westhealth

Forging Aligned Partnerships Between Value Based Care Organizations & Geriatric Emergency Departments:

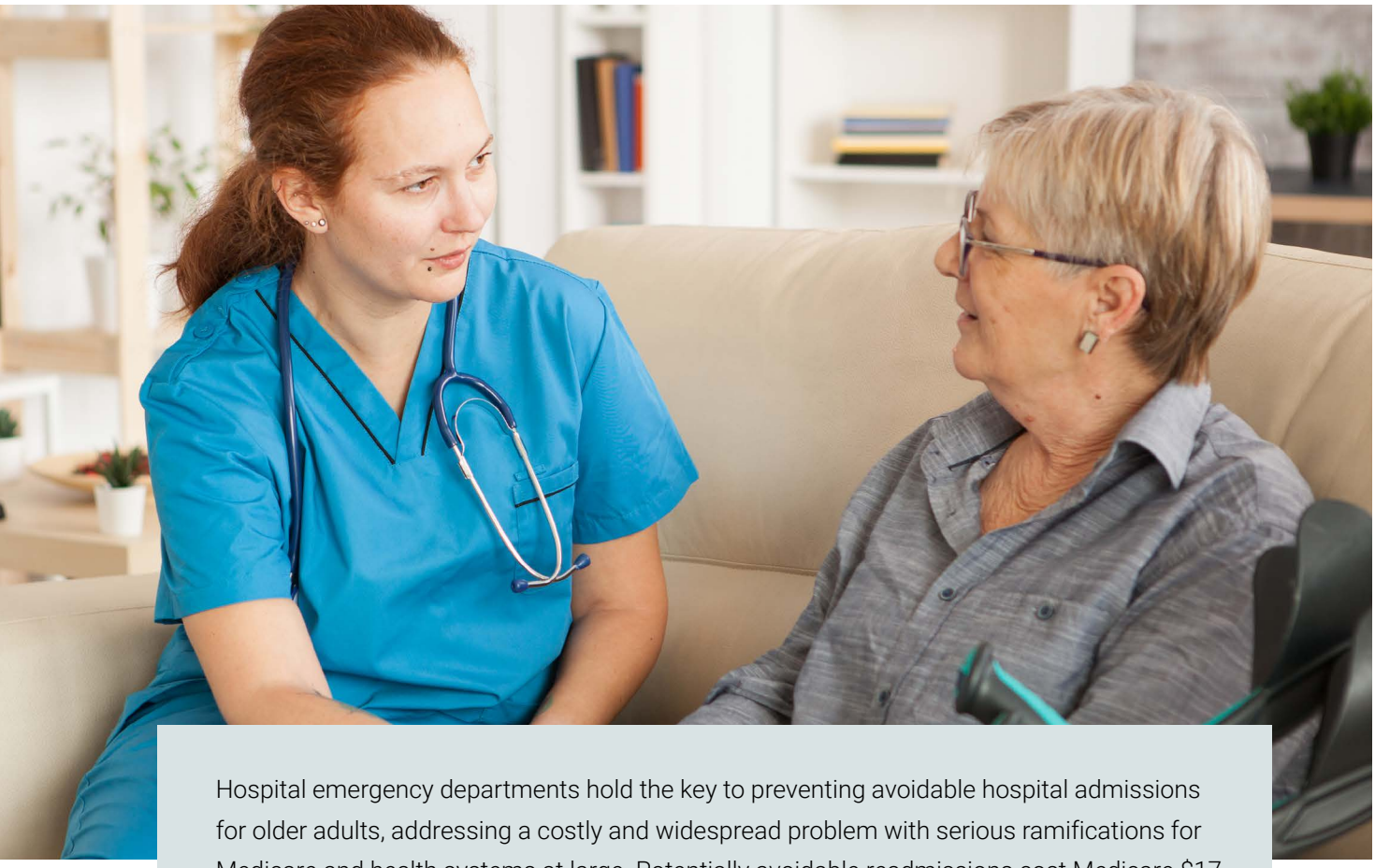
A Toolkit for Geriatric Emergency Departments

This resource was developed and funded by the West Health Institute, a nonprofit applied medical research organization. West Health collaborates with top researchers and academic institutions to explore and validate innovative care models that reduce healthcare costs and enhance care for older adults.
Learn more at westhealth.org

westhealth

Table of Contents

Executive Summary

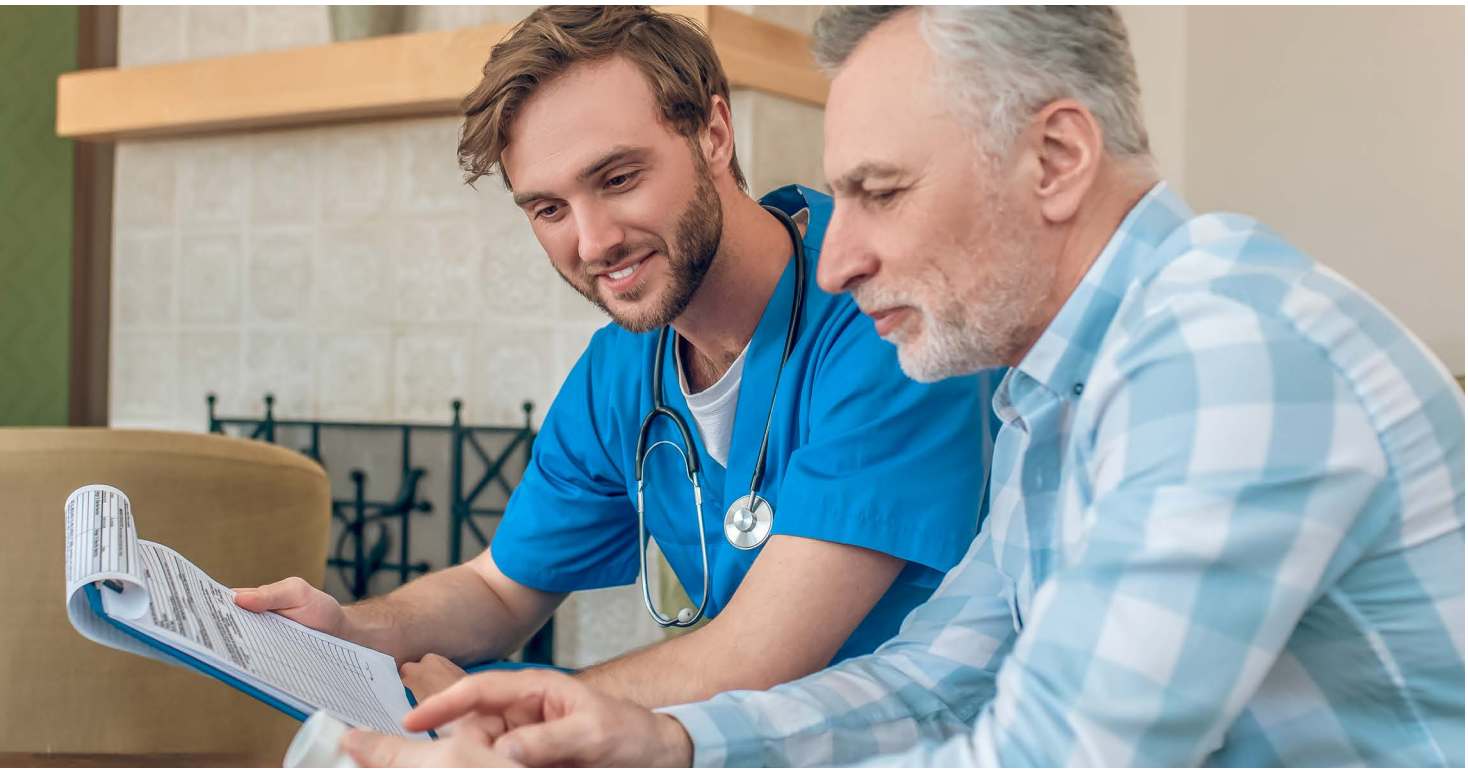


Hospital emergency departments hold the key to preventing avoidable hospital admissions for older adults, addressing a costly and widespread problem with serious ramifications for Medicare and health systems at large. Potentially avoidable readmissions cost Medicare $17 billion a year[1], in large part because they're so common. Seventy-three percent of hospital readmissions from skilled nursing facilities are rated as potentially avoidable[2], as are 63% of hospital readmissions from long-term care settings[3]. Emergency departments (ED) play a central role in the trend; a recent study found that hospital EDs account for nearly 60% of hospital admissions for older adults and, increasingly, also serve as an advanced diagnostic center for primary care providers (PCP)[4]. As a result, reducing potentially preventable ED visits and subsequent hospitalizations or readmissions has become a priority for Medicare and Value-based Care Organizations (VBCOs)[5]. Despite these efforts, Medicare beneficiaries continue to seek care in EDs for non-emergent, primary-care treatable, and preventable or avoidable issues.

Emergency physicians are typically limited to three disposition options: 1) admission, 2) discharge with recommendations for follow up, or 3) observation for a time, then a decision to admit or discharge. VBCOs may be able to provide additional disposition options or outpatient resources that ED clinicians are not aware of or do not know how to easily access, such as acute care at home[6] which is why partnering could be so valuable. With policies and protocols specifically designed to support older adult emergency care[7], Geriatric Emergency Departments (GEDs) accredited by the American College of Emergency Physicians (ACEP) are well suited to partner with VBCOs to ensure each older adult receives the post-ED care plan best suited to his/her goals of care and clinical needs.

GEDs are well positioned to forge aligned partnerships with VBCOs to connect clinical operations to outpatient resources available through the VBCO. Such partnerships could reduce unnecessary admissions and improve transitions of care back to VBCOs and primary care providers. Like GEDs, VBCOs are motivated to ensure patients receive care in the setting best matched to the patient's needs. Due to the influx of patients going to the ED in recent years, EDs are also driven to reduce time spent in the ED and get patients back home, when possible.

This Toolkit and associated resources lay out an approach for GEDs to forge aligned partnerships with their local VBCO. The Toolkit proposes a framework for GEDs to understand their local VBCO capabilities and key stakeholders, mobilize action, move towards partnership, remove barriers to partnerships, and launch collaborative projects.



Introduction

Value-Based Care (VBC) is a healthcare reimbursement model that is based on quality of care rather than quantity. VBC is a relatively new concept that was first proposed in 2006 by Professors Michael Porter & Elizabeth Teisberg in their book, Redefining Health Care, which argued that our healthcare system should be organized in a way that compensates providers for delivering value to patients.

Providing payment based on the value of care is common throughout the world, but is relatively new to the United States, which has historically utilized a fee-for-service payment model. In the fee-for-service model, healthcare providers charge the insurer (e.g., Medicare) a fee for each service provided. Under this payment model, providers are financially incentivized to prescribe more services than may be necessary to result in more reimbursement. This leads to increased cost without the guarantee of better quality care.

VBC is a fundamentally different reimbursement model from fee-for-service. Reimbursement is tied to positive patient outcomes and therefore incentivizes reducing spending, decreasing avoidable hospitalizations and increasing outpatient resources. There are four main types of value-based care reimbursement models:

1. **Performance Based Payment:**

   Payment based on achievement of certain quality metrics or completion of specific activities.

2. **Bundled Payment:**

   Instead of paying for each individual service, such as a hospital stay/office visit/physical therapy, payments are lumped together (i.e: "bundled")

3. **Shared Savings & Risk:**

   Provider organization paid using the traditional fee-for-service model but at year's end, total spending is compared against a target. If spending is below target, the provider keeps the difference. If spending is above the target, the provider must pay a penalty.

4. **Capitation:**

   Provider organization receives a fixed payment (i.e: "per member, per month"), intended to pay for all an individuals care, regardless of what healthcare services they use.

Many factors have influenced the move towards VBC. First, the older adult (65+) population has grown by over a third (34.2% or 13,787,044) since 2010[8], driven by a variety of factors including the aging of those born during the 'baby boom' (mid-1946 to 1964), increased longevity, and lower rates of fertility[9]. Additionally, older adults

have more complex, chronic conditions than ever before. As of 2014, 60% of American adults had at least one chronic condition and 42% had more than one[10]. Taken together, the increase in the older adult population and complex, chronic condition state has led to an exorbitantly high cost of healthcare in the United States. In 2022, U.S. healthcare spending reached $4.5 trillion[11].

High costs do not lead to better patient outcomes[12] and high cost is not fiscally sustainable for Medicare, the U.S. federal health insurance program for those aged 65+. Based on current projections, the deficit facing Medicare totals $247 Billion between 2028 and 2031[13]. Medicare insolvency and low quality of care are the largest driving forces behind the Center for Medicare and Medicaid Services (CMS)'s recent goal to ensure that 100% of Medicare beneficiaries are to be in value-based care arrangements by 2030[14].

VBC is primarily implemented through Accountable Care Organizations or ACOs. ACOs are groups of healthcare organizations, physicians and other providers that work together in a network to provide coordinated, holistic care to patients. There are many different types of ACOs, most created by the federal government. Some of them include Medicare Advantage (MA) or Medicare Shared Savings Plans (MSSPs). For more detailed information on the various types of ACOs and their associated payment models, check out: All About ACOs. Additionally, a glossary of common VBCO abbreviations, terms, definitions, and key performance indicators is included in the Appendix.

In 2023, there were 456 MSSP ACOs caring for 10.9 million beneficiaries, making MSSP ACOs the dominant value-based payment program in the United States[15].

