The University of Michigan Pioneer ACO Lessons Learned

Date: 11.4.13

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Agenda

- Overview of University of Michigan
- Population Management Evolution
- UM Approach & Strategy
- Future Direction
- Questions

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University of Michigan Health System

- 1.9 million out-patient visits per year
- 45,000 hospital admissions per year
- 15 Primary Care Health Centers
- 4 Hospitals (990 licensed beds)
- 9,000 full-time-equivalent staff
- 1,700 faculty members
- 960 house officers / residents
- Home grown EMR / data warehouse converting to EPIC

UMHS Strategies to Address the Evolving Healthcare Landscape

- Manage payment reform demonstration projects (i.e. ACOs)
- Improve care coordination across UMHS
- Engage UMHS providers to transform care delivery
- Engage providers external to UMHS
- Collaborate with payers on payment reform efforts

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Evolution of Population Management at UMHS

Programs

2012 Population Health
2008 Quality Management Program
2005 Faculty Group Practice assumes out-patient ownership
2003 5 MMC Disease Management Programs receive approval by JCAHO
2002 iCARE† – *pharmacy initiatives*
1998 GUIDES – *measurement / implementation*
1998 Medical Management Center (MMC)
1996 GUIDES* – *guidelines development*

Projects

2012 Pioneer ACO: CMS
2012 Michigan Primary Care Transformation (MiPCT): Multiple
2011 PGP Transitions Demonstration Project: CMS
2009 Performance Recognition Program: BCN
2008 Speaking Together: RWJ
2006 GME Chronic Care & Quality: AAMC-AHRQ
2005 Physician Group Incentive Prg: BCBSM
2005 Chronic Care Collaborative: AAMC
2004 Physician Group Practice (PGP) Demonstration Project: CMS
2002 Prescribing Pilot: BSBSM

* GUIDES = Guidelines Utilization, Implementation, Development and Evaluation Studies
† iCARE = Improving Care with Appropriate, Responsible, cost-Effective prescribing

Physician Group Practice (PGP) Demonstration Project

- Geisinger Clinic
- Marshfield Clinic
- The Everett Clinic
- St John's Health System
- Deaconess Billings Clinic
- The University of Michigan
- Dartmouth-Hitchcock Clinic
- Park Nicollet Health Services
- Forsyth / Novant Medical Group
- Integrated Resources (Middlesex)

PGP Basics (2005 – 2010)

- Designed to encourage increased care coordination, improved quality, and decreased costs in the context of fee-for-service reimbursement model for Medicare beneficiaries
- Large, multi-specialty group practices selected for participation
- Sites eligible for savings bonus of up to 80% of total cost savings over 2% <u>if</u> quality targets met with variable cost / quality weighting over the duration of the project
  - Year 1 cost/quality weighting 70%/30%; Year 2 - 60%/40%; Years 3 to 5 - 50%/50%
- PGP demonstration sites serves as a model for ACO structure and reimbursement
- 5,000 Physicians and 224,000 Medicare Beneficiaries

PGP & Transition Demonstration Results

	PGP Demo					TD
	2006	**2007**	**2008**	**2009**	**2010**	**2011**
Total Target Expenditures	$11,881	$12,679	$13,512	$13,780	$13,828	$13,230
Total Actual Expenditures	$11,473	$12,344	$13,042	$13,136	$13,212	$13,020
Total Target Minus Actual	$408	$334	$470	$644	$615	$210
Percent Savings	**3.40%**	**2.60%**	**3.50%**	**4.70%**	**4.40%**	**1.60%**

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Reasons to Pursue Pioneer ACO

- Multiple care coordination and quality interventions in place due to experience in PGP and Transition Demo
  - Transitional Care program
  - Complex care management
  - Post-acute clinical programs
  - Strong primary care medical home effort (MIPCT)
  - Quality Management Program
- Strong institutional leadership support; ACO is key component of UMHS strategic plan
- Strong physician/institutional culture supporting evidence-based care
- Partnership with high quality regional PO: will improve care of co-managed patients and IHA will manage their aligned patients well
- Blue Cross of Michigan is interested in the ACO concept – developing an Organized System of Care concept

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UMHS Accountable Care Organization Development

Home Care Services
Sub-acute care

Public Health
Safety Net Clinics

Hospital Care

Specialty Care

Patient Centered
Medical Home

Primary
Care

Data and Analytics

UM Initial Focus

- Target the highest cost, most complex cases first
  - Complex Care Management Program
  - Outpatient Case Management
  - Inpatient-Outpatient Transition Management
  - Mental Health Care Coordination

- Primary Care Engagement
  - Patient Centered Medical Home

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Improving Care Coordination Across UMHS

Michigan Primary Care Transformation Project (MIPCT)

- Embedded Care Navigators in all primary care ACUs
  - Follow patients as they transition from hospital to home
  - Work closely with complex patients to manage their chronic illnesses

Inpatient care management initiative

- UMHS is transitioning from a centrally-based discharge planning program to a unit-based discharge planning program

Complex care management program

- Case managers work with the most complex patients in UM (uninsured, homeless, physically and psychologically impaired, etc.)

