Building an ACO Post-Acute Network

Skilled Nursing High-Quality Network

An independent, physician-led Accountable Care Organization (ACO) made up of a wide range of health care providers and services – from doctors to dietitians, from hospitals to home health services.

- Wholly-owned MultiCare Subsidiary
- Independent Accountable Care Organization
- 25 Value-Based Contracts
- 328K+ lives under risk
- 4,500+ practitioners
- Headquartered in Tacoma, Washington

Our Vision

MultiCare Connected Care will be the leading catalyst of patient and population centered value in the Pacific Northwest

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MultiCare Health System at a Glance:

11 Hospitals*

2,099 Beds*

8,989 Births

19,669 Employees*

1,568 Employed Providers*

458,921 ER Visits

240+ Clinics Primary, Specialty & Urgent Care*

166 Research Investigators

7,141 Patient Visits for Research Studies

76,043 Hospital Admissions

$3.8 Billion Revenue

Bond ratings: Aa3 (Moody's), AA- (Standard & Poor's) and AA- (FitchRatings).

As of 12/31/2021 unless specifically indicated

*Our joint venture with CHI Franciscan Health, Wellfound Behavioral Health Hospital, and its 120 licensed beds, are included in these counts.

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Skilled Nursing Facility High Quality Network

- Twelve partners that span across two regions supporting 7 hospitals
  - Seattle/Tacoma – 7 partners, supporting 5 hospitals
  - Spokane – 5 partners supporting 2 hospitals

» Network Requirements
  - Star Rating >3
  - Meet/exceed regional/national benchmarks
    - ED visits
    - Hospital Readmissions
    - CAPUs
    - Community Discharges
    - LOS

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High Quality Network Requirements

1. On-site, in-person physician rounds weekly
2. 24/7 clinical coverage
3. See MSSP/BPCI patients within 72 hours for new admission/stability visit
4. Hold patient care conferences in a timely manner (72 hours)
5. Tightly manage length of stay (LOS 20 days or less)
   a) Including setting target discharge dates from admission

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High Quality Network Participation Requirements

- Participation in weekly IDT meetings
  - Review POCs for risk sharing populations – MSSP/BPCI-A
    - Meetings conducted by PAC Outreach Coordinators
- Engagement in Quality Improvement across the continuum of care
  - Transitions of Care
  - Clinical protocol development
- Participation in monthly performance review for each SNF
  - Key Performance Indicators review for both quality and cost
- Participation in HQN Quarterly Quality meetings
  - Administrator, DON, DOR and Medical Director

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Example Scorecard

Overall Star Rating
(as of 2020-11-01)

5 Stars

Star Rating Components
(as of 2020-11-01)

Quality Measures: 4 Stars
Health Inspections: 4 Stars
Staffing: 5 Stars

Quality Measure[1]	Score	Benchmark	Met Benchmark?
% w/ ER Visit:	12.39%	< 9.62%	0
% Rehospitalized:	20.2%	< 21.04%	1
% Discharge to Community:	69.85%	> 48.57%	1
% Pressure Ulcer new/worsened:	1.9%	< 1.6%	0
Total Benchmarks Met:		2/4	

Total Spent[2]	Total Bed Days[2]	Total Admits[2]	SNF Readmits[2]	Avg Length of Stay[2]	Avg Cost Per Day[2]	Avg Cost Per Admit[2]
2017: $2,332,879.86	**2017:** 4,200	**2017:** 179	**2017:** 25	**2017:** 23	**2017:** $555.45	**2017:** $13,032.85
2018: $3,245,674.20	**2018:** 5,552	**2018:** 258	**2018:** 32	**2018:** 21	**2018:** $584.60	**2018:** $12,580.13
2019: $4,394,886.05	**2019:** 7,518	**2019:** 372	**2019:** 65	**2019:** 20	**2019:** $584.58	**2019:** $11,814.21
2020: $2,000,616.18	**2020:** 3,325	**2020:** 130	**2020:** 17	**2020:** 25	**2020:** $601.69	**2020:** $15,389.36

1) Quality Measure data based on November 2020 public data
2) Claim outcomes based on Track1+ claims serviced thru September 2020, received prior to December 19th. Based exclusively on 2020 aligned members

