THE CAMDEN GROUP

ideas. answers. action.

“Uh Oh…I’m an ACO…Now What Do I Do?

The Fourth National Accountable Care Congress
Los Angeles, California
November 4, 2013

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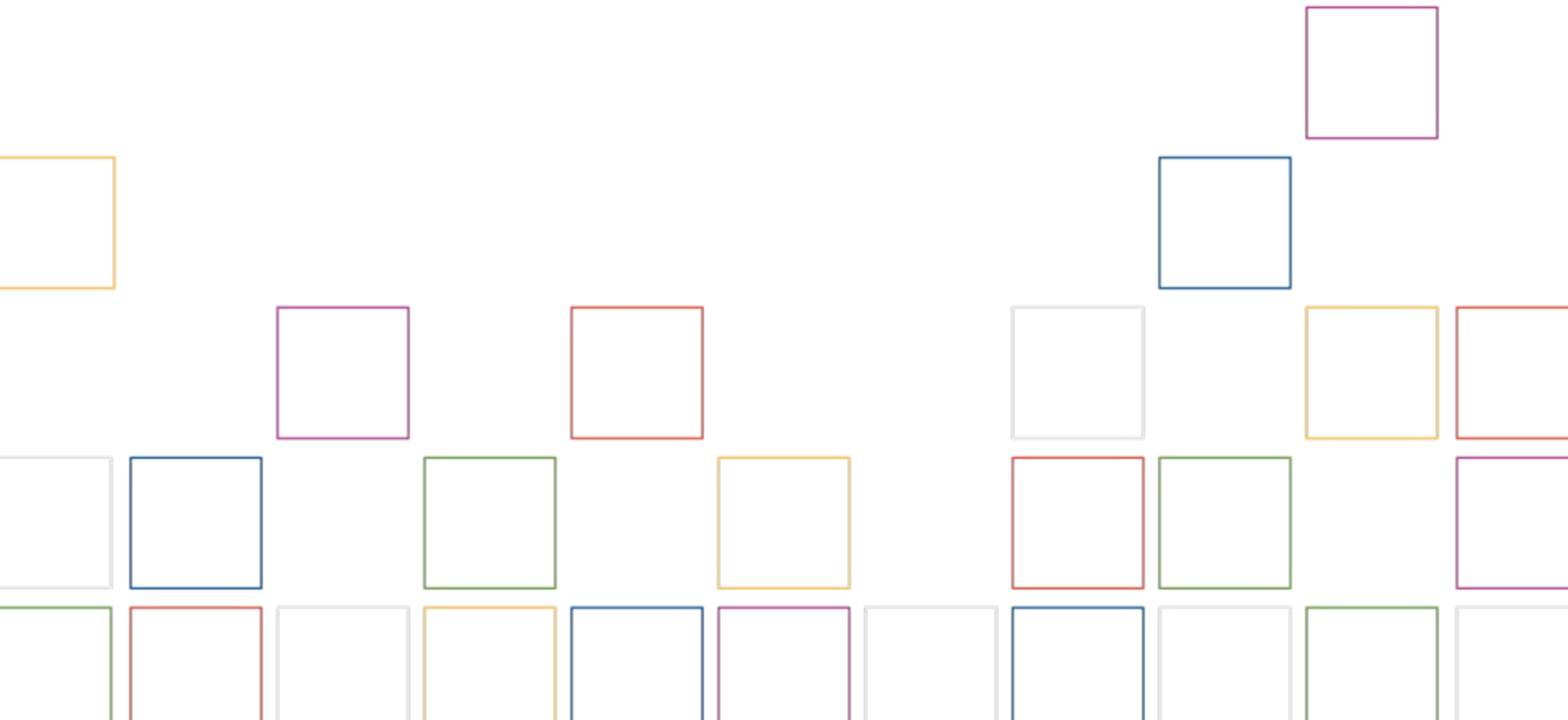
Introduction



Top 10 Ways You Know You Operate An ACO

10. Hospital CEO wants to know where the volume went
9. Medical Group Compensation Committee is stalemated on value of production vs. quality
8. CMS is on speed dial
7. Your CIO is on speed dial
6. The Help Desk has blocked your calls and your e-mails are considered spam
5. Your budget for meals and meetings has tripled
4. Consulting firms have you on speed dial
3. Seniors want to know why so many people are suddenly calling them
2. CV surgeons want to know why no one is calling them
1. You spend more time on the speaking circuit than in your office

The Challenge: Pursue Two Paths Simultaneously

Growth and Dispersion of ACOs

- ACOs have spread to 49 states, Washington D.C., and Puerto Rico
- California, Florida, and Texas lead the nation with 53, 41, and 30 ACOs, respectively
- Approximately half of all Medicare ACOs are physician-led
- Most extensive ACO growth throughout Midwest and West Coast

Organization Type	Number of Organizations
Commercial ACOs	228
Medicare Pioneer ACOs	23
MSSP ACOs	228
Medicaid ACOs	7

Source: Definitive Healthcare (accessed October 24, 2013); “Continued Growth of Public and Private Accountable Care Organizations,” Health Affairs Blog, February 2013.

Who's Joining the ACO World?

Medicare Shared Savings Program

Walgreens

Universal American

A Healthy Collaboration℠

Commercial

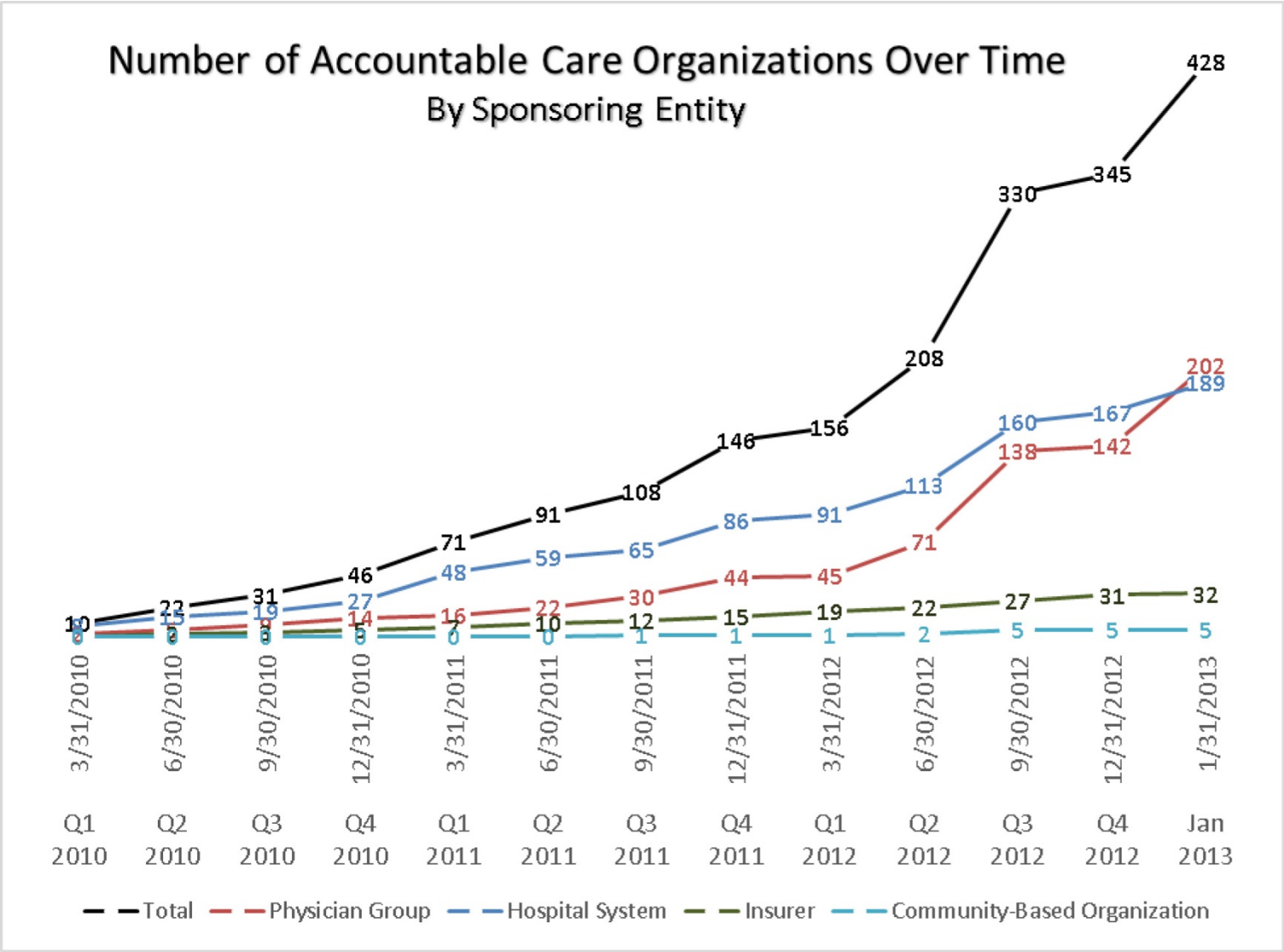
aetna

UnitedHealthcare

Cigna

Anthem BlueCross BlueShield

Growth and Dispersion of ACOs



Source: Continued Growth of Public and Private Accountable Care Organizations," Health Affairs Blog, February 2013.

What We Hear…

- We've got the network, figured out funds flow, spent a bunch of money on IT, now what?
- We can't get the data we need to manage and focus on care
- We don't know who the patients are
- Are we sure we want to keep doing this? ...look what happened to hospital utilization!
- Our patients are dazed and confused
- Our physicians are dazed and confused
- We are dazed and confused

But…

- More payers and/or employers are asking us to consider shared savings models

What are the Major Issues You Face?

What We Will Focus on Today

Leadership and Culture Change

- Culture change: what does it take?
- Physician engagement

At the Core: Care Model Redesign

- Making the best of imperfect data
- Focusing on how care models need to be reinvented or adapted
- Engaging the team in change

Where's the Money?

- Dealing with the financial realities
- Mitigating risks

Leadership and Culture Change

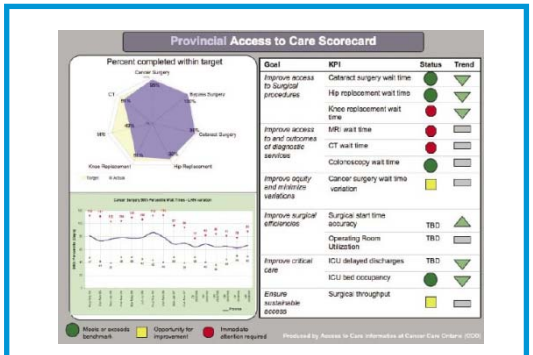
ACOs: What's In It For…Hospitals?

Participate in new models of care

Improve patient care and satisfaction

Transition to new payment models

Improve connectivity and relationships with physicians



Enhance quality improvement results

ACOs: What's In It For…Physicians?

Care Management Support

Participate in new models of care

Financial Rewards

Enhance Connectivity with Colleagues

Improve Patient Health and Satisfaction

Marketplace Challenges Impacting Physicians

- Reduced health plan benefits
- Physician group consolidation

- Health plan consolidation
- Medicare/ Medicaid cuts
- Limits on joint ventures

- IT requirements
- Administrative requirements
- Supply costs
- Employee benefit costs

- Investment income evaporated (retirement)
- Younger physicians expect more

(Patient Volume) × (Revenue) − Expenses = Physician Income

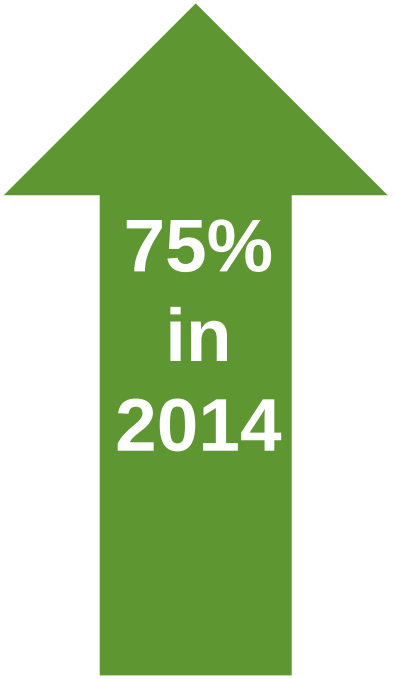
↓ ↓ ↑ ↓

Fewer Patients × Inadequate Reimbursement − Continued Increase in Expenses =

Physician Employment Rates

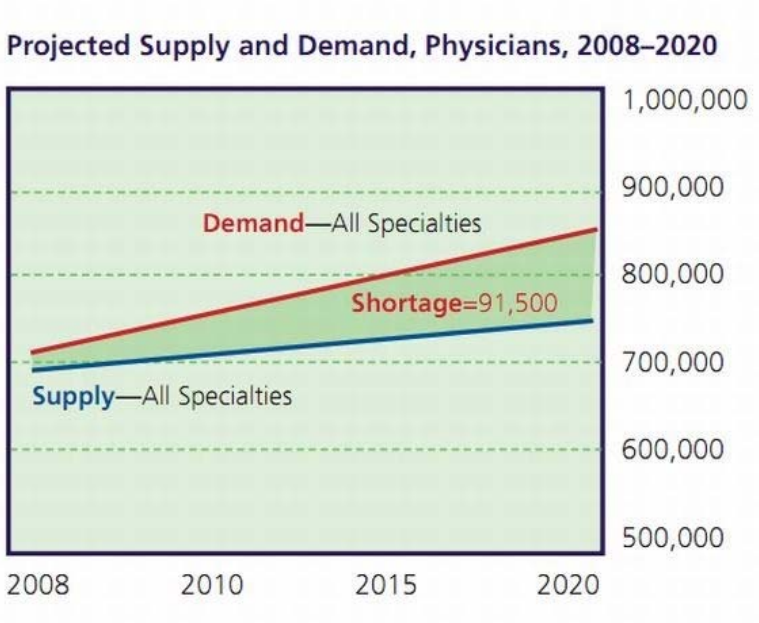
- One percent of 2,710 physician recruiting assignments Merritt Hawkins conducted nationwide were for solo physicians
- Down from 20 percent in 2004
- Increasingly difficult to practice solo

