ACO 2013 Collaborative: Reflecting on Progress, Preparing for the Future

AMGA
American Medical Group Association

"In the beginning, ACOs were unicorns—a fantasy that no one had ever seen. Now ACOs are seen. We're changing from that fantasy world to reality."

—Jerry Penso, MD, MBA, AMGA Chief Medical and Quality Officer

Dr. Jerry Penso presented some interesting challenges as he welcomed participants to the final meeting of AMGA's Accountable Care Organization (ACO) collaborative. Since the collaborative's inaugural conference in September 2010 in Hollywood, Florida, participants have grappled with physician engagement, care delivery, payment structures, and more. They've encountered obstacles, achieved milestones, and addressed the overarching question—Do we really want to become an ACO?—in a variety of ways.

At this meeting, some of the challenges discussed were new; others were evergreen.

- How do you get data into the hands of physicians in a way that they actually look at it?
- How are physician report cards working out?
- How can you use metrics to make effective dashboards?
- What have others done to partner with hospitals outside of their systems?
- How do we actually save money?

Two-and-a-half intensive days of workshops, networking, and collaboration covered topics from patient engagement to population health. Participants left with fresh ideas about managing care transitions, structuring care teams, using data analytics, and more, as well as resources for future collaboration. But most important, they took away shared knowledge and lasting connections.

Highlights from this final ACO meeting follow. Complete presentations are available to collaborative participants at www.amga.org.

Ongoing ACO Support

The completion of the ACO collaborative doesn't mark the end of AMGA's ACO activities. Other resources include:

- A free listserv for Medicare ACOs
- A policy workgroup to address regulatory and design issues
- An advisory group for educational needs

Billings Clinic: Transforming from Volume to Value

Nicholas Wolter, MD, Chief Executive Officer, Billings Clinic

> ### "We are trained to be fighter pilots—delivering care at the point of service. Now we have to be like astronauts, captains of a large ship working as team members to coordinate care across silos."
>
> —Dr. Nicholas Wolter, Billings Clinic

From his perspective of 15 years leading a clinic that recently was named number one by *Consumer Reports* for patient safety, Wolter reflected on the past five years of accountable care organizations—and what the future may hold.

Alignment, Progress, Challenges

The 2010 Affordable Care Act aligns with many key pillars of ACOs, high-performing health systems, and the move from volume to value. "All of the things in that bill are becoming the reality of our daily work," Wolter said.

"We've seen the lowest spending growth rate in national health expenditures in 50 years," he observed, then wondered: Has this been due to system improvements or the recession?

In 2013, with sequestration and major Medicare cuts on the table, "the issue about how to pay for things we're asked to do is an important one." A full 55 percent of variation in healthcare spending remains unexplained, according to an American Hospital Association task force. By 2015, with value-based purchasing, money is taken away if you're not meeting Meaningful Use requirements. By 2017, hospitals will see 6 percent of all diagnosis-related group payments at risk.

Payment reform will impact how care delivery systems are organized, Wolter said. And because reforms will be "frustratingly imperfect," leadership, innovation, and improvement in policy will be vital moving forward. These three things played a critical role in Billings' journey through the Center for Medicare and Medicaid Services (CMS) Physician Group Practice (PGP) demo program and Patient Centered Medical Home (PCHM) program to its current status as an NCQA-accredited ACO.

Wolter also cited the importance of:

- "Scouting missions" to learn from others
- Magnet designation for nursing
- Internal leadership development
- Lean Six Sigma training
- Establishment of a center for translational research
- Creation of a board quality and safety committee
- The launch of the first internal medicine residency program in Montana and Wyoming

Highlights from the Billings Journey

Over the past five years, Billings Clinic has achieved several successful milestones:

- Activities as a PGP demo site helped reduce psychiatric hospitalizations, chronic condition management, ER visits, and care management navigation for complex patients.

- Electronic health records (EHRs) installed system-wide helped improve quality scores.

- Bundled payments and a designed Comprehensive Cancer Center Program brought the clinic research dollars and otherwise unavailable protocols.

- The Billings Culture of Quality and Safety initiative decreased some categories of safety events to zero.

- Hospital admissions decreased by 20 percent.

- The clinic realized $22 million in benefits since 2009.

The clinic addressed gaps and leveraged opportunities through enhancing its physician leadership, improving its cost accounting, implementing decision support tools, and coordinating care across its nine clinics. Key strategies were "hardwired" into tactics, roles and responsibilities, and a balanced scorecard—and grounded in a steadfast commitment to culture. For instance, Billings used "best in nation" language in its vision statement, brought in a retired Disney employee to consult on service improvement, put an emphasis on internal recognition and physician and engagement, and committed its cornerstone principles in writing.

"It used to be 'I just came here to practice medicine.' Now doctors say 'I used to think this was crazy, but now I believe this.' It's very internally motivated," said Wolter.

Charting the Right Path

Moving forward, Billings aims to continue as an accredited ACO and work toward even more milestones: reduce preventable harm by 50 percent (and ultimately to zero), put in a business intelligence system to measure and track costs, and use sepsis treatment and end-of-life care to reduce the observed-to-expected mortality ratio—to name just a few.

For other medical groups considering an ACO pathway, Wolter observed that:

- **The PCMH program may help improve care delivery and cost management** through things such as patient registries, chronic disease monitoring, and performance reports back to providers.

- **The Physician Quality Reporting System will be an "interesting experience" for small and free-standing medical groups,** as the system puts a fair amount of payment at risk for doctors and issues a 1.5-2 percent penalty for not reporting.

- **Medicare Shared Savings will be challenged by attribution and threshold requirements**. "We've decided to participate in the project so we can learn how to get better," Wolter said. "But it's clearly an issue when you don't likely have a chance to share savings."

- **Bundled payments will provide opportunities for learning.** "In many studies, the variation in spending is bigger in post-acute care than in in-patient stays. What are other good organizations doing? How can we tackle costs that are above benchmarks?"

Questions for the Future

Which type of ACO will be more likely to succeed—Medicare Advantage or commercial ACO partnerships? What about programs like PACE that focus on high-risk, high-cost patients? What happens if the Affordable Care Act is repealed or modified, or if the economy improves substantially?

As these questions play out, Wolter advised participants to:

- Let physicians lead

- Create new partnerships—especially with hospitals, which have been "making more by doing more" for decades

- Develop skills around the science of healthcare delivery and a strategy for patient engagement

- Become more involved in the development of innovative policy

"There's not an active agenda about improving the underlying fee-for-service system, and that's a big problem," said Wolter. "If we don't start thinking of new things and dealing with underlying fee-for-service payment structure, we may find these new things not working out too well."

Collaborative Thinking

Participant questions ranged from specific operations to overarching culture.

Q: How does Billings Clinic, which serves such a huge geographic area, use telemedicine?
A: The organization started in mental health and is "aggressively" expanding in clinical areas such as cardiology follow-up. From administrative tasks to interacting with patients in their homes via Skype and Facetime, "I think there's a lot of promise there," said Wolter.

Q. What kind of staff does Billings devote to performance and QA improvement?
A: The clinic engages nurses, right up through the chief nursing officer, and does some work in HR, such as surveys and Pascal metrics. Doctors tapped from more than 40 medical departments are compensated for their time with stipends. In terms of integration, department chairs support both hospital work and clinical work.

