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ideas. answers. action.

Building a Successful ACO: A Blueprint for Implementation

National ACO Congress

Beverly Hills, California

October 30, 2012

ACO Critical Implementation Issues

ACOs: Now or Later?

Attracting Loyal Patients: Patient Engagement

Team Building: Physician and Provider Engagement

Enhancing the Care Delivery Model

Building and Nurturing Strategic Alliances

Are You Ready?

I. ACOs: Now or Later

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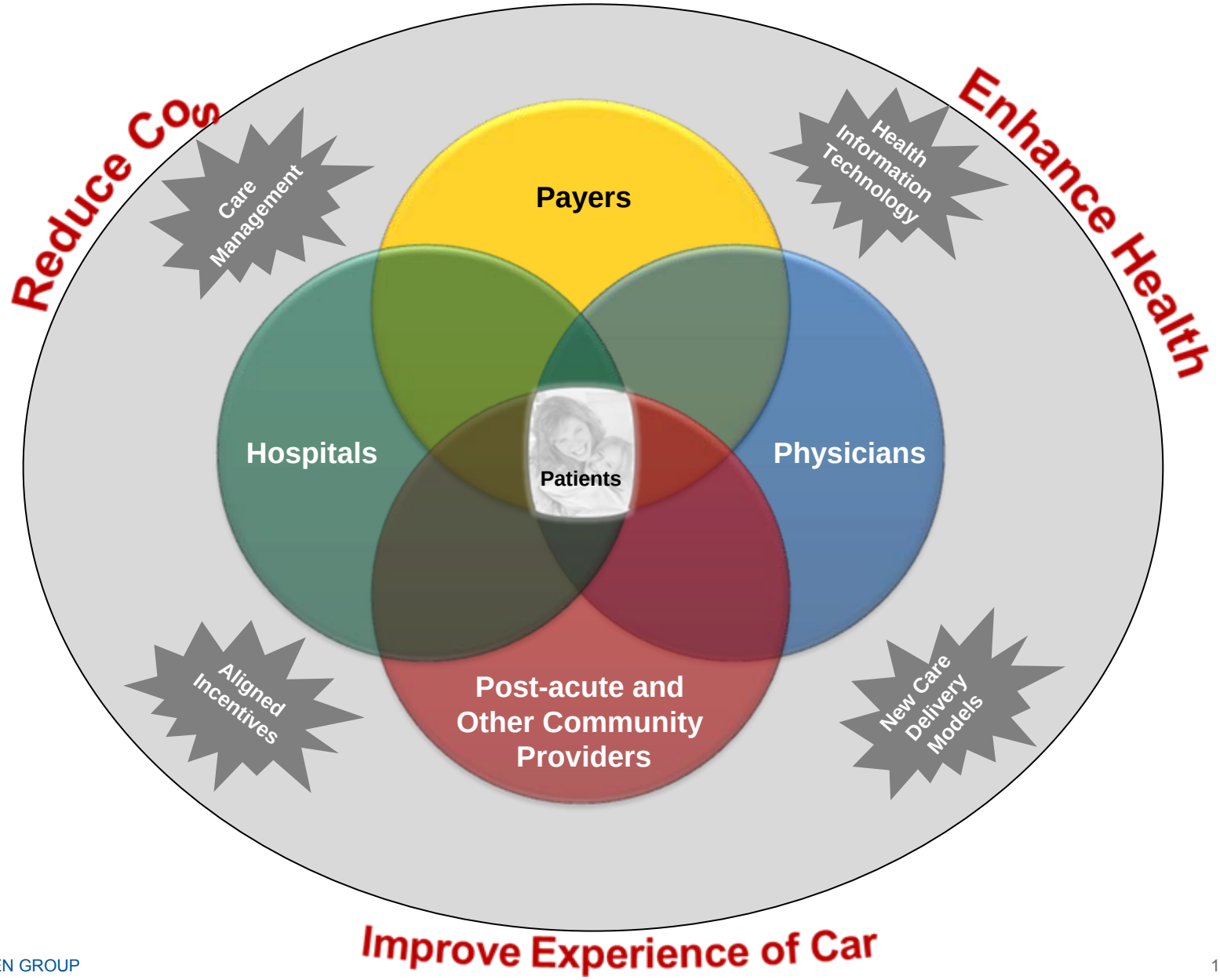
Clinical Integration – Aligning to Achieve the "Triple Aim"



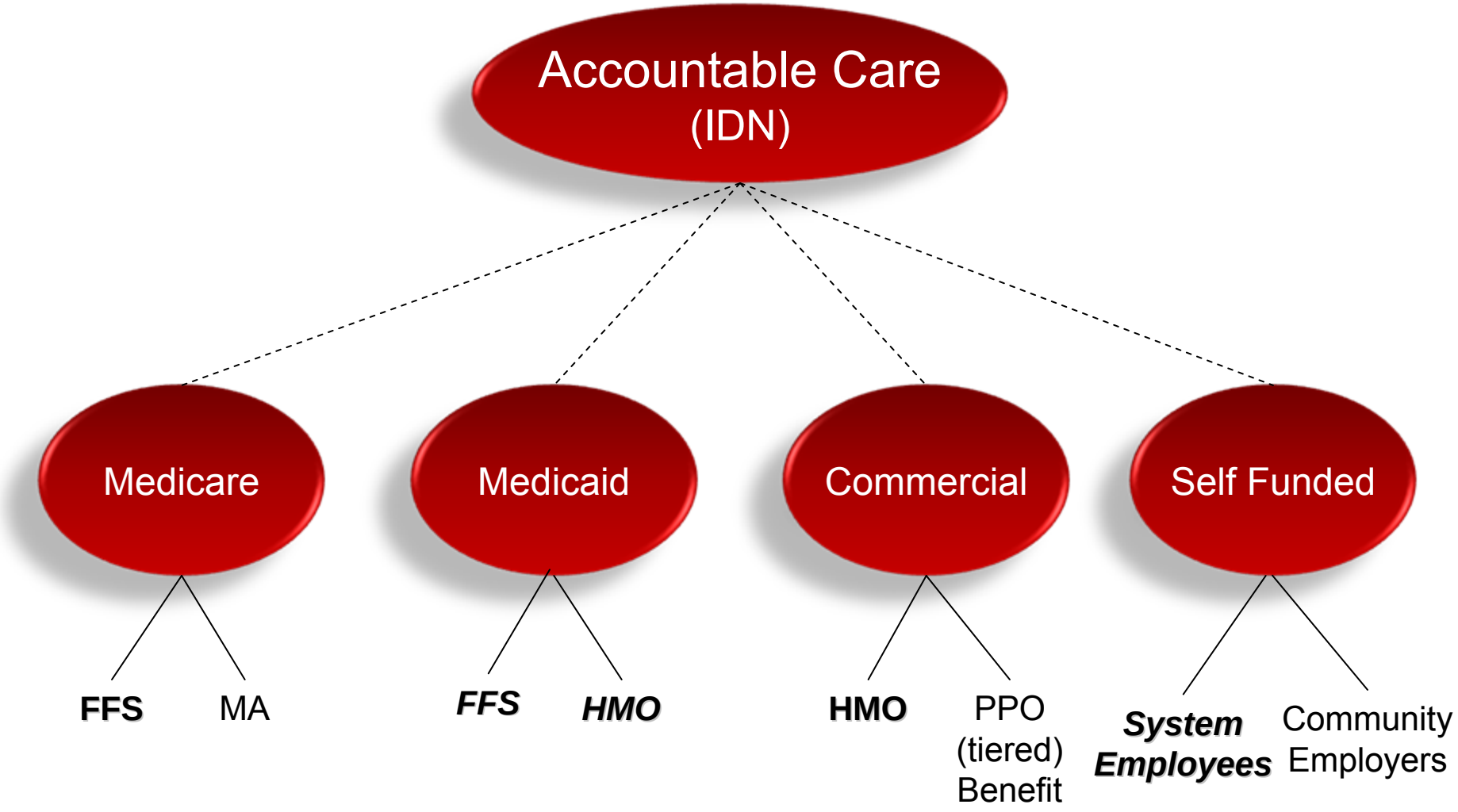
ACO Structure

- ACO responsible for:
  - Clinical care management (clinical integration)
  - Capture data for continuum of care
  - Measure and monitor costs and quality

Infrastructure (Provided or Contracted ACO Operations)

- Information Technology
  - EMR, CPOE, PACS
  - Data warehouse
  - Reporting
  - HIE
- Care Management
  - Hospitalists and Intensivists
  - CMO
  - Disease management
  - Clinical protocols
  - Advanced analytics and modeling
  - Call center
  - Utilization management
  - Knowledge management
- Health Network
  - Delivery network
- Financial/Payment Systems

Accountable Care Potential Market Segments: Enlarging the Pie



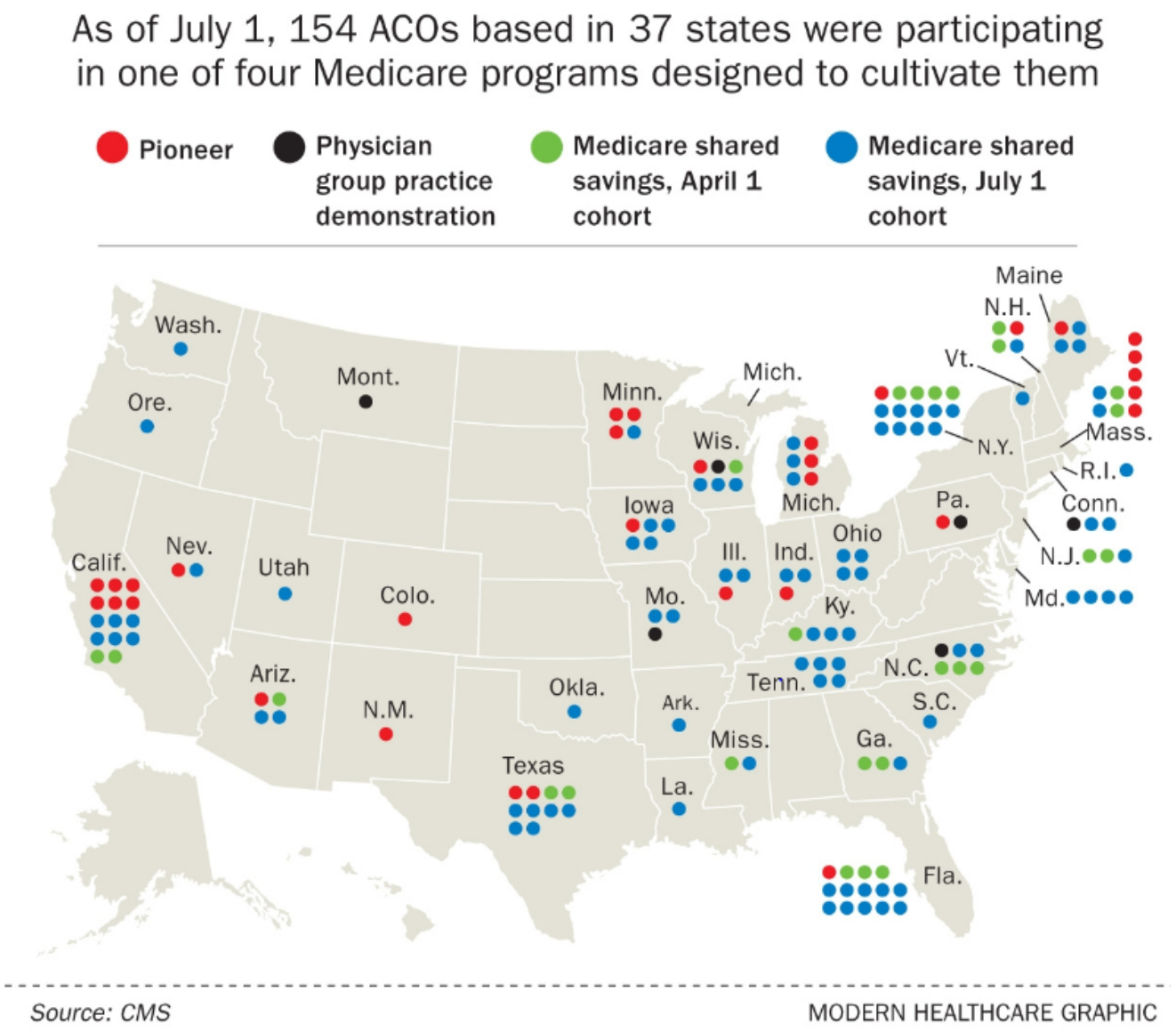
Motivation for ACOs

- Medicare volume growth unsustainable
- Check the rapid adoption of costly technology against efficacy
  - Give comparative effectiveness a chance to work
- Duplication of services due to defensive medicine or poor communication between providers
- Inconsistent care approaches result in uneven quality
- Lack of care coordination
- Need a mechanism to:
  - Counteract the incentive for volume growth in the Fee-for-Service ("FFS") system
  - Reward improved quality

Source: MEDPAC, *Report to the Congress: Improving Incentives in the Medicare Program*, June 2009

ACOs Are Sweeping the Nation

- Over 2.4 million Medicare beneficiaries have been assigned or “attributed” to these ACOs.

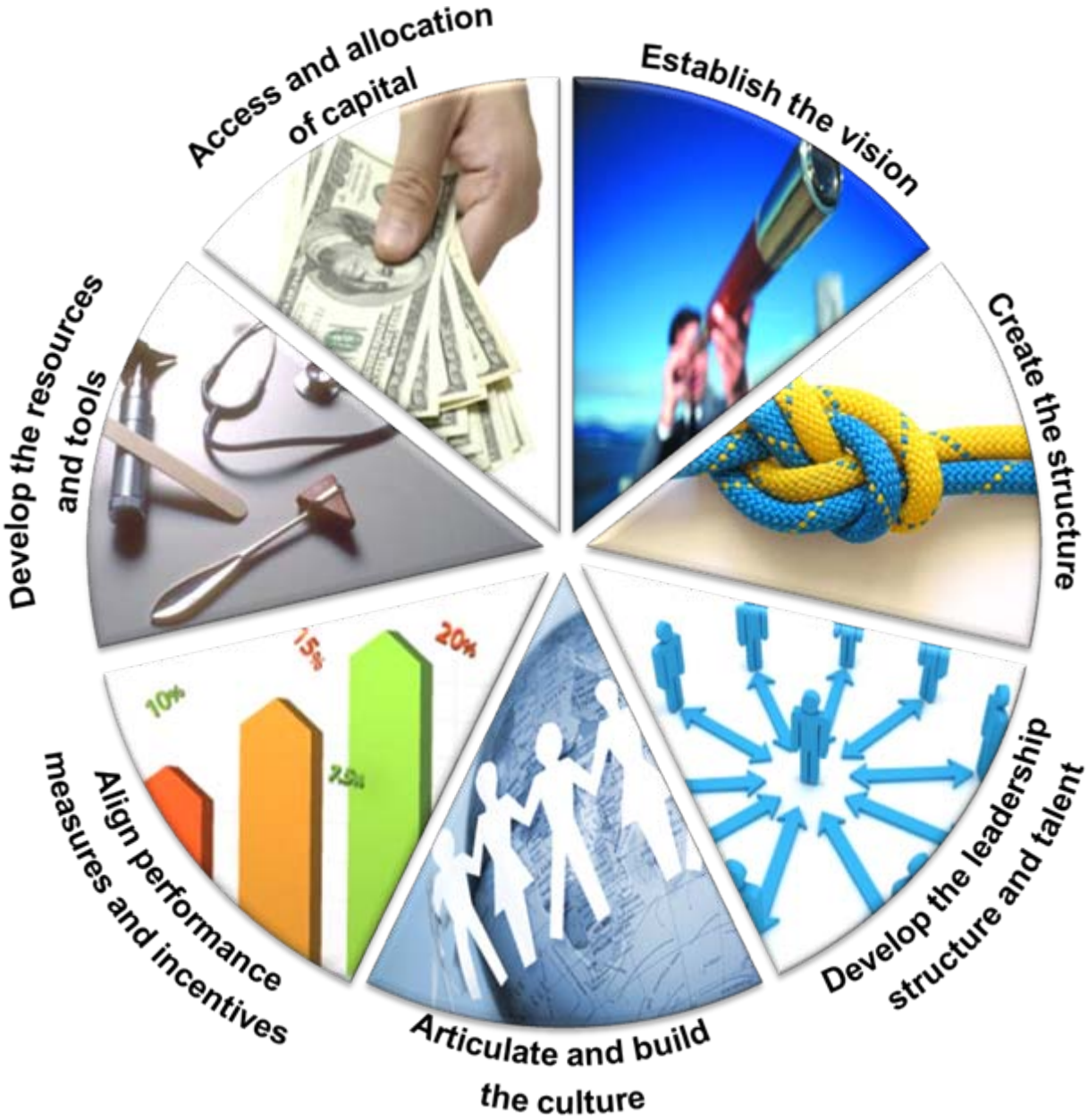


But It Is More Than Just Medicare…

Now or Later…Checklist for Consideration

- ☑ Market activity: payers, competition
- ☑ Market position and scope of services
- ☑ Primary care relationships
- ☑ Capabilities and experience with population management: care coordination, risk
- ☑ Organizational fortitude and fit with strategic direction
- ☑ Capacity and willingness to change

Critical Success Factors – Becoming “Accountable”



Establishing the Vision

How would you answer these questions…

- How does our organization define our role in population health?
  - Leader?
  - Manager?
  - Provider/Participant?
  - Wait and see?
- What roles do our “partners” (hospitals, physicians, payers, other providers, community organizations) want to play with us in improving community health outcomes…and taking risk?
- Are the resources to invest in the required capabilities available internally or will success likely require a partner or affiliation with others?
- What is our organization’s tolerance for risk and rapid change?