Private Practice



Employed Physicians

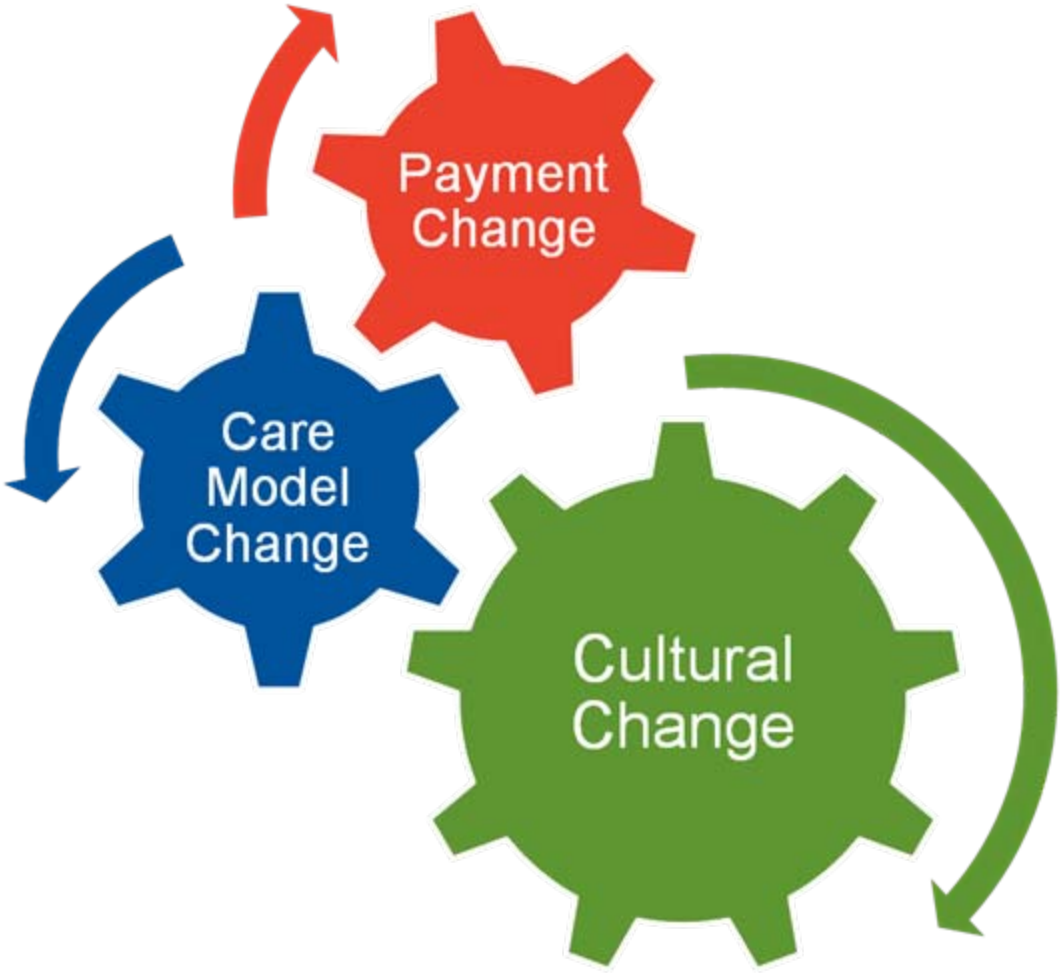
Physician Shortfall



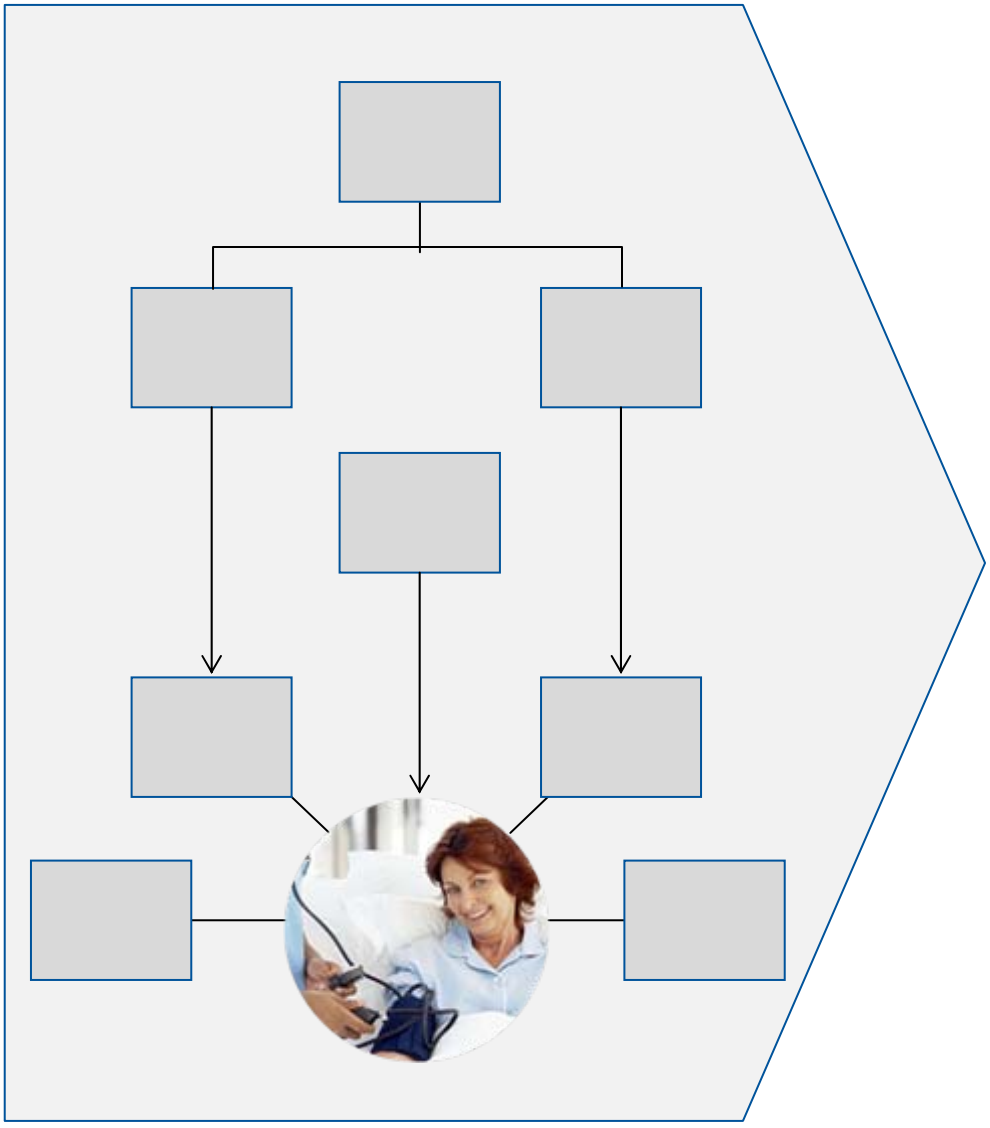
- 52,000 primary care physician shortfall expected by 2025
  - Increased demand due to population growth, aging population, and increase in insured population
  - Severe impact on vulnerable and underserved populations
- Nearly one-third of all physicians will retire in the next decade
- Medicare's support for physician training has been frozen since 1997
- Critical shortfall projected in the specialties that care for older adults

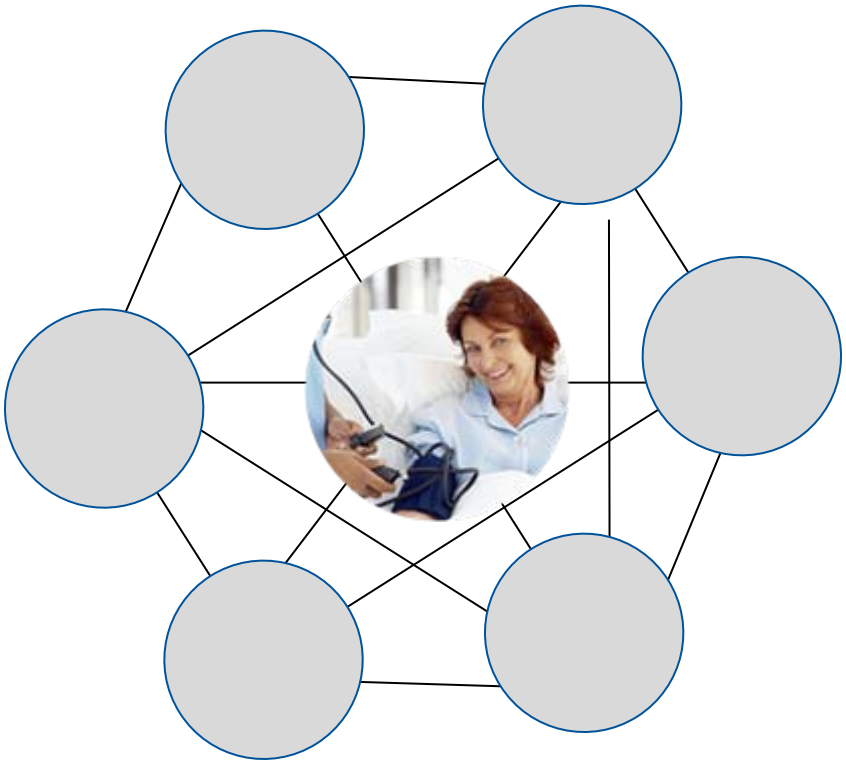
Source: "Shortage of 52,000 Primary Care Doctors Projected by 2025." American Medical News, December 2012. "Physician Shortages to Worsen Without Increases in Residency Training." Association of American Medical Colleges.

Getting the Gears of Change Aligned

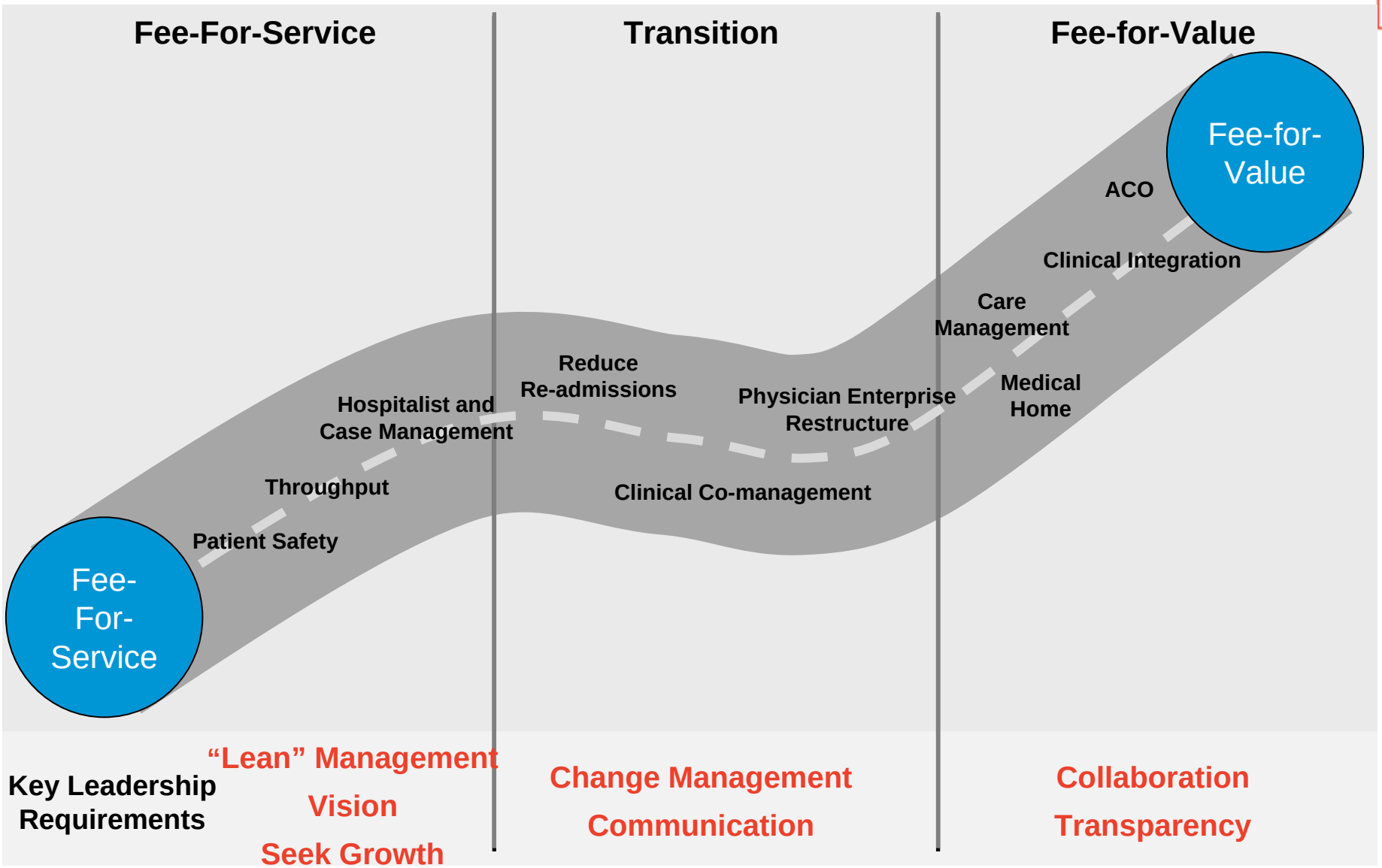


Rethinking Our Organizational Orientation



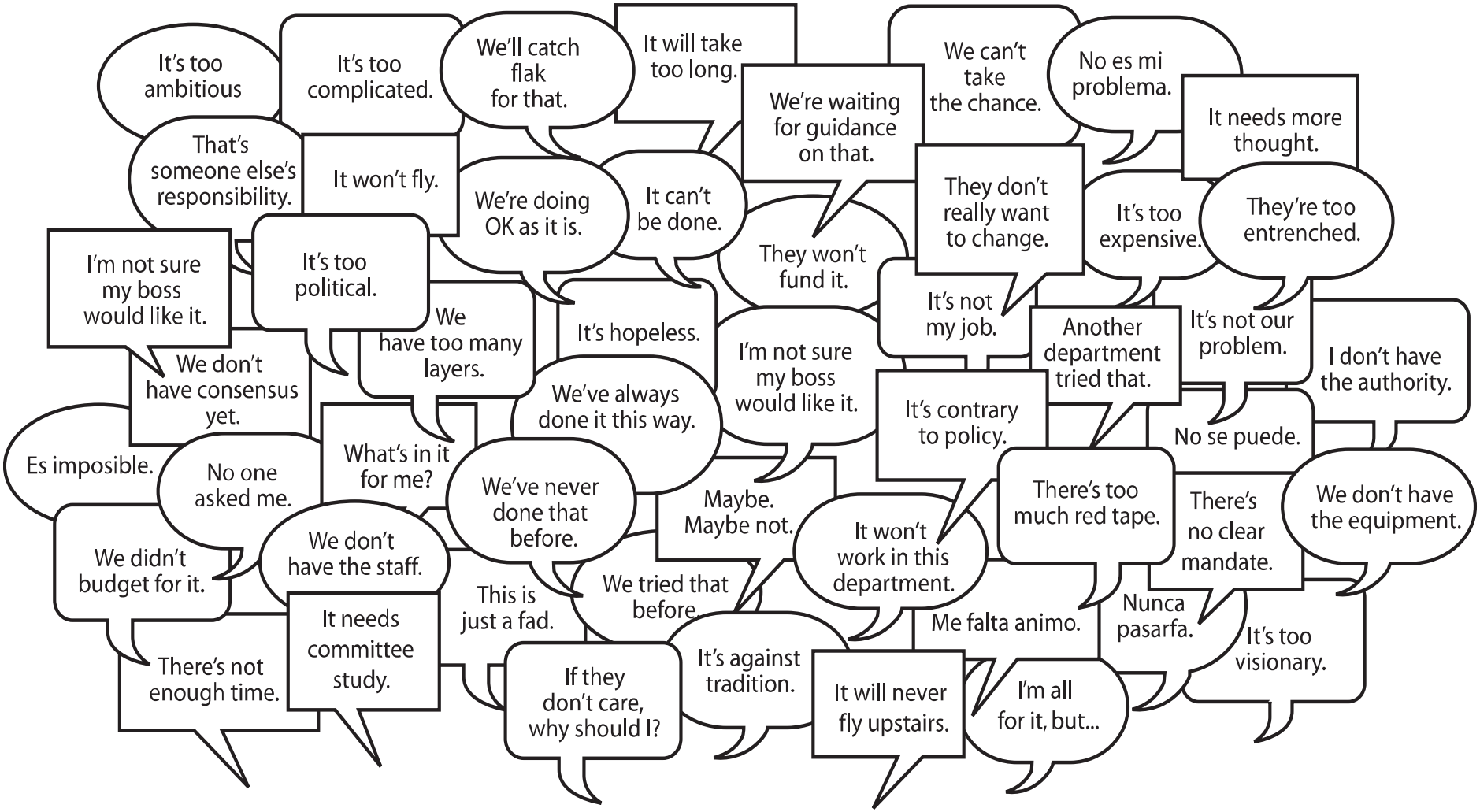


Evolving Leadership Requirements



How Do you Define Leadership in Your Organization?

