The Account of an ACO in Minnesota and its import To RCPA Disability and Health-care Members

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Agenda

• Overview of the Minnesota– Disability led Altair ACO
• The future is now
• Dual paths to success
• Open discussion and questions
• Provider panel experiences
Altair Minnesota ACO---Overview

• Disability led social ACO with 10 providers: 7 disability providers, 3 health & behavioral health

• 7,200 consumers statewide

• Leverage best practices to design an integrated continuum of service offering that supports a person-centered model while focusing on the fiscal responsibilities of the provider (how do we make money?)
Altair Minnesota ACO---Overview (cont.)

- Service designs developed:
  - Community Integration Programs: Housing and employment
  - Wellness to healthy outcomes: Medical, behavioral health and in-home services
  - Intensive Services: High acuity clients in residential settings. (Care Management at core)
Social Service / Community Providers

Behavioral / Mental Health Providers

Primary / Acute Care Providers
Service Designs Developed

• Community Integration Programs- Housing and Employment
• Wellness to healthy outcomes- Medical, Behavioral Health and In-Home Services
• Intensive Services- High acuity clients in residential settings- Care Management at core
Incentive & Shared Payment Models

- Integrated Health Payment- Shared savings on a TCO basis with Medical Group
- State-wide Incentive Payment Grant- Community housing, employment and integration
- Braided funding payments based on TCOC- Waiver and SNBC (state disability insurance program)
Developed common technology

• LifePlan- Standardized assessment tool and process (housing, employment, wellness, health)
• LifePlan 2- Standard + Behavioral Health Expansion
• Health Information Exchange- Social and Health integrated Data Model
Funding

• Start-up- LSS Minnesota funded with private donors and grants- Dedicated Director & Grant Manager
• Year 2- Current- Member annual fees, $1.5M in grants to date, all incentive and shared payments provided directly to participating members
• Year 4,5- Member annual fees, grants and shared value based payment models
CASE STUDY

A 65 year old – with moderate I/DD, a seizure disorder and dysphagia is given an accidental overdose of Ativan.

The person is brought to an ER, where they are admitted, treated and discharged requiring enhanced care.
The person is then discharged to a Skilled Nursing Facility.

9 weeks after the incident the person is transitioned back to their group home.

What is the impact of this scenario?
Current state of most providers

Patient/Person Receiving Services

[Many silos of information with little access]

Significant gaps, inconsistencies and lag in communications

Care team lacks definition

Only events that could lead to a fine are consistently reported:

- Exploitation
- Hospitalization
- Abuse
- ER Visit
Sustainability Pressures

Total Revenue

- Medical
- Barriers
- Quality
- Expenses Incurred

Absorbed Expenses

- Medical
- Covering inefficiencies and barriers
- Quality of Life Costs
Leveraging Innovation

Governance/Partnership

Care & Service Management

Delivery Model

Stakeholder Involvement & Analytics

LIFEPLAN
Prerequisites to support area of opportunity

**Life Plan + Pre-Intake Assessments**
- Pre-intake assessments will have built in Behavioral/Mental health need assessments
- Ability to track individual goals and quality measures

**SNBC – Special Needs Basic Care**
- Medical Plan Benefits
  - Large network of providers
  - Access to primary or specialty care
  - 100% coverage of MA copays
  - Care Coordination Program
Prerequisites to support area of opportunity (cont.)

Care Coordinator

• A disability competent care coordinator will drive care for the person receiving services
• Key to making referrals quickly if a need is identified

HIE & Consent to Share

• Leverage eHealth Project to keep the Care Coordinator (and the entire care team) informed in near real-time of changes in condition.
Engagement Tactic: Add Value – Access to Information

Patient/Person Receiving Services [With a PHR]

Event Driven Bi-Directional & Actionable Communications

Clearly Defined Care Team

Clearly Defined Events
- Life Events
- Gen. Change
- Med Errors
- Adv. Reaction
- Assess. Risk
- Illness
- Accident
- Hospitalization
- ER Visit
- Exploitation
- Injury
- Depression
- Abuse
- Srvc Barrier
- Behavior Chng
- Aggression
SIMPLY CONNECT
PERSONAL HEALTH RECORDS

PHYSICIANS
HOSPITALS
PAYERs
PHARMACY
LONG-TERM CARE
ACO
CARE VENDORS
Expected Outcomes

- Continued Quality of Life
- Continuity of Care
- Lower TCOC
- Reduction in Crisis Care
- DSP Career Path
Care team management & health data

My Care Team

Lukas Smith
Guardian, description if exists
emergency contact
(123) 456-3434

Zoe Adams
Guardian
(123) 456-4421

Carrie Vasquez
Primary physician
(123) 456-8741

Roy Stevens
Behavioral health
(123) 766-2453

Lukas Smith

Access to all data
My personal health record
Medications list
Event notifications
My care team visibility
LifePlan – Analytics Example (BHS Needs)

13% of people stated that fixing their mental health concern was their top priority.

53% of people stated that they had a behavioral health need.
Future realities ... today’s survival

• Promotion of Coordination, Wellness, and Prevention

• IDD Providers can Play a Key Role...Leading or Lagging?

• Technology Will Be Increasingly Important
  • Use of Tablets, Smartphones- Mobile Application
  • Electronic Visit Verification (EVV)
Future realities (cont.)

• Unlocking Healthcare Data and Information- Portability of Health Records

• Decreases in Health Plan Network Size

• Healthcare Reform will Continue; Just Different Names, Paths

• Revision of Payment System: Movement to Provider Risk
  • Increases in MCO’s/ACO’s (forget name; think concept)
  • “Value Based Payment”
  • Community Providers integration
Health care trends that include us....

• Consolidation
  • Payer/ Insurer
  • Government
  • Social Services Providers

• Movement to Value Based Payment

• Increase in Retail Care (e.g., Walmart, CVS, Rite-Aid)
Health care trends (cont.)

• Focus on Post-Acute Care and “Preferred Networks”

• Clinically Integrated and Collaborative Networks

• IT Transformation
  • EHR Yesterday
  • Analytics; Population Health
Why is it important to participate as a Community Provider?

• Proactive v. Reactive
• “Seat at the Table;” “High on the Food Chain”
• Diversification Discussion
• Technology
• Capitalization
• Partnerships
• Focus on Models not Definitions
• Balances risk is can be a good transitionary step
Dual paths for success...

• This is hard stuff...requires big culture shift
• Social Services must evolve to Health not Medical Model
• Intersection Care Management across sector
• Sharing Best Practices (“LifePlan” & HIE)
• Movement from Pen and Paper to an Electronic Model
• Adaptability/Flexibility in Design
• Use as a Learning Experience
• Vision, Commitment, Values... and Business
Open discussion & questions