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The Athletic Trainer and the ACO Model?

JJ Wetherington, MS, AT, ATC, OTC
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- The views expressed in these slides and today's discussion are mine.
- My views may not be the same as the views of GLATA, Spectrum Health, or my colleagues.
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Agenda

Healthcare Reform?

Accountable Care Organizations

Cost containment and relationship to ACO

Where do ATs fit in

Future for ATs and ACOs

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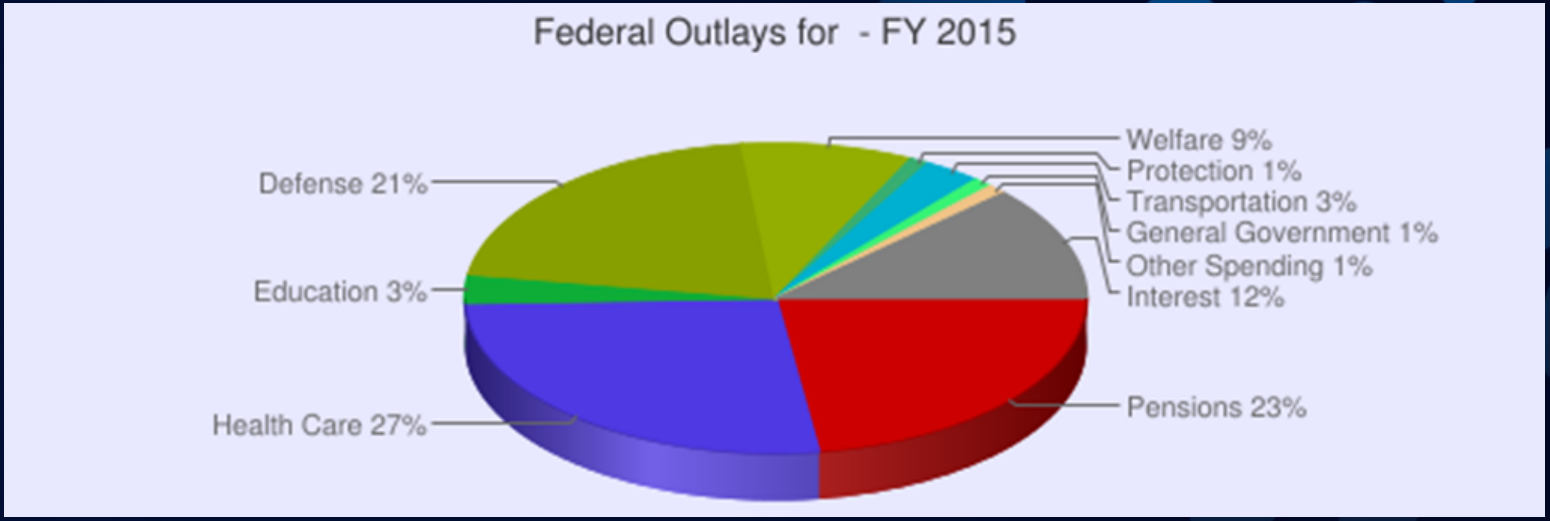
How important is healthcare (financially)?

We now outspend:

- Education
- Pension
- Defense



http://www.usgovernmentspending.com/federal_budget_detail_fy12bs12015n

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Affordable Care Act[1]

- It was intended to:
  - Improve quality and system performance
  - Increase consumer protections, emphasize prevention and wellness
  - Intended to expand access to insurance
  - Curb rising health care cost
  - Expand the healthcare workforce

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Expanded Coverage[1]

- Expands Medicaid to cover people with incomes below 133% of poverty line (~ 9.5 million)
- Allows individuals to purchase private insurance (~ 19 million Americans)
- Requires insurance plans to cover young adults on parents policy
- Extends coverage to 32.5 million Americans

