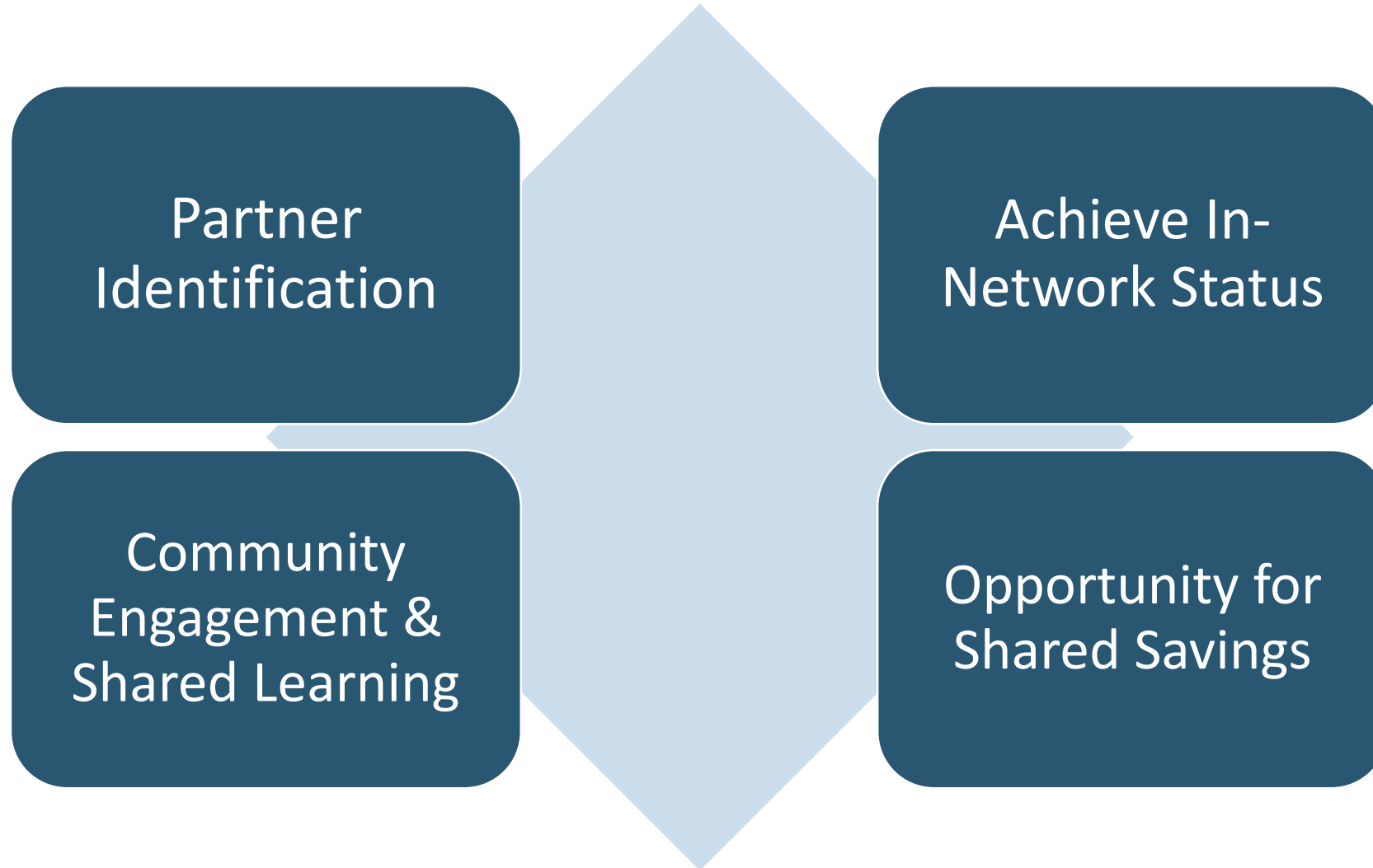




**The Principles of Partnerships: Creating
Affiliate and Preferred Provider
Agreements That Drive ACO Results**

Jake Woods
Director, Accountable Care Models

Preferred Provider Agreements – Key Components



About PSW

HISTORY

Founded in 1995, PSW has led healthcare innovation with the guiding principle of supporting the physician–patient relationship to improve quality of care.

MISSION

Accelerating the transformation of healthcare from volume to value through innovation and collaboration to achieve outcomes that improve the health of our communities.

ACCOUNTABLE CARE MODELS

In 2017, PSW created Northwest Momentum Health Partners (NWMHP) Accountable Care Organization (ACO). NWMHP is a pioneer in accountable care for the PNW with over 25,000 beneficiaries. Currently participating in the Global & Professional Direct Contracting (GPDC) Model.



27 YEARS EXPERIENCE



FOUNDED BY INDEPENDENT PHYSICIANS



LOCAL EXPERTISE, NATIONAL FOOTPRINT



300,000+ LIVES IMPACTED



ACO MODEL PARTICIPATION SINCE 2017



PSW Business Line



Payer Network Operations

As a delegated entity that manages critical operations for contracted health plans including claims processing, credentialing, contracting and care management.



Accountable Care Models

PSW leads healthcare innovation through its ACO's participation in CMS Models. By partnering, we can improve health outcomes and lower expenditures for Original Medicare fee-for-service beneficiaries.



Advisory & Management Services

PSW offers a full suite of services, tools and resources that support population health management, the volume-to-value transition.

Total Lives Impacted: 300,000+



ACO Partnership Map

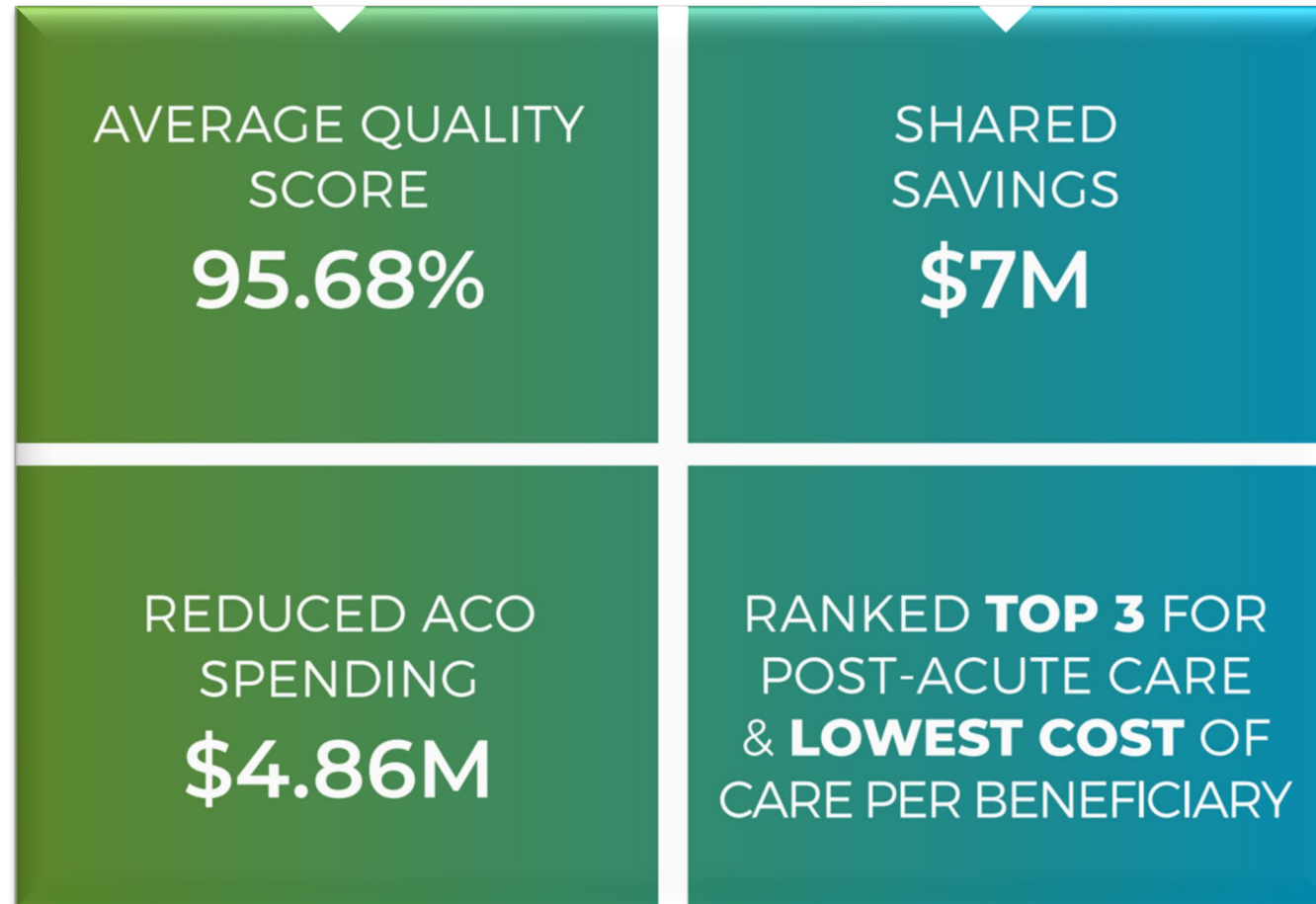
NWMHP serves beneficiaries across Washington State

- 29,000 GPDC beneficiaries
- 600+ providers 
 - Independent providers, Hospital Systems, and Rural Health Systems
- 31 Post-Acute Facilities 
 - 21 Skilled Nursing Facilities
 - 10 Home Health Agencies



NWMHP Performance Outcomes

2017 – 2020 Performance





PARTNER IDENTIFICATION

Identifying Partners for a Preferred Network

Key components used to evaluate potential new Preferred Providers

1. Star Rating – Must look beyond overall rating

1. Health inspections tend to have a heavier weight on the overall rating
2. Staffing and Quality must meet the network standards to be included as a Preferred Provider

