

NWX-HHS-AOA-1

**Moderator: Marisa Scala Foley
July 16, 2013
1:30 pm CT**

Coordinator: Welcome and thank you for standing by.

All participants will be in a listen only mode until the question and answer session of today's call.

At that time to ask your question please press star 1. You'll be prompted to state your name. Please do so, so that we may announce you.

Today's call is being recorded. If anyone has any objections you may disconnect at this time.

Now I would like to turn the call over to your host Lauren Solkowski. You may begin.

Lauren Solkowski: Thank you (Diane). And thank you everyone for joining us today for the ACL Targeted Technical Assistance webinar, Perspectives from an Accountable Care Organization and a Health Plan.

On today's webinar we will be hearing from both a health plan and the Accountable Care Organization in terms of how they come to some of their decisions in partnering with community-based organizations and what also are some of their expectations or requirements of CBOs that are part of their network.

So before we get started with the actual presentations, there are a few housekeeping announcements that I'll run through so to start if you have not done so yet please use the link included in your calendar appointment to get onto WebEx so that you cannot only follow along with the slides as we go through them but also ask your questions as you have them through the chat function.

If you don't have access to the link that we emailed you, you can also go to www.webex.com. Click on the Attend a Meeting button at the top of the page and then enter the Meeting Number which is 665887127 so that's 665887127.

If you have any other problems getting into WebEx you can also call the WebEx Tech Support at 1-866-569-3239, that's 1-866-569-3239.

Now as (Diane) mentioned we are - all the participants are in listen only mode. However we do welcome your questions throughout the course of this webinar. And there are two ways that you can ask questions.

The first being through using the chat function in WebEx, you can enter your questions and we will sort through them and answer them as best we can when we take breaks for questions between each speaker.

And then the second way is that after the speakers wrap up we will offer you a chance to ask questions through the audio line. And when that time comes (Diane) will provide instructions as to how to queue up to ask your questions.

If there are any questions that we cannot answer during the course of the webinar we will be sure to follow-up with you and get them answered. If you think of any questions after the webinar you - please feel free to email them to me at lauren.solkowski@acl.hhs.gov.

And as (Diane) had mentioned we are recording the webinar. We will post the recording, the slides and the transcript during the course of this webinar on the ACL web site as soon as possible.

And I will notify everyone once the slides and the recording are available.

So with that I'd like to begin with our speakers. And the first of our speakers being - is Merrill Friedman. She is the Assistant Vice President of Advocacy for the Amerigroup Corporation.

So with that Merrill you are welcome to begin.

Merrill Friedman: Great, thank you so much Lauren. I appreciate it, thank you guys for allowing me the opportunity to speak with you all today.

Being a VP of Advocacy for Amerigroup and WellPoint this conversation is so incredibly important to me because I have it almost daily, actually probably daily with people around the country and (frame) that we're really building strong dialogue and conversation about the role of AAAs and Centers for Independent Living, people with disabilities, seniors, families and that they're really at the table as states look to develop and design managed care systems

as they look to implement managed care systems and really as managed care organizations look to do the same things within the state.

So I think this is just incredibly important and thank you again.

That being said we can move to the next slide. It's really just a quick overview because Amerigroup was bought by WellPoint and just wanted to make sure that, you know, we stated that in here.

And so it's new and so I am now really on the side of the Government Business Division which they've called it GBD because it's what we do. We put an acronym to everything.

So it's now the GBD. We're learning all the new terminology as well and really just the strength that the joining of these two organizations and having a larger enterprise and hopefully behind that strength the resources to make sure that we can really comprehensively implement Medicaid Managed Care presence within the states that are really meaningful to people and their families.

When I talk about managed care it's not everybody's favorite conversation. There's still a lot of fear, a lot of confusion. And rightfully so, I think we've certainly gone beyond the days of the 1-800 say no managed care.

But I still don't think that we're at a time where things are perfect and probably far from it.

So and literally, you know, what value can managed care brand bring to providers, to service organizations, to AAAs and centers as they fit in that,

you know, their service capability as well as the advocacy, systems change and other influences.

And really looking at that value along with the risks of design and implementation because we really I think all know that managed care is a tool or a vehicle. And it's really only good if it's done right.

So what does it mean to do it right?

I would say it really means engaging a community in the process which is you all as well as consumers and their families. And I don't mean, you know, getting started down the road and then, you know, calling upon you guys. I think this is something that you all should be involved with early before the process begins. I think you should be involved constant (often) at the forefront of this dialogue.