Due to its prevalence, an analysis of Medicare claims data was conducted to understand the overlap between Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACO) and Geriatric Emergency Departments. The analysis concluded that:

- 45% of patients receiving care at a GED are MSSP ACO beneficiaries (a 27.7% increase from 2019)
- All 315 (100%) of GEDs treat a minimum of 100 MSSP ACO unique beneficiaries annually
- 74 (23.5%) of GEDs treat a minimum of 1,000 MSSP ACO unique beneficiaries annually

In other words, clinicians within Geriatric Emergency Departments are treating patients in VBCOs. It is important to note that the analysis only included MSSP ACOs. Therefore, the number of patient visits conducted within GEDs for VBCO beneficiaries is likely significantly higher.

Knowing that VBC beneficiaries are receiving care in GEDs, we believe that VBCOs and GEDs can forge aligned partnerships to improve the cost and care trajectory for older adults by reducing unnecessary admissions and improving transitions of care.

To exemplify the impact of such a partnership, let us consider a real-world case: JR. JR is an 82-year-old retired electrical engineer and substitute math teacher, devoted husband of 62 years, father of 6, grandfather of 17, and great grandfather of four. JR was an avid fan of Notre Dame sports, fly fisherman, mountain climber, marathoner, and devout Catholic.

JR's health issues include:

- Chronic kidney disease and a successful transplant managed with an anti-rejection medication regimen.
- Heart disease with three stents; managed with an anti-platelet inhibitor, baby aspirin, beta blocker, statin, and calcium channel blocker.
- Advanced Parkinson's with bouts of dementia; PK symptoms managed with Sinemet.
- Aggressive advanced metastatic skin cancer; daily niacinamide for prevention.

JR was doing well and in a period of less than two years, had eight hospital admissions; **seven were preceded by visits to an ED.** The below encounters occurred under the care of eight physicians in *three different health* systems within the same metropolitan area. JR's hospital visits included:

- Three cardiac related admissions were treated medically with stents.
- Three falls related admissions: one with intensive care, and two followed by post-acute rehabilitation admissions.
- Dehydration and low blood pressure resulting in a week-long admission, delirium, and antipsychotic administration causing disposition delays.
- Planned admission for radical skin cancer surgery (delirium prolonged stay).
- Two observation stays.

Imagine JR is a patient within your GED and is also a VBCOs beneficiary. **What opportunities do you see where interventions might have been made to avoid hospitalization, better coordinate care, improve JR's outcomes, enhance his and his family's experience, and lower his cost of care?** Has the VBCO been considered as an impactful partner to reduce JR's potentially avoidable admissions?

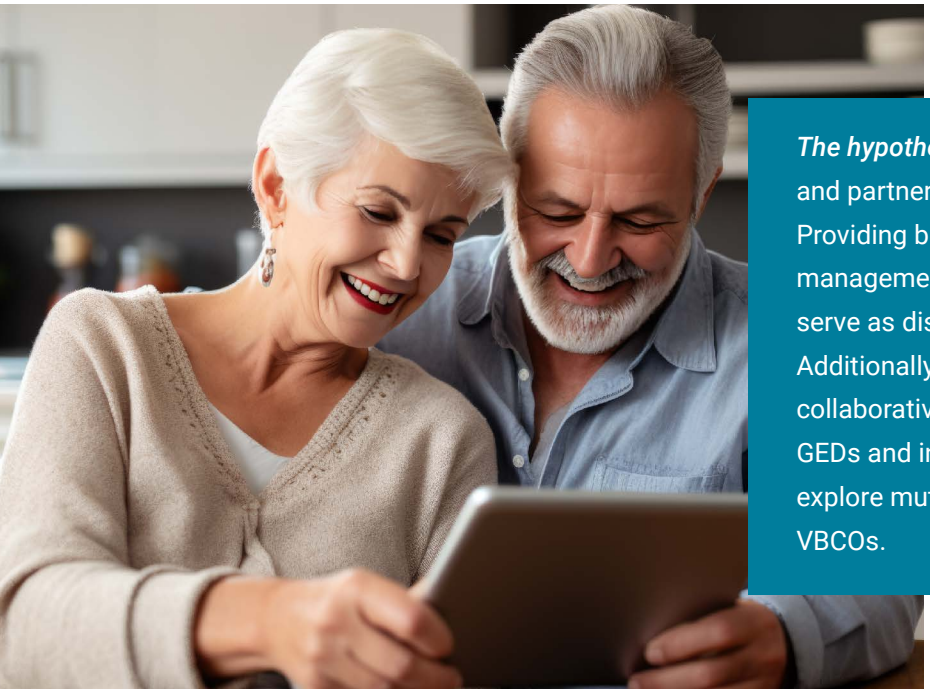
Imagine what it would mean to have an aligned partnership between your GED and JR's VBCO. Imagine a partnership where JR's VBCO care manager was notified when JR presented at your GED and was engaged in the ED visit alongside JR. The VBCO care manager would have been able to inform the GED care team of JR's medical history in detail, including his baseline mental status, potentially assisting to detect JR's delirium at an earlier stage and thereby preventing or shortening a hospital admission. Prior to the decision to admit, the VBCO care manager would have been able to provide the GED care team with background and contact information regarding JR's family, community supports, and home environment, thus enabling the best care pathway for JR. **Most importantly, the VBCO may have access to alternative dispositions** for JR, such as enrollment in a hospital-at-home program or same-day clinic follow-up. Working with JR's VBCO team may have avoided an unnecessary admission and/or reduced ED use.

Would it be fair to say that, if such partnerships existed, some of JR's hospital admissions might have been avoided? In the case of his cardiac events, the severe fall with head injury and skin surgery admissions, probably not. However, a few other admissions may have been preventable or avoided. If a VBCO was able to partner with the GED clinicians overseeing JR's care in the GED prior to the decision to admit, perhaps some of these hospitalizations could have been avoided. We believe such partnerships are impactful enough to change JR's care trajectory and avoid unnecessary admissions.

Purpose

The purpose of this Toolkit is to provide a structured approach and operational resources to aid GEDs in partnering with local VBCOs. The goal of the Toolkit is to foster meaningful connections and provide a framework for GEDs to take actionable steps to build a collaborative project with a VBCO.

Each GED and VBCO collaboration will look different based on the configuration of the delivery system in your area, the needs of older adults in the community, the capabilities of the local VBCO and the current state of understanding between both groups.



The hypothesis: there are clear areas for opportunity and partnership between GEDs and VBCOs. Providing bi-directional education or creating a care management connection are key first steps and can serve as discrete collaborative projects themselves. Additionally, we lay out some ideas for potential collaborative projects in the Appendix but encourage GEDs and individuals to fully leverage this Toolkit to explore mutually beneficial pilot projects with VBCOs.

Although the Toolkit is laid out in a simple, linear process, it's understood forging partnerships can be messy and occur over longer periods of time than what is proposed. For instance, if conducting a meeting is suggested, there may be preparatory or follow-through conversations that may need to take place to fully enable success.

The approach in the Toolkit is structured loosely on the Institute for Healthcare Improvement's Model for Improvement and Dr. John Kotter's 8-Step process for leading change, in an effort to blend healthcare process improvement and business management into an easy-to-use guide. The materials include practical tools, templates, and other resources to aid you in the journey.

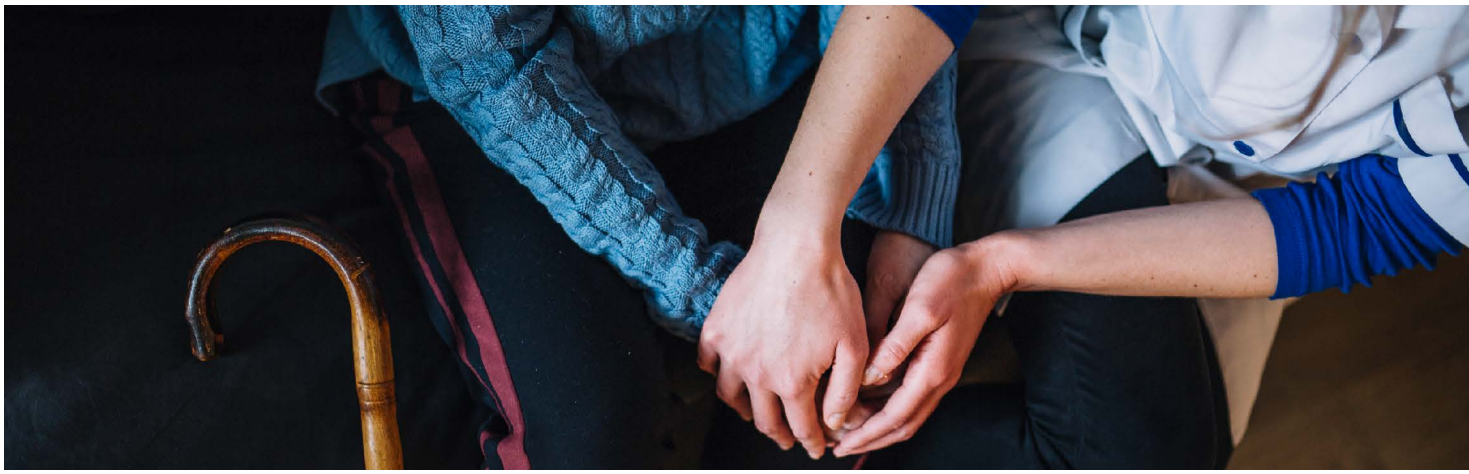
What makes Value Based Care Organizations compatible with Geriatric Emergency Departments?

Sixty percent of older adults admitted to the hospital come through the ED[16]. On average, a hospital admission for an older adult costs a minimum of $14,900 more than if the patient had been discharged to an alternative setting, such as the home[17]. GED physicians have the ability to make decisions that tremendously impact the cost, quality, and trajectory of the patient's entire care experience. VBCOs are highly incentivized to partner with GEDs to lower costs, improve quality and improve the patient experience.

Literature demonstrates that VBCOs can:

- Lower cost[18]
- Reduce hospitalizations[18]
- Improve care quality[19]
- Improve the patient experience[20]
- Reduce unnecessary or redundant treatment[21]
- Improve care coordination[22]

GEDs and VBCOs are motivated to help patients receive needed care in an outpatient setting (oftentimes their own home) when admission is not necessary. As emergency physicians typically are limited to dispositions of admission, discharge with recommendations for follow up, or observation to assist with the decision to admit or discharge, partnering with VBCOs may be especially attractive to enable additional disposition options due to VBCO-provided outpatient resources, such as medical services and therapies provided in the home. Partnerships can help make these options known and easy to access.



Missed Opportunities: GED clinicians are treating VBCO beneficiaries

In collaboration with the Institute for Accountable Care, the West Health Institute conducted an analysis to determine the degree to which Medicare Shared Savings Program (MSSP) ACO beneficiaries were seeking care in GEDs. The analysis revealed that in 2022:

- 45% of patients receiving care at a GED are MSSP ACO beneficiaries (a 27.7% increase from 2019)
- All 315 (100%) of GEDs treat a minimum of 100 MSSP ACO unique beneficiaries annually
- 74 (23.5%) of GEDs treat a minimum of 1000 MSSP ACO unique beneficiaries annually

Of note, the above analysis focused on 2021 ACOs and used Q1 2021 provisional MSSP attribution. These figures do not include Next Generation ACOs or Direct Contracting entities as these program claims were not yet available to researchers. Therefore, the true values for the number of patients receiving care in GEDs is known to be significantly higher when accounting for all types of VBCOs.

In short, GEDs are treating VBCO beneficiaries right now. There are natural synergies between the work and outcomes associated with GEDs and value-based care that should be explored. Below, we lay out a framework and tools for forging an aligned partnership with the VBCOs providing benefits to your older adult patients.

Framework and tools to partner with your local Value-based Care Organization(s)

There are two key building blocks to enhance successful partnerships:

1 Bi-Directional Education:

Create a shared understanding of the GED model, the VBCO's risk-based arrangement, and knowledge of both the VBCO's and GED's unique capabilities, goals, key outcomes, and performance metrics. Bi-directional education will be required to create this shared understanding and could take the form of in-person or virtual meetings, presentations and/or training sessions, webinars, online modules, or other engaging educational delivery methods.

2 Care Management Connection:

Create a mechanism by which GEDs and VBCOs can share real-time patient status. Such a connection will help GED clinicians know when they are treating a patient in a VBCO arrangement, and will help VBCOs understand when patients present in the GED. Only when a care management connection exists will GED clinicians and VBCO representatives be able to work collaboratively to reduce unnecessary admissions and improve transitions of care back to the primary care provider and community-based VBCO services. More about creating a care management connection is in the 'Remove Barriers' section of this Toolkit.

Below are four steps to begin the process of creating mutually beneficial alliances with your local VBCO.

1 Understand the VBCO Landscape & Key Stakeholders

The first step toward making a meaningful connection with the VBCO(s) providing benefits to your GED patient population is to gather information on the VBCO landscape in your local area.

First, conduct some informal internal discovery by asking representatives from your hospital or health system's Population Health, Utilization Review, Executive Suite, and/or Contracting teams to inquire about at-risk beneficiaries receiving care in your GED. Oftentimes, the people who are most familiar with whether a patient is in a value-based care arrangement are the care managers or social workers that work within your ED. You will likely discover the main VBCO players within your geographical area by simply having informal conversations with your colleagues.

To gain a deeper understanding of your local value-based care landscape, you can conduct additional research by utilizing information from two main sources. We suggest reviewing the sources below in the order listed, to first gather the information we believe will have the greatest likelihood of pertinence for your patient population.

A Institute of Accountable Care GED/ACO Overlap:

Identify local MSSP ACOs providing benefits to your older adult patients by downloading the most recent analysis conducted by the Institute of Accountable Care demonstrating the overlap between GED patient visits and MSSP ACO attributed beneficiaries. Select the third tab: "2022 GED BY ACO AND HOSPITAL" and search for your GED using the "Hospital City" and "State" columns. For more detailed instructions about how to access and analyze the data, please refer to the Appendix.