2. Population Density*

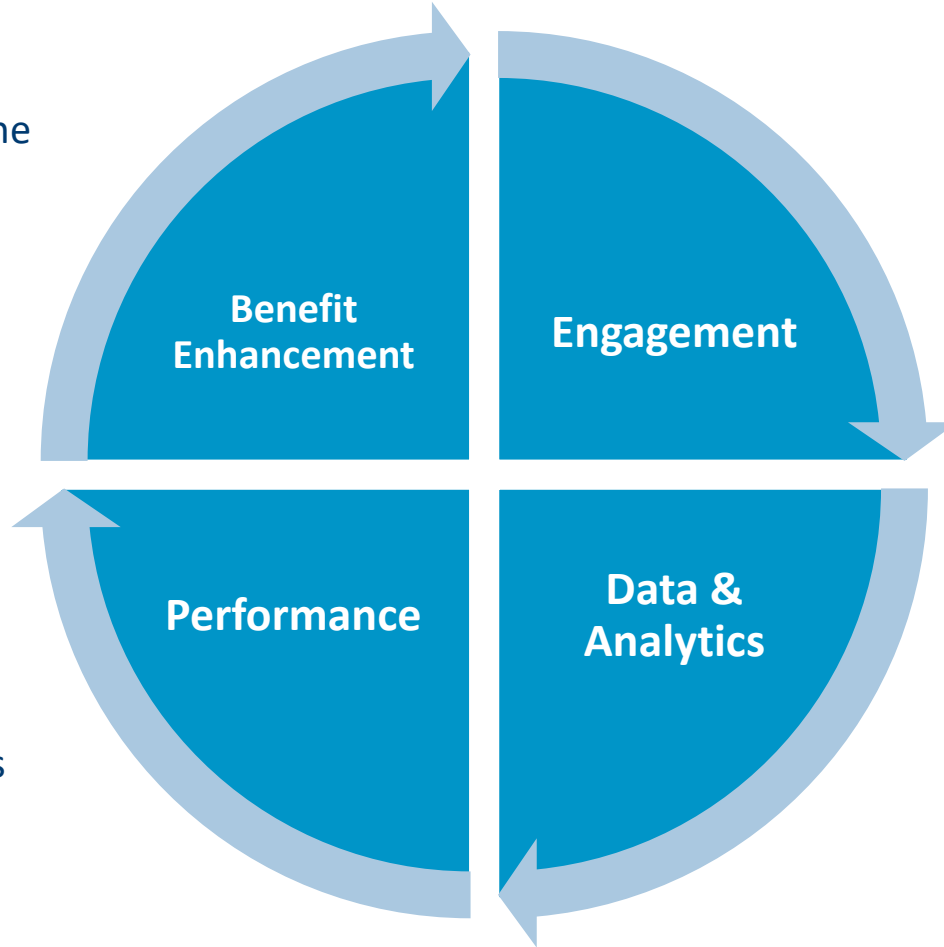
1. Separate by residential Zip Code of beneficiaries

3. Historical performance

1. LOS, Cost, Quality
2. Used to inform performance benchmarks

*Can not always be used as a qualifier in rural areas

Establishing Expectations



- ❖ Preferred Providers should utilize the 3-Day SNF Waiver
- ❖ This waiver can only be used when appropriate

- ❖ Preferred Providers must attend collaborative sessions and engage with our team

- ❖ Preferred Providers must demonstrate improvement towards the performance goals

- ❖ Preferred Providers have access to multiple sources of data
- ❖ Users must obtain access to the data platform





IN-NETWORK STATUS

Benefits of In-Network Status

Participation in the 3-day SNF waiver – increased volume

Improve community collaboration

Access to additional patient benefits through SDoH program

Improves resident transitions of care

Support efforts to reduce risk of readmission

Residents will have access to Remote Patient Monitoring upon discharge

Using Data to Drive Performance

SNOWY HILL
NPI: 6631042871

9753 Frosty Dr
Clear Lake WA, 98502



Overall Star Rating
(as of 2021-01-01)
5 Stars

Star Rating Components
(as of 2021-01-01)
Quality Measures: 5 Stars
Health Inspections: 5 Stars
Staffing: 4 Stars

<u>Quality Measure¹</u>	<u>Score</u>	<u>Benchmark</u>	<u>Met Benchmark?</u>
% w/ ER Visit:	15.87%	< 10.26%	0
% Rehospitalized:	19.05%	< 20.73%	1
% Discharge to Community:	66.1%	> 48.57%	1
% Pressure Ulcer new/worsened:	1.5%	< 1.6%	1
Total Benchmarks Met:		3/4	

Performance indicators reviewed quarterly



Total Spent²	Total Bed Days²	Total Admits²	SNF Readmits²	Avg Length of Stay²	Avg Cost Per Day²	Avg Cost Per Admit²
2019: \$928,693.08	2019: 2,115	2019: 76	2019: 16	2019: 27	2019: \$439.10	2019: \$12,219.65
2020: \$802,165.34	2020: 1,573	2020: 70	2020: 6	2020: 22	2020: \$509.96	2020: \$11,459.50





COMMUNITY ENGAGEMENT & SHARED LEARNING

Partner Engagement Strategies

Quarterly Joint Operating Committees

Quarterly Workgroups

Data Delivery

Weekly interdisciplinary review of Medicare population

Quarterly Provider Work Groups

Bringing together the Post-Acute Preferred Network

Purpose

- Greater discussion on each organization's perspectives & challenges
- Presentation from a different organization each time
- Focus more on best practices and less on the data

Attendees

- Care Management team members from Preferred Provider Organizations
- Administrative team members from Preferred Provider Organizations
- PSW Director of Post-Acute Network and Post-Acute Care Coordinator

Topics

- Readmission Work Group
- Managing Length of Stay

Quarterly Joint Operating Committees

Purpose

- Review current performance and program updates
- Identify areas of opportunity
- Report on current initiatives

Attendees

- Administrative team members or key leadership from Preferred Provider Organizations
- PSW Director of Post-Acute Network and Post-Acute Care Coordinator

Topics

- Review individual PAC Key Performance Indicators
- Provide unblinded peer performance and compare
- Discuss opportunities for improvement
- Offer educational opportunities to PAC provider's staff as indicated

Using Data to Drive Performance – Peer Review

	Facility #1	Facility #2	Facility #3
Cost Per Day	\$592	\$718	\$649
Cost Per Admit	\$15,097	\$12,382	\$11,190
Length of Stay	25 days	17 days	17 days
IP Readmit Rate	0%	25%	0%
ED Readmit Rate	0%	0%	50%
Benchmarks Met	2 out of 4	4 out of 4	4 out of 4
Overall Star Rating	3 Stars	4 Stars	5 Stars





SHARED SAVINGS

Opportunity to Achieve Shared Savings

Preferred Providers can achieve Shared Savings, but do not take downside risk

Savings opportunity determined upon:

- I. Volume (participation in 3-Day SNF Waiver*)
- II. Quality benchmarks

***Difficult to measure during the pandemic due to low utilization of the ACO 3-Day SNF Waiver**

Preferred Provider Agreements – Key Components

❖ It is crucial to identify motivated partners ready to engage



❖ Strong collaboration in the network helps everyone improve



Achieve In-Network Status

❖ In-Network benefits can incentivize participation



❖ Upside financial opportunities are a great motivator





THANK YOU!

319 7th AVE SE, St. #201, Olympia, WA 98501

Phone: 360.943.4337

Fax: 360.754.4324

pswipa.com | nwmomentumhealthaco.com

We are called to make a healthy difference in people's lives.

Principles of Partnership

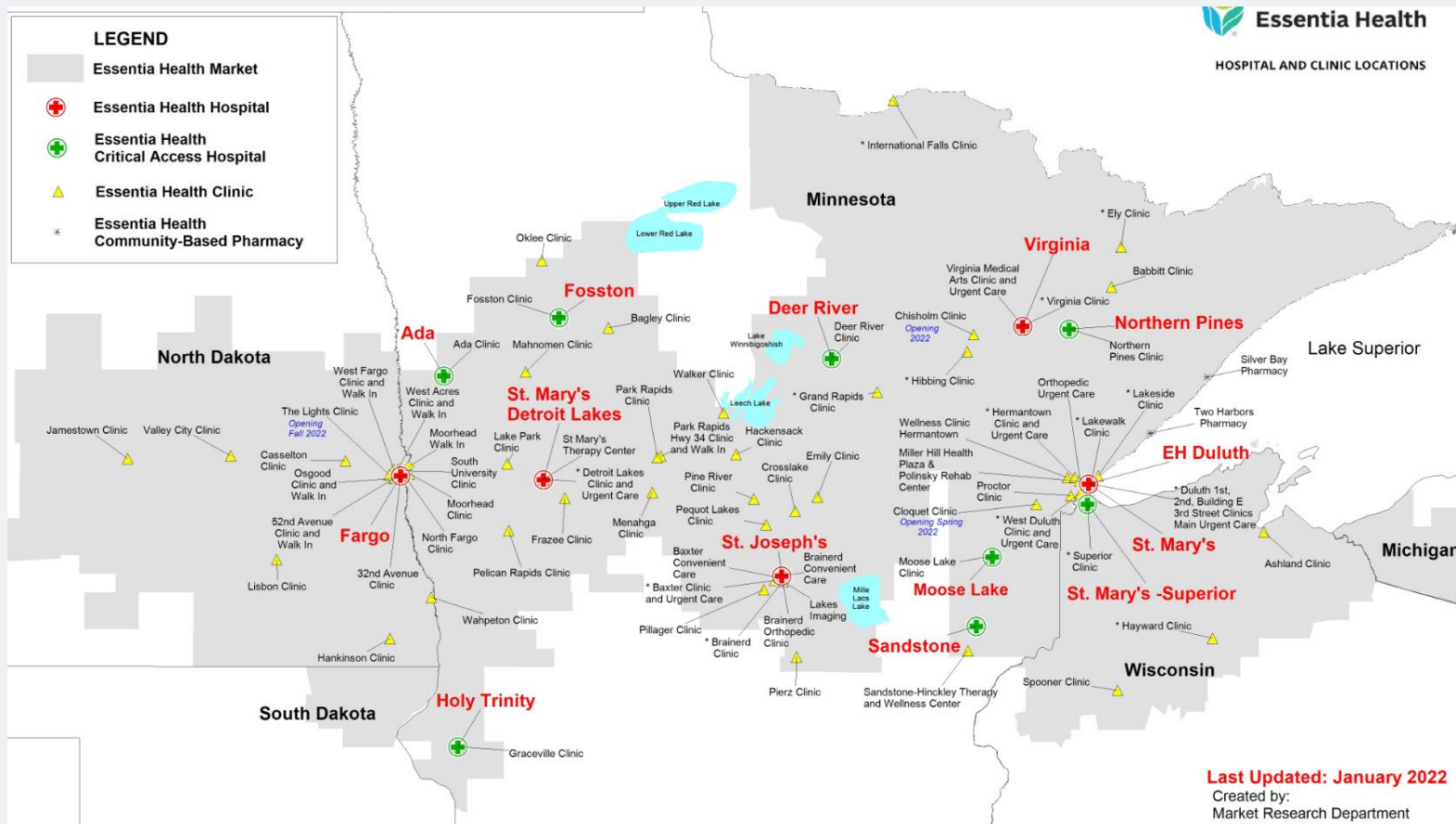
Creating Affiliate and Preferred Provider Agreements
That Drive ACO Results