It also means that ensuring that the services are really robust enough so that people who are living independently in the community, in the settings of their choices really can access the services that they want and that they need.

And I don't think managed care is ever going to work without that level of participation and home and community-based services and having you guys at the table really helping to figure out what those are and how they should be networked then within a managed care environment.

So requires making sure, you know, that's the case is building that collaboration with you all. There is nobody better at providing services to seniors and people with disabilities than AAAs and centers so to me it always seems to make sort of this very good fundamental sense. And I probably say

that because I'm a simple person. I just think this is the best way to start and finish it with you guys.

States really are looking, you know, in designing their Managed Care Programs beyond those typically required services for prevention, primary care, specialty and acute and really now looking at de-medicalizing the system and the processes.

So that, you know, that's where - when I, you know, happen to say mutual, you know, goals for Medicaid Managed Care. I mean this is such an incredible place for you all to be and to leverage your experience.

So if we start talking then about what that, you know, is, its transportation, housing, employment, habilitation. I'm starting to wear out. All family support, caregiver support and training, meaningful community inclusion and participation, in-house services and support, personal incentive services; it's the list of things that really help people to live independently and live lives, you know, that they can choose, that they can direct, that their families are a part of but have access to services and support.

So when you look at, you know, those goals and you're looking at improving quality of care and services, lowering overall program costs, supporting families and caregivers, fostering independence, coordination and that concept of enhancing home and community-based services, utilizing centers and AAAs, it's those (mutual) goals then that seemed again to be so clear that you guys are getting engaged and driving these conversations with the MCOs and with the state.

So what are some of the steps that, you know, we can possibly lay out for getting involved in the managed care dialogue?

I started on pretty much the very beginning and we can move forward and during conversation, you have questions, we can, you know, tap into some of these further as you wish.

But really it starts with knowing what the state plans are doing around managed care because none of us like surprises.

So we do know that many, many states, I think we're looking at up to 28 to 30 now getting engaged, you know, in long-term services and support. Many more are engaged in the Medicaid Managed Care.

So it's asking and proposing a question, you know, to the state. If it's not already in your state, you know, what's coming down the pike. If there's Medicaid Managed Care already implemented in your state clearly where, you know, you guys are looking and collaborated already it's what's next because many states are adding on.

So it's staying ahead of that conversation and getting involved really with your state administrators, knowing which waivers are going to be included and what, you know, what those plans are because you can then start to predict from a business sense, you know, what your sustainability is.

So if they're going to design around conflict pre-case management, do you need to pick and choose where you're going to be on providers, you know, providing assessment or possibly service delivery?

And they're really difficult, you know, conversations around what the designs will look like that go beyond rates and evaluating their services. I talked to a

lot of folks really who struggle with evaluating services because they've not had to put a price to them.

But so that's one level of the conversation. And the other is then service coordination and case management being such a significant part of what centers and AAAs do but it's also such a core part in the heartbeat of what managed care bases their assessments on as well.

So similar conversations are pretty difficult but if we can plan ahead for those and get together on those early with the state it makes it easier I think for you guys to build-out, you know, your sustainability, how to resource staff, how to enhance your capabilities and where you'd want to diversify both in your funding and your service capability.

Getting involved early and sharing, know there's transparency and input in the design and composition of the plan, the approval processes, oversight mechanisms, I think that, you know, managed care organizations see more oversight now than ever before. And I think it's really built-out some of those safeguards and outcomes that people really want to see that will make it easier to continue to move forward.

Other things would be you know the rule of the ombudsperson, of course stakeholder engagement. Building allies, there's so much about a health insurance plan that's really very technical. So let's say in the support of healthcare advocates, legal service, attorneys and weaving these (stay to the) rules and regulations by building alliances with various disability and aging groups like you all have already done really provides a way through collaborating to have better brainstorming and sharing of the resources to do that.

As far as really engaging folks who are actually going to be served by the plan, you guys are working with people every day advocating for people, advocating for the services and people utilizing the services themselves.

But really building out that consumer voice and speaking out on basic principles in the design and in the contracting as well around consumer direction, choice and services and providers, protection such as the (PO) rights and ombudsperson, having end-of-life conversations and planning for that, ensuring that services are accessible compliant with (ADA). What a great role, you know, for you guys in terms of being that trainer and working with the managed care plans to ensure that.

