Coordination at ACC of Syracuse: Staffing and Resources

- Staffing: 5 FTEs RNs for 17,000 beneficiaries
  - One Clinical Manager
  - 4 Care Coordinators with 20-25 providers each
  - Work remotely in the region
  - Conduct telephonic, home visits and office visits
  - Office Visits: Care Coordinators make rounds at each office at least quarterly

- Technology and Analytics for Care Coordination:
  - Access to 3 EMRs; frequent outreaching and triaging
  - Access to daily hospital ED and IP, observation admission & discharge reports: 4 area hospitals
  - Access to 2 Hospital EMR’s
  - Healthy Impact 360 – a CHS system with beneficiary paid claims data
  - C3 – a CHS system with acuity algorithms for predictive modeling
  - Healthy Connections – NY’s RHIO
  - CHS reporting: Quarterly with focus on ED, CHF, and ACSC
Care Coordination at ACC of Mount Kisco: Staffing and Resources

- **Staff:**
  - 4 Registered Professional Nurses
  - 1 Licensed Social Worker

- **Outreach Activities:**
  - Telephonic
  - Field Visits
  - Embedded

- **Resources:**
  - Facility and Provider EHR Access
  - Daily ADT Hospital Reports
  - Hospitalist Discharge Summaries
  - SNF Census Reports
  - Online and Hardcopy Educational Tools
  - Assessments, Care plans and Workflows
Care Coordination Assessments/Education

- Evidence-based tools: Barriers to self care
  - Function:
    - TUG, mobility and safety
    - ADL/IADLs
  - Self Care:
    - Cognitive Screening/Executive function
    - Affective testing
    - Hearing/sensory
    - Health literacy
  - Supports:
    - Care giver stress
    - Elder abuse
  - Education:
    - Onsite education using company site and printer
    - Hard copies mailed and reviewed with teach-back
Care Coordination: Beneficiaries and Identification

- Only focus on MSSP aligned beneficiaries
- Beneficiaries are identified for care coordination through:
  - MD/provider referrals
  - Recent hospital admission (care coordinators are notified through RHIO or hospital ADT feed)
  - Frequent ER visits
  - Care management system (C3) risk stratification
- Patients with certain conditions are prioritized:
  - CHF
  - COPD
  - Community-Acquired Pneumonia
  - Falls
  - Palliative care/Cognitive impairments
    - Diagnosed
    - Uncovered
Care Coordination: Transitions and Gap Identification

- We identify and target gaps in care for individual patient care coordination using our Healthy Impact 360 portal, which generates lists of patients with chronic conditions and those that have not had AWVs.
- CHS has implemented a quality measures form that also helps identify gaps in care.
- Collaboration and Transparency with HC/SNF: hand offs at transitions.
- Collaboration/transparency with Hospice – engaging MDs: High utilization review
  - Engaging patients and caregivers to discuss with MD.
- Fall risk identification and process for providers.
- Focus on cognition and long-term support; avoidance of ‘crisis’.
Accountable Care Coalition of Syracuse

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Coastal Medical

Meryl Moss, MPA, EMHL  
Chief Operating Officer

Allyson Manning, RN, CDOE  
Nurse Care Manager
Coastal Medical

- Track and Start date: Track 1, July 1, 2012
- State: Rhode Island
- Advance Payment? Yes
- Primary Care Driven ACO
- 111 providers in over 20 locations
- 10,000 SSP ACO beneficiaries
- eClinicalWorks since 2006
ACO Formation, Culture & Background

- Coastal Medical is a Primary Care driven ACO
- Practices are located throughout Rhode Island
- Physician owned and governed
  - Improved buy-in for clinical program development
  - New workflow development
  - Focus on quality and patient experience
- Savings achieved 2013 & 2014
  - Infrastructure investments
  - Expansion of the clinical team
  - Development of centralized clinical programs
Care Coordination

- Coastal Medical provides transition of care management for all patients

- At discharge, patient risk and level of care determines which member of the transition of care team will outreach:
  - Nurse Care Manager (NCM)
  - Registered Nurse
  - Transitions of Care Specialist (medical assistant)
  - Pharmacist
Care Coordination

**Hospitalization**
- Daily Census report
- Patient ID bands
- ER Communication
- Current Care

**Community Resources**
- Hospital based NCM
- SNF based NCM

**TOC Team**
- Outreach in 48 hours
- Direct practice booking
- EMR templates

**Practice**
- Follow up PCP
- NCM for high risk patients
Closing the Gap

- Patient Level
  - Care Plans
  - Education about Coastal services
  - Referrals to preferred clinical service providers
  - High risk care management
Closing the Gap

- **Population Level**
  - Quality measures embedded in templates
  - Enroll in Current Care and patient portal
  - Disease Management Programs
    - Diabetes
    - COPD
    - CHF
    - Integrated Behavioral Health
  - Annual Wellness Program
  - Prescription refills
Contact Information

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Roundtable Discussion: Using Data for Care Coordination

- Please discuss which key **data reports** you review in order to support your work (aggregate and/or individual-level). Which data do you find to be most useful, and why?

- Do you use any **mechanisms to get timely data** from other settings (especially hospitals and skilled nursing facilities)? If so, please describe.
Roundtable Discussion: Engaging Beneficiaries and Clinicians

- Please discuss one specific strategy that your ACO has found most beneficial in **engaging beneficiaries** in care coordination and managing their own healthcare.
- Please discuss one specific strategy that your ACO has found most beneficial to **engaging clinicians** in coordinating beneficiaries’ healthcare.
Roundtable Discussion:
Behavioral Health Needs and Social Factors

• How does your ACO address the need to integrate behavioral health services in to beneficiaries’ care? Please discuss one specific strategy that you have implemented.

• How does your ACO address non-medical issues that impact health and health care (such as issues related to transportation, home environment, literacy, financial resources, etc.)? Please discuss one specific strategy that you have implemented.
Roundtable Discussion: Lessons Learned and Future Directions

• What are some of the **key lessons** that your ACO learned as you developed and implemented your care coordination strategy? What **advice** would you give to other ACOs?

• What is the **future direction** of your ACO’s care coordination strategy?
Questions & Answers

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

• Documents for this session are in the Resource List widget below.
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• Feel free to send questions, comments, and suggestions for future topics to ACOLearningActivities@mathematica-mpr.com