Jessica Martensen, Essentia Health



Essentia Health

Essentia Health



Nonprofit, integrated health care system headquartered in Duluth

14,700 employees

14 hospitals, 75 clinics

Serving 560,000+ unique patients in Minnesota, Wisconsin, North Dakota

180,000 at risk lives: commercial, Medicare: Enhanced Track MSSP, Medicaid

Post Acute Care:

6 SNFs

3 Assisted Living Facilities

3 Home Care Agencies

2 Hospice Agencies

Essentia's Journey: Volume to Value

2005: First Value Based Contract

2009: Partner in Medicare Advantage Plan

2012: Accountable Care Organization

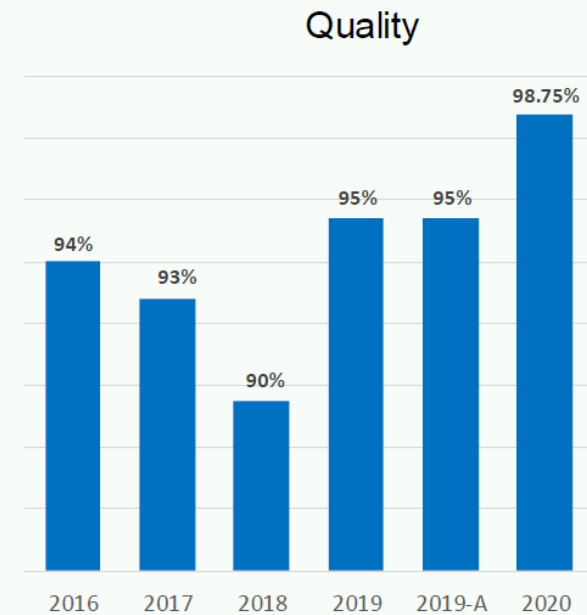
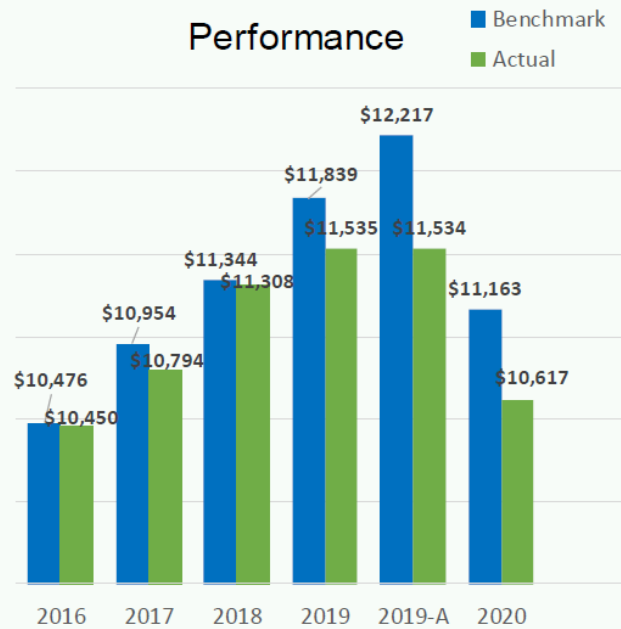
2016: MSSP Downside Risk

2019: MSSP Pathways



MSSP Performance

- Earnings totaled \$10.6M in 2020, up from \$9.5 in 2019 and \$0 in 2018.





Post Acute Care: Where did we start?

Post Acute Spending- 2015

Average SNF LOS: 33 days

- PMPY Costs \$931
- \$23M total spend, including swing bed Med A stays
- Care provided at over 200 SNFs



