Transcript for podcast

The DL on ACO's with Larry Preston

00:02 - Melody King (Announcement)

Welcome to TCN Talks. The goal of our podcast is to provide concise and relevant information for busy Hospice and Palliative Care leaders and staff. We understand your busy schedules and believe that brevity signals respect. And now here's our host, hris Como.

00:24 - Chris Comeaux (Host)

Hello and welcome to TCN Talks. I'm so excited. Today Our guest is Larry Preston. He is the CEO and co-founder of Silver State ACO. Larry, welcome, it's good to have you.

00:35 - Larry Preston (Guest)

And thanks very much, Chris. Pleasure to be here today.

00:38 - Chris Comeaux (Host)

Awesome. Well, what does our audience need to know about you? To know about you.

00:41 - Larry Preston (Guest)

Well, from a very simple point of view, I started in healthcare in 1973, so I'm 51 years into it. I still enjoy what I do, which I'm very fortunate to. I started off in the hospitals. For the first 21 years I had great mentors. Both the CEO and the CFO of the hospital told me whatever you do, get a degree in accounting or finance and that's going to be the future of healthcare. And here we are, 50 years later and everything's about that. So from that I was able to work for a couple of large entities for a while HHA being the biggest, obviously, and I was able to get my master's degree at that point in time. And then by being involved with certain organizations like HFMA, ache, it's really been able to broaden my experience, because I've been able to have the opportunity to see not only the provider side, the hospital side, and

now my consulting side and working with the providers for the last 31 years on that end of the table.

01:42 - Chris Comeaux (Host)

Wow. And then tell us about Silver State, and so I think I've gotten the privilege of knowing you. For a lot of our listeners this is the first time. Silver State is one of the most successful ACOs in the country, so can you talk about that just a little bit?

01:56 - Larry Preston (Guest)

Yeah. So Accountable Care Organization is something that CMS came up with as a demonstration project back in 2009, 2010. 2012 was actually the first year and it was an 18-month rollout. So 2012, 2013. And Medicare did have a good idea on this demonstration project how can we get doctors who are technically generally not associated with each other to work with each other, to be able to somehow start looking at a way of reducing cost but increasing the quality of care that's been given to the patient?

02:34

So in 2012, we actually started looking at this, me and one of my business partners, and said this we think is a future for us. This is what we need to do here in the state of Nevada. Our costs were extraordinarily high. We have a lot of for-profit entities here, so the communication wasn't probably what I'd say is the best, but by looking at this, we realized this probably is a great way to go and to see if we can get competitive people to work collectively together. So our first foray was a total failure. We decided to do a joint venture with a physician and we should have known that it wasn't going to work out, and a few months into it we decided, okay, wrong partner, let's do this in a different way and we decided that we would go in a totally different direction and in 2013, we put our application into CMS and got approved and we started in 2014. And to be qualified in the ACO at that time you had to have a minimum of 5,000 lives. So it wasn't going to be just a small mom and pops or the world's were going to be very difficult to collectively get 5,000 Medicare lives and these people had to also have what Medicare calls a plurality. So they had to be attributed to. You know somebody who was in your ACO and they determined plurality based on the number of E&M codes that get billed out during a calendar year. And if they go to 14 doctors and maybe a specialist, like a cardiologist, has seen them more times in a

primary care, then they're attributed to that cardiologist. If that cardiologist is not in your practice or in your ACO, then those patients are not going to be involved in your ACO.

04:22

So by starting off so early, especially our bad situation and then understanding what we needed to do was to find good partners, and I mean good partners in the IT realm. So we had to go out and we had to find people and we were able to do. People like Experian Obviously, you know most people have heard of Experian, but they had the ability to go in and tap who was a Medicare beneficiary and who is a Medicare beneficiary. That was on a managed care plan. They were in probably 85% of the hospitals in the United States so we were able to help create a process with them that when a patient got admitted that was attributed to our ACO, then they would go ahead and ping us and then we could let that doctor or that hospitalist know there are one of our patients and, please, you know, here's the protocol that we would like to follow up.