And, you know, looking at we know still people who use wheelchairs that are going to feed and grain stores in rural areas to get weighed. And we can be implementing and incentivizing providers to ensure that they have the accessible (GMA) and (MDE), accessible tables for GYNs.

And when I look at accessibility I look at, you know people with mental health condition. It's like actually disabilities that are sitting in packed waiting rooms for two hours to see a doctor. You know if you have an anxiety disorder of any kind you're really not going to stick around for that so it's really educating that provider and being engaged in what those provider training's need to be.

Looking at the services that are being embedded in these Benefit Design Programs like sleep cycle support, you know, we saw one state where sleep cycle support, you know, was removed as a covered benefit.

But that's really another proponent of what ensures people, you know, to be able to stay at home. So that should be included by advocate, everybody advocating together, you know, add it back in.

Financing mechanisms, incentivizing for long-term services and support, incentivizing for home and community-based services and not institutionalization; again, you know, places, you know, really to be engaged.

Not cutting services for short term savings so really helping to build-out what these models are, to invest in the prevention, really everyday needs that people have.

I know one story where a young man needed - he's in his 20s and needed adult briefs. But the benefit was changed so that they limited to the number of adult briefs. He really ended up at that point with a stem (brake) on because of that. It doesn't make sense.

So really, you know, to have you guys at the table and engaged with the managed care organization to make sure that we're not running into situations like that. Those are very preventable situations that you all deal with every day but really helping to influence that with the state.

Not to be - I would say, don't be intimidated by the technical nature of health insurance plans because consumer direction, choice and adequate caring services really shouldn't be complicated. Clearly the nuances are. We're all in this together in enough states to know that it is very difficult to get through it.

But we really should be educating each other on what the language is on all sides, what the service needs are on all sides so that we're really moving the ball on this and not getting hung up in variation.

Laruen Solkowski: Merrill?

Merrill Friedman: Yes.

Lauren Solkowski: This is Lauren. If I could just - I'm just going to interrupt for one second.

Merrill Friedman: Thank you.

Lauren Solkowski: Apparently we're having a problem here with the slides, everyone seeing the slides being advanced. I'm advancing them but they're not changing.

So I wanted to let everyone know we are going to be sending the slides around, you know, through an attachment to everyone so that you can look, you know, view them that way.

And we apologize for this problem. We're not sure what the problem is. But so just so you know Merrill the slides aren't advancing for people to see so but you can - we will get through it.

So and now...

Merrill Friedman: I will.

Lauren Solkowski: ...I'm showing the third or the key steps for getting involved.

Merrill Friedman: Yes, it's not even showing on mine so but I mean I have them (out there) so I'm happy to revisit anything.

Lauren Solkowski: Okay. Well I think we're okay. And but, you know, if you could just say - maybe pull up your slides and say Slide 4 and/or whatever slide number you're on and we can - so folks will know what slide you're referencing.

Merrill Friedman: Happy to.

Lauren Solkowski: Okay.

Merrill Friedman: I think, see that's how good I am at the slides. We're on Slide - well for the key steps to getting involved so I believe its Slide 3.

Lauren Solkowski: Okay, great. That's the one I was on but.

Merrill Friedman: So sure.

Lauren Solkowski: Okay, thank you Merrill.

Merrill Friedman: Sure. So there it goes. Working with some of these (ADHD), I just completely lost my track too.

Lauren Solkowski: I apologize for that.

Merrill Friedman: Oh please don't. I jump around so much.

So, you know, we can talk - I know there are questions related to look at engaging managed care organizations.

And looking at the requirements I mean that MCOs are held accountable to. Because the thing is you all have such a significant influence on that and the

space in there to leverage your services and your history and your experiences and the talent.

So there are requirements that managed care organizations, you know, work directly with beneficiaries so individuals and their families. Having Stakeholder Advisory Boards, having influence directly by members on consumer direction.

So I think that there are really great places to come together. There are ways that you can actually help at the beginning but even throughout. Because, you know, you can change it on ongoing training's and oversight, input on program design, elements of care and services, working on assessment processes and outcome measures that really consider an individual's ability to live either independently in the community, with their family, in the community setting of their choice, using transportation, live in accessible and integrated housing, all of those areas.

There are also measures attached to them and performance measures. And that's where again you all really influence the success of a managed care or health plan.