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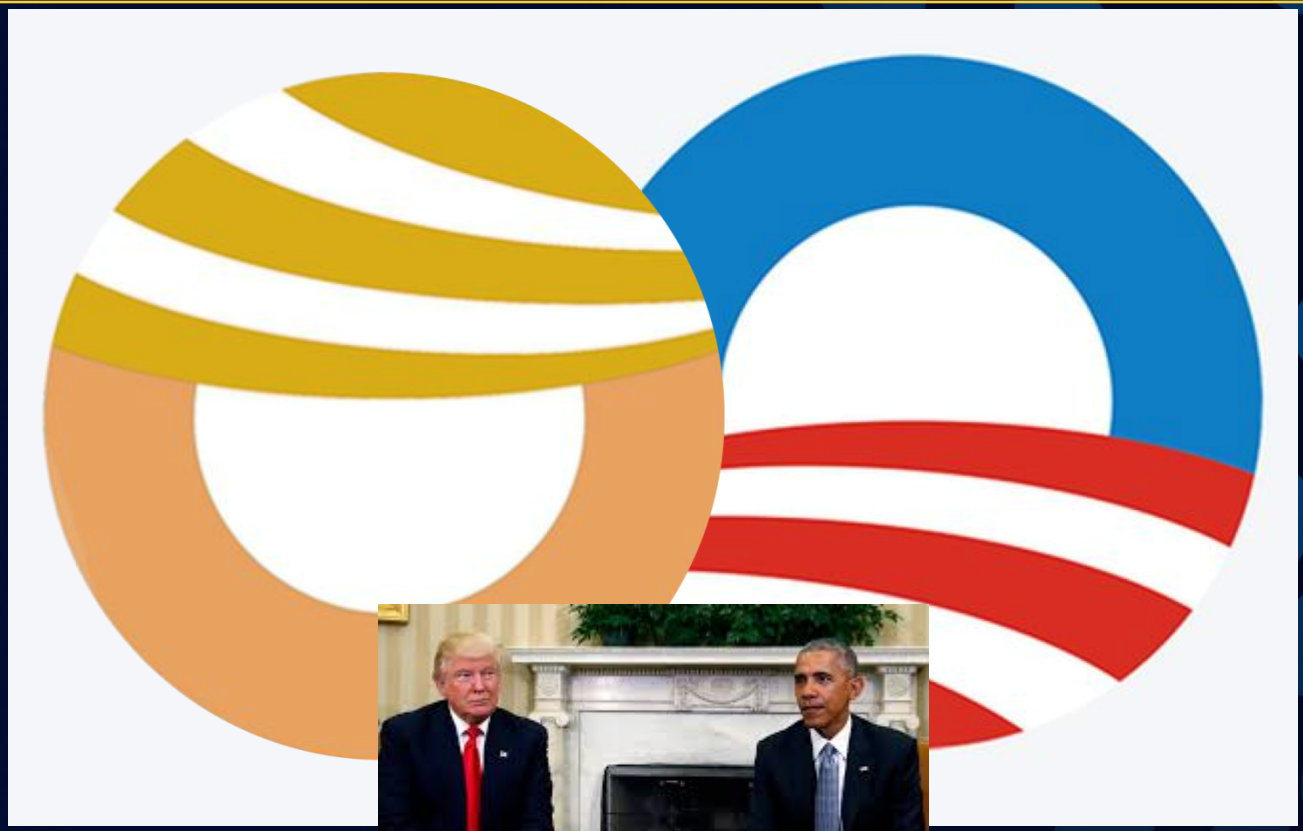
Replacement for ACA?



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Affordable Care Replacement (My Guess)

- Changes
  - Repeal mandate to have insurance
  - Reduction in Medicaid funding (Block Grants?)
  - Reduction of Medicaid eligibility
- Not Changing
  - Continued transformation from Fee-for-service to Pay-for-value
  - Continue to strive for complete population health
  - Accountable care organizations

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Accountable Care Organizations (ACOs)[1]

- Group(s) of doctors, hospitals, and other health care providers, who come together “voluntarily” to give coordinated high quality care to their Medicare patients.
- When an ACO succeeds both in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves

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ACOs are not going anywhere![2]