Engaging UMHS Providers to Transform Care Delivery *(1)*

Specialty Engagement

- Cardiology
  - Improving rates for cholesterol screening (BPA, external lab process, reporting)
  - Collaborating with existing workgroups to offer PM or analytic assistance (Heart Failure re-admissions, Arrhythmia coordinated management and Cardiology care management)
- Nephrology
  - Improving primary care utilization and decreasing inappropriate ED utilization for dialysis patients
- Oncology
  - Develop a process for chemotherapy consents
  - Code status conversations with patients

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Engaging UMHS Providers to Transform Care Delivery *(2)*

Clinical decision support for population management

•Optimize decision support tools in MiChart to improve chronic care management and preventive services

•Provide supportive mechanisms for providers, panel managers and support staff to remind of care needs

•Maximize financial incentives for delivery of evidence based care

•Continue to educate physicians to use clinical decision support

Engaging providers external to UMHS

Skilled nursing facility collaboration

•Establish relationships with local SNFs to reduce LOS and increase quality, communication

Collaboration with local providers

•Collaborative relationship through ACO, OSC

•Identifying opportunities for community advance care planning collaboration

Acute Care for Elders (ACE) Unit

•Specialized inpatient unit at local community hospital for UMHS geriatric patients

  – Run by UM geriatricians, staffed by local hospital clinicians

Collaborating with payers on payment reform efforts

PremierCare

•Currently working with PremierCare to take on full responsibility/risk for the health and outcomes of all University of Michigan employees

SilverScript Partnership

•Collaboration with SilverScript (CVS) on a Part D shared savings project

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UMHS ACO Future

- Continue to engage specialists
  - Geriatrics
  - Psychiatry
  - Pulmonology
  - Emergency physicians
- Continue to work with community partners
  - Subacute rehab/skilled nursing
  - Hospice/Palliative Care
  - Homecare agencies
- Initiate homecare visit for Complex care management program
- Transition to POM ACO starting 1.1.14

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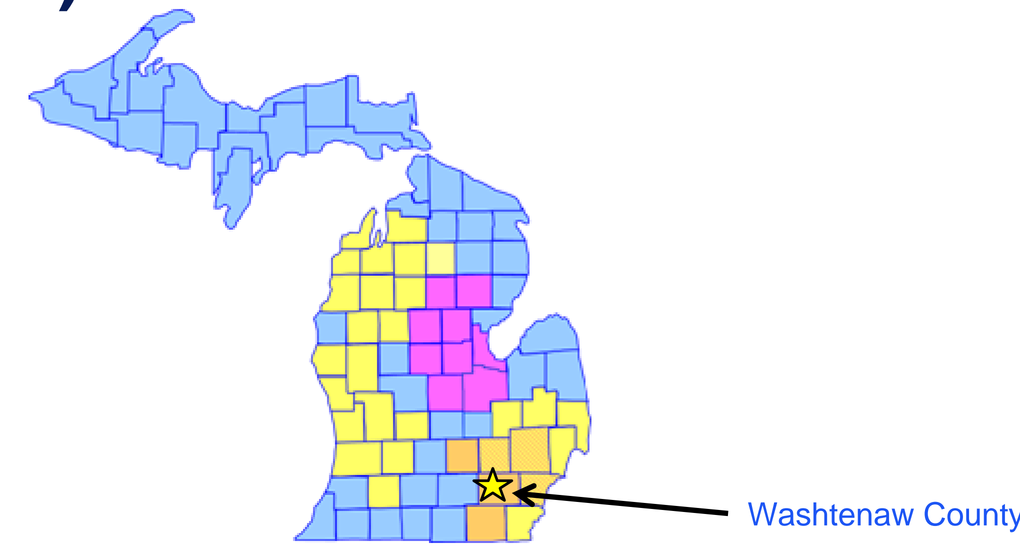
Physician Organization of Michigan Accountable Care Organization (POM ACO)



<u>POM-ACO Medical Groups (2013)</u>

Advantage Health Physicians (386)
Crawford PHO (77)
Lakeshore Health Network (356)
Oakland Southfield Physicians (233)
Olympia Medical (191)
United Physicians (805)
Physicians of West Michigan (344)
Wexford PHO (395)
University of Michigan (Specialists)

Medicare Pioneer ACO (UM and IHA)

BCBSM Organized Systems of Care (UM, IHA and HVPA)

CMS Shared Savings Program (POM-ACO)

Mid-Michigan Health Plan * (UM and Mid-Michigan)

* Not part of an ACO / Shared Savings Program

Transition from Pioneer to MSSP

- UMHS fully supports transformation efforts by CMS
- Administratively align UM ACO programs
- Benefits:
  - Risk adjusted methodology
  - No IME costs included in performance measures
  - No impact on institutional strategy to develop capability to compete in alternative payment contracts
  - Increases partnership with physicians across MI

Lessons Learned

- Culture – change in mindset from project to new way of delivering care
- Leadership – buy-in and prioritization of efforts & corresponding resources
- Communication – leaders and local providers
- Implementation – data perfection limits operational performance
- Patient Engagement – develop mechanisms to reach out to patients (e.g. opt outs)
- Analytics – must be capable of processing data & develop leadership and actionable reports

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Suggested Initial Areas of Focus for MSSP

- Readmissions
  - Duals
  - Disabled
- High utilizers
- Sub-acute facilities
- Home Health
- Hospice
- Ambulance expenses

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