And then my last - this one slide on key steps for getting involved in, I think, you know, we'll continue. I'll continue to go through some others. Is really is not to say no to the managed care conversation. It's incredible the number of times that we reached out to people and organizations just don't want to talk to us.

And I can understand that, you know, to some extent. But we're really - if states are going to go forward with this as much as managed care is difficult to embrace, if you're there and you're talking with the managed care entity you

can really help to break down some of those barriers that managed care organizations may put up even unintentionally.

So if you're sitting there at a table and looking at services, I know in one state where we did letters of intent with all of the AAAs and all of the Centers for Independent Living there was one entity that didn't want, you know, to provide services, didn't want to meet with the managed care organizations or anything. So the other AAAs and the other centers really took over that region.

But it's really hard then for individuals to have choice if the organizations are not enrolling in managed care because they're not going to have as many choices of providers in that area.

So it'd be great, you know, to really ensure that we had everybody talking at those tables and everybody really enrolling as providers and working through that so that there's as much choice for people and their families.

When states look at the outcomes and performance incentives that they set in place for managed care entities they look at improving coordination and integration of physical healthcare and behavioral healthcare, supporting members successfully in their communities, promoting wellness and healthy lifestyles, reporting on money as well as the person, improving health status by increasing or decreasing hospitalization, appropriate use of psychotropic, preventing pressure sores and (UTI). These are areas we're contracting with AAAs and centers. You guys are the ones that really make that happen for people and also for the managed care organization.

So there's a great spot obviously where you are the center of, you know, that service delivery.

And now when you look at some of the newer outcomes, performance incentives that are out there some of the states are seeing incentives around employment for people with disabilities, people with mental health condition. Managed care organizations are having incentives around increasing life expectancy, decreasing utilization of any inpatient services, (NRS). Follow with management, decrease hospital admissions post-nursing facility discharge and increased community inclusion post-transition to the community.

So really it's no longer just ensuring that we're transitioning people to the community, but really that they are engaged in meaningful activities within their community whether it be work, social, family.

And so you guys really are the core, you know, to seeing that happen. Some of the NOMs that are out there, those National, you know, Outcome Measures support those. And so you can really see. And you can go on that federal web site. You can look at in contract.

And that's where your services are, you know, with those outcomes. And so it really shows you exactly your influence in that (sphere).

I'm not sure if I've gone beyond my time or not Lauren so I'm happy to quit talking for a while and...

Lauren Solkowski: Okay. I mean I think you're fine. I think we will move to Emily's presentation.

But before we do that we did have a question come in on chat. Who should be the first contact, Medical Director, Community Relations or etcetera?

Merrill Friedman: So depending on when the - when that conversation, you know, when you're going to start contacting. If the health plans are already there in the area you can call directly to the executive, the CEO or the health plan President and engage there. You may already know who their outreach people are and if you know those people enter that way. Because I have heard from several organizations that they've had trouble connecting with the health plans. They're not getting returned calls or they're not calling the right person.

So you can escalate up to that, you know, health plan Director or you can just start there.

If it's a state where it's new, and let's take Kansas for example just because there was literally no managed care there before they implemented KanCare so there wouldn't have been a Medical Director to call. There wouldn't have been a CEO or health plan President to call.

And then you really are working with advocacy people like myself who are on the ground or whoever their government relations people are that are on the ground first.

And you can, I mean can - if you reach out to those folks, you know, early on they're going to connect you as well.

Lauren Solkowski: Great, thank you Merrill. Okay with that so our next presenter we have is Emily Brower. She is the Executive Director of Accountable Care Programs at Atrius Health.

And Emily I'm going to pull your slides up. I think we've figured out what the problem is, should come up in one second here.

Emily Brower: Okay, well thanks for having me and thanks everyone on the call who's listening.

I could say this has been one of my favorite projects within the work we're doing on accountable care so glad to speak with you all today.

And I see my slides so I'll start.

So what I'll just cover today in our time is a little bit about Atrius Health, a little bit about our Pioneer ACO strategy because that's really the context within which we started to ramp up and do some new work with our AAAs which in Massachusetts are called ASAPs or Aging Services Access Points, a little bit about the work that we're doing in that area with - which includes our work with Merrimack Valley which is one of your participants. And then some lessons learned and next steps.

So you can advance that. So Atrius Health, so Atrius Health is a group of six multispecialty physician group practices and one home health agency, VNA.

And together we care for - provide primary and specialty care for about 1 million patients in that geography that you can see there so Eastern and Central Massachusetts.

