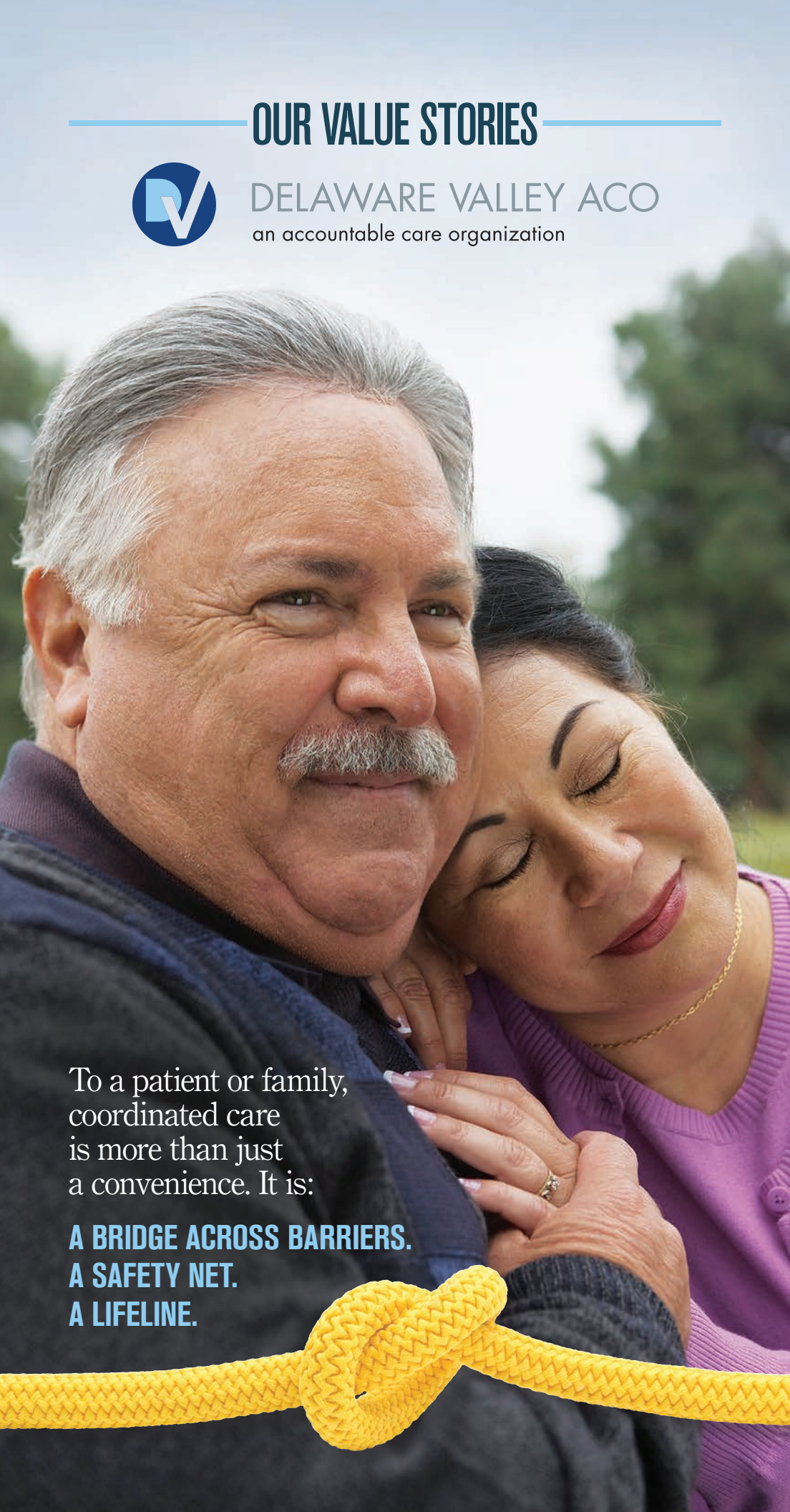
OUR VALUE STORIES

DELAWARE VALLEY ACO
an accountable care organization



To a patient or family,
coordinated care
is more than just
a convenience. It is:

A BRIDGE ACROSS BARRIERS.
A SAFETY NET.
A LIFELINE.

A MESSAGE FROM KATHERINE SCHNEIDER, MD, MPhil, FAAFP
PRESIDENT AND CEO, DELAWARE VALLEY ACCOUNTABLE CARE ORGANIZATION (DVACO)

SHARING OUR STORIES

Why produce a booklet about value stories?

One reason is that the role of an accountable care organization (ACO) is not as easily understood as that of a doctor or hospital or payer. Delaware Valley ACO (DVACO) is owned by two not-for-profit health systems whose shared mission is to improve the health of the communities they serve. This aligns well with our organization's purpose: to enhance the quality of health care and reduce the growth rate of health care costs in our region. Our role is to serve as a facilitator and accelerator for our participants as they move from a fee-for-service, volume-based system of care to a value-based model focused on population health. Together we are working to achieve the Triple Aim of better health, better care, and smarter spending.

WHAT IS AN ACO?

An Accountable Care Organization (ACO) refers to a group of providers and suppliers of services (e.g. hospitals, physicians and others involved in patient care) that work together to coordinate care for a defined population of patients (e.g. Medicare beneficiaries) with the goal of meeting or exceeding quality performance standards while also reducing the rate of growth in health care costs.

DVACO is one of the largest ACOs in the United States, serving a region where the cost of patient care is sometimes higher, and the health outcomes of our population lower, than in other areas of the country. Our story is not just the story of DVACO, but spotlights

SHARING OUR STORIES

a fragmented system of health care and the challenges and opportunities we share nationwide. Value stories help bring this narrative to life.