Post Acute Management Timeline

2016: 2 RN SNF
Utilization Specialists

- RESULTS: 33 days >> 30 days

2017: Standardized
Reporting to SNFs

2018: Set 19 d LOS
targets

2019: Created SNF
Preferred Network

- Results: LOS 24 days

2020: Home Health,
Hospice & Infusion
Preferred Network

2021: Added Physical
Therapy Reviewer

2022: Relaunch of
Preferred Network
Strategies

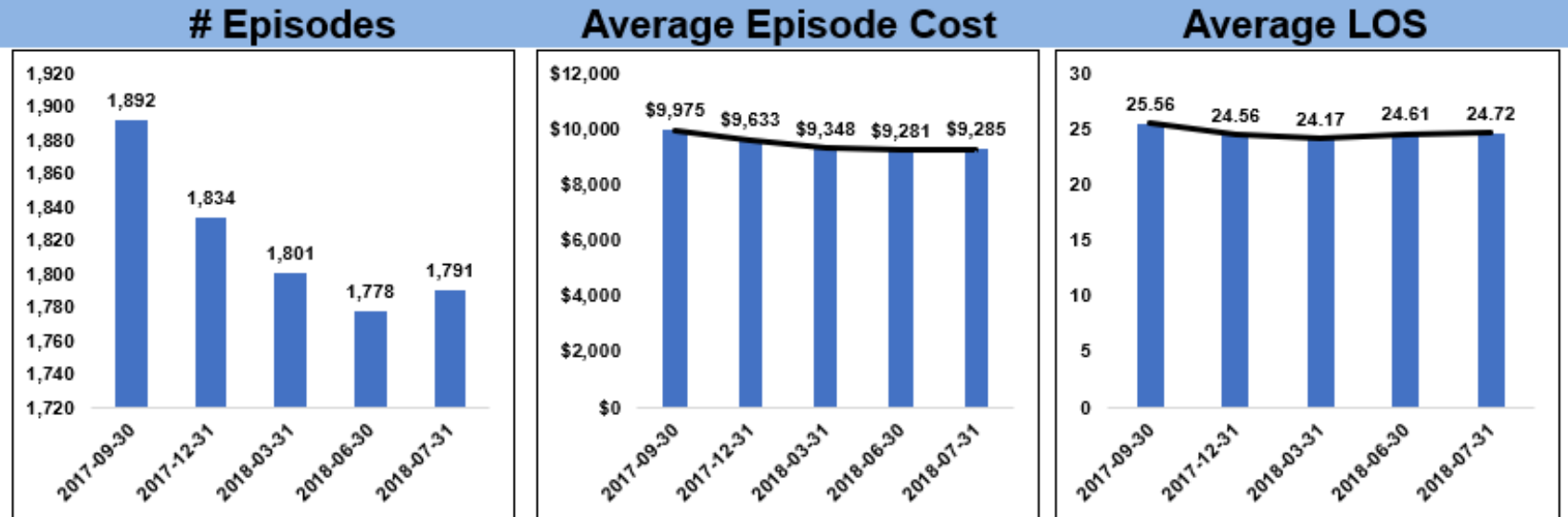


MSSP SNF utilization results: 2018

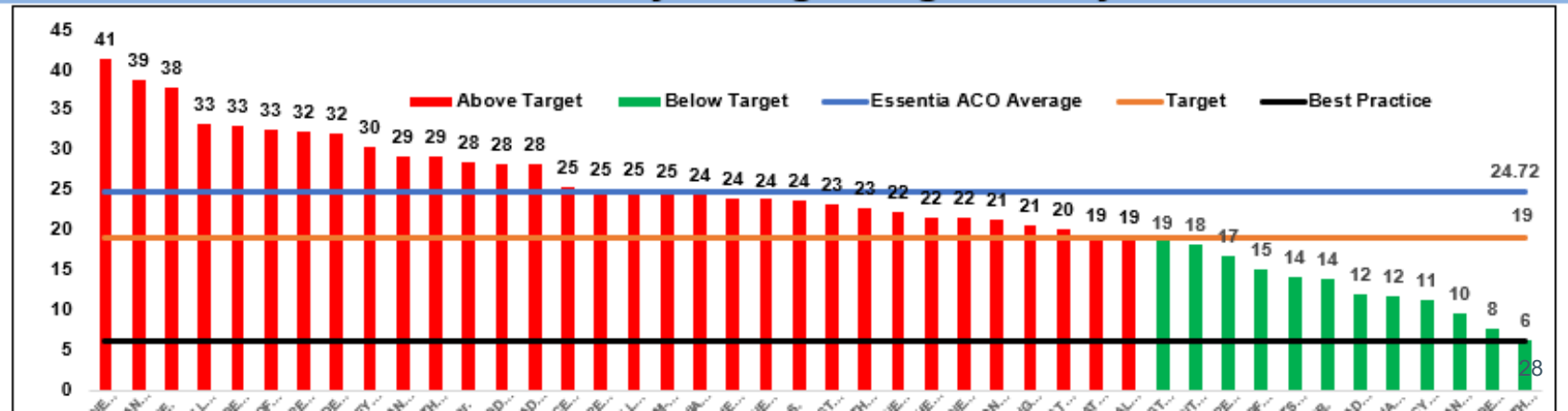
44 Main SNFs

LOS: 24 days

MSSP SNF Performance as 7/31/2018



SNF Facility Average Length of Stay



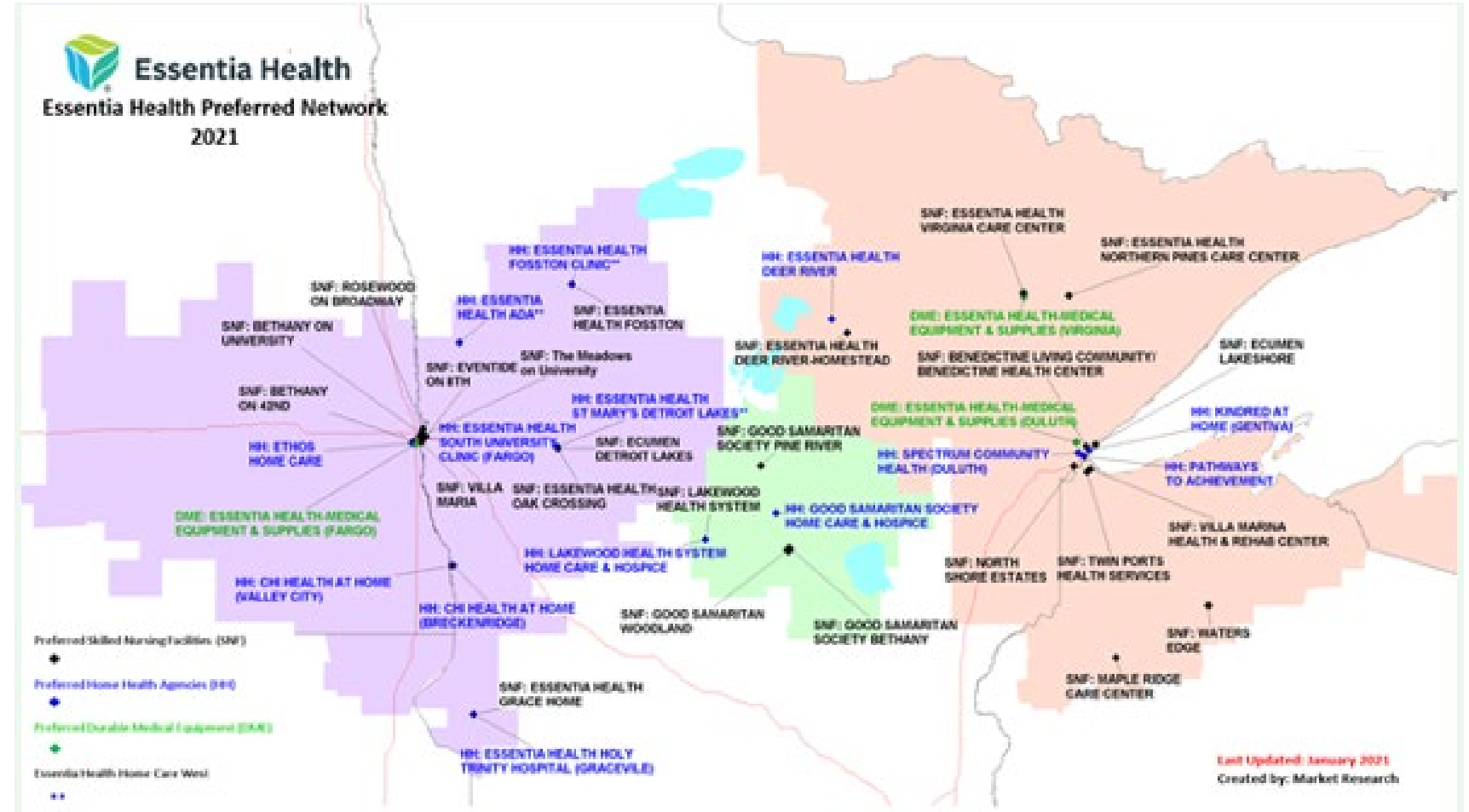
Preferred Network

The preferred network is a *partnership* between Essentia Health and multiple skilled-nursing facilities (SNFs), home health agencies (HHAs), hospice care, durable medical equipment (DME) and infusion care with the goal of providing high quality and efficient care.

Preferred Network Criteria

Post-Acute Service	Criteria Reviewed
Skilled-nursing Facility (SNF)	<ol style="list-style-type: none">1. CMS Quality Overall Star Rating2. Average Length of Stay3. Historical Patient Volume4. Positive Relationship with Essentia Care Teams (Case Managers, Discharge Planners, Utilization Management Reviewers)5. Live with online resource directory6. Quality Data including readmission rates7. Complete the CMS SNF Affiliate Agreement (if applicable).
Home Health Agency (HHA)	<ol style="list-style-type: none">1. CMS Quality Overall Star Rating2. Average Length of Home Care episode3. Utilization data including cost of episode4. Historical Patient Volume5. Quality Data including readmission rates
Hospice	<ol style="list-style-type: none">1. CMS Quality Overall Star Rating2. Length of Stay
Infusion Care	<ol style="list-style-type: none">1. Historical Patient Volume2. Patient Survey Satisfaction3.
Durable Medical Equipment	<ol style="list-style-type: none">1. Historical Patient Volume

Preferred Network



2022 Preferred Network:

- 24 SNFs
- 10 Home Health Agencies
- 2 Infusion Care Providers
- 2 Hospice Agencies



Program Manager

- Liaison between Preferred Network & SNFs/Agencies
- Hosts monthly meetings with SNF Preferred Partners
- Hosts monthly meetings with Discharge Planners
- Responsible for the data/reporting/tracking
- Coordinates educational events



Utilization Management Reviewers

- Registered Nurse
- Physical Therapist

Standard Work:

- Benchmark Length of Stay (LOS) based on condition
- Share LOS goal with facility
- Weekly Care Conference with facility interdisciplinary team
- Monthly Review of Key Performance Indicators with SNF



Workflow

POPULATION CARE MANAGEMENT: MSSP UTILIZATION MANAGEMENT REVIEWER (UMR) WORKFLOW

Initial: 12/14/2020, 1/25/22 via CD



General Guidelines: MSSP (Medicare Shared Savings Program)

Definition:

MSSP is an alternative payment model in which eligible providers, hospitals, and suppliers are rewarded for achieving better health for individuals, improving population health, and lowering growth in healthcare expenditures. To participate, providers must be part of an Accountable Care Organization (ACO), a patient-centered network that shares financial and medical responsibilities with the goal of improving patient care while limiting unnecessary spending. The MSSP requires ACOs to promote evidence-based medicine, engage beneficiaries, report internally on quality and cost metrics, and provide coordinated care across and among primary care physicians, specialists, and acute and post-acute providers. In the ACO, everyone works together to streamline processes, reduce duplication, and improve quality—and everyone shares in the financial savings as well as potential risks that ensue.

High-level Overview of Responsibilities:

1. MSSP UMR follows THE Medicare Shared Savings Program (MSSP) Patients that are admitted to a skilled-nursing facility (SNF) or swing bed (SB) on Med A. They do not have direct patient care.
2. The UMR stops coordinating and tracking the patient once they are no longer on Med A.
3. UMRs coordinate these patients' care by having *weekly* meetings via phone and/or email regarding each MSSP patient admitted in the SNF. Preferred Network SNF Partners IDT is asked to participate weekly call with UMR's.
4. There is a Preferred Network of SNFs which have an extra meeting 1 time a month with these facilities to review data include average MSSP patient Med A Length of stay, rehospitalization rates and overall coordination of care from Essentia to this SNF Partner.
5. The primary Population Health MSSP UMR & Preferred Network Team is composed of the: 2 UMRs, 1 Senior Director, and 1 Program Manager.

Medical Director

Weekly Meeting with Medical Director on complex or extended stay MSSP members

Priorities of the meeting:

1. Questions or immediate concerns regarding a MSSP patient admitted within a SNF or swing bed.
2. Review monthly Med A LOS Data and outliers (1x per month for both data and outlier review).

Presentations of MSSP patient concerns (SBAR):

Situation: State why case is being discussed at today's meeting

- Over expected LOS
- Questions over treatment options/care
- Pushback from providers