VNA Care Network and Hospice is the newest Atrius Health member. And it's very different for us to have a home health agency as part of the Atrius Health System so we're doing a lot of work, new work around that.

But that gives you a sense of who we are and what area we cover.

Next slide, so some of the foundations or what we think of as the core competencies of Atrius Health that have supported much of the work that I've been leading and some of the work that we're doing with our ASAP partners is the fact that we do a lot of our population management, patient care under global payment. We have a lot of tools to be able to do that including a very rich corporate data warehouse, rosters, lots of population management tools.

And we've been doing - historically have been a leader in quality and performance measurements as well as and global payment.

So for us this is a strong foundation to go into the Pioneer ACO and other risk-based global payment like contracts within which - wherein which we have the opportunity to work in new ways with our elder services or AAA partners.

Next slide, so a little bit about the Pioneer ACO so as most of you know Medicare has two ACO Programs, the Shared Savings Program and the Pioneer ACO. And we participate in Pioneer.

The reason that we decided to be part of that program is that we wanted to take - get out of a payer-based approach to managing care for Medicare patients into a population-based approach. So rather than having different programs and services depending on the payer, if we can take a population-based focus and say it doesn't really matter if it's a fee-for-service patient, a patient in the Pioneer Program or a patient in Medicare Advantage. We are going to look for the best opportunity to manage the care of that population.

And it gives us a chance to treat all of the patients in the kind of payment model as close as we can towards global payment that we think best aligns with meeting our goals around quality.

Next slide, so some of the key features of the Pioneer model which are helpful to understand as we talk about some of the new work we're doing with our ASAP partners. So it's a three to five year program and we're taking the five year or long term view. The first term is three years and then there are two additional years.

And we are hopeful that we will be participating in the full five years. Unlike the Shared Savings Program ACO the Pioneer Program goes through the Center for Medicare and Medicaid innovation. They are sort of CMS partners in this.

And we can - we feel like we can be responsible or accountable for this population because we're getting claims data. So we can understand what services they're using, what care they're getting. Put that together with the electronic health record information and really have a much fuller picture of this population that we - than we had under fee-for-service.

Even though people refer to this as a Shared Savings or Shared Savings and Loss Program, we really do think of it as global payment because you have a population-based budget that your performance is measured against.

We chose a model that has both up and downside risk sharing so some pioneers have upside only. In the first year we have both up and downside.

And then there's a lot of incentive and really an important feature of the program is around meeting the quality measures.

So unlike a typical pay-for-performance or managed care performance bonuses kinds of arrangements, with Medicare Pioneer ACO performance on

quality is the gate through which you receive any savings or losses that you're responsible for.

So your performance on the quality measures, determine your actual financial performance. So that's very different and the quality measures really are front and center and so are very important to the program.

Next slide, so some of these quality measures because we are working with our ASAP partners to collect some of these so give you a sense of that.

So there are 33 measures, many are new. Not measures that - not metrics that we have been measuring before. We have patient experience which Medicare actually does a survey and brings that data back. There's a measure around participation and meaningful use so with our electronic health record, a meaningful use record and are reusing it that - using it that way.

And then there's a set of measures meant to reflect our efforts around coordinating care. Are we doing a good job preventing avoidable admissions? That's the ambulatory sensitive condition admissions. And how are we doing at managing readmissions?

And then there's a whole set of measures around preventative health as you see there.

And it's not highlighted here that I wish was, was a measure around falls risk, but you can see that - which is a new measure for most plans to be looking at capturing falls risk. So those are some of the quality measures.

Next slide, so this is our - what Medicare calls our Driver Diagram. So every Pioneer ACO had to produce a diagram like this that talks about what your -

what outcome you're trying to achieve, your primary drivers for achieving it and then what are the particular tactics or secondary drivers.

And you can see there the one I circled is that integration of home and community-based support we see as integral to achieving our goal of high value care for Medicare patients.

And that's sort of the strategy under which we started to do more and new work with our ASAP partners.

Next slide, so in particular when we looked at home-based care we understood that there's sort of two pieces to that. One is are patients getting skilled care at home when they can, in other words are we really using home health and VNA in the most effective way?

And then what's the primary care at home since we have part of our model includes home-based primary care?

And what are we doing to connect with our ASAP partners in supporting patients to both get the care they need at home and also get the support they need to avoid unnecessary hospital stays, ED visits, the kinds of things that we all care about. Not having our Medicare patients have to go through those transition visits at all possible to avoid them.