Our region is home to a multitude of trusted and acclaimed hospitals and clinicians who provide excellent patient care every day. Yet as a whole, our health system can often be overwhelming and disjointed. While there is high quality care taking place, it often happens in silos: within the walls of a hospital, at a physician's office, in a skilled nursing facility, and so forth.

Think about each part of the health care continuum as an individual piece of string. There is strength in each strand, but there is also potential for entanglement with other strands, knots that represent barriers to care, and areas of weakness where communication breakdowns can occur.

Most vulnerable are medically complex patients and those who are transitioning from one "strand" of care to another, where care coordination can make the difference between recurrent emergency room visits and hospital stays, and effective disease management with successful outcomes.

That's where we come in. DVACO is not a health plan. We serve as part of the care delivery system, working with our participating providers, payers, patient beneficiaries, and community resources to bring the many strands of our health care system together through care coordination, clinical initiatives and practice transformation. Those individual strands are now woven together into a single, cohesive unit, resulting in care that is more effective, efficient, and durable.

Our work is all about connection. We help connect primary care physicians and nurses to the hospitals, skilled nursing facilities, specialty providers, ambulatory centers and community resources that are caring for their patients. We use data and sophisticated algorithms to evaluate patient risk and connect the dots between evidence-based care protocols and better outcomes. And we connect directly with patients who require additional intervention to prevent them from slipping through the cracks.

It is increasingly acknowledged that social determinants of health are the primary drivers of outcomes. Factors such as housing, transportation, access to fresh food and clean water, employment, education and other concerns that affect health outcomes are now being recognized and addressed through care coordination and population health management.

Though our efforts are effective, they are not overnight fixes. Our current system of care evolved over decades, and its transition into a value-based model takes time. Population health is a living, breathing model of care with many moving parts, and as such, it can be difficult to fully grasp its importance and value.

Which brings us back to the question of why we are sharing our value stories. The answer is simple. We want people to understand the impact of our work. Not only from a provider perspective,

SHARING OUR STORIES

but from a patient's point of view. When it comes to the patient experience, seamless, coordinated care—the rope in our earlier metaphor—is more than just a convenience. To a patient or family, it is a bridge across barriers. A safety net. A lifeline.

We share our stories because they are more effective than graphs and data to explain what we are doing. In the following pages we will tell you how our team at DVACO collaborates with providers, facilitates practice transformation, and coordinates patient care—often working behind the scenes to serve a role the average person is unaware of. We will also share what we call our value stories—real life examples of how patients* and families have been positively impacted by the work that we do. These stories inspire our team every day. We hope they will do the same for you.

WHO IS DVACO?

The Delaware Valley Accountable Care Organization (DVACO)—the largest and most successful ACO in the greater Philadelphia region—is a limited liability company owned by Main Line Health and Jefferson Health. DVACO operates under the Medicare Shared Savings Program (MSSP) through an agreement with the Centers for Medicare and Medicaid Services (CMS).

Currently, DVACO is the region's largest Medicare ACO with:
- 670+ primary care physicians
- 86,000+ Medicare fee-for-service beneficiaries

In addition, DVACO holds performance-based contracts with four private payers, Aetna, United, Humana and our own health system employees, increasing our total number of beneficiaries to over 200,000 and enabling us to expand our population health capabilities to benefit non-Medicare commercially insured residents in our region. DVACO has consistently achieved high scores for quality. Visit dvaco.org for more information.

* Names and identifying details were changed to protect patient privacy.

VALUE STORY
NO TIME OFF FROM CHF

Scott,* a patient with congestive heart failure (CHF), returned from a vacation and was experiencing shortness of breath. He had not reported this to his doctor, but revealed it during a routine phone call with his DVACO care coordinator, who helped Scott avoid a visit to the emergency room by getting him in to see his doctor right away.

The doctor instructed Scott to take extra Lasix, a diuretic pill, in an effort to get rid of extra fluid in his body and bring his weight back down to his baseline.

The treatment worked. Scott's weight dropped, his shortness of breath went away, and he felt much better, with a lot more energy. The cause of the problem was traced to how he ate while on vacation. Like many people do when they travel, Scott embraced his time off as a chance to let go. He did not pay attention to his normal diet and not only consumed too much salt while he was away, he ate too much in general, leading to health problems upon his return.

Patient education is an important part of chronic disease management. When it comes to congestive heart failure, lifestyle changes such as losing weight, reducing sodium in your diet, managing stress and exercising can make a difference and improve your quality of life.

The care coordinator recognized this temporary setback as an opportunity for Scott to review his approach to self-care. They worked together to evaluate how Scott was managing his heart condition, discussed his diet and medications, and formed a plan for avoiding similar complications moving forward.

*Names and identifying details were changed to protect patient privacy.

PARTNERING WITH PROVIDERS

DVACO is committed to facilitating and enhancing patient-centered care. We do this by collaborating with our health system partners and other providers to meet our ACO goals. Under the direction of Chief Clinical Officer, Mitchell A. Kaminski, MD, MBA, our team utilizes clinical information and claims data to identify areas where we can improve the quality of patient care and achieve better outcomes and smarter spending.

Prior to the formation of accountable care organizations, claims information was only available to insurance companies. Today, our physician-led organization is able to use advanced information systems to support our primary care physicians (PCPs) by improving care, and making sure the care is the best option for the patient. In other words, care that follows guidelines that we know results in patients doing better.