Background

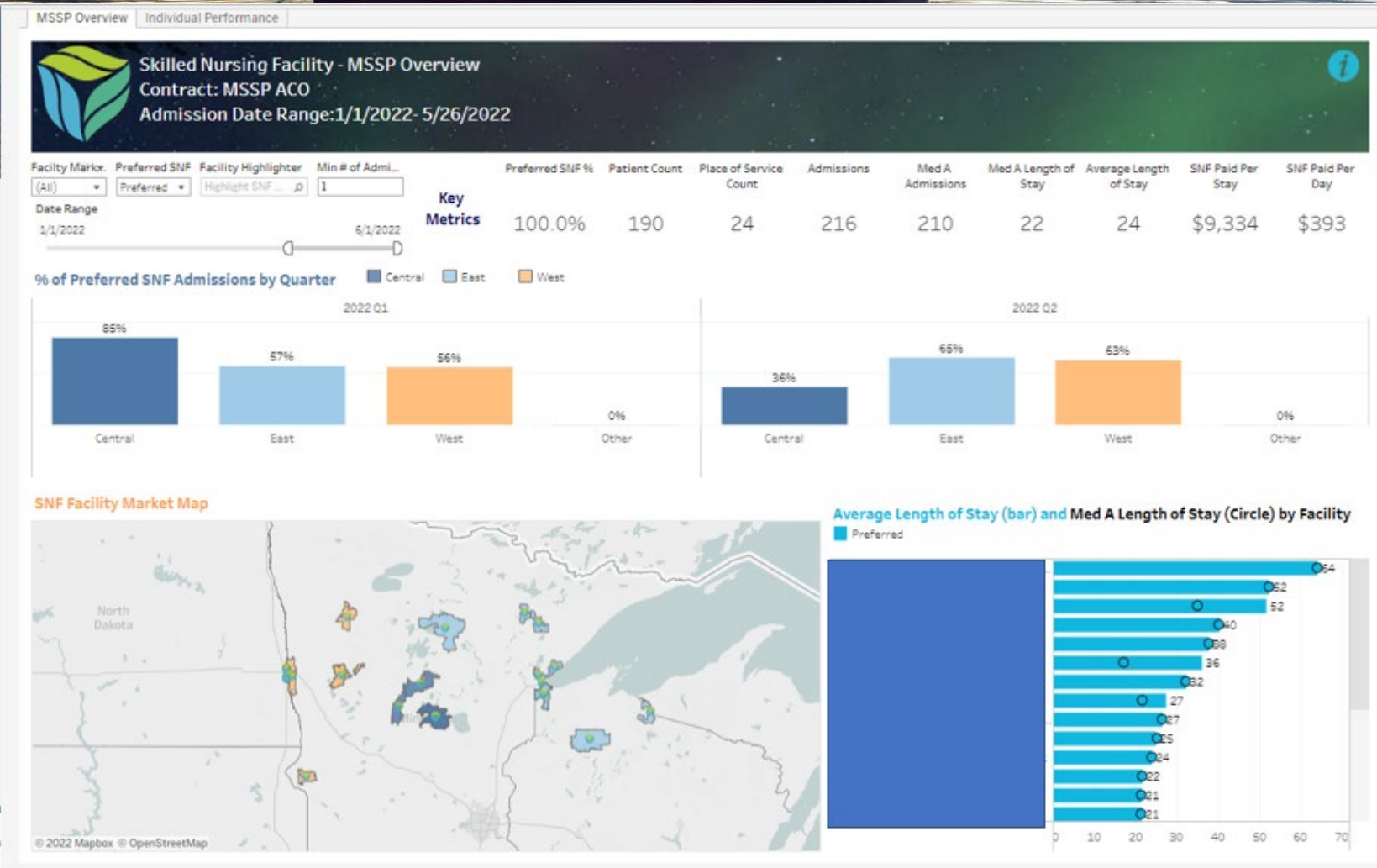
- Report a short synopsis of patient's history related to current situation
- What is the expected LOS (eLOS)?
- Current discharge plan

Assessment: What is your evaluation of the case's outcomes?

Recommendation

- What would you feel should be the next steps in the management of this case?
- What involvement would you like to have from Medical Director or Director?

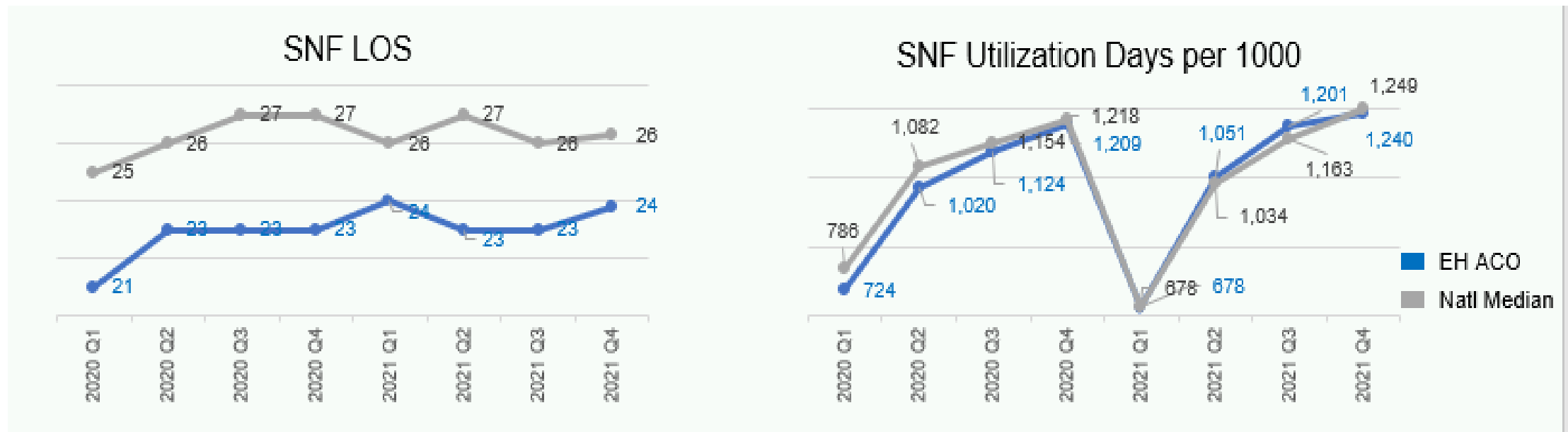
Tracking Success: Preferred Network



Average Med A: 5 days longer at non-preferred SNF
 Higher SNF cost per day

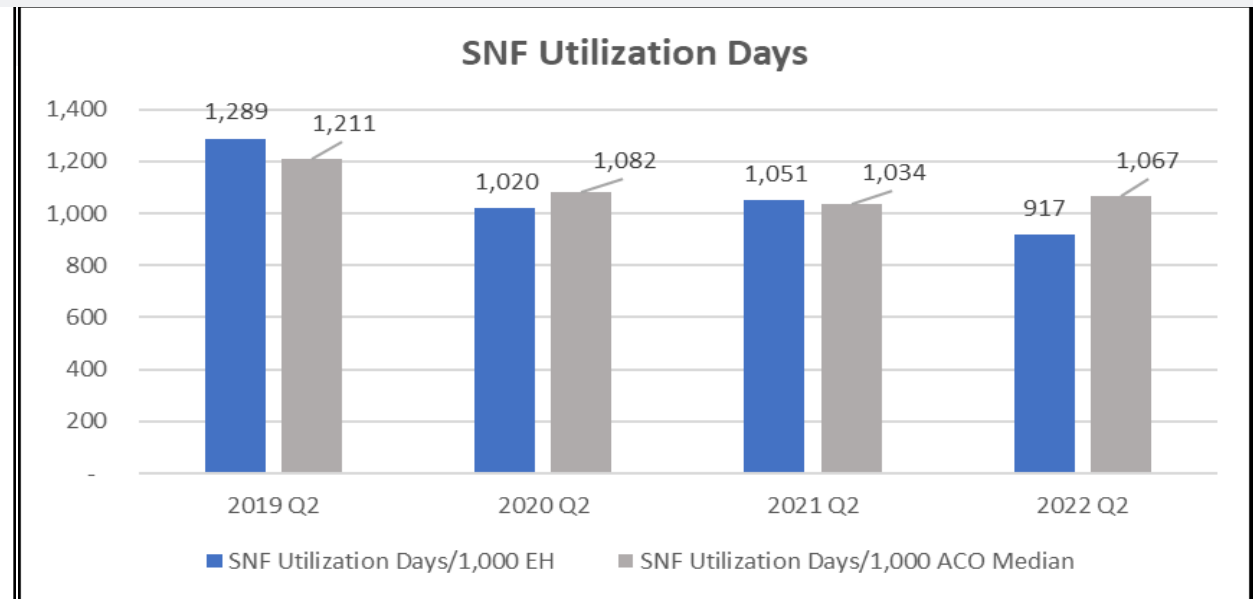
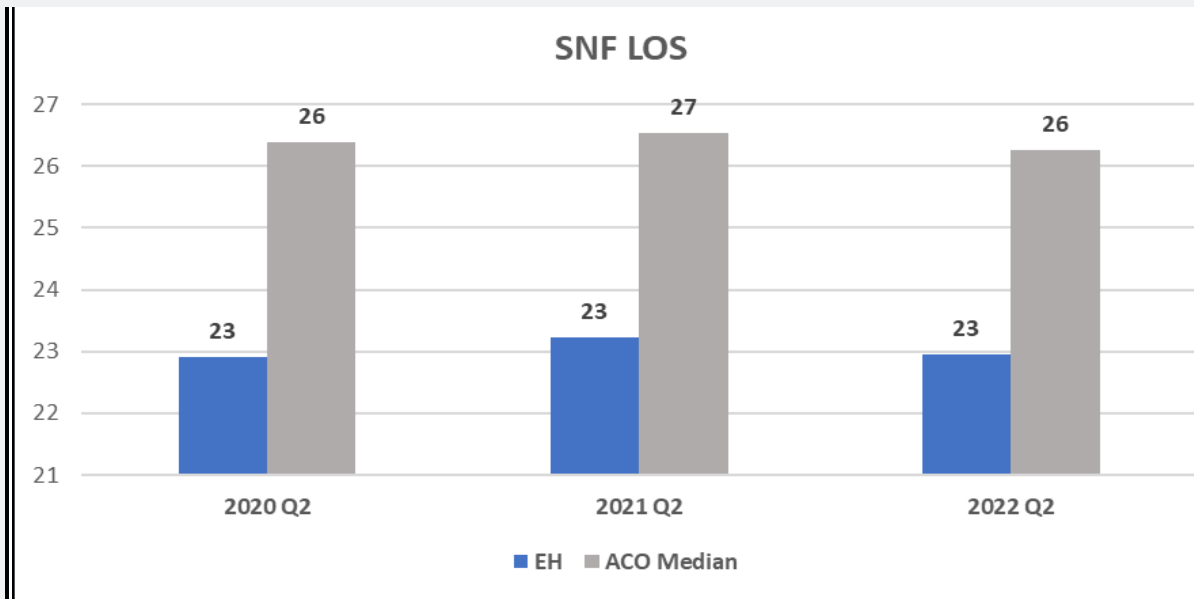
With current utilization/ cost, every 1 day change in LOS = \$1M

Trends Over Time- 2020 & beyond





MSSP Q2 LOS Comparison - Utilization



- SNF discharges/1000 increased from Q1 2022 30 to 40 in Q2
- While SNF LOS stayed the same year over year, it did increase from Q1 2022 average of 22 to 23



SNF Challenges

BUSINESS DAILY NEWS

Nursing home workforce shortages hit Minnesota the hardest, California the least

RON RAJECKI

APRIL 18, 2022

Understanding and Responding to Immediate Jeopardy Citations

On November 4, 2021 by Jonathan Lips

As members are acutely aware, Immediate Jeopardy (IJ) citations for nursing homes have increased significantly compared to prior years, and 2021 is proving to be no exception.