Q: Are there any shortcuts for developing culture?
A: According to Wolter, "It takes three generations of leadership for all these changes to be really deeply rooted. It's not likely that a four-year ACO project will get you where you want to go, although many of the things we're working on are things we need to be doing. One thing is certain: Unless you have persistence and cornerstones that will withstand time, it's likely you won't get there."

Park Nicollet Health Services: Dispatches from an Accountable Care Pioneer

Sam VanNorman, MBA, Co-Chair, Office of Population Health, and Director, Business Intelligence, and Meg Cox, Director, Population Health/Medicare, Park Nicollet

An integrated care system based in St. Louis Park, Minnesota, Park Nicollet Health Services was one of 32 health systems chosen nationwide to participate in the Pioneer ACO program. As a Pioneer ACO, the organization dealt with aligning teams to tasks, managing data, and grappling with the transition from pay-for-reporting to pay-for-performance (requirements a group of Pioneer ACOs recently asked CMS to reconsider). VanNorman and Cox discussed challenges faced and lessons learned along the way as a Pioneer ACO and as a PGP demo participant.

Pioneer ACO Quality Measure

Domain	# of Individual Measures	# of Measures for Scoring
Patient/Caregiver Experiance	7	2 measures; including 6 combined survey model measures & 1 individual survey measure
Care Coordination/ Patient Safety	6	6 measures: including the double weighted EHR measure
Preventive Health	8	8 measures; all individual measures
At Risk Population	12	7 measures; including a 5 component diabetes composite measure + a 2 component CAD composite measure + 5 individual measures
Total	33	23

Pay for Performance Will Be Phased in
• Year 1: 33 measures @ reporting level, 0 @ performance level
• Year 2: 8 measures @ reporting level, 25 @ performance level
• Year 3-5: 1 measure @ reporting level, 32 @ performance level

Taming the Data Beast

Collaborating with the CMS, which doesn't always provide concrete information or reliable help, can be a lot of hard work, VanNorman and Cox pointed out. Participants need enough manpower, stamina, and time to make organization-wide changes and report speedily on mountains of data. Before making such an enormous data tracking and reporting commitment, it's helpful to ask:

- Do we have enough employees who are well suited to this work?
- What pre-work should we do, such as building reporting systems or data warehouses?
- How much effort can we devote to our pay-for-reporting measures?
- How much effort can we devote to our pay-for-performance measures?
- Are we sure we want to do this?

Delegate, Automate, and Keep Moving

Park Nicollet decided its clinical reporting and analysis team was best suited for the work of managing chronic disease registries, core measures, Minnesota community measures, and pay-for- performance quality reporting. Staff in business intelligence, IT, care delivery, and population health were placed nearby to support the team and develop collegial cross-functionality—a crucial element for ACO success.

Automating as much abstraction as possible as early as possible made a huge difference, even if it meant correcting some files later by hand. Since collecting and analyzing data is a time-intensive, machine-assisted manual process—and likely always will be, VanNorman and Cox added—they started the process immediately and found ways to motivate staff to persist. To maximize efficiency, they assigned one employee specialist to each specific data set.
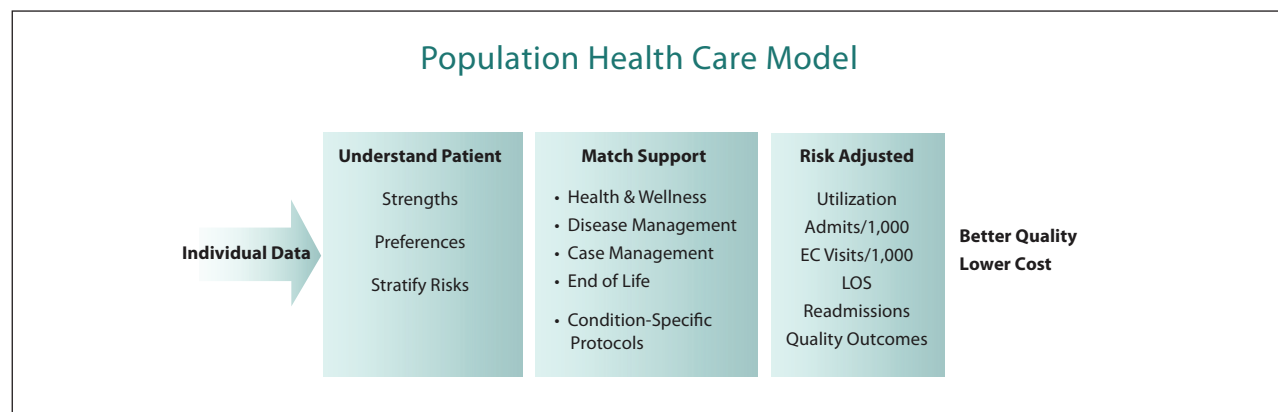
Ultimately, VanNorman says, ACO participants must be comfortable with "pretty good data." The rate of growth for organizations can be so fast, there's only time for general indicators, not peer-reviewed research or concrete findings. "We have to allow ourselves to say 'we know this is directionally correct—it's getting bigger or smaller,' and have that be enough for us right now," said VanNorman

Strengthening Operations

As with data reporting, providers should ask key questions before undertaking a quality improvement initiative:

- Do we have the technical skills and resources to identify opportunities?

- Do we have enough discipline to innovate?

- Do we have enough discipline to kick bad habits?

- Will we improve quality for all our patients or use test populations first?

- What will success look like?

- Are we sure we want to do this?

Organizations should be ready to implement new programs. Park Nicollet, for example, began walking physicians through 30-minute "care conferences." These sessions allowed providers to evaluate five patients from high-risk, high-complexity populations and recommend interventions. Another product of Pioneer ACO was Care Consultant, a home visit nursing program built on restoring a patient's health, independence, and social network.

Population Health Care Model

Individual Data →	Understand Patient	Match Support	Risk Adjusted	Better Quality Lower Cost
	Strengths	• Health & Wellness	Utilization	
	Preferences	• Disease Management	Admits/1,000	
	Stratify Risks	• Case Management	EC Visits/1,000	
		• End of Life	LOS	
		• Condition-Specific Protocols	Readmissions	
			Quality Outcomes	

Finding an Attribution Solution

Participants asked which model Park Nicollet used for patient attribution—its own model or Medicare's? Cox and VanNorman explained that attribution has been a multifaceted process. They've been using the care team functionality of Epic to identify a "quarterback" and other members of the patient care team.

Although many clinicians saw this as an IT solution, the change was cultural as well. Cox and VanNorman described it as a business negotiation that's changed the way the front lines do work and how Park Nicollet tracked patients, as well as a shift in mindset from "I haven't seen this patient for two years; I don't want to be accountable for them" to "I'm going to be accountable for this person no matter what."

Putting the ACO Experience into Perspective
Park Nicollet also participated in the CMS PGP demonstration project, the first pay-for-performance initiative under the Medicare program. Despite frustrations in areas such as quality reporting and shared savings, Cox and VanNorman said that the PGP and Pioneer ACO programs delivered value by enabling Park Nicollet to implement clinical improvement initiatives, create a foundation for quality improvement, grow capabilities in data management, and address important questions in the care delivery process.

