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Letter from the Medical Director

Fredrick Wallisch, MD, OCC Market Medical Director

Punxsutawney Phil did not see his shadow, so spring may come early this year. After some of the January deep freeze that we have had in the area, any promise of warmer weather is a welcome thing.

This time of year as we look toward spring, in the ACO world, we try to assess the results of 2018 and implement the plans we have made for 2019.

Final data will not be in on our 2018 performance, but some very promising trends are appearing. Our electronic RAF efforts (as well as those continued paper RAF) look like they will pay off with a higher risk score as we start 2019. This means that patients are getting stratified into care management programs more accurately, and our cost target for the ACO is higher. We are looking forward to launching this process at Good Samaritan and Methodist as well in the next couple of months.

Financial performance in 2018 was also very strong. We are on track to save even more than in 2017. CMS delivered a check to the ACO for just over $16.1 million in December for the 2017 performance year. This ranked us as number 2 out of 44 ACOs on a total savings amount. We also were top 10 in percent of savings and quality performance! A lot of hard work from you and your offices went in to making this a reality.

As we look toward 2019, we are planning out further initiatives in the post-acute space as well as more integration with the inpatient world. Also going on this year: Our CKD work is underway with our Care Advisors; the CHF work has been incorporated into EPIC and will be rolling out mid-year; the Post-Discharge Home Visit Waiver through the ACO has been piloted and will be coming on a wider scale this year; and our team will be working with your offices on reaching more patients that have declined our Care Advising services.

Enjoy the early spring...

Thanks,
Fred

Success Story: Transition Care

The Care Advising team received a referral for Transition Care for a patient living with multiple health conditions including CAD, diabetes, hypertension and mental health issues. The patient was admitted to the hospital due to chest pain. Upon discharge the patient was started on 4 new medications and one medication was discontinued. The patient was also scheduled several follow-up visits and testing for CABG.

The Care Advisor jumped into action to support the patient after discharge. The Care Advisor visited the patient at home to review medication and discharge plan. The Care Advisor assisted the patient with setting up a medication management plan that helped the patient be more compliant. The Care Advisor also encouraged the patient to take daily blood pressure and blood sugar readings. The Care Advisor also educated the patient on the importance of keeping all scheduled tests and appointment so that the patient could be cleared for CABG.

As a result of the care coordination and support of the Care Advisor, the patient completed all scheduled follow-up appointments and testing. The patient expressed that the Care Advisor helped a lot with managing medications. The patient was also checking blood pressure and blood sugar readings daily but still needed to find a way to record them for easy retrieval. The Care Advisor referred the patient to Complex Care to continue the progress and support made through the Transition Care program.

2017 NGACO Final Results

For the second year in a row, Deaconess Health System's Next Generation Accountable Care Organization (ACO), Deaconess Care Integration (DCI), has been ranked by the Centers for Medicare and Medicaid Services (CMS) as one of the top-performing Next Generation ACOs in the U.S. As announced by CMS on December 21, DCI generated more than $16 million in savings to Medicare during the 2017 performance year, which ranks DCI as the second-best performing Next Generation ACO out of 44 Next Generation ACOs in terms of earned shared savings in 2017.

In addition to these savings, DCI achieved an impressive care quality score of 92.83% and ranked #10 across all Next Generation ACOs in the category of Savings as Percentage of Benchmark. These results reflect DCI's continued focus on delivering high-quality care while reducing unnecessary health care costs for patients. Several drivers contributed to these clinical and financial outcomes, including DCI's emphasis on coordinating care to help ensure patients, especially the chronically ill or those who are hospitalized, get the right care at the right time, and avoid unneeded duplication of services.

Another factor that contributed to these savings was DCI's focus on reducing Emergency Department (ED) utilization for patients with non-emergent conditions. Through a combination of analytics, patient education and physician engagement, DCI was able to decrease potentially-avoidable ED visits and ensure patients were directed to a primary care provider, an urgent care clinic or other resources as necessary.

Earlier this year, Deaconess Health System was recognized as a Best Hospital for 2018-19 by U.S. News & World Report. Specifically, Deaconess was ranked the number two hospital in Indiana, out of more than 160 hospitals statewide.

"We are proud of our continued strong performance in the Next Generation ACO model and the significant clinical and financial outcomes we've seen in our value-based care efforts—most of all, because of what it means for the communities we serve," said Deaconess Health System President James Porter, MD, FAAP, FACHE. "Providing high-quality care, while reducing health care costs, positions us well to continue to serve our community in a sustainable way. Our physician-led, evidence-based clinical programs and population health technology have been critical to our performance in the Next Generation ACO Model, as well as our ability to improve the quality and care experience for Medicare beneficiaries."