Using information to improve care

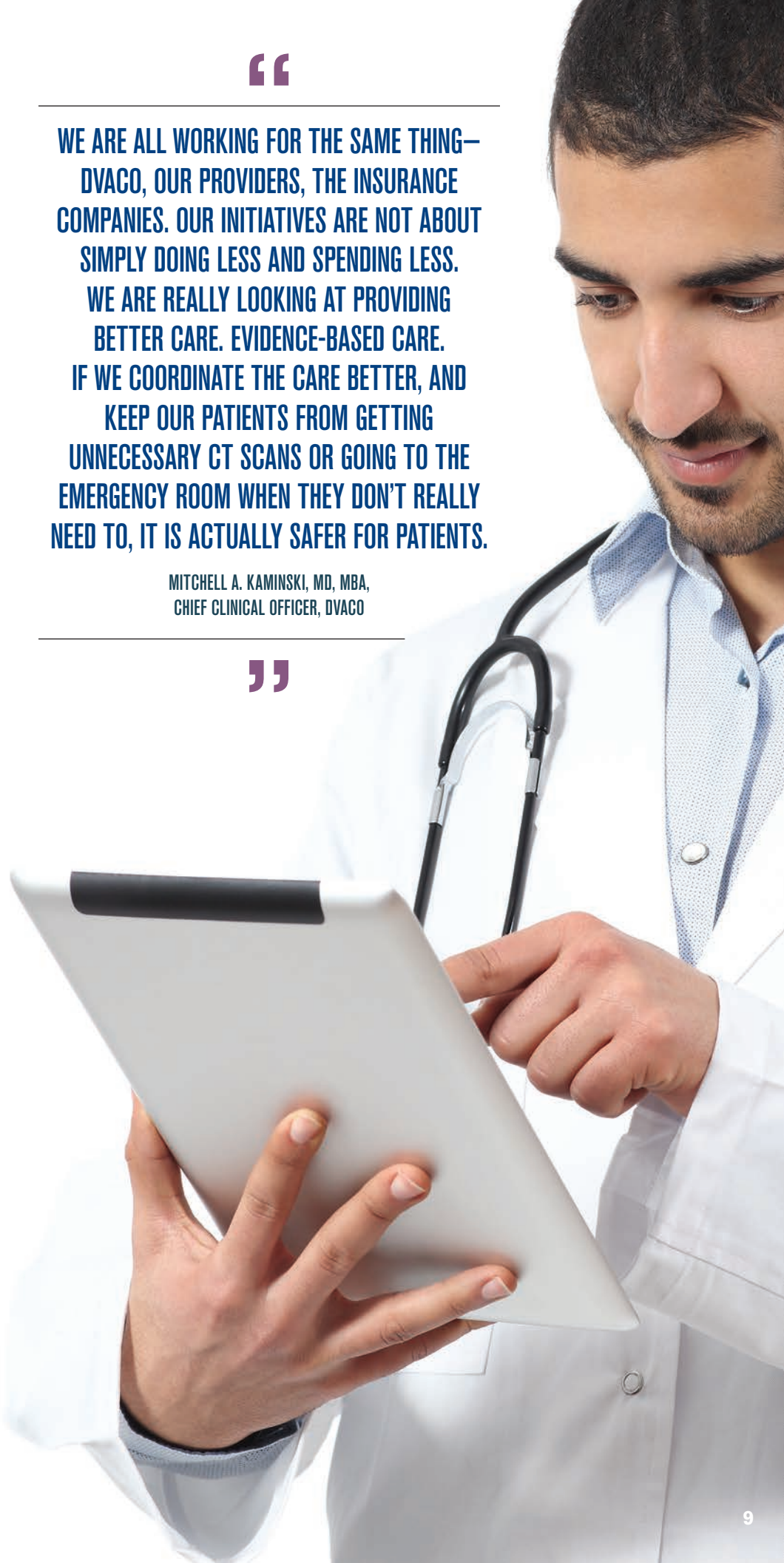
DVACO reviews claims information available through our contracts with the Centers for Medicare and Medicaid Services (CMS) as well as private commercial payers, Aetna, United and Humana, and uses that information to drive patient care initiatives. We also measure our performance in these areas to ensure quality and meet the reporting requirements for an ACO.

One such initiative is to make sure primary care physicians are seeing their patients for an annual wellness visit and offering preventive care measures such as health screenings and flu shots. If the patient has a chronic disease such as diabetes or hypertension, the PCP follows evidence-based guidelines to manage that condition. We then have the ability to look at test results and other claims data to know if the patient is being successfully treated or requires additional intervention.

Smarter spending

By comparing our performance to other ACOs, DVACO has recognized that we are in a high-cost area. The Philadelphia metropolitan area, like a lot of east coast cities, spends more on patient care than other parts of the country, without improved outcomes to show for it. This information helps us look more closely at those specific areas where we spend more, in order to determine how we can achieve smarter spending while maintaining high quality patient care.

> “WE ARE ALL WORKING FOR THE SAME THING—DVACO, OUR PROVIDERS, THE INSURANCE COMPANIES. OUR INITIATIVES ARE NOT ABOUT SIMPLY DOING LESS AND SPENDING LESS. WE ARE REALLY LOOKING AT PROVIDING BETTER CARE. EVIDENCE-BASED CARE. IF WE COORDINATE THE CARE BETTER, AND KEEP OUR PATIENTS FROM GETTING UNNECESSARY CT SCANS OR GOING TO THE EMERGENCY ROOM WHEN THEY DON’T REALLY NEED TO, IT IS ACTUALLY SAFER FOR PATIENTS.”
>
> MITCHELL A. KAMINSKI, MD, MBA,
> CHIEF CLINICAL OFFICER, DVACO



VALUE STORY
A CRITICAL CONFESSION

Having a trusted care coordinator in your corner can have a significant impact on a patient's health. Beth* was living with two chronic health conditions. Though she was under a doctor's care, her health was suffering, and her providers did not understand why.

After reaching out to Beth by phone and taking the time to get to know her, the DVACO care coordinator earned her patient's trust. Beth told the care coordinator that she felt like she cared about her situation. She then confided in her what she had been unable to admit to her own doctor: that she had not taken her prescribed medications, for either condition, in at least two years.