05:15

So, looking at that, that first year was a tough year for us because we were totally learning. We brought in some great partners Health Endeavors out of Scottsdale Experian, like I said, and they had the IT background, they had some legal background that helped us and it just allowed us to learn really on the fly. And then CMS to their credit, they assigned us an ombudsman or somebody out of their San Francisco office and so we had a contact Anytime we had a problem. We could give her a buzz and say why are they doing this or why are we getting reports that we cannot manipulate in any way of shape or form. So that learning curve in that first six or seven months of 2014 was very large. But we realized really early in 2014 that we'd actually hit on something when we got our first claims run from CMS Stuff that we did not know that a patient is being seen by 14 primary carers are three cardiologists, drug seekers A lot of the stuff that's pretty nationally acceptable now that you could find out through whether it's WebIZ in our state or whether it's in your drug interaction programs.

06:31

They weren't in existence across the board back then. So we were able to start looking at things and we got our first set of reports. The first thing we noticed was the hospital was 43% of our cost, so every dollar that was going out of our ACO, we were spending it on the

hospital. So instead of trying to change physician behavior, what we tried to do is to try to figure out a way to change the behavior at the patient level and looked at what we saw were the people that were going to the hospital frequently, at what we saw were the people that were going to the hospital frequently and the more times they were going to the hospital. Obviously it was costing Medicare $16,000 to $18,000 on a minimum permit and about $2,500 for an ED visit.

07:15

So when we started looking at our process, we started looking for how can we make a pretty big impact early on. But we know we had to change that physician. But we couldn't do that initially until we told them where their problems were and, quite honestly, where they were losing revenue. Because if that patient's going to the emergency room, that doctor is not getting a penny for that visit. But if we could figure out a way to have them go to the office more frequently, I'd rather pay that office visit at $175 a visit than pay a $2,300 visit to go to the emergency room just because they couldn't get access to something.

07:53

So that was our beginning of our learning curve in 2014. By the third quarter it changed dramatically. Now we had late third quarter. We had two quarters worth of data being filtered to us and then we just started seeing even more information and we were very fortunate again to have a great partner in Health Endeavors that said look, help us, help you design reports, because we want to grow our business horizontally with more ACOs, and by doing that they basically gave us carte blanche to help them write reports that all of her clients after that are starting to use and were using, and it helped us really start that first year off in a great way, but in a long learning curve.

08:38 - Jeff Haffner (Ad)

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09:16 - Chris Comeaux (Host)

So what? I think last time you and I interacted you guys had just come off a really big savings year. Has it kind of been like an up and down, larry, or has the trajectory been? It's just gotten better every year. I imagine it's probably a bit of a mixed bag, right?

09:32 - Larry Preston (Guest)

It is and the way this system was designed and being a non-clinical financial guy I call it it was designed to be an EKG, so the better you did. Then the next year there was no way you could do it again and your baseline kind of stayed the same. So if we started off with our average cost per beneficiary per year at, let's say, $12,000, and we knocked it down to $11,500, then we didn't get judged on the $12,000. In year two we got judged on $11,500. And then in year three we knocked that down to $11000, then 10,007, then 10,000. So every year you did better. It made it harder for you to make savings in the next year.

10:14

Now we're an anomaly and we understood that is that we came from like Florida and a few other states. We were a high cost state. So we looked at it and said our expectation is to probably make savings every couple of years and then have a reset year. We're going to change. We just can't keep peeling that onion down to where there's nothing left. So somehow and I'll say it's great fortune, it's good luck, it's good people I was very fortunate of the staff that we have great partners at the hospital level who understood we're trying to keep patients out of their hospital. At the same time they actually joint ventured with us and understood this is probably the future of where healthcare is going to go. So for eight years we've had consecutive savings.

11:04

We don't. We're always a year behind with CMS, so we don't know what our 23 results are going to be until September, maybe late August. So you're already three quarters into the year before you know what your prior year was. But in our particular situation, like I said, we've been very fortunate and I know you said we've had savings in eight straight years. So in almost 1,000 ACOs that have been coming and going during that eight years, only 17 have been able to do this year over year over year over year, eight straight years. So we

know we're pretty lucky in that respect. And it's even more prominent because and, chris, I know you all know this and probably a lot of your folks know that the East Coast, or I should say the Northeast and the West Coast, were far ahead of the game as far as being in risk models and value-based performance. So we were worried that we wouldn't be able to get to certain levels because our people were so used to it. And so out of those 17,. We're the only one west of Texas.

