

# Accountable Care



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Lourdes Health System

Today

LHS HEALTH NETWORK

## Lourdes ACO Sets Regional Mark for Cost Efficiency

The Lourdes Health System accountable care organization—the LHS Health Network—was the only one of the Delaware Valley/southern New Jersey region’s ACOs that achieved high enough savings to receive reimbursement last year from the Medicare Shared Savings Program. ACOs are voluntary partnerships of doctors, hospitals and other providers that use care coordination and disease management, with special emphasis on high-cost patients, to reduce expenses and increase care efficiency and effectiveness for a given population of either government-pay or private-insurance-pay patients.

ACOs that can provide care at significantly below a benchmark cost figure set in advance by CMS receive a share of the savings. The recent report showed six of the area’s 10 ACOs had expenses below their benchmark figure. But only LHS Health Network qualified for a shared-savings payment under the program’s guidelines. Four of the region’s ACOs incurred expenses above their targeted goal.

“With continuity of care and preventive measures, we are able to improve the healthcare experience for members, while helping providers to better quality and efficiency,” said Jennifer L. Schwartz, President of the LHS Health Network.

### Integrating with Efforts of Primary Care Staff

Twenty nurses and eight social workers at the ACO helped its 180 affiliated primary care physicians manage the health of some 5,500 Medicare patients. CMS established a goal of \$61.5 million for the care, based on the historical costs for these attributed patients, looking back across three weighted years and adjusting for risk.

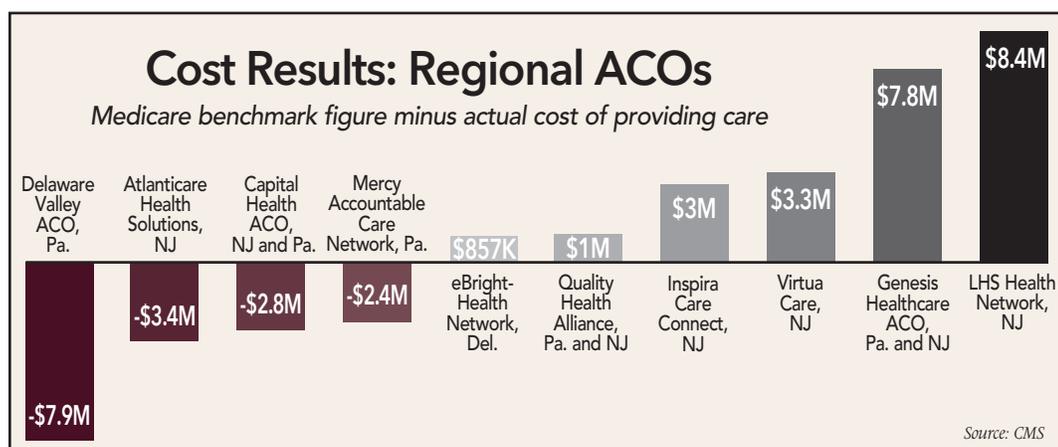
LHS Health Network assigns to each participating practice one of its care coordinators, who becomes part the practice’s team and makes calls to patients on behalf of the practice. Through the EHR, this care manager also communicates with practice staff, including doctors, nurse practitioners and physician assistants. The ACO team works to reduce inpatient admissions and emergency room visits, and shorten stays at skilled nursing facilities, by remotely monitoring patients’ vital signs, helping patients schedule follow-up visits and reminding about medication. For its patients, the ACO also maintains a preferred list of nursing homes that provide the best care, at the lowest price.

The resulting cost of care for this panel of patients was \$53 million. This was the sixth-highest savings rate by percentage in the country among the more than 400 organizations that participated in the program. An award payment to the ACO of more than \$3.5 million was split between the ACO and its physician members.

### Commitment to Pop. Health, Physician Collaboration

LHS Health Network also covers more than 50,000 patients in commercial health plans such as Horizon, Aetna and AmeriHealth—using a similar arrangement for shared savings when goals are achieved. In addition, it is now the region’s only ACO participating in the Next Generation CMS program, in which it accepts more downside risk but potential for greater shared-savings awards.

“Our success is partly a tribute to the commitment that our parent organization, Trinity Health, has to population health,” said Ms. Schwartz, who oversees a staff of 70 at the ACO, including an analytics team and provider relations team.



Said Reginald Blaber, MD, FACC, MBA, President of Lourdes Health System, “This ACO’s work proves that hospitals and independent physicians can work together to achieve the three-part aim of better quality, better access to care and lower costs.”

**Providers interested in joining the LHS Health Network, please call 856-580-6314.**

## Patient Case Illustrates Role of ACO Nurse Care Managers and Telemonitoring

*LHS Health Network cites a representative patient-management case:*

In August of last year, one of the network's payor partners attributed a 74-year-old woman to the ACO's panel. The patient came under the ACO's care because she had complex and chronic morbidity and was at high risk for hospital readmissions and other avoidable care.

The patient had a history of COPD, chronic heart failure, atrial fibrillation and controlled type 2 diabetes. Previously, between June 2016 and July 2017, the patient had eight inpatient admissions and one emergency department evaluation for complaints of chest pain, shortness of breath, cough and fatigue.

The ACO team set up home health monitoring immediately, relaying readings to the patient's providers. It assisted with medication adjustments and scheduling office visits. A network population health nurse worked with the patient on techniques for success with chronic disease management, proper diet and drug compliance, as well as signs and symptoms to report to her physician.

"This patient has a scale at home that is Bluetooth enabled, a pulse oximeter and a blood pressure cuff, all of which collect information that is electronically transmitted to us," said Debra Zubris, RN. "The patient also has a tablet that she uses to video chat with me. The impact of our work with her is very clear."



Since coming under network management, the patient has had no inpatient admissions or ER visits. The ACO has assisted in a plan for her to attend senior medical daycare five days per week. This step will likely permit her to discontinue home telemonitoring; however, the patient will remain connected to the nurse coordinator.

"The ACO model allows us to serve patients in ways that incorporate patient education, self-care coaching and assistance with navigating the healthcare system. Our population health nurses use innovative techniques, such as video chat with telemonitoring, to check on patients and engage them," said Donna Antenucci, RN, Chief Operating Officer and Vice President of the clinically integrated network. "The relationships that are fostered through our programs are invaluable to us as nurses, as well. Improvements in the quality of life of

our patients are the ultimate reward for the work we do." 

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