Upon hearing this confession, the care coordinator offered to partner with Beth to help her straighten out her medical situation and take back control of her health. First, she encouraged Beth to call her doctor and explain her current circumstances. The doctor got Beth into the office right away and immediately adjusted her medications to get her back on an appropriate drug regimen.

When a patient is unable or unwilling to comply with medication orders, there may be life-or-death consequences. In Beth's case, one of her prescriptions was blood pressure medication. Because the drug had seemed ineffective as originally prescribed, Beth's doctor had increased the dose, not realizing that the patient was ignoring instructions to take the drug. Had she started taking her blood pressure medicine at the higher strength, Beth may have put herself at risk for a stroke. Thanks to intervention by her care coordinator and help from her physician, the patient was able to get her treatment back on track.

*Names and identifying details were changed to protect patient privacy.

PARTNERING WITH PROVIDERS

We identified that we spend a lot more for post-acute care here than in other parts of the country. To address this, DVACO reached out to those nursing homes utilized most frequently by our patients, and invited them to participate in a preferred skilled nursing facility (SNF) network, provided they meet certain criteria. The SNFs in our preferred network must collaborate well with outpatient providers and receive good ratings by accrediting agencies. These facilities partner with us to spend smarter, communicate more effectively, and better coordinate patient care, resulting in a more responsible stewardship of community resources.

Another area we identified for improvement is pharmacy costs. In recent years, this issue has received news coverage highlighting the practice of pharmaceutical companies that create a generic version of a specific drug, buy the patent, then increase the price astronomically. To address this issue, we've established communications to our providers about better drug choices. One recent example is a diabetes pill formulated at a 1,000 mg dose that costs more than $2,650 per month. We alerted physicians that an alternate formulation (two 500 mg pills) costs $39 per month, with no discernable difference in quality.

Capturing accurate diagnoses

A corollary to following evidence-based guidelines for care is making sure that when providers submit bills for their care, they accurately detail the patient's diagnosis in order to set appropriate benchmarks.

Post-acute care: after a patient is in the hospital, if he or she is too weak to go directly home or requires additional care, that patient is sent to a post-acute facility such as a skilled nursing facility or rehabilitation center.

For example, if a physician is seeing a patient with diabetes, he or she could submit a bill that states the patient has type 2 diabetes. However, if the patient has type 2 diabetes with kidney disease or retinopathy (complications of diabetes), by including that information on the bill, Medicare or the commercial payer can recognize that patient as more medically complex. As a result, when establishing a benchmark for spending toward that patient's care, the payer—now aware of these complications—may allow more money to be spent on that patient.

Accurately capturing these detailed diagnoses requires extra training and work on the part of the provider. To support the PCP in this initiative, we developed educational tools for physicians and provide reports on the complexity of their patients.

PARTNERING WITH PROVIDERS

The importance of primary care

Primary care physicians are the key to achieving higher quality, better coordinated patient care and improving population health. Scientific literature provides ample evidence that a higher ratio of primary care to specialty services in a population correlates with better health outcomes and smarter spending.

Patients have relationships with their primary care doctors, placing PCPs in a position to influence behaviors and encourage healthy habits. It is the least expensive form of care as compared to specialty and inpatient care. At DVACO, we believe that when health issues are managed at the primary care level, before specialty or inpatient care is needed, it is better for the patient and more efficient for payers.

DVACO supports the primary care practices in our ACO through our Practice Transformation Team, which works closely with physician practices to help them smoothly transition from a fee-for-service reimbursement model to a value-based model, in which more of the revenue is based upon quality and outcomes metrics. Additional information about practice transformation can be found on page 22.

We assist practices that are working toward achieving Patient-Centered Medical Home (PCMH) recognition, help educate practices on the importance of electronic health record (EHR) optimization and quality reporting, and provide nurse care coordination for their more complicated patients.

In addition, we provide our primary care physicians with a broader perspective on how the health care market is evolving, what changes are required, and how the practice can achieve them. Most physicians are very busy with their day-to-day responsibilities, so by providing practice coaches and tools to help them meet these new challenges, we serve as a valuable resource and partner in improving care.

VALUE STORY
PRESERVING INDEPENDENCE

After a recent visit, Mary's* physician had a sinking feeling that her patient was unsafe in her home and needed additional intervention. The physician referred her patient for care coordination through DVACO.

Mary was 75-years-old and living alone in Section 8 housing. Though she had a good church base for support and several friends who looked in on her, her doctor was concerned that Mary's medical condition and living situation were putting her at an increased risk for a serious fall.

A social work care coordinator and a nurse care coordinator from DVACO conducted a home visit with Mary in order to assess her medical situation and living environment. The care coordinators talked to the patient to determine any barriers to care, physical limitations and needs for daily living. Living at home and maintaining her independence were Mary's primary goals of care.

Mary had a chronic, neurological disease that impaired her motor skills and muscle control. Though she was almost at a stage to be recommended for a wheelchair, the spirited senior insisted she could get around with the use of a walker and continued to drive on occasion, against recommendations.

Most recently, Mary was having difficulty pulling herself into a standing position from the chair she was sitting in, because her hands were so disfigured from her condition. Her attempts to leave her chair and retrieve items from another room had led to several falls, and her doctor was worried that she would seriously injure herself without help.

From talking with the patient, the care coordinators learned that while using her walker, Mary was unable to carry her meals from her kitchen into the living room, where she

(continued on page 14)

VALUE STORY
PRESERVING INDEPENDENCE

wanted to eat. Together, they came up with a list of daily activities for which Mary was in need of assistance; then the care coordinators got to work.

Within days, the social work care coordinator was able to connect Mary with a local volunteer program that would make a weekly delivery of seven meals to her home. The volunteers who make deliveries also stay for several hours to check in with patients and help with light household chores such as taking out the trash.