Fifty-one Reasons Not To Change



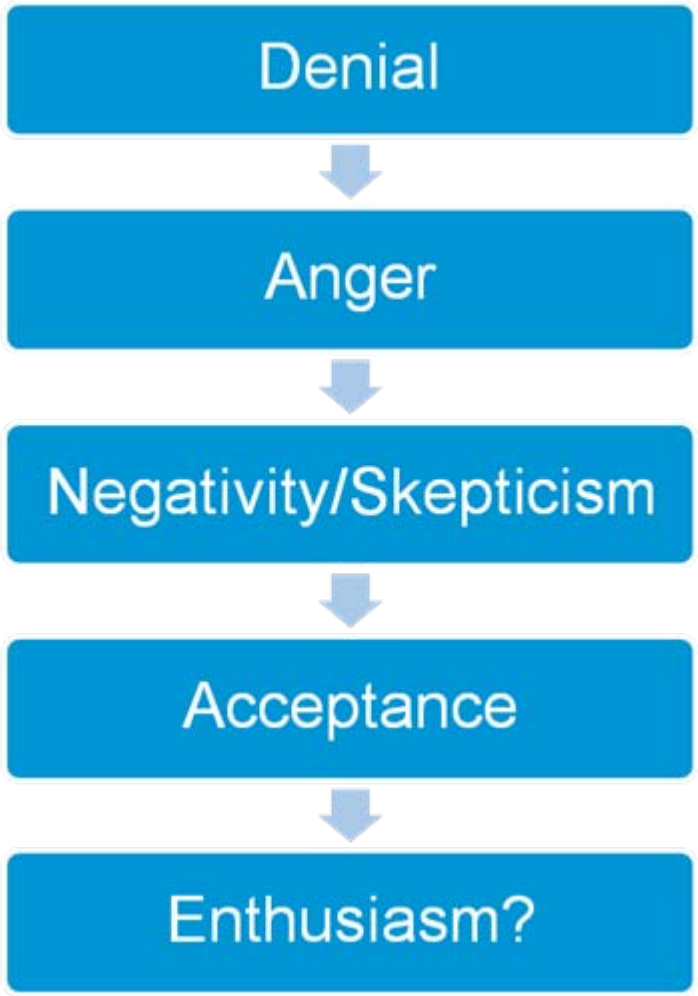
A Challenging Time For Change

Multiple Factors

- Many do not believe there is a need to change
- Transition during a schizophrenic time of payment models
- Loss of autonomy
  - Lose Control
    - Office
    - Patients
    - NPs/PAs/Others
- Reimbursement continues to decrease
- Expenses continue to increases
- Expanding knowledge base

Leads to Emotional Factors

Similar to Kubler-Ross Stages of Dying



Physician Change and Communication

Critical Elements

Make a Case for Change

Why, How, What

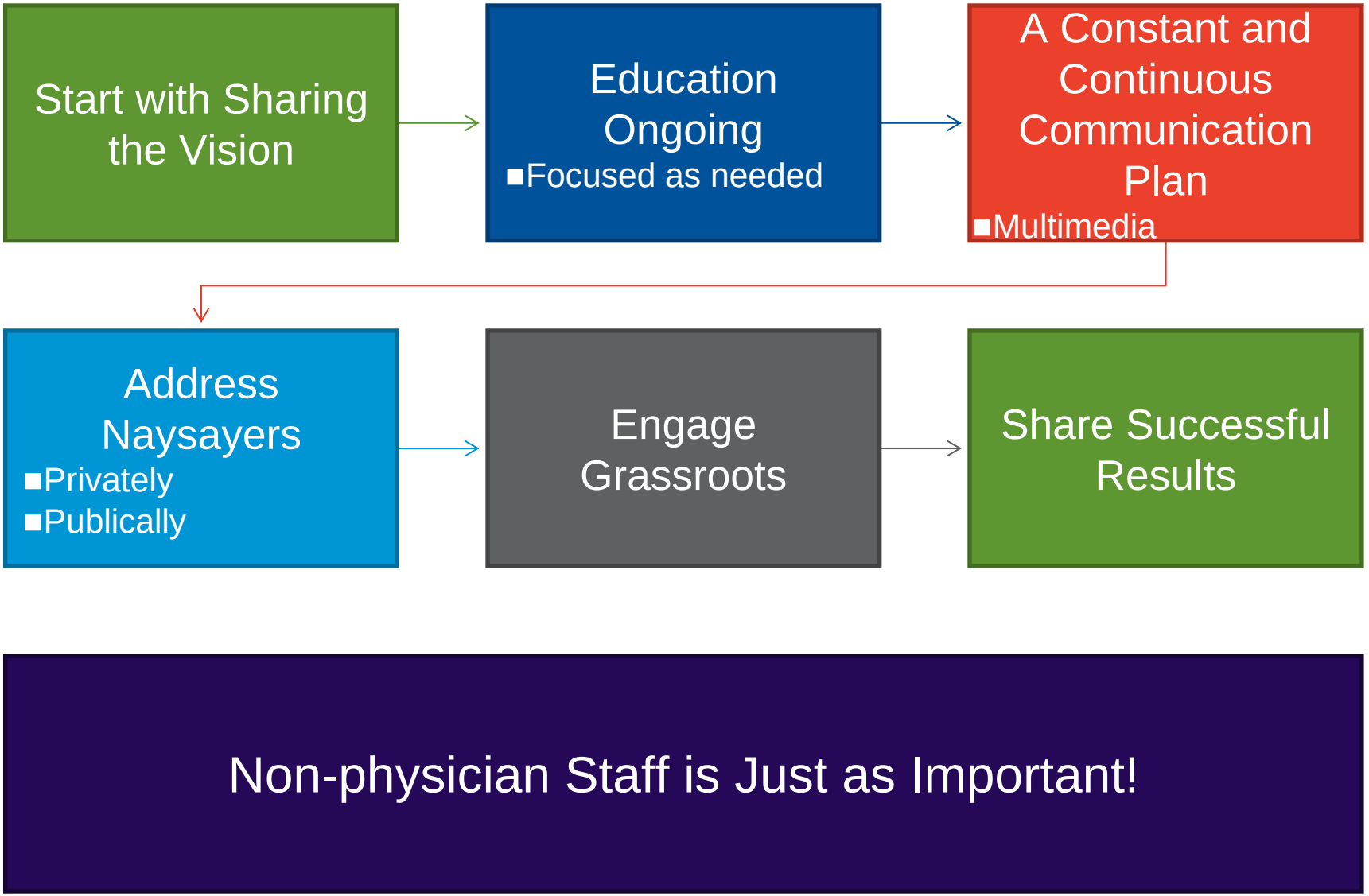
- Create need for change based on data and information
  - Quality metrics
  - Outcomes
  - New financial metrics and payment models
  - Industry market trends
- Address new emotional dynamics that may arise
- Implement change by supporting the processes needed for the change
- Sustain change by sharing results of success
  - Quality
  - Financial

Group Dynamics for Change

- Identify the “right” people
  - Formal and informal leaders
  - Need some with positions and power to get things done
  - Expertise and credibility to influence others
- Start with a small number of clear goals
- Develop an environment of trust and commitment within the team

Create an “Integrated” Culture

Communicate Progress of What is Being Changed



Enable Implementation of Change

- Supply training, support, and opportunities for success (i.e., make life easier)
- Remove identified barriers that impede progress to the goals and vision
- Encourage and value (monetary) involvement
- Organization must commit the time and necessary resources

Target Short-term Wins (Walk Before Run)

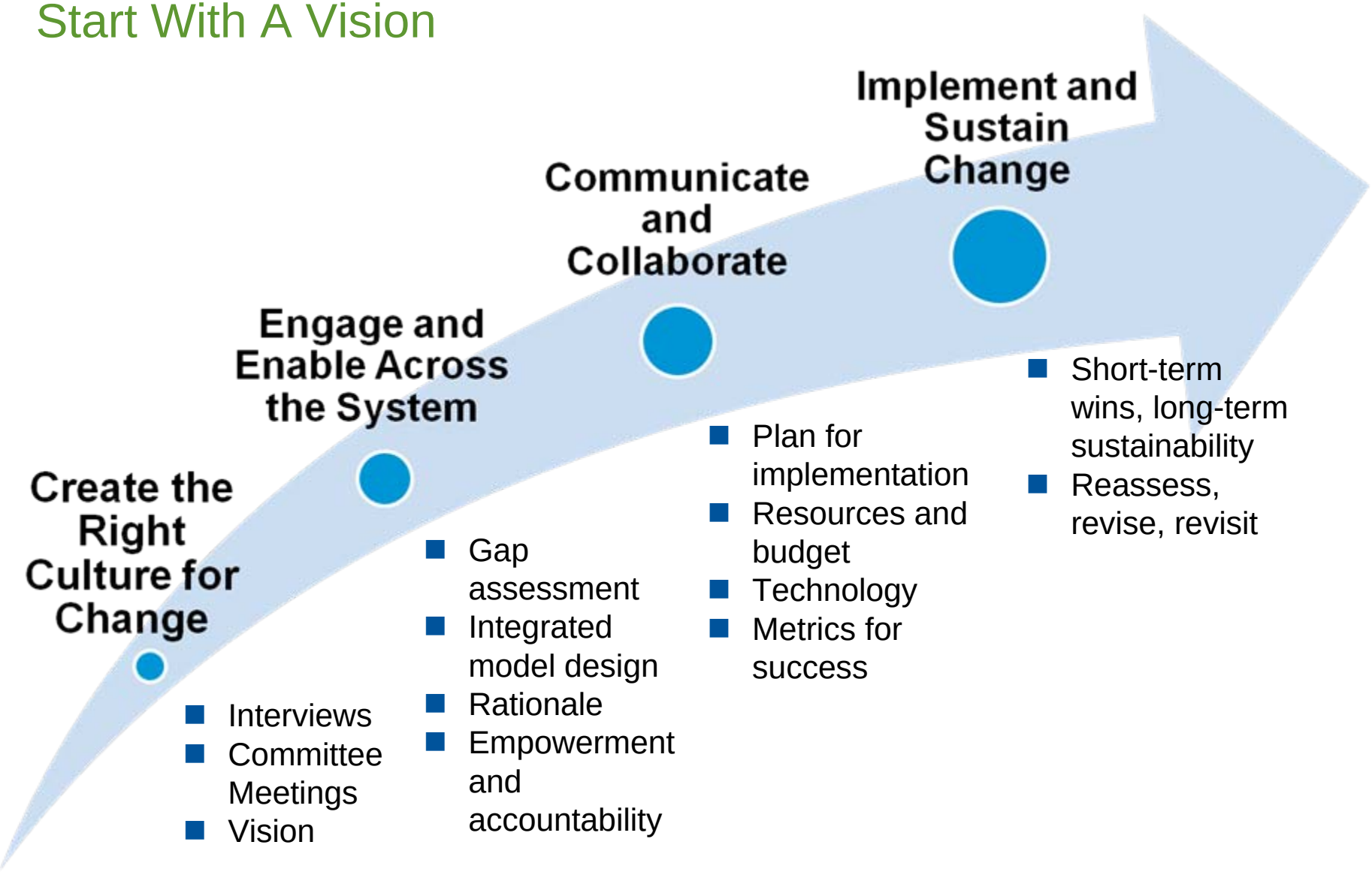
- Target a few agreed upon metrics of success that resonate with providers and the population
- Secure broad acceptance through communication and education
- Communicate success enthusiastically
- Include and learning that led to success into the plan
- Engage others that want to improve

Build and Expand On Success

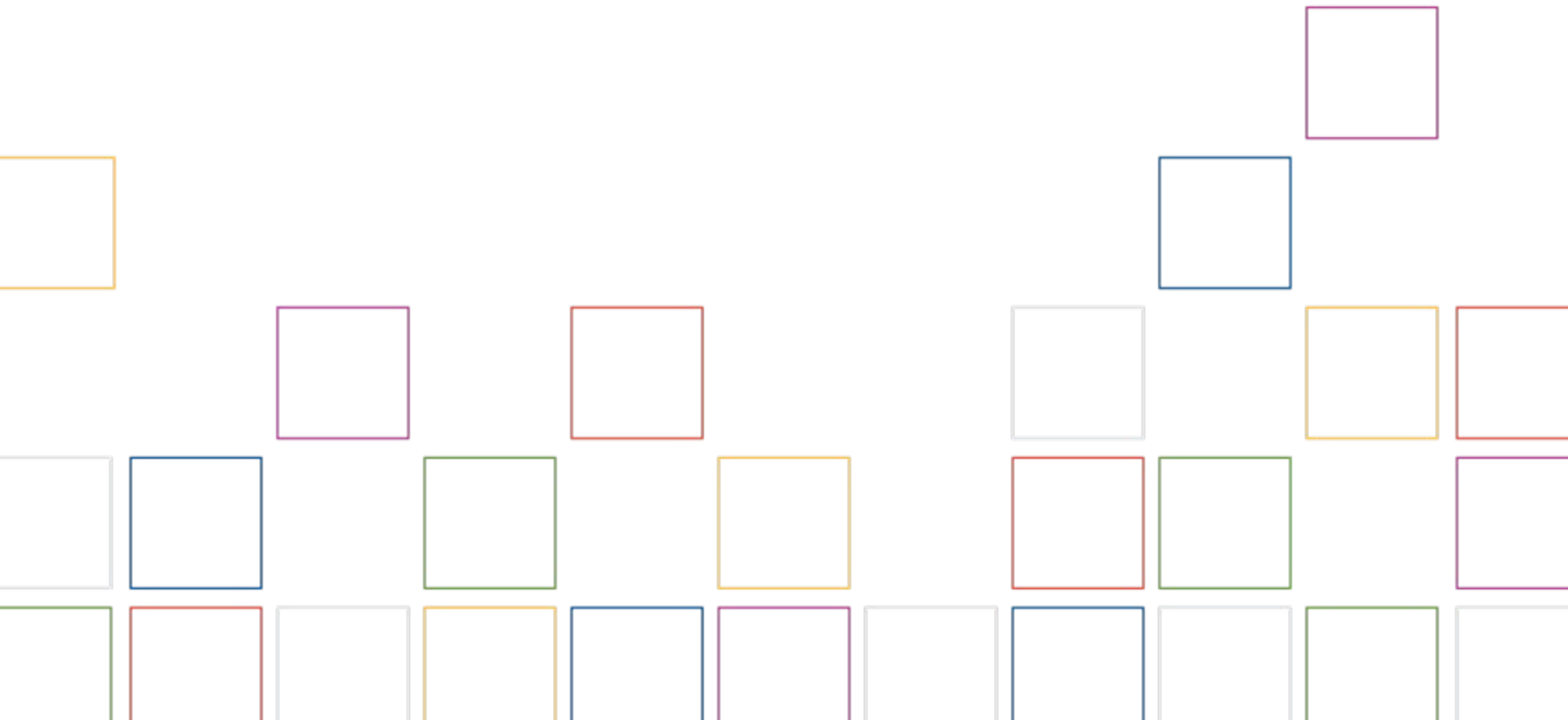
- Any small short-term win can lead to bigger longer term wins
- Build on what works, change what does not
- See what works and continue to improve on it
- Continue monitoring metrics an reporting results – good and bad
- Achieving tangible results as quickly as possible
- Build infrastructure that expands, and emphasizes new behaviors
- Continue to align financial rewards to behavior change
- Add new metrics, models, processes, and programs