How is the “ACO Era” Different from the ‘90s?

The ‘90s	Now
Discounted Payments to Providers	Right Care/Right Time/ Right Place
Withholds	Incentives/Gain-Share
Booming Economy	Recession
Limited Government Intervention	Government Pushing Out Alternative Models
Assignment of Patients	Attribution/Relationships
Limited Systems to Implement	Installing Robust Systems and Care Models
Prevention	Management of Chronic Disease

Key Analytics Required to Plan for and Manage an ACO

- ACO budget: need historical actuarial data to develop model for future utilization and unit cost targets
  - Also need actuarial-driven model to assess reasonableness of revenue offered in payer agreements
  - What is the ROI?

- Risk management = Care management
  - Utilization reduction key to achieving financial targets, but need to balance with quality goals
  - Compare actual utilization to benchmarks for key clinical areas, adjusting for demographics and risk
  - Analytics to identify patients at risk, then care models to address their needs
  - Need physician referral data to monitor and manage network “leakage”
  - What are costs associated with care outside of network?

Who's You Competitor/Collaborator Now?

Sample CI/ACO Gap Analysis by Assessment Area

Assessment Areas	Capability	Comments
Share Vision/Goal for CI/ACO	**2**	■ Physicians recognize that the care delivery model and financial reimbursement models are changing. Need to identify strategies that are appropriate for each market.
Governance/ Structure	**3**	■ Network could be an able vehicle for developing the physician structure for the ACO. ■ Factions among the medical staff – employed and independent, others along specialty lines.
Physician Leadership and Alignment	**2**	■ Must find ways to bring together employed and independent physicians. ■ Broad geographic reach adds complexity and makes meaningful inclusion more difficult. ■ Physicians have a more involved role in leadership and decision making, however, systems have not been created for clinical quality management.
Delivery Network and Continuum of Care	**3**	■ Health system and its affiliated physician partners offer the full continuum of services from primary and specialists care to hospitalization and post-acute services (long-term care, home health, telemedicine). ■ Efforts are underway to develop a more coordinated/integrated care delivery model.

Sample CI/ACO Gap Analysis by Assessment Area

Assessment Areas	Capability	Comments
Care Management Platform	**2**	■ A limited number of hospital-based order sets are presently in use. ■ Hospitalists quality incentives implemented in Q3 2010. ■ Case managers are responsible for managing pre-authorizations and identifying at-risk patients.
Care Innovation to Accountable Care Delivery	**1**	■ Organization has committed to implementing Medical Home starting with Family Medicine residency program.
Quality Monitoring and Reporting	**1**	■ Limited physician quality reporting initiative ("PQRI"), P4P. Implementing Crimson physician reporting tool and electronic health record ("EHR").
IT Infrastructure	**2**	■ Hospital is committed to a successful electronic medical record ("EMR") adoption with rollout in 2011; some physicians have EMRs in their office. ■ Limited capabilities exist to share data across practice sites and with the hospital.
Payment Methodology and Incentive Alignment	**2**	■ Blue Cross has a well established Medical Home program and is expanding to "Systems of Care." ■ Local employers, as well as system employees, offer potential areas for shared-savings program development. ■ However, employed physician compensation model is not aligned to deliver value-based care and there are few P4P incentives for either employed or independent physicians.

II. Attracting Loyal Patients: Patient Satisfaction, Experience, and Activation

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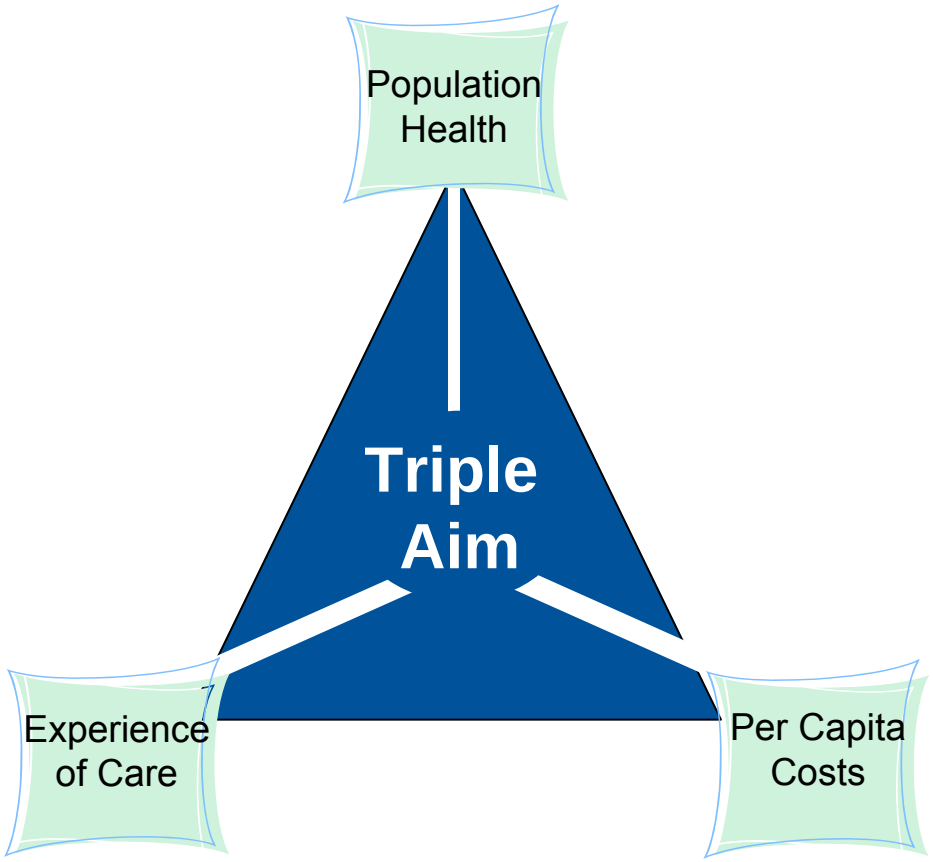
Why is the Patient Experience Important?

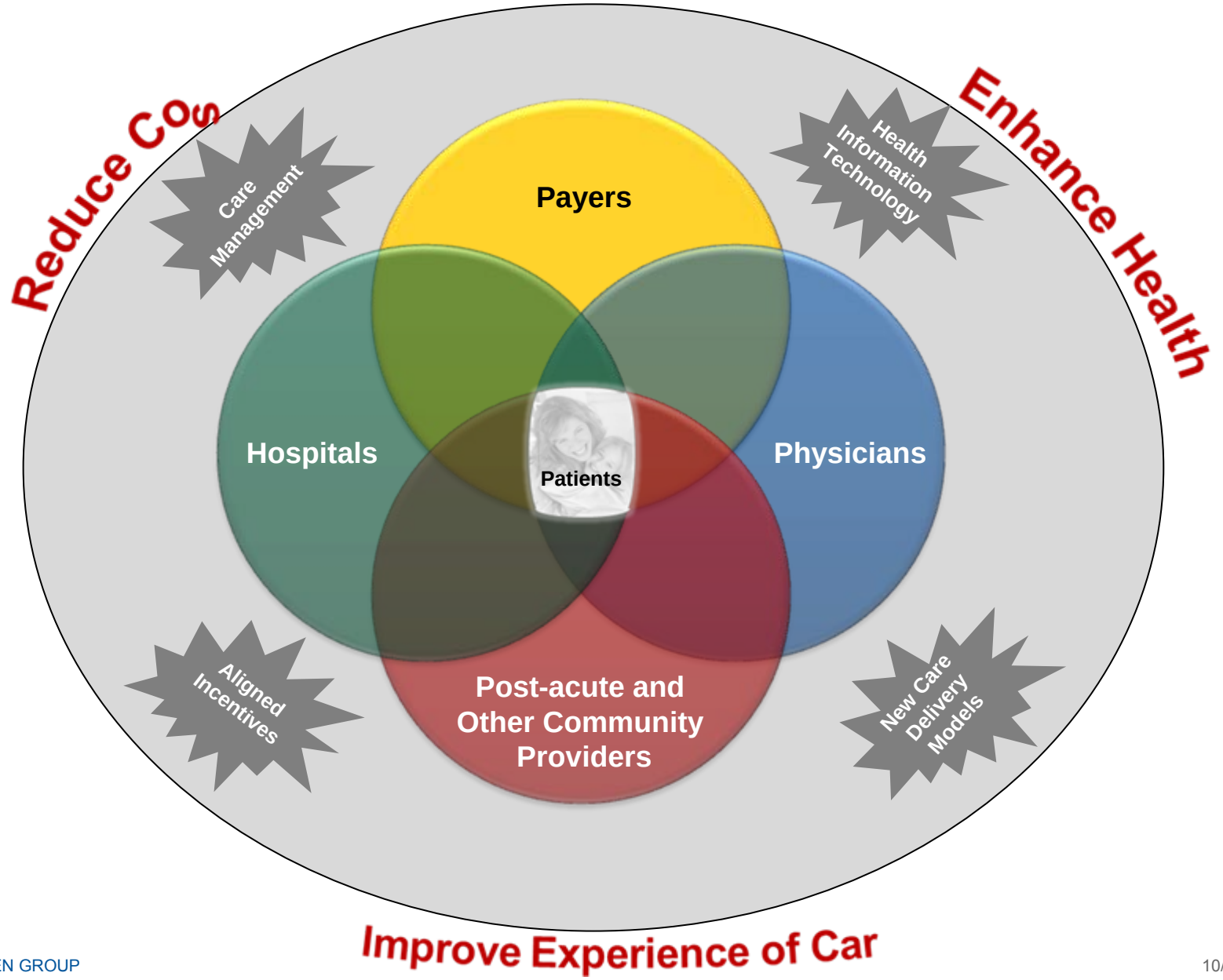
Institute for Healthcare Improvement: The Triple Aim



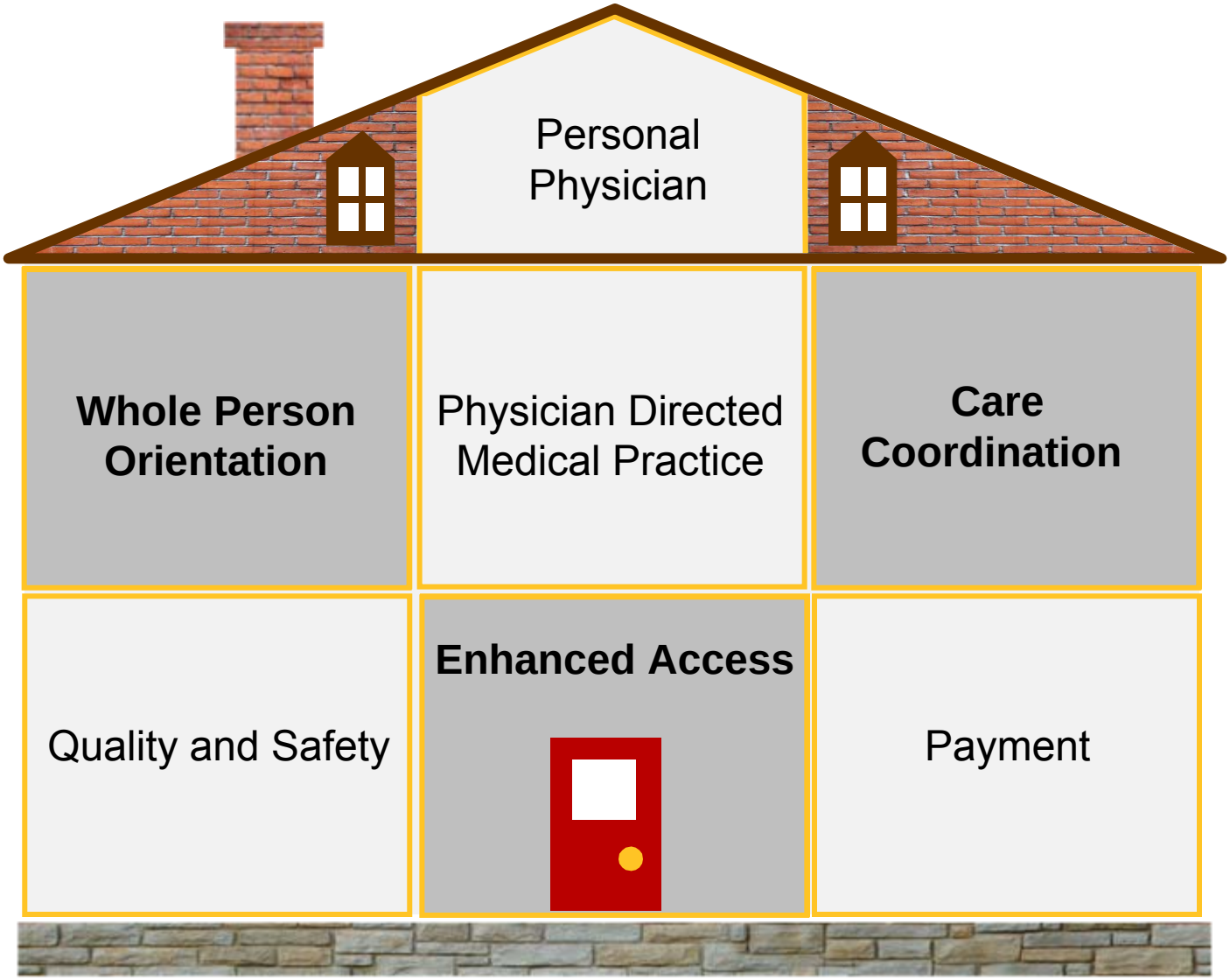
Source: *http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm*

- The Triple Aim™ set forth by the Institute for Healthcare Improvement:
  - Optimal care delivery within and across the continuum
  - Focused on improving the health of the population and cost of care
  - Right care, Right place, Right time

Clinical Integration – Aligning to Achieve the "Triple Aim"