In addition, she referred Mary to the county's Office on Aging, which approved for her to receive services in the home, and arranged for her to be set up with a medical alert system that would call for help in the event of a fall. The social worker also found a charitable organization willing to help pay for a chair lift so that Mary would not have to worry about falling out of her chair when attempting to stand.

Working with Mary's physician, the two care coordinators got her a referral to receive physical and occupational therapy in her home and arranged to have the patient fitted for a child-sized walker, since her own was too big for her small stature. The walker was then modified with a tray on the front so that Mary could now carry her food from her kitchen into her living room at meal times.

Mary's care coordinators followed her progress for another six months. She did well, avoiding any falls or emergency room visits. Most importantly, she continued to live on her own thanks to the assistance and resources made available to her through partnerships with various community-based agencies.

*Names and identifying details were changed to protect patient privacy.

PARTNERING WITH PROVIDERS
TRANSFORMING PATIENT HEALTH THROUGH ROBUST PRIMARY CARE

The physicians who partner with DVACO are committed to fulfilling the promise of primary care by following best practices for patient care and population health. Two of the ways they are achieving this are through Patient-Centered Medical Home recognition and participation in the Comprehensive Primary Care Plus program.

PATIENT-CENTERED MEDICAL HOME (PCMH)

DVACO required all of our primary care practices to achieve recognition by the National Committee for Quality Assurance (NCQA) as a Patient-Centered Medical Home within two years. A PCMH is a model of care that takes a comprehensive, patient-centered approach, helping patients achieve the highest level of health and wellness through partnership, outreach, education and support.

Within a PCMH, staff members work as a team to provide comprehensive care that follows guidelines for optimal outcomes. Patients are encouraged to ask questions and take an active role in decision making, and have access to patient portals and other tools to help them stay better informed about their health. Physicians, nurses and staff take a proactive approach, reaching out to patients who are overdue for their annual wellness visit, coordinating specialty care, and providing assistance to those who need help managing chronic conditions.

COMPREHENSIVE PRIMARY CARE PLUS (CPC+)

Introduced by the Centers for Medicare & Medicaid Services (CMS), CPC+ is an innovative partnership between CMS, state Medicaid agencies, commercial health plans, self-insured businesses and primary care physicians, aimed at providing improved access to quality health care at lower costs. The five-year pilot program, launched in January 2017, provides primary care practices with additional resources to improve care coordination and support enhanced services on behalf of Medicare fee-for-service beneficiaries. Southeastern Pennsylvania was one of just 14 regions in the U.S. chosen for participation in the CPC+ initiative. Of the more than 2,900 primary care practices selected nationwide, over 100 are part of the DVACO.

CARE COORDINATION

DVACO's Care Coordination Team works with patients in collaboration with their primary care providers, specialists, hospital-based care managers, practice-based care coordinators, and a multitude of agencies, in an effort to reduce fragmentation of patients' care.

Our experienced team includes registered nurse care coordinators who focus primarily on patients of our independent physician practices—those practices not employed by Main Line Health or Jefferson Health—as well as a social worker who supports all of the practices within the DVACO.

Our care coordinators utilize sophisticated technology platforms to identify patients within the population who are most likely to benefit from enhanced care coordination. They also work with patients who are referred for assistance by the primary care physicians within our system.

In addition to the care coordinators employed by DVACO, care coordinators from Jefferson Health, Abington–Jefferson Health, and Main Line Health provide services to all of the employed practices within each health system. All of the care coordinators under the DVACO umbrella gather regularly to review best practices, share success stories and advice, answer questions, and troubleshoot issues.

The goal of all care coordinators is to serve as an extension of the primary care providers' staff. They provide outreach to at-risk or medically complex patients, helping to connect the various providers involved in a patient's care, so treatment is seamless, communication is improved, best practices are followed for optimal outcomes, and redundant tests and procedures can be avoided.

Care coordinators also help monitor the patient's transition of care from hospital to nursing home or home health, as well as to and from the patient's own home setting. This includes an evaluation of prescribed medications and discharge instructions, scheduling of follow-up appointments, and assessment of patient barriers to recovery. Our care coordinators then develop a care plan with the patient and primary care provider to help track the identified problems, goals and interventions.

> "WHEN A PATIENT OF OURS IS ADMITTED TO A REHAB OR SNF. . . I AM ABLE TO FOLLOW UP AND SEE IF THEY HAVE A CASE MANAGER OR ASSIGNED SOCIAL WORKER, AND CAN EVEN CALL THE PATIENT DIRECTLY TO LEARN DETAILS ABOUT WHAT'S GOING ON. I'VE SENT NURSE PRACTITIONERS TO VISIT PATIENTS AT HOSPITALS AND REHAB FACILITIES AND IN THEIR HOMES. PATIENTS APPRECIATE THIS DEEPER LEVEL OF CARE AND COMMUNICATION, AND OFTEN WE ARE ABLE TO WORK IN PARTNERSHIP WITH THESE FACILITIES TO AVOID COSTLY READMISSIONS AND IDENTIFY ADDITIONAL CARE NEEDS."
>
> SYLVIA CRUZ, BSN,
> CARE COORDINATOR FOR JEFFERSON FAMILY PRACTICE

VALUE STORY
GOING THAT EXTRA MILE

Care coordination can help a patient avoid a relapse or hospital readmission. This may be achieved by scheduling follow-up appointments, reviewing discharge instructions from a hospital or skilled nursing facility, or educating a patient about medications and self-care.

Other times, a care coordinator is most effective when advocating for a patient—helping an individual or family navigate a complex health care system, addressing barriers to care, or connecting them to community-based agencies that provide vital services.

Sam* had suffered a concussion caused by a fall. He needed to go to a specialized rehabilitation facility for outpatient concussion therapy, but was too dizzy to drive himself and did not have someone who could take him. He contacted a transportation service in his community, but because he lived outside of the designated zone, the company would not pick him up.