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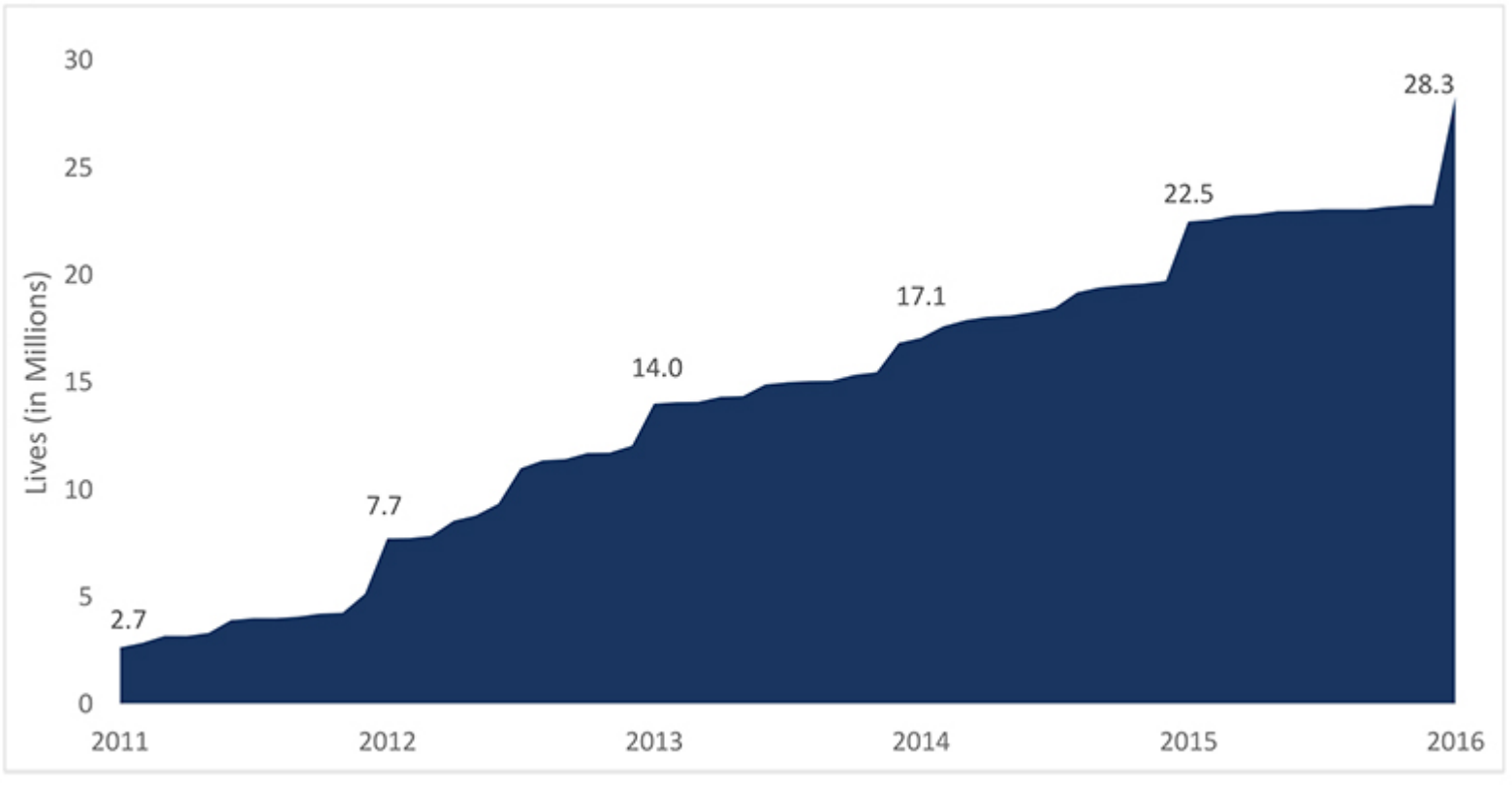
ACOs effects how many lives?[2]