B CMS's website to identify MSSP ACOs:

You can visualize the data by using an interactive map or download raw data to Excel in order to find a MSSP ACO in your local area. If you've identified the name of an ACO in the step above, you can search for it and find the associated contact information in the raw Excel file. For detailed instructions about how to access and analyze the data, please refer to the Appendix. If you are able to confirm that there is a MSSP ACO serving beneficiaries in your local community, but you are unable to locate contact details for that entity, you may contact CMS directly to request information at SharedSavingsProgram@cms.hhs.gov

C Local Capitated Provider Groups:

If you are unable to identify an MSSP ACO with beneficiaries receiving care in your GED in steps A or B, there may be a local capitated provider group that is also incentivized to reduce avoidable admissions. These groups can include Programs of All-Inclusive Care for the Elderly (PACE), delegated primary care groups (Oak St. Health, ChenMed) or payviders (Wellmed, Conviva, Centerwell).

Knowledge and data are power. Now that you have more information around the VBCO landscape, key VBCO stakeholders, and potential overlap between your patients and your local VBCO(s), you are ready to take the next step towards mobilizing action.

2 Mobilize Action

The first activity towards mobilizing action is engaging the relevant VBCO stakeholders. Contact the VBCO lead you've identified while discovering your unique value based care landscape to introduce your GED and outline its shared objectives.

> An email template with supporting background information to make the initial connection with your VBCO lead are included in the Appendix.
>
> If you cannot reach the VBCO lead within a week, or you experience difficulty connecting with local VBCOs please contact Amy Stuck, PhD, RN, Senior Director of Value-based Acute Care at West Health Institute at: arstuck@westhealth.org or the West Health Institute at (858) 535-7000 and ask to be connected to the Director of Value-based Acute Care. West Health can help facilitate introductions.

Following an e-introduction, schedule a time to meet (virtually or in person), conduct a brief, introductory conversation with the VBCO lead to gain an understanding of the unique capabilities and challenges VBCOs have when it comes to their beneficiaries receiving care within your GED. Additionally, share if your GED has any current initiatives or efforts that involve similar organizations.

The goal of the initial introductory conversation is relationship building and to generate buy-in with the VBCO lead to convene a larger conversation among the VBCO and GED stakeholders regarding a potential collaboration. To make partnering with your GED attractive, recommend ways the GED can address VBCO goals, metrics, assist to navigate around barriers, and solve pain points. To do this, you first need to inquire of the VBCO in these first introductory meetings:

1. What are your strategic goals for this year?
2. What are your barriers in achieving these goals?
3. What key metrics are you working to improve related to emergency care for your population?
4. What key metrics are you working to improve related to your older adult beneficiaries?
5. What barriers prevent you from improving these metrics?
6. If you had a magic wand to improve emergency care for your older adult beneficiaries, what would improved care look like to you?

Now that you understand what is important to the VBCO, demonstrate how your GED services align with those values. Position the GED as a solution that is relevant to VBCO priorities.

Once you understand what your target VBCO partner values, you will need to craft a proposal for what a collaboration could look like. Present a proposal for collaboration that is practical based on existing resources and the desired timeline. Propose ideas that mitigate risks and maximize return.

As a starting point, you will want to showcase GED standard care protocols and policies that support the VBCO's priorities. For example, share information regarding your GED's routine screening of older adults regarding mobility needs as a way to address a VBCO's goal to reduce iatrogenic falls. Highlight the urgency behind implementing the GED model now, given the growth of the older adult population, surges in illnesses disproportionately affecting older adults (e.g., COVID-19, Respiratory Syncytial Virus (RSV)), hospital staffing shortages, lack of in-patient beds, etc.

Tell the story of how GED and VBCO care teams align. Focus on integrated care coordination and transitions within the health system and to social and community services.

Most importantly, suggest a consultative partnership that is designed to address key outcomes pertinent to local VBCO. The outcomes you select should be based on mutual benefit. For example, this might be reducing cost, reducing repeat hospitalizations, preventing downstream healthcare usage costs, etc. The outcomes and/or metrics you propose should directly align to mutual GED and VBCO priorities, and ideally address mutual pain points.

A draft agenda for the introductory conversation is included in the Appendix, titled: Agenda Template | Introductory Conversation. The questions listed above are included within the agenda. A best practice is to send the agenda with a brief reminder about the scheduled conversation a few days in advance of the meeting. This will also have the added benefit of giving your VBCO counterpart some time to brainstorm thoughtful responses to your questions.

Following the introductory conversation, determine the appropriate stakeholders from your GED to form a project team that can help drive greater collaboration between your organization and the VBCO.

A description of the roles and responsibilities included in successful project teams is included in the Appendix, titled: Roles & Responsibilities | Project Teams.

Complete the Stakeholder Map included in the Appendix and share it with the VBCO lead to generate buy-in and determine the appropriate VBCO representatives to include in the guiding project team. A draft email message back to the VBCO lead is included in the Appendix, titled: Email Template | Introduction Follow-Up.

Once the appropriate GED and VBCO stakeholders have been identified, conduct a Scoping meeting with the Executive Sponsor and Senior Project Team to generate a mutual understanding of current GED and VBCO capabilities, goals, metrics (especially any daily-use dashboards), challenges and current applicable work.

If you are seeking support in securing an Executive Sponsor, please refer to the "Making Your Business Case to an Executive Sponsor" resource located in the Appendix.

The goal of the Scoping meeting is to generate buy-in from stakeholders to pursue aim-setting. A draft agenda for the Scoping meeting is included in the Appendix, titled: Agenda Template | Scoping Meeting.

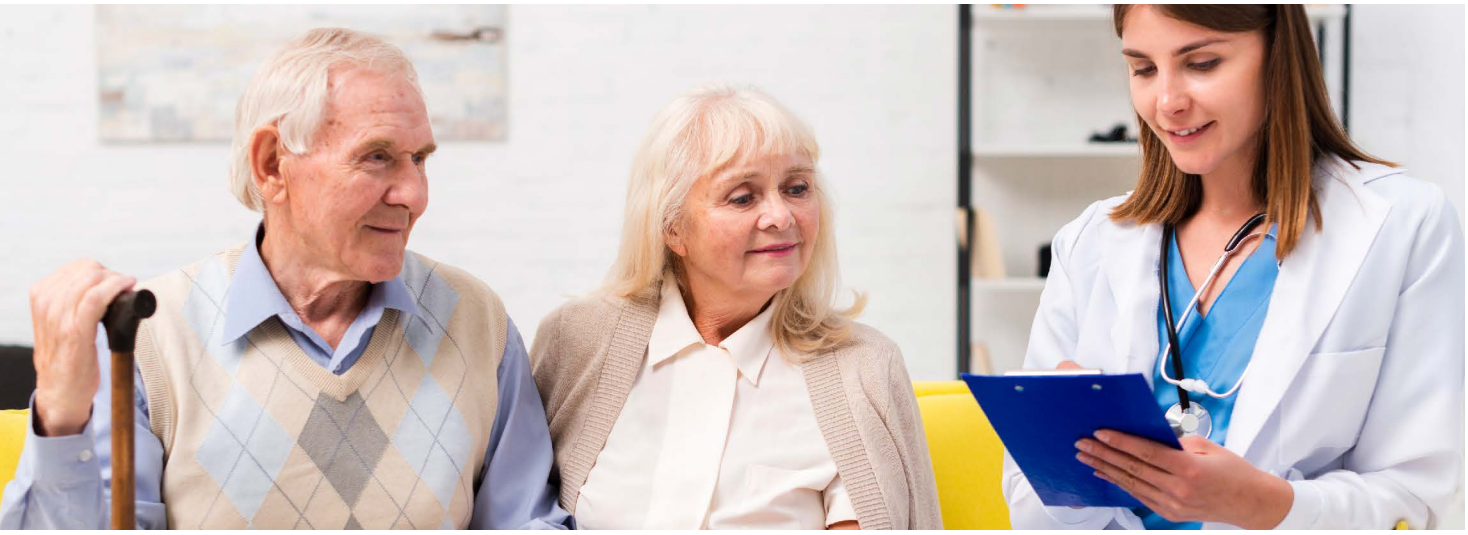
Follow-up from the Scoping meeting by sharing a framework with stakeholders to begin setting up a collaborative project. A follow-up email template is included in the Appendix, titled: Email Template | Scoping Meeting Follow-Up. Although the needs of each VBCO may be different, some ideas for collaborative projects with the VBCO could include:

- Creating a Care Management Connection
- Medication Management
- Physical Therapy Consultations
- Primary Care Follow-Up

A template to use for brainstorming collaborative project aims, as well as an example of the above collaborative projects, are included in the Appendix.

After engaging and exchanging with the members of the Scoping meeting via your follow-up email, conduct a follow-up Aim Setting meeting with the Sponsor and Senior Project Team to set the aim of a potential collaboration. The goal of the meeting is to finalize the aim(s) to mutually pursue with a larger coalition of GED and VBCO representatives. A draft agenda is included in the Appendix, titled: Agenda Template | Aim-Setting Meeting.

Next up: Moving a larger Field Team towards the partnerships you hope to create.



3 Move Towards Change

After making in-roads with the VBCO lead in your GED service area, engaging with Executive Sponsors, and scoping the project aim(s), it is now time to build consensus and forge relationships with other members of the GED and VBCO. These team members are critical to implementing a collaborative project.

After selecting the aim(s) to pursue and identifying individuals from each organization to participate as members of the Field Team, conduct a kick-off meeting with the Senior Project Team and the Field Team. The goal of the meeting is to communicate the vision for the collaborative project to the greater team, while making sure to capture their hearts and minds regarding the rationale for the aligned partnership and collaborative project. A draft agenda is included in the Appendix, titled: Agenda Template | Kick-Off Meeting with Field Team.

Following the kick-off meeting with the Senior Project Team and Field Team, continue to work towards developing a solidified, collaborative project team; a draft email message is included in the Appendix, titled: Email Template | Follow-Up to Kick-Off Meeting with Field Team. One way to achieve this is to work with the group to build a team charter, establish a meeting cadence and schedule, and create general project timeline and goals. A draft team charter and example is included in the Appendix.

Once you have finalized your team, selected the collaborative project aim(s), and determined the measures to ascertain whether the aim(s) lead to an improvement, the next step is to test some change ideas hypothesized to positively impact the aim(s). The Institute for Healthcare Improvement (IHI) has a toolkit in support of creating and measuring process improvement, which may be downloaded for no cost at: Quality Improvement Essentials Toolkit. A key component of this process, and the associated toolkit, is implementing a Plan-Do-Study-Act (PDSA) cycle. PDSA provides a framework that can be used for testing change ideas. In other words, the PDSA cycle is "the scientific method, used for action-oriented learning (IHI, 2022)." For more information on the PDSA cycle, please visit: How to Improve: Model for Improvement.

A PDSA worksheet and an example of a completed PDSA cycle based on creating a care management connection between the GED and VBCO are included in the Appendix.

Moving towards forging aligned partnerships and launching collaborative projects is not a linear process. The steps laid out are suggestions to help inform aligning your GED with the work of your local VBCO. Many times, the steps suggested may take the form of multiple meetings, email exchanges, or face-to-face conversations to reach the desired goal.

Effective change management requires ongoing actions and check-ins as the project team begins to work together. There are four key tactics teams can employ to ensure ongoing change momentum:

1 Track quantitative outcomes:

Project success is only as strong as the data. Monitoring outcomes toward achieving the collaborative aim allows teams to determine what is working and what is not. This is where PDSA cycles are useful and essential. When change efforts are not resulting in outcomes that indicate progress toward the intended aim, examining that data during the 'Study' phase of the PDSA cycle allows the team to identify the issue, thus paving the path to 'Adjust' in the next phase. In this way, by continually planning, implementing, evaluating, and adjusting, improvement toward the aim can be achieved through iterative PDSA cycling. In addition, monitoring quantitative outcomes may provide insights into adoption of and adherence to the proposed change within the team.

2 Solicit and respond to feedback:

Each one of the project team members brings a unique perspective and skill set to the table. Soliciting feedback (in informal one-on-one settings or through formal surveys or roundtable discussions) and responding to concerns or ideas can go a long way in generating buy-in and building solutions that work for both organizations.

3 Support the team:

At the heart of change are the people. Success in forging aligned partnerships will be enhanced by consistent and frequent communication with, and education of, the members of the project and larger GED and VBCO teams. Make sure to reinforce what is changing and why it is important through ongoing communications, training, and individualized coaching.

4 Celebrate success:

Do not forget to celebrate the wins along the way! Celebrations can be as simple as handwritten thank-you notes, public moments of recognition or as formal as a launch party or happy hour. It is important to practice gratitude for the hard work of the team and celebrate all the hard work accomplished.

Keep at it! Change is messy and gaining the buy-in of all the stakeholders necessary to launch your collaborative project aim and actively participate in the project is no small feat.

4 Remove Barriers

As you move towards partnership and launching collaborative projects, there will inevitably be barriers along the way. For example, you may receive push-back from VBCOs resistant to collaboration. Below we review common concerns from VBCOs regarding GED collaboration, and outline a potential reply for each issue.

— *"We cannot prioritize patients in your GED over other beneficiaries."*

Response: "The purpose of this collaboration is not to treat patients in our GED differently. The goal with this collaboration is to ensure that all patients are provided the best possible disposition when they are receiving emergency care. It is our understanding that the VBCO may be well positioned to support an optimal transition from the Emergency Department by connecting the patient with services, benefits, and programs available through his/her VBCO. We would like to establish an improved workflow whereby the VBCO may be viewed as another resource available to that patient to facilitate optimal disposition (much like adult caregivers or family members are invaluable resources, but not available for every patient)."

