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](https://portal.cms.gov) to access recordings and summaries of past webinars, including:

- **ACO Experiences with Engaging Beneficiaries and Annual Wellness Visits** – 7/22/15
- **ACO Lessons Learned from GPRO Reporting** – 10/28/15
- **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
Past Webinar Materials (cont.)

- Coordinating with Post Acute Care Providers—11/21/14
- 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, 10/28/14, 10/28/15
- 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

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 by Dr. Terri Postma, CMS
• Hackensack Physician-Hospital Alliance ACO Introduction
• Coordinating Care with Post-Acute Providers Presentation
• Questions and Answers
• 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.

The Help widget provides immediate access to technical resources and information, like the system requirements and technical FAQs. In addition, you can test your system to see if you are meeting the minimal technical requirements.

The Q&A widget allows attendees to submit questions to the presenters – technical or content related – at any time.

The Slides widget is the presentation display area for the PowerPoint slides that are presented to the audience. It also displays any polling questions.

The Resource List widget contains documents related to this webcast.

The Closed Captioning widget opens a separate URL featuring the live closed captioning feed for the webcast.

The Survey widget contains a link to a survey, which you can use to submit feedback about the webcast.
Hackensack Physician-Hospital Alliance ACO, LLC

Peter Gross, MD
Chair, Board of Managers
Hackensack Physician-Hospital Alliance ACO, LLC

Veronica Betts, RN-BC DNP
Manager of Care Coordination
Coordinating Care with Post-Acute Providers

Hackensack Physician-Hospital Alliance
Accountable Care Organization
Hackensack, NJ
Hackensack Alliance ACO
(Hackensack Physician-Hospital Alliance ACO)

- Track 1 and Start date of April 1, 2012
- State: New Jersey
- Advance Payment: No
- Are any of the ACO participants hospitals:
  - Yes
- Number of practitioners: 167 PCPs & 477 other providers
- Number of assigned beneficiaries: 19,908
  - Plus 65,000 more in commercial plans
- Percent EHR penetration: 77.6%
- Number of EHR platforms used: 11
ACO Formation, Culture and Background

• Strong collaboration between hospitals and providers
• Suburban
• Patient-Centered Medical Home certification by NCQA required
• Strong care coordination commitment on day 1
• Significant savings above MSR for two years
• Hospital admissions, readmissions, & ER visits below normal, physician office visits above normal and high risk score account for savings.
What Demographic and Utilization Factors Worked in our Favor*

- Average Age: 75.9 years versus group of 71.7 years
- Average Risk Index of 24.34 versus 17.17 for group
- Our inpatient PMPM costs were 10% above norm while our utilization was 10% below norm.
- Our ER PMPM costs were 2% above norm while utilization was 23% below norm.

*Analysis provided by Verisk and Premier Inc. Group is a 5% sample of CMS data
Review of Utilization That Made a Difference*

- Total admissions per 1000: 274.1 (us) vs. 316.8 (group)
- ER visits per 1000: 641.9 (us) vs. 835.0 (group)
- Urgent care visits per 1000: 44.2 (us) vs. 53.8 (group)
- Total office visits per 1000: 13,210.8 (us) vs. 9,631.7 (group)
- The relative increase in office visits accounts for greater attention to the patients in order to avoid hospital admissions, ER visits, and urgent care visits.

*Analysis provided by Verisk and Premier Inc.
Group: 5% sample of CMS data
Conclusion

• Our costs are higher because, in part, our risk index is so much higher than the norm.
• Yet our utilization numbers are significantly below expected for such a high risk index.
• This means that the physicians are taking cost-efficient care of very high risk patients. This is primarily responsible for our savings.
Next Question—Is the Care Suffering?

• The answer is a definite NO as demonstrated by the average care gap index (CGI). For our ACO, the CGI is 4.80 while the CGI of 4.96 is higher for the group of ACOs being monitored.

• In summary, our ACO is taking care of much higher risk patients but because of more efficient care we are generating a savings while providing excellent care.

• This is a tribute to the physicians, care coordinators, office nursing staff, and other providers in the offices. This message needed to get out to the ACO providers in each ACO practice.
Reducing PMPM Spend

• Top process identified for improvement by PMPM spend
  – Skilled nursing facilities: $135.60 PMPM or $28,323,645 per year
  – We can break down the data by SNF and by referring provider
  – Also, break down by admissions, readmissions, length of stay, cost per day, etc.