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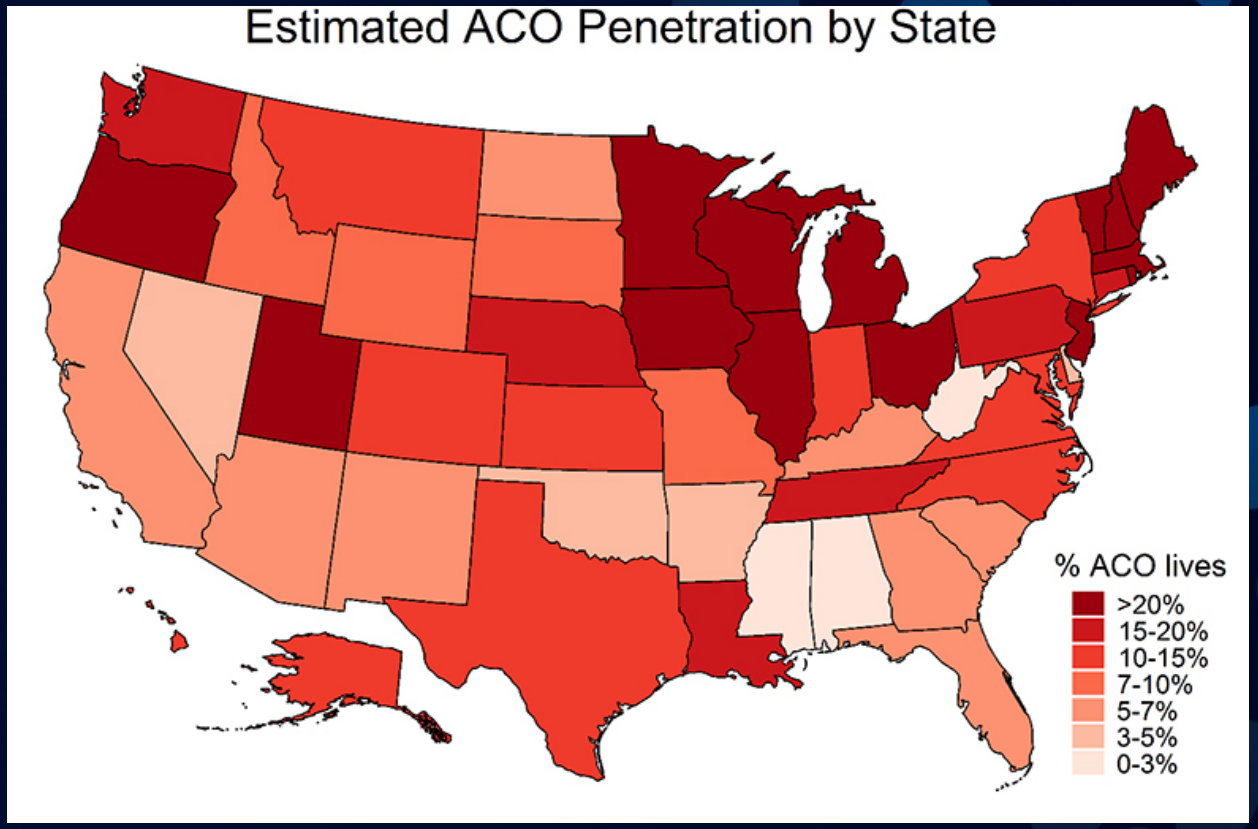
ACOs effects how many lives?[2]



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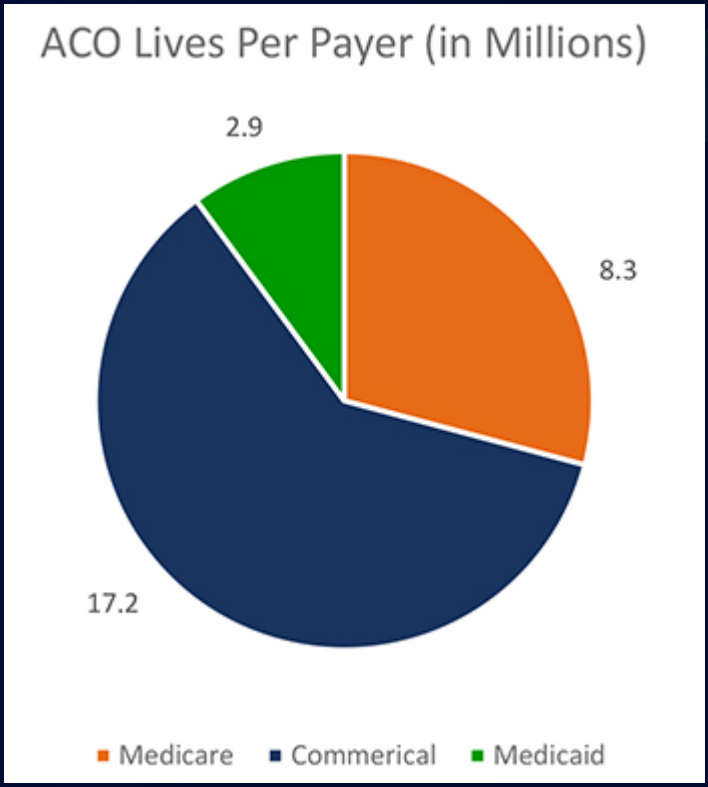
ACOs are only Medicare and Medicaid?