12:08

So, that means all the California ones, oregon, washington, the big states, arizona none of those were able to keep this consistency going because they were already at a level that managed care had been ingrained with us for 35 years already in our state. So that's why we're waiting for that hiccup to happen. We know we're going to have a bad year at some point in time, but we also are probably very, very adapted at watching what's going on in the Federal Register, watch what's going on in the open market. We've been as high as 55,000 attributed lives down to 35,000. So our success has created other people to want to come into our market and take our patients and quite honestly, we're not unhappy about that because we think the more people that can get into trying to figure out a way to deliver quality care and reduce the cost if they're not in our ACO. We tell the groups that we talk to if you don't want to join us, join somebody.

13:06

It doesn't have to be us. We prefer that, but it doesn't have to be us.

13:10 - Chris Comeaux (Host)

That's interesting. I've never asked you this before earlier, but how many employees are actually in your ACO?

13:16 - Larry Preston (Guest)

So to manage our population, we have I'd say, as of right now, we have 18 employees. Wow.

13:23 - Chris Comeaux (Host)

Total, and those competencies are technology, case management and finance minds, or just talk a little bit about what the makeup.

13:30 - Larry Preston (Guest)

Yeah, actually that's a great one. So we had a director of operations who was our first person and her background was legal. So we figured, since all we're going to be doing about it is dealing with CMS and all the legalities, we might as well get somebody who's got a really good background in that way. Her husband has been an attorney and still is for the last 40 years. She became our director of operations and said look, make sure we don't go sideways with CMS. The regulations are going to change literally any time. A federal register potentially comes on out, I need you to read and read and read potentially comes on out. So I need you to read and read and read and then you know from there.

14:09

Our second hire was was a nurse and I needed somebody with that clinical background. A lot of these people I already was in our in my other business was their manager, their practice consultant. So I knew those, those people in the practices, relatively well. But clinical I didn't know the clinical side of it. So I brought in a person and she had worked at one of the hospitals here and what her experience was was the fact that she was also doing clinical auditing. So we realized that if we don't let them understand what we're looking for and how that charting has got to be done in the CMS format, not necessarily their EMRs format that we were going to be lost. So by bringing in Rhonda was great, and then within a year and a half or two, we elevated her to the chief operating officer of the entity. Then we started looking at, okay, who are the people that are going to be in the offices? Then we started looking at, okay, who are the people that are going to be in the offices? And I think, as we have talked about once before, one of our key successes is and again, technology is beautiful, but if you don't have somebody physically boots on the ground, going into that physician office, talking to that physician and talking to their staff as to why we need to have certain things done in a format that CMS will allow it to happen, it's not going to work.

15:27

So our next five hires I brought in MAs. All of them worked in a physician office. Two of those five actually worked in groups that joined our ACO, so then they had a lot more intimate understanding of that. And then, as we expanded, we did the same thing. We started just

looking for people more clinical oriented and somewhere around year seven we started realizing we were getting a lot of analytical information and we weren't getting it out back to our providers properly. So then we hired somebody with that background a PhD background. So then we hired somebody with that background, a PhD background who could run these massive reports and take them into actionable items. And I think that was one of the biggest things that we were hearing from our board as well as we were hearing from the doctors that we were going out.

16:16

There is that man, you're giving me a lot of stuff, but what do I do with it? Well, here's what you do with it. We can show you avoidable ED visits. We can show you people that are your frequent flyers, that are going into the hospital. So if you can help us, we'll give you the data to that. We'll tell you when a patient's being admitted, whether it's in Southern Nevada, northern Nevada or it's outside of Nevada because it's CMS, it doesn't matter where they're getting their care. So we can give you that information. But we will give you now reports that will show you how well you're doing with that information.

16:54

And I think when we got that side of it working for us where we were actually giving them monthly reports and we forced the doctors, as part of staying in the ACO, that they had to attend these meetings and they had to sign off on the reports.