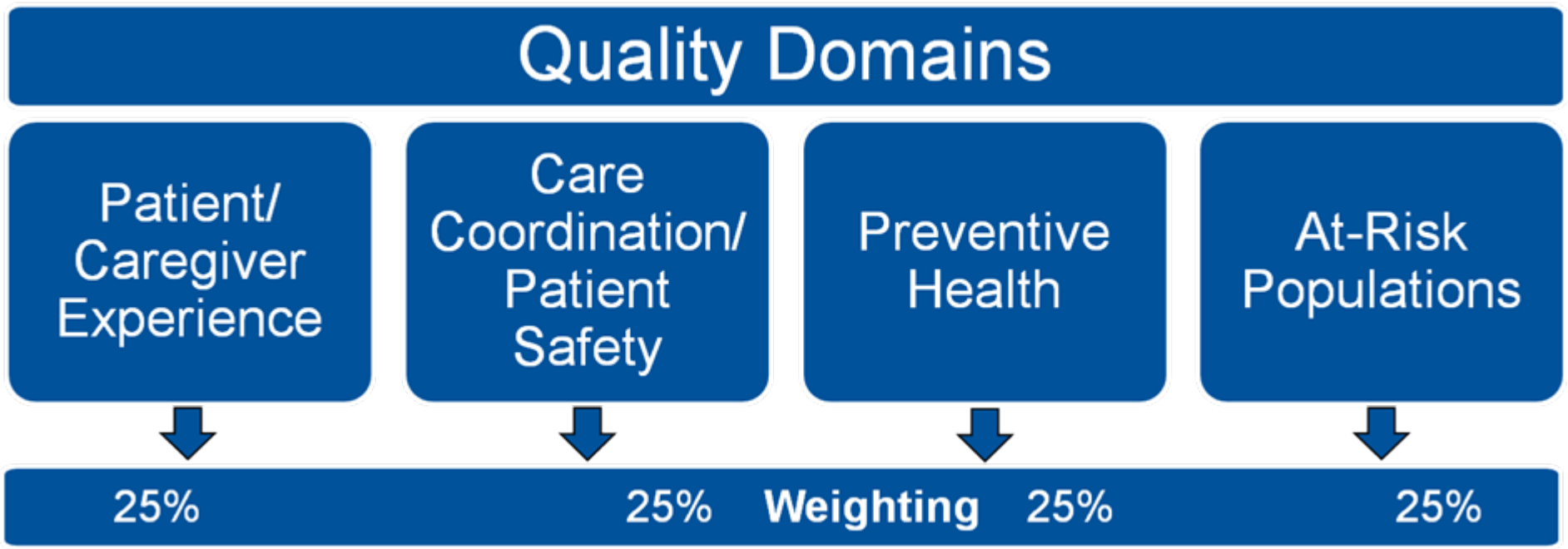
Patient-Centered Medical Home



- Focus on Patient Centeredness and Patient Experience
- Three of seven principles directly address the Patient Experience

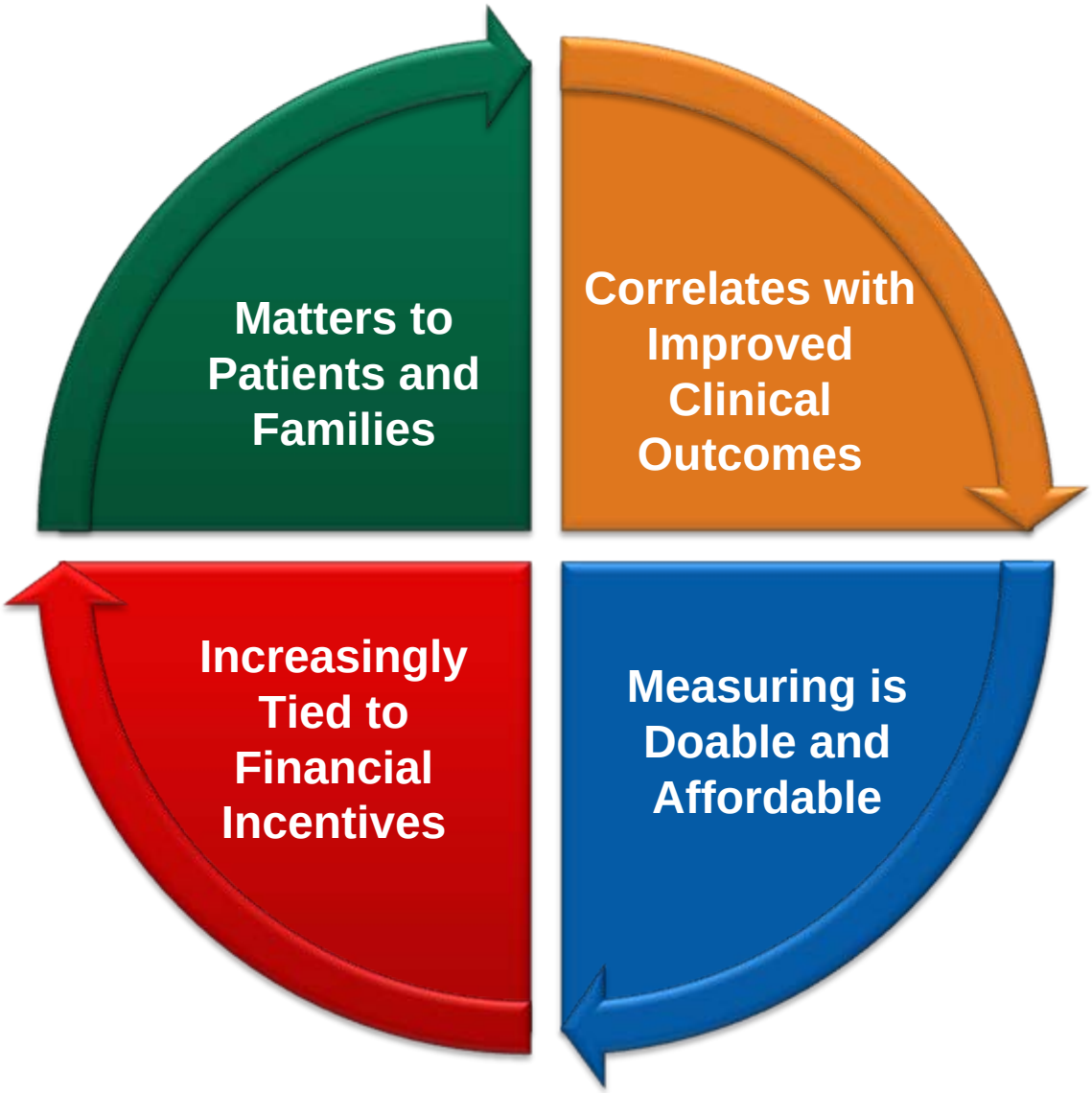
SSP Quality and Performance Payment

- Pay-for-Performance Calculations



	Number of Measures Included in Each Quality Calculation by Year		
Quality Calculation	Year 1	Year 2	Year 3
Pay for Reporting	33/33	8/33	1/33
Pay for Performance	0/33	25/33	32/33

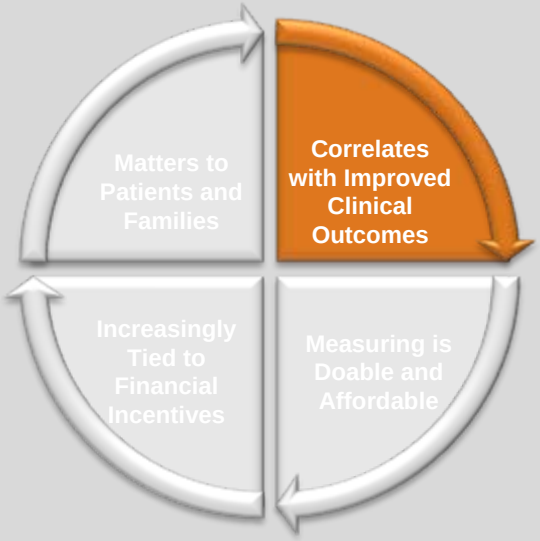
Positive Patient Experience



Positive Patient Experience

Matters to Patients and Families

- Patients prioritize communication of the provider-patient relationship as key elements of quality
- Assess experience rather than satisfaction to obtain actionable improvements



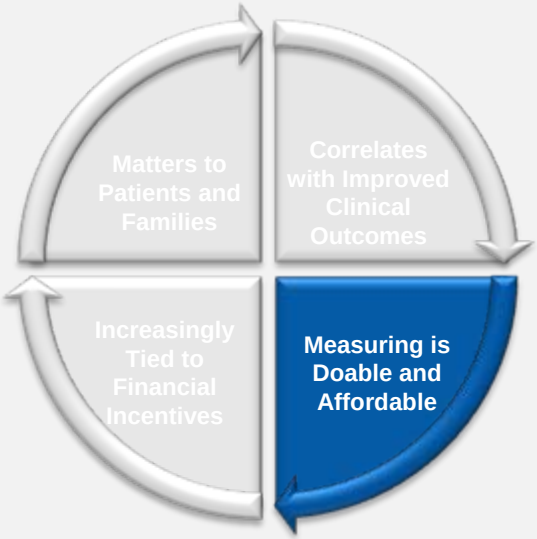
Correlates with Improved Clinical Outcomes

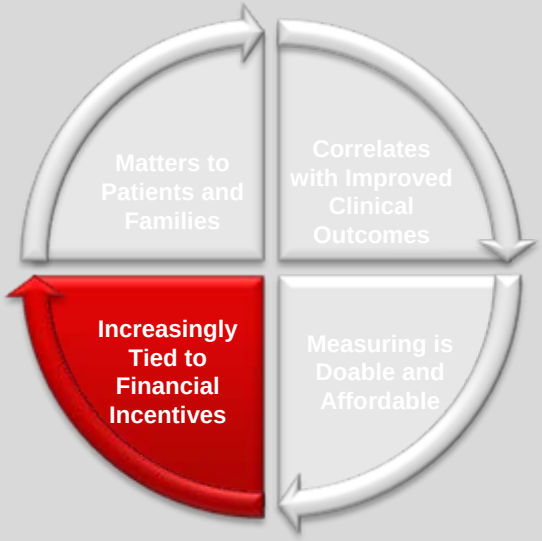
- Patients with better care experiences have better health outcomes
- Measures of communication from and coordination between providers and staff are highly correlated with clinical measures

Positive Patient Experience

Measuring is Doable and Affordable

- Patient experience varies at the practice and provider level, highlighting opportunity for improvement
- Public reporting facilitates quality improvement
- Survey costs are reasonable





Increasingly Tied to Financial Incentives

- Private plans, CMS, and state Medicaid programs are recognizing good patient experiences as good care and business and rewarding with compensations.
- Decreased malpractice risk and staff turnover

CG CAHPS

- Clinical and Group Consumer Assessment of Health Care Providers ("CG CAHPS") survey is a measure of patient and caregiver experience of care
- Intended to bring transparency and standardization to medical community
- Contains the following seven components:
  - Getting Timely Care, Appointments, and Information
  - How Well Doctors Communicate
  - Patient Rating of Doctor
  - Access to Specialists
  - Health Promotion and Education
  - Shared Decision Making
  - Health Status/Functional Status

Patient Engagement and Activation

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Patient Engagement

> "Actions individuals must take to obtain the greatest benefit from health care services available to them."
>
> The Center for Advancing Health

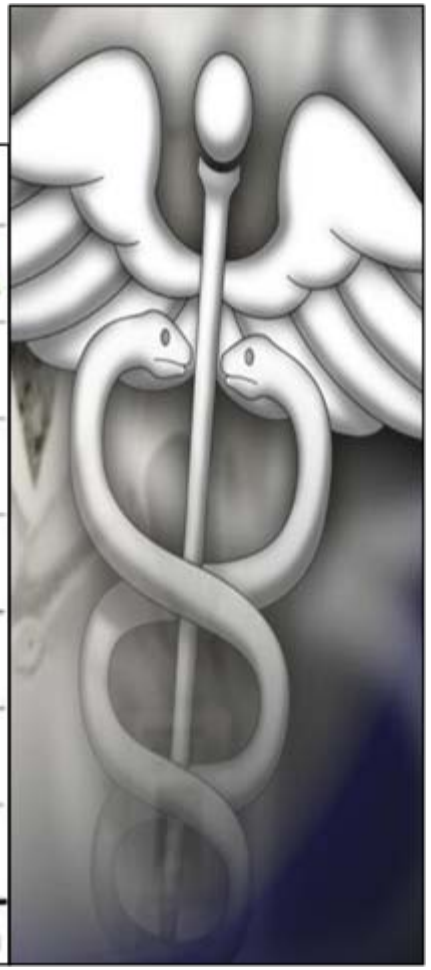
- Focus on behaviors of individuals relative to their health care that are critical to health outcomes
- Individual synchronizes information and professional advice with their own needs, preferences and abilities
- Characteristics that affect engagement include:
  - Age
  - Literacy
  - Acuity of Disease
  - Care Delivery Setting
  - Cultural Norms

Behaviors Associated with Engagement

Self Management

Teamwork with provider

Maintain function/prevent declines



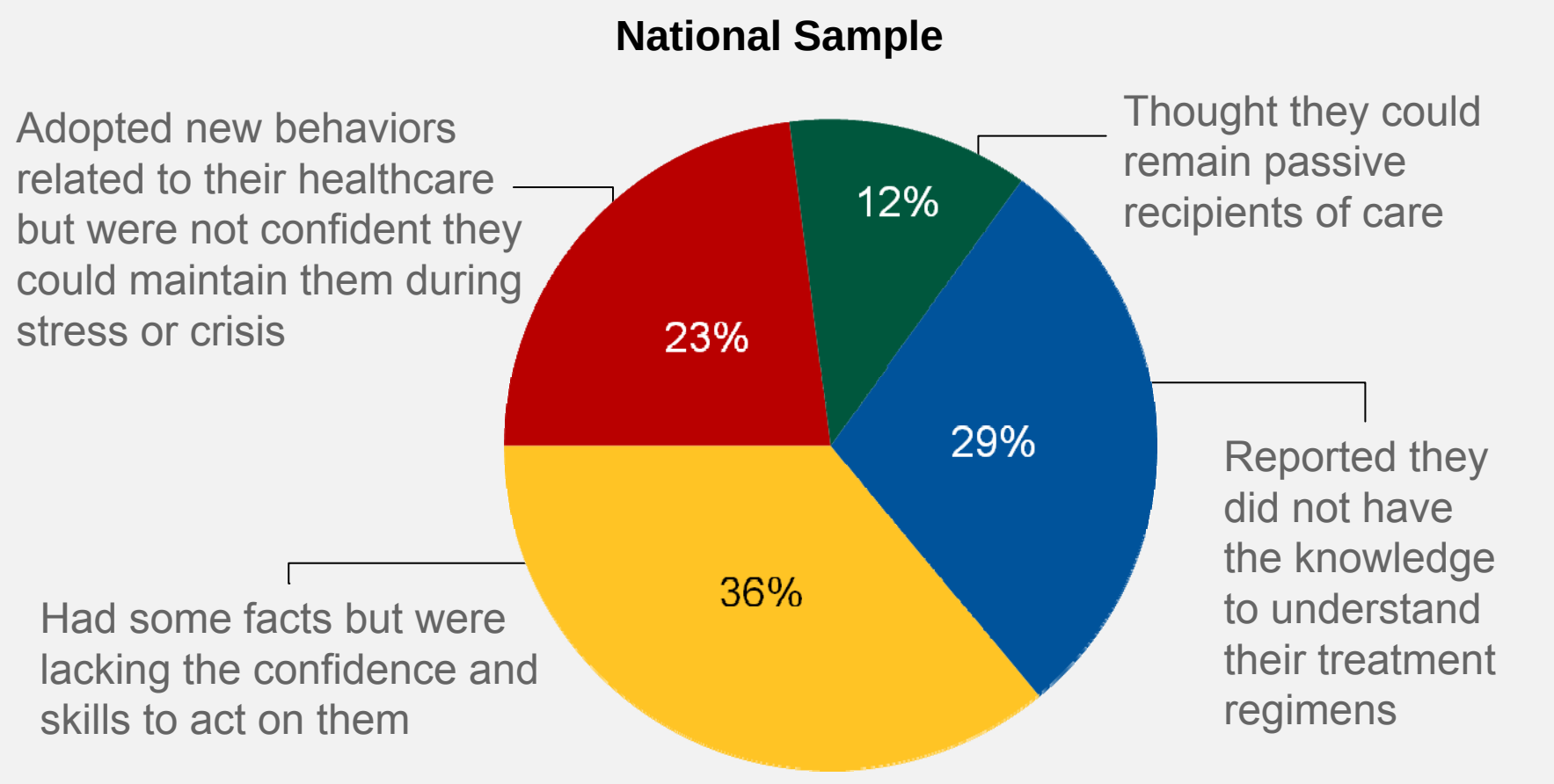
Access to appropriate and high quality care

Source: Hibbard, J.H. (2008). Patient Activation and Engagement for ACOs. University of Oregon.