In 2012, Deaconess Health System launched a new ACO, Deaconess Care Integration (DCI), to join the Medicare Shared Savings Program (MSSP). Working closely with its operational partner, Evolent Health, Deaconess Care Integration then launched a Next Generation ACO in January 2016. To support its Next Generation ACO efforts, Deaconess partnered with its OneCare Collaborative, a group of five regional hospitals and more than 250 primary care providers dedicated to value-based care. Deaconess also invited several regional health systems—Good Samaritan Hospital, Memorial Hospital, and Methodist Hospital—as well as independent primary care physicians, to join Deaconess in its move to value-based care.

In its first year as a Next Generation ACO, Deaconess Care Integration was one of the top five-performing Next Generation ACOs in the U.S. This year, DCI entered its third year in the Next Generation ACO Model and currently serves more than 40,000 Medicare beneficiaries through its ACO.

2019 Initiative Updates

In 2018, the OneCare team launched several new network savings initiatives, such as our Chronic Kidney Disease management program. This year, the OneCare Team hopes to leverage the following network savings initiatives:

- **3 Day SNF Waiver-** this is a NGACO benefit enhancement waiver that waives the CMS rule requiring a 3 day stay in an inpatient hospital, acute-care hospital, or critical access hospital (CAH) with swing-beds prior to admission to a skilled nursing facility (SNF). This initiative allows us to reduce unnecessary inpatient admits, ensure appropriate level of care, and help reduce SNF average length of stay (ALOS) by leveraging approved preferred provider facilities.

- **Chronic Kidney Disease Management (CKD)-** by leveraging focused CKD management of identified patients, we can help delay progression of CKD to end stage renal disease (ESRD) among high risk populations.

- **Congestive Heart Failure (CHF)-** through the creation of a checklist created by the OneCare Specialist Council, we will expand our pilot into the full operational stage for all EPIC providers. This checklist helps in reduction of unnecessary utilization and increase engagement in Care Programs by promoting a value-based CHF protocol/checklist and improving care coordination.

- **Post Discharge Home Visit Waiver (PDHVW)-** this is a NGACO benefit enhancement waiver that allows home visits for patients who do not qualify for the Medicare coverage of home health services. These services are furnished in the beneficiary's home after the beneficiary has been discharged from a inpatient facility. Services can be provided up to 9 times within 90 days. A small pilot was launched late December 2018 for CHF and COPD Deaconess Clinic patients- and we hop to role this out more broadly in 2019.

- **Patient Decline Process-** a great way to maximize medical expense management for complex care patients is to ensure that high risk patients who decline engage. A incentive is being built for a initiative to launch in 2019 aimed at office assistance in engagement of patients who initially decline complex care services.

- **Dialysis Transportation-** there are many patients without means to get to dialysis appointments, so they utilize a ambulance, which can be very costly. This initiative uses analytics to help identify these patients and help them connect with other community resources.

- **Risk Adjustment-** our documentation rates for risk adjustments were at their highest levels in 2018 with the implementation of risk adjustment in EMRs. We look to further expand these to additional sites in 2019.

- **Other-** some other initiatives still be being built in 2019 will focus around post-acute care, readmission rates, quality improvement PDSAs, lower back pain, and COPD

Look for more information in 2019 on these exciting initiatives from your Population Health Manager (PHM).

2018 Risk Adjustment Completion Update

In 2018, we ended the year at over 10,000 patients risk adjusted- which is an all time record! Appropriate coding helps us ensure that we are completely documenting the burden of illness of our patients- which improves our care program stratification and helps us unsure we have a cost targets with our Payers are appropriately set. We want to thank everyone for all their assistance with our risk adjustment efforts in 2018! For 2019, we hope to start risk adjusting in the beginning of April.

2018 Care Program Success!

Clinical Programs: In 2018, we rolled out Real Time Strat as a Pilot. The goal was to decrease the overall days the patient is identified to Outreach. We drastically decreased the days from 121 days to 1-2 days. We also surpassed our engagement goals for Complex Care, Transition Care and Advanced Illness Care. We plan on continuing to meet our engagement targets in 2019 and starting a patient decline process.

Final Next Gen Engagement Numbers

Programs	DEC Goals	End Of Year	% to Goal
Complex Care	1125	1172	104%
Transition care	945	1000	105%
AIC	107	113	105%

Post Discharge Home Visit Waiver

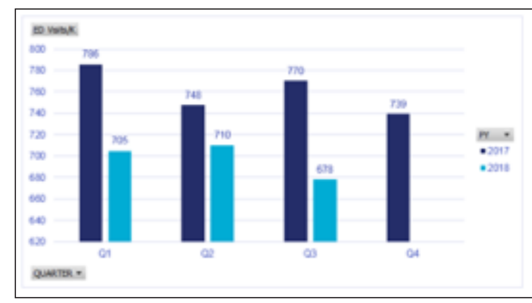
In late December 2018, we started a soft pilot for launching the NGACO Post Discharge Home Visit Waiver (PDHVW) benefit enhancement waver. This NGACO benefit enhancement waiver allows home visits for patients who do not qualify for the Medicare coverage of home health services. These services are furnished in the beneficiary's home after the beneficiary has been discharged from a inpatient facility. Services can be provided up to 9 times within 90 days.