Sam had other health issues, and his inability to receive treatment for his dizziness was making matters worse. A social work care coordinator at DVACO contacted Sam and learned the patient had fallen several more times at home. It was time to get him into therapy.

"I heard about a gentleman with his own licensed transportation service, and I contacted him on Sam's behalf," said the care coordinator. "He was very kind and compassionate when he learned of the situation, and his cost was less than Uber or a cab."

The care coordinator put Sam in touch with the driver and the two worked out a schedule and rate. Sam began his concussion therapy and was delighted with his new arrangement.

*Names and identifying details were changed to protect patient privacy.

CARE COORDINATION

The tools of care coordination

DVACO's nurse care coordinators use an advanced population health management platform to identify at-risk patients based on claims history and clinical records. Every patient is assigned a risk category, which helps the care coordinator know which patients are at risk for medical complications and hospitalization.

Each morning, the care coordinators risk stratify patients and reach out by telephone to check on those who may need assistance. Karen Canning, Manager of the Care Coordination Team at DVACO, explained, "Using our data, we can look at each patient individually, flag anyone who was recently hospitalized, view their risk assessment page to determine their likelihood for readmission, and provide outreach as needed. We factor in how many chronic conditions they have, how many medications they are on, the number of providers that they are seeing, and more. Generally, the more complex a patient's medical situation, the higher the risk that not everyone involved in their care is aware of what the other providers are doing. As care coordinators, we help close these gaps of communication."

Care coordinators also monitor data feeds from HSX (HealthShare Exchange of Southeastern PA) which posts up-to-date information about patients who belong to DVACO. HSX was set up by a consortium of hospitals and health plans in the Philadelphia region and provides valuable information, including prompt notifications when patients are admitted, discharged or transferred (ADT) to or from acute hospitals, emergency departments, skilled nursing facilities (SNFs) and home care. Our care coordinators utilize a real-time alert system, which identifies additional DVACO patients, their primary care providers, and the care coordinators aligned with those providers, enabling admission sites to work in partnership with the patient's care team and fill in any omissions in the patient's care plan and medical history.

"With these alerts, we can make sure a care coordinator is following a patient while still an inpatient in our hospitals. This allows us to coordinate a plan of care with the patient and hospital discharge planner before the patient actually goes home, to ensure everyone is on the same page," said Canning.

Coordinating follow-up care

When a patient is discharged from the hospital, there is often a lot of information to review and pages of instructions to follow. One of the ways our care coordinators assist patients is to reach out to hospitals to request a copy of the patient's discharge instructions. With this information, the coordinator can review all of the instructions, including medication orders, with the patient and help coordinate follow-up visits with the primary care physician. The care coordinator also informs the primary care practice of the patient's situation, so care is not taking place in a silo, and any communication gaps are closed.

CARE COORDINATION
OFFERING PATIENTS A LIFELINE

Not all care coordination centers around medical intervention. DVACO's care coordination team includes social worker, Nikole Becker, MSW, a resourceful care coordinator who leaves no stone unturned when it comes to helping her patients address social determinants of health.

"Patients are referred to me by nurse care coordinators who, in the process of evaluating a patient, discover a barrier to care or recovery that I may be able to resolve. Sometimes a physician will request assistance with a patient who is struggling with issues in their home environment or is at risk for worsening medical problems due to circumstances that can be improved or reversed through social intervention," Becker explained.

Becker will occasionally visit a patient at home, accompanied by a nurse care coordinator, after clearing it with the primary care doctor. Most of her work takes place over the phone, reaching out to a wide range of government and community service organizations to arrange assistance for her patients. While these services–from food delivery to transportation, adaptive equipment to home repairs–are available directly to patients, it can be overwhelming for the average person to find and navigate these resources, let alone someone who is elderly or living with a disability or complex medical condition.

> "I WANT OUR PROVIDERS TO KNOW THAT NO ONE HAS TO STRUGGLE. OUR GOAL AT DVACO IS TO BRING VALUE AND COMPASSION AND ASSISTANCE TO EVERY PATIENT, SO IF THEY NEED HELP, LET US KNOW. LET US DO OUR JOB TO HELP THEM BE AS HEALTHY AS THEY CAN BE IN THE COMMUNITY AND IN THEIR HOME, AND HELP THEM AVOID GOING BACK INTO THE HOSPITAL."
>
> NIKOLE BECKER, MSW,
> CARE COORDINATOR–SOCIAL WORK, DVACO

Becker serves as an advocate and voice for her patients, connecting them to resources and services they may otherwise be without. To her patients, she is nothing less than a miracle worker, providing assistance to improve their quality of life, removing barriers to care, and letting them know that they are not alone.

VALUE STORY
REMOVING BARRIERS TO CARE

Care coordinators manage a variety of situations on behalf of their patients, including identifying and removing barriers to care. Among the more common challenges that can interfere with patient care are lack of transportation or financial concerns. Occasionally, they discover something completely unexpected.

Such was the case with Patricia,* a patient who was battling cancer but had been missing her chemotherapy sessions of late. Patti's care coordinator was unable to determine why she was not showing up for treatments, even after speaking with her on the phone. Then the care coordinator had an idea.

"If I could magically do one thing for you, what would it be?" she asked.

"I have bed bugs," Patti confessed.

"A lot of people do," the care coordinator said. "How bad are they?"

"Pretty bad," Patti answered.

It turned out that Patti was hesitant to go to chemotherapy because she was too embarrassed to risk transmitting bed bugs from her home to the facility, and she couldn't afford to hire an exterminator.

The care coordinator made a call to a home advisor to ask if he knew of any exterminators who had done work for charity. He gave her three numbers to try. Upon hearing Patti's story, the first exterminator on the list generously agreed to donate two professional treatments to rid her house of the pests. With this obstacle removed, Patti was able to resume chemotherapy and focus once more on her health.