"ACO is probably not the end of the road or the payment method we'll stick with forever," said Cox. "But becoming accountable for quality and costs is something we are likely to stick with."

"The perverse incentives are starting to go away, we're starting to align our healthcare in a way I haven't seen since I've been in healthcare," said VanNorman.

Mastering the Rules of Patient Engagement

Angie Hochhalter, PhD, Research Scientist, Scott & White Healthcare

> ## "The distinction between improving health outcomes and improving healthcare is having the people we're serving involved in the decisions."
>
> —Angie Hochhalter, PhD, Scott & White Healthcare

Improving patient engagement is a growing priority in today's healthcare environment, and for many, it's a difficult challenge. Hochhalter discussed common issues and helpful strategies for building active partnerships among clinicians, patients and families.

Cornerstone Behaviors

According to the Center for the Advancement of Health's Engagement Behavior Framework, to receive optimal care, patients must know how to:

- Find good care
- Participate in treatment
- Communicate with providers
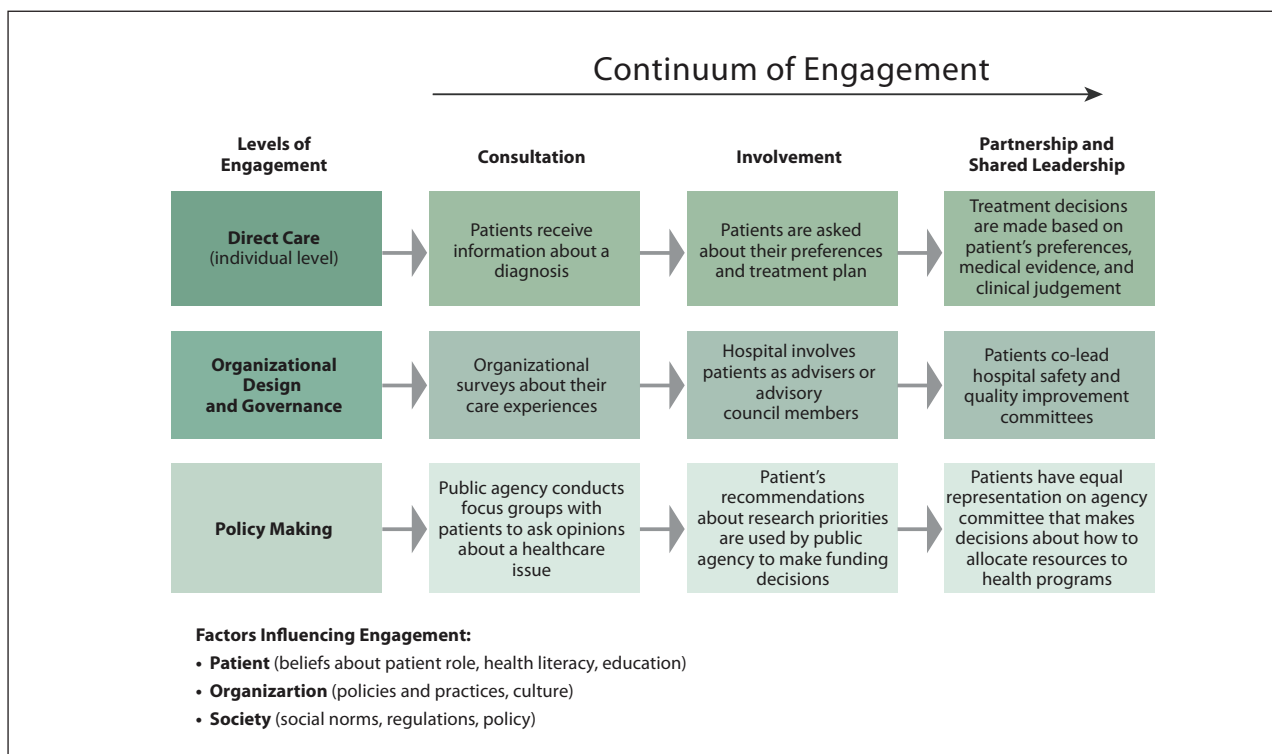- Seek health knowledge

Understanding Patient Motivation

For a health system, patient engagement occurs at three primary levels: direct care, organization design and governance, and policymaking. At every point, engagement is influenced by such factors as patient beliefs about his or her role, health literacy and education; an organization's culture, policies and practices; and societal norms and regulations.

Patients are driven by different motivations, said Hochhalter. One size does not fit all, and the healthcare community needs to respond accordingly when trying to encourage patients to adopt these behaviors.

Hochhalter outlined the three major drivers of behavior that affect engagement for patients (as well as the clinicians who treat them):

- **Autonomy:** The degree to which an individual has a say and is involved in decisions; the more autonomy people have, the more likely they will be to talk with doctors and accept services
- **Competence:** Both the ability to obtain care/get to appointments and the perceived ability to make changes.
- **Relatedness:** Relationships with healthcare providers, the community, and family, as well as the influence of others

Continuum of Engagement

Levels of Engagement	Consultation	Involvement	Partnership and Shared Leadership
Direct Care (individual level)	Patients receive information about a diagnosis	Patients are asked about their preferences and treatment plan	Treatment decisions are made based on patient's preferences, medical evidence, and clinical judgement
Organizational Design and Governance	Organizational surveys about their care experiences	Hospital involves patients as advisers or advisory council members	Patients co-lead hospital safety and quality improvement committees
Policy Making	Public agency conducts focus groups with patients to ask opinions about a healthcare issue	Patient's recommendations about research priorities are used by public agency to make funding decisions	Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programs

Factors Influencing Engagement:
- **Patient** (beliefs about patient role, health literacy, education)
- **Organizartion** (policies and practices, culture)
- **Society** (social norms, regulations, policy)

Turning Patients into Active Care Participants

Clinicians learn how to interact with patients. What if patients were similarly trained on how to interact with their doctors? Scott & White recently finished a pilot project focused on training older adults at risk for hospitalization. Facilitators noticed dramatic improvements in how participants asked questions about their healthcare.

Scott & White also conducted the Care Transitions Intervention® (CTI) initiative with a grant from CMS. This evidence-based, 30-day program supports patients as they transition home from the hospital with the goal of reducing preventable readmissions. The four pillars of CTI are:

- **Medication management:** Understanding the purpose, dosing schedule, and possible side effects of each medication
- **Red flags:** Knowing the warning signs that indicate the patient's condition may be worsening
- **Medical care follow-up:** Scheduling and attending follow-up appointments
- **Personal health record:** Keeping a centralized record of the patient's medical history, medications, red flags, and questions for the physician

The Importance of Health Literacy

Nearly 60 percent of adults over age 65 have below-average health literacy, Hochhalter said. "It's a problem if patients don't understand how to use what we're giving them." Making information and processes more understandable is no simple task, but there are resources and examples, including the AMA literacy guide for clinicians and the ARC toolkit.

The intervention consists of a visit to the hospital room, one home visit, and two follow-up phone calls from a CTI coach. Only 28 percent of eligible cases enrolled, which Hochhalter attributed to the fact that many people don't want home visits, especially after just leaving the hospital.