— *"Our VBCO care managers manage dozens of patients at a time and cannot be everywhere at once. We cannot guarantee immediate response."*

Response: "That is understandable. VBCOs do essential work to support patients, and we do not want this project to prevent you from doing your best for all on your patient panel. From our view, the most important thing is that the patient is provided with quality care while in the Emergency Department, followed by a well-planned care transition. Even if your care managers are not able to be onsite to meet with the patient in the ED, having knowledge about and access to VBCO services, benefits, and programs available to the patient should help to facilitate optimal disposition. We can discuss a bi-directional cross-organizational communication plan to keep VBCO and GED staff informed and best support our mutual patients."

— *"We love this [idea] but we do not have time/we are already stretched too thin/it is not realistic with our current demands."*

Response: "Understood. Can you let us know when there might be more time to explore working together? For what it is worth, our goal is to have [idea] be seamlessly integrated into workflows. A seamless integration would reduce any significant time burdens."

In parallel, below are hesitations you may receive from your Emergency Medicine colleagues when working with VBCOs. We offer suggested responses for each concern below.

— *"We treat all patients the same regardless of whether they are in a value-based contract/arrangement."*

Response: "The purpose of this collaboration is not to treat VBCO patients differently. The goal with this collaboration is to understand that, when a patient is within a VBCO risk pool, the VBCO may be viewed as another resource available to that patient (much like adult caregivers or family members are invaluable resources, but not available for every patient)."

— *"We love this [idea] but are worried that it will contribute to increased boarding time and/or reduced throughput for our patients."*

Response: "Our goal is to be at least throughput neutral. We do not want to inadvertently increase boarding time or reduce throughput. This [idea] will allow you to discharge patients with additional services from the VBCO, that you otherwise may have to admit or place in observation. This may actually decrease the length of ED stay."

Being able to effectively respond to the valid concerns of your VBCO partners and GED colleagues is one way to remove barriers towards establishing collaborative project aims.

Furthermore, there are two key barriers to remove to establish collaborative project aims between your GED and your local VBCO.

Beneficiary Status. It will be important to inventory how your GED and VBCO currently share patient beneficiary status. A recognized pain point is that ED clinicians do not always know when they are treating a patient in a risk-based arrangement that may have extra resources available to them. Likewise, VBCOs do not always know when their beneficiary ends up in the ED. Lack of awareness about beneficiary status is a key first barrier to remove.

Communication & Information Sharing. Designing a safe alternative to in-patient admission requires an efficient, durable, provider-provider communication protocol between the GED and the Primary Care Provider and/or VBCO care coordinator, prior to a decision to admit. Creating communication pathways between the two providers' organizations is a key to success, such as an alert mechanism or integrated feature within a hospital's electronic health record.

One way this can be achieved is through leveraging your state or county's health information exchange, specifically the Admission, Discharge, Transfer (ADT) notification. Depending on the locality, the ADT feed may be available (either real-time or in batches every few hours) to qualifying organizations. The Michigan Health Information Network has free user guides and resources about implementing your own ADT exchange.

For example, Gary and Mary West PACE, a nonprofit Program of All-Inclusive Care for the Elderly (PACE), has begun to leverage the ADT notification when a patient arrives in an Emergency Department. Other industry solutions, such as Bamboo Health's (formerly PatientPing) "Pings" feature*, exist to address this problem.

Features of communication information sharing protocols should include:

- The specific communication process (dedicated phone line, text, electronic health record message, etc.)
- Expectations regarding the time to respond
- Required information (goals of care, acute change in condition, designated health care surrogate, etc.)

Much of what comes next will depend on how your organizations agree to share patient beneficiary status, information, and communicate with one another. The next step is to determine the resources required to share patient information and the communication channels to coordinate care. Integrating this work into the workflow of your guiding project team will ensure successful completion.

Conclusion

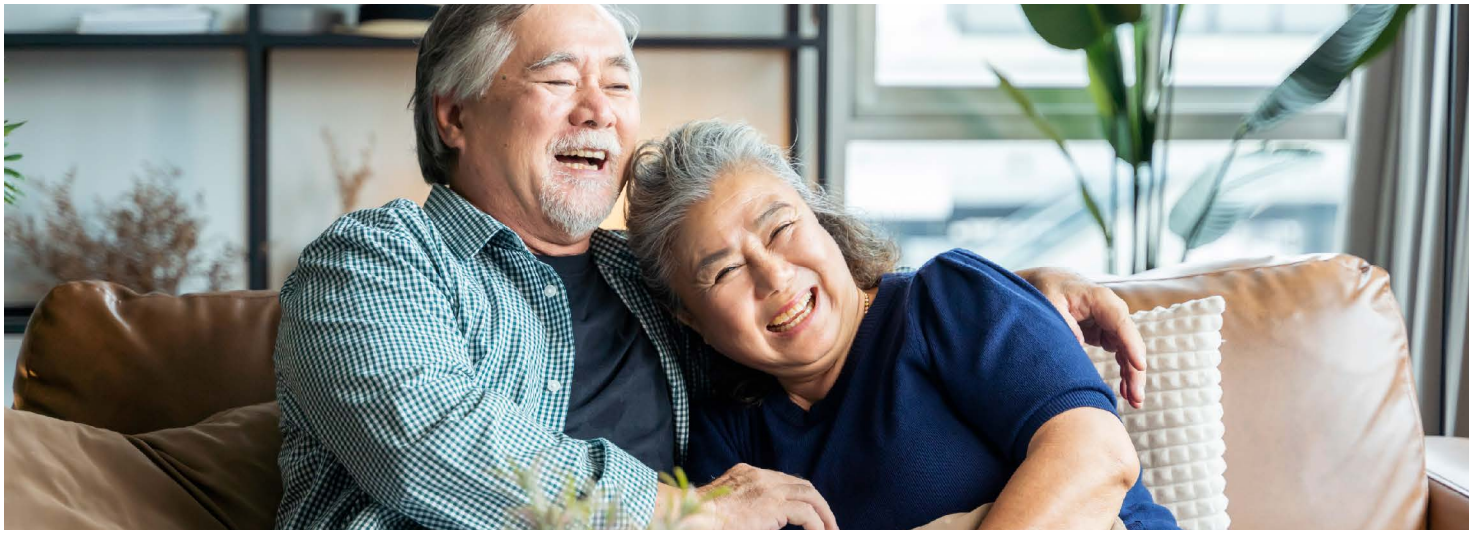
Congratulations! You have done the work to understand the VBCO landscape and key VBCO stakeholders, mobilized action, moved towards forging aligned partnerships, and removed barriers hindering your organizations from working successfully together. Our hope is that by forging aligned partnerships and launching collaborative projects, your GED and local VBCO can be at the forefront of delivering high-quality, lower cost care for older adults.

For more information on how other GEDs have forged aligned partnerships with their local VBCOs, please refer to the list of exemplary organizations located in the Appendix.

For more information on how you can connect to and work with Value-based Care Organizations, please contact Amy Stuck, PhD, RN, Senior Director of Value-based Acute Care at West Health Institute at: arstuck@westhealth.org or the West Health Institute at (858) 535-7000 and ask to be connected to the Director of Value-based Acute Care.

Finally, our gratitude to Accountable Care Organization of Aurora, LLC, Aurora Accountable Care Organization LLC Geriatric Emergency Departments, Advocate Physician Partners Accountable Care, Inc., Gary and Mary West PACE, Mission Health Coordinated Care, St. Joseph's Geriatric Emergency Department, UNC Health Alliance, UNC Hillsborough Medical Center Geriatric Emergency Department, Cleveland Clinic's Main Campus Geriatric Emergency Department, Cleveland Clinic Quality Alliance, Integra Community Care Network and Kent Hospital, for paving the way for other Geriatric Emergency Departments and Value-based Care Organizations to forge aligned partnerships and for their expert feedback in enhancing and improving this resource.

**The reference to specific products, services or companies contained in this Toolkit does not constitute endorsement or recommendation by West Health.*



Appendix

All tools and templates are designed to be flexible and are merely suggestions. When using the tools and templates, please amend them freely to align with your own personal and/or professional brand.

The examples provided in the Appendix are fictional, unless otherwise noted.

Action Checklist

1. Understand the VBCO Landscape & Key Stakeholders by researching and gathering information.
   - Identify if there is a VBCO within your hospital service area.
   - Understand the basic capabilities, programs, and services available to patients through their VBCO.
   - Determine who the VBCO lead contact is.
   - Learn to what degree patients seeking care at your GED are VBCO beneficiaries.

2. Mobilize Action by convening introductory conversations with VBCO stakeholders to determine shared goals. Once on common ground, identify a guiding coalition/project team, and finalize a collaborative project aim.
   - Contact the VBCO lead.
   - Host an introductory conversation with the VBCO lead.
   - Determine the appropriate GED and VBCO stakeholders.
   - Create a Stakeholder Map.
   - Conduct a scoping meeting with the Sponsor and Senior Project Team.
   - Follow-up from the scoping meeting.
   - Conduct a follow-up meeting with the Sponsor and Senior Project Team to formulate the project aim.
   - Finalize the project aim.

3. Move Towards Change by sharing a vision and empowering others to act on that vision.
   - Conduct a kick-off meeting with the Senior Project Team and Field Team.
   - Create a team charter.
   - Establish meeting cadence & goals.

4. Remove Barriers by determining how to share information and identify when patients in the GED are VBCO beneficiaries.
   - Inventory how your GED and VBCO currently share information.
   - Outline desired future state.
   - Determine resources required to move to future state.
   - Integrate removal of barriers into workflow of guiding coalition/project team

Glossary of VBCO Abbreviations, Key Performance Indicators and Terms

The terms listed here are in no way comprehensive, but are the most common value-based care abbreviations, key performance indicators and terms that you may come across. CMS maintains a comprehensive, easily searchable database of acronyms as well as a glossary.

- ACA: Affordable Care Act; federal legislation enacted in 2010 that enabled value-based care.
- Accountable Care: A care delivery model that is person-centered. A care team takes responsibility for improving quality of care, care coordination and health outcomes for a defined group of individuals, to reduce care fragmentation and avoid unnecessary costs for individuals and the health system[23]
- ACO: Accountable Care Organization; a local group of physicians, hospitals and other providers who are responsible for the quality and total cost of care for their patients[24]
- ADT: Admission, discharge, transfer; secure health information exchange between qualifying healthcare organizations as facilitated by local government; notifications serve as alerts that are sent when a patient is admitted to a care setting, transferred to another care setting, or discharged from a care setting[25]
- APM: Alternative payment model; a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population[26]
- Capitation: A way of paying health care providers or organizations in which they receive a predictable, upfront, set amount of money to cover the predicted cost of all or some of the health care services for a specific patient over a certain period of time[27]
- CMMI: Center for Medicare and Medicaid Innovation; created by the Affordable Care Act to test payment and service delivery models to reduce program expenditures
- CMS: Centers for Medicare & Medicaid Services; federal agency that provides health coverage to more than 160 million through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace[28]
- Downside Risk: uncertainty associated with potential financial losses; a risk arrangement that includes both upside and downside risk may be referred to as a "two-sided risk arrangement."[29]
- FFS: Fee For Service; payment model under which direct reimbursement is issued per service or treatment.
- HaH: Hospital at Home; a care delivery model that has been shown to reduce costs, improve outcomes and enhance the patient experience[30]
- HCBS: Home and Community Based Service; types of person-centered care models delivered in the home and community[31]
- HH: Home Health; wide range of health care services that can be given in a patient's home for an illness or injury[32]; delivered by a HHA: Home Health Agency
- IAC: Institute for Accountable Care; independent non-profit organization dedicated to building the evidence base on the impact of accountable care delivery strategies[33]

- MSPB: Medicare Spending Per Beneficiary; key performance indicator that shows whether Medicare spends more, less, or about the same for an episode of care at a specific hospital compared to all hospitals nationally[34]
- MSSP: Medicare Shared Savings Program; groups of doctors, hospitals, and other health care providers who collaborate to give coordinated high-quality care to people with Medicare, focusing on delivering the right care at the right time, while avoiding unnecessary services and medical errors[35]
- NAACOS: National Association of Accountable Care Organizations; primere professional organization formed by ACOs, governed by ACOs, and wholly focused on ACOs.
- PACE: Program of All-Inclusive Care for the Elderly; Medicare program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility.
- PCMH: Patient-centered Medical Home; a team-based health care delivery model led by a health care provider to provide comprehensive, continuous and relationship-driven medical care to patients[36]
- Return Visit: When a patient returns to the ED after being discharged; typically measured in 72-hour, 7-day and 30-day time periods; a common key performance indicator
- Risk: uncertainty associated with potential financial gains or losses[37]
- Risk-Based Arrangement: an agreement in which a health provider is held financially responsible for the quality and cost of care delivered to beneficiaries in exchange for flexibilities regarding the way they deliver care[29]
- Risk Adjustment: A way to calculate what to pay a health provider based on a patient's health, their likely use of health care services and the costs of those services[37]
- Risk Score: A number representing the predicted cost of treating a specific patient or group of patients compared to the average Medicare patient, based on certain characteristics and health conditions[27]
- Total Cost of Care: The process of holding participating states accountable for quality and population health outcomes, while constraining costs of health care services delivered in a state or specified sub-state region. As applied by the CMS Innovation Center, this process takes place across all health care payers, including Medicare, Medicaid, and private health insurers and plans[38]
- Two-sided risk: risk-based arrangements that include both upside and downside risk. In such arrangements, participants who deliver quality care at a lower cost may be eligible to receive a payment from CMS, while participants who increase overall spending may owe a payment to CMS[29]
- Upside Risk: uncertainty associated with potential financial gains; a risk arrangement that only includes upside risk may be referred to as a "one-sided risk arrangement[29]
- VBC: Value-based care; a reimbursement model that is tied to positive patient outcomes and therefore incentivizes reducing spending, decreasing avoidable hospitalizations and increasing outpatient resources.