Patient Engagement

Medicare Current Beneficiary Survey

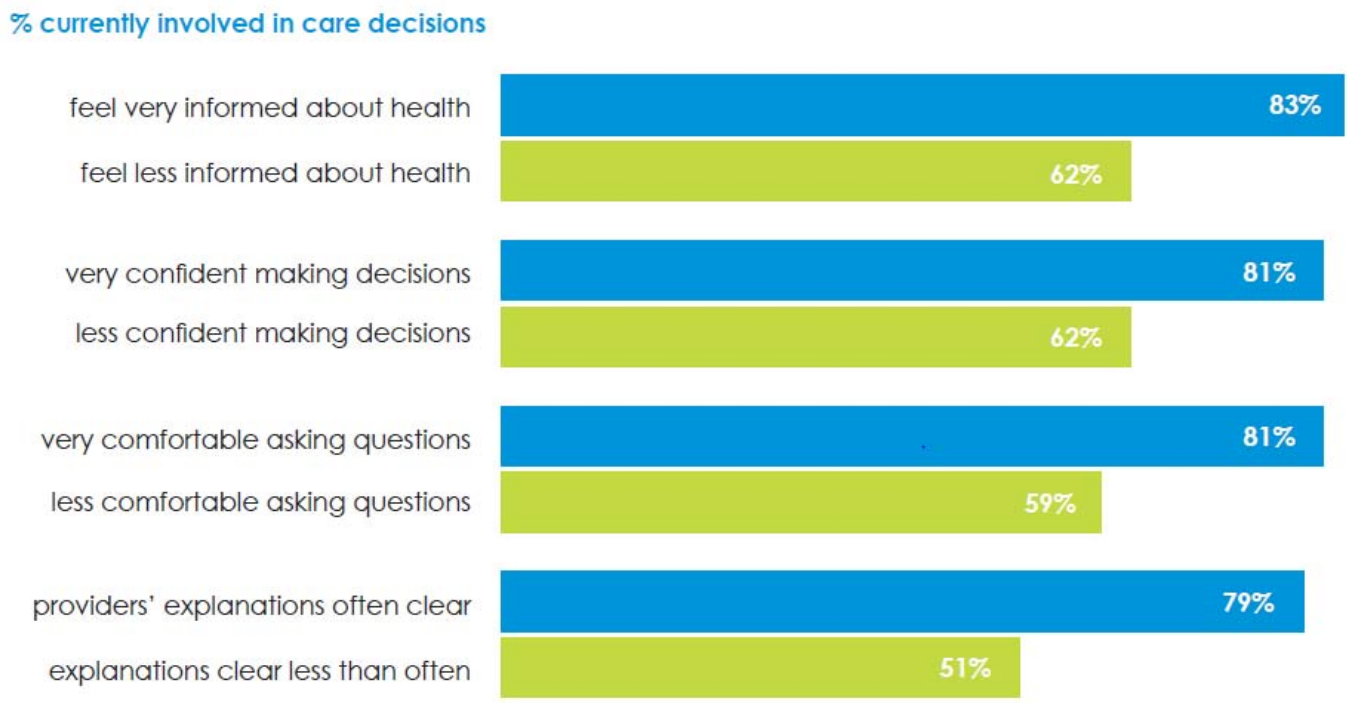
- 30 percent of older Americans possess the motivation and skills to actively engage in their healthcare



Hibbard JH, Mahoney ER, Stock R, Tusler M. Do increases in patient activation result in improved self-management Behaviors? Health Serv Res 2007;42:1443-63
Williams SS, Heller A. Patient activation among Medicare beneficiaries; segmentation to promote informed decision making. Int J Pharm and healthcare Marketing 2007;1:199-213

Informed Patients

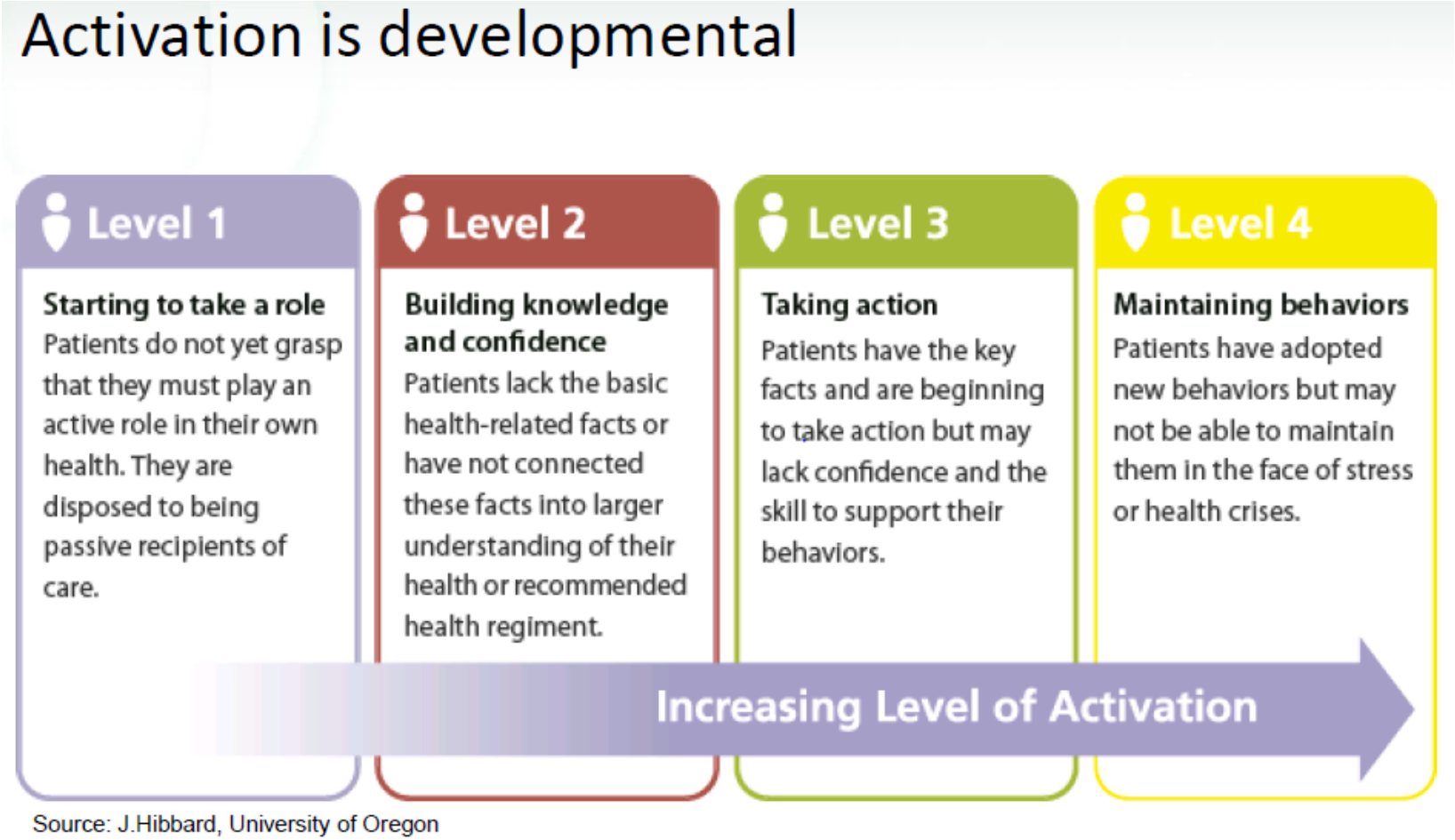
- Well-informed patients are substantially more likely to take an active role in healthcare decisions
- Respondents wanted a closer connection with their provider
- Adherence closely tied to understanding provider recommendations
- Feeling informed is one of the strongest predictors of patient engagement



Source: Blue Shield of California Foundation. Empowerment and engagement among low-income Californians: Enhancing patient-centered care. September 2012.

Patient Activation

- An individual understands their role in the care process, and has the knowledge, skill and confidence to carry it out



Source: Hibbard, J.H. (2008). Patient Activation and Engagement for ACOs. University of Oregon.

Paradigm Shift

From...	To...
■Telling patients what to do	■Listen, problem solve, and collaborate
■Transfer of Information	■Developing confidence and skills
■Compliance	■Building capability

- Engagement in healthy behaviors
- Better care experiences
- Less likely to be hospitalized, readmitted or use ED
- Overall lower costs

Source: Hubbard, J.H. (2008) Patient Activation and Engagement for ACO's University of Oregon

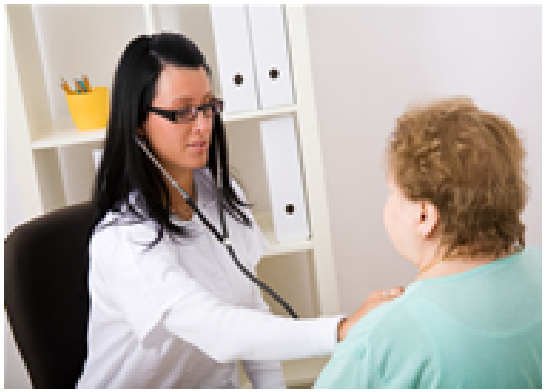
A Patient's Perspective

"As a savvy and confident patient who is flummoxed by so much of what takes place in health care, I am regularly surprised by how little you know about how little we patients know. You are immersed in the health culture. But we don't live in your world. So we have no idea what you are talking about much of the time. One way to help us feel competent in such unfamiliar environments is to give us some guidance about what this place is and how it works. What are the rules?"

Jessie Gruman, Ph.D.
Founder and President
Center for Advancing Health

Difficulties Facing Providers New to ACOs

- Managing patients with a wide range of benefit plans
- Infrastructure developments that challenge traditional Fee-for-Service processes and expectations
- New orientation to patient management and office administration
  - Extensive care coordination
  - Patient-physician relationship management
  - Electronic health records
  - Clinical reporting requirements
  - Physicians must be measured on customer service (patient satisfaction)



Source: Grant, Barbara. KBM Group: ACO Success Factors: Communications that Connect. August 2012.

What Matters and How to Improve the Patient Experience

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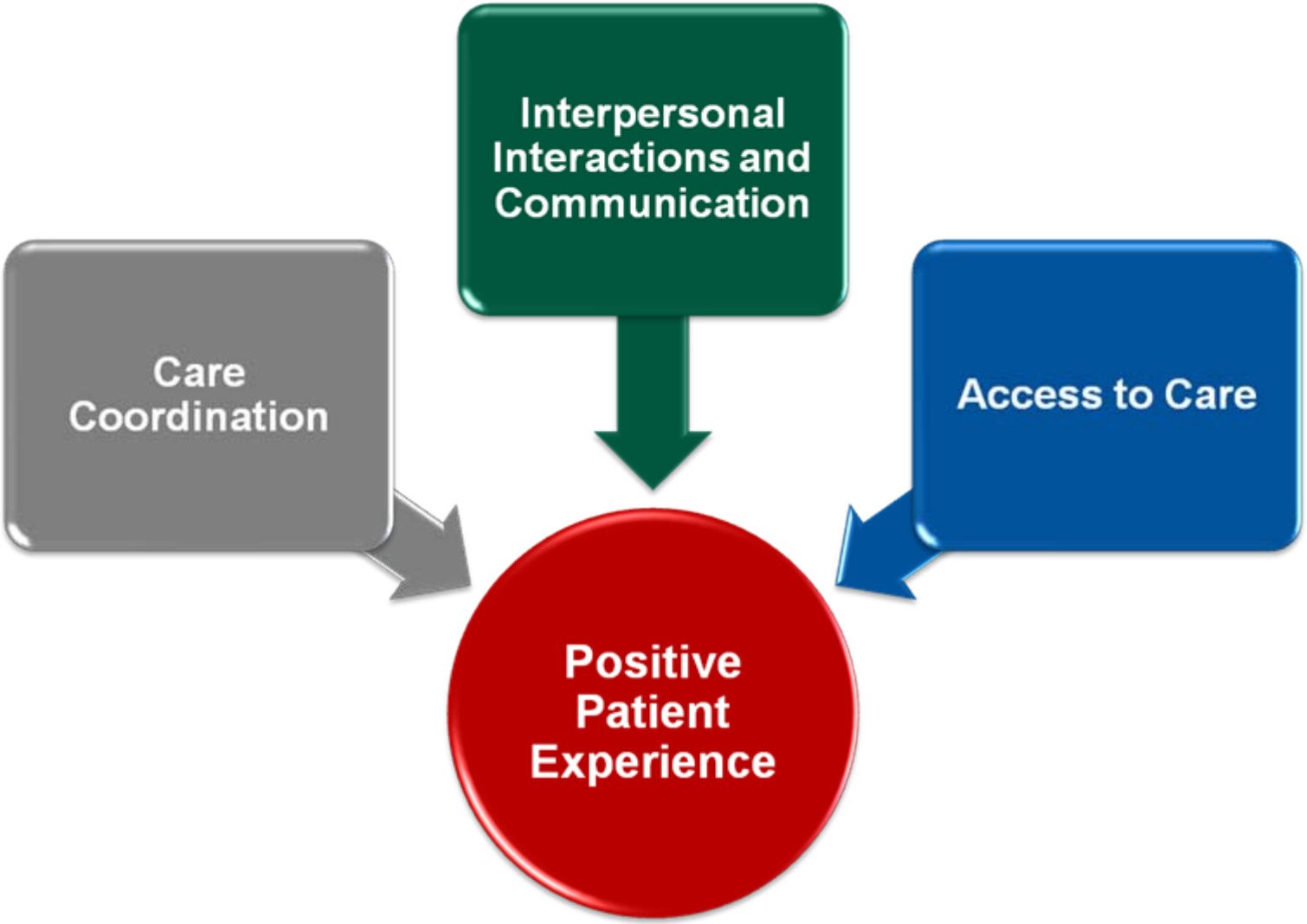
Important Dimensions of Care



Source: Patient Experience in California Ambulatory Care: California Healthcare Foundation

Care Coordination

- Be proactive in identifying patients needs and activate patients early
- Establish goals for care and responsibility for health related behaviors
- Equip patients with customized resources to manage their illness
- Manage the episode of care, not episodic care
- Medicare FFS national readmission rate 18.6% vs. 13.6% ACHP MA plans with care coordination programs (The Benefits of Care Coordination: ACHP Study)

Interpersonal Interactions and Communication

- Make a personal connection and demonstrate empathy through eye contact and empathetic statements.
- Base communication on patient preferences and needs
- Elicit the patients point of view
- Involve the patient in shared decision making regarding treatment
- Affects Patient Satisfaction – Top 5 drivers of Press Ganey and HCAHPS scores relate to patient-provider communication (Press Ganey Associates, Inc. 2008)

Access to Care

- When and how based on patient preferences and needs
- Open same-day appointments
- Utilize health care professionals to full extent of their license
- Manage expectations on wait times
- 20.3 days is average wait time for family practice appointments nationwide (Source & Assoc. 2009 survey of physician appointment wait times)