*Names and identifying details were changed to protect patient privacy.

PRACTICE TRANSFORMATION

The Practice Transformation Team at DVACO provides ongoing, hands-on training and support to the independent primary care practices in our ACO. Each physician office is assigned to a Practice Transformation Coach who works closely with practice managers, physicians and other staff to assist them as they transition to a value-based model.

This support may take the form of education about the tools used for population health management and reporting, reminders of important deadlines for data submissions, workflow solutions to optimize billing and operations, quality improvement initiatives, or recommendations for improving patient satisfaction scores.

Our coaches regularly meet with the providers on site or via webinar, at intervals determined by the specific needs of each practice.

The employed physician practices in our ACO (under Main Line Health and Jefferson Health) benefit from Practice Transformation initiatives as well. These practices are assigned a practice transformation lead who is employed by the corresponding health system. These leads meet monthly with the coaches at DVACO in order to compare best practices, discuss challenges and questions, and share templates and tools.

"Often, learning what works or doesn't work for one practice will yield a solution for another practice of a similar size," explains Kara Barnes, Practice Transformation Manager at DVACO.

Expertise in a changing industry

Most physician practices are extremely busy managing the day-to-day business of patient care. For these providers, Practice Transformation Coaches deliver an invaluable service, making it possible for them to keep current in an ever-changing industry—from receiving the latest updates on CMS regulations or diagnostic codes, to learning the newest technology for collecting and tracking quality indicators, to transitioning from paper records to electronic. DVACO's team is dedicated to staying at the forefront of these changes to provide real-time guidance and support for each practice.

Our expertise includes:

• Technology

We help practices to utilize their electronic medical record (EMR) from basic training through optimization, assisting the staff in understanding the features and benefits of their system.

• Clinical quality measures

We work closely with providers to help them close gaps in care, using tools to identify patients who are overdue for visits or screenings. We also coach practices on how to respond proactively to any areas for improvement that may be revealed in patient surveys, such as wait times or communication.

• Optimizing operations

We work closely with practices to enhance operations by optimizing workflows and keeping them apprised of new health care programs and requirements.

• The road to Practice Transformation

We provide hands-on support to practices that are working to achieve NCQA recognition as a Patient-Centered Medical Home (PCMH). Our team also supports practices selected for the CPC+ program by hosting collaborative webinars for practices to discuss questions, challenges, and lessons learned.

VALUE STORY
EMPOWERING SELF-CARE

William,* a 58-year-old male with a diagnosis of heart failure, hypertension and sleep apnea, was referred for care coordination following a two-day hospital admission. After contacting the hospital case manager, the nurse care coordinator learned that home care nurse visits and telemonitoring had not yet been set up for the patient because he planned to return to work. It was determined that William would benefit from outreach and patient education.

After multiple attempts, the care coordinator was able to reach William by phone. He was very receptive to the idea of care coordination. They began with a comprehensive assessment of his medical, work and living situations. The care coordinator learned that William had returned to his job, only to work half a day and realize he was exhausted. His goals were not only to eventually return to work, but also to get strong enough to travel the four-hour journey to visit his son and grandchildren.

His care coordinator took the time to review William's understanding of heart failure management and taught him how to monitor himself daily, how to report his findings and to whom, and what to do if he became symptomatic. Together they went over his list of medications, and the care coordinator encouraged William to move up his next doctor's appointment so he could discuss with his physician his concerns about possible overexertion.

With the patient's permission, the care coordinator emailed William's primary care physician and provided a brief outline of his hospitalization and discharge plan, as well as the name and phone number of his cardiologist, in order to foster collaboration amongst his PCP, cardiology team, and other health care providers.

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VALUE STORY
BREATHING EASIER

Jessica* was referred to a DVACO nurse care coordinator to assist with her transition home following a two-day hospital admission for an asthma exacerbation.

Jessica's initial concern was that she would run out of the asthma medication she started using in the hospital, before her follow-up appointment with her pulmonologist. The care coordinator instructed Jessica to call the doctor, who refilled it for her immediately.

The patient also expressed concerns about feeling jittery and experiencing insomnia and heart palpitations. The care coordinator talked to her about the side effects of the medication she was taking and explained what to expect during the tapering process. Once she finished her course of the drug, her symptoms resolved.

The care coordinator continued reaching out to Jessica to check on her recovery. Together they reviewed all of her medications and discussed the purpose of each one. The patient had edema (water retention) of the hands and feet and was taking a diuretic she had left over from the year before. The nurse explained the importance of checking in with her primary care physician (PCP) before taking any medications not currently ordered for her.

They discussed Jessica's long-term battle with depression and options for managing the condition, which had gone unreported to her current doctor and untreated for years. She was also referred by her care coordinator for a recommended cancer screening.

Finally, they talked about the patient's ongoing sleep apnea and her inability to use a CPAP (continuous positive airway pressure) device after an unsuccessful attempt three years prior. The care coordinator encouraged Jessica to discuss

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VALUE STORY
BREATHING EASIER

it with her pulmonologist, who recommended she see a sleep specialist. The sleep specialist ordered Jessica a newer device to try instead. Her care coordinator partnered with the patient's insurance company to make sure Jessica understood her benefits and received the equipment she needed to treat her condition.

Jessica's case is a reminder of the value of care coordination. Though she is independent and capable of managing her own care, the patient benefited from having a nurse to answer her questions, educate her about her prescriptions, and help her navigate next steps in her care.

As a result, Jessica is now better informed about her medications, has been successfully treating her sleep apnea, is back in therapy to address her depression, is scheduled for a colonoscopy, and has had no readmissions for her asthma.

*Names and identifying details were changed to protect patient privacy.