So when we took a look and said okay so where are the gaps in that model of improving care for patients at home, we had some individual practice-based good work between a practice and a local AAA or ASAP. But we nothing system wide that looked at how to work more closely with our ASAP partners so that's what we decided our work was, is sort of to bring it to the level of trying to create a system wide strategy.

And then roll that down to what's the actual standard work around how we communicate referrals, information and close the loop back to the practice. When we have an ASAP providing care to our patients how do we really make them an authentic member of the Care Team? That's our overriding goal.

Next slide, and so we would expect that by partnering better with our ASAP partners we could better - we could improve care for the populations. If you think about the triple aim of better care, better health and lower cost we think that our ASAP strategy should be able to deliver on all of those.

So we should be able to have better costs by taking some of the waste out of the system. Unnecessary care particularly unnecessary hospitalizations or ED visits that are very disruptive.

We should improve health outcomes by improving the care for the population. And the patient experience should improve because it would really be a wow for the patients to be able to get what they needed at home and live independently for as long as possible.

Next slide, so as I mentioned our sort of overriding theme was how do we work with our ASAP partners so they're an authentic member of the Care Team.

So when we have our Multidisciplinary Care Team Meetings we're thinking about how do we include our ASAP partners in that. When we are doing individual patient support and we're calling up an ASAP to refer that we know the information they need to be able to connect with the patient, they

have the information they need and then we have the information back about what's the results of the assessment and what are the services.

So again we have a more holistic care plan that includes the view of the patient at home, a unique view that the ASAP partners can give us.

So we started our collaboration through some practice-based pilots that I'll talk a little bit about. And then also looking across the population and saying what are the kinds of - what's the value that an ASAP brings particularly around say falls risk where we may be able to assess falls risk in a practice but there's a population who really needs to have falls risk assessed in the home.

So how do we leverage the good work that the ASAPs do around those kinds of population-based interventions?

Next page, so this shows you where the Atrius Health practices are that are involved in some of this pilot work.

So Harvard Vanguard which is the largest of the Atrius Health practices. Its Chelmsford, Massachusetts site and Elder Services of Merrimack Valley; that's one pilot that's - and pretty far along, also Southboro Medical Group out to the west a little bit and Bay Path as the other ASAP out in that area.

And then we have sort of in development, three and four. And there are more beyond that. But that gives you a visual.

Next slide, so what we're - how we're approaching this work that we're doing between the individual practice and its local ASAP is sort of starting with how do we improve communication between the two entities, build on what good relationships there might be between say a social worker or a nurse in a

practice and a case manager at the ASAPs. How do we take the good relationship there and turn it into some standards around communication.

We set up a secure email so that we can exchange information in a way that is HIPAA compliant.

And then we build on top of that the sort of what we think of as one-to-one communication. So contracting with the local ASAP to provide a - an individual in the ASAP who can work with an individual in the practice to really be able to close the loop on the care that patients are receiving.

And the pilot with Elder Services and Merrimack Valley we have sort of a part of a social worker that we're working very closely with, part of FTE.

And with Southboro Medical Group it's somebody who's onsite in the practice so a slightly different model. But again making sure that we've got good communication, coordination and we're closing the loop to make sure that we have a comprehensive care plan for each patient.

Next slide, so what we - so having done a couple of these pilots where we see the opportunity is moving from a good relationship between one social worker and one social worker and trying to build a system that says it shouldn't be dependent on an individual relationship. We should have systems that work well together.

I think we're both seeing that because we're involved in new programs where it makes a lot of sense to have the ASAP be part of the Care Team and our local ASAPs in Massachusetts are also looking for ways to partner differently with medical groups and with health plans. So there's very good collaboration on how we can do things differently together.

And then what we are tracking, sort of what we are calling, you know, the performance that we're trying to measure is, are we seeing clinical and financial results? So are we hitting goals around that triple aim?

And we're starting to see some good results there.

The challenges is that we've sort of - we're building it as we go. So we're figuring out what it means to work more closely together as we work more closely together which makes it hard to scale because we haven't really built the model yet that we can scale and spread although we're trying to do that.

We've got - it takes a while to get enough data to know whether or not we're having an impact. And we are trying to leverage the work. When the ASAP is in the home if there's certain pieces of information they sort of can collect on our behalf that demonstrates the quality and captures some of those quality measures. It's taken us a little bit of time to build that but we're doing that now.