Data Overview | Institute of Accountable Care GED/ACO Overlap

https://www.institute4ac.org/data/

**Note that the analyses conducted for years 2019-2022 included MSSP ACOs only, as other ACO models (e.g., NextGen ACOs, Direct Contracting) had CMS data restrictions at the time of analysis.*

Figure #1. IAC | MSSP ACO/GED Overlap Analysis

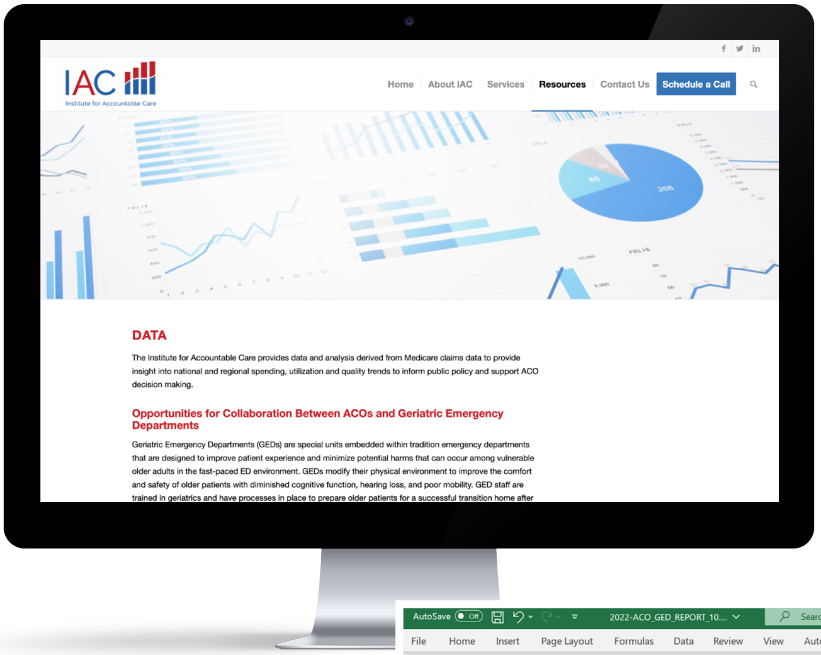
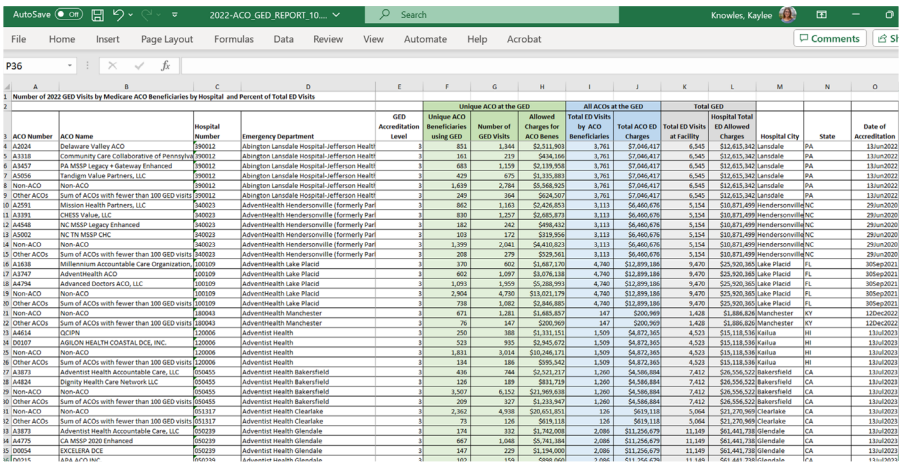


Figure #2. MSSP ACO/GED Overlap Analysis Download



Within the downloaded Excel file, explore all the tabs to find relevant information, including your hospital name, number of ACO beneficiaries that visited your emergency department within the analysis year, and total cost attributed to those visits.

Locate the information regarding your GED, if available. If you do not see your GED listed, this may be due to several factors, each of which can be worked through using the instructions provided below:

1 Possibility A:

There is not a unique MSSP ACO with at least 100 encounters for their beneficiary population taking place within your GED. *(See 'Notes' tab within the spreadsheet for additional details.)*

- In this instance, you may find your GED listed with 'Other ACOs' listed within the 'ACO Name' column. This indicates there are MSSP ACO beneficiaries receiving care at your GED, but the beneficiary population was less than 100 per MSSP ACO, and therefore the analysts elected to exclude the entity name due to the limited number of patients. In this instance, skip to Step 2 to follow instructions for how to search for local ACOs using a map.

2 Possibility B:

Your GED was accredited by ACEP after the cut-off date for the downloaded analysis. You can confirm the date your hospital was most recently accredited on the ACEP GEDA website by downloading the 'Geriatric ED Accredited List' here: https://www.acep.org/geda

3 Possibility C:

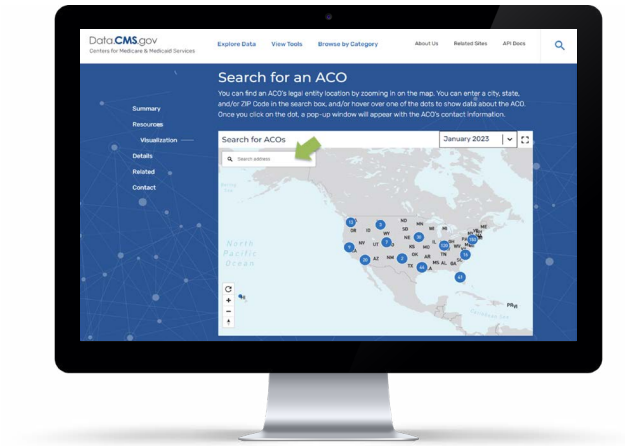
The hospital name entered in the ACEP GEDA application does not match your search terms. In this case, we suggest you search for the name of the health system you are a part of, prior names of your hospital, potential abbreviated names, etc.

Review the city and state columns to identify ACOs active in your area. At this point, if you have identified an MSSP ACO serving your local area, we suggest you contact the ACO with the highest degree of beneficiary/patient overlap.

Data Overview | CMS's website to identify MSSP ACOs

https://data.cms.gov/medicare-shared-savings-program/accountable-care-organizations

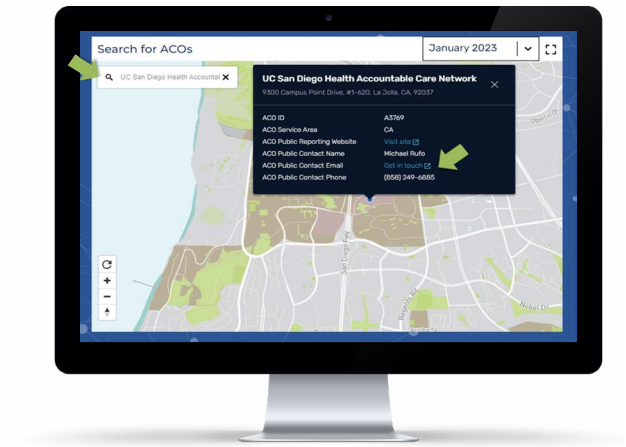
Figure #1. Search for an ACO using the interactive map



Use the 'Search for an ACO' interactive map within the 'Visualize Information' section of CMS's website to identify MSSP ACOs with a legal entity in your local area https://data.cms.gov/medicare-shared-savings-program/accountable-care-organizations

1. Enter your city, state or zip code into the 'Search address' field. Press 'Enter'.
2. The map will zoom in to display your search results. You may then hover over each blue dot to view additional details for each ACO, including:
   - ACO ID
   - ACO Service Area
   - ACO Public Reporting Website
     - When available, the 'Visit site' will open a link to the ACO's website where you can learn more and locate contact information.
   - ACO Public Contact Name
   - ACO Public Contact Email
     - When available, the 'Get in touch' link will provide an email address to contact the ACO.
   - ACO Public Contact Phone

Figure #2. Zoomed in example when searching for an ACO via the interactive map



You may choose to navigate the *MSSP Accountable Care Organization Participants* list via one of the following formats:

- Select 'Download' to export the list as a Microsoft Excel or comma-separated values (CSV) file
- Select 'View Data' to navigate the list using filters on the website *(See Figure 6)*

Email Template | Making the VBCO Connection

New Message

To VBCO Contact Cc Bcc

Subject Request for Introductory Conversation

Hello [VBCO Contact],

My name is [NAME] and I am the [TITLE] at [NAME OF HOSPITAL/GED].

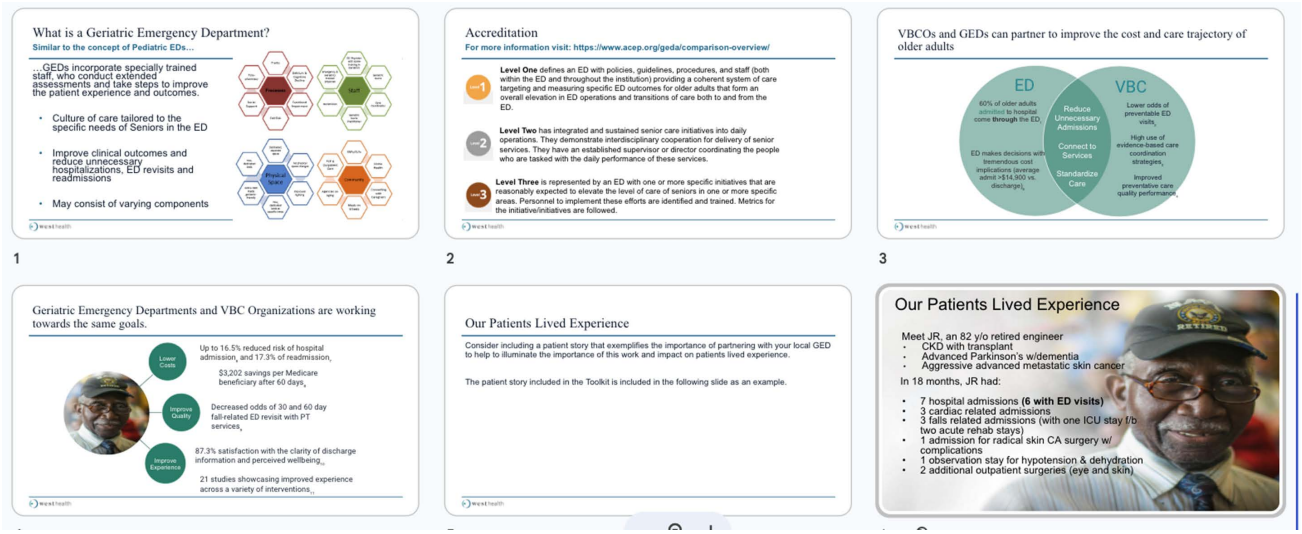
I believe that some of your value-based beneficiaries may be seeking care at our GED. A GED is not a highschool equivalent diploma! I've attached some information on what a GED is and why I think we have similar goals. There have been demonstrations indicating that connecting GEDs with value-based care organizations may be mutually beneficial and result in better outcomes for our patients.

Would you be willing to have a conversation over the coming weeks about your organization's capabilities and challenges? If so, please do not hesitate to provide some dates/times that work for you and I will follow-up with a calendar invitation with [VIRTUAL MEETING PLATFORM] log-on information.

Thank you,
[NAME]

Send

Presentation Attachment | Making the VBCO Connection



Agenda Template | Introductory Conversation

Invitees: VBCO Contact & GED Senior Project Team Lead

Introductory Conversation

[DAY OF WEEK, DATE]
[TIME, TIME ZONE]

[VIRTUAL MEETING PLATFORM] Details: [ADD HERE]

Agenda Items

[START TIME - END TIME e.g.: 1:00-1:10]	*Introductions - All*
[START TIME - END TIME]	*Overview of VBCO capabilities & challenges - [VBCO LEAD]* *Questions for the VBCO:* 1. *What are your strategic goals for this year?* 2. *What are your barriers in achieving these goals?* 3. *What key metrics you are working to improve related to emergency care for your population?* 4. *What key metrics you are working to improve related to your older adult beneficiaries?* 5. *What barriers prevent you from improving these metrics?* 6. *If you had a magic want to improve emergency care for your older adult beneficiaries, what would improved care look like to you?*
[START TIME - END TIME]	*Current GED efforts - [YOUR NAME]*
[START TIME - END TIME]	*Next Steps - [YOUR NAME]*

Roles & Responsibilities | Project Teams

Project Team Roles & Responsibilities				
Role	Definition	Responsibilities	GED Example	VBCO Example
Executive Sponsor	A senior executive who will be responsible for the collaboration	Providing executive-level support, needed resources to carry out the collaboration and ability to liaison with other areas of the organization. Not a day-to-day participant in meetings and workflow, but highly involved in the outset of a collaboration and should review the team's progress periodically	Department of Emergency Medicine Chair Service Line leader for emergency medicine	Chief Medical Officer
Senior Project Team	Leaders with ample authority to make decisions	Developing the vision and strategy for the collaboration, providing resources to the team, removing obstacles, resolving conflicts, managing stakeholders. Understands both the clinical implications of proposed changes and the consequences such a change might trigger in other parts of the system.	GED Lead Physician and/or Nurse Champion	Senior Vice President Director
Field Team	Highly respected and credible individual contributors or mid-level managers who represent key constituencies involved in the collaboration.	Actively engage in the collaboration, suggest areas of ongoing improvement, and bring others along in the collaborative effort. Someone who knows the subject intimately and who understands the processes of care.	• Nurse Champions • Physical Therapists • Social Workers • Geriatricians • Pharmacists	Care Managers
Day-to-day Leadership	The driver of the project.	Day-to-day leader in meetings and workflow, responsible for completion of collaboration deliverables. Manages the collaboration from inception to completion.	If you are reading this Toolkit, it is likely that this person is… you.	