Don't Forget to Track and Measure

Who participated? How were they engaged? Did phone calls work better than personal visits? Measurement is vital to any engagement initiative. "You cannot do one thing and reach everyone," said Hochhalter. "So you need to consistently determine who accepts what you offer, who doesn't and why."

Reaching Out in New Ways

Many people just don't trust the healthcare system. For these kinds of patients Scott & White teams with community groups. These include the National Aging Services Network, which offers health promotion and self-management classes.

Scott & White uses crowdsourcing to get feedback on hospital spending initiatives. Members of the community are invited to submit and vote for ideas online. Program leaders provide regular updates and maintain a dialogue with respondents. By submitting their ideas, participants can earn points to redeem for healthy cooking class, lunch with Scott & White's CEO, and other rewards.

To Incentivize or Not to Incentivize

Linking incentives to engagement is gaining popularity. But Hochhalter, a self-described "incentives cynic," believes incentives may do more harm by promoting extrinsic versus intrinsic motivation. While incentives work well for one-time behavior, data shows they can negatively impact long-term motivation for both patients and physicians.

Open Session: Priority Issues, "Crowdsourced" Answers

Throughout the ACO Collaborative, peer exchange has played an essential role in identifying areas of concern, advancing best practices, and delivering value. In this spirit, Penso facilitated an open session that gave participants the opportunity to air top challenges and find out what their peers were doing to address them in their own health systems. An audience poll identified two priority areas for discussion: saving money and sharing data with physicians—what data should you provide and what should you expect physicians to do with it?

Collaborative thinking on saving money

- Focus on healthcare management, especially re-admissions

- Manage the "frequent flyers" (high-cost patients)

- Integrate partners like social workers and skilled nursing facilities into care delivery

- Incorporate mental health into care

- When working with hospitals, hone in on one opportunity for savings, e.g., post-acute care

- Look for opportunities with payers

- Leverage past successes to attract future partners

Collaborative thinking on sharing data with physicians

- Before sharing data, first build the groundwork of trust

- Make sure they feel that their clinical expertise is respected

- Have two-way conversations about their goals and the resources they need

- Ask for feedback when you offer feedback

- Be able to show them what's behind the data

- Work with them and medical societies to pick the metrics to track

- Make patient tracking a system-wide job

- Understand and accommodate for their culture of skepticism

CEO Perspectives

Spencer Berthelsen, MD, Chairman and Managing Director, Kelsey-Seybold Clinic; Stacey Hrountas, CEO, Sharp Rees-Stealy Medical Centers; Richard Fish, CEO, Brown & Toland Physicians

In this panel, leaders of three award-winning healthcare systems discussed their challenges and successes across a range of topics, including leadership, care delivery, risk management, IT, and payer and partner relationships. The three diverse groups included:

- Kelsey-Seybold Clinic, a multispecialty for-profit practice with 370 physicians across 20 locations in the Houston area

- Sharp Rees-Stealy Medical Centers, the largest healthcare system and private employer in San Diego

- Brown & Toland, a multispecialty, clinically integrated independent practice association (IPA) with 500 primary care physicians and 1,000 specialists across the Bay Area, as well as multiple hospital partners

Leadership Starts with Engagement

Kelsey-Seybold is working to get current physicians invested in the process and hiring doctors who fit will with the group practice culture. Its leaders are well compensated for time devoted to governance, and the very active and engaged operating board meets frequently and wields real control—contributing to all important or controversial clinical decisions. Berthelsen described how new physicians must be ready for an "elbow-to-elbow" practice and a productivity-based compensation system.

Sharp-Rees Stealy launched its ACO in January of 2012 as a collaborative effort, leveraging the Anthem ACO methodology. They created an interdisciplinary subcommittee structure and a governing body that included a consumer advocate and patient representative. Hrountas noted that the process got easier over time: "We had to pull and tug hospitals at first, but then they were eager to be on committees."
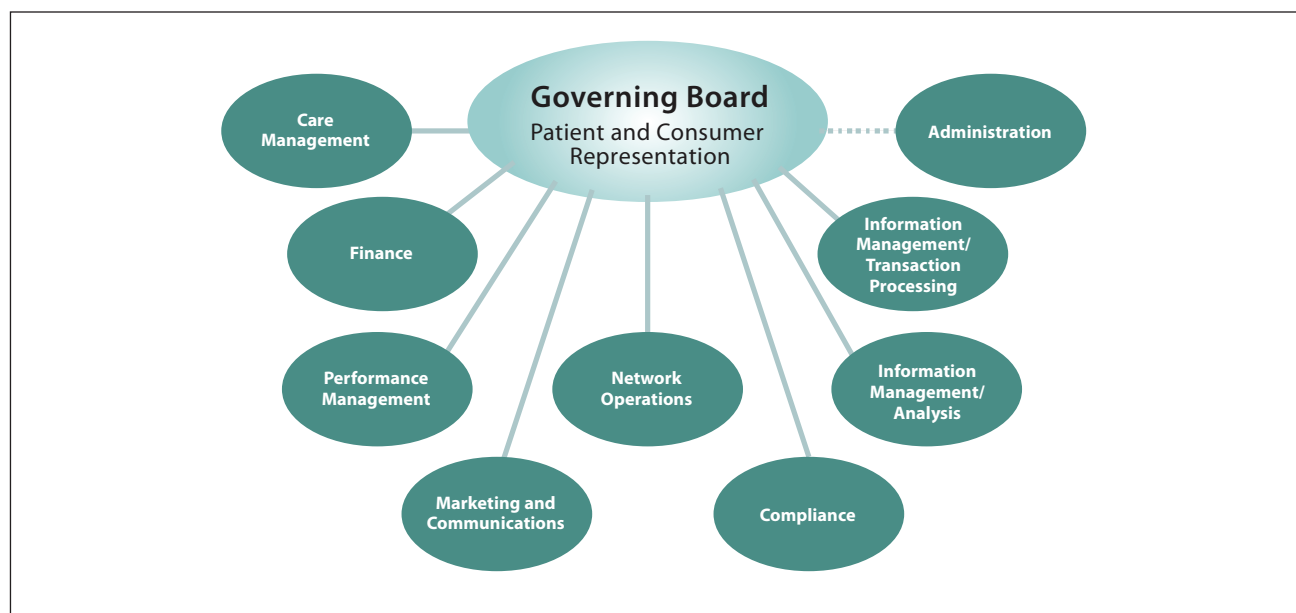
Fish described Brown & Toland's board committee structure as less structured, with an emphasis on getting physicians involved, engaged, and able to view their individual work within the context of the organization as a whole. "In our culture, it's an honor to be elected—which pulls good people into leadership roles," he noted.

Multiple Aspects of Care Delivery

Hrountas commented on how Sharp-Rees Stealy engaged patients in the process via websites, hotlines, and other communications and looked for efficiencies everywhere— from using pharmacy students to streamline the refill process to dabbling in telemedicine.