- Nationally 8.9% of the population is covered by ACOs[2]
- States that have adopted ACOs have higher penetration
- Markets with high penetration may be driven by competition among multiple providers or by single ACO taking large portion of population.

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ACO Triple Aim

- Improve Health (Population health)
  - Disease prevention
  - Better access & better systems of care
  - Improved quality
- High Patient Experience
  - Patient centered care to improve approach and delivery
  - Improved patient experience
- Lower Cost
  - Improve efficiency
  - Multi-skilled non-physician providers
  - Value models (outcomes v. cost)

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Cost containment and relationship to ACO

- VALUE BASED CARE!!!
- The payers (insurance company) sets cost and quality benchmarks for care of their population of patients
- ACOs goal is to meet or surpass the quality and cost benchmarks
- ACOs are strongly incentivized to change how they are delivering care with the goal of decreasing spending while improving quality measures and patient satisfaction

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Cost Containment Strategies

- Bundled Payments
  - Comprehensive Care for Joint Replacement (CJR)
    - Must accept financial risk for hip and knee replacements with it mandatory 90 day bundling program
- Quality measures
  - Readmissions/Complication rates (Truven)
  - Outcomes/Quality of life scores

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ACO and Cost Containment: Does it work?

- Cost Savings[3]
- Nov 2014 (year 1) ACOs generated $877 million in savings
  - $460 million was returned to ACOs as part of incentives
- Quality Improvement
  - Improved on 28-30 of 33 quality measures in Year 1

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Keys to successful ACOs

- Committed leadership and system accountability
- Capability for management of financial risk
- Ability to measure and report on quality of care
- Coordinated relationships with Specialist and Hospitals
- Culture of teamwork among staff
- Resources for patient education & self management support
- Capable of population management & coordination of care
- Provide Information about patients and services

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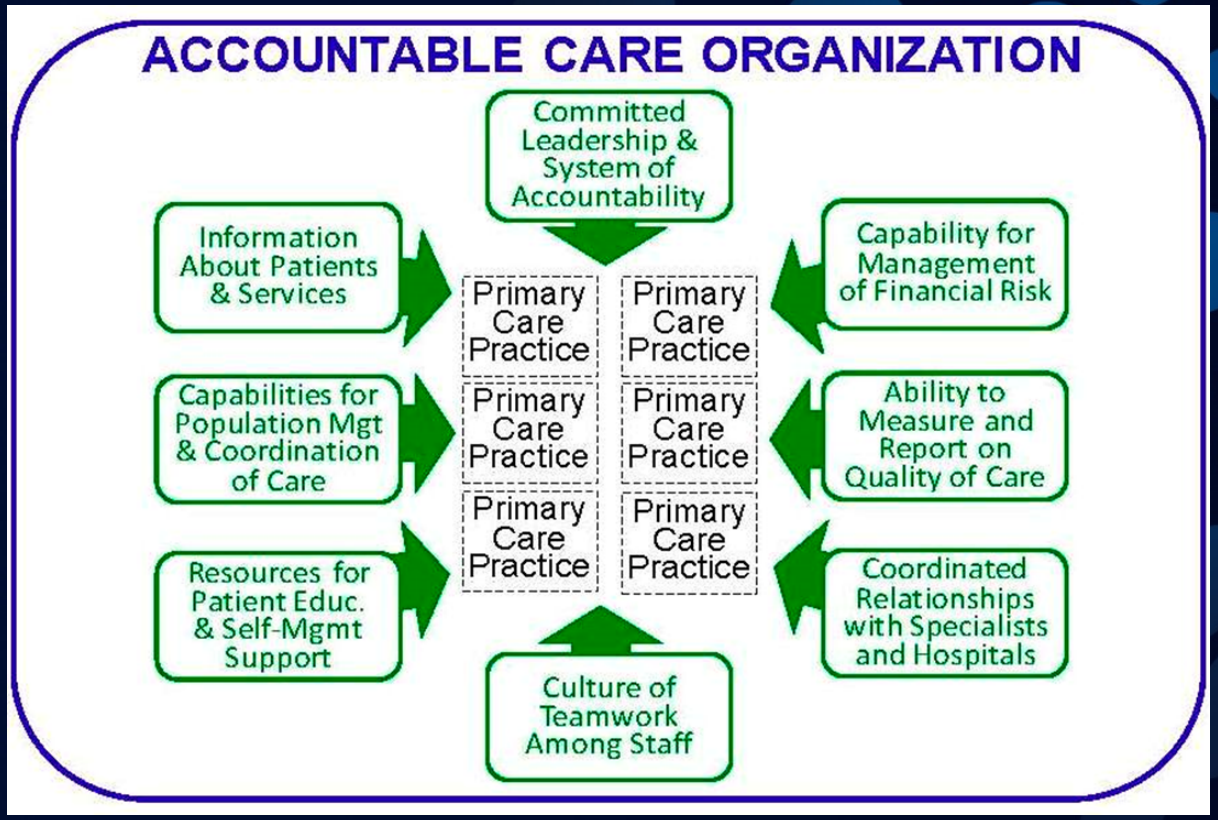
Linchpin of ACOs