Stakeholder Map

Stakeholder	Role	Title	Location	Importance in Approval	Importance in Execution	Notes

Stakeholder	Role	Title	Location	Importance in Approval	Importance in Execution	Notes
Sally Sue	Executive Sponsor	Chief Medical Officer	VBCO Internal	High	High	Advancing our work with EDs is a top priority in the recent strategic plan. Sally has a vested interest in the project
Samantha Smith	Executive Sponsor	Department of Emergency Medicine Chair	GED Internal	High	Low	Sydney will require Samantha's approval to proceed with the project but she has other high priorities
Stacey Salem	Senior Project Team	Vice President for Population Health	VBCO Internal	Medium High	Medium	Stacey is relatively new to the organization and may need additional contextual information while onboarding
Sydney Shiloh	Senior Project Team	GED Lead Physician	GED Internal	Medium High	Medium	Sydney's area of research is Delirium, a potential high interest area for partnership
Serena Stevie	Field Team	Care Manager	VBCO Internal	Low	High	Serena has participated in simillar project at here prior organization and may have expertise to share
Sylvia Shelby	Field Team	GED Nurse Champion	GED Internal	Low	High	Sylvia is first point of contact for GED staff and will coordinate with others as necessary
Savannah Scott	Project Leader	Chief of Staff	VBCO Internal	Low	High	Savannah has wide connections in the industry which can be leveraged if necessary

Email Template | Introduction Follow-Up

New Message

To VBCO Contact Cc Bcc

Subject Follow-Up from our Introduction

Attachment Stakeholder Map

Hello [NAME OF VBCO CONTACT],

It was a pleasure to speak with you the other day and I look forward to our continued collaboration. As I mentioned during our conversation, I would like to convene a larger group of [NAME OF YOUR GED] and [NAME OF VBCO] stakeholders to have a broader conversation around how we can best collaborate.

Attached, please find a stakeholder map of GED representatives that I would like to attend an initial kick-off conversation. Who from your team should be included?

Thank you,
[YOUR NAME]

Send

Agenda Template | Scoping Meeting

Invitees:

VBCO Executive Sponsor

GED Executive Sponsor

VBCO Senior Project Team Lead

GED Senior Project Team Lead

Scoping Meeting

[DAY OF WEEK, DATE]
[TIME, TIME ZONE]

[VIRTUAL MEETING PLATFORM] Details: [ADD HERE]

Agenda Items

[START TIME - END TIME e.g.: 1:00-1:10]	*Introductions - All*
[START TIME - END TIME]	*Introduction to the GED - [YOUR NAME or GED LEAD PHYSICIAN AND/OR NURSE CHAMPION]* • *Overview of unique capabilities (e.g., physical therapy, social work, community connections, palliative care, direct admission to skilled nursing facility, etc.)* • *Review goals, key outcomes, and metrics/measurement of the GED (share relevant daily dashboards, if applicable)* • *Discuss challenges* • *Overview any current partnerships, projects, or work with VBCOs.*
[START TIME - END TIME]	*Introduction to VBC organization - [VBCO SENIOR PROJECT TEAM LEAD]* • *Define risk-based arrangement* • *Overview of unique capabilities (e.g., care management, hospital at home, community paramedicine, same day at-home visits, etc.)* • *Review goals, key outcomes, and metrics/measurement of the VBCO (share relevant daily dashboards, if applicable)* • *Discuss challenges* • *Overview any current partnerships, projects, or work with GEDs.*
[START TIME - END TIME]	*Next Steps - [YOUR NAME]* • *Brainstorm an aim for our collaboration*

Toolkit | Making Your Business Case to an Executive Sponsor

Making Your Business Case to an Executive Sponsor

Get informed: Understand the priorities and pain points facing your C-suite

- Create a business case which clearly addresses the top priorities facing your C-suite rather than highlighting your own priorities. Projects that meet the priority strategic initiatives of your health system are more likely to receive a favorable response.
- Find out what the top priorities or initiatives are for your system coming from the C-suite. These have often already been vetted against a return on investment (ROI) and have been packaged into specific objectives to be cascaded through the organization.
    - The American College of Healthcare Executives (ACHE) reports the top issues confronting hospitals are: financial challenges; governmental mandates; patient safety and quality; personnel shortages; patient satisfaction; access to care; physician-hospital relations; population health management; technology; and reorganization.
- Understand the financial impact of your proposal. For example, if making the case for a project aimed at reducing hospital admissions from the ED, calculate patient-level Medicare dollar margins (patient revenue minus cost) for ED-initiated admissions and non-ED-initiated admissions [1] to illustrate the cost differential.
- For some cases, it may be difficult to calculate an actual dollar value. However, you can connect your initiative with other important factors such as full-time employee (FTEs) dollars saved, potentially avoided unnecessary admissions, or other numerators of a quality metric impacted. Your business office can translate those numbers into monetary impact when you do not have the information to do so.
- Understand how the ED is incentivized from a payment/quality perspective.
- Understand the system-level payment/quality drivers, payer mix and payer-led drivers: there may be opportunities to connect your project to an existing initiative that has C-level support and visibility.

westhealth institute

Develop your project's "elevator pitch" to the C-Suite in language they will easily understand

You may have limited time to describe your proposal to your C-suite. Be prepared to present your ideas in a quick and simple format that highlights the sources of ROI and how it directly links to the top priorities for your hospital—priorities the C-suite cares about. This can be a concise "elevator pitch" and/or a visual (such as the table below, which illustrates how two projects (models) can support a goal of reducing readmission penalties.)

*Component	Emergency Department	Hospital
Model	Establish a Geriatric ED	Establish an Acute Care at Home option from the ED
Goal	Provide senior-focused emergency care to prevent avoidable hospitalizations; improve patient outcomes and satisfaction; and reduce iatrogenic complications	Prevent hospital admissions when and where appropriate
Target Population	Seniors experiencing a medical emergency	Seniors experiencing a medical emergency that can be treated at home
Source of Hospital ROI	Reduce ED revisits and readmissions; reduce readmission penalties; reduce penalties for preventable errors; increase patient satisfaction scores	Reduce readmission penalties; backfill beds with high-margin admissions; increase patient satisfaction scores; reduce the cost to treat; reduce low or negative margin Medicare admissions
Source of Societal ROI	Reduce ED crowding and time on divert status; improve patient outcomes and reduce iatrogenic complications	Improve patient outcomes and reduce iatrogenic complications; reduce the cost of care; allow seniors to receive care where they prefer to be treated

*Adapted from [2]

Document the details of the project to support decision-making

A more complete business case will include the following components:

1. Brief, executive summary describing the key points of the project, including the need
2. Introduction and rationale describing the objectives, predicted outcomes and benefits tied to C-suite's priorities
3. Describe how outcomes will be measured and reported
4. A section should provide cost details related to the expenses associated with setting up, assessing, maintaining and ultimately sustaining the program. This section should also describe the expected financial ROI of the program.
    a. It's important to be transparent about what your project will cost in terms of FTEs, equipment, or loss of efficiency in other areas. Any unrealistic or non-transparent information will reduce the credibility of the proposal.
5. Include a section that describes the timeline and resources for implementing the program.

[1] McHugh, et al, 2008
[2] Siu, et al, 2009

Email Template | Scoping Meeting Follow-Up

New Message

To Invitees and Attendees of the Scoping Meeting Cc Bcc

Subject Follow-Up from the *[NAME OF GED]/[NAME OF VBCO]* Scoping Meeting

Hi all,

It was a pleasure to meet you and I look forward to our continued collaboration. As we discussed at our kick-off meeting, our next step is to reconvene and brainstorm an aim for our collaboration. This will include ensuring our aim is time-specific, measurable and should define the specific patient population we are targeting.

In preparation for our next meeting, please come prepared with 2-3 ideas on potential aims. I have attached a template for your use in capturing your ideas.

Best,
[YOUR NAME]

Send

Template | Potential Collaborative Projects

Project Description	Patient Population	Project Timing	Measurement	Aim Statement

Example | Potential Collaborative Projects

Project Description	Patient Population	Project Timing	Measurement	Aim Statement
Care Management Connection	All At-Risk Beneficiaries	Within 1 year	80%	Connect 80% of at-risk beneficiaries to VBCO care management function within 1 hour of GED admission
Medication Management	All At-Risk Beneficiaries	Within 1 year	75%	Improve medication reconciliation at GED transition points by 75% within 1 year
Physical Therapy Consultations	Join Replacement and/or High Fall Risk Beneficiaries	Within 1 year	75%	Provide PT cpnsults to 75% of joint replacement and/or high dall risk beneficiaries in the GED within 1 year
Primary Care Follow-Up	All At-Risk Beneficiaries	Within 9 months	100%	Offer all patients within one week access to their primary care physician within 9 months

Agenda Template | Aim-Setting Meeting

Invitees:

VBCO Executive Sponsor
GED Executive Sponsor
VBCO Senior Project Team Lead
GED Senior Project Team Lead
VBCO Day-to-day Leadership
GED Day-to-day Leadership

Aim Setting Meeting

[DAY OF WEEK, DATE]
[TIME, TIME ZONE]

[VIRTUAL MEETING PLATFORM] Details: [ADD HERE]

Agenda Items

[START TIME - END TIME e.g.: 1:00-1:10] *Review GED Aim Ideas - [GED SENIOR PROJECT TEAM LEAD NAME]*
- *GED Senior Project Team Lead and/or ED physician/nurse champion presents ideas for potential collaborative project aims.*

[START TIME - END TIME] *Review VBCO Aim Ideas - [VBCO SENIOR PROJECT TEAM LEAD]*
- *VBCO Senior Project Team Lead presents ideas for potential collaborative project aims.*

[START TIME - END TIME] *Discuss Aims and Select Aim to Pursue - All*
- *What do we know about [AIM]?*
- *What is some relevant information we should consider related to [AIM]?*
- *What is our experience with [AIM]?*
- *What is our initial reaction to the [AIM]?*
- *How might this new [AIM] enhance our care for the targeted patient population?*
- *What are the implications of launching the [AIM] in the GED?*
- *What are the implications of launching the [AIM] for the VBCO?*

[START TIME - END TIME] *Next Steps - [GED DAY-TO-DAY LEADER]*
- *If we are to move forward with [SELECTED AIM], what needs to happen?*
- *If we move forward with [SELECTED AIM], when do we begin?*
- *If we move forward with [SELECTED AIM], who else needs to be included in our Field Team?*
- *What measures do we need to ascertain whether [SELECTED AIM] results in improvement?*

Agenda Template | Kick-Off Meeting with Field Team

Invitees:

VBCO Senior Project Team Lead
GED Senior Project Team Lead
VBCO Day-to-day Leadership
GED Day-to-day Leadership
VBCO Field Team
GED Field Team

Kick-Off Meeting with Field Team

[DAY OF WEEK, DATE]
[TIME, TIME ZONE]

[VIRTUAL MEETING PLATFORM] Details: [ADD HERE]

Agenda Items

[START TIME - END TIME] *Introduction to the GED & GED Field Team Attendees - [GED SENIOR PROJECT TEAM LEAD NAME]*

- *GED Field Team Introductions*
- *Overview of unique capabilities (e.g., physical therapy, social work, community connections, palliative care, direct admission to skilled nursing facility, etc.)*
- *Review goals, key outcomes, and metrics/measurement of the GED (share relevant daily dashboards, if applicable)*
- *Discuss challenges*
- *Overview any current partnerships, projects, or work with VBCOs.*

[START TIME - END TIME] *Introduction to VBCO & VBCO Field Team Attendees - [VBCO SENIOR PROJECT TEAM LEAD NAME]*

- *VBCO Field Team Introductions*
- *Define risk-based arrangement*
- *Overview of unique capabilities (e.g., care management, hospital at home, community paramedicine, same day at-home visits, etc.)*
- *Review goals, key outcomes, and metrics/measurement of the VBCO (share relevant daily dashboards, if applicable)*
- *Discuss challenges*
- *Overview any current partnerships, projects, or work with GEDs.*

[START TIME - END TIME] *History of the Collaboration - [GED DAY-TO-DAY LEADER]*

- *Describe impetus for the partnership by reviewing patient/beneficiary overlap, if available.*
- *Describe work thus far to bring your GED and the VBCO together.*

[START TIME - END TIME] *Vision Statement / Review Aim - [VBCO SENIOR PROJECT TEAM LEAD & GED SENIOR PROJECT TEAM LEAD]*

- *Review and discuss identified collaborative project aim.*
- *Benefits of the aim for identified patient population.*
- *Cutting edge nature of the collaboration*

[START TIME - END TIME] *Next Steps - [GED DAY-TO-DAY LEADER]*

- *Review what needs to happen to begin.*
- *Review when intended to begin.*
- *Overview team charter process and what to expect next.*
  - *Build a team charter*
  - *Establish a meeting cadence and schedule*
  - *Create project timeline*
    - *Identify change ideas hypothesized to positively impact the aim*
    - *Create PDSA cycle(s) to test the change idea*

Email Template | Follow-Up to Kick-Off Meeting with Field Team

New Message

To Invitees and Attendees of the Kick-Off Meeting with Field Team

Subject Follow-Up from the *[NAME OF VBC]/[NAME OF GED]* Kick-Off Meeting

Hi all,

It was a pleasure to meet you and I look forward to our continued collaboration. As we discussed at our kick-off meeting, our next step is to develop our team charter, establish a meeting cadence and schedule, and create our project timeline. In addition, we agreed to [ADDITIONAL NEXT STEPS DISCUSSED/IDENTIFIED AT KICK OFF MEETING].