17:09

So it's one thing to have a meeting, but it's to have the follow-up paperwork and the sign-off on it, yeah. So then we go there the next month or the next quarter and they're like well, I don't remember you ever telling me that. Well, here's the two pages of our meeting notes. It says, right here, you were there, you agreed to it, oh, and you signed off on it. So that personal action does make a difference. And along that way, chris, we also found out how many charts or how many patients could a quality coordinator was what we call them how many could they actually handle to be effective. We started out at a high number, had to move it on down, but in the long run we found a good number and we know how many people those auditors can touch effectively. And because they do it 12 months out of the year, versus a lot of the ACOs they do it at the end of the quarter or after the year's over and

they just are basically attributing the information down. But it's too late to make any impact and change.

18:08 - Chris Comeaux (Host)

I was wondering about that when you were talking about the data. Like you know, typically like we use an interesting vendor, but the lag on that data is like six months old, so do you have more timely access to the data that's happening with the patients?

18:24 - Larry Preston (Guest)

Well, it's a quarter behind, so that's not too bad and you can see the trends. So again, having that trend information quarter after quarter after quarter, we still have a fluctuation of anywhere between six and eight percent of the patients per month. So, people coming on, people leaving, obviously the new Medicare patients, those are the ones that come in during the year, the ones that have expired or the ones that have somehow changed over to a managed plan. Luckily that's open enrollment, so we don't see that fluctuation, except for in the first month or two of the new year. But overall we still have, whether they've changed our market or they've changed their primary cares.

19:10

Under this arrangement with CMS, our agreement with CMS, we cannot tell the patient where to go. So if they one day just don't like the physician and they go to the physician next door to another doctor who's not in her ACO, a couple, three months down the road they're attributed to that guy now and he's no longer in there. So that's why we have that 8%, 6%, 8% swing on a monthly basis. We still try and follow them and when they do go out of the ACO, we let the doctor who's the primary doctor, we let them know says why did you lose that patient? I mean what's happening? Access to getting under your phone system, access to the next appointment, available, appointment. We are in a severe shortage here in Nevada with primary care, so it's not unusual to call and not be able to get an appointment for 45 days to 60 days. Yep, yeah. So there again lies some of our problem of why people go to the ED. Um, because they just can't get out.

20:07 - Chris Comeaux (Host)

Yeah, um so I want to back up a little bit. Larry, this is so good. There's so many pearls in what you're saying and every time I get to interact with you I learn more. But I'm thinking about our listeners, and a lot of my goal with this podcast is just to for hospice and palliative care leaders to start to get their minds up around what is an ACO, how does it work and, of course, where we're going to go is how do we partner with them? My first you'll appreciate this my first CEO in hospice was an ex-hospital administrator and he had all these interesting, very, very stern kind of things like Como if you want to understand how healthcare works, figure out how people reimburse and that'll tell you why they do what they do. That was actually a brilliant piece of advice and so so in the spirit of that. So how exactly is an ACO reimburse would be, I think, so helpful for a lot of our listeners. So how are you reimbursed?

20:57 - Larry Preston (Guest)

So I'll give the analogy of think of it like a budget and in fund accounting and budgeting or governmental accounting they put a swath of money out there and say, okay, here's what you get to do your charge. And in our particular case it's like $700 million. And so what they do is they look at the spend of our patients over the cumulative three years. But they look at the spend of our patients over the cumulative three years, but they look at the average spend and they come up with a budget and say, basically, here's what it costs us. Under the old fee-for-service business it costs $11,000 per patient per year. So if you can save money on that, you've got an opportunity to share in that savings. And when we started there was only one level, but now there's multiple levels and multiple types of ACOs. So if you come under budget, in those first few years it was a 50-50 split. Now, with anything with the government, nothing's truly 50-50. So obviously the 2% sequestration comes off that. So it's really 48%. And then you have quality scores. So then those quality scores are measured to a point where the first couple of years if you got 90% or above, you got 100%. Probably the way they balance their budget in Washington the same way. It's a weird way of doing it, but they finally said look, whatever your score is is what your score is. So if you have a maximum of 48% that you're going to get, and you got a 90% quality score, you'll get 90% of the 48% that you go back to it. Now it gets more complicated because there's factors within all of that stratification, but for most of the time we've been able to have extremely good success. And then we had a really successful period during COVID where our costs really dropped which where everyone else's were going out of the roof ours actually were dropping which, where everyone else's were going out of the roof, ours actually were dropping. So those were some of our bigger years, but that's the basic formula. About six years ago they said you know what Some of these ACOs are performing

so well. Maybe they want to take more risk, and if you take more risk, we'll give you more of the pie.