- Primary Care Providers



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Primary Care Practice

AAFP definition of Primary Care Practice:

- A primary care practice serves as the patient's first point of entry into the health care system ...
- Primary care practices provide health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings …

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Primary Care Practice (cont'd)

- Primary care practices are organized to meet the needs of patients with undifferentiated problems, with the vast majority of patient concerns and needs being cared for in the primary care practice itself. Primary care practices are generally located in the community of the patients, thereby facilitating access to health care while maintaining a wide variety of specialty and institutional consultative and referral relationships for specific care needs. The structure of the primary care practice may include a team of physicians and **non-physician health professionals.**

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Who does this sound like

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Where do ATs fit in?

- ACOs exist to reduce costs, there is considerable more emphasis placed on:
  - Conservative management of illness and injuries
  - Minimize of the unnecessary referrals to subspecialists
  - The development of more ancillary services in the ACO
- Currently there is not a requirement that all providers must recognized by CMS to work for a ACO.
- So not being recognized may not affect our ability to provide care

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How can ATs leverage their skills?

- A PCP driven ACO saves money by:
  1. Improving access to care
  2. Improving prevention and early Dx
  3. Reducing unnecessary testing, referrals, and meds
  4. Use of lower cost treatments

- ATs skillset:
  1. ATs have shown to increase throughput by 15% to 30%
  2. ATs First domain of practice: Prevention
  3. Minimize of the unnecessary referrals to subspecialists
  4. Lower cost alternative to PMR

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ATs and ACO model

- ATs are no strangers to the ACO model
- ACO Model → Traditional Collegiate/University Model?
  - Access to patients (athletes)
  - Provide good outcomes (return to sport)
  - Good patient experience (can play)
  - Fixed Cost (AT budget)
  - Preventative measures

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ATs in Physician Practice Setting

- Not something new!
- Unique ability to treat and manage the care of musculoskeletal injuries
- Integrate into clinic to increase productivity

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Improved Access to Care

Patient Throughput Studies	
Study	Increased Throughput
UW – Health (6,7)	15 - 30%
Emory Sports Medicine (8)	23%
St Luke's Sports Medicine (9)	21-23%
Portland OFC (10)	18%
Children's of Wisconsin (11)	25%
Heartland Orthopedics (12)	15 – 20%

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High Patient Experience

- Time to task study[5]
  - Efficiency & Productivity
  - 171 half-day clinics
  - **Total N = 1542** (athletic trainer, physical therapist, medical resident, orthopedic fellow/resident, primary care fellow/resident, medical student)

UW Health
University of Wisconsin
Sports Medicine

- AT spent an average of 2.17 min less in ever category expect patient education
- AT still most economical with time

- What does 5.23 minutes per patient mean

	AT	Non-AT
History/Phys. Exam	8.67	12.57
Case Presentation	1.94	2.36
Patient Education	2.40	1.11
Documentation	4.03	6.23
	17.04	22.27

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ATs and the ACO

- Prevention
  - 38% reduction in injury risk = 43% reduction in healthcare cost [13]
- Management without referral (Cost Containment)
  - Occupational setting resolution rates
    - Avg work reported: 76.50%; Avg personal reported: 82.50%
  - High School/Collegiate[14]
    - 77% resolution rate
    - ~$65,000 in treatments