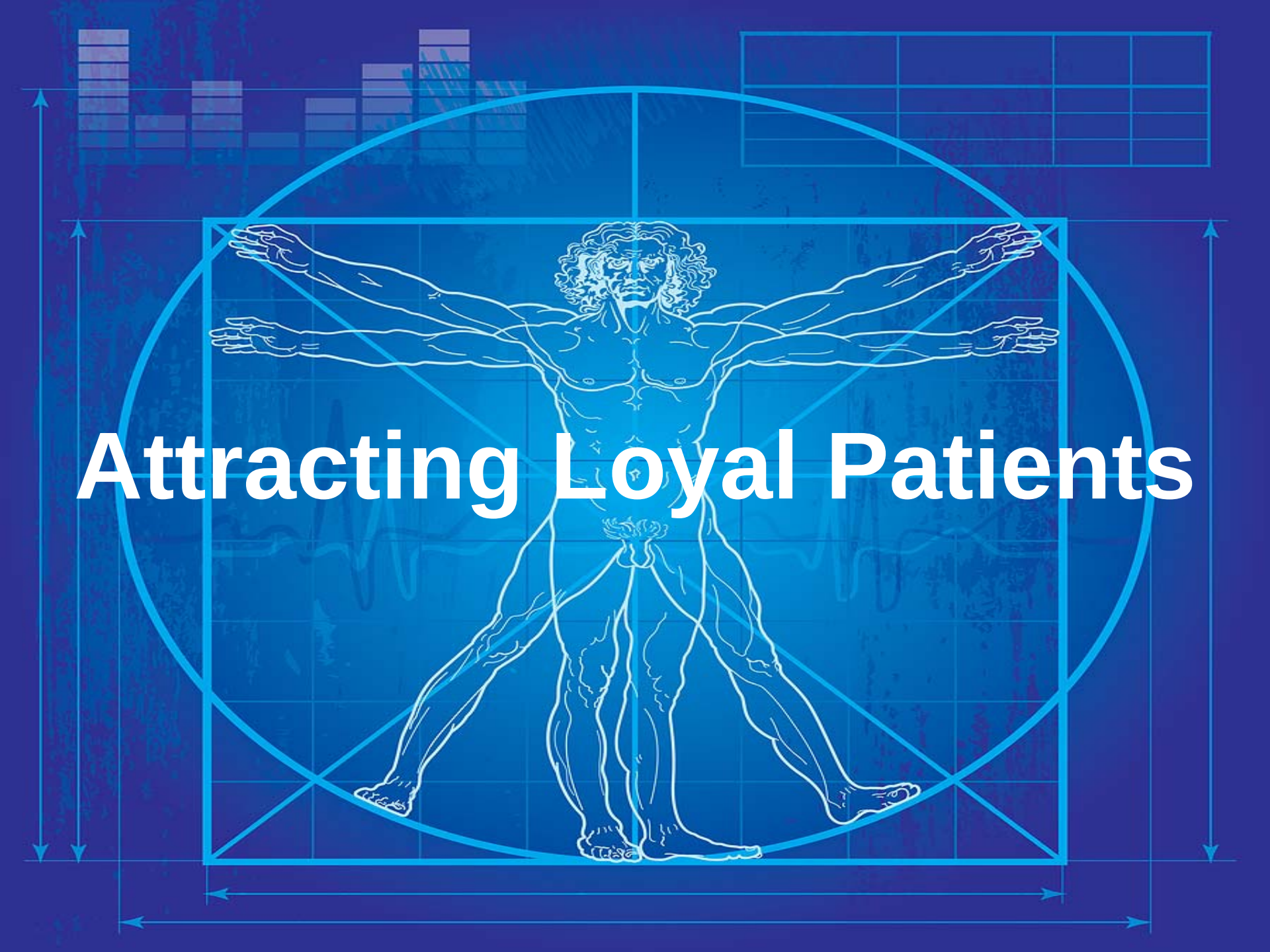
Source & Assoc 2009 survey of physician appointment wait times

Key Drivers of Satisfaction

Conclusions

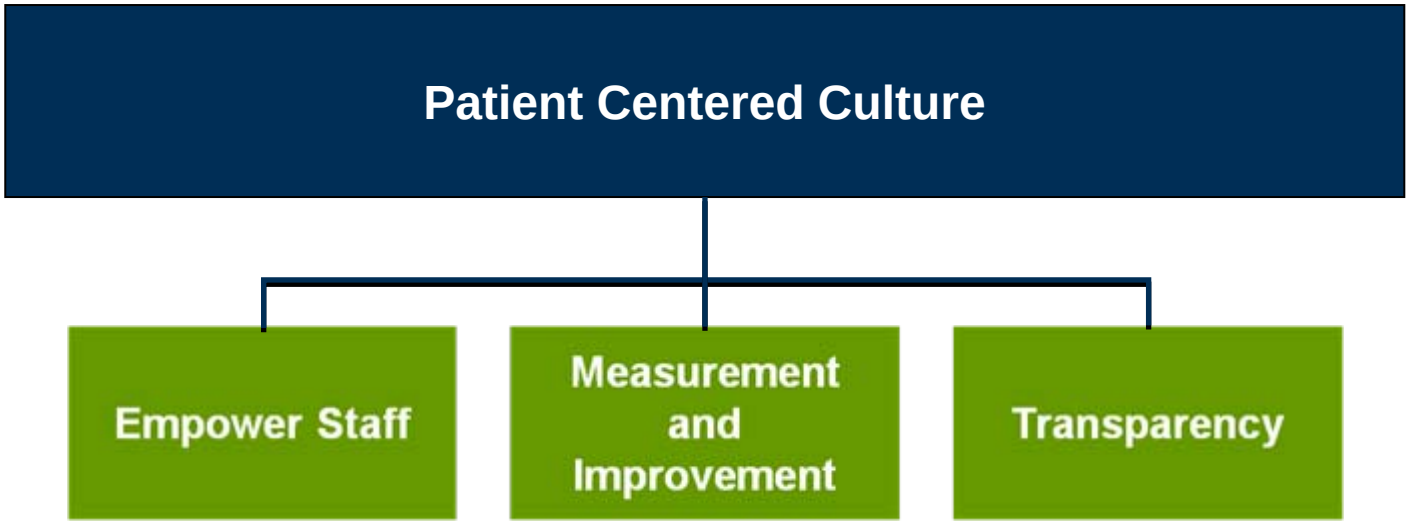
- Showing respect for what patients have to say, spending enough time with them and knowing important information about their medical histories are shown to be highly important in both analyses.
- Issues related to wellness, though less important, still are shown to be important contributors to the patient experience in both analyses.
- Talking to patients about exercise or physical activity, discussing a healthy diet and eating habits and talking to them about worries and stressors contribute to their satisfaction with the patient experience.
- Finally, two items related to tests and treatment are shown to positively impact the patient experience in both analyses:
  - Making sure you follow up with test results.
  - Offering patients treatment options and letting them participate in the decision making process.

Clinician and Groups CAHPS® Statistical Analysis of the Key Drivers of Satisfaction with the Patient Experience: More Exploratory Analysis
Posted on June 16, 2011 by DSS Research

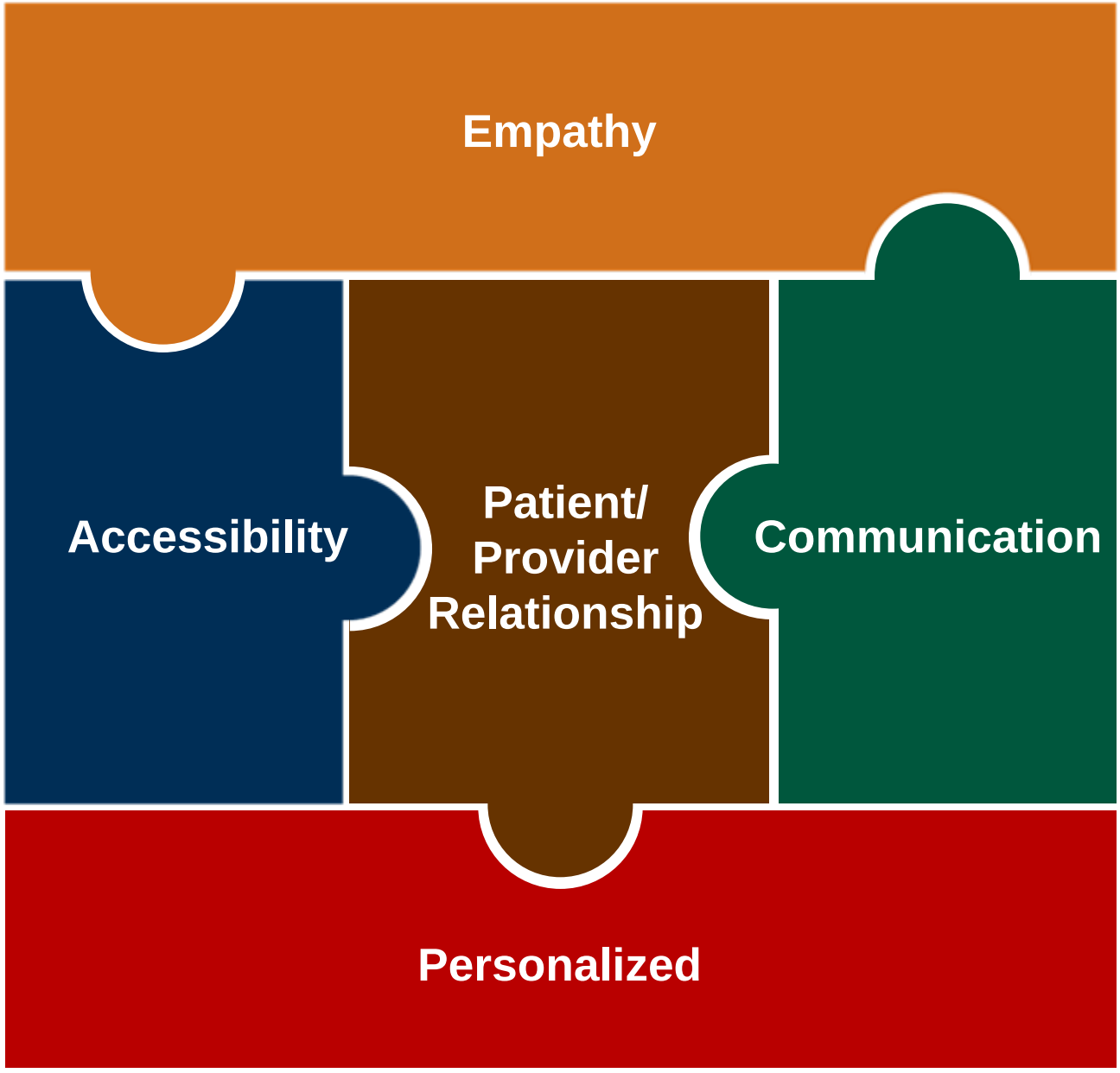

Attracting Loyal Patients

Leadership

- Providers are putting their patients at the center of their day-to-day operations
- Governance and executive leaders demonstrate a culture of patient centeredness
- Ensures sufficient staff are available with tools and skills to deliver high quality patient care
- Relentless focus on measurement, improvement and transparency



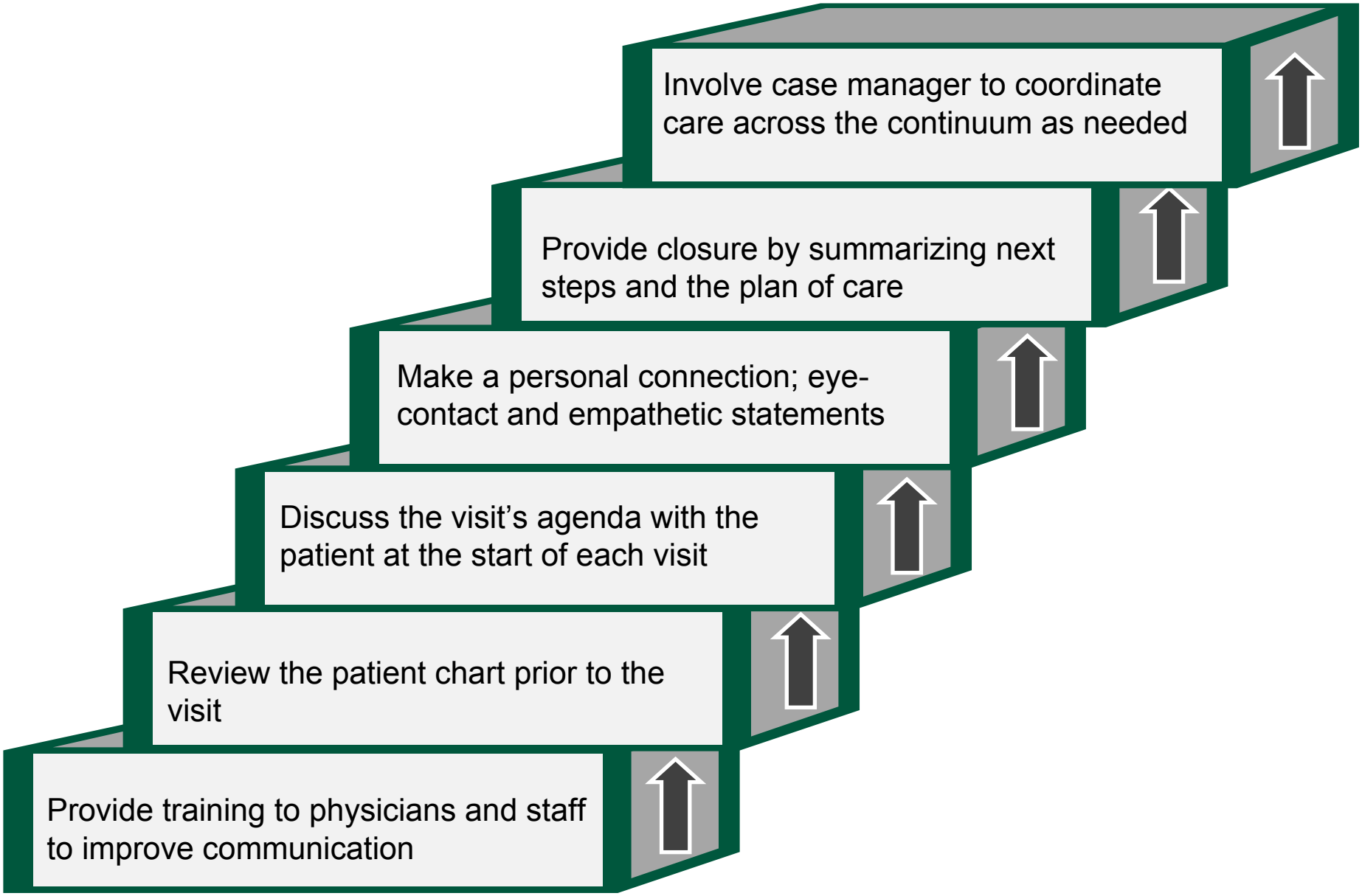
Key Characteristics of Patient/Provider Relationship



Establish Fundamental Capabilities

- Patient and Consumer Relations
  - Service-oriented culture
  - Patient/Care giver needs are put first
  - Patient engagement and activation training programs for staff
- Continuity and Coordination of Care
  - Develop Patient-Centered Medical Home (“PCMH”) model
  - Implement multi-disciplinary teams that coordinate care across the continuum
- Patient Education and Engagement
  - Involve the patient in their own care plan
  - Implement strategies that educate the patient help them feel informed
- Information Technology System
  - Infrastructure should support sharing of information
  - Patient portals and online learning tools
  - Reduce variability in care delivery
- Performance Assessment
  - Identify and track key performance indicators
  - Monitor patient experience, patient education, and gaps in care delivery concurrently

Strategies to Maximize the Patient Experience



Strategies to Maximize the Patient Experience

Obtain ongoing feedback from patients and provide data at the physician level at least quarterly

Implement daily office “huddles” to monitor and manage patient flow

Open same-day appointment slots and extend hours

Handle more than one medical problem per visit

Source: California HealthCare Foundation. Patient Experience in California Ambulatory Care. December 2010.

Benefits of an Exceptional Patient Experience

- Patient satisfaction plays an increasingly important role in the accountability of healthcare (payers, providers, and consumers alike)
- Improved outcomes and healthier patients
  - Conversation is easier
  - Patient-provider relationship built on trust
  - Greater adherence to care plans
- Patient retention, loyalty, and growth
  - Become provider of choice
  - Positive word-of-mouth from current patients
- Success with accreditation and regulatory agencies
  - Health plans receive annual patient satisfaction measures
  - Accreditation requirement

Source: Quality-Patient_Experience.com: The Benefits of a Quality Patient Experience and Exceptional Patient Satisfaction for Medical Practices and Ambulatory Care.