MCC SNF INW Summary

2021 Q3 Report

Facility Name	Total Admits	Avg Length Of Stay	Net Pay	Cost Per Day	Cost Per Admit	Met ER Visit Target	Met Readmission Target	Met Discharge to Community Target	Met Pressure Ulcer Target
	48	18	$556,927.65	$625.06	$11,602.66	Y	N	Y	Y
	38	18	$463,625.92	$660.44	$12,200.68	N	Y	Y	N
	36	28	$525,938.74	$521.25	$14,609.41	N	Y	Y	Y
	30	21	$387,655.49	$602.89	$12,921.85	Y	Y	Y	Y
	16	17	$165,338.96	$607.86	$10,333.69	N	Y	Y	N
	6	17	$72,631.89	$691.73	$12,105.32	Y	Y	Y	Y

* Contains all INW Region Contracted SNF's
* Cost data based on claims serviced January-September 2021, received by November 9th, 2021
* Measure data based on October 2021 public CMS data, available at https://data.medicare.gov/data/nursing-home-compare

MCC SNF PSR Summary

2021 Q3 Report

Facility Name	Total Admits	Avg Length Of Stay	Net Pay	Cost Per Day	Cost Per Admit	Met ER Visit Target	Met Readmission Target	Met Discharge to Community Target	Met Pressure Ulcer Target
	73	25	$1,075,607.00	$579.84	$14,734.34	Y	Y	Y	N
	56	18	$717,891.27	$696.98	$12,819.49	Y	Y	Y	Y
	48	20	$629,625.99	$631.52	$13,117.21	N	Y	Y	N
	34	18	$373,983.92	$593.63	$10,999.53	N	Y	Y	Y
	32	16	$323,300.22	$628.99	$10,103.13	Y	Y	Y	Y
	30	15	$314,185.54	$658.67	$10,472.85	N	Y	Y	Y
	24	16	$254,435.24	$645.77	$10,601.47	Y	Y	Y	Y
	23	27	$379,267.49	$596.33	$16,489.89	Y	Y	Y	N
	5	27	$74,663.08	$541.04	$14,932.62	Y	N	N	Y

* Contains all PSR Region Contracted SNF's
* Cost data based on claims serviced January-September 2021, received by November 9, 2021
* Measure data based on October 2021 public CMS data, available at https://data.medicare.gov/data/nursing-home-compare

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2021 Progress to Goals

Reduce 30-day all-cause readmissions & ED Utilization

- Maintain a readmission rate at or below 20%
- Activation of crisis support to the network
  - PPE and laboratory supplies
  - Advocacy with Governor’s office
  - Infection control guidance

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2021 Progress to Goals

Reduce SNF Utilization for MSSP and BPCI

- SNF admissions were depressed due to COVID
  - 2021 Utilization 3% under goal for BPCI (23%)
- Limited access to SNFs during surge provided the opportunity to hardwire use of AMPAC (6 clicks) for next site of care disposition

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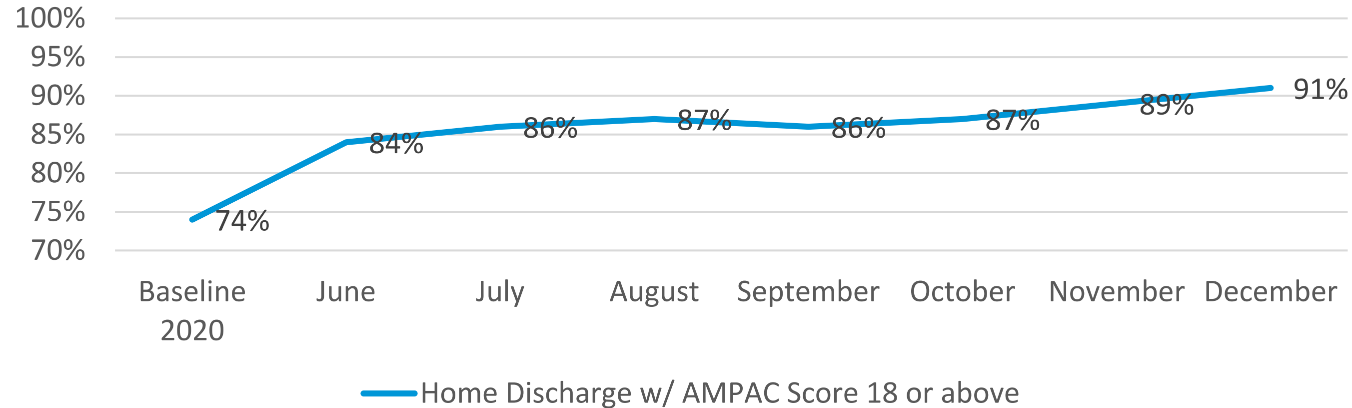