And then just making sure that we're always thinking about when we're making changes in the primary care practice how do we include the ASAP in that. So how do we make sure that this good work that we're building stays integrated as we continue to transform care in the practice?

Next slide, so one of these pilots the one that is probably furthest along is the one between Southboro Medical Group and Bay Path. And they have pulled together some slides around their work so I'm sharing one of those here.

So in that practice besides a contract with Bay Path, their local ASAP, for one of their staff social workers to really and have that person be onsite in the

practice part of the Primary Care Team and to integrate them as much as they possibly can into the multidisciplinary case reviews, ongoing longitudinal management, making that sure patients who are at home are getting all of the services that they need and collecting some of those quality measures.

And you can see some of the comments from that practice which is that they love it. The Primary Care Team thinks it's great. The care management staff wish that they had even more of this person's time because it's so helpful to them in managing their high risk patients in particular.

Next slide, so some of the lessons learned, some of this I've already touched on, is that first of all you need to have an existing good relationship between the practice and the ASAP. So you need to have folks who feel like on both ends of it we're doing a good job to support each other.

And once you - when you have that then you can build something on top of that or around that to make that more systematic and less independent on individual relationships. But you need that good relationship to start.

And then you need time for the practice to really experience the value. So seeing how much the ASAP services can help support the care plan for the patient.

And then this piece around (Loss) Review, that's that Multidisciplinary Care Team Meeting so it's really important to integrate the ASAP into that work.

So internal to Atrius Health, some of the things that we've seen that helps us to make this successful is making sure that we've got physician engagement that physicians can experience. It doesn't just stay within the sort of Care

Management Nurse Social Work Team but that the physicians are seeing how this helps to improve the care for their patients.

That said the really day-to-day work is done by the care management staff whether those are nurses or social workers and then always making sure that we're looking for those opportunities to spread.

On external side what we're seeing is that our work within Pioneer ACO is bumping up against other Medicare demonstrations which could be an opportunity but could conflict. And a lot of that we're just starting to work out right now. You can see them there. The Community-based Care Transitions Program, the other ACOs in our neighborhood and the bundled payment pilots and I'd be happy to talk about questions around that.

Next slide, so what's next?

What's next is trying to take the best of the pilots that we've got going and spread that across Atrius Health. Making sure that whatever we do we're tracking our performance against our triple aim goals because this is an investment for the practice. So like any other investment they want to make they want to see that they're getting results.

Also Pioneer is just one of the programs where we are trying to work more closely with our ASAP partners. We're also in both of the dual plans in Massachusetts. These happen to be the acronyms for them. So the Senior Care Options is what Massachusetts called the program for the duals who are 65 and older. And the Integrated Care Organizations are now called One Care Plan for the duals under the age of 65 so more of the disabled population.

So a lot of the work that we're doing in Pioneer should spill over into success with those other programs.

Next slide, so I put here my contact information. Also the contact information for Amy MacNulty who's the Project Director for what is called Community Care Linkages, the effort that the Massachusetts ASAPS are doing to work together to figure out how to be part of healthcare reform, work with practices, groups like Atrius Health more directly.

So Amy's been very involved in the projects and pilots and you can see the logos on a bunch of the slides because she and I have presented some of this work before. So she's helped developed these slide decks. So I want to give her credit there.

I did get some questions and I hope that I've talked a little bit about the value that community-based organizations, ASAPS, AAAs bring to any - really any population-based approach to managing patients whether it's through managed care, global payment, shared savings like the ACO. We definitely believe that the AAAs bring a lot of value there particularly around avoiding preventable admissions, readmissions, ER visits, some things that are very important for this population as well as supporting patients to age and place and be independent for as long as they can.

Thanks.

Lauren Solkowski: Thank you so much Emily. That was really great.

I think - so with that I will now open it up for Q&A. So (Diane) if you could please provide instructions for our participants for asking a question through the audio line.

Coordinator: Thank you. If you would like to ask a question from the audio line please press star 1. You'll be prompted to state your name. And we ask that you do that so that we may announce you. Be sure that your line is unmuted so that the system can pick up your name. If you'd like to withdraw your question please press star 2.

Once again to ask your question, please press star 1. One moment please.

Lauren Solkowski: Thank you (Diane), and as - while we're waiting for questions to come in I'll go through some that have come in through the chat.

So one of the first ones Emily I think this is for you. You were speaking of the up versus the down risk.