Fish discussed how Brown & Toland applied medical management programs initially developed for HMOs and fee-for-service patient populations toward Triple Aim goals:

- Improving the patient experience
- Improving the health of the patient population
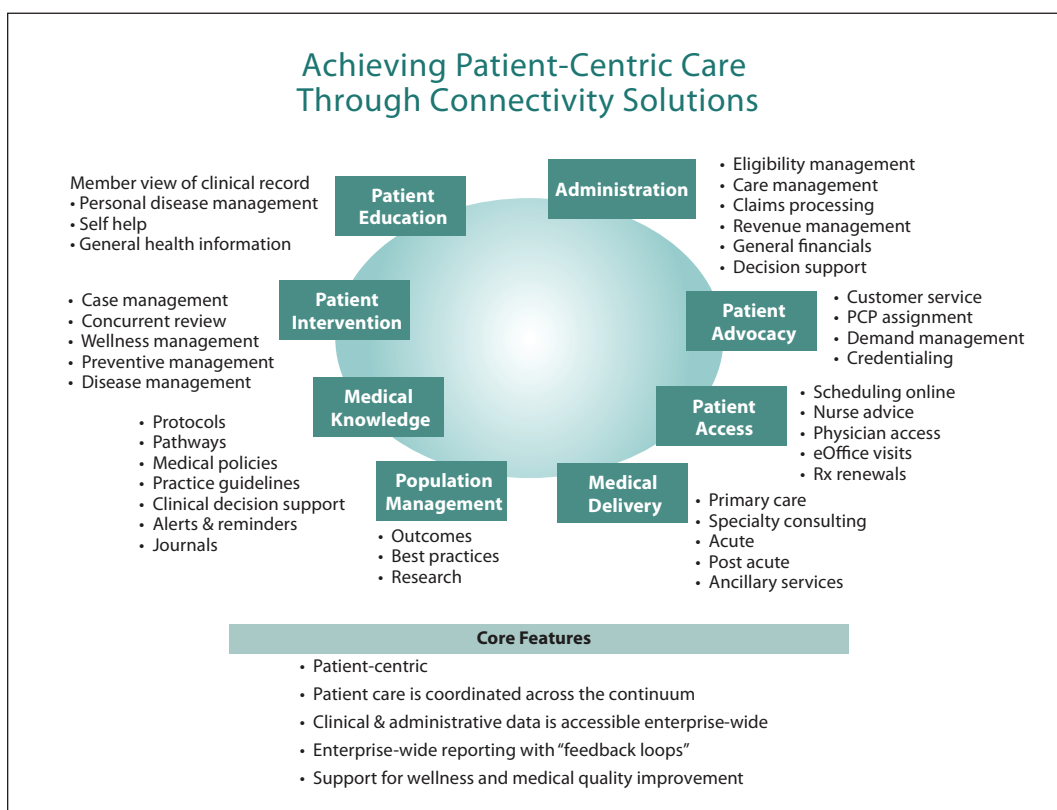- Reducing the cost of care by improving quality and efficiency

Berthelsen touched on how important brand image has been to Kelsey-Seybold—a multi-year investment that communicates the organization's commitment to care through details like an identifiable set of buildings.

The Tactical and Cultural Aspects of Risk Management

Hrountas noted that Sharp-Rees Stealy has been doing risk-based contracts for several decades, describing it as a culture with years of evolution and 25 years under population-based payments.

According to Berthelsen, the willingness to accept and manage total cost risk has been a key strategy at Kelsey-Seybold: "We behave and operate as if we were at risk for 100 percent."

Brown & Toland has been taking responsibility for all the products it supports by putting in more case managers and addressing the needs of moderate- to high-risk patients burdened by acute illness, chronic conditions, age, or self-care deficits.

Achieving Patient-Centric Care Through Connectivity Solutions

Member view of clinical record
- Personal disease management
- Self help
- General health information

Patient Education

Administration
- Eligibility management
- Care management
- Claims processing
- Revenue management
- General financials
- Decision support

- Case management
- Concurrent review
- Wellness management
- Preventive management
- Disease management

Patient Intervention

Patient Advocacy
- Customer service
- PCP assignment
- Demand management
- Credentialing

Medical Knowledge

Patient Access
- Scheduling online
- Nurse advice
- Physician access
- eOffice visits
- Rx renewals

- Protocols
- Pathways
- Medical policies
- Practice guidelines
- Clinical decision support
- Alerts & reminders
- Journals

Population Management
- Outcomes
- Best practices
- Research

Medical Delivery
- Primary care
- Specialty consulting
- Acute
- Post acute
- Ancillary services

Core Features
- Patient-centric
- Patient care is coordinated across the continuum
- Clinical & administrative data is accessible enterprise-wide
- Enterprise-wide reporting with "feedback loops"
- Support for wellness and medical quality improvement

Technology's Vital Role

Kelsey-Seybold has made $38 million in IT investments over five years to monitor dollars flowing through the system. Sharp-Rees Stealy used IT resources to guide the ACO's implementation plan. For instance, a 2011 claims analysis identified key opportunities for improvement—skilled nursing bed days were 42 percent higher than benchmarks and just 3.5 percent of beneficiaries were generating 21 percent of Part A paid claims.

Fish reported how Brown & Toland's more distributed model lends itself to technology platforms and e-tools for integrating care management, clinical care programs, and financial incentive programs for its network physicians.

Partner and Provider Relationships

At Kelsey-Seybold, Berthelsen cited, "a very disciplined approach to contracting with payers that requires knowing your value and delta, leveraging that delta into dollars and a very courageous board."

Fish related how Brown & Toland started out as a clinically integrated IPA to support physicians, with PPOs contracting across the network. They were unique in the country at the time, and it was hard working with payers. Today, the organization lists partnerships with Cigna, Aetna, and Blue Shield/City and County of San Francisco among its accountable care initiatives. Priorities include putting claims and clinical data to work toward patient care and working to keep rate increases in check.

"In order for us to play with you, you have to develop products that create incentives for patients to want to go to an ACO," said Hrountas.

Collaborative Thinking
Q: For complex, high-risk patients, what interventions lowered the cost of care?
A: According to Berthelsen, Kelsey-Seybold has leveraged palliative care, pharmacy management, and home care and emphasized getting patients into the system and to the right doctor. "It's hard work every day. It's also about avoiding catastrophes, avoiding surgery if they won't do well, and trying to avoid making things worse."

Fish responded that in his experience, getting patients to be more interested in their own health management and making those efforts scalable has been crucial. He described how RNs supported these less stable populations in the past. Today one RN oversees a team of 10 health coaches—all focused on earlier interventions.

Perspectives on Care Coordination

Frederick Bloom, MD, MMM, Chief, Care Continuum, Geisinger Health System; Julie Day, MD, Quality Medical Director, University of Utah Community Clinics; Betty Shephard, RN, BSN, MBA, Lead Vice President of Care Management, Davita HealthCare Partners

Three health systems at different phases of the care coordination process discussed actions taken, results achieved, and lessons learned.

Geisinger Health System: A Mature Program

Geisinger made case management an early focus and an important part of the overall PCMH model. Bloom cited primary care design, team-based delivery of care, medical neighborhood, quality outcomes, and value-based reimbursements as the core components of the Geisinger model—all with an emphasis on ROI.

Geisinger redesigned work flow to:

- Eliminate work without added value

- Automate tasks that could be done by a computer or outside of the office

- Delegate office visit tasks to trained non-physician staff when possible

- Incorporate new workflows into the provider practice with reminders and EHR tools

- Use EHR tools to engage and motivate the patient when possible

By March 2012, Geisinger had achieved a 7 percent reduction in costs balanced by additional expenses for case managers and infrastructure that represented approximately $2 in savings for each $1 invested. Analysis also identified the prevention of 140 strokes and 165 cases of retinopathy.