POLITICS

Minnesota legislators aim to tackle 'dire' staffing shortages in long-term care

There are 23,000 job vacancies in long-term care across the state, representing a fifth of the workforce.

By Briana Bierschbach Star Tribune | APRIL 9, 2022 — 6:00PM



Swing Bed- Critical Access Hospitals

Swing Bed placement is recommended for patients with complicated, high acuity medical needs.

May be required for long hospital LOS

Skilled Nursing Facility care is the recommended disposition for all patients whose needs can be adequately met.



Partnering Opportunities

- Improving Discharge Orders & One Call phone line for questions
- Education
 - Non-Pharmacologic Pain Management
 - Delirium & Dementia in Post-Acute Care
- Relaunching Readmission Workgroup
- Exploring Epic Virtual Visits for just in time care
- Updating Data Sharing



Keys to Success

- Partner with the Best!
- Benchmark Data
- Utilization Review & Medical Directors

We are called to make a healthy difference in people's lives.

Thank you!

Jessica Martensen, MBA, RN, FACHE

Vice President, Care Management Programs

Essentia Health

Jessica.Martensen@EssentiaHealth.org



Essentia Health



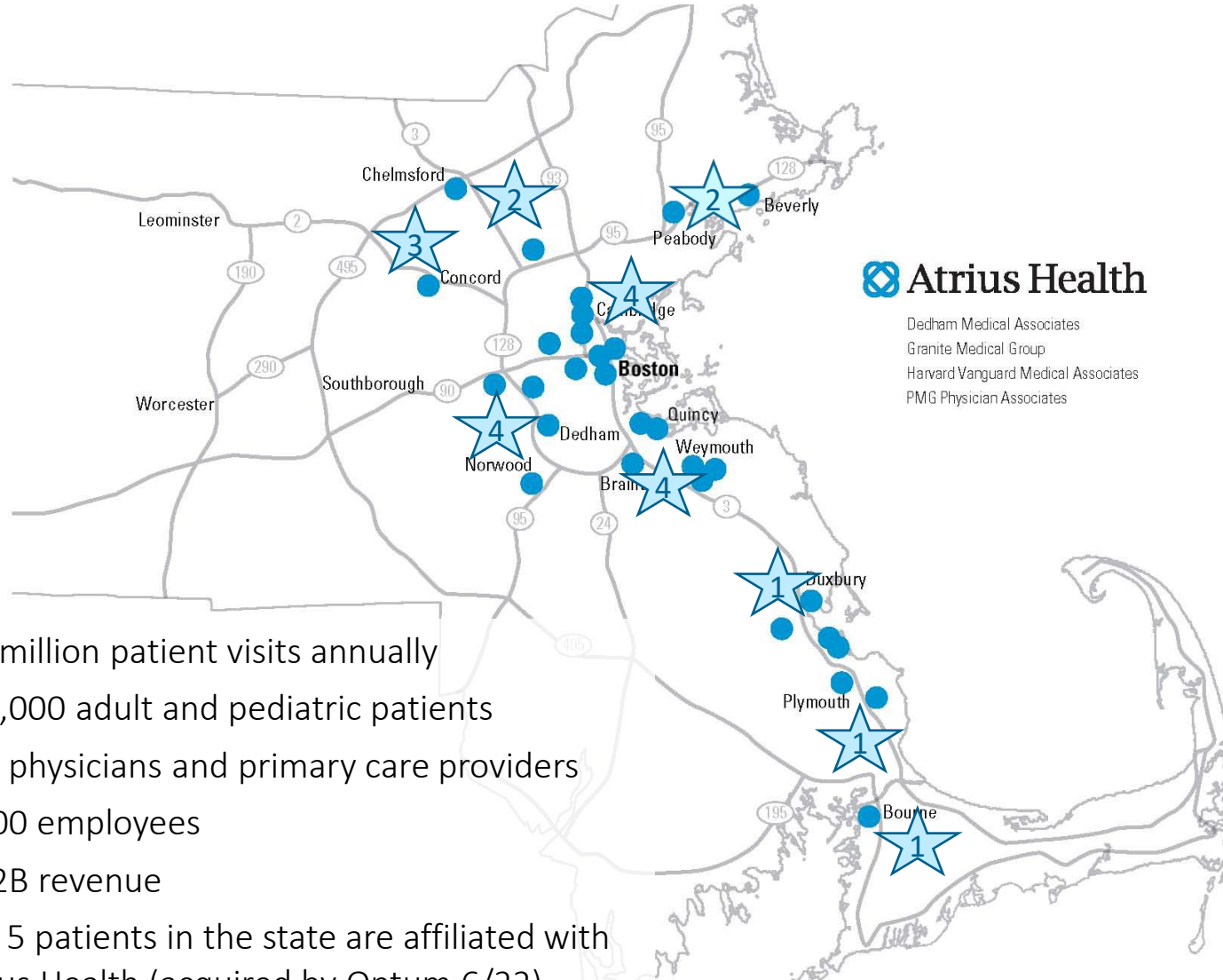
Atrius Health Preferred Skilled Nursing Facility Network

September 9th 2022

Christina Della Croce, MBA OT/L

Executive Director, Acute and Post-Acute Network Performance

30 medical practice locations in eastern Massachusetts

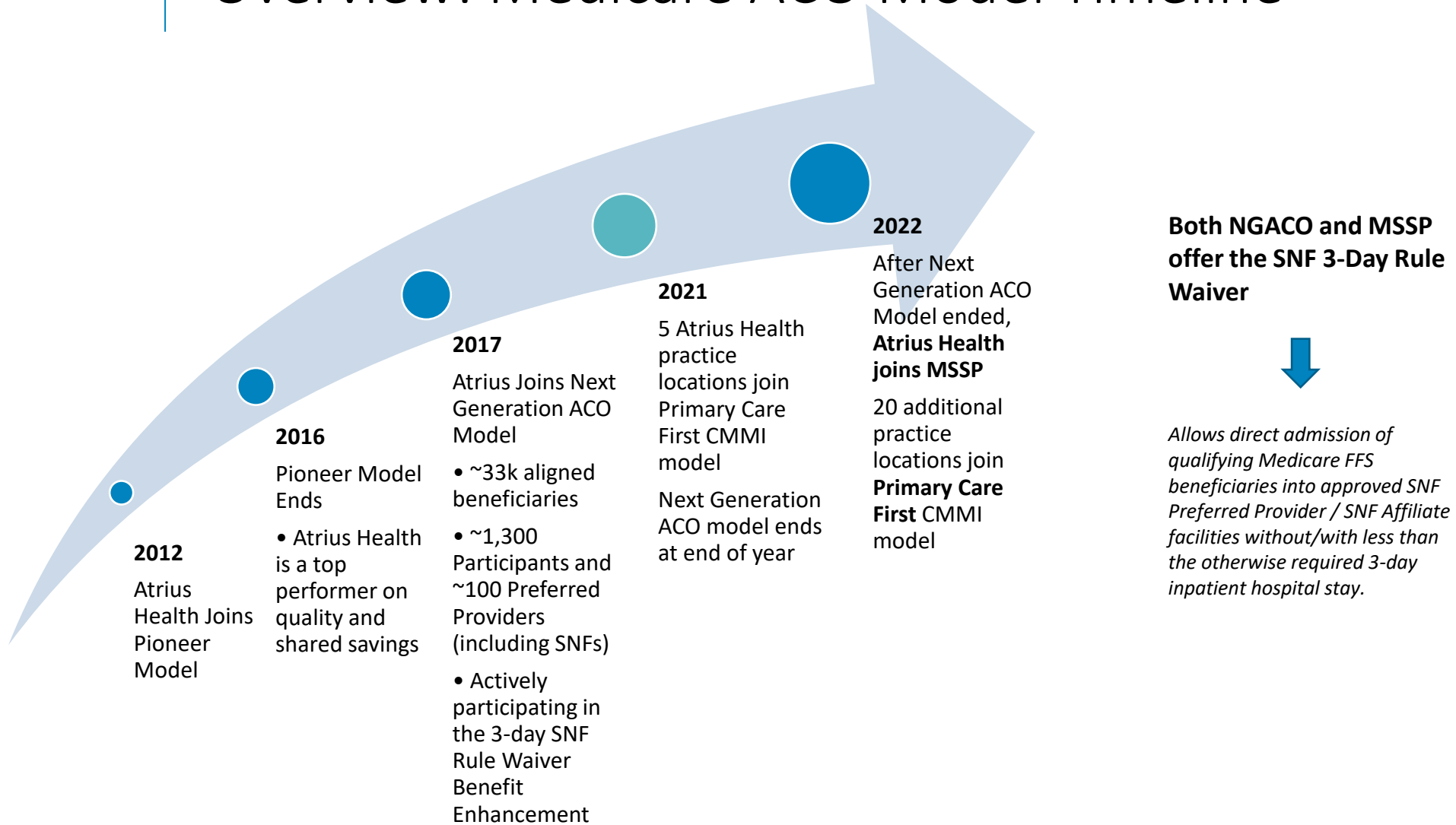


- 1.9 million patient visits annually
- 690,000 adult and pediatric patients
- 645 physicians and primary care providers
- 5,000 employees
- \$2.2B revenue
- 1 in 5 patients in the state are affiliated with Atrius Health (acquired by Optum 6/22)