Benefits of an Exceptional Patient Experience

- Favored relationships with health plans
  - Retain patients in plan
  - Incentives or sanctions instituted to encourage patient satisfaction
- Lower costs of doing business
  - Staff are more satisfied; less turnover
  - Fewer malpractice suits
- Reputation, pride, and satisfaction
  - Care team is trusted
  - Admirable reputation in community
- Profitability
  - Financial health and profitability is directly tied to consumer approval

Source: Quality-Patient_Experience.com: The Benefits of a Quality Patient Experience and Exceptional Patient Satisfaction for Medical Practices and Ambulatory Care.

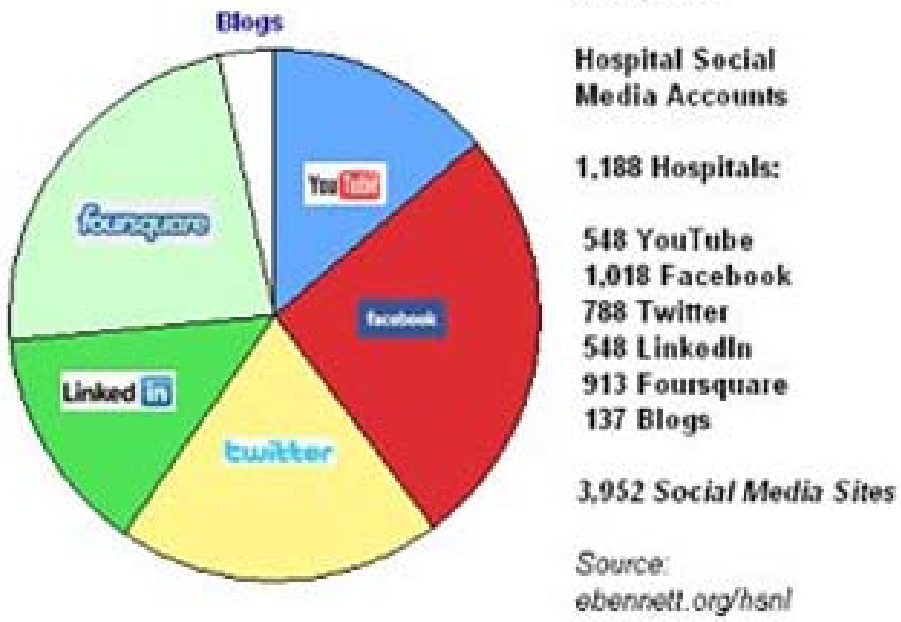
Technology and Patient Engagement

- Technology is part of the answer to getting patients more engaged in their care
- Providers are placing patients on mobile apps to foster wellness and lifestyle changes
- Personal Health Records (“PHR) allow patients to view their health records online
- Interactive Voice Response (“IVR”) technology motivates patients and improves compliance with medical regimens
- Mobile phone applications that allow patients and their family to track location and time of appointments
  - Increasing use of texting to communicate with patients
- Robots/computers are used for online conversations between patients and health care providers
- Telehealth enables the transmission of critical health indicators (such as blood pressure) from the patient’s home to their physician’s office
- Home monitoring to facilitate care management for high risk patients

Source: Informationweek.com. Patient Engagement Requires Right IT Tools. July 2, 2012..

Social Media and Patient Engagement

- 81 percent of consumers believe that if a hospital has a strong social media presence, they are likely to be more cutting-edge
- 57 percent of consumers state that a social media connection is likely to impact where they seek treatment
- More than 1,100 hospitals are using sites such as Twitter, YouTube, and Facebook to engage patients
  - 197,000 who follow the Mayo Clinic on Twitter
  - 30,000 who "like" Cleveland Clinic on Facebook
- Social media supports a variety of formats to disseminate information
- Social media gives providers a way to "humanize" their identities
- Providers can disseminate real-time information form reliable sources



Source: MED 3000. Social Media and Patient Engagement. July 11, 2011.

Summary

- Patient experience is critical component in success of the ACO
- Ability to retain patients is crucial
- Focus on Communication, Access, and Coordination of Care
- Leadership must create a culture of patient centeredness and accountability
- Patient interactions that are engaging, positive, and meaningful will create patient loyalty
- Superior patient experience is relevant to the needs of the individual and is personal

III. Team Building: Maintaining Physician and Provider Engagement

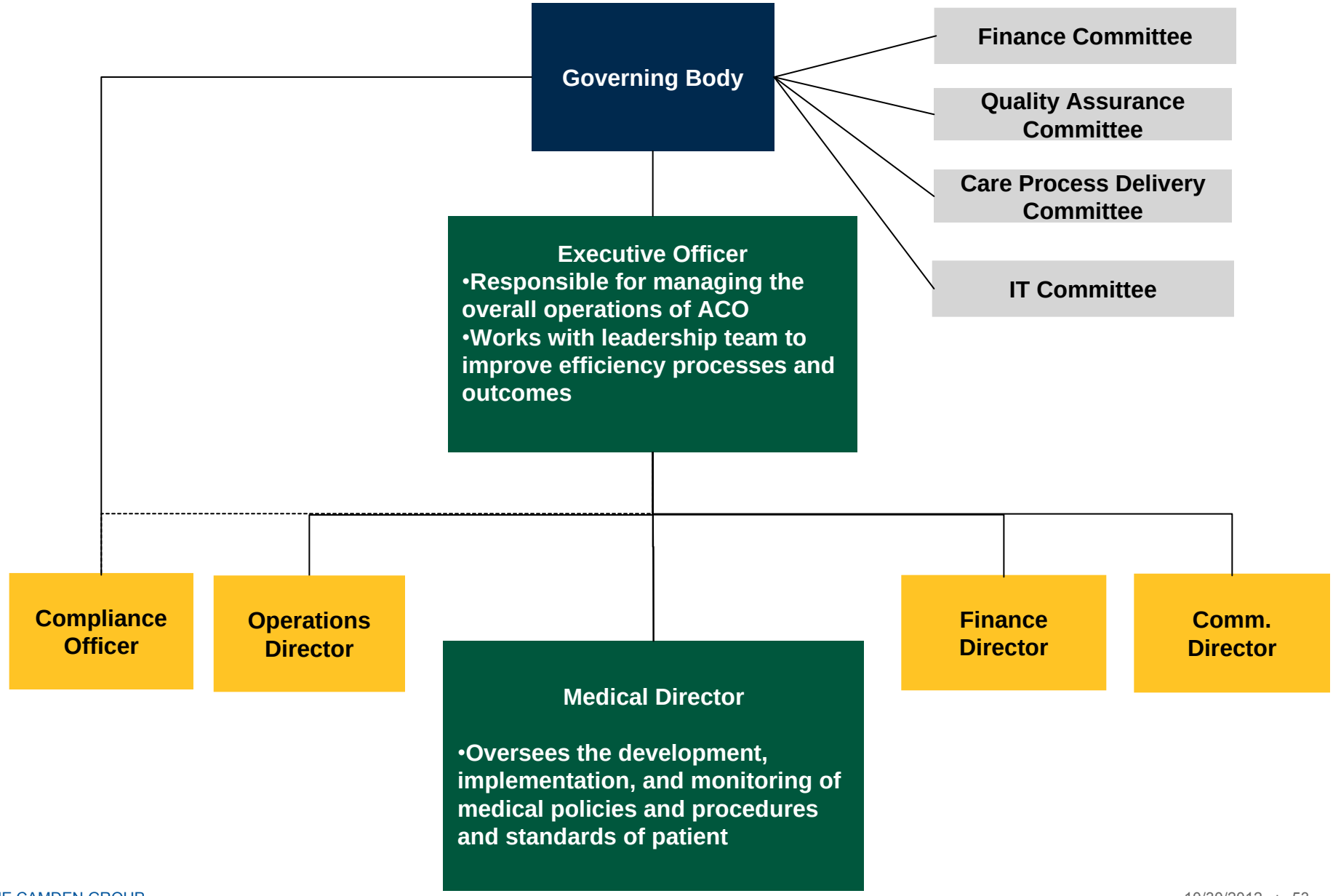
THE CAMDEN GROUP

Enhancing Physician Involvement

- Use of physician leaders is vital
- ACO development and success relies on physician buy-in and ownership of change
- Physicians will listen to well-respected colleagues
- Outreach and education to inform physicians on the benefit of participation
  - Understand individual and organization-wide goals
- Support from clinical staff for new programs or workflow processes
- Commitment to transparency

Source: National Institute for Health Care Reform. Lessons from the Field: Making Accountable Care Organizations Real. January 2011.

Physician Governance Participation



Physician Roles and Responsibilities

- Physicians play integral role in committees by developing clinical capabilities and processes for the ACO
- Below are examples of physician responsibilities/input:

Quality Assurance Committee

Clinical Advisory Board

- Ensure appropriate and optimal use of EBG
- Oversees clinical advocacy
- Responsible for developing clinical training and education programs
- Optimize the use of personnel

Quality Assurance

- Qualified healthcare professional responsible for the CMS-required quality assurance and improvement program
- Optimize the use of quality/performance improvement efforts

Care Process Delivery Committee

Population Health and Network Relations Management

- Stratify population using claims data and clinical data (EMRs)
- Inform ACO's goals and approach to care management/coordination
- Manages relationships with non-participant providers

Clinical Coordination and Care Management

- Manages clinical integration, care coordination and clinical programs
- Monitors and adjusts clinical pathways for patients
- Change management from current delivery system

Set the ACO Team Up for Success

- Build a culture of accountability
- Educate to succeed in a shared savings world
- Feed providers information
- Provide value to ACO providers
- Make the provider's life easier
- Reinforce with economic benefit!

Build a Culture of Accountability within the ACO

- Move from a “Me” perspective to a “We” perspective
- Establish shared responsibility for achieving measurable results by setting expectations together
- Have clarity in expectations for performance and in roles and responsibilities for each provider team member in the ACO
- Build trust and confidence through leadership’s demonstrated commitment to the success of the ACO
- Communicate, communicate, and communicate

Educate to Succeed in a Shared Savings World

- Convey the realization that there is no “going back”
  - All Payers are moving to reward high-value regardless of outcome of the election

- Promote and reinforce acute understanding of accountable care, the clinically integrated model and paths to success
- Keep ACO providers abreast on “What’s to come?” “What’s the impact on you? Me? Us?,” “What we’re doing about it,” and stay true to your word
- Introduce ACO processes and protocols that add value and make ACO providers’ lives easier…today

Feed Providers Information to Ensure Success

- Develop and disseminate tools and processes that add value and take into account work flow impacts
  - Real-time alerts whenever possible to facilitate consistent care paths
- Offer tailored provider reports that will be useful
  - For PCPs, lists of patients assigned to their practice, lists of specialists in the ACO who consistently achieve jointly established performance benchmarks
  - For specialists, lists of PCPs in the ACO who are accepting new patients

- Show individual physicians progress reports at regular intervals prior to year-end performance reconciliation and help them with ways to improve

ACOs Must Provide Value to ACO Providers

- Provide credits for EMR implementation, enhancement, connectivity
- Build, maintain, and support accessible, robust Health Information Exchanges that offer multiple interfaces from any web-based portal
- Assist providers with CMS or other payer reporting outside of ACO where allowable (e.g., PQRS)
- Provide in-office alerts/guidelines/protocols for care

- Offer patient portals, physician portals that support coordination of care and have real-time access to plans of care, laboratory results

Clinical Integration/ACOs - What's in it For…

Physicians?

- Access to electronic tools to enhance patient care efficiency
- Opportunity to earn additional compensation from shared savings
- Enhance market positions and "preferred" network
- Enhance satisfaction with clinical delivery model
- Increase ability to deliver outcomes, quality care, and patient satisfaction

Shared Savings Funds Flow Distribution Philosophy

- Emphasizes a shared focus on organizational success via a philosophy of shared commitment
- Facilitates specific measures that are quantitative, simple, and structured to show a clear relationship to improved performance
- Improves organizational productivity, quality, and cost reduction across the continuum
- Leverages automation to the fullest extent
- Awards a commitment to increasing efficiency and also encourages improvement
- Values physician engagement and outcomes success

Medicare Shared Savings Model

Estimated Distribution

Medicare Shared Savings Program		
		Assumptions
Total Budgeted Medical Expenditure	$60,000,000	5,000 assigned patient lives x $1000 per patient per month x 12 months
Actual Expenditure	$57,000,000	5% Savings
Gross Shared Savings	**$3,000,000** *	
Quality Score	100.0%	100%
Shared Savings Net Quality Score	**$3,000,000**	
50% Share after Split with Medicare in Track 1 MSSP	1,500,000	50%
Less Management Fee from Shared Savings	0	0%
Before Distribution	**$1,500,000**	
Total Available for Sharing Distribution	**$1,500,000**	

* Assumes that minimum savings threshold achieved. First dollar shared savings applied

Medicare Shared Savings Model

Budgeted Pools	Portion of Budgeted Pool Surplus Distribution			
	PCP	Spec	Hospital	Total
PCP	100%	NA	NA	**100%**
Spec	20%	80%	NA	**100%**
Facilities	33%	34%	33%	**100%**
OP Diagnostic	35%	40%	25%	**100%**
OP Services	35%	40%	25%	**100%**

Sample Distribution Example: PCPs

Surplus Distribution Calculation to Individual PCPs Using Share of Medicare Shared Savings Distribution as an Example

MAXIMUM DISTRIBUTION FOR PCPS: $960,000

PCP	PCP NAME	STEP 1: QUALIFICATION CRITERIA MET?	ASSIGNED PATIENTS	% TOTAL PTS	STEP 2: POTENTIAL MAXIMUM DISTRIBUTION
1	Dr. Smith	Y	250	5.00%	$48,000
2	Dr. Jones	Y	150	3.00%	28,800
3	Dr. James	Y	75	1.50%	14,400
4	Dr. Andrews	N	20	0.40%	3,840
	All Others	Y	4,505	90.10%	864,960
TOTAL 100			5,000	100.00%	$960,000

MAXIMUM DISTRIBUTION FOR PCPS: $960,000

STEP 3: INDIVIDUAL PCP PERFORMANCE SCORE

25% QUALITY MEASURES	25% NETWORK EFFICIENCY	25% PATIENT SATISFACTION	25% CITIZENSHIP	100% QUALITY SCORE	STEP 3 PAYOUT
0%	100%	50%	100%	62.5%	$30,000
50%	100%	100%	0%	62.5%	18,000
100%	100%	100%	100%	100.0%	14,400
50%	100%	100%	100%	87.5%	0
100%	100%	100%	100%	100.0%	864,960
				Step 3 Distributed Funds to PCPs	$927,360

Key	
Tier 0	*0%*
Tier 1	*50%*
Tier 2	*100%*

STEP 4: REDISTRIBUTE QUALIFICATION CRITERIA UNDISTRIBUTED FUNDS

Total Undistributed Funds from Step 1:	$3,840
75% Reallocated to Physicians Receiving Step 2 Payout	$2,880
25% Retained by ACO	$960

Make ACO Providers' (and their Staff's) Lives Easier

- Assign the ACO as much responsibility as possible for reporting and data collection (e.g., reporting interface between provider and payer)
- Offer care model/protocol training for providers along the continuum of care that are thoughtful, complete, and tested
- Be considerate of provider office work flows in instituting ACO processes and tools
- Convenience is paramount: Meetings, training at convenient times, offer multiple opportunities for and modes of communication

Lessons Learned from ACOs Implementing Now

- Communicate, Communicate, Communicate
  - Over-communicate
  - Use multiple modes of communication
  - Do not underestimate the power of one-to-one meetings
- Embrace financial alignment models that support the behaviors that will maximize success in shared savings
- Realization that there is “no going back”
  - Payment models are moving to shared savings across all payer types

IV. Elevate the Overall Performance of Your ACO: Enhancing the Care Delivery Model

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Enhancing Care Delivery - What Does it Mean?