*Analysis provided by Verisk and Premier Inc.
## Skilled Nursing Facility Comparison for Year 2014 for Aged, Non-Dual Beneficiaries Only

<table>
<thead>
<tr>
<th>SNF CATEGORY</th>
<th>HUMC ACO</th>
<th>ACO AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF admissions/1000</td>
<td>69.6</td>
<td>62.9</td>
</tr>
<tr>
<td>Risk-Adjusted SNF admissions/1000</td>
<td>56.3</td>
<td>53.3</td>
</tr>
<tr>
<td>SNF average LOS</td>
<td>27.1</td>
<td>25.3</td>
</tr>
<tr>
<td>% of SNF stays over 21 days</td>
<td>49.3%</td>
<td>42.5%</td>
</tr>
<tr>
<td>Average paid per SNF day</td>
<td>$550</td>
<td>$430</td>
</tr>
<tr>
<td>Average paid per SNF discharge</td>
<td>$14,895</td>
<td>$10,857</td>
</tr>
<tr>
<td>% cost contribution to total spend</td>
<td>9.8%</td>
<td>7.5%</td>
</tr>
<tr>
<td>% of SNF stays with 30-day readmits</td>
<td>16.2%</td>
<td>14.6%</td>
</tr>
</tbody>
</table>
| Number of distinct SNFs utilized    | 76       | 77          

*Analysis provided by Verisk and Premier Inc. Group is a 5% sample of CMS data.*
Misaligned Incentives

• Payments for therapy services are tied to the amount of therapy provided
• Payments for non-therapy ancillary (NTA) services do not vary with these services’ costs or a patient’s need for the services
How Do We Attack the Problem

• Ensure that an ACO-affiliated physician takes primary responsibility for ACO patients admitted to SNF
• Agreements with high-value facilities
  – Identify facilities with “best practices”
  – Volume = Leverage
  – Redesign throughput
• Active intervention
  – Care Navigators see every patient in the SNF
  – Active participation in patient care meetings
Strategies to Optimize SNF LOS

• Inpatient care coordinators meet with patients at bedside within 24-48 of admission and screen for post-acute needs
• A discharge plan is discussed and patients are referred to the least restrictive medically appropriate post-acute setting
• For patients requiring SNF, a list of facilities is provided including a list of high-value facilities and allows for patient choice
• Patients/family are educated that the SNF benefit does not acknowledge a break in the stay unless it is greater than 60 days for time to recycle
• Informed co-pays incurred beyond day 20
Transition of Care

- A handoff tool was developed and implemented for use to ensure a seamless transition to the next level of care
- Tool identifies the patient as an ACO patient
- Alerts facility to assign ACO SNFist physician to manage patient while in facility
- Provides contact information for care coordinator and PCP
- Includes pertinent information that needs follow up such as follow up appointments, INR, etc.
Nursing Handoff Sheet Includes:

• Patient identifiers:
• Code Status:
• Date/Place of Transfer:
• Hospital Diagnosis/Reason for Admission:
• PMD & PMD Fax #:
• Please follow up with Specialists:
• Please Assign ACO MD in Facility:
• Patient Care Coordinator: Phone #: Email:
• Upon discharge from Facility please email/fax: d/c summary, med rec, copies of Rxs & last labs
Transition of Care (Continued)

• Establish a target LOS
• Ensure a transition of care plan is discussed with patient and/or family within 2-3 days of admission
• Care coordinators need to be actively involved in the discharge plan
• Biweekly calls to facility at a minimum
• Care coordinators attend UR rounds at high-value facilities and have a set of standard questions that address clinical condition, health status and progression
• Patients receive follow up phone calls within 48 hours of discharge and an appointment with PCP is scheduled
Prompt Questions for Discharge Rounds Include:

- Name, diagnosis, and admit date
- Targeted discharge date; discharge plan:
- Prior level of function:
- Bed mobility:
- Transfers:
- Ambulation:
- Activities of Daily Living (ADLs):
- Barriers to discharge:
- Family involvement in plan
- Need for Medicaid application
- Equipment/services ordered
Post Acute Scorecard

• Develop scorecard to measure LOS, readmissions, and other quality indicators

• Ask for root cause analysis for readmissions to determine trends

• Implement protocols to address identified trends
Contact Information

• Michael Dardia, Administrative Director at
  – phone: 551-996-3766
  – email: mdardia@hackensackumc.org
Questions & Answers

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

• Documents for this session are in the Resource List widget below, and will be posted to the ACO portlet.
Please give us your feedback!

Open the survey widget located in the widget menu at the bottom of your event console.
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 you used to attend.

- Please complete the webinar evaluation

- Feel free to send questions, comments, and suggestions for future topics to ACOLearningActivities@mathematica-mpr.com