General Guidelines

Score	Expected DC
20-24	Home without services
17-19	Home w/ services (HH, OP)
≤ 15	May need SNF/IPR
≤ 11	May need SNF/IPR/LTAC

Our 2021 Journey

- Retroactive review 2020 AMPAC scores
- March-May: 6-Clicks training w/ therapy and case management, emphasis on home first for score ≥ 18
- Immediate impact in June with roll-out
- With Q4 hospital surge, reinforced training, tip-sheets, ‘home first’ motto
- Highest rate of recommendations for home DC in Dec 2021 - 91% of patients

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2021 Progress to Goals

Implement Best Practice Guidelines for top 3 readmission categories – CHF/COPD/Diabetes

- Successful Pilot of CHF Pathway:
  - 2 HQN SNF Partners
  - Heavy socialization of CHF Readmit rates
  - CHF readmit chart reviews
  - Medical Director engagement
  - Therapies engagement
  - Nursing engagement

MultiCare Pulse™ Heart Institute

Heart Failure Patient Action Plan

Zone	My symptoms:	My actions:
	Excellent – keep up the good work!	
GREEN ZONE I feel well	• My weight is stable • I have no new or worsening shortness of breath and no chest pains • Physical activity level is normal for me • My feet and legs look normal for me • No new or worsening swelling	• Keep taking your heart & water pills as directed. • Eat low-salt foods, goal is than 2,000 mg sodium per day. • Drink limited liquids, 64 fluid oz. or 2 liters per day. • Weigh yourself daily and write it down. • Go to your medical appointments for follow up care. The provider managing your heart failure is: ________________
	Pay attention; be cautious.	
YELLOW ZONE I do not feel well	• I have had a weight gain of more than 2 pounds in a 24 hour period I feel some new or worsening shortness of breath with activity • I have a new dry, hacking cough or wet, wheezing cough • I see increased swelling of my legs, feet and ankles • I see or feel discomfort or swelling in my belly • I have more trouble sleeping or lying flat	• Your symptoms may indicate worsening heart failure • Please call your doctor's office or your heart failure doctor's nurse at____________________ You may need to step up treatment
	Medical alert – you need to be evaluated right away!	
RED ZONE I need to get help now	• I am having chest pain or shortness of breath at rest • I noticed an increase in discomfort or swelling in my lower body and/or my belly • I am having more trouble sleeping; I can't lie flat • I have noticed a loss of appetite; I have new or worsening dizziness, confusion, sadness or depression • I have a cough that is worse – dry hacking or a wet wheezing sound • My weight has suddenly gone up by more than 2 pounds in a 24 hour period or more than 5 pounds this week	• Get help now. • Call your doctor or 911. STOP! Get help now. Call your doctor or 911.

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CHF Clinical Pathway

Key Interventions

- 7-day follow-up appointments
- Direct contact plans for post-acute facilities to reach cardiology offices
- Pulse heart failure team provided targeted outreach to patients outside the post-acute environment
- Clinical Practice Guideline development and execution
- Patient education following through transitions of care

MultiCare Pulse™ Heart Institute

Patient Sticker here

Post-Acute Best Practice Guidelines: Heart Failure

Primary/Secondary DX(s):

Heart failure diagnosis: ______________________

Ejection fraction: ______________________

Objective: *Improve the management of Heart Failure in adults to reduce morbidity and mortality, hospital readmissions, and Emergency Department (ED) visits and optimize quality of life in alignment with goals of care.*

Cardiologist or PCP Managing Heart Failure: ______________________

Follow up Appointment: ______________________

Transportation: ______________________

Contact for any questions/concerns regarding care or any support needed at ______________ for patients established with Heart Failure Clinic. For those not established with Heart Failure Clinic, contact Primary Care Clinician ______________.