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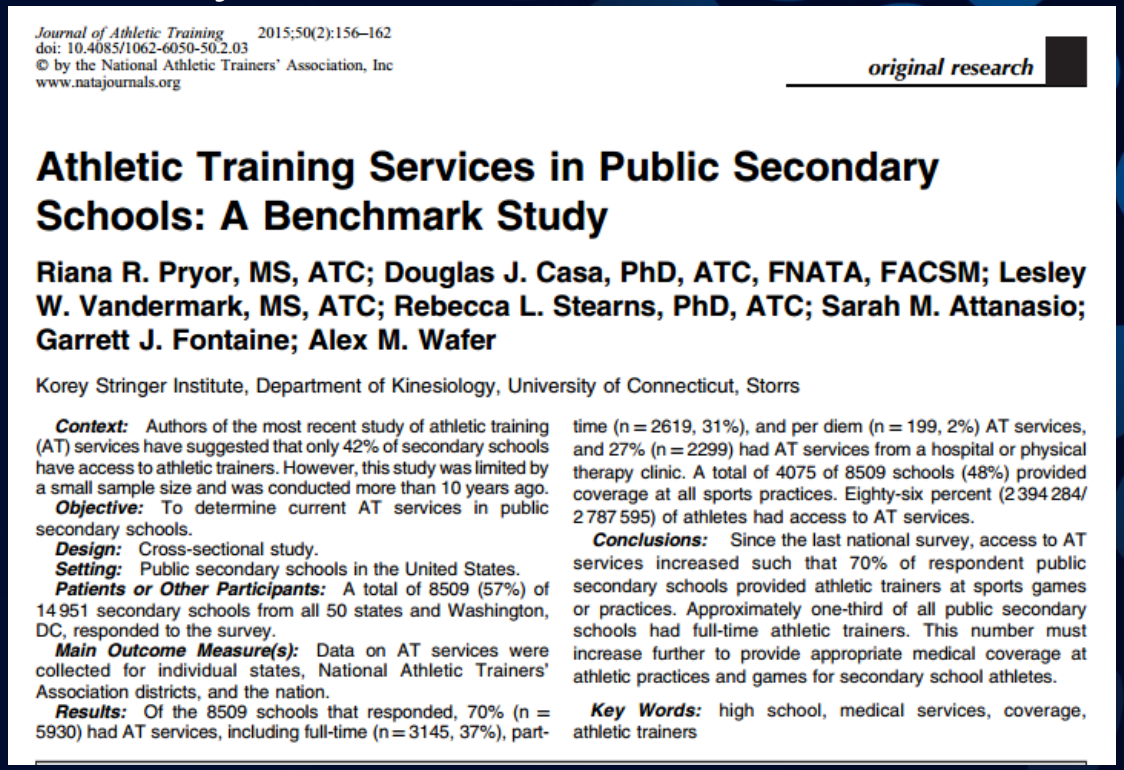
Impact on Community: Population Health

- Access to AT
  - 70% nationally have some sort of access



Journal of Athletic Training 2015;50(2):156–162
doi: 10.4085/1062-6050-50.2.03

www.natajournals.org

original research

Athletic Training Services in Public Secondary Schools: A Benchmark Study

Riana R. Pryor, MS, ATC; Douglas J. Casa, PhD, ATC, FNATA, FACSM; Lesley W. Vandermark, MS, ATC; Rebecca L. Stearns, PhD, ATC; Sarah M. Attanasio; Garrett J. Fontaine; Alex M. Wafer

Korey Stringer Institute, Department of Kinesiology, University of Connecticut, Storrs

Context: Authors of the most recent study of athletic training (AT) services have suggested that only 42% of secondary schools have access to athletic trainers. However, this study was limited by a small sample size and was conducted more than 10 years ago.

Objective: To determine current AT services in public secondary schools.

Design: Cross-sectional study.

Setting: Public secondary schools in the United States.

Patients or Other Participants: A total of 8509 (57%) of 14 951 secondary schools from all 50 states and Washington, DC, responded to the survey.

Main Outcome Measure(s): Data on AT services were collected for individual states, National Athletic Trainers' Association districts, and the nation.