Could you elaborate on what you meant by that?

Emily Brower: Sure. So up and down risk meaning risk for savings and loss so taking both, if you - people talk about upside only models; that means if there are savings you share in savings but if they're losses you're protected against any losses. You don't share in losses. So that would be upside only.

Up and down would be that you're sharing in both savings and losses so you have what we would consider full financial risk. And that's the model that we're in both financial risk, both up and down sharing.

Lauren Solkowski: Great, thank you. Another question that came in I think would be for either one.

Will you share some of your quality measures for the caregiver experience assuming that this is for family caregivers?

Emily Brower: Sure. And you can actually go to the cms.gov web site and look on the - you can get all - you know lots of information about the quality measures which are for both Pioneer and the ACO. Pioneer and shared savings ACO are the same.

But I can tell you. I actually have those in front of me. So the patient experience measures are around access so being able to get appointments, information from the practice when they need it.

How well they feel that their Clinical Team communicates with them. How they rate their doctor. How they're able to access specialty care.

What kind of a job does the practice do around health promotion and education?

And do patients feel like they're part of their healthcare decisions?

So those are the, one, two, three, four, five, six domains and under that there are specific questions.

There's also as part of the Patient Experience Survey there's a question around patient self-reported health status and functional status which is very new. That's not something that's ever been measured in this survey before.

And the survey mostly asks about their experience in the practice. So it's really asking about the care that's being delivered in the medical group.

Lauren Solkowski: Thank you. And before we go to the audio one final question on chat, is there a payment made to the AAAs and ASAPs for their support to the practices?

Emily Brower: Yes. So as I said already (unintelligible) for two of the pilots, we do actually have a contract where there is, you know, it's a professional services contract where we are making payments to the ASAP. Yes.

Lauren Solkowski: Thank you so much. And (Diane) I think we'll - we can turn it over and check to see if there's any questions through the audio line.

Coordinator: We have one question at this time from the audio portion. Earle your line is open.

Tom Earle: Hi Merrill. This is Tom Earle from Liberty Resources in Philadelphia. And together with the Statewide Independent Living Council here and our AAA we're very excited about getting to the table in Pennsylvania to design a system that really maintains consumer's choice and consumer self-direction.

And we're wondering if there are any particular MCOs that we should focus on in Pennsylvania and what advice you might have on that.

Merrill Friedman: Hey Tom. Good to hear your voice. So I can't call out, you know, any MCOs that are there. I don't know who all is interested or has been having conversations with the state. You can find that out though from your state.

And then, you know, my advice really would be to if they have not reached out to you yet for you to go ahead and reach out to them. And contact kind of like, you know, we talked about earlier but get in touch with whoever their

government relations person. Often they're going to have a lobbyist there first as you well know.

So get in touch with them and start getting, you know, your way into building relationships within that health plan, explaining to them really the services that centers provide. And if you're partner again, you know, is yourself and any of the AAAs in your area are really the strength in capabilities that you all have for supporting people in the community. Because really that helps, you know, on multiple levels, you know, of course one, with diverting any nursing home or institutional placement; and two, it will really help when the managed care organization gets up and running that they immediately start looking at people who wish to transition to the community as well.

So you can really help them from both ends. And then also there are going to be readiness reviews and other things where they have to have a network and network capabilities up and going, you know, before going live.

And you all are a part of that. So your services really should be covered. All the centers that you can get to the table there, you know, should be there and contracting them with - for those services that you - so you are part of the initial network.

Tom Earle: Great, thank you.

Coordinator: I'm showing no further questions from the audio portion.

Lauren Solkowski: Okay, thank you (Diane). And actually I'm not showing any other questions through chat.

So if no one has any other questions I'd like to thank our speakers again for presenting and thank all of our participants for great questions.

We are planning another webinar for August so please watch your email for more information about the topic, date, time and registration information for that webinar.

Also if you do have any - if you think of any additional questions once the webinar - once we get off the phone, as I mentioned before please email me at lauren.solkowski@acl.hhs.gov.

And I also wanted to - before we hang up, to give a quick update on our August Learning Collaborative Meeting. Per a meeting that we had today with senior staff a decision has been made to move this meeting back to the fall. And we will provide more information on that very soon.

So I think with that we are done. So thank you again to Emily and Merrill for presenting today.

Coordinator: Thank you for your participation. Your call has concluded. You may disconnect at this time.

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