Bloom attributed Geisinger's success to:

- Activated, engaged providers and case managers trained in full disease management, including transitions, escalations, telemonitoring, and pharmacy management

- Professionals working at the top of their licenses

- A focus on post-discharge transitions

- Case managers embedded at the primary care site to support proactive care

- Close follow-up with patients with complex conditions

- Use of interactive voice recognition tools to engage low-risk patients

- Relationships with community partners like nursing homes and home health agencies

Effective Redesign and Care Coordination Delivers Rapid Impact

Activity	Expected Impact	Time to Impact
Short-term effects		
Transitions of Care Management	Reduce Readmissions	3 Months
Case Management for High-Risk Patients with Target Conditions: DM, HF, COPD	Reduce Primary Admissions & ED	3-6 Months
Case Management for Other High-Risk Patients	Reduce Primary Admissions & ED	6-12 Months
Pharmacy management	Increase Generic Use	6-12 Months
Mid-term effects		
Nursing Home Management	Reduce Readmissions / Primary Admissions	12-18 Months
More Efficient Specialists and Ancillary Providers	Decrease Cost per Episode of Care	12-18 Months
High End Imaging	Reduce Unnecessary Testing	12-18 Months
Mid-term effects		
Interventions for Low-Risk Chronic Disease Patients: Disease Registries; Chronic Disease Care Optimization	Improved Control; Avoid Complications	2-5 years
Preventive Care; Screening; Lifestyle Change; Wellness	Earlier Identification & Treatment; Decrease Incidence of Chronic Diseases	2-5 + Years

University of Utah Health Clinics: The Creation and Development Stage

In January 2013, UUHC's full capitation contract started and the system assumed risk for 43,000 Medicaid lives and 7,000 employees. It was "a wake-up," Day said.

UUHC's current model is focused on transitions management, medication reconciliation, and high-risk patients. Key activities have included:

- Training case managers heavily in motivational interviewing and behavioral change

- Establishing baselines and tracking improvements in areas ranging from depression to quality of life

- Investing in transitions management, such as staffing a "transition navigator" to support follow-through for complex cases.

According to Day, providing patients with support when they're being discharged from the hospital has reduced noncompliance by 50 percent. "One phone call can be the matter of life or death."

Moving forward, UUHC aims to reduce emergency room visits, preventable hospitalizations, and hospital readmissions while improving quality scores and total cost of care savings.

Davita HealthCare Partners: Undergoing Continual Reinvention

Davita has revitalized its coordinated care program through:

- **Accountability:** Each team member is accountable to a specific population.

- **Scalability:** The system flexibly adapts to meet market needs and adaptable for all products: HMO, PPO, Dual Eligible, and ACO.

- **Affordability:** Team members work at the top of their licenses.

New Care Delivery Team

- Leverage PCP
- Improve efficiencies
- Maximize team performance
- Create team alignment
- Deliver patient-focused care

PCP

Care Team Supervisor

Care Manager

Patient

Care Team Member

Patient Coach

Social Worker
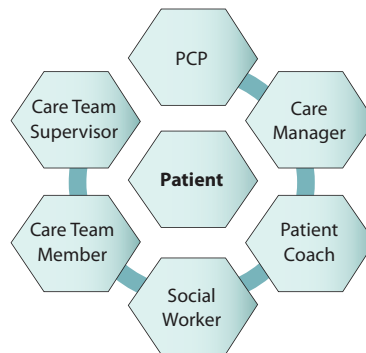
Based on experiences so far, what would Shephard tell other healthcare systems in similar circumstances? Rely on experts for building areas of expertise; don't try to develop things on your own. Conduct a lot of case reviews. Capitalize on IT tools—exception-based monitoring via interactive voice response (IVR) tools, for instance. And recognize that teamwork doesn't just happen. Train all members of your team. Web-based seminars can be effective if you don't have the resources for in-person training.

As the program moves forward, Davita is focusing on:

- Nurse and clinician training
- More effectively matching interventions to patients
- Leveraging technology to reduce face-to-face visits, monitor lower acuity patients and train staff

Collaborative Thinking
Q: When one care manager is working with 150 patients, how long should patients stay in care management?
A: Bloom noted that it's important to make sure that patients fall off of a case load as they graduate/stabilize and are re-activated if they fall into trouble. His team follows COPD and CHF patients long-term with check-ins like monthly phone calls. Providers can use non-medical staff, rather than RNs, for some phone calls and administrative tasks. Day noted that UUHC has been using IVRs for some of its follow-up.

Q: How do you manage case managers? Do you have systems to track their work?
A: An RN oversees case managers at UUHC. At Geisinger, care managers are employed by the health plan, and Epic EMR is used for documentation. Davita uses AllScripts to track encounters and run reports, "so we understand who's touching patients and who's having an impact."

Q: How do you prepare practices for embedded care managers?
A: Bloom said it can take up to 12 months for a practice to really get used to a care manager. "You have a win when the case manager makes everyone's day go better."

Breakout Sessions: Perspectives from the Field

From getting started to tackling readmissions to integrating health coaches into care teams, leaders of these three sessions shared firsthand lessons from their ACO experiences.

Triad HealthCare Network

*Steve Neorr, VP/Executive Director, Cone Health; William Hensel, MD, Operating Committee*

Just as its North Carolina community adapted to profound changes in the textile industry decades before, Triad Healthcare has been adapting to profound changes in the medical community. According to Hensel, "We have not been on the cutting edge of change in our organization until the last couple of years."

And the organization has experienced transformative change ever since. It began with the creation of a 20-member, physician-led steering committee in fall 2010, engaged independent and employed physicians with Cone Health over the next eight months, and officially became the clinically integrated Triad Healthcare Network in 2011.

Work has involved:

- **Developing a structure:** "We needed to get primary care and specialists to work together. We didn't want private practice and employed doctors butting heads," said Hensell. But most importantly, they needed to decide whom to invite to the table in terms of collecting data and dividing money.

- **Engaging physicians:** How do you get doctors to this "new religion of value-based reform"—especially members of the previous group's medical executive committee? Get them involved through leadership initiatives like a quality committee.

- **Transforming the delivery of care:** A multifaceted mission, efforts here included creating a care management team to support physician practices, redesigning the care process, achieving PCMH recognition, and deploying IT systems for population management.

"We had to decide with limited resources where to focus our efforts," said Neorr, adding that IT resources drive everything.