Our current pilot focuses on Deaconess Clinic patients who are admitted for either CHF or COPD. As we learn from this pilot in quarter 1 of the calendar year, we hope to roll this waiver out more broadly in 2019 to the rest of our network. We are excited to see the impact this initiative will have on readmission rates for COPD and CHF patients.

ER Initiative Continued Success

The One Care Collaborative physician network has focused on reducing ER visits for almost 2 years. Significant work was completed in 85+ office locations with over 600 distinct changes made to voicemails, patient education, same day appointments and staff training. We have seen this hard work pay off in a reduction of total ER visits for the Next Gen patient population in 2018.

We are tracking the number of ER visit per thousand and have seen a year over year reduction in 8% for the first three quarters of 2018. We hope to have the full year comparison in March of 2019. Hats off to all the providers and practices who have participated in these efforts!



ED Visits/K	Year		
Quarter	2017	2018	% Change '17-'18
Q1	786	705	-10%
Q2	748	710	-5%
Q3	770	678	-12%
Q4	739		N/A
Grand Total	761	698	-8%

Deaconess Care Integration Compliance Plan

Deaconess Care Integration (DCI), our Medicare Next Generation ACO, appreciates you and your leadership in our commitment to exceptional patient care. As part of our DCI compliance plan we are required to provide education on Compliance, Privacy and Fraud, Waste and Abuse as defined by federal law. Below, please find an educational document on Fraud, Waste and Abuse along with a website for further information. If you are a participating provider in Deaconess Care Integration, please review these materials and familiarize yourself with their content. If you have any questions regarding the information provided, feel free to contact our Compliance Officer Mindy George at (812) 450-2361.

REVIEW OF FRAUD, WASTE, AND ABUSE FOR MEDICAL STAFF

According to the Government Accounting Office (GAO), healthcare fraud and abuse accounts for as much as $100 billion of all healthcare costs annually.

DEFINITIONS	**Fraud** – Intentionally or knowingly and willfully attempting to execute a scheme to falsely obtain money from any health care benefit program. **Waste** – Occurs when there is over-utilization of services, or other practices that result in unnecessary costs. **Abuse** – Improper behaviors or billing practices that create unnecessary costs. The state of mind is what separates fraud from abuse.
NAVIGATING FRAUD & ABUSE LAWS	**The Civil False Claims Act [31 U.S.C. §§ 3729–3733]** addresses fraudulent billing of the Federal Government. This Act assigns liability to any person who knowingly submits a fraudulent claim for payment to the Federal Government. It also addresses the creation and submission of false records relating to false claims, among other provisions. **Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)]** states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of Federal health care program business, including Medicare and Medicaid, can be charged with a felony. In the Federal health care programs, paying for referral is a crime. **Physician Self-Referral Statute [42 U.S.C. § 1395nn]** prohibits, with certain exceptions, the practice of physicians' referring patients to facilities in which they have ownership or other financial interests. **The Civil Monetary Penalties [42 U.S.C. § 1320a-7a]** law covers an array of fraudulent and abusive activities and is similar to the False Claims Act. **The Exclusion Statute [42 U.S.C. § 1320a-7]** excludes individuals or entities from participating in the Medicare or Medicaid program from a minimum of 3 to 5 years, depending on the offense, to possible lifetime exclusion. **Criminal Health Care Fraud Statute [18 U.S.C. Section 1347]** prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program; or in connection with the delivery of or payment for health care benefits, items, or services. Proof of actual knowledge or specific intent to violate the law is not required. **Penalties for violations of these laws include monetary penalties, exclusion from participating in federal health care programs, and/or imprisonment.**
RECOGNIZING FRAUD, WASTE, & ABUSE	EXAMPLES: Illegal payment schemes; Falsifying information; Unnecessary treatment; Billing for services not rendered; Double billing; Upcoding; Unbundling; Altering claim forms
CONTACT INFORMATION FOR COMPLIANCE OFFICER	**MINDY GEORGE** **Phone:** 812-450-2361, **Fax:** 812-471-2061 **Email:** mindy.george@deaconess.com **Anonymous Hotline:** 1-855-834-6438
FOR MORE INFORMATION	The website of the Office of Inspector General of DHHS offers free educational resources, and one of note is **A Roadmap for New Physicians** which summarizes the five most important Federal fraud and abuse laws that apply to physicians and provides tips on how physicians should comply with these laws in their relationships with payers, vendors, and fellow physicians and other providers. http://oig.hhs.gov/compliance/physician-education/index.asp