Results: Of the 8509 schools that responded, 70% (n = 5930) had AT services, including full-time (n = 3145, 37%), part-time (n = 2619, 31%), and per diem (n = 199, 2%) AT services, and 27% (n = 2299) had AT services from a hospital or physical therapy clinic. A total of 4075 of 8509 schools (48%) provided coverage at all sports practices. Eighty-six percent (2 394 284/2 787 595) of athletes had access to AT services.

Conclusions: Since the last national survey, access to AT services increased such that 70% of respondent public secondary schools provided athletic trainers at sports games or practices. Approximately one-third of all public secondary schools had full-time athletic trainers. This number must increase further to provide appropriate medical coverage at athletic practices and games for secondary school athletes.

Key Words: high school, medical services, coverage, athletic trainers

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Impact on Community: Population Health

- Healthcare professional with unique skillset
  - Concussion
  - Emergent Care
  - Preventative Care
- Services ATs can provide
  - Local sport coverage
  - Community education
  - Preventive maintenance

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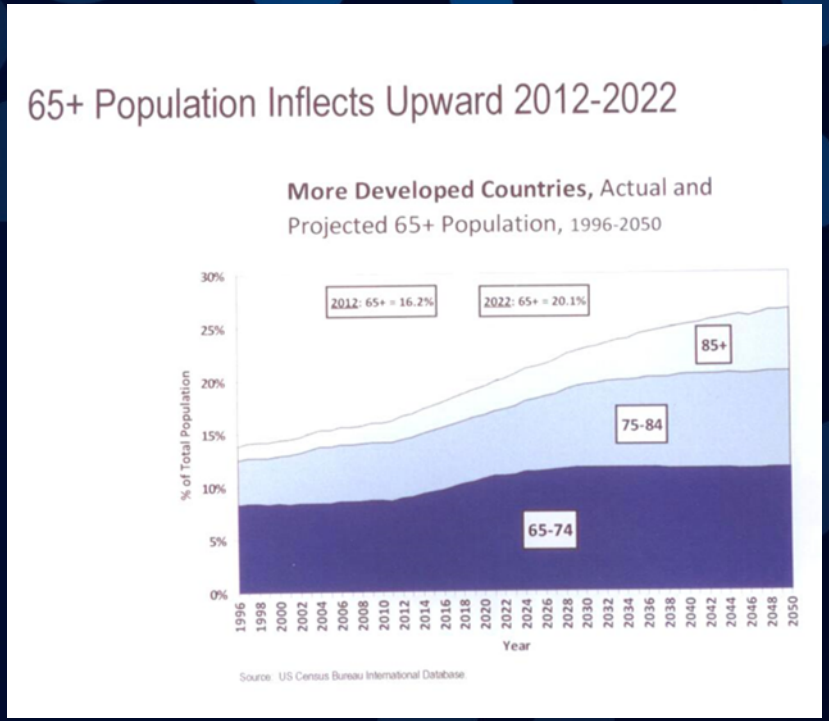
Challenges for the AT in ACO?

- The impact of our status with CMS is challenging….
  - Population getting older and staying more active (Medicare)
  - About 50% of the newly insured will be added to the underinsured population (Medicaid)



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Challenges for ATs

- Challenge #1 – CMS FFS recognition
  - ATs current unable to participate in the current CMS FFS (Fee-for-Service) model
  - Huge roadblock
- Challenge #2 - CMS and DME
  - Currently not recognized by CMS as provider to dispense custom fitted or custom fabricated DME

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CMS recognition - Why do we care?

- Our participation as a CMS FFS provider may not affect our ability to provide care
- Recognition will affect our ability to function in the ACO

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Challenges for ATs

- Challenge #3 – Engagement of the profession
  - CAATE operational and curricular content standards were open for public comment over summer 2016
    - 1800 comments received
    - Only 7% of ATs commented
  - NPI number?
  - Contacted a legislator?

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We should not settle for our current place in healthcare

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Future areas for ATs to impact ACOs

- Rehabilitation setting
  - Third Party Pilot
  - Outcome Studies!!!!!
- Bundled Payments
  - Non-billed services
  - Improved Outcomes
- Population health/Prevention medicine
- Rural Primary Care
  - Access to care in underserved areas

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Summary

- Accountable Care Organizations developed to improve care, reduce cost, with high patient experience
- ACO are not going any where, can we position ourselves to fill a need in the ACO
- Multitude of areas for ATs to work and grow in ACOs
- Can not settle with our current place in healthcare community
- We need to be engaged as a profession

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