Triad HealthCare Network
The challenge of aggregating data in a community
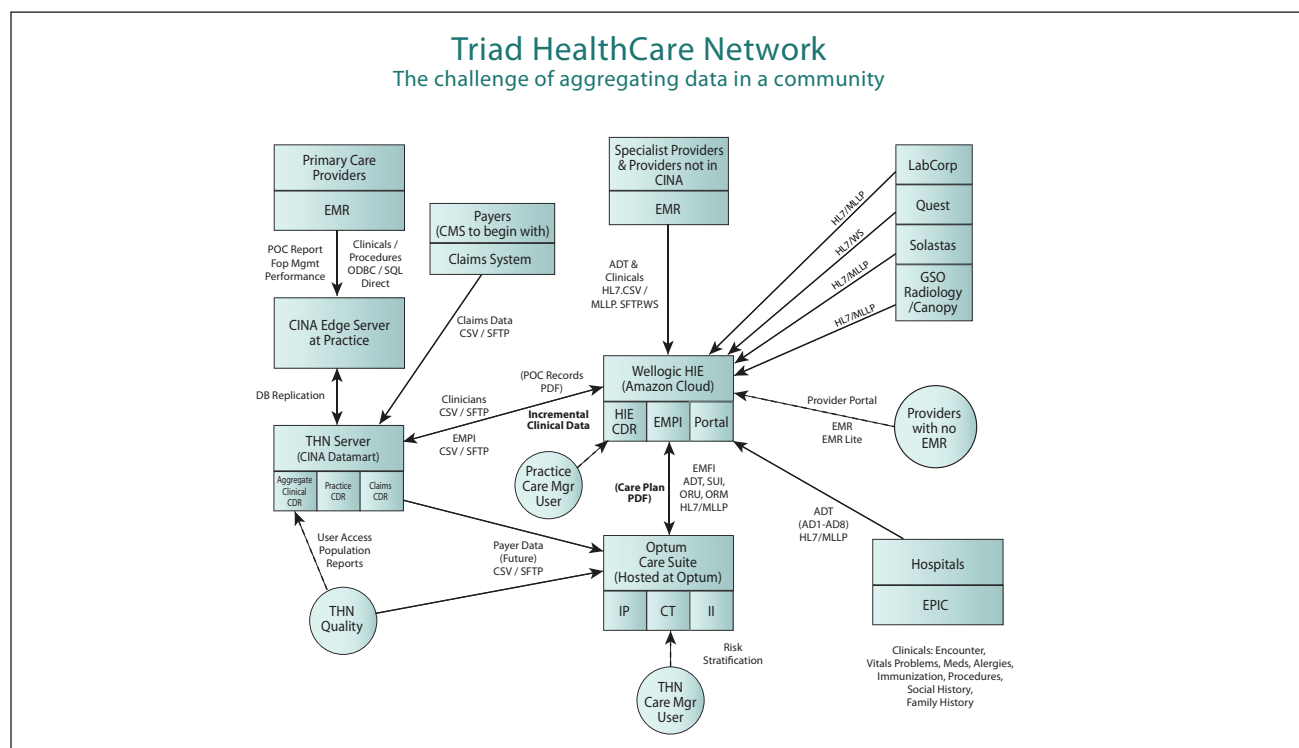
## Summit Health Solutions
Robert Kolock, MD, Medical Director

Summit started its ACO journey in July 2012 with care coordination as a central focus. One key initiative was the Summit Transition and Readmission Program, which initially focused on COPD and heart failure patients. Hospitals sent daily feeds of patient lists and treatment plans to care coordinators, who reached out to patients with information about post-discharge medication usage, follow-up appointments, and self-care. Eighty percent were contacted within two days of leaving the hospital.

"Tackling readmission first makes sense—you get the biggest bang for your buck," said Kolock. "Hospitals should be partners on this, since they're losing money as well if they can't get their numbers down."

For other care management approaches and tactics, participants shared ideas and examples from their own health systems, including:

- Embedding care managers in clinics, such as RNs, MAs, social workers, and health educators
- Training community health workers to serve as health coaches in areas such as home visits and helping underserved populations navigate the system
- Engaging MAs, LPNs, and paramedics for taking patients home and conducting assessments
- Tapping pharmacists and pharmacy students to help with medication-related recommendations and tasks as appropriate


Toward PCMH Value-Based Model
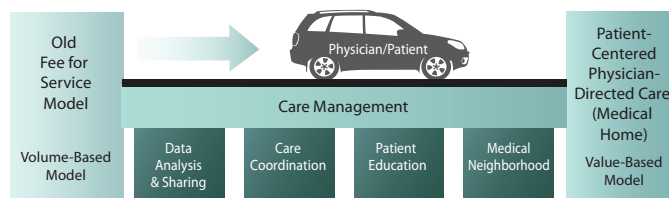
Mercy Clinics

David Swieskowski, MD, MBA, CEO, Mercy ACO; Senior Vice President and Chief Accountable Care Officer, Mercy Medical Center, Des Moines

Mercy Medical Center's $1.7 million investment in health coaches represents one of its biggest expenditures—and potentially most versatile resources. Staffed at a ratio of 1 for every 2,000 ACO patients, these professionals are responsible for:

- Interviewing patients about their motivations and goals

- Coordinating care

- Serving as an access point for patients and families (via phone and e-mail)

- Connecting patients to community resources

- Distributing decision aids

- Supporting patient self-management activities

- Closing the loop on referrals and transitions

- Managing high-risk patient cases

- Serving as a point person for the introduction of new care processes

- Reviewing population data for intervention opportunities

Percent of Hypertensive Adults with Controlled BP

U.S. Average	51%
MCI All (N=20,000+)	76.24%
MCI on P4P (N=5,000+)	84.90%
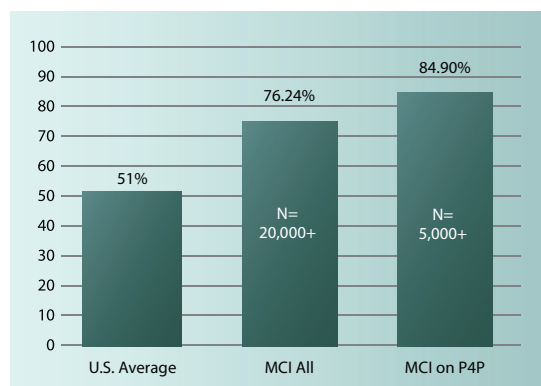
Participants had many questions about the program.

Q. How do you know what your health coaches are doing?
A. Mercy is putting in software to track and manage these activities. It's part of an overall effort to put care management protocols into an electronic format so it can be standardized and capture information such as language preferences and community resources.

Q: Every clinic wants coaches, yet no department wants them on its budget. Where do you put them?
A: Each clinic hires its own health coach. To lower resistance, Mercy was able to demonstrate that health coaches have the potential to generate ancillary revenue far greater than their salaries.

Q: Are coaches incentivized?
A: All Mercy employees are incentivized under the same program of shared metrics.

Insights from Other Collaboratives:
PACT and the Dartmouth-Brookings ACO Learning Network

Joe Damore, Vice President, Engagement and Delivery, Premier Healthcare Alliance; Greg Kotzbauer, Project Manager, Health Policy and ACO, The Dartmouth Institute

Hosted by Premier Healthcare Alliance, the PACT Population Health Collaborative helps members navigate the shift toward population health in public and private markets. This includes population health assessment tools to use in areas like readiness and bundled payment. When it comes time for members to implement programs, PACT provides templates to reduce time and effort and metrics to assist with performance improvement.

Members meet in summits and idea exchanges. Organizations offer their own specialized on-site training sessions. And a team of content experts, from payer negotiation to care management, is available to members anytime. For upper member levels, shared learnings hone in on specific issues like diabetic care management and new revenue opportunities in smaller group settings.