23:14

So it took me two years to convince our shareholders that this is what we should do. We should go to that higher risk and, by the way, if we had gone to it one year before, we lost $2 million because you guys were afraid to take the risk. So I was able to convince the board. We shifted from a 50-50 to a 75-25 plan. Was able to convince the board. We shifted from a 50-50 to a 75-25 plan.

23:45

So when we did that, that exposes to if our benchmark, our budget, if we exceeded our budget, then we had to pay Medicare money back. So we had to go out and get some reinsurance. And then there was some qualifiers and added how much? But our potential exposure was $17 million. And so I went to our shareholders and I said, look, I believe in this so much, I'll take that entire risk, I'll buy you all out. And they were like well, wait a second, why would you do that if you didn't believe in it so much? And so they stayed in and luckily they did, because you know it helped us all out. But so we've been on that 75% risk now for the four years. So, and then some of the ACOs have chose to go to another track. It's called the reach and it's kind of a hybrid right between what we're doing and an HMO.

24:32

And there's another couple of them that are coming into play. So CMS is every year they're tinkering with this, and we've been fighting vehemently between the National Association of ACOs, us writing letters to everyone we can talk to in Congress. If we're so successful, why do you keep making it harder for us to continue to be successful? Because you're saving money and as a senior citizen myself, I'm looking at trying to make sure that system stays alive as long as I'm alive. So, but I hope that kind of explains it.

25:06 - Chris Comeaux (Host)

We have semi-risk and a risk, but it's based on a budget have to cash flow this thing because yeah, and then like, even when you reconcile, so is that runway like two years from the time that you do this. Is that about right?

25:27 - Larry Preston (Guest)

yeah, it's actually. It works out to be about 19 months, so july or august. So when we've got our first year, we lost money and and we had brought luck, we brought in in some stakeholders. So we used that money to fund year one and two. And the way we designed our system is that each year was a silo, so if we lost money in year one we didn't get it repaid back in year two. That would be the shareholder's responsibility and not our physicians. When we entered the market which is I probably should have prefaced that is that we went into this market knowing the physicians were not going to be in favor if they had to put money up. Most physicians don't like to put their own money up, they just like to get money back.

26:11

So we said, look, we'll take 100% of the risk. You'll never have any liability at all. But when we have savings we want to get our expenses paid back and then we'll go to our distribution of our formula of how the physicians get paid and how the shareholders get paid the difference. But we also need to be able to think that this isn't designed to be successful financially every single year. I mean, so we have to have a reserve. So we built in a long-term and I want to say we built in a 10-year project, even though we had a three-year agreement, then a second three-year agreement, then a five-year agreement. So we're actually in that model right now. This will be our 24, is our last year under our five-year agreement, which is our third agreement. And we just submitted our agreement for the next five years and it'll probably be July or August before they tell us if we've dotted all the I's and crossed all the T's properly. But the formula was that this was not expected to be one where we thought the physicians were going to be reliant upon making money out of the ACO, they were going to be driving costs down and they were going to be giving better quality of care. So when I would go out there and sell it, they were like, oh, I've got people telling me that they're going to give me $40,000 or $50,000. Well then, go with them. But how is that going to help your patient and, realistically, how's it going to help our goal, which our goal is to coordinate care and reduce cost? So if you think the patient is more important than the dollar, which is a hard sell then the dollar, follow the dollar first. But if you think the long-term is a better product for you, then stay with our formula. Our formula is we would like to

get reimbursed, we would like to get our costs back, we would love to be able to get distribution to you. But if we can improve that quality of care and give you an opportunity as a small practice and we've had very small practices and very large practices a small practice is from getting gobbled up by a, by, you know, an outside entity. You're not going to be able to do that unless you understand what, why they're selling themselves to the anthems or the uniteds or the yetness and stuff like that. They're selling that they got a product that's going to give them quality metrics and heat is reporting and and and scores. That that they want to be able to sell to those employers who they're selling their plans to. Well, it started off on the Medicare side of it, because you can wean that right down into the commercial side. So what you're learning on this side can help you on that side.