Hospitals

- Enhanced linkage and alignment with physicians
- Implementation of quality improvement initiatives
- "Branding" consistency to patients and payers
- Physician leadership in clinical care redesign

Physicians

- Shared clinical information
- Adherence to care plans and protocols
- Accountability for clinical results
- Access to electronic tools to enhance patient care efficiency
- Enhance market positioning, referrals, "preferred" network
- Ability to negotiate with larger provider group for payer contracts

Patients

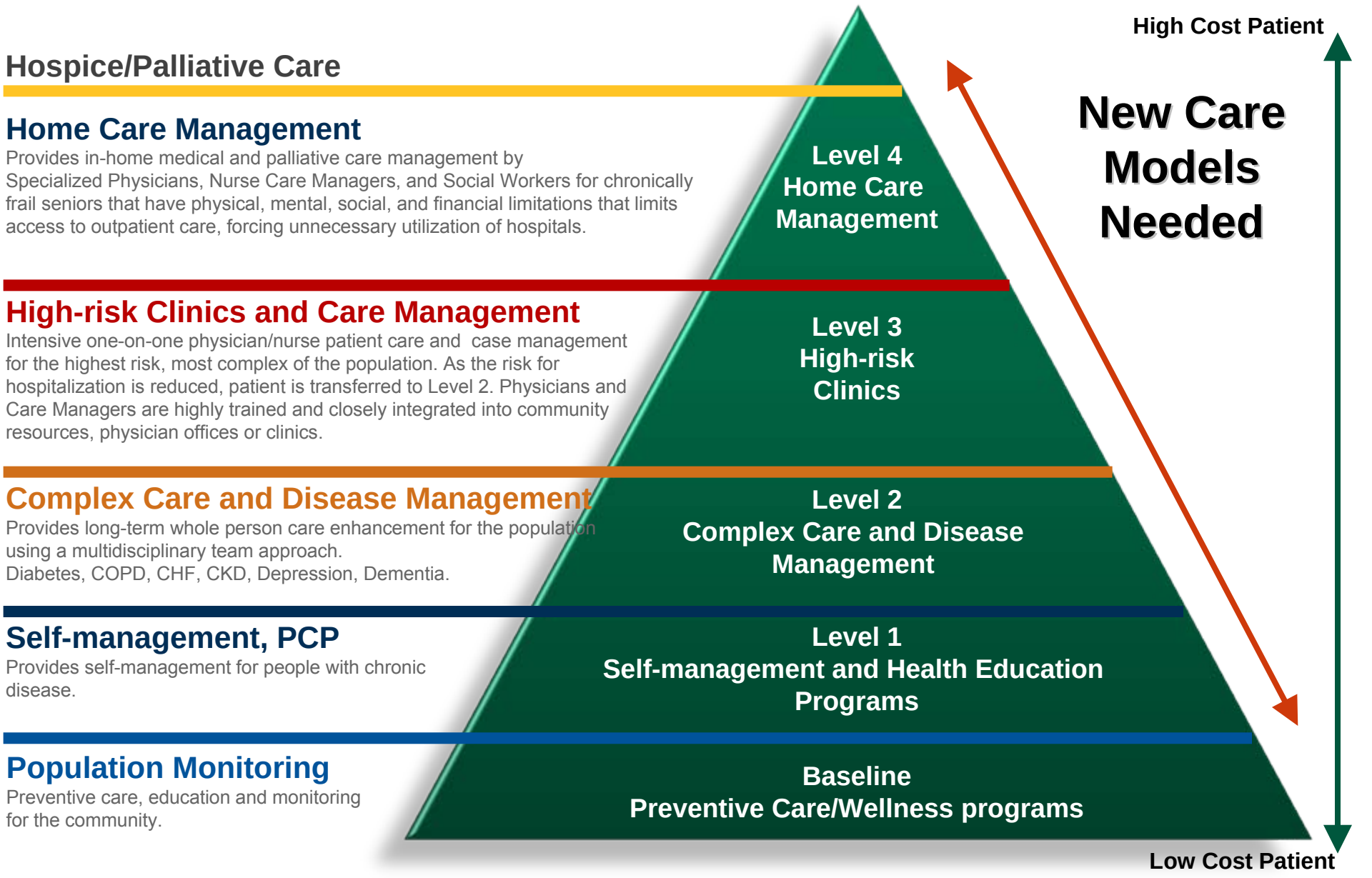
- Clarity on which provider has primary responsibility for my care (medical home)
- Engaged in the care plan and follow-up process
- Reasonable access to care and information

The Care Team

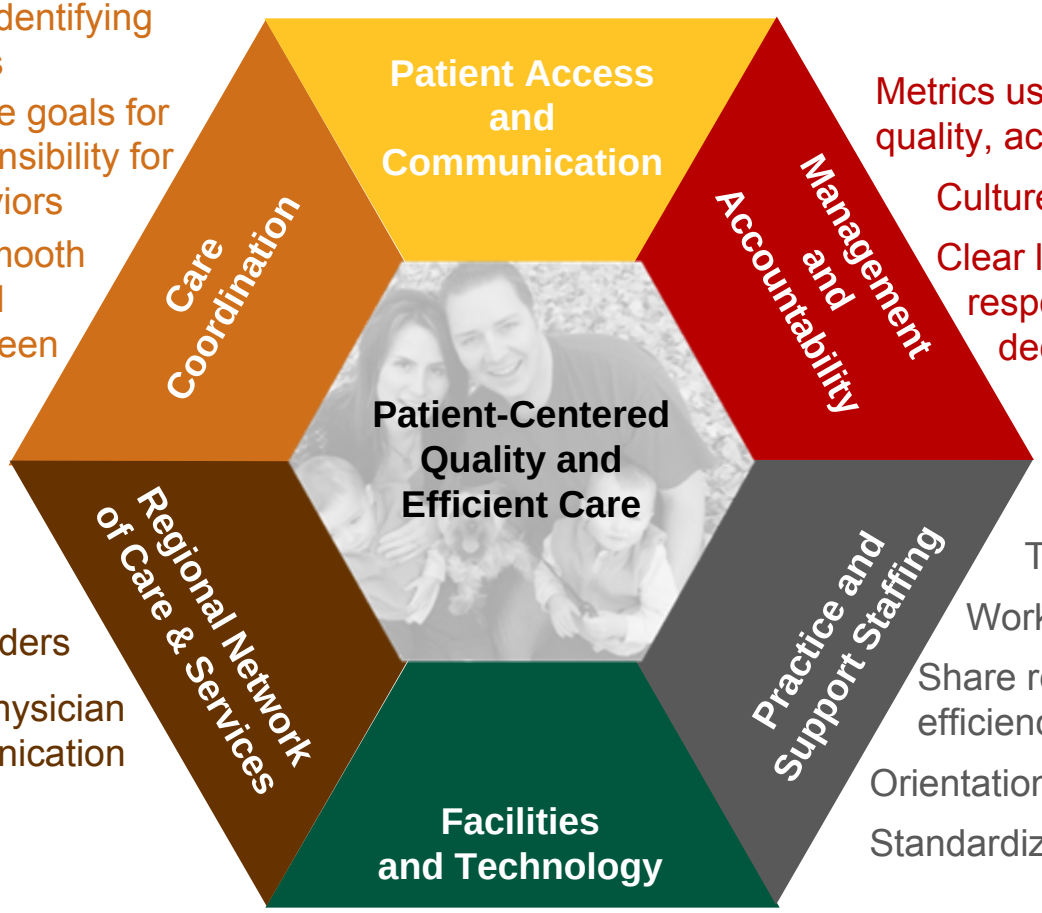
Stratification of Patients

- Should occur through the use of disease registries and predictive modeling
- Registry tool should exist that identifies patients and places them into appropriate care management programs
- Should expand to other care sites and physicians
- Predictive analytics should identify the complex, high-risk patients for comprehensive, coordinated care management programs

Stratifying Patients: Not as Simple as “Inpatient” and “Outpatient”



Principles of Patient-Centered Medical Home



"When and how" based on patient preference and needs

Proactive in identifying patient needs

Ensure patients have goals for their care and responsibility for health related behaviors

Processes assure smooth transition of care and communication between providers (across continuum)

Metrics used to define performance: quality, access, efficiency

Culture of continuous improvement

Clear lines of authority/ responsibility and process for decision-making

Team orientation

Work to top of license

Share resources to maximize efficiency

Orientation and training

Standardized roles and work flows

Aligned providers

Facilitate physician-physician communication

Facilities support teamwork, and efficient work flow

Technology facilitates aims of care model

Source: The Camden Group

Care Management Programs

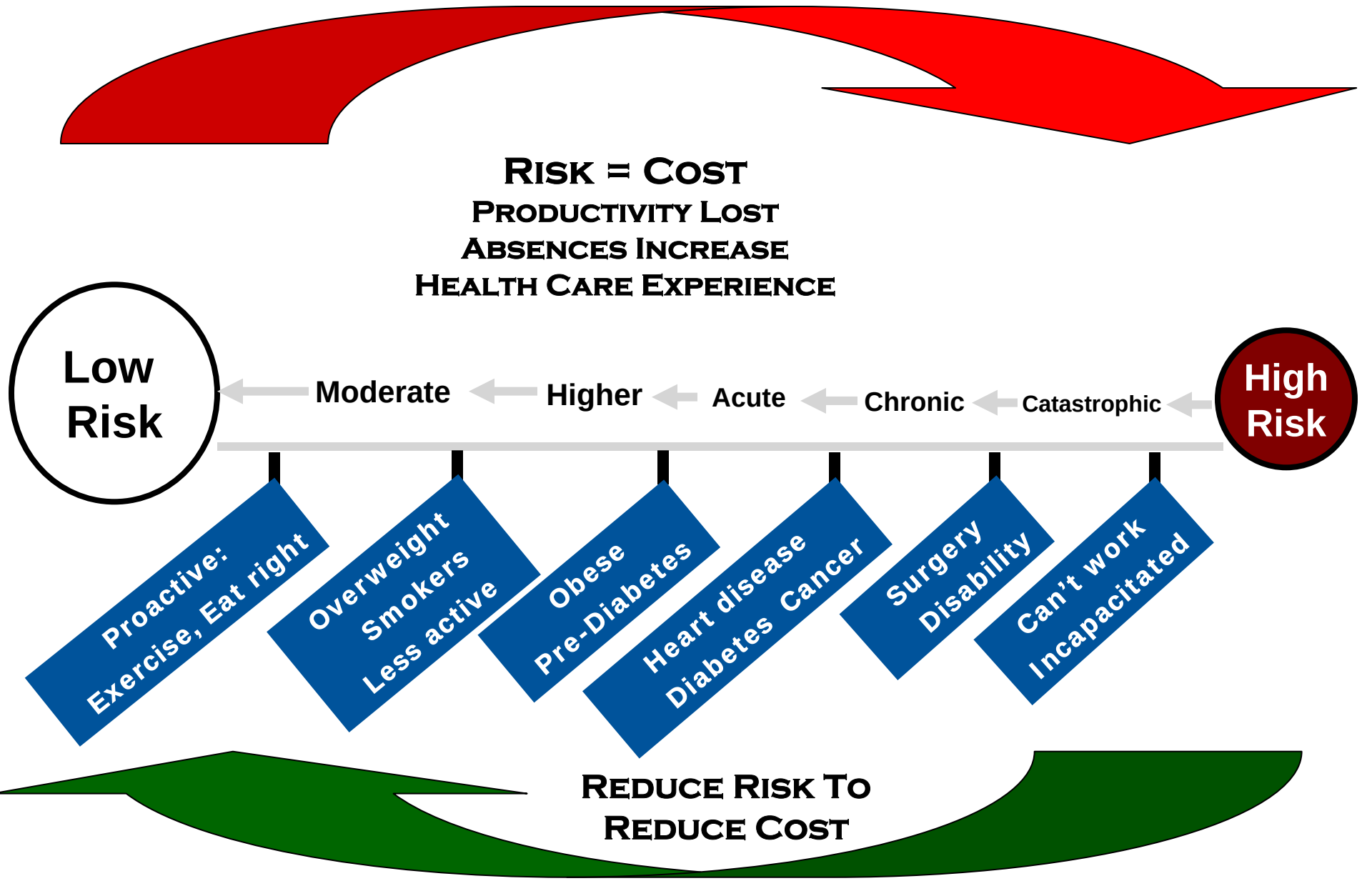
- Disease Management
- Complex Case Management
- Episodic or Short-term Care Management
- Home Care
- ESRD
- Comprehensive Care Clinics

Additional Support Programs

- Physician Office-based Care Management
- Behavioral Health
  Specialists provide outpatient care to members with no prior authorization; geropsych RNs oversee inpatient mental healthcare and coordinated with PCPs and care managers
- Referrals Screening and Management
- Patient Support Line (Call Center)
  Nurse advice, triage, and referral to clinical team members as needed, 24/7
- Health Education
  Through classes and 1:1 consultation with certified educators, RNs, and dietitians

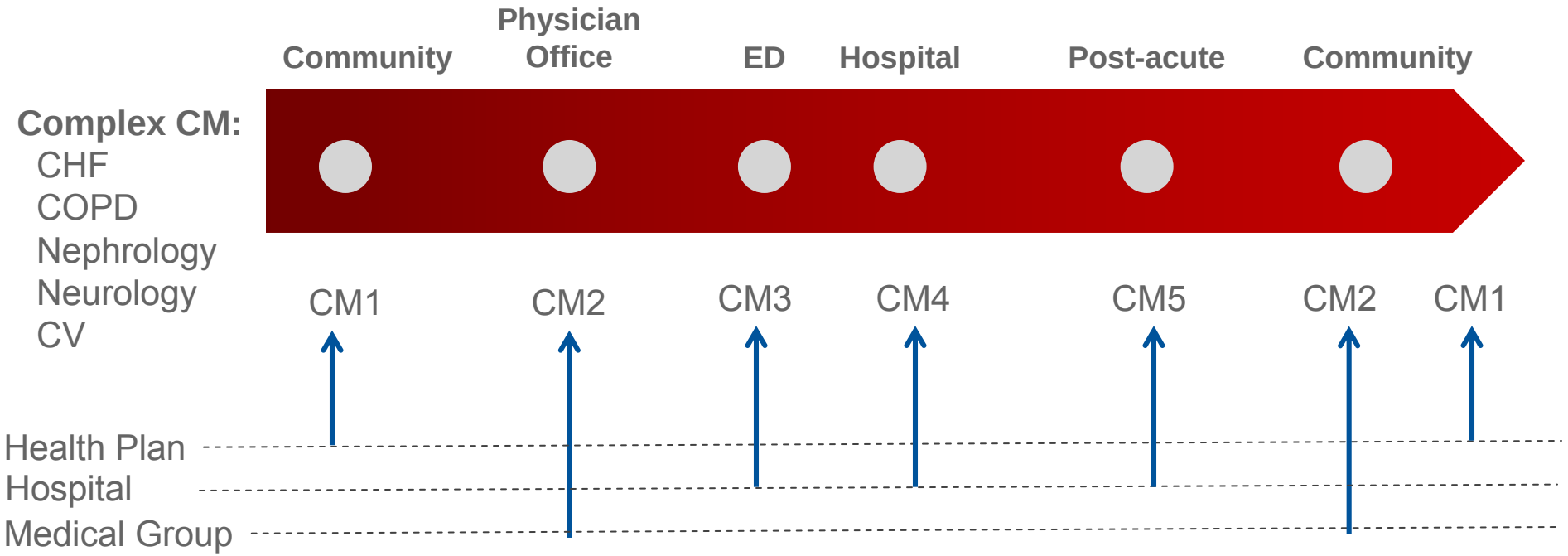
Your Care Model Needs to Evolve to Meet Patient Needs

Change Health Risk Continuum



Example of Fragmentation in the Continuum of Care

A patient experience in an episode of care could result in many different Care Models ("CM") with a perspective of their specific care setting (model) serving the patient.