Cultural Transformation

Start With A Vision

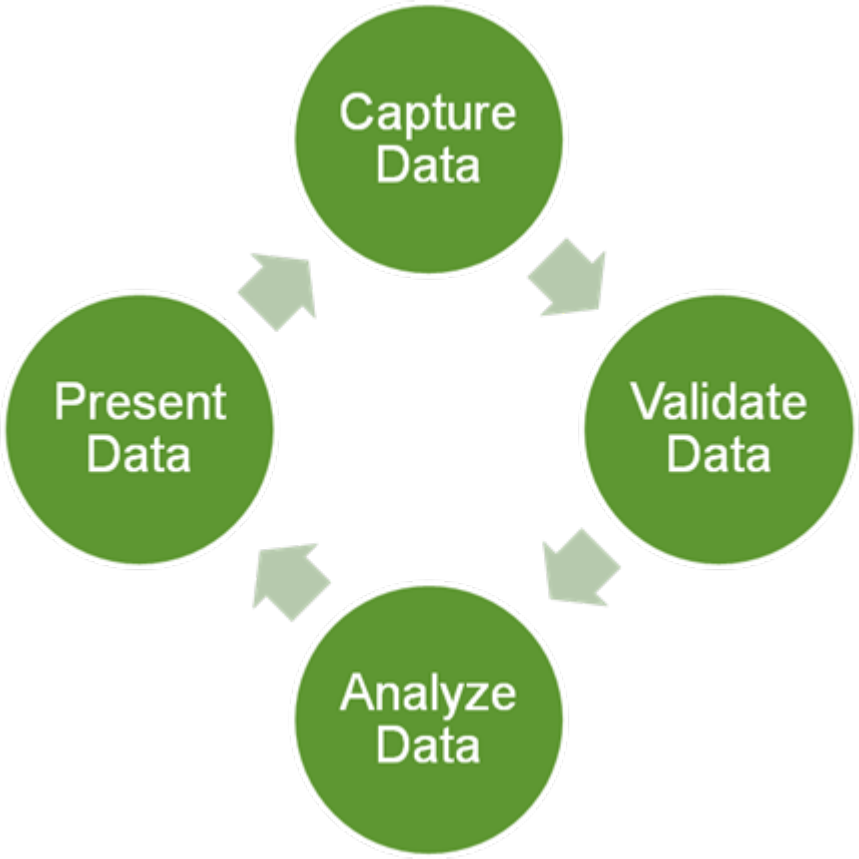


Being Data Focused When Data Is Imperfect

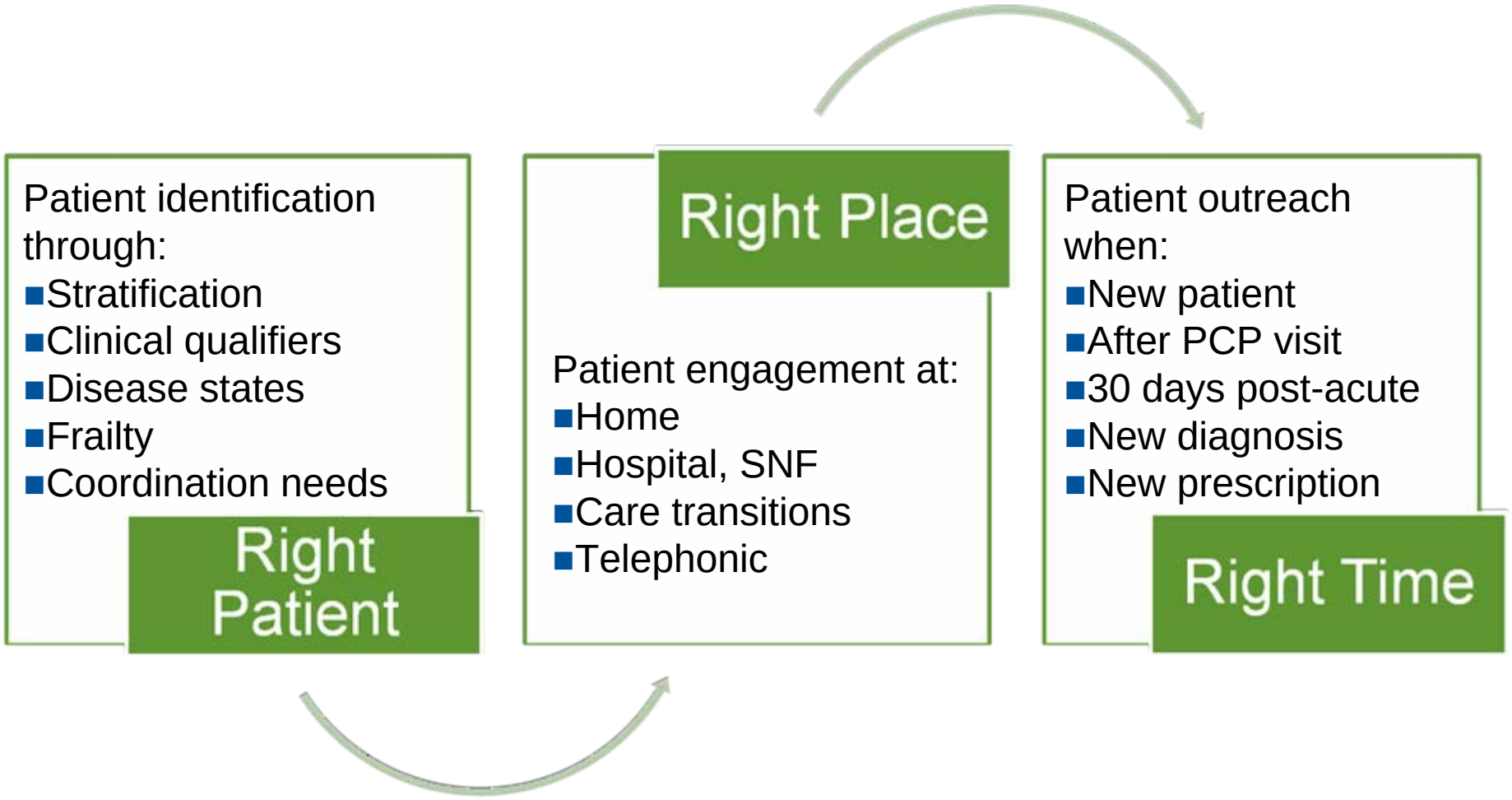


Why is Data Important?

- Identifies opportunities to provide better care
- Predicts trends and behaviors
- Provides clinicians, staff, and patients with knowledge and specific information
- Is intelligent and actionable
- Informs clinical workflow
- Helps to focus efforts
- Supports decisions
- Prove success



Find the Low Hanging Fruit



Source: The Camden Group

Data from Across the Continuum

Identify key data sources:

- Medical claims and pharmacy claims
- Clinical data from EMR
- Authorizations or provider self-report

Stratify patients by:

- Risk score (e.g., “top 100”)
- Diagnosis (e.g., disease registries)
- Patient population or business line

Sort and query the data for admits and readmits by:

- Facility
- Diagnosis
- Provider
- Risk score

Estimate total cost of care

Target Populations

Risk Stratification

- Consolidate data from CDR, EMR, DWH
- - Analyze claims and clinical data
- - Stratify patients by risk levels
- - Refer to appropriate level of care

High Risk Programs	Complex Care Management	Disease Management	Preventive Health

Clinical Decision Support

Integrating data and supporting technology tools can streamline and support providers:

- Care alerts should be made available at the point-of-care in physician practices and in inpatient settings
- Order sets and clinical guidelines should exist and prompt next steps
- Care plans should be embedded in the EMR/CPOE to track progress, manage adherence, and measure success
- Data from other providers (inpatient, post-acute, and outpatient providers) and health plans should be shared

Collect More Data…and Then, More Data

Across the Continuum

Attempt to collect data in structured fields vs. free-text so that the data can be reportable and actionable.

- **Electronic Medical Record**: includes clinical documentation, templates, e-charge (coding), e-prescribing, lab interface, evidence-based guidelines and orders
- **Care Management System**: includes patients' care plans, goals, follow-up schedules, and pertinent documentation
- **Physician Information Portal**: providers can track quality measures (e.g., HEDIS, STAR), review lab results, identify high risk patients, refer patients to appropriate services and programs
- **Patient Online Portal**: patients can self report progress toward goals, update health status, complete satisfaction surveys

Measure Success

Track and Trend Performance

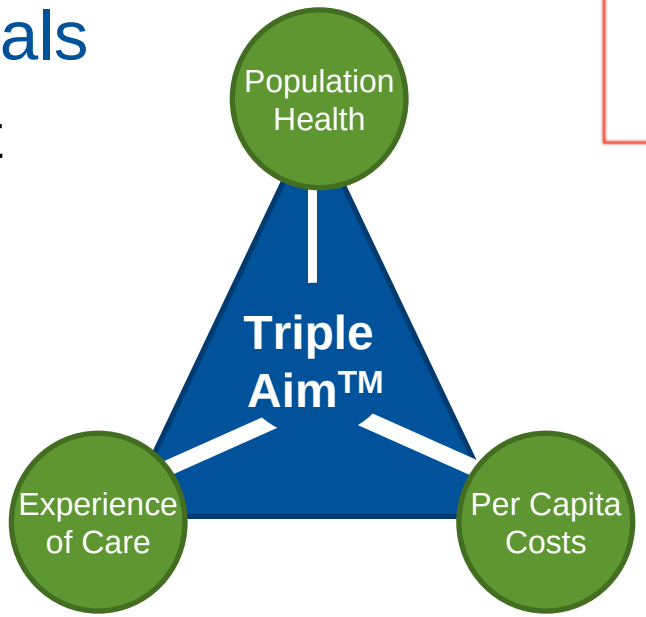
Detailed utilization reporting and quality measurement at the entity, group, and individual physician level. Metrics may include:

- Hospital bed-days
- Emergency department visits
- Urgent care visits
- Readmission rates (30, 60, 90 days)
- Acute costs and LOS
- Sub-acute costs and LOS
- Pharmacy costs
- Total cost-of-care
- PCP visits per year
- Provider variability
- Medication adherence
- Clinical quality metrics (e.g., HEDIS)
- Patient satisfaction scores
- Referrals to care management
- Program ROI

Redesigning Care at the Ground Level

Triple Aim™: Establish Patient Care Goals

- Provide appropriate clinical management to achieve designated clinical outcomes (HEDIS, Core Measures, P4P)
- Support and inform clinical decision-making using meaningful data and protocols
- Support members' self-management and independence
- Arrange care management and high risk programs according to need
- Improve patient understanding and satisfaction with their health status and health services
- Reduce total cost of care, including unnecessary hospitalizations, while maintaining or improving outcomes



Adopt Evidence-based Care Models and Best Practices

- Readmissions Prevention
  - Project R.E.D. (Re-engineered Discharge)
  - Eric Coleman's Care Transitions Intervention
- Chronic Care Management
  - Guided Care
  - Geriatric Resources for Assessment and Care of Elders ("GRACE")
  - EverCare
- High-risk Management
  - HealthCare Partners
  - CareMore
- Medicaid Care Management
  - Community Care North Carolina
  - Commonwealth Care Alliance Brightwood Clinic

Readmission Prevention

Project R.E.D. (Re-Engineered Discharge)

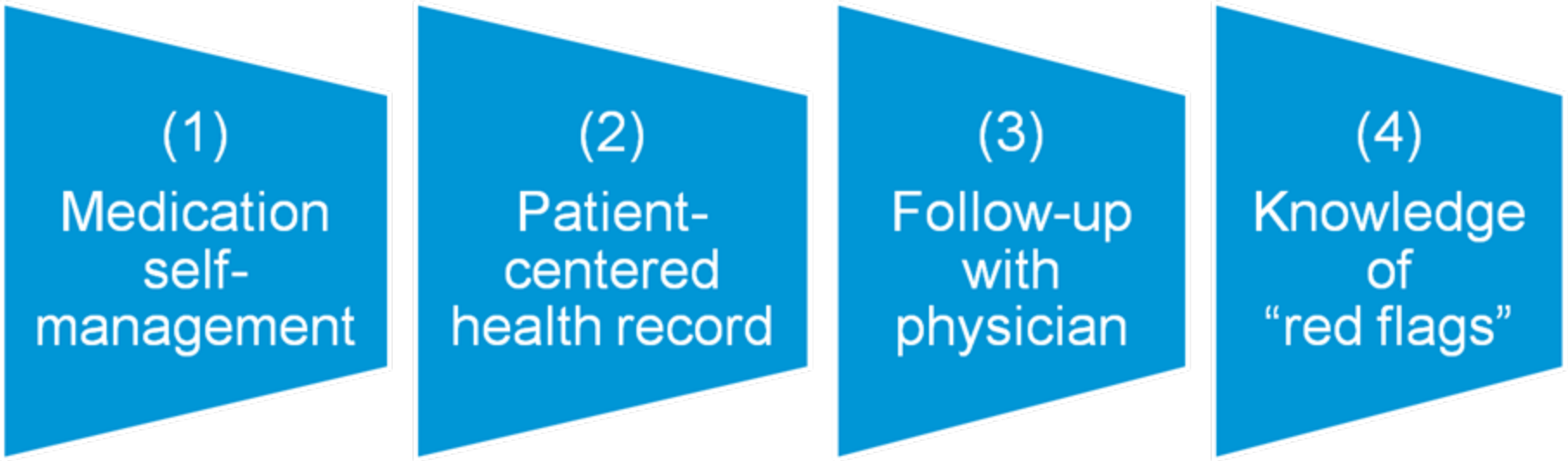
The hospital-based program improves patient preparedness for self-care and reduces preventable readmissions. A specially trained nurse “Discharge Advocate” is responsible for:

- Educating patient about diagnosis and discharge plan
- Making appointments and following up on test results
- Organizes post-discharge services
- Confirms the medication plan
- Reconciles the discharge plan with clinical guidelines
- Expedites discharge summary to outpatient providers
- Calls to reinforce of the discharge plan and offer problem-solving two to three days after discharge

Readmission Prevention

Eric Coleman's Care Transitions

- The Care Transitions Program ("CTP") is designed for community-dwelling patients age 65 and older, and centers on the use of a Transition Coach. The Transition Coach, who is a nurse or nurse practitioner, conducts a home visit within 72 hours of discharge and speaks with the patient by phone on post discharge days 2, 7, and 14.



Chronic Disease Management

Guided Care

A specially-educated RN works in partnership with primary care physicians in clinics and cares for the sickest patients and their caregivers by:

- Assessing the patient and their primary caregiver at home
- Creating an evidence-based care plan
- Promoting patient self-management
- Monitoring patients' conditions monthly
- Coordinating the efforts of all care providers
- Smoothing transitions between sites of care
- Educating and supporting family caregivers
- Facilitating access to community resources

Chronic Disease Management

Geriatric Resources Assessment and Care of Elders ("GRACE")

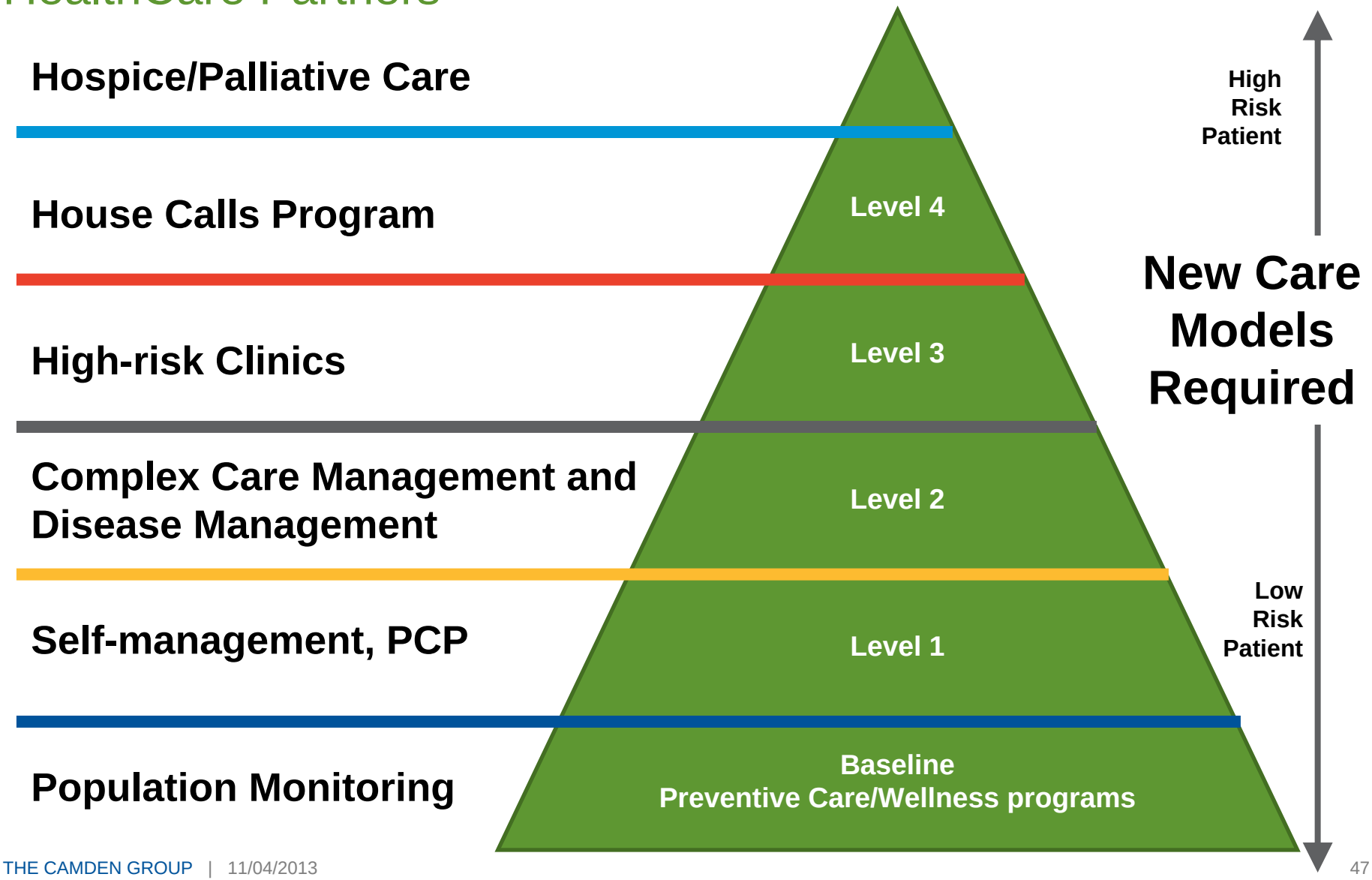
New model of primary care for low income seniors, using a nurse practitioner and social worker who collaborates with PCP and a geriatrics interdisciplinary team. Responsibilities include:

- Conducting telephonic and in-home assessments and visits
- Coordinating of care across all sites of care
- Integrating the program into primary care
- Using an electronic medical record to support physician practices and facilitate monitoring of clinical parameters
- Developing care plan using GRACE protocols
- Attending interdisciplinary reviews regularly

GRACE TEAM CARE™

High Risk Care Management

HealthCare Partners



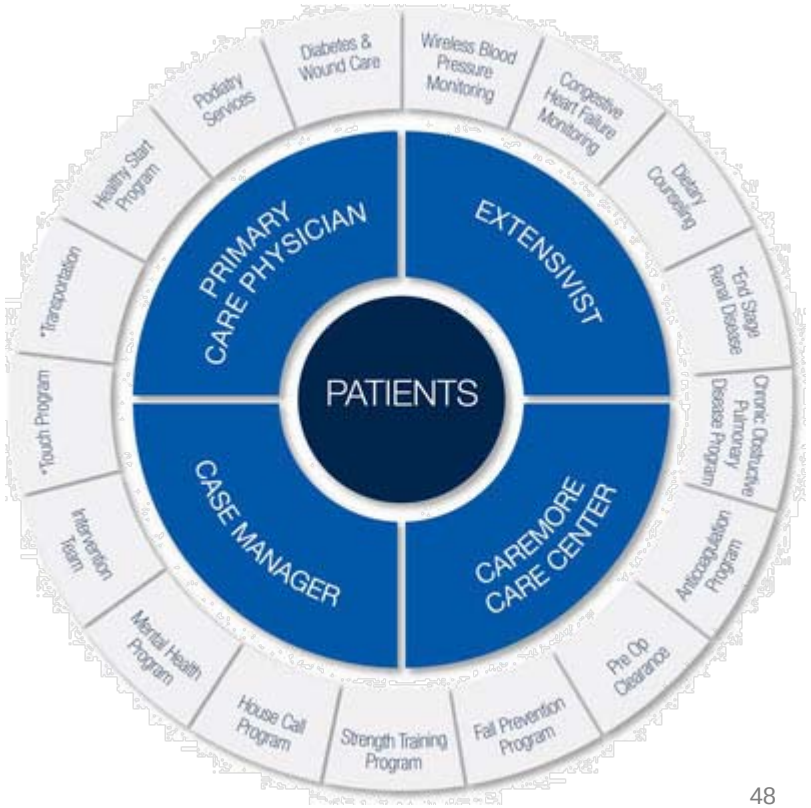
High-risk Care Management

CareMore

Clinical model focused on frail and ill (20 percent who drive most of the costs). The model revolves around the CareMore Care Center, a one-stop shop for members.

The CareMore staff team includes:

- RNs
- Medical Assistants
- Social Workers
- Podiatrists
- Behavioral Health Professionals
- Extensivists



Medicaid Care Management

Community Care North Carolina

Community-based care management program for over a million Medicaid recipients, with developed local networks and primary care providers to coordinate prevention, treatment, referral, and institutional services. Community Care North Carolina created case management for high-risk/high-cost patients and disease management for:

- Asthma
- Heart failure
- Diabetes
- Emergency department use
- Readmissions
- Pharmacy initiatives

Community Care of North Carolina

Medicaid Care Management

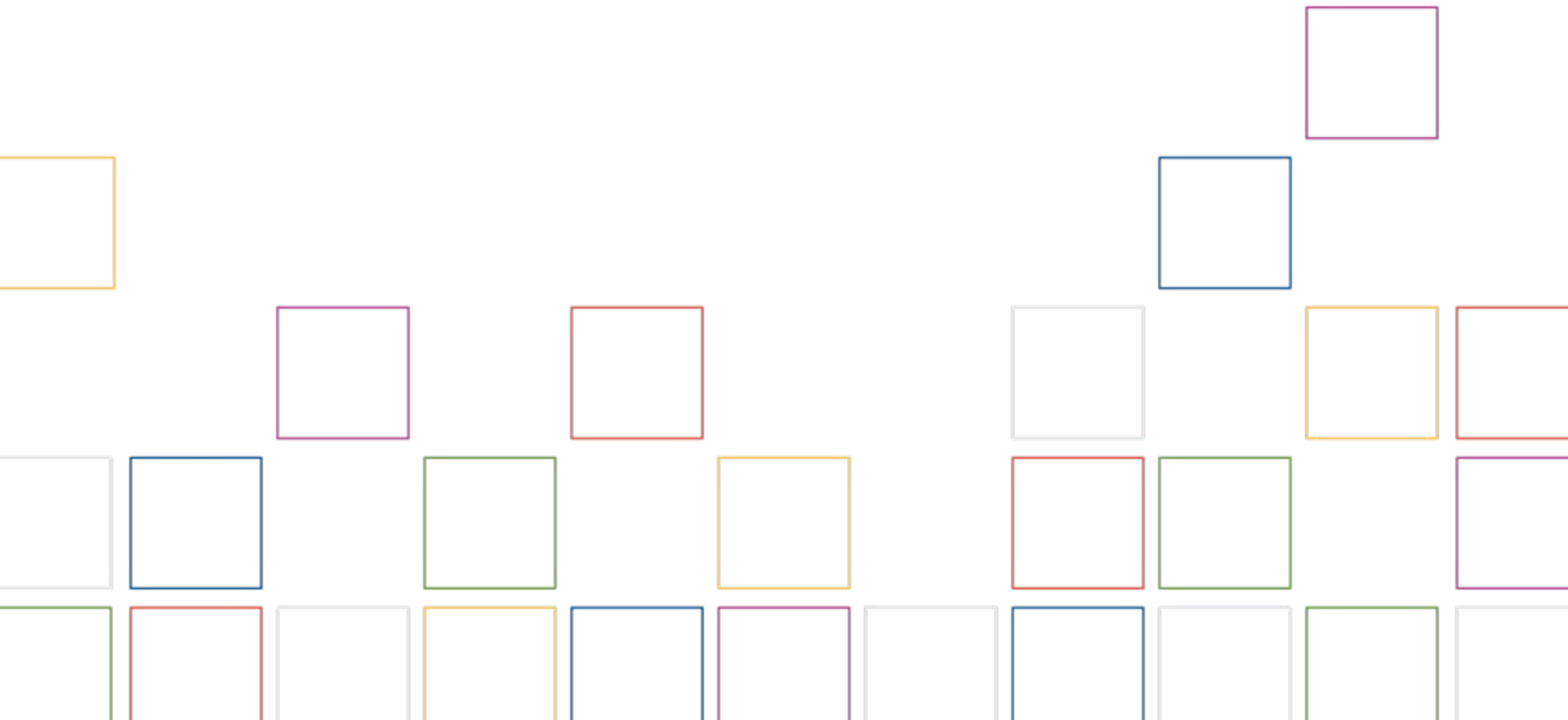
Commonwealth Care Alliance Brightwood Clinic

- Care management model for Medicaid low-income Latinos with disabilities and chronic illnesses providing special health care needs, enhanced primary care, on-site mental health, addiction advocacy services, care coordination, and support services
- Multidisciplinary clinical team model: PCP as care team member, with nurses, nurse practitioners, mental health and addiction counselors, and support service staff
- The key components of the intervention included:
  - Reminder calls for preventive care
  - Follow-up on ED, hospital, and detox admissions
  - Support groups, health education, and promotion
  - Bilingual staff and clinicians

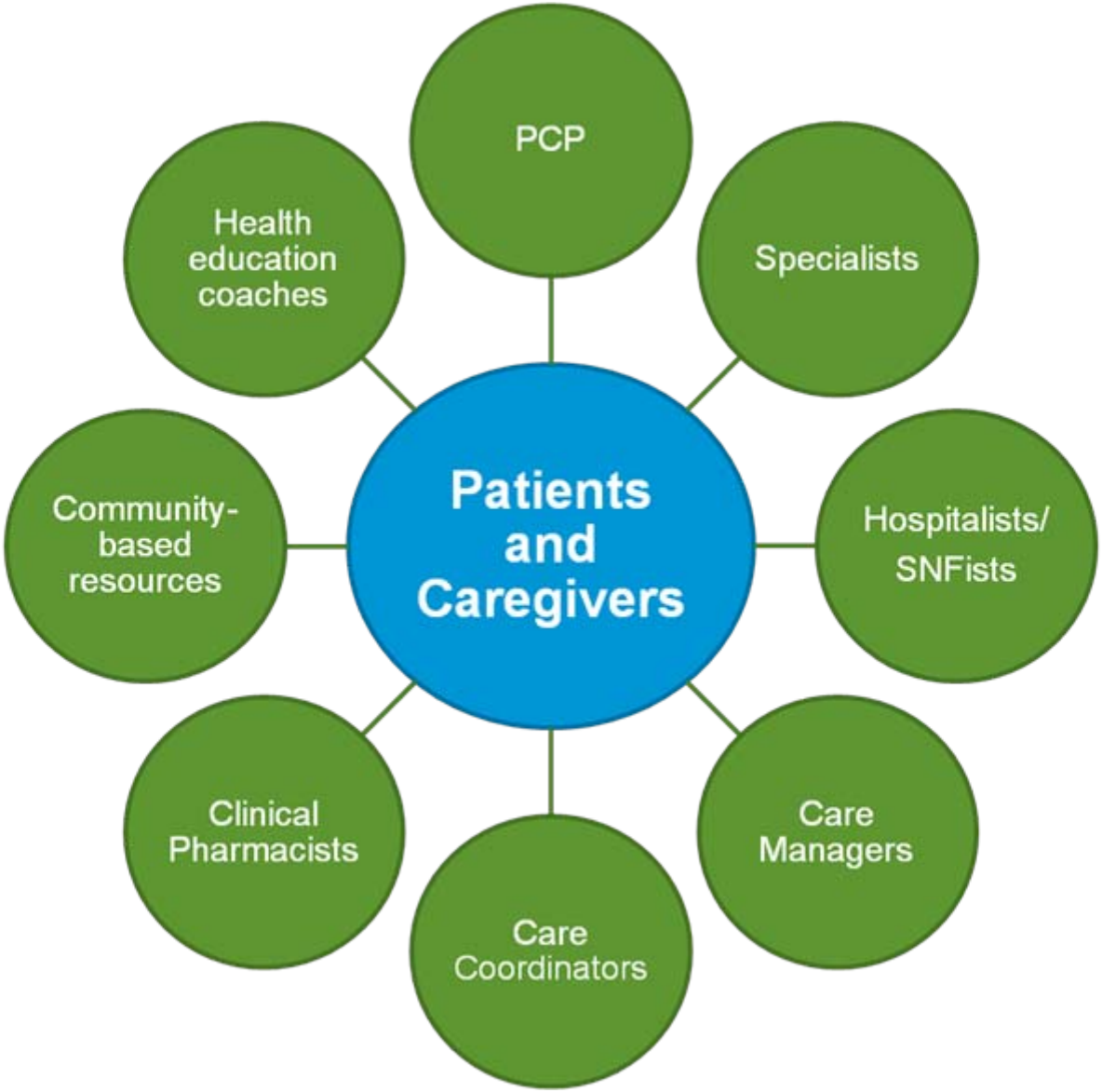
Care Models and Best Practices To Consider

- Patient-centered Medical Home
- Interdisciplinary Teams
- Palliative Care Program
- House Calls
- High-risk Clinics
- Readmissions Program
  - Post Discharge Clinics
  - Medication Reconciliation Program
- Hospitalists/SNFists
- Emergency Department Re-direction
- Urgent Care Centers
- Inpatient Care Management
- Ambulatory Care Management
- Utilization Management
- Disease Management
- End-Stage Renal Disease/Dialysis Program
- Social Work
- Pharmacy Management
- Out of Area Re-direction
- Transplant
- Patient Support Center
- Health Education
- ACO Liaisons

Program Development Considerations



The Interdisciplinary Care Team



Staffing Ratios

- Variables to consider include:
  - Patient population
  - Encounter frequency
  - Interventions
  - LOS in program
  - Location of services
  - Geography
  - Team composition
  - Technology support
  - Other resources

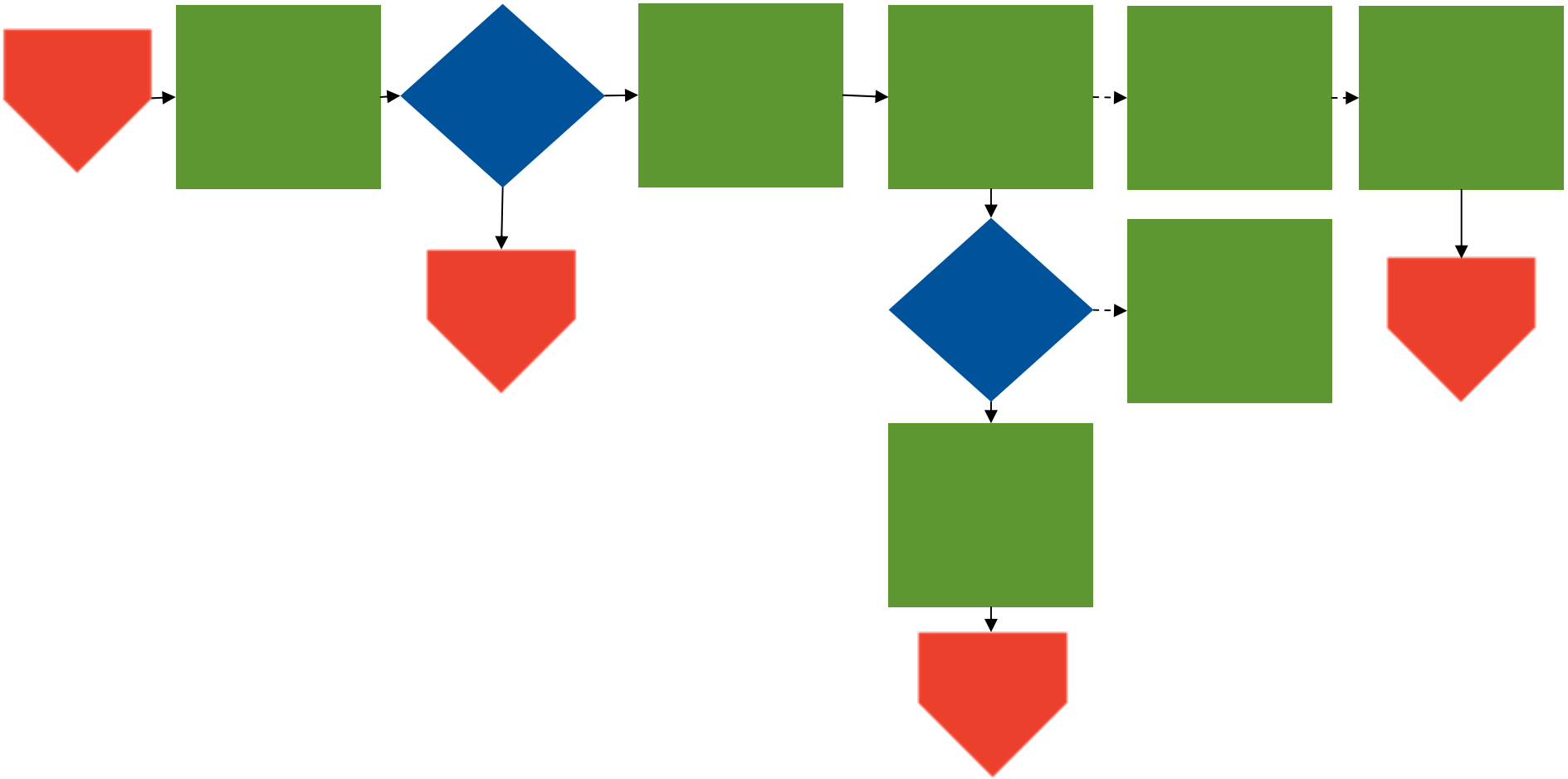
Benchmarks	
Ratios	**Population**
1 CM : Tier 3 Patients	5-10%
1 CM : Tier 2 Patients	15-20%
1 CC : Tier 1 Patients	70-80%
Staffing	**Panel Sizes**
Hospitalist	18-22
Primary Care Physician	1,500-2,500
Inpatient Care Manager	25-50
In-Home Care Manager	25-100
Telephonic Care Manager	100-250
Care Coordinator	250-500
Social Worker	50-150
Clinical Pharmacist	150-500