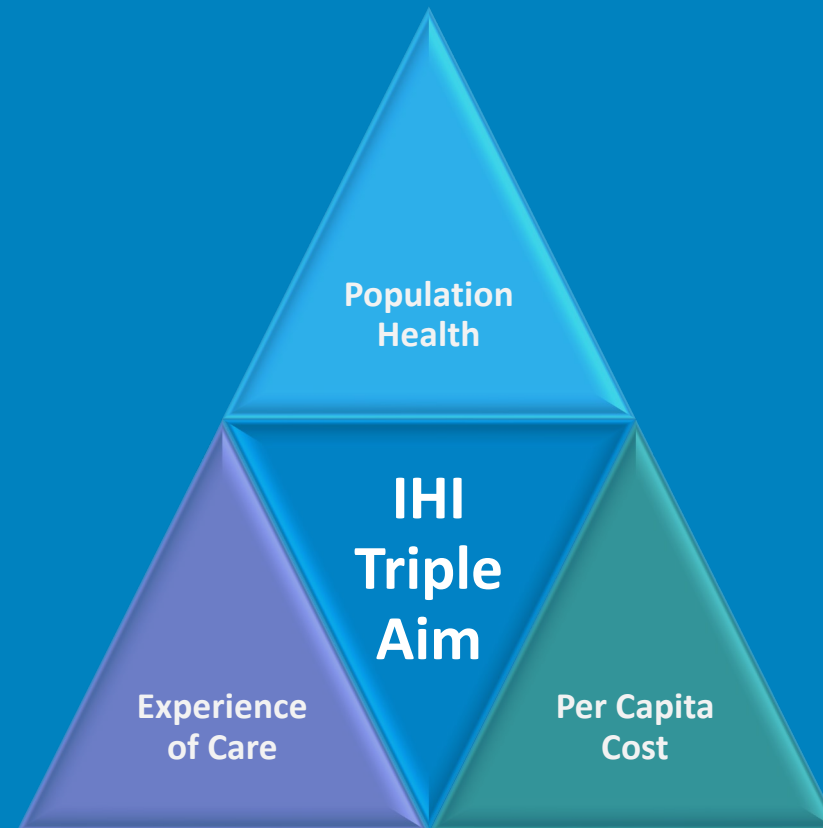
Care Provided in the Right Setting



Overview: Medicare ACO Model Timeline



In the era of COVID-19, what makes a good SNF partner for your ACO?



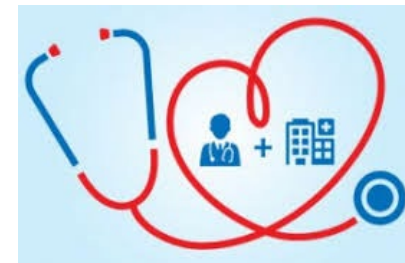
Selecting the best for your patients

Atrius Health strives to be a **Leader in Value**, we select premier SNFs to join our post-acute network recognizing all decision points need to be in alignment.

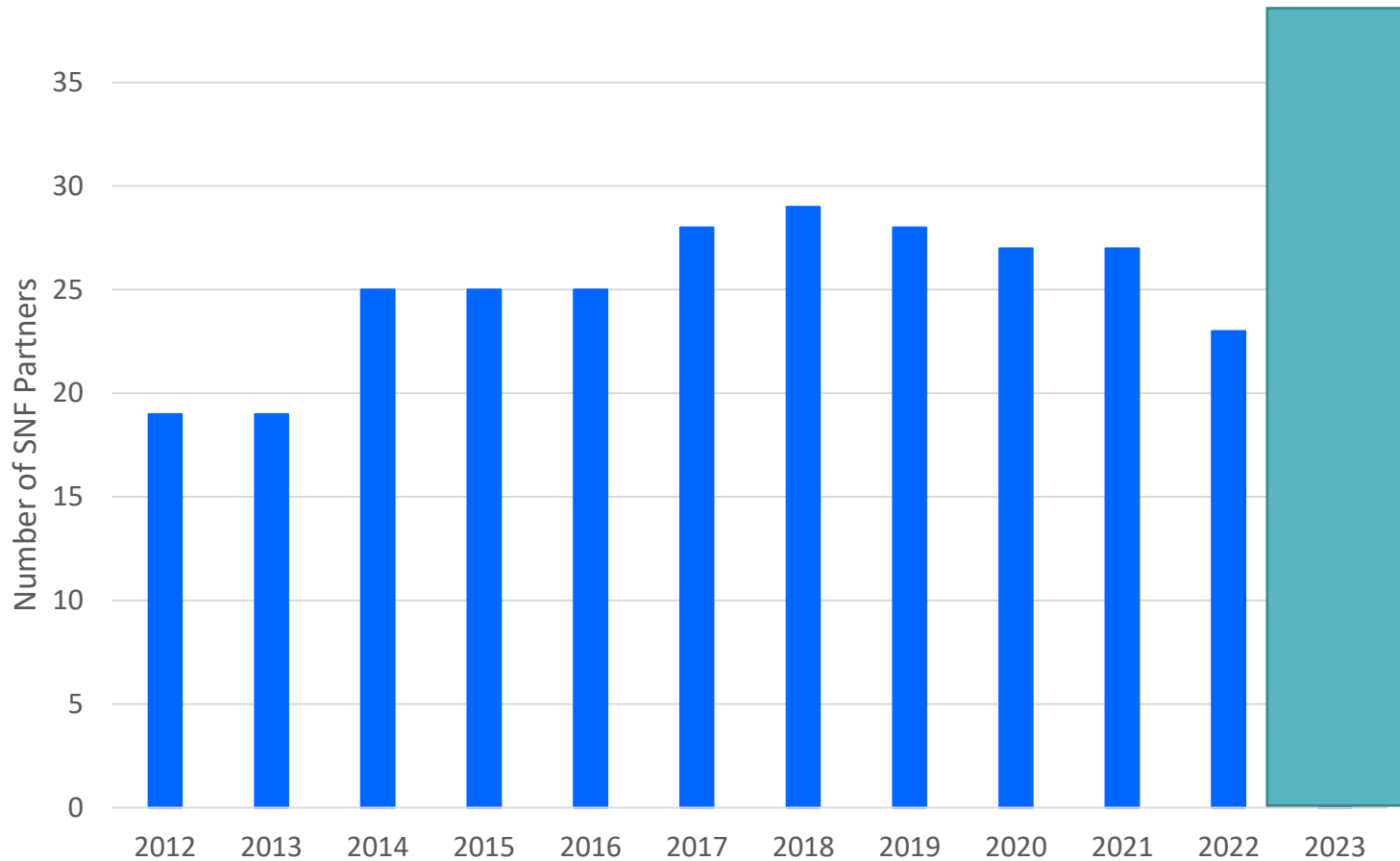
Decision Points	Assessment
1. Quality Care	Does the SNF meet the needs of your population? Specialty programs? How does the SNF Tour? Star rating?
2. Location	Is the SNF in your market? Does the practice/hospital recommend the SNF? Patient feedback?
3. Volume	Do they have beds? Can they manage your volume?
4. Willingness to Partner	Do they agree to your ACOs expectations? Agree to contract terms? Can they think like an ACO?

Benefits of Preferred SNF Partnership

- **Meet the population's care needs:**
 - Diverse SNF network with specialty programs
 - Close to PCP and the home of the patient/family
 - Patient satisfaction
- **Reduce cost and variation in post-acute care via:**
 - Creating partnerships with high value health care providers
 - Tight clinical collaboration with those partners
 - Integrated clinical care teams
 - Atrius Health case management
 - Keeping care within network
 - Minimize re-admissions & bounce backs
 - Optimize 3-day waiver
- **Preferred SNF partnerships**
 - Partner with high-performing facilities that have dedicated short term care units that meet our patient's geographic needs to deliver quality care
 - Enhanced systems to communicate and share information (Patient Ping, EPIC encounters)
 - Aligned to achieve targets



SNF Network- *Today and Tomorrow*



*Note: Initial network count as of 1/1/22 = 27
4 SNF removed due to survey and star rating*

SNF Targets

2022 ATRIUS HEALTH PREFERRED SNF NETWORK -TARGETS

2022 Targets	Readmission Rate (%)	Bounce Back Rate (%)	Average Length of Stay (Days)	Cost Per Case (\$)	ACP Completion (%)	Preferred SNF Utilization
Tier 1 & Tier 2	7%	8%	14.6 Days	\$8,600	50%	60%
Tier 3	7%	8%	18 Days	\$10,600	40%	40%

2021 ATRIUS HEALTH PREFERRED SNF NETWORK TARGETS

2021 Targets	Readmission Rate (%)	Bounce Back Rate (%)	Average Length of Stay (Days)	Cost Per Case (\$)	VNA Utilization (%)	Preferred SNF Utilization
Tier 1 & Tier 2	7%	8%	14.5 Days	\$8,500	55%	70%
Tier 3	7%	8%	17.5 Days	\$10,500	55%	30%

2020 Targets	Readmission Rate (%)	Bounce Back Rate (%)	Average Length of Stay (Days)	Cost Per Case (\$)	VNA Utilization (%)	Preferred SNF Utilization
Tier 1 & Tier 2	6.8%	8%	13.5 Days	\$8,000	55%	70%
Tier 3	7%	8%	17.5 Days	\$10,500	55%	30%