Fragmented Patient Care Can Lead To:

- Poor patient quality outcomes
- Inefficiencies in transition of care
- High-cost
- Poor patient satisfaction

Why Post-acute Care is a Key to Managing Costs

- 37.5 percent hospitalized Medicare beneficiaries use one or more post-acute settings
- Average Medicare payment for post-acute care = $30,000

PAC Setting	Percent Discharged from Hospital to PAC Setting	Percent Rehospitalized After Using PAC Setting	Percent Died in PAC Setting	Percent Discharged to a Second PAC Setting	Most Common Second PAC Setting Used
SNF	17.3%	22.0%	5.4%	29.3%	Home health
Home Health	15.0	18.1	0.8	2.3	Hospice
Inpatient Rehabilitation	3.2	9.4	0.4	56.8	Home health
Hospice	2.1	4.5	82.2	2.4	Home health
Long-term Care Hospital	1.0	10.0	15.5	53.4	SNF
Inpatient Psychiatric	0.5	8.7	0.4	25.4	SNF
TOTAL	**40.0%**	**18.0%**	**6.2%**	**19.8%**	

Care Management Toolkit

Use of Hospitalists (SNFists)

- Hospitalists must be integrated into the continuum of care just as any other specialist
- Hospitalist program should take care of most of the inpatients
- Aligned primary care physicians should use hospitalists
- Communication should be coordinated between case managers, hospitalists, and physicians
- Hospitalists should review, consult, or approve admissions from the ED
- Hospitalists and primary care physicians should communicate regarding discharge instructions and a follow-up appointment
- Hospitalists/SNFists and primary care physicians should identify appropriate end-of-life care plan
  - Refer patients to hospice/palliative care
  - Educate patient and their family on available options
  - Ensure religious support, if necessary

Use of Evidence-based Guidelines and Protocols

- ACO quality measures mandate that evidence-based guidelines are incorporated into care plans
- Use of evidence-based protocols should occur within the EMR, aEMR, or CPOE
- Admitting order sets should be used, as well as clinical pathways or protocols
- Leadership personnel should envision a point-of-care model/care plan that supports clinical decision-making and assesses/stratifies the patient into the appropriate care management program
- Organization should have a functional call center

Availability and Adoption of Clinical Decision Support

- Care plans should be embedded in the EMR/CPOE
- Viewing capability and order sets should exist
  - Commenting or data from post-acute or outpatient providers should be available
- Care alerts should be made available at the point-of-care physician practices and inpatient care

Use of Data Reporting

- Can track and trend performance and type of metrics used
- Should provide detailed reporting and quality measurement at the entity, group, and individual physician level
- Report should be available to improve physician behavior such that consequences exist
- Value-based clinical and payment models should be in progress (PCMH, BP, P4P, etc.)

V. Strengthen Your ACO: Building and Nurturing Strategic Alliances

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Building Preferred Networks

- ACO is strengthened through its alliances
- Networks are created through sharing of information, aligning protocols, and processes, and a shared vision
- Networks may include:
  - High-performing SNF
  - Hospice/Palliative Care Agency
  - Transportation
  - DME

Community Stakeholders

- ACOs are looking to the community to add value to the patient experience
- Patient engagement is encouraged through use of community resources
- Social and medical support
- Local senior centers may provide grocery services, in-home care, transportation services, or meals-on-wheels
- Disease management classes
- Group exercise classes
- Mental health services

Community Stakeholders

- Support for the family may also be available; respite care
- Adult Day Care where seniors can spend the day in a safe environment
- Support groups
- Alzheimer's education classes
- Legal guidance on end-of-life considerations and guardianship

Preventive Care

- Partner with an Area Agency on Aging (“AAA”)
- Mobile healthcare in the community
  - Health Screenings
  - Risk Assessments
  - Immunizations
  - Partner with a University’s gerontology department for Fall Prevention Courses
  - Partner with an architectural firm to provide basic home repairs for frail, elderly adults

VI. Summary

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Key ACO Prerequisites - Are You Ready?

- Robust IT infrastructure that supports real time reporting, point-of-care support, care coordination, population management
- A compensation structure that appropriately incentivizes quality and cost effectiveness
- Access to capital to create and support the necessary ACO infrastructure
- Ability to aggregate clinical and financial data from all components of the care continuum, including community physicians, hospitals, skilled nursing facilities, home health, pharmacies, etc.

Characteristics of Winners in the Reform Setting

- Proactive, value-driven organizations
- Long-term thinkers
- Early adopters: practice redesign and technology
- Ability to quickly deliver data to drive decision-making
- Information transparency
- Genuine physician leadership and engagement
- Provider incentives based on quality
- Demonstrated patient and provider satisfaction
- Ability to financially bridge the gap between current operations and improved performance on cost and quality
- Capital reserves to invest in systems and infrastructure
- Success in managing risk

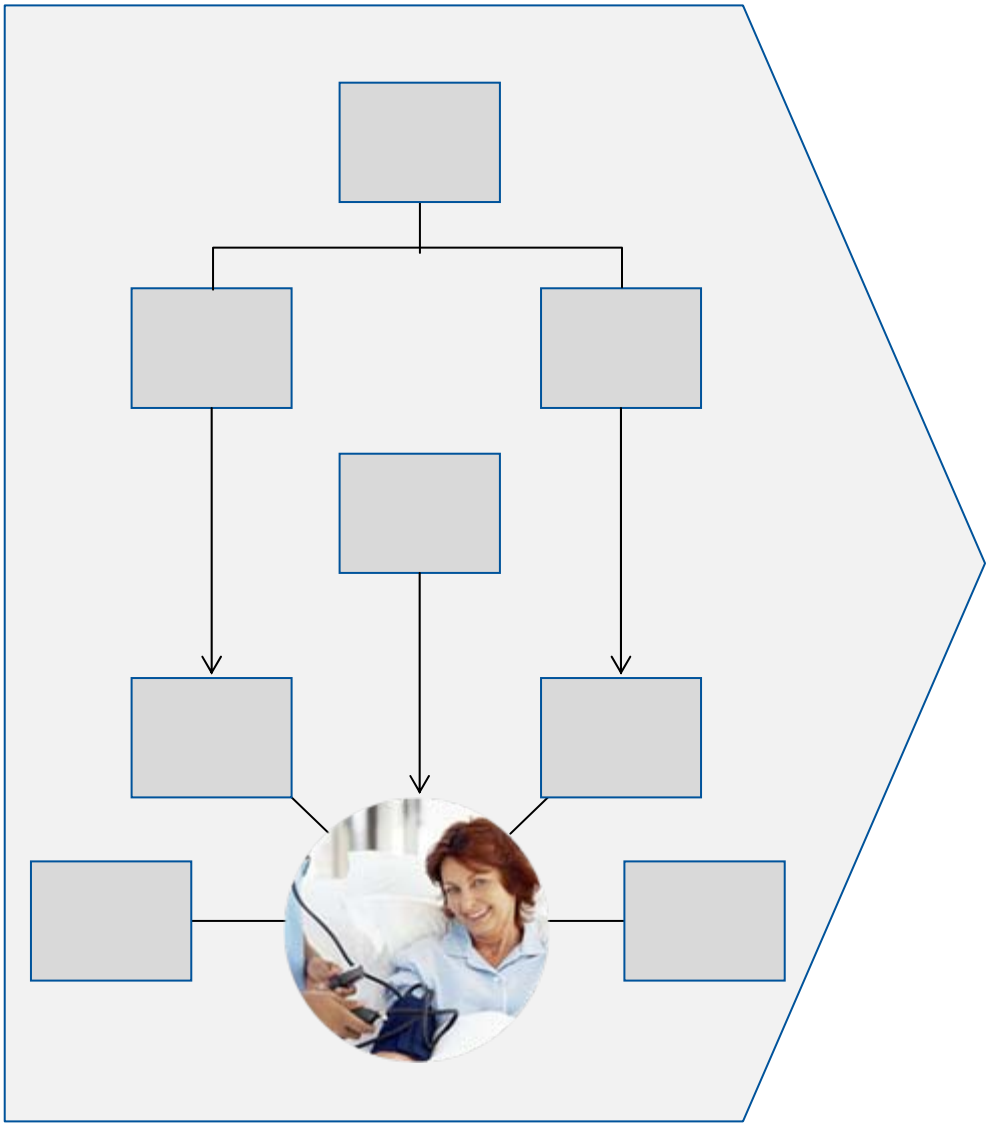
Characteristics of Laggards in the Reform Setting

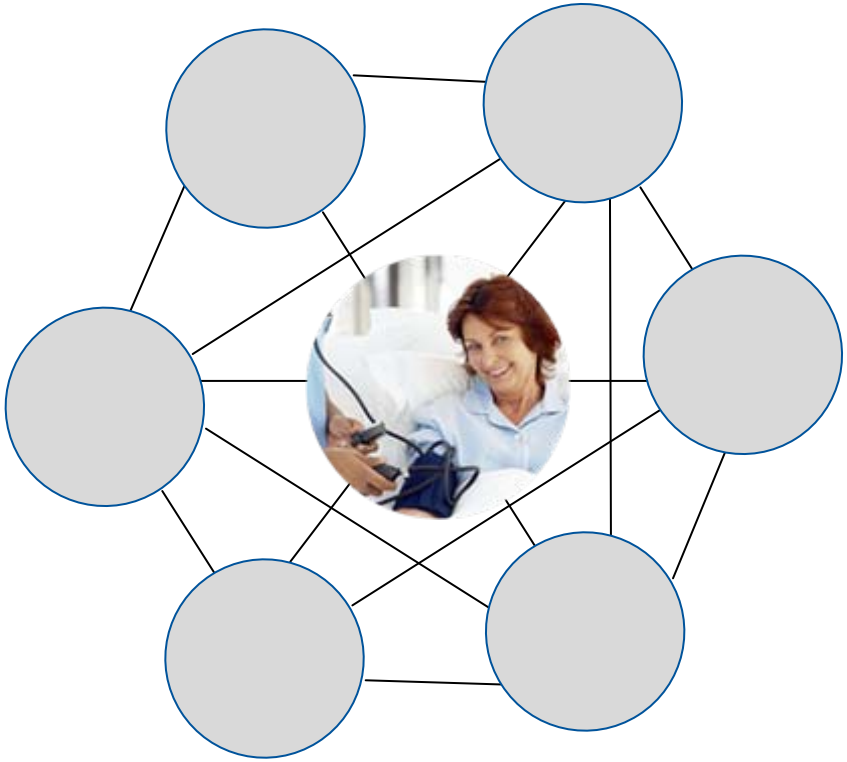
- Reactive decision-making
- Limited physician integration or slow-to-move physicians
- High cost structure: redundant and inefficient systems
- Inability to critically assess strengths and weaknesses
- Lack of a systematic process to evaluate quality and drive improvement
- The patient is an afterthought
- Lack of resources to invest in systems and infrastructure
- Unwillingness to acknowledge that success under value-based payment means a reduction in historically profitable services (e.g., admissions, ED, diagnostics)
- Failure to increase market share as FFS business decreases

Potential Barriers to Success

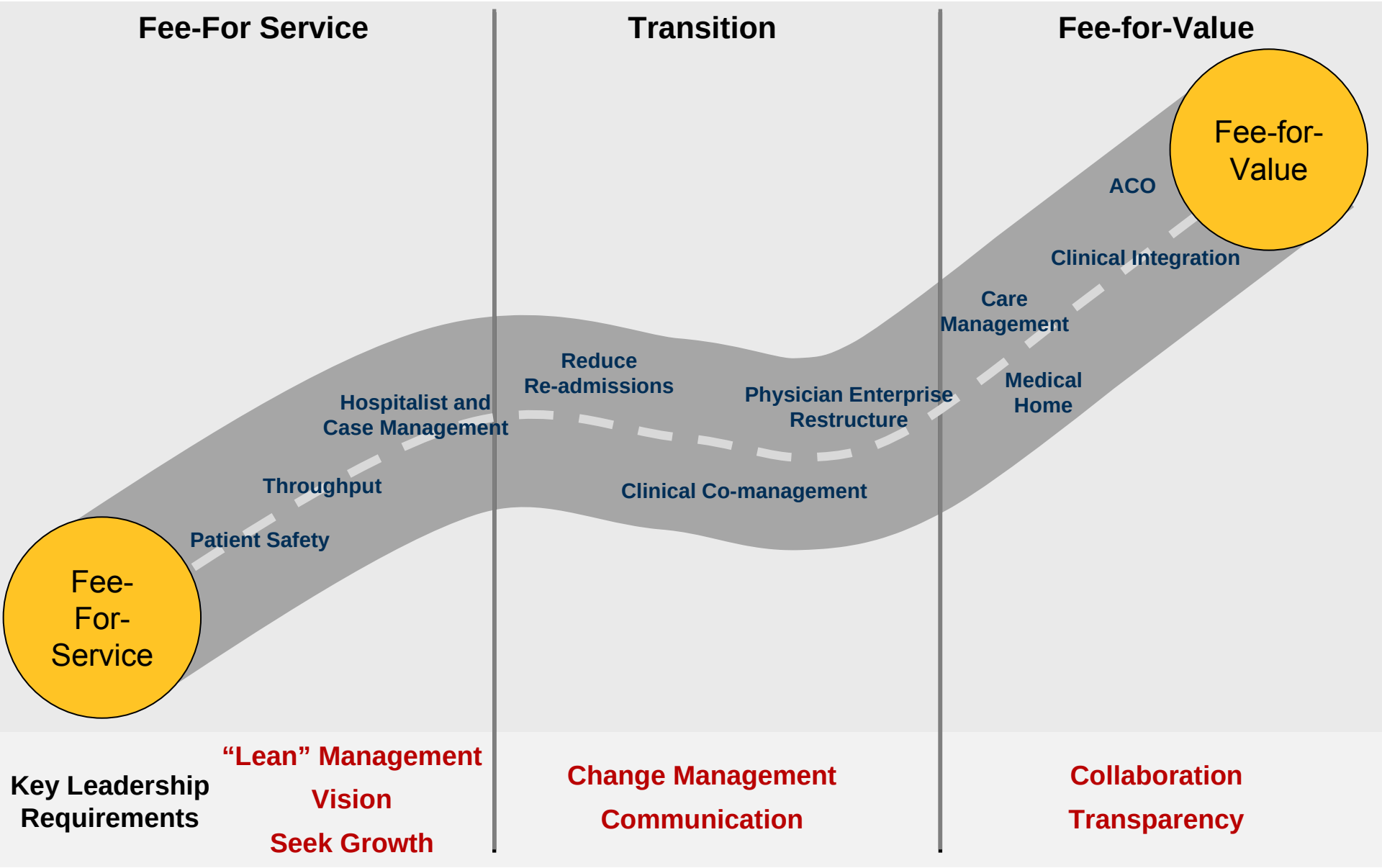
- Not devoting focus and resource to the formation and operationalization of the value-based care delivery organization
- Clinical and management leadership not fully committed to Clinical Integration and its role in service line/market growth
- Lack of urgency and inadequate energy focused on an accountable culture and care transformation
- Not enough attention given to getting Board members and physicians engaged and committed
- Not developing a culture of accountability
- Failing to define and/or deliver value-based care
- Silo-thinking (e.g., internal management fixation on entity financial targets)
- Lack of engagement of constituencies regarding the value of Clinically Integrated care
- Not recognizing the unique challenges and changes that must occur within the care delivery model across the continuum

Rethinking Our Organizational Orientation





Evolving Leadership Requirements



How Do you Define Leadership in Your Organization?

How Will the Goals be Communicated?

Physician Leadership Requirements

Physician Practice		Hospital Practice
■ Medical Group Leadership	■ Clinical Integration	■ Hospitalist/ Care Management
■ Physician Practice Leadership	■ Service Line	■ Hospital Quality/Peer Review

Creating an “Integrated” Culture

How Do We Collaborate Now?

Or Does it Feel More like This?

Transparency: Are You Ready to “Get Naked?”

Critical Success Factors for the "New Normal"

- Aligned, broad delivery network of providers with **strong primary care base** who are able to participate in/connect to the IT network
- Effective health information management capability including the ability to deliver, track, and document patient-centered, evidence-based care provision at the point of service
- Organizational comfort with **managing risk**; value-based payment requires new types of risk and population focus
- Integrated **clinical management** infrastructure (e.g., care management capability with real-time feedback)
- Engaged **physician leadership** able to influence outcomes across the continuum of care
- Commitment to **continuous innovation**

Who Will Be the Winners?

- Multispecialty physician groups that have the proven ability to manage risk across the continuum of care
  - Strong primary care base with adequate access
- Large integrated systems with:
  - Large/Growing employed medical groups and/or closely aligned physician organizations
  - Systems with experience managing risk
  - Partnership or ownership of the continuum of care (home care, skilled nursing, etc.)
  - Supports for movement to population health
- Low cost, high quality community hospitals
- Collaborators who can facilitate population health management
- YOU???