Clinical Workflow

Design, Document, and Communicate

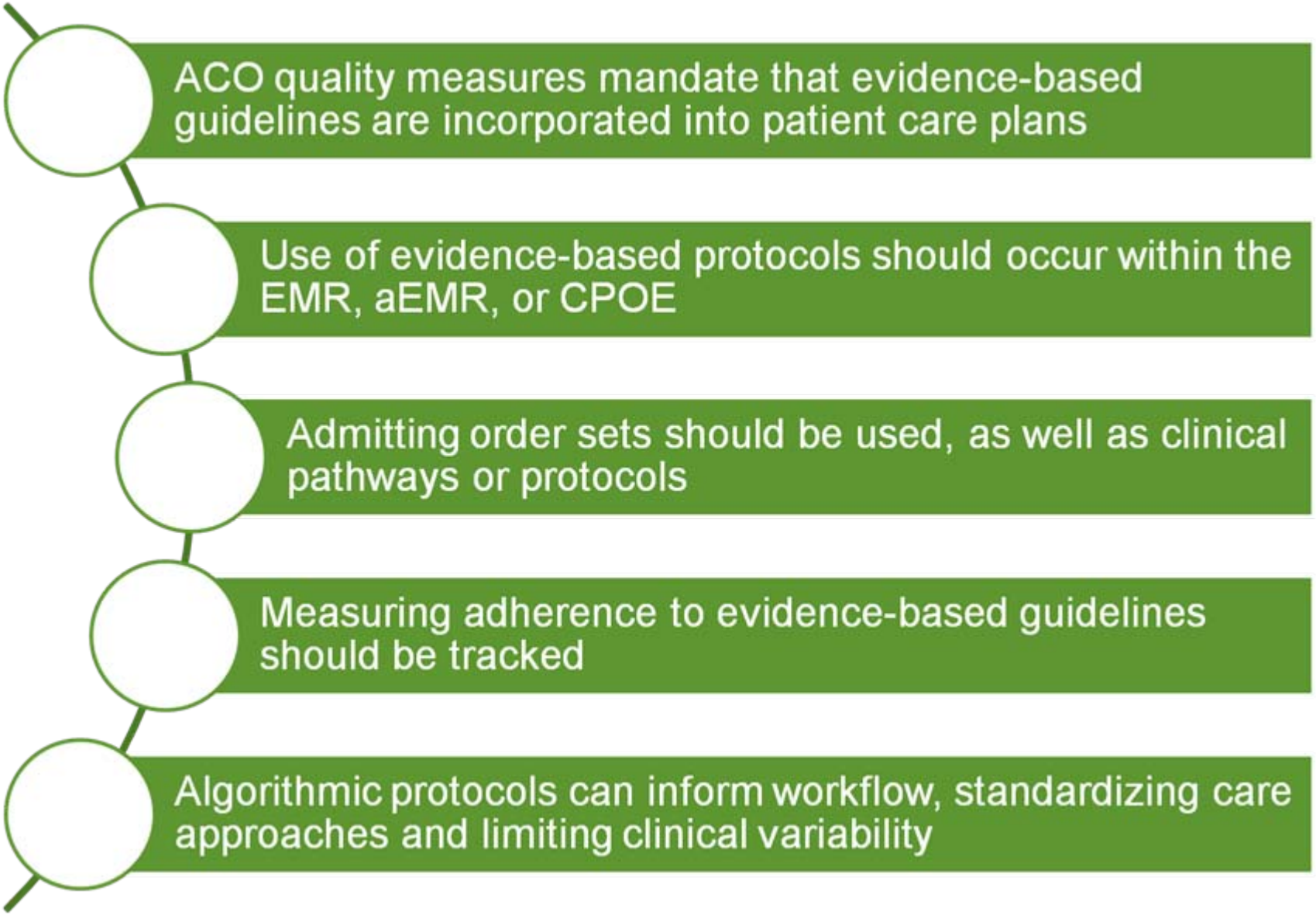
- Compose a workflow team with representation from every care team member
- Draw workflows outlining how a patient moves through the system. Processes might include:
  - Referral and enrollment
  - Escalation paths
  - Discharge and transition
- Address and outline:
  - Roles and responsibilities
  - Interventions and procedures
- Coordinate processes with all providers and care team members
- Share clinical information and communicate with entire care team
- Use technology systems to support workflows

Clinical Workflow



One Patient Care Plan

Evidence-Based Guidelines and Protocols



Care Management Technology

Risk Stratify

- Identify, analyze, and refer patients to the right intervention
- Incorporate clinical review and validation

Develop Workflow

Use algorithmic rules-based processes and technology to support consistent care

Assess

- Collect and store relevant, up-to-date patient information
- Ensure consistent documentation and central repository

Access Clinical Resources

Access electronic links and references for clinical decision support

Care Plan

Create and share patient goals, needs, action items using prompts and embedded protocols

Communicate

Share care plans electronically and collaborate with all providers

Follow Protocols

Follow evidence-based clinical guidelines embedded into technology to ensure quality care

Monitor

Report and analyze data, measure success, identify best practices, improve processes

Data sources include EMR, Care Management Tool, Utilization & Cost data from data warehouse and claims

Communication Plan

Internal Communication Plan
Staff and Providers

- Provide education on ACO, care model changes, new care team members, updated workflows, resources
- Anticipate questions ACO patients are going to ask
- Ensure staff and providers aware of all the programs offered along the continuum
- Create a process for staff and providers to refer patients to appropriate programs
- Encourage providers to collaborate
- Solicit feedback from providers

External Communication Plan
Patients, General Public, Network

- Consider designating ACO liaisons at clinic sites and facilities
- Develop a branding campaign, which might include an ACO hotline and website
- Align published patient materials with regulatory guidelines and distribute
- Establish relationships with key providers in the network

Community Resources and Services Across Continuum

- Develop and foster relationships with:
  - Sub-acute and long-term care skilled nursing facilities
  - Assisted living facilities/board and care
  - Ambulance services/EMS
  - Transportation services
  - Home health
  - Hospice care
  - Adult day care centers
  - Pharmacies
  - Other community-based services

Getting Started

Step by Step

Pilot Programs

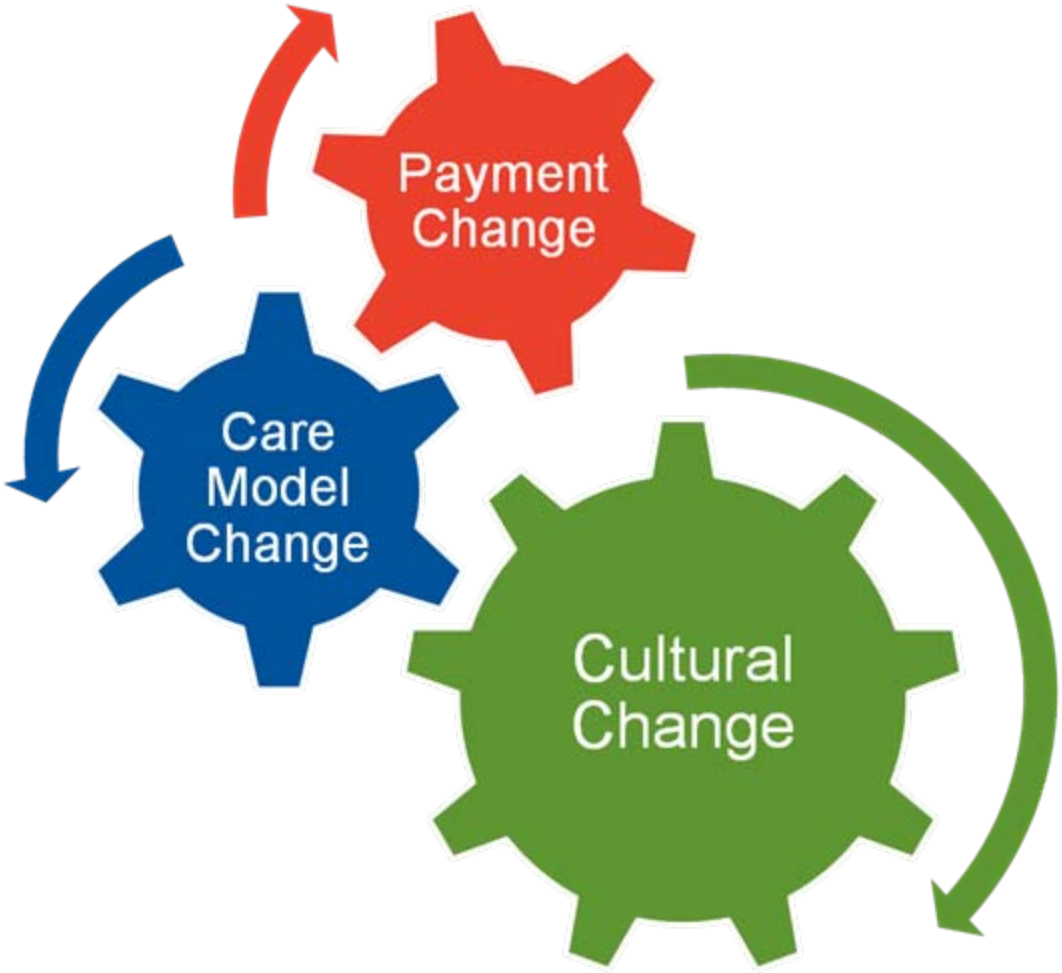
Develop a pilot with engagement from a few champion physicians and patients. The benefits include:

- Rapid testing
- Process development
- Relationship development
- Physician buy-in
- Understanding training needs
- Solicit feedback
- Understanding time, budget, resources needed at a larger scale
- Making an informed decision to expand

Source: California Quality Collaborative, "Complex Care Management Toolkit," April 2012

The Financial Realities of the ACO

Getting the Gears of Change Aligned



A Difficult Year One for MSSP and Pioneer ACOs

- Attribution: Who am I responsible for?
- Care Management: How do I best manage a non-HMO population?
- Reporting and Benchmarking: I have to cover my costs, so what benchmarks should I be using?
- Data Collecting: Is there something wrong with this information?
- CMMI Understaffed: Why can't I get a hold of anyone to help me?
- Looking Forward: What are we planning to do after Year 3?

System CFO : "I Have Concerns…"

- "Someone remind again why we are doing this?"
- "Although we are a health system, our hospitals still need patients."
- "What will the rating agencies say?"

Striking the Right Balance

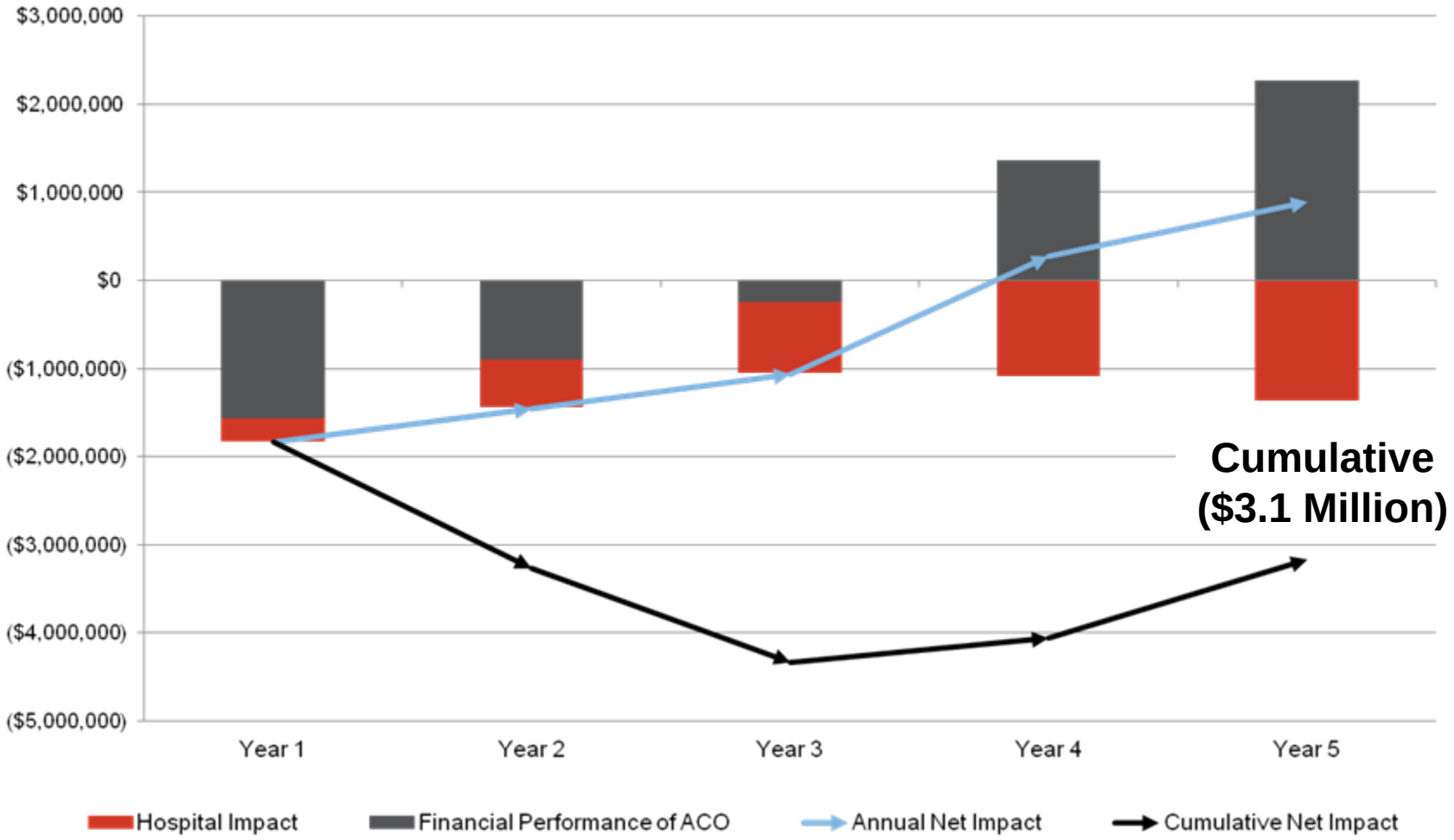
Health systems will have to find the appropriate balance between generating shared savings for the ACO and maintaining hospital financial performance.

The Financial Impact of ACOs: An Example

- Minimal ACO infrastructure needs
- Shared savings split with payers at 50 percent
  - Except employees
- Distributions of 45 percent of net savings to physicians
- Move from loosely managed to moderately managed for inpatient admissions

Financial Impact of ACOs: An Example

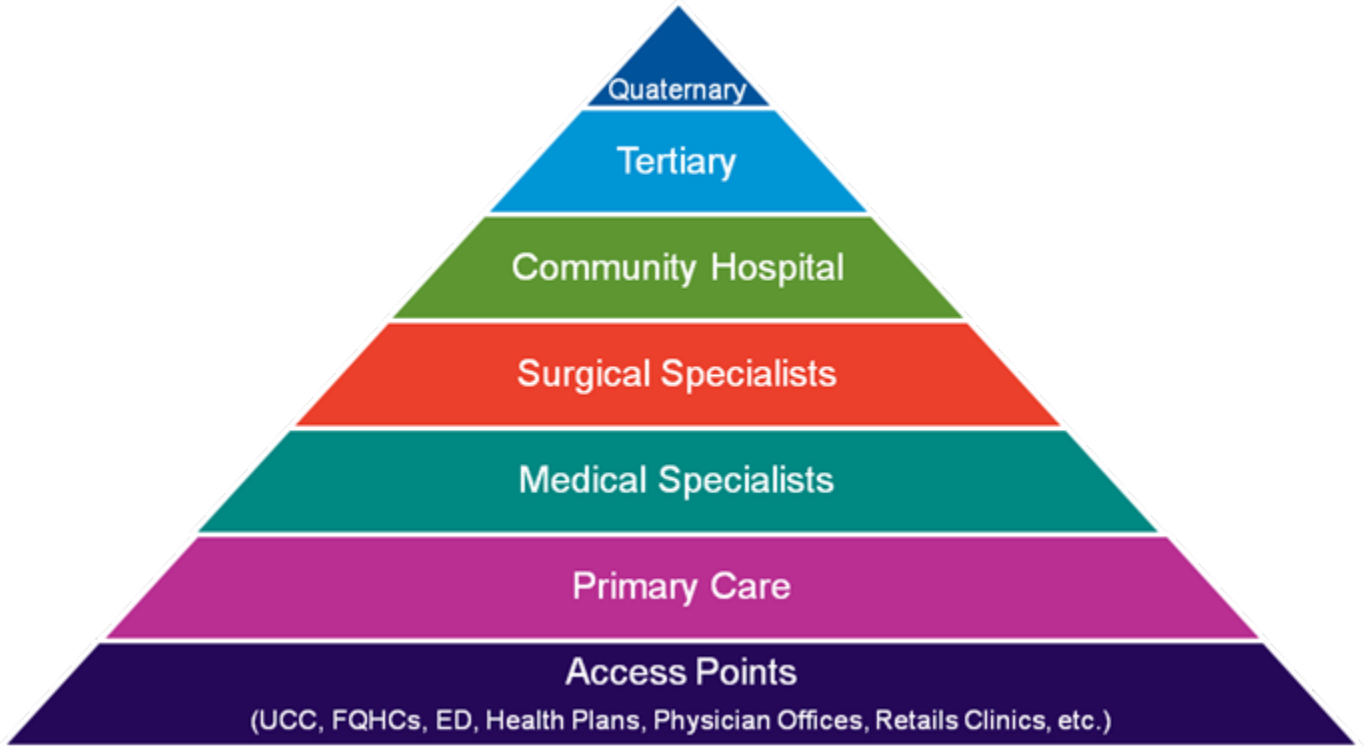
Lower utilization reduces the financial benefit of the ACO to the system.