[INSERT OTHER RELEVANT PROJECT UPDATES SINCE THE KICKOFF MEETING AND/OR FURTHER DISCUSSION AROUND NEXT STEPS OR IMMEDIATE ACTION ITEMS.]

Best,
[YOUR NAME]

Send

Template | Team Charter

[NAME OF GED] / [NAME OF VBCO]
[TITLE OF COLLABORATIVE PROJECT]

Primary Goals & Objectives

The primary goal of the project is *[FILL IN PRIMARY GOAL].*

This project aims to *[INSERT COLLABORATIVE PROJECT AIM].*

The project will be a *[BASIC DETAILS REGARDING THE COLLABORATION]* between *[NAME OF GED]* and *[NAME OF VBCO].* The project will culminate in *[BASIC DETAILS REGARDING PROJECT OUTPUTS/RESULTS].*

Defining Success

The move towards value-based care and the standardized protocols and processes of a Geriatric Emergency Department are important initiatives to both *[NAME OF GED]* and *[NAME OF VBCO].* A successful project will be able to *[INSERT GENERAL SUCCESS STATEMENT].*

Specific measure of success include:

1. *[LIST OUT SUCCESS MEASURE(S) OF COLLABORATIVE AIM DETERMINED BY SENIOR PROJECT TEAM LEADS]*

The general timing for the *[TITLE OF COLLABORATIVE PROJECT]* will be:

- *[KICK-OFF DATE]*
- *[MIDPOINT DATE]*
- *[CONCLUSION DATE]*
- *[ANY OTHER RELEVANT KEY MILESTONES]*

Team Roles & Responsibilities

Team Member	Role	Responsibilities
[NAME, CREDENTIALS OF TEAM MEMBER]	*[ROLE OF TEAM MEMBER, VBCO OR GED]*	*[LIST RESPONSIBILITIES OF TEAM MEMBER]*

Operational Plan (Logistics, Procedures, Communications)

- When and where will the project team meet?
  - Consider meeting frequency, timing, and location.
- What platform will the project team use for Virtual Meetings and how will the team conduct these?
- What are our expectations of each other for team meetings?
  - Include information regarding meeting protocol, leading the meetings, setting the agenda, individual team member preparation, team etiquette for meetings, taking minutes and recording action items and next steps, and other relevant information.
- Who will take and post the minutes of each meeting, including action items and next steps?

Project Management

- What is our platform and process to share deliverables and manage document versions?
  - (e.g., Dropbox, Email, Google Docs, Other)
- Include platforms and etiquette for data sharing, communication, and final documents.

Version Control

We will accept the below naming convention for all documents:

- *[LIST DOCUMENT NAMING CONVENTION]*
  - Example: *[PROVIDE EXAMPLE OF DOCUMENT NAMING CONVENTION]*

Team Profile

Team Member	Strengths	Weaknesses
[NAME, CREDENTIALS OF TEAM MEMBER]	*[PERSONAL STRENGTHS TO BRING TO THE PROJECT]*	*[PERSONAL WEAKNESSES TO BE AWARE OF]*

Example | Team Charter

St. Simon's Health Partners & St. Simon's Hospital's Geriatric Emergency Department
Creating a Care Management Connection

Primary Goals & Objectives

The primary goal of the project is timely notification that St. Simon's Health Partners beneficiaries have presented to the St. Simon's Hospital's GED.

This project aims to utilize the health information exchange to send a text message to a designated St. Simon's Health Partners care manager, alerting them to the beneficiary presenting to the GED.

The project will be a joint initiative between St. Simon's Health Partners & St. Simon's Hospital's Geriatric Emergency Department. The project will culminate in a shared process map, roles and responsibilities matrix, and operational procedures for creating a care management connection between our two organizations.

Defining Success

Providing high-quality coordinated care, lowering costs, and the standardized care protocols and processes of a Geriatric Emergency Department are important to both St. Simon's Health Partners & St. Simon's Hospital's Geriatric Emergency Department. A successful project will create a care management connection between our two organizations that leads to optimal dispositions and reduces unnecessary admissions.

Specific measure of success include:

1. Notification of St. Simon's Health Partners beneficiary presenting to the GED within 1 hour of arrival
2. Care management hand-off completion rate of 75% between St. Simon's Hospital's Geriatric Emergency Department & St. Simon's Health Partners
3. At least 5 avoided hospitalizations per quarter, for a total of 20 avoided hospitalizations for the year

The general timing for the Creation of a Care Management Connection initiative will be:

- January 2022 - Project Kick Off
- April 2022 - Finalized Project Team Charter & Data Measurement Design
- May 2023 - Initial Data Collection
- June 2022 - PDSA Cycle #1 Test
- July 2022 - PDSA Cycle #2 Test
- August 2022 - PDSA Cycle #3 Test
- September 2022 - PDSA Cycle #4 Test
- December 2022 - Project Wrap-Up

Team Roles & Responsibilities

Team Member	Role	Responsibilities
Samantha Smith Department of Emergency Medicine Chair GED	Executive Sponsor GED	Providing executive-level support and needed resources to carry out the collaboration. Ability to liaison with other areas of the organization.
Sally Sue CMO VBCO	Executive Sponsor VBCO	Providing executive-level support and needed resources to carry out the collaboration. Ability to liaison with other areas of the organization.
Sydney Shiloh Emergency Department Director GED	Senior Project Team GED	Co-develops the vision and strategy for the collaboration, providing resources to the team, removing obstacles, resolving conflicts, managing stakeholders. Understands both the implications of proposed changes and the consequences such a change might trigger in other parts of the system.
Stacey Salem Vice President for Population Health VBCO	Senior Project Team VBCO	Co-develops the vision and strategy for the collaboration, providing resources to the team, removing obstacles, resolving conflicts, managing stakeholders. Understands both the implications of proposed changes and the consequences such a change might trigger in other parts of the system.
Sean Scott Clinical Operations Manager GED	Day-to-day Leadership GED	Day-to-day leader in meetings and workflow, responsible for completion of collaboration deliverables. Manages the collaboration from inception to completion.
Sylvia Sowers Care Management Program Manager VBCO	Day-to-day Leadership VBCO	Day-to-day leader in meetings and workflow, responsible for completion of collaboration deliverables. Manages the collaboration from inception to completion.
Scott Shelby Nurse Champion GED	Field Team GED	Subject matter expert who understands the processes of emergency care. Actively engages in the collaboration, suggest areas of ongoing improvement, and bring others along in the collaborative effort.
Serena Stevie Care Manager VBCO	Field Team VBCO	Subject matter expert who understands the processes of care management. Actively engages in the collaboration, suggest areas of ongoing improvement, and bring others along in the collaborative effort.

Operational Plan (Logistics, Procedures, Communications)

Virtual Meetings will be conducted weekly (when deemed necessary) via Microsoft Teams. Savannah, or her assistant, will take the lead on scheduling or canceling all meetings. A weekly meeting Agenda will be sent in advance by Savannah.

Team Members will come on-time and prepare for meetings, as requested in the meeting agenda or pre-meeting communication(s). Serena will take meeting notes, including recording action items and next steps. Meeting agendas and notes will be housed in a shared Google Doc for all to access at any time.

Project communication will be primarily through email, although collaboration on project documents will occur via Google Docs.

Executive sponsors will attend optionally or when the project team requests attendance.

Project Management

Savannah will take the lead on creating a Google Drive folder for the team to collaborate on and share project documents. Savannah will be the manager of all internal project files in the Google Drive, including but not limited to creating new folders and archiving information. In the interim, documents will be shared via email.

Version Control

We will accept the below naming convention for all documents:

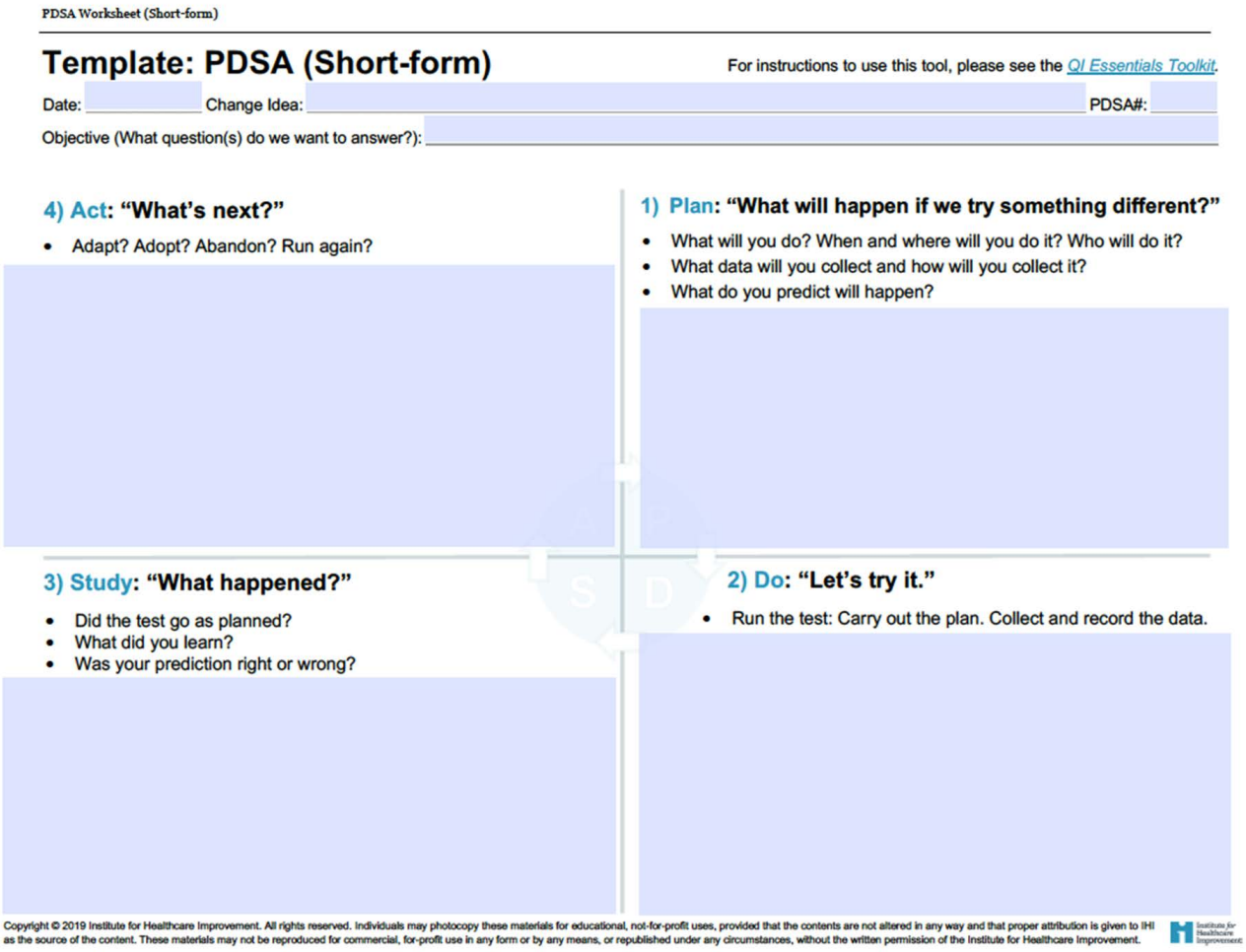
- TYPE_describe item_version_date (yyyy.mon.dd)
  - Example: PROCESS MAP_St. Simon's VBCO & GED_v3_2022.Aug.02

Team Profile

Team Member	Strengths	Weaknesses
Samantha Smith Department of Emergency Medicine Chair GED	Harmony Developer Futuristic Adaptability Self-Assurance	Find it difficult to enjoy the present moment. Difficulty in getting other people to understand my vision.
Sally Sue CMO VBCO	Significance Focus Empathy Responsibility Realtor	Often perceived as overly concerned about reputation and success, due to masking vulnerability. Often told it makes it difficult for others to know how to support me.
Sydney Shiloh Emergency Department Director GED	Individualization Developer Strategic Arranger Harmony	Can tend to put individual needs and goals ahead of what is best for the group, which can appear like favoritism and bias.
Stacey Salem Vice President for Population Health VBCO	Activator Focus Command Analytical Discipline	Tend to become absorbed in work, and may be slow to respond to others' immediate needs. Can appear emotionally distant.
Sean Scott Clinical Operations Manager GED	Analytical Individualization Focus Maximizer Learner	Have a desire to explore and exhaust all possible outcomes before coming to a conclusion, which can frustrate those who want to move forward.
Sylvia Sowers Care Management Program Manager VBCO	Strategic Intellection Consistency Belief Relator	Been told that others find it difficult to follow or understand my thought process.
Scott Shelby Nurse Champion GED	Responsibility Developer Empathy Arranger Maximizer	Find it difficult to turn down others' requests so I can often overcommit.
Serena Stevie Care Manager VBCO	Organizer Empathy Adaptability Persistent Goal-oriented	Sometimes emotionally impacted by the difficult life circumstances of beneficiaries in caseload. May need to take breaks during moments of high stress to maintain wellbeing.

