



June 22, 2015

Senator Mark Warner
Co-Chair, Senate Finance Committee Working Group on Chronic Care
475 Russell Senate Office Building
Washington, DC 20510

Senator Johnny Isakson
Co-Chair, Senate Finance Committee Working Group on Chronic Care
131 Russell Senate Office Building
Washington, DC 20510

RE: Breakthrough Physician and Nurse-Driven Care Model for Hospitalized Medicare Patients

Dear Senators Isakson and Warner:

Thank you for the opportunity to share a breakthrough innovation in hospital care coordination – the Accountable Care Unit (ACU) – with the Senate Finance Committee’s Chronic Care Working Group.

As the Working Group outlined in its May 22 letter, we are faced with a significant challenge to streamline care coordination and reduce costs for patients with chronic conditions. One-third of national health expenditures (\$921B) are spent on hospital care. Medicare beneficiaries with multiple chronic conditions are more likely to be hospitalized: each year nearly two-thirds of Medicare beneficiaries with 6 or more chronic conditions are hospitalized and nearly 1 in 6 are hospitalized 3 or more times. Clearly, any serious effort to improve the value of American healthcare must address care coordination in hospital units, where so much acute care and post-acute care utilization is set in motion for so many complex Medicare patients.

Yet, as leaders what we overlook is that hospital units have never been explicitly designed, organized, or engineered at all, certainly not to produce anything near the level of care coordination or performance the American public assumes, expects, and deserves. Unfortunately, every day in U.S. hospitals the illusion of care coordination is much more common than its reality. Although immensely dedicated, physicians, nurses, and case managers on hospital units simply have never developed a standard approach or routine practice to communicate with each other, let alone to coordinate care of complex patients, including of course Medicare and Medicaid patients.

As a result, our outstanding professionals who work in hospital units fail at the most basic fundamentals of communication, coordination, and teamwork. These failures manifest as fragmented care, all too often resulting in preventable death, disability, marginal resource consumption, and significant financial waste for Medicare, Medicaid, and private payers.

Many of the downstream effects of hospital unit failures generate familiar headlines. Preventable complications of hospital care are the 3rd leading cause of death in the U.S., behind only heart disease and cancer. The Institute of Medicine and other independent bodies have concluded that the U.S. spends \$700B more than it should on healthcare with approximately \$220B of that waste going to hospital care.

Among policy proposals and ideas today, the ACU care model is the only proven, readily adopted innovation that explicitly designs, organizes, and engineers hospital units to achieve outstanding care coordination every day. Since 2010, the ACU care model has spread organically by word-of-mouth to hospitals in 14 states, an indication of the serious needs it addresses, its embrace from hospital physicians and nurses, and the feasibility with which it can be imported. Physicians, nurses, and hospital managers are driving the grass roots adoption for two reasons. First, these hospital professionals are desperate for a hospital care model that helps them become more effective and efficient, both for themselves and for their patients. Second, the outcomes observed in ACUs simply impel its adoption. Reports from ACUs in the U.S. show just how much better (and less costly) hospital care can be:

- Improved Clinical Outcomes: lower in-hospital mortality (25% lower) and fewer complications of care (25% lower) through improved culture, communication, coordination, and safety practices
- Improved Experience of Care: higher patient satisfaction and family engagement, higher staff satisfaction and engagement, and greater teamwork skills among staff and trainees
- Improved Cost Outcomes: reduced length of stay (9-15% lower), lower readmission rates (5-50% lower), and reduced direct variable costs (\$500-\$5,500 lower) due to reduced marginal resource consumption, with decreased staff turnover

For the most complex patients, such as Medicare patients with chronic conditions, the benefits of the ACU care model are expected to be most pronounced.

The ACU Care Model: Background

Those who spend time in a hospital as a patient, family member, or observer recognize that decision making by care teams is often fragmented, resulting in frustrating and often shocking levels of inefficiency and ineffectiveness. The ACU care model solves this fragmentation with a simple, yet revolutionary composite of features, the most notable of which is Structured Interdisciplinary Bedside Rounds (or SIBR®, pronounced “cyber”). The SIBR rounding approach brings each patient’s physician, nurse, and allied health providers to the bedside every day to exchange thoughtful inputs and to develop a collaborative plan for hospital care and post-hospital recovery.

The ACU care model is particularly powerful because it was specifically created for physicians and nurses *by* physicians and nurses to be a “convergent” solution. In other words, the ACU care model represents a ground-up unified approach to organize ourselves to address the challenges of communication, safety, timeliness, and reliability in the hospital. While ACUs can dramatically improve the care outcomes and experience of hospitalized patients, they can also energize the dedicated hospital professionals who for too long have been struggling in disorganized hospital units to bring their best to those who are sick and suffering. What we hope to accomplish in improving the care and costs for beneficiaries with chronic conditions can only be accomplished if every hospitalized Medicare or Medicaid patient receives care in a hospital unit as organized as an ACU.

The ACU Care Model: Chronic Care

The fundamental innovation of the ACU care model is the daily routine of performing inter-professional care and discharge planning at the bedside with the patient and family to meet the needs and goals of care for each patient. A structured interdisciplinary bedside rounding team, including the patient, family, physician, nurse, and case manager, revise the care plan daily to match patient needs with appropriate resources.

By way of illustrating what is possible, an ACU in Ohio designed to care primarily for elderly patients has observed a nearly 50% reduction in 30-day readmissions and an almost three day shortened length of stay relative to age matched controls in the same hospital, highlighting that improvements in acute and post-acute care service utilization are within reach if hospital units organize and operate properly.

For Medicare patients at highest risk for mismatched post-acute care services allocation, such as those hospitalized with multiple chronic conditions, the ACU care model has a large positive impact on costs and outcomes of care.

Conclusion

Thank you again for the opportunity to share the ACU care model with the Senate Finance Committee Working Group. We hope that 5 years of real world experience refining this modern approach to hospital care and supporting its spread to dozens of hospitals in the U.S. can serve as a benchmark or resource to you as you look for the most common sense and ready solutions to meet the challenges outlined in your May 22 letter.

If we can be of additional assistance to the Working Group or the Committee, you can reach me at jason.stein@1unit.com.

Best Regards,

A handwritten signature in black ink that reads "Jason Stein". The signature is written in a cursive, flowing style.

Jason Stein MD SFHM
CEO | 1Unit
CMS Innovation Advisor | CMS Innovation Center