Critical Success Factors in Transitioning

- Establish a clear payer strategy
- Achieve critical mass of members
  - Spread risk
  - Cover infrastructure costs
- Effectively manage care
  - Incentivize physicians engaged
  - Keep patients within the network
- Hospital reimbursement mechanisms that minimize the impact to hospitals
  - Per diems to case rates
- Increase hospital market share within the population
- Move beyond shared savings
  - Full risk

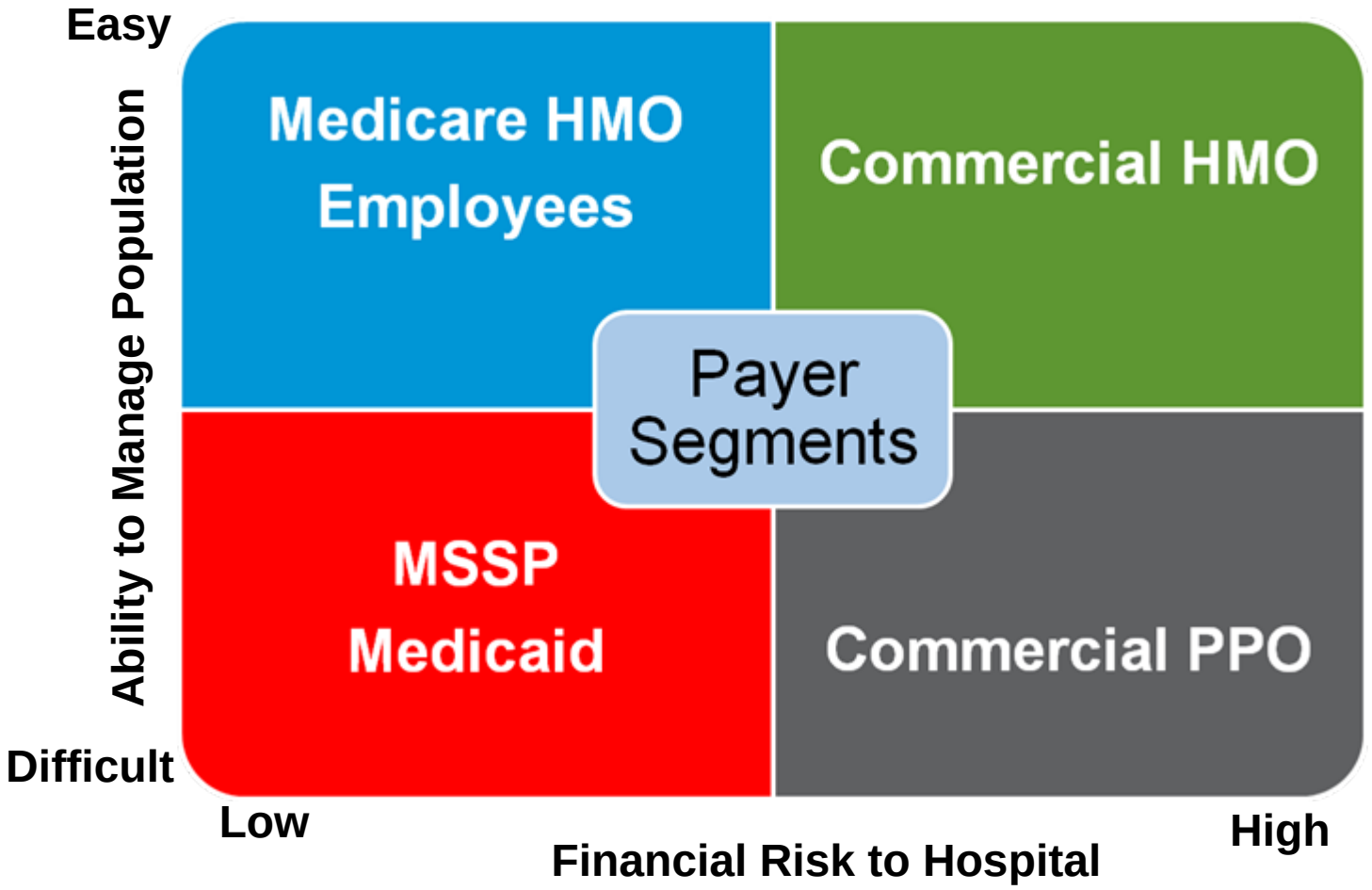
Paradigm for Success



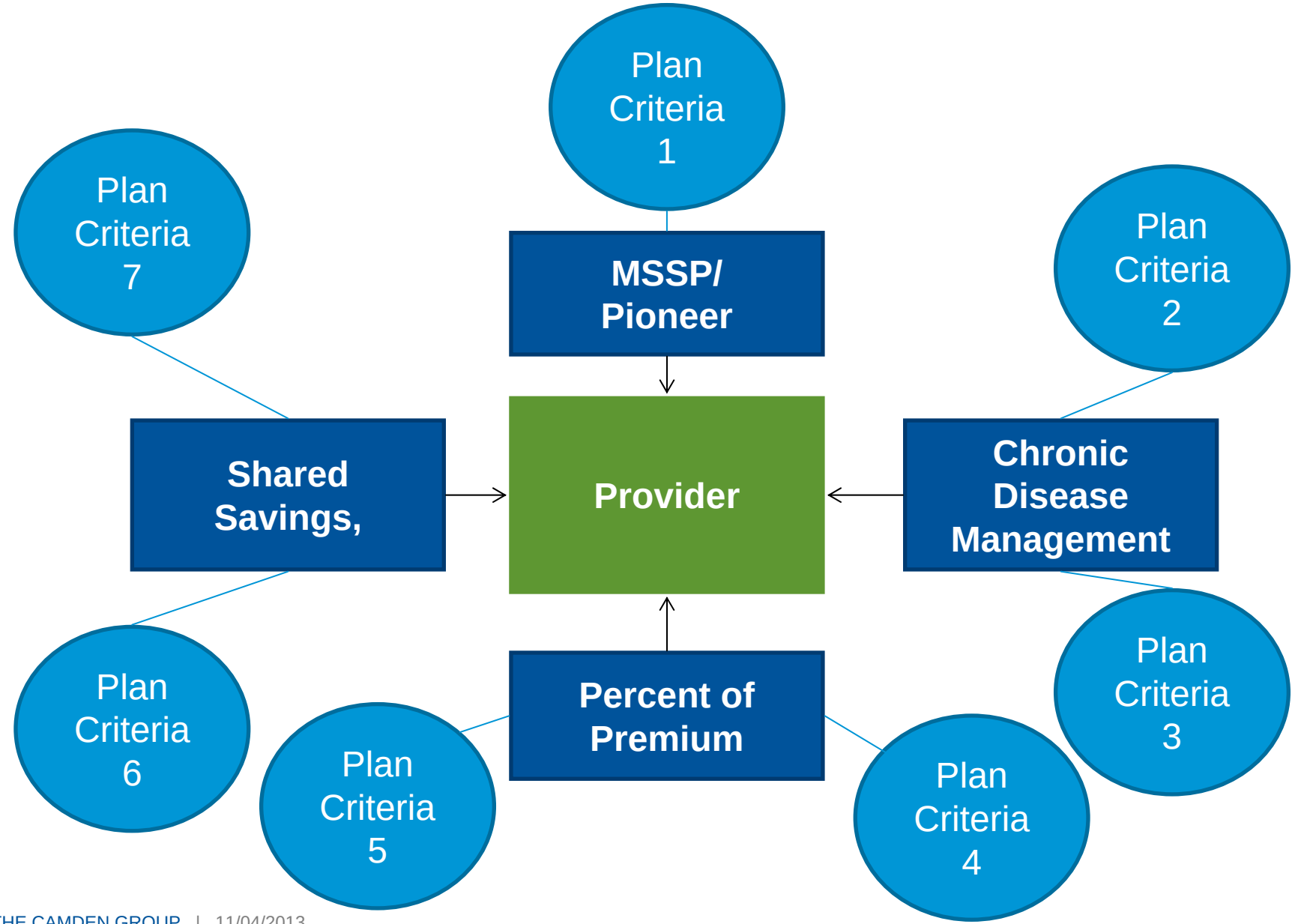
Commercial	CMS	Dual Eligibles	Medi-Cal
■ HMO ■ PPO ■ Direct to Employers ■ Covered California ■ Bundled Payment	■ Risk products ■ ACO-MSSP ■ Pioneer ACO ■ Medicare Advantage ■ Bundled Payment	■ HMO	■ HMO ■ Fee-for-service

Payer Strategy

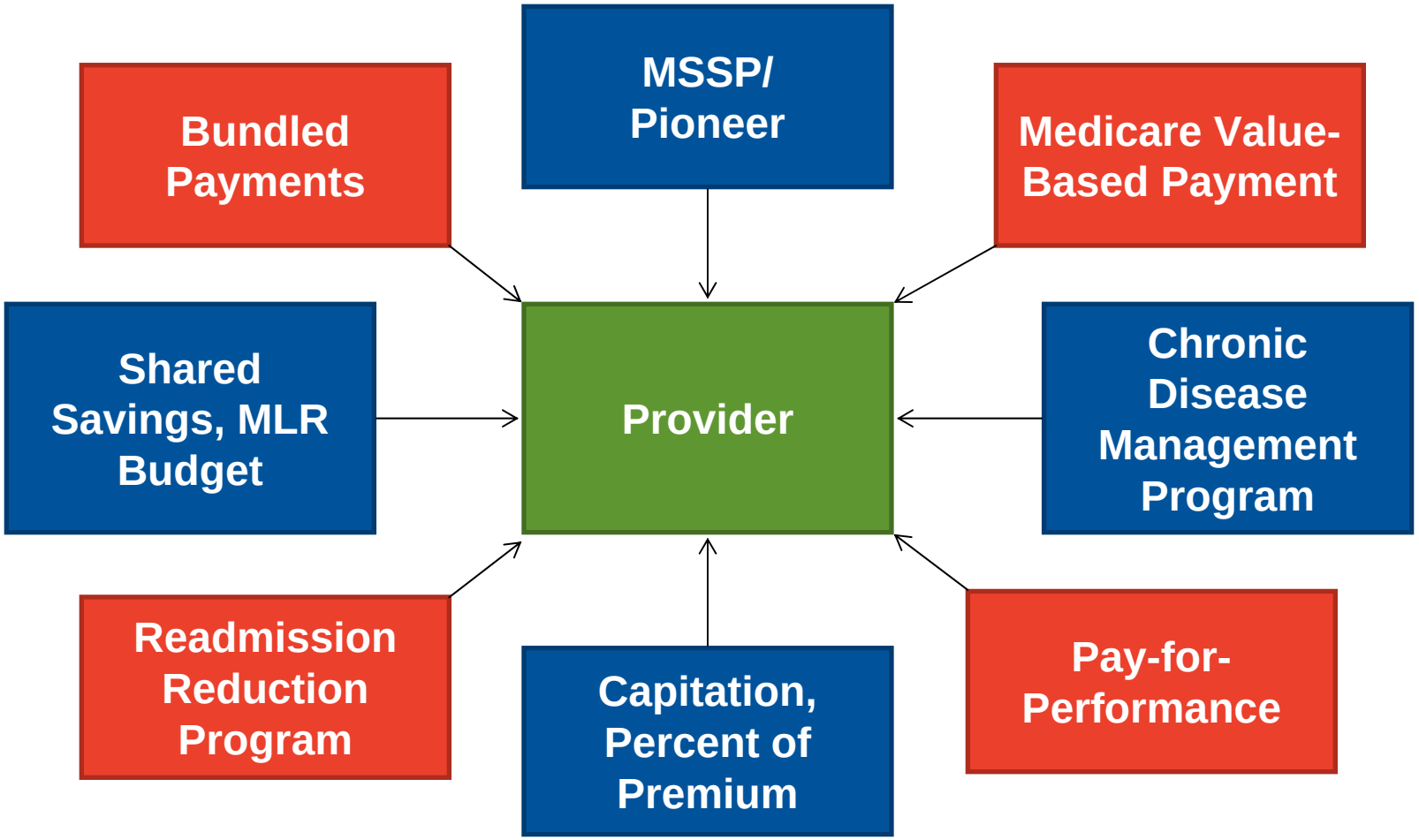
The following table evaluates key payer segment attributes when considering which payer segments should be in an ACO.



Payers Are Not on the Same Page



Other “Value” Programs Make it More Complicated

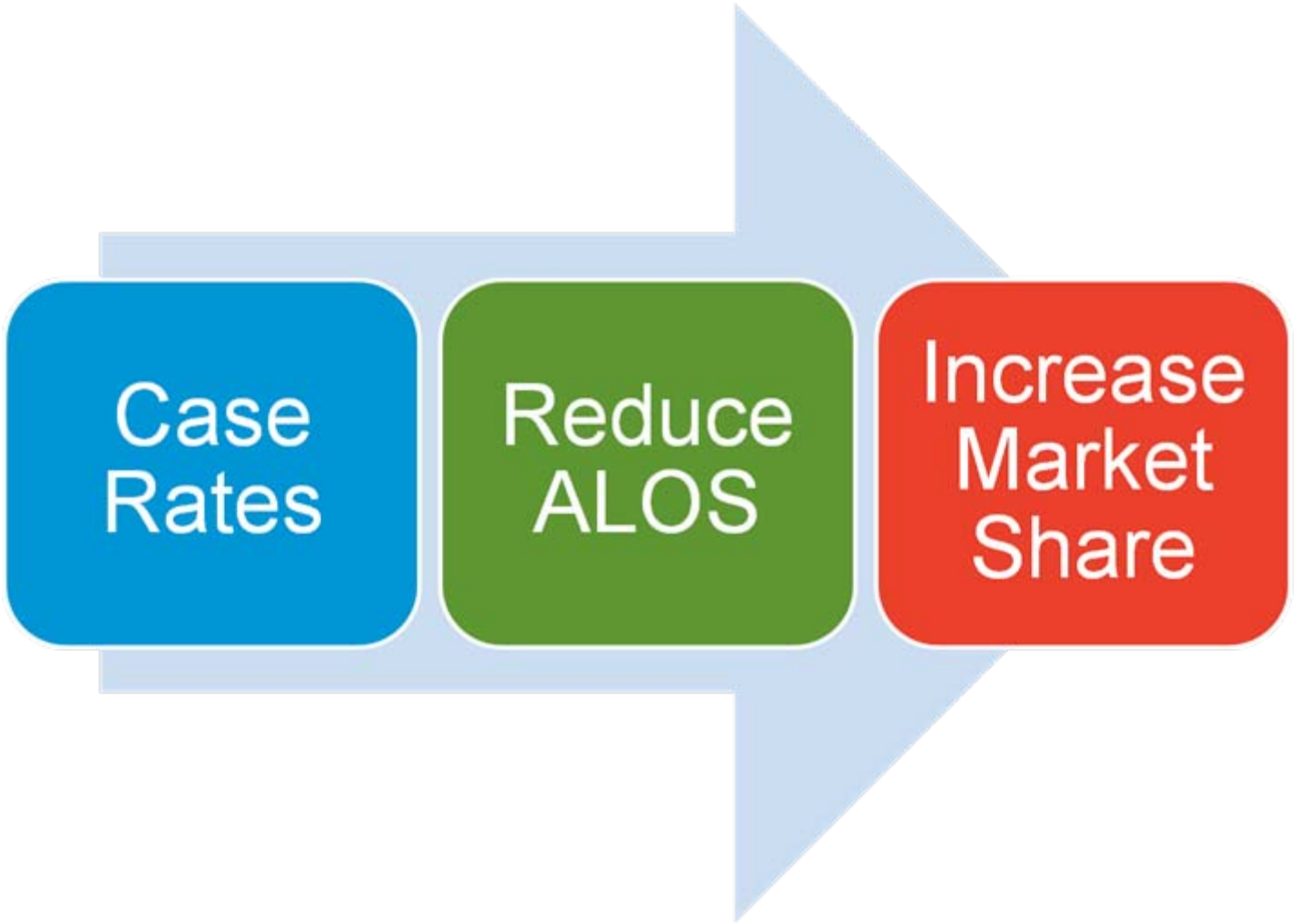


Establishing a Clear Payer Strategy

- Select payer segments that fit the system's risk profile.
  - Systems with limited experience managing risk should start with "no regret" populations such as their employees or Medicare.
- Lay out the timing of each payer segment.
- Limit the criteria variation between payers segments and programs.
  - Set a standard approach and quality criteria internally and negotiate the approach into managed care agreements.