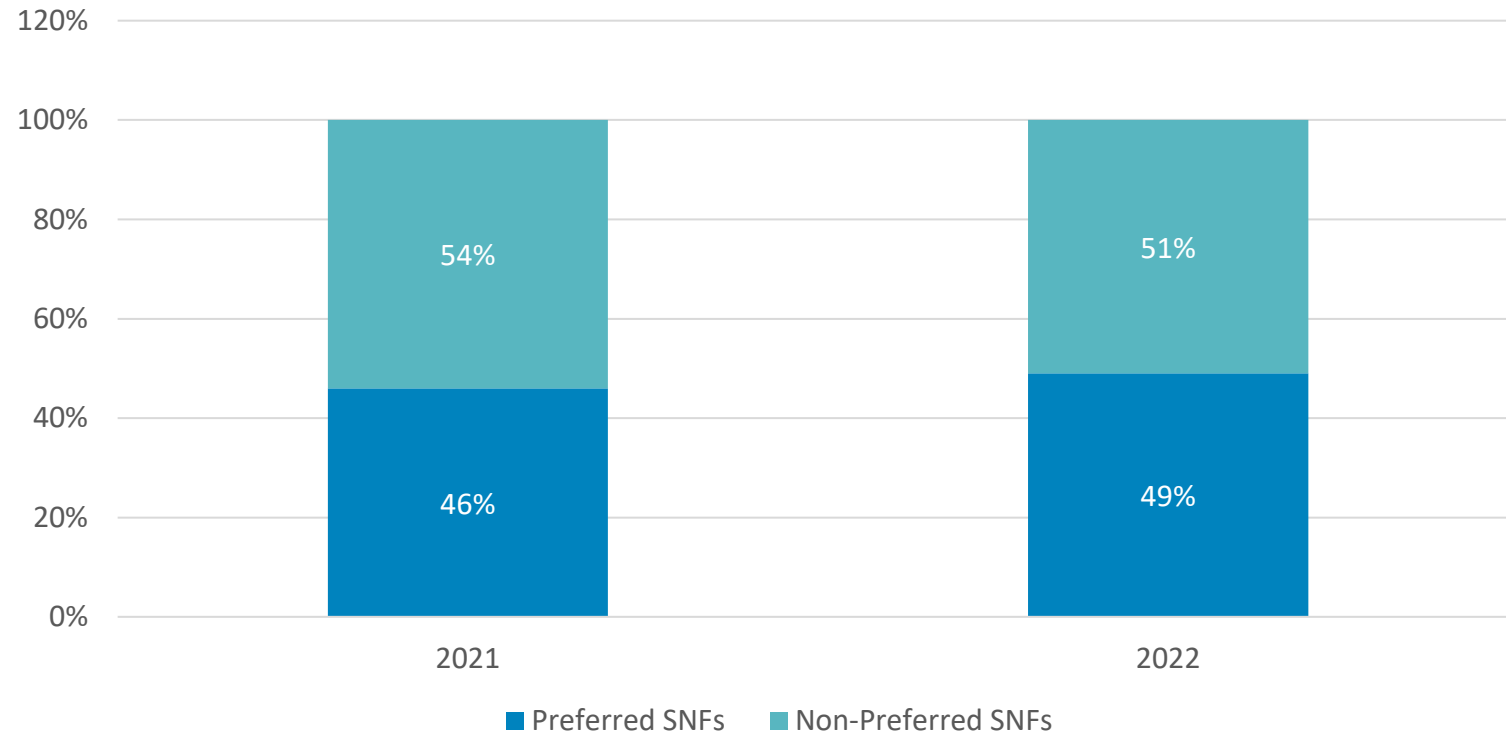
Outcomes: Network Utilization

Are the patients going to our preferred SNFs?

Note-
MSSP Utilization: 35%

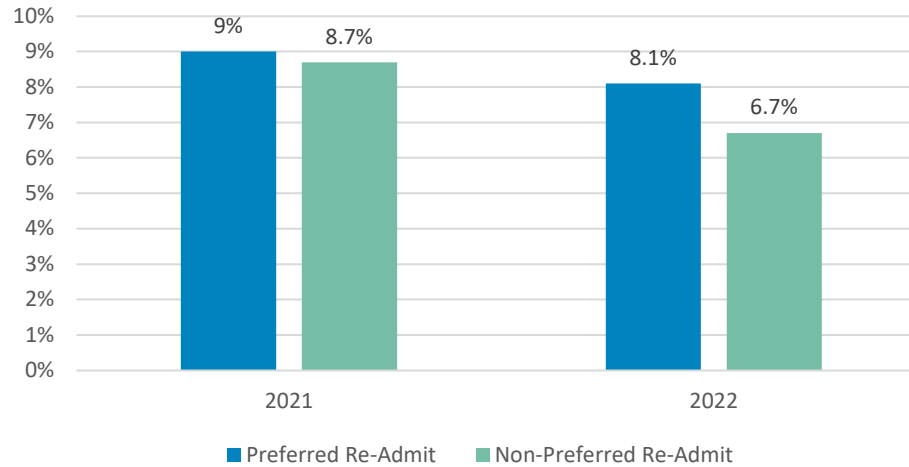
Admits from January 2021 thru April 2022
All data is from Claims (CMDM), paid thru June 2022

Preferred network utilization



Outcomes: Acute Readmission & Bounce Back

Acute Re-Admission Rate

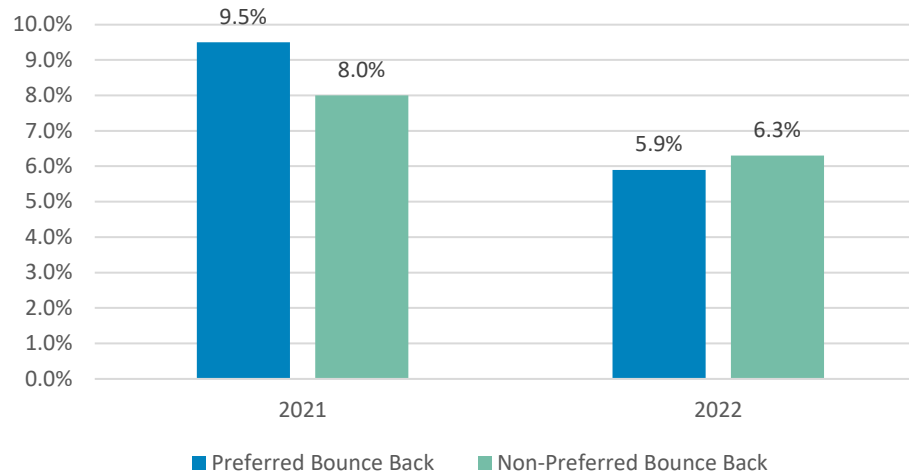


Note-Network Performance

MSSP Re-Admit Rate: 10%

MSSP Bound Back Rate: 8.3%

Bounce Back Rate



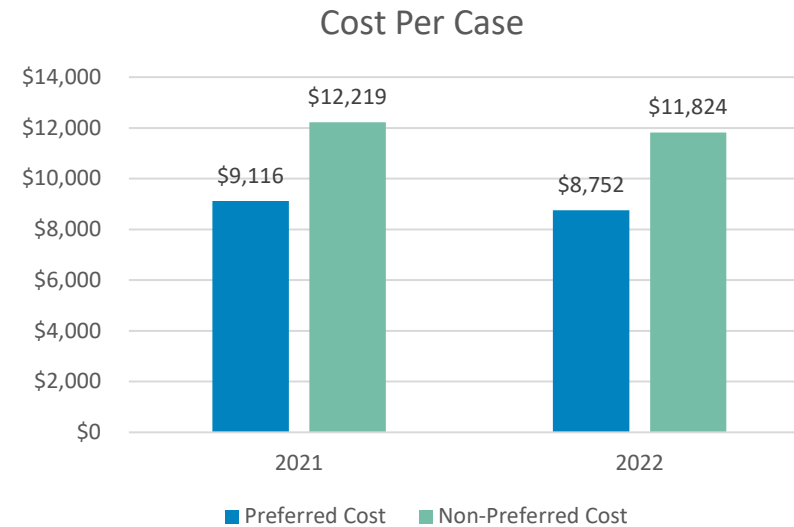
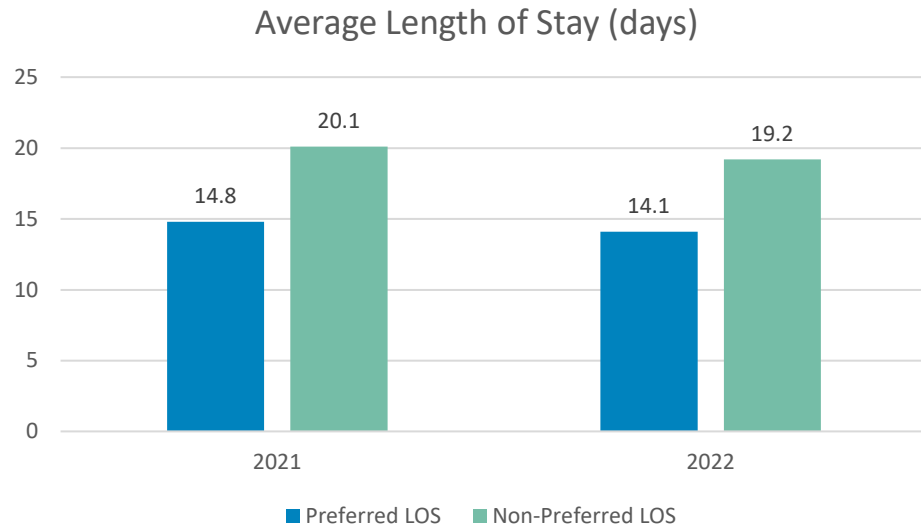
Admits from January 2021 thru April 2022
 All data is from Claims (CMDM), paid thru June 2022

Outcomes: Length of Stay & Cost per Case

What is the impact on care and cost if they don't go to a preferred SNF?

Note-Network Performance


MSSP ALOS: 15.5 Days
MSSP Case: \$10,775



Key Take Aways

- **Inspect what you expect**
 - Set targets, provide regular feedback
 - Visit regularly
 - List to the practice and patients
 - Monitor star rating
- **Direct patient care**
 - Optimize your network
 - Ask hospitals to optimize for your patients
 - Assess clinical and quality outcomes including survey results
- **Support the network to be successful**
 - Volume of admits
 - Accessibility of PCP and follow up care as needed

Thank you

 Atrius Health

Christina Della Croce

Christina_DellaCroce@atriushealth.org
Transforming care to improve lives.