28:48

And, shockingly, some of and two of our board members who basically had maybe a hundred attributed lives in Medicare they didn't want it. It was low paying, they didn't want it. They've almost moved an entire plan to Medicare their population out of Medicare. They didn't want it. It was low paying, they didn't want it. They've almost moved an entire plan to Medicare their population out of Medicare because they realized what they were missing was they were just trying to see the patient more frequently instead of treating the patient, and if they went to the hospital it didn't hurt them, but they weren't really treating the patient, and so I think that transition for them has been remarkable.

29:20

So the doctors did it more of a favor to me as, being with them and being an apraxic consultant, they didn't really know what the ACO could do for them and it really turned them around, where now they're a great spokesman for us, because they realized they weren't doing all the quality metrics and they weren't treating the patient other than as a come on in and get a 99213 and go back out. So now they want to treat the patient, be very much more cognizant of making sure the referrals they're not coming from another ologist, they're coming from the primary care and when they send it to a radiologist or they send it to a hematologist or they send it to a specialist, that that specialist, if he wants to send it to somebody else, send it back to the primary care first. And when they didn't know where they were going, our analytics now can tell them. Why did you send it to the cardiologist? And next thing you know there's four other neurologists working on the patient. Did you know that?

30:17

No, so now you can call the cardiologist up and say, hey, if you do that again on my patients, I'm not sending any more patients. I want to be the centerpiece of this patient's care. I know I'm not the specialist, but I need to be that centerpiece. We try not to use the word gatekeeper, even though that's the nomenclature that was there for years, but be the centerpiece of that patient's care, and I think that's been a great enlightenment for our physicians on the board and just as the physicians come into the practice when they're not on the board, we are able to give them that data and show them this information, and sometimes they're just absolutely mad at themselves that they didn't know this was what was going on with their own patient.

31:00 - Chris Comeaux (Host)

So, Larry, I'm going to say some things to kind of speak to my Hospice and Palliative Care leader peers and I want you to clean up what I'm about ready to say. So the question is just generally, you know, how does an ACO really bend the cost curve? And I was talking to a peer and they're like well, you know, all the people are paid differently now and I said that's not totally right. I said everyone's using the methodologies they were getting paid before, but the ACO as an overlay. And actually, as I listened to you, I'd actually change that to say more of how it's infused throughout the care continuum, the care model it shapes and molds and helps behaviors in a much more efficacious way for the patient to get a good continuum of care. Would you clean that up anyway or say that differently? Again, I'm trying to speak to my hospice and healthcare peers of what they understand.

31:54 - Larry Preston (Guest)

Right. So nothing changes on the way they submit claims or how they get paid.

32:00

That's the first misconception. It doesn't go to the ACO and then we pay the provider. It goes directly to CMS claims clearinghouse same clearinghouse that you've always used. Nothing changes on that. The only difference is that they never saw those reports from Medicare, so that physician could not go in and see anybody's claim but his own. Now they get to see everything on that attributed patient, so they know when he went to the hospital they went to the emergency room, they went to a radiology, they went to anybody who's

paying Medicare. That Medicare is paying. They now have access on that for that attributed patient.

32:41

And that's where we can get down there. We can give them wonderful flash reports. We can give them benchmarking tools. We can show them within our ACL where do you stand? How many avoidable EDs did you have compared to your peers?

32:59

We have quarterly meetings with our office staff that we get them in a room. Let's say we have 40 or 50 in the South, we have about 30 up in the North. We have them quarterly and then we call out the good people and we call out the bad people. And it's not to shame them, but it's to say look, two years ago he was in the bottom of the list. Now he's in the top what clicked? And then we usually will.

33:23

Physicians don't come on in, but we usually will be able to have one of those practice managers say here's what we did. Our revenue increased because the patient was going to other places and we didn't know that. So now we can at least get them into our facility as frequently as they need and not have to go to so many people. From a reporting point of view, that's the best thing we can tell anybody who's in the business. You've got to look at those reports and see where these patients are going and you've got to set up some guidelines or some KPIs that say what should be normal. How do we define best in class? And what's good for an internist is not necessarily going to be good for a family medicine guy, but there's ways to manipulate that as well, to say here's what should be going on.