VALUE STORY
EMPOWERING SELF-CARE

William spoke with his employer and applied for short-term disability, while the care coordinator worked with William's cardiology team to set up home care nurse visits and telemonitoring. She even arranged to provide him with a scale so the patient could monitor his own weight at home. Finally, the coordinator suggested that William set up his home voicemail in order to make it easier for his care team to reach him moving forward—which he did.

Through periodic follow-up calls, the care coordinator learned that William successfully completed his home care and telemonitoring program, continues to monitor his own weight, and follows up regularly with his heart failure nurse practitioner and cardiologist. He even became part of a medical study under the care of his cardiologist. William has returned to work part time, and has had no recent hospital admissions or emergency room visits.

His nurse care coordinator will continue to provide patient outreach and collaborate with his other health care providers to help William manage his heart failure and to support and improve his quality of life.

TELEMONITORING:
the use of technology that enables health care providers to monitor a patient's medical condition, such as heart failure, from a distance. Patients enjoy the comfort and freedom of being in their own homes, while having peace of mind knowing that any abnormalities will trigger a response by the health care team.

*Names and identifying details were changed to protect patient privacy.

VALUE STORY
DELIVERING SUSTENANCE

Barbara* had received assistance from a nurse care coordinator during a rough period of illness, including a trip to the emergency room for a suspected bowel obstruction. Now that she had gotten through her immediate health crisis, Barbara faced an ongoing issue that put her health at risk–she lived alone and lacked access to food.

DVACO's social work care coordinator connected Barbara to a community organization that provides home-cooked meals to individuals who are isolated and homebound. With one meal a day now covered, they discussed options for closing the remaining gap.

Shopping for food was too physically taxing for Barbara, so the care coordinator suggested that she try ordering groceries from the supermarket and having them delivered. When Barbara tried to order by phone, she learned that the store would only accept online purchases, and she did not own a computer.

The care coordinator announced to her patient, "Okay, get comfortable. We are going to order your groceries." With Barbara on the phone, she went to the supermarket's website and proceeded to place an order for delivery.

"Sometimes it's the little things that make the biggest difference," says the care coordinator. "Now, every month I get a call from Barbara when she is ready to place her order. She reads me her list and I do the actual ordering from my computer. It keeps Barbara healthy, and she no longer has to worry about going hungry or getting to the store on her own." ●

*Names and identifying details were changed to protect patient privacy.

VALUE STORY
MAKING CONNECTIONS

Mike* was initially contacted by a nurse care coordinator to help him manage diabetes. Her intervention opened the door for him to seek support for other medical concerns as well.

Mike reported that he had been experiencing hypoglycemic (low blood sugar) episodes almost daily, and was having problems with his insulin. He had reached out to his endocrinologist's office but had not yet heard back. With Mike's permission, his care coordinator called the specialist, who followed up with Mike immediately. His next appointment was also moved to that same day, after the doctor reviewed data that Mike downloaded from his pump.

Mike told his care coordinator that he wanted to quit smoking. She connected him to a smoking cessation program offered through his employer, and he registered for a class. The care coordinator also spoke with a pharmacist to discuss cost saving options and the insurance requirements to get Mike approved for a prescription drug to help with smoking cessation.

Mike visited his primary care physician and reviewed all of the concerns he had been discussing with his care coordinator, so everyone would be on the same page.

He expressed additional health concerns with his care coordinator, including his desire to see a counselor because of stress. The coordinator connected Mike to an employee assistance program and he began counseling.

Mike had also been having gastrointestinal symptoms and scheduled an overdue colonoscopy. Finally, the care coordinator referred him to a social work care coordinator for assistance with financial concerns. ●

*Names and identifying details were changed to protect patient privacy.

About Delaware Valley Accountable Care Organization:

The Delaware Valley Accountable Care Organization (DVACO)—the largest and most successful ACO in the greater Philadelphia region—is a limited liability company owned by Main Line Health and Jefferson Health, with around 2,000 participating physicians. DVACO's purpose is to enhance the quality of health care and reduce the growth rate of health care costs by acting as a convener, accelerator, and provider of the foundation needed to assist its participating members to transition from a fee-for-service model, a business model focused on volume, to a model focused on value-based care and population health. DVACO operates under the Medicare Shared Savings Program (MSSP) as well as multiple private payer contracts.

About Main Line Health

Founded in 1985, Main Line Health is a not-for-profit health system serving portions of Philadelphia and its western suburbs. At its core are four of the region's respected acute care hospitals—Lankenau Medical Center, Bryn Mawr Hospital, Paoli Hospital and Riddle Hospital—as well as one of the nation's premier facilities for rehabilitative medicine, Bryn Mawr Rehabilitation Hospital; Mirmont Treatment Center for drug and alcohol recovery; and Main Line Health HomeCare & Hospice, a home health service. Main Line Health also consists of Main Line HealthCare, one of the region's largest multi-specialty physician networks, and the Lankenau Institute for Medical Research, a non-profit biomedical research organization located on the campus of Lankenau Medical Center. Main Line Health is also comprised of five outpatient health centers. With more than 10,000 employees and 2,000 physicians, Main Line Health is the recipient of numerous awards for quality care and service.

About Jefferson

Jefferson, located in the greater Philadelphia region and southern New Jersey, is reimagining health care and education to create unparalleled value. Jefferson is 28,000 people strong, dedicated to providing the highest-quality, compassionate clinical care for patients, preparing tomorrow's professional leaders for 21st century careers, and discovering new treatments to define the future of care. With a university and hospital that date back to 1824, today Jefferson is comprised of nine colleges and four schools offering 160 undergraduate and graduate programs, 13 hospitals, over 50 outpatient and urgent care locations throughout the region, serving more than 7,800 students and millions of patients annually.

DELAWARE VALLEY ACO
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