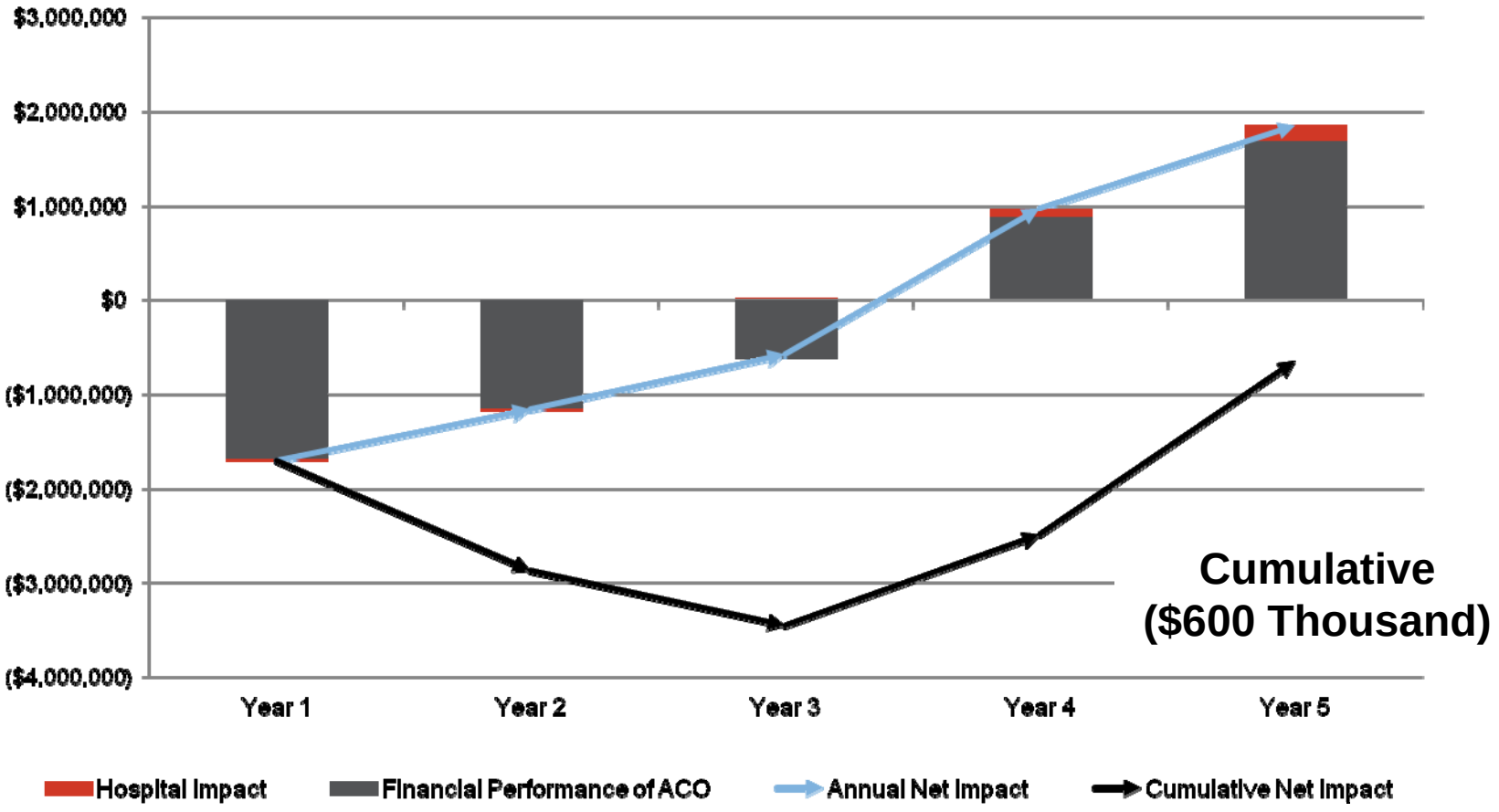
Minimizing the Impact to the Hospital

Systems should consider moving to episode based care with payers, maximize resource efficiency and market share.



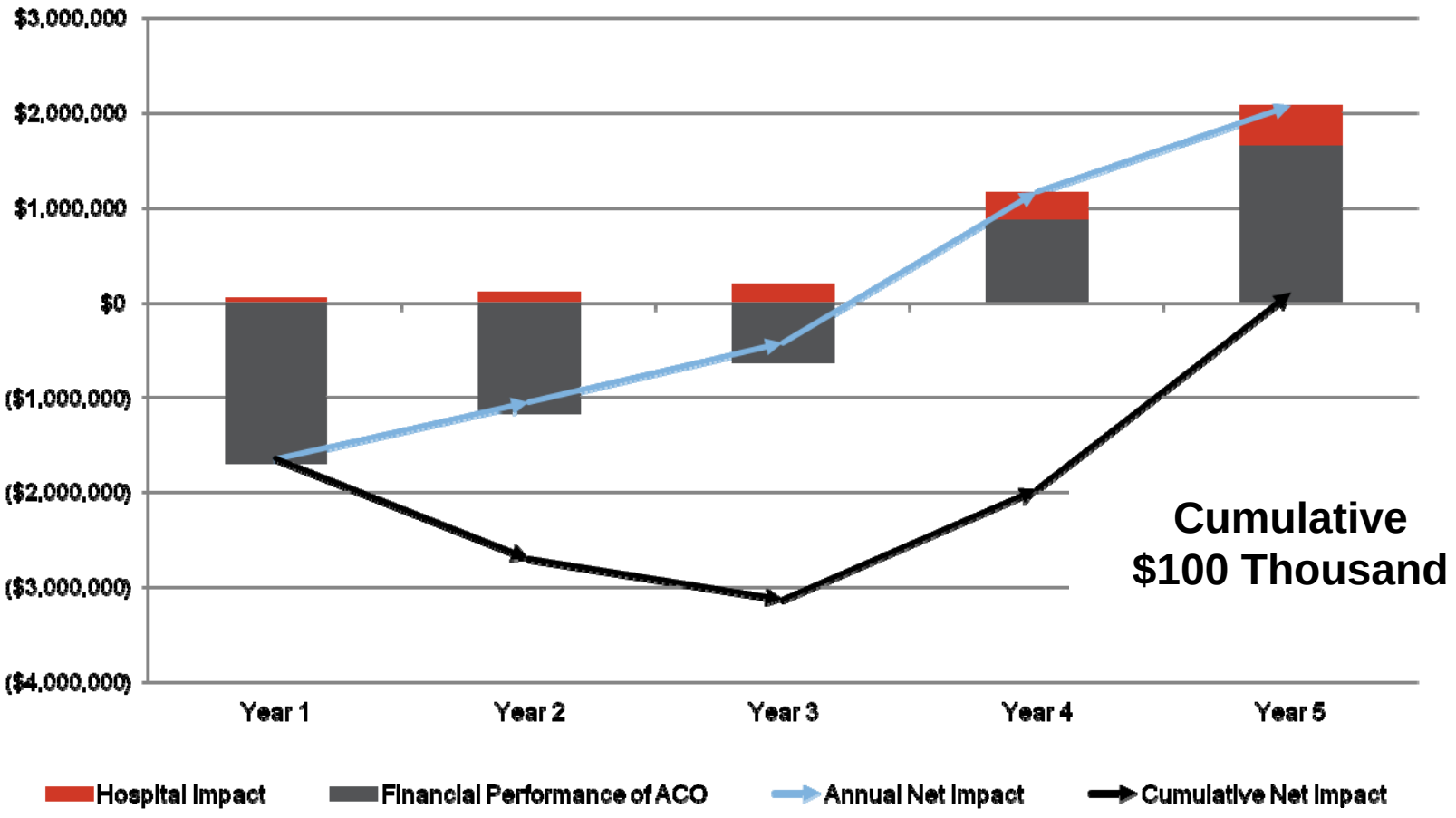
Move To Case Rates and Reduce ALOS: An Example

Move commercial to case rates and reduce ALOS by two percent annually for all ACO populations.



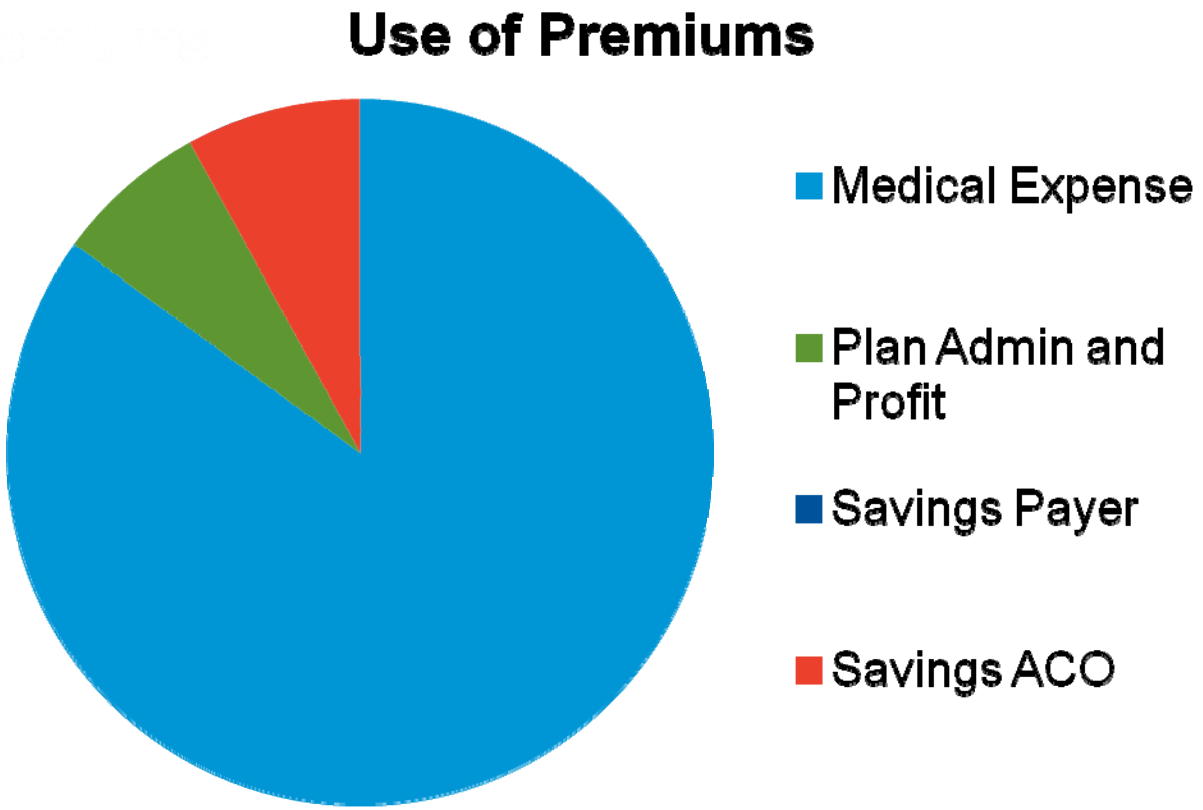
And Then Improve Market Share: An Example

Increase market share from 60.0 percent to 62.5 percent by Year 5 of the projections.



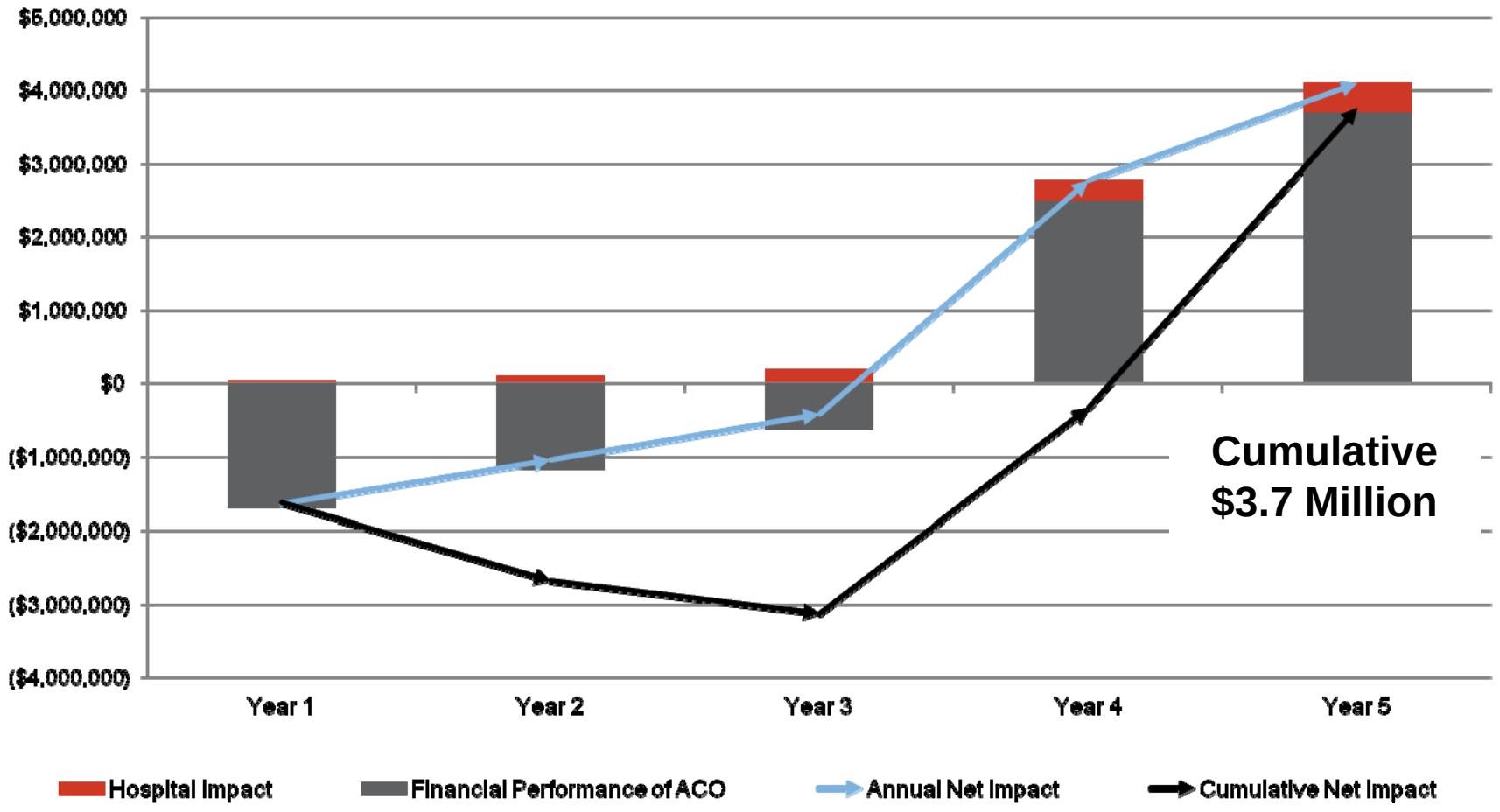
Full-risk As a Strategy

- When ready, access more of the premium dollar by moving full risk for select payers.
- Could also improve cash position.



Go Full Risk: Example