Template | PDSA Worksheet

Image source: Institute for Healthcare Improvement, 2017



PDSA Worksheet (Short-form)

Template: PDSA (Short-form)

For instructions to use this tool, please see the *QI Essentials Toolkit*.

Date: Change Idea: PDSA#:

Objective (What question(s) do we want to answer?):

4) Act: "What's next?"

- Adapt? Adopt? Abandon? Run again?

1) Plan: "What will happen if we try something different?"

- What will you do? When and where will you do it? Who will do it?
- What data will you collect and how will you collect it?
- What do you predict will happen?

3) Study: "What happened?"

- Did the test go as planned?
- What did you learn?
- Was your prediction right or wrong?

2) Do: "Let's try it."

- Run the test: Carry out the plan. Collect and record the data.

Copyright © 2019 Institute for Healthcare Improvement. All rights reserved. Individuals may photocopy these materials for educational, not-for-profit uses, provided that the contents are not altered in any way and that proper attribution is given to IHI as the source of the content. These materials may not be reproduced for commercial, for-profit use in any form or by any means, or republished under any circumstances, without the written permission of the Institute for Healthcare Improvement.

Example | PDSA Worksheet for Creating a Care Management Connection

PDSA Worksheet (Short-form)

Template: PDSA (Short-form)

For instructions to use this tool, please see the QI Essentials Toolkit.

Date: July 2022 Change Idea: Health information exchange sends text to designated ACO contact PDSA#: 1

Objective (What question(s) do we want to answer?): Timely notification that ACO beneficiaries are in the GED

4) Act: "What's next?"

- Adapt? Adopt? Abandon? Run again?

We will revise the process map based on what we learned and will plan to test the process with one beneficiarie's notification from HIE's ADT feed text to the ACO rep.

1) Plan: "What will happen if we try something different?"

- What will you do? When and where will you do it? Who will do it?
- What data will you collect and how will you collect it?
- What do you predict will happen?

Develop proposed workflow for real-time/near real-time notification by HIE's ADT feed to designated ACO contact
Conduct virtual table top simulation of process with HIE representative and ACO contact representative the week of July 11th
We will collect data on the areas of the process that failed and were successful.We predict the simulation of the ADT feed to the ACO contact representative will reveal barriers to successful and timely notification

3) Study: "What happened?"

- Did the test go as planned?
- What did you learn?
- Was your prediction right or wrong?

Yes, the simulation went as planned and our prediction was correct. We learned that there is a delay of about 2 hours before the ADT feed prompts the text message to be sent, and it comes in batches with other ADTs feeds (specialist visits, hospital discharges, etc.)

2) Do: "Let's try it."

- Run the test: Carry out the plan. Collect and record the data.

We ran the simulation on July 11th with a rep from the HIE and our designated ACO contact. We simulated a patient registering in the ED, HIE receiving the ADT feed and sending a text message to the ACO representatives cell phone. We carefully logged where the process map needed revising

Copyright © 2019 Institute for Healthcare Improvement. All rights reserved. Individuals may photocopy these materials for educational, not-for-profit uses, provided that the contents are not altered in any way and that proper attribution is given to IHI as the source of the content. These materials may not be reproduced for commercial, for-profit use in any form or by any means, or republished under any circumstances, without the written permission of the Institute for Healthcare Improvement.

Exemplars in Forging Aligned Partnerships

Exemplars in Forging Aligned Partnerships Between VBCOs & GEDs			
	Cleveland Clinic	St. Joseph's Health	UNC HEALTH
GED System Name	Cleveland Clinic	St. Joseph's Health	UNC Health
GED Accreditation Level	Level 1 - 1 Level 2 - 2 Level 3 - 10	Level 1 - 1	Level 2 - 1 Level 3 - 2
GED Contact Name	Stephen Meldon MD, FACEP	Nilesh Patel, MD	Katie Davenport, MD
GED Contact Title	Vice Chair, Emergency Services Institute	Vice Chair, Emergency Medicine	Medical Director
GED Contact Email	meldons@ccf.org	patelnin@sjhmc.org	katie_davenport@med.unc.edu
	Cleveland Clinic QualityAlliance	MissionHealth Coordinated Care	UNC Health Alliance
VBCO Name	Cleveland Clinic Medicare Accountable Care Organization (CCMACO)	Mission Health Coordinated Care	UNC Health Alliance
VBCO Location	Ohio	New Jersey	North Carolina
VBCO Contact Name	Jessica Hohman, MD	James Giordano	Tony Rodriguez, MD
VBCO Contact Title	President and Medical Director	Executive Director	Medical Director
VBCO Contact Email	HOHMANJ@ccf.org	giordanoj@sjhmc.org	antonio.rodriguez@unchealth.unc.edu
VBCO Arrangements	MSSP Enhanced (+ Primary Care First)	MSSP Basic E, BPCIA, MA	MSSP Enhanced, MA APMs
Percent Beneficiary Visits at GED in 2022	53% for MSSP ACO	68% for MSSP ACO	20% for MSSP ACO
Scope of Pilot Project Participation	Bi-directional education for VBCO and GED staff; identification of VBC beneficiary in GED; workflows to enhance alternative dispositions to Home Care Plus program	Real-time notification of VBC beneficiary presentation to GED through Bamboo Health; care coordination of VBC beneficiaries to outpatient care settings to avoid unnecessary hospital admissions	Bi-directional education for VBCO and GED staff on capabilities of VBCO and GED for alternative beneficiary dispositions

References

1. Offices of Enterprise Management, & Brennan, N., Real-Time Reporting of Medicare Readmissions Data27–43 (2014). Washington, D.C.; CMS.
2. Vasilevskis EE, Ouslander JG, Mixon AS, Bell SP, Jacobsen JM, Saraf AA, Markley D, Sponsler KC, Shutes J, Long EA, Kripalani S, Simmons SF, Schnelle JF. Potentially Avoidable Readmissions of Patients Discharged to Post-Acute Care: Perspectives of Hospital and Skilled Nursing Facility Staff. J Am Geriatr Soc. 2017 Feb;65(2):269-276. doi: 10.1111/jgs.14557. Epub 2016 Dec 16. PMID: 27981557; PMCID: PMC5311021.
3. Ouslander JG, Lamb G, Perloe M, Givens JH, Kluge L, Rutland T, Atherly A, Saliba D. Potentially avoidable hospitalizations of nursing home residents: frequency, causes, and costs: [see editorial comments by Drs. Jean F. Wyman and William R. Hazzard, pp 760-761]. J Am Geriatr Soc. 2010 Apr;58(4):627-35. doi: 10.1111/j.1532-5415.2010.02768.x. PMID: 20398146.
4. Gonzalez Morganti, Kristy, Sebastian Bauhoff, Janice C. Blanchard, Mahshid Abir, Neema Iyer, Alexandria Smith, Joseph Vesely, Edward N. Okeke, and Arthur L. Kellermann, The Evolving Role of Emergency Departments in the United States. Santa Monica, CA: RAND Corporation, 2013. https://www.rand.org/pubs/research_reports/RR280.html. Also available in print form.
5. Reyes B, Ouslander JG. Care transitions programs for older adults-a worldwide need. Eur Geriatr Med. 2019 Jun;10(3):387-393. doi: 10.1007/s41999-019-00173-5. Epub 2019 Feb 22. PMID: 34652789.
6. Stuck AR, Crowley C, Killeen J, Castillo EM. National Survey of Emergency Physicians Concerning Home-Based Care Options as Alternatives to Emergency Department–Based Hospital Admissions. The Journal of Emergency Medicine. 2017;53(5):623-628.e2.
7. Ehrlich AL, Erickson M, Oh E, James T, Saxena SA. Prioritizing Care of Older Adults in Times of Emergency Department Overcrowding. Journal of Geriatric Emergency Medicine. 2023;4(3). doi:10.17294/2694-4715.1067
8. Bureau, U. S. C. (2021, October 8). 65 and older population grows rapidly as baby boomers age. Census.gov. Retrieved May 18, 2022, from https://www.census.gov/newsroom/press-releases/2020/65-older-population-grows.html
9. Roberts, A. W., Ogunwole, S. U., Blakeslee, L., & Rabe, M. A. (2018). (rep.). The Population 65 Years and Older in the United States: 2016 (pp. 1–25). Washington, D.C.: U.S. Census Bureau.
10. Buttorff C, Ruder T, Bauman M. Multiple Chronic Conditions in the United States [PDF -393kb] Santa Monica, CA: Rand Corp.; 2017.
11. Why are Americans paying more for healthcare?. Peter G. Peterson Foundation. (n.d.). https://www.pgpf.org/blog/2024/01/why-are-americans-paying-more-for-healthcare#:~:text=The%20United%20States%20has%20one,less%20than%20half%20as%20much
12. Hussey PS, Wertheimer S, Mehrotra A. The association between health care quality and cost: a systematic review. Ann Intern Med. 2013 Jan 1;158(1):27-34. doi: 10.7326/0003-4819-158-1-201301010-00006. PMID: 23277898; PMCID: PMC4863949.
13. Juliette Cubanski and Tricia Neuman Published: Jun 17, 2022. (2022, June 17). FAQs on Medicare financing and Trust Fund Solvency. KFF. https://www.kff.org/medicare/issue-brief/faqs-on-medicare-financing-and-trust-fund-solvency/

14. The CMS Innovation Center's strategy to support high-quality primary care. CMS.gov Centers for Medicare & Medicaid Services. (n.d.). https://www.cms.gov/blog/cms-innovation-centers-strategy-support-high-quality-primary-care#:~:text=CMS%20has%20set%20a%20goal,mechanism%20for%20achieving%20this%20goal

15. LaFayette, A. (n.d.). Press release: Medicare ACO Participation Grows in 2023. Home. https://www.naacos.com/press-release--medicare-aco-participation-grows-in-2023

16. Gonzalez Morganti, Kristy, Sebastian Bauhoff, Janice C. Blanchard, Mahshid Abir, Neema Iyer, Alexandria Smith, Joseph Vesely, Edward N. Okeke, and Arthur L. Kellermann, The Evolving Role of Emergency Departments in the United States. Santa Monica, CA: RAND Corporation, 2013.

17. Moore BJ (IBM Watson Health), Liang L (AHRQ). Mho HCUP Statistical Brief #262. August 2020. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb262-Medicare-Advantage-Costs-2009-2017.pdf.

18. Colla CH, Lewis VA, Kao L, O'Malley AJ, Chang C, Fisher ES. Association Between Medicare Accountable Care Organization Implementation and Spending Among Clinically Vulnerable Beneficiaries. JAMA Intern Med. 2016;176(8):1167–1175. doi:10.1001/jamainternmed.2016.2827

19. James, J. (2012, October 12). Pay-for-Performance. Health Policy Brief. https://www.healthaffairs.org/do/10.1377/hpb20121011.90233/

20. Guta A, Wilson MG, Lavis JN Rapid Synthesis: Examining the Impacts of Accountable Care Organizations on Patient Experience, Population Health and Costs. Hamilton, Canada: McMaster Health Forum, 28 March 2016.

21. Wilson M, Guta A, Waddell K, Lavis J, Reid R, Evans C. The impacts of accountable care organizations on patient experience, health outcomes and costs: a rapid review. Journal of Health Services Research & Policy. 2020;25(2):130-138. doi:10.1177/1355819620913141

22. Anderson AC, Chen J. ACO Affiliated Hospitals Increase Implementation of Care Coordination Strategies. Med Care. 2019;57(4):300-304. doi:10.1097/MLR.0000000000001080

23. Accountable care and accountable care organizations. CMS.gov. (n.d.). https://www.cms.gov/priorities/innovation/key-concepts/accountable-care-and-accountable-care-organizations

24. LaFayette, A. (n.d.-a). ABCs of ACOs. https://www.naacos.com/abcs-of-acos

25. Admission, discharge, transfer notifications (ADT) use case. MiHIN. (2023, July 24). https://mihin.org/admission-discharge-transfer-notifications-use-case/

26. APMs overview. QPP. (n.d.). https://qpp.cms.gov/apms/overview

27. Capitation and pre-payment. CMS.gov. (n.d.-b). https://www.cms.gov/priorities/innovation/key-concepts/capitation-and-pre-payment

28. About CMS. CMS.gov. (n.d.-a). https://www.cms.gov/about-cms

29. Risk-based arrangements in health care. CMS.gov. (n.d.-d). https://www.cms.gov/priorities/innovation/key-concepts/risk-based-arrangements-health-care

30. Hospital-at-home: AHA. American Hospital Association. (n.d.). https://www.aha.org/hospitalathome

31. Home- and community-based services. CMS.gov. (n.d.-d). https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services
32. What's Home Health Care? Medicare. (n.d.). https://www.medicare.gov/what-medicare-covers/whats-home-health-care
33. About IAC. Institute for Accountable Care. (n.d.). https://www.institute4ac.org/about-iac/
34. CMS. (2024, January 17). Medicare Spending Per Beneficiary - Hospital. https://data.cms.gov/provider-data/dataset/rrqw-56er
35. About the program. CMS.gov. (n.d.-b). https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/about
36. O'Dell ML. What is a Patient-Centered Medical Home? Mo Med. 2016 Jul-Aug;113(4):301-304. PMID: 30228482; PMCID: PMC6139911.
37. Risk adjustment. CMS.gov. (n.d.-f). https://www.cms.gov/priorities/innovation/key-concepts/risk-adjustment
38. Total cost of care and hospital global budgets. CMS.gov. (n.d.-h). https://www.cms.gov/priorities/innovation/key-concepts/total-cost-care-and-hospital-global-budgets

westhealth

www.westhealth.org