The Dartmouth-Brookings ACO Learning Network provides best practices and tools for medical groups planning and implementing accountable care reforms. Its purpose, according to Kotzbauer, is to translate strategy into operational goals and having a plan for moving forward. "We specialize in asking questions," said Kotzbauer. "And to avoid pushing any sort of agenda, our member-driven network simply brings like-minded people together to move toward a common goal."

Monthly calls, informal workgroups, and conferences connect members with outside experts. The network also works with health systems to build basic tools. These include a self-assessment that helps users measure proficiency levels for key clinical transformations and then identify methods for improving them.

Damore and Kotzbauer shared observations and insights gained through their collaboratives' work.

Achieving Cost Savings
Cost savings is on everyone's mind, Damore said. How can we do these reforms and save money?
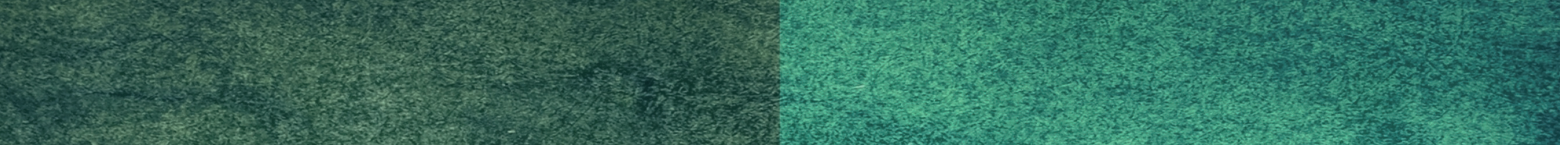
Based on what he's seen in the PACT collaborative, Damore suggested focusing on:

- High-risk populations, especially to the top 1 to 2 percent
- Chronic disease, including asthma, diabetes, and chronic depression.
- By focusing on PCMH and replacing more expensive locations with less costly ones, health systems can reduce care management costs by up to 8 percent
- Better transitions of care—for instance, better management of the discharge process
- Reforming pharmaceutical costs and usage

Opportunity also can be found in intensive care. One PACT participant hosted a special site visit for peers that highlighted its six years of ICU outpatient experience. The organization shared its lessons learned and impressive results, which included a 12 percent reduction in costs, dramatic quality improvements, and increased patient satisfaction.

Managing Population Health
Population health starts with knowing your patient population and its needs, said Kotzbauer. Do you have the right leadership, staff, and community programs in place? What about your processes and tools? And how do these processes and tools influence interactions and decisions?

According to Damore, who has conducted many of PACT's assessments in the area of population health, organizations need a robust primary care network—for attribution and many other reasons. A PCMH also can be helpful. Other crucial elements to population health management include:

- Transitions that are physician-led and professionally managed

- Care management programs (centralized or decentralized)

- Chronic disease management, especially for the "big six" conditions

- Population health analytics, including historic claims and predictive modeling

- A clinically integrated network for shared savings

- Aligned payer arrangements

Also important, "Get patients to understand that they have skin in the game, that health care is not just about us taking care of you," Kotzbauer said. "Provide patients with the tools so they are more empowered."

Navigating Medicare Shared Savings

The CMS Medicare Shared Savings program is one way a health system can become an ACO. PACT field experts took a small group of participants interested in this model through a 10-week process that involved implementation support and one-on-one development and guidance. Regular meetings involved sharing best practices, contracting templates, shared savings models, public policy considerations, and more.

How do we get specialists engaged? Should we try building incentives for certain specialty areas? How do we embed care managers and navigators into practices and patient-centered medical homes?

PACT participants faced these questions, as well as challenges in the areas of:

- Beneficiary notification and communication

- New physician recruitment

- Physician engagement and education

- Timely and accurate collections of claims data

- Implementation of population analytics

Many Models, Common Needs

"Systems are dipping their toes into value-based delivery—and some systems are doing this without calling themselves ACOs," Kotzbauer said.

Whatever the model, "we need to identify how everything comes together, in order to provide patients with no more and no less than what they need," said Kotzbauer. "Understand the importance of patient experience and clinician satisfaction, and assign patients to the right providers."

The Anceta Collaborative: Leveraging Data for Operations, Patients, and Populations

John Cuddeback, MD, PhD, CMIO, Anceta

Data-driven collaboration is the premise behind AMGA's Anceta data warehouse collaborative. Through working with detailed, disease-specific models, participants are able to benchmark their operations and identify opportunities for improvement. Anceta helps participants gain data-driven insight into:

- The quality and cost of their care delivery
- Interventions for high-risk, high-cost patient groups
- Referral patterns
- Operational efficiencies

New Developments

Optum Insight's early 2013 acquisition of Humedica makes Anceta the only system in the industry capable of integrating clinical and administrative data—and delivering "apples to apples" comparisons across its 25 health-system participants. AMGA is expanding the scope of the Anceta collaborative to include seven disease models, population management, and a dashboard.

Shared Challenges

Anceta participants work together to share best practices and find ways to achieve favorable outcomes at the lowest costs. Current challenges include:

- Integrating operations when two organizations with different systems merge
- Deciding whether to go with "best of breed" or "monolithic" technology
- Supporting an integrated care delivery process across areas such as ambulatory care, acute care, and community resources
- Attributing patients across organizations and care teams
- Reporting to external partners
- Getting a complete picture of the total cost of care, including claims for services from other providers

Analyzing Costs

Through technology and shared learning, Anceta is helping participants find answers. In the area of cost accounting, users can look at expenses per unit, compare costs against utilization and get a "real cost" view of the world. It enables modeling for bundled and other contracts, statistical risk adjustments, and the creation of resource profiles, which can be used to create standardized costs.

Allocating Resources

For integrating care delivery, Anceta can be used to guide resource allocation—particularly in opportunity areas like primary and ambulatory care—and map process flow. Who's the right person to talk to a patient? What's the best next step in the process?

When delivering patient care itself, you need to look at outcome metrics as well as process metrics, Cuddeback advised—things like a patient's functional status and mental health status. In one mental health use case, he said, doctors were able to identify severe depression as a key factor in patient health, even though it wasn't part of their original discussion dialogue.

Insight without the Wait

Modeling and analytics tools also give medical groups the ability to focus in on correlations and variations without having to wait for the outcomes of controlled studies. Providers can analyze readmissions data to predict future emergency room visits for congestive heart failure patients. Or they can break out a cohort in a pharmacy study by drug class or BMI—for instance, to test the relationship between insulin treatment and weight gain.

"It challenges the rationales people have in their heads for things like drug choice," said Cuddeback.

Support for Population Health

As population health becomes a growing focus for ACOs, Cuddeback anticipates a growing demand for intermediate-level population management—the processes for extracting and loading data when analyzing it at the patient and population levels.

What processes work best for getting data in and out of systems? How can these processes be most effectively implemented? Anceta participants will grapple with these and other questions.

Meanwhile, need also exists for viewing process execution and improvements. This includes:

- Provider performance reports
- Patient registry for outreach and care coordination
- Comparative data linking process to outcomes

For information about the Anceta collaborative, visit www.anceta.com/join.htm.

"A window has opened for providers of care to take the initiative to prove that lower cost and higher quality are not only compatible, but strongly linked. But the window will not stay open for long if results are not forthcoming. American healthcare providers face an opportunity and a test — now."

—Donald Berwick, MD, MPP, CMS Administrator 2010-2011

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