34:10 - Chris Comeaux (Host)

No, this is so good, Larry, it's just there's so many pearls in how you describe it. So let's now segue, because I think you've done a great job helping them understand, kind of how an ACO works. When you and I last year kind of started off with well, how can hospices partner better with ACOs, I'm so glad we backed up and like better education. And, by the way, I almost feel like we just came back from MPHI again and that's where you and I first met last

year it really feels like the time is now for hospice-empowered care programs to be approaching ACOs. I got a sense of that last year and it was kind of a leading-edge thought. Now it very much feels so. So how would you advise these listeners and hospice-empowered care leaders? How should they approach ACOs? It's about how to be better partners for them.

34:56 - Larry Preston (Guest)

Well, the best way is to find out who is an ACO in their neighborhood. You can find it right on the CMS website, just Google accountable care organizations in your state, your locality. Go talk to them. There are ACOs that are now being specific to hospice that are going to come up. I don't know, because of the payment mechanism, if that's going to really be the way to go. But your patients, especially if they're the Medicare patients, find out who their PCP is and ask them if they're in an ACO. If they're in an ACO, then there's data that they can start getting out of that ACO with that PCP. They can transition that data back and forth and obviously, when they're at home they're doing the palliative care.

35:41

There's a lot of things that that nurse can't do and even the medical director can't do that that physician can say hey, I've been treating this patient for 10 years. I didn't know that you wanted to do this. I can help you with that. It may not cut the cost, but it'll curb it enough to make a difference as well as give that person that last few months to six months of life, we hope in a much better, better format. The role of the hospice is just is so underestimated in this United States, and so I applaud what they do and we talked about that at the meeting as well. Just, it's absolutely amazing what they go through.

36:16 - Chris Comeaux (Host)

Whenever you were alluding to earlier, when you look at that average benchmark of cost per year. So I'm going to say something out loud. You tear me down if I'm off base, but that's an average, right. But hospice can really help hospice and public care with those sick, those sickest patients, which you know they may be $200,000 a year. So is there a way to partner with an ACO to say, well, let's look at those sickest patients and because you know hospice is about $5,000 a month, so, just off the top of my head, well, if my benchmark's 11,000, but you're talking about at a time when usually those people are going way beyond that average. So is there a way to make that conversation? Because, again, I always hear

what the benchmark is and I get it. That makes so much sense, that's like one of your key KPIs, but it feels like maybe there's a different way to look at this particular population.

37:08 - Larry Preston (Guest)

Yeah, when they go into hospice then they're kind of moved out of the ACL risk responsibility, just like in-stage renal same thing. So there's carve-outs, but that doesn't mean the data is not available to them and again it goes back to you know what can we see? Does the hospice really know that they're going to an emergency room before you know? Let's just say the nurse is coming over. You know, once a week did they go to the hospice just with that nurse, or were they working with a nurse or did they go to the ED? Patients sometimes either don't remember or don't want to tell.

37:43

Well, when you start seeing data coming through and you go, what happened? Why did you go to the hospital twice? We didn't seem to know about it and I give the example of my mom's the best example that she's. She'll be 94 in July, luckily. And if it wasn't for our neighbor who, luckily, I went to school with because she still lives in the same house for 60 years, I wouldn't have known. The ambulance came and took her to the hospital because she didn't want to tell us. So trying to get people to give you the information is difficult, especially at the seniors and especially in the hospice patient. But if you have that data, you'll be able to see it a little late, but you'll be able to see it and you want to curb that and maybe that gives a little more ammunition also for what the nurse when they go there, what questions they have to ask and why are they asking those questions? So they make sure they didn't go outside of their system. I don't know if that helps or not.

38:36 - Chris Comeaux (Host)

It does, and actually I think I may have misunderstood you. So when a patient goes on their hospice benefit Medicare hospice benefit that doesn't go into your total cost of care as the ACO, or is it?

38:48 - Larry Preston (Guest)

Now, that is now then turfed off. Yes, no kidding.

38:51 - Chris Comeaux (Host)

Wow. Well, that's okay, then that's a key. Now, Palliative Care. That's probably not the case because that's a part b service. But that's?