Discharge planning and self-management begins upon admission

Teach Self Care Management and create an action plan:

- Symptomatic atrial fibrillation
- Heart Failure Zones
- Heart Failure Medications
- Use of Weight, Blood Pressure, & Heart Rate log
- Symptom Management & what and whom to report
- Importance of Follow up Care
- Any activity parameters
- Rules of 2
  - Daily Weights (**2 pounds** in 24 hours or 5 pound in 1 week)
  - Daily Sodium goal and Label Reading (= or <**2 grams/100 mg** serving)
  - Daily fluid goal (=**2 liters**)

Key Parameters for Discharge:

- Euvolemic on exam
- Lungs clear to auscultation
- Stable HF symptoms, if any
- If atrial fibrillation or Flutter/ HR <100 at rest
- Vital Signs at goal
- If HF Guideline Directed Medical Therapy (GDMT) held, restarted, or other, cardiology or PCP has oversight

CHF Pilot Results

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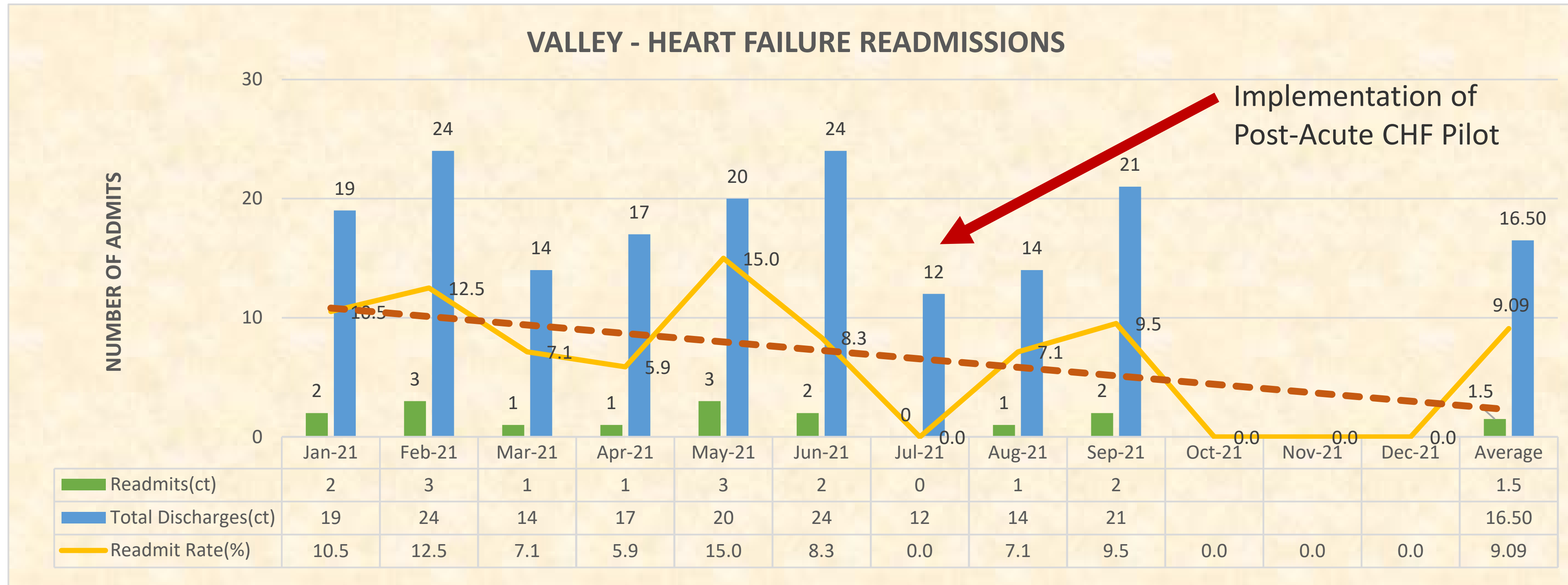
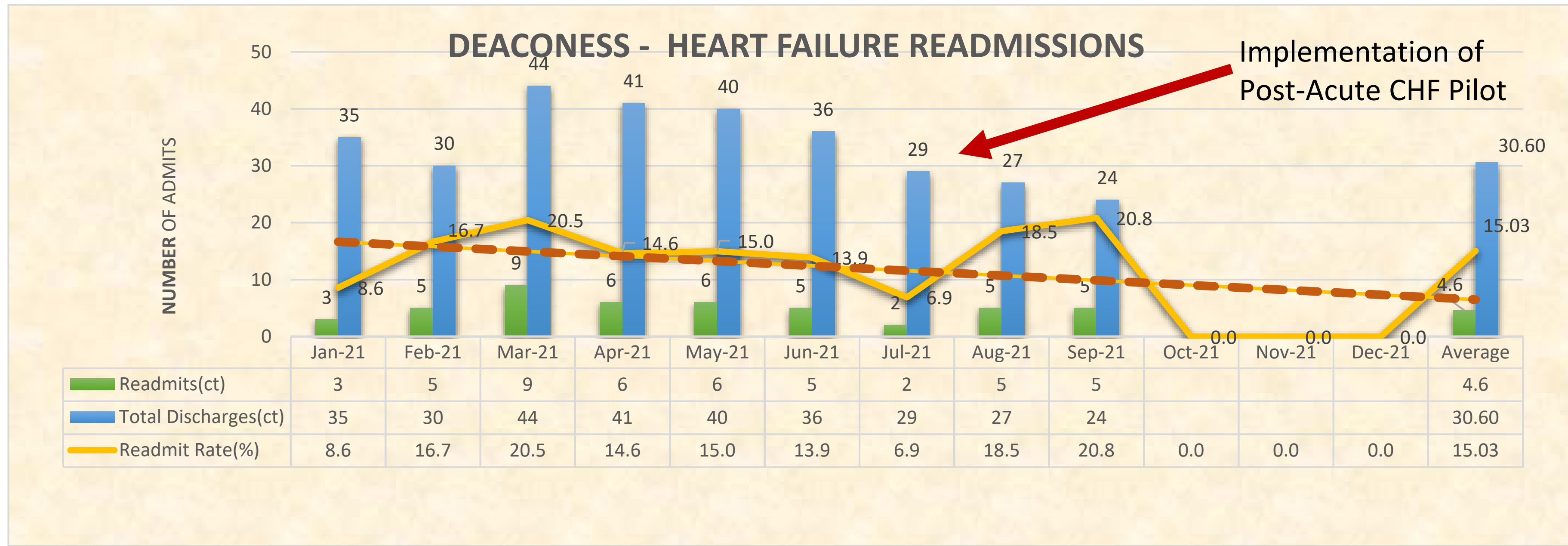


	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Average
Readmits(ct)	2	3	1	1	3	2	0	1	2				1.5
Total Discharges(ct)	19	24	14	17	20	24	12	14	21				16.50
Readmit Rate(%)	10.5	12.5	7.1	5.9	15.0	8.3	0.0	7.1	9.5	0.0	0.0	0.0	9.09



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Average
Readmits(ct)	3	5	9	6	6	5	2	5	5				4.6
Total Discharges(ct)	35	30	44	41	40	36	29	27	24				30.60
Readmit Rate(%)	8.6	16.7	20.5	14.6	15.0	13.9	6.9	18.5	20.8	0.0	0.0	0.0	15.03

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Covid Impact & Recovery

- Impacts to Performance
  - Out of Network Utilization increased by 60%
  - SNF LOS increased from 18 days to 23 days
  - Slight increase in Cost per Admit
- Recovery Strategies
  - Monthly JOC meeting with inpatient case management
    - Network Utilization
    - VBA performance
  - Monthly newsletters to hospitalists/case management
    - Highlighting HQN accomplishments
      - Progress to goals
      - Readmission reduction strategies
  - Outreach Coordinators return to in-person attendance to weekly IDT meetings and monthly KPI reviews