38:58 - Larry Preston (Guest)

yeah, that's just going through the system yeah, that's it. So again, there's carve outs in the in in that stuff. You know, behavior health we've always thought should be a carve out because we cannot get information on the patient on behavior health. We're responsible for it, but they won't give. So we were like, why don't you carve that out? Because you're asking me to control something you won't tell me anything about.

39:18 - Chris Comeaux (Host)

So I can't do anything about it. Yeah, it totally makes. Well, that's probably a good segue, so, larry, you guys are on the leading edge. So what future innovations are you seeing in ACOs?

39:29 - Larry Preston (Guest)

From innovation is technology right now. How can we get the information onto it? With our 55 practices we have 23 different EMRs, so those electronic medical records are the key to be able to go through 24. But in 25, it's the typewriting or typing in their information is no longer acceptable to Medicare so it has to be in a menu drop-down menu. It has to be something that's already enabled into the software. That's our biggest challenge. Going forward in 25 is we've already gone through the practices and identified out of those 55 how many are willing to change. You know they've got to be able to do this, interfacing this information through your electronic medical records. Not just that, it's being placed in your electronic medical record. So our biggest challenge right now is convincing them why they have to change, and sometimes there is some cost to that.

40:27

Our second one that we went with a couple of years ago, we looked at ways that we can get information into somebody's medical record without them being too intrusive and without it costing a lot of money, and through going to well, I'll call it HIMSS, the Health Information Management Systems Society going to their expo every year. Even if you don't like computers, go to it, it is the kid in the candy store shop and we found a couple of people that were doing things that we didn't realize we could use. One of them was a company called Holon and the other one was Illumicare, and both of these have software that will fit on top of your software without being intrusive. But when that patient, larry Preston, goes to the doctor's office, it'll come up and say, hey, he hasn't had an A1C, this guy's prediabetic, why hasn't he had an A1C in three months? You know your blood pressure doesn't make any sense.

41:20

So it's feeding information out of our data that we collect within the ACO and their claims and putting it into that pop-up menu that comes up on their screen within their EMR. And right now I think we've got 30 or 35 of the practices to use it. But the best thing is that two of the practices and it always seems to be in twos that we were able to segue this out they went from 60% to 90% in their quality scores just by using Illumicare, because they just don't have time to look at their notes to see, oh yeah, but if it's sitting on the screen for them now, we made it really easy and it's worked for large like Epic and Cerner. It's worked for the large system, it's worked for the small systems, so we know if they can do that. That's our bonus for 25, 26 is to make sure everyone's on one of the well that product is Illumicare in our case and that they have to upgrade their software. The EMR is the only way CMS is going to allow us to judge our final outcome.

42:27 - Chris Comeaux (Host)

Wow, Well, Larry. Final thoughts to our listeners.

42:30 - Larry Preston (Guest)

Engage in analytics, nurse, engage in analytics. You know, from the hospital side of it, I knew every day how many people went into my ED, how many people were admitted, how many people were on what floor and for what reason. Physicians generally don't know that, they just don't. They're focused on seeing the patient episodically. You know versus you know in a total totality. So, whether that's you know, the home care type situation or the any

other situation, they've got to look at the analytics of their practice. They've got to understand their patient demographics and whether it's social determinants of health as being, you know, one of the big plays right now is, you know, access to care. Is that why they're sickers? Because they can't get transportation, they can't get into your office. So technology is not going to solve everything, but it's going to help them be more efficient and we truly believe that the technology has got an opportunity to give them that quality of care and extend that quality of care.

43:32 - Chris Comeaux (Host)

Well, Larry, thank you for what you and your team, you guys, have been successful. For a reason I learned every time around you just understand more and more. You are just a wealth of information, and so I can imagine the same is true of all of your team. So again, thank you for the work you guys are doing.

43:45 - Larry Preston (Guest)

Awesome, appreciate it.

43:47 - Chris Comeaux (Host)

To our listeners. Thanks for listening to TCN Talks and, as always, we always want to leave you with a thought-provoking quote, and so this is one Larry and I agreed on. It's from Martin Eaks. It says "if you focus 20% externally and 80% internally, you will rot from the inside out, which is really interesting if you think about what we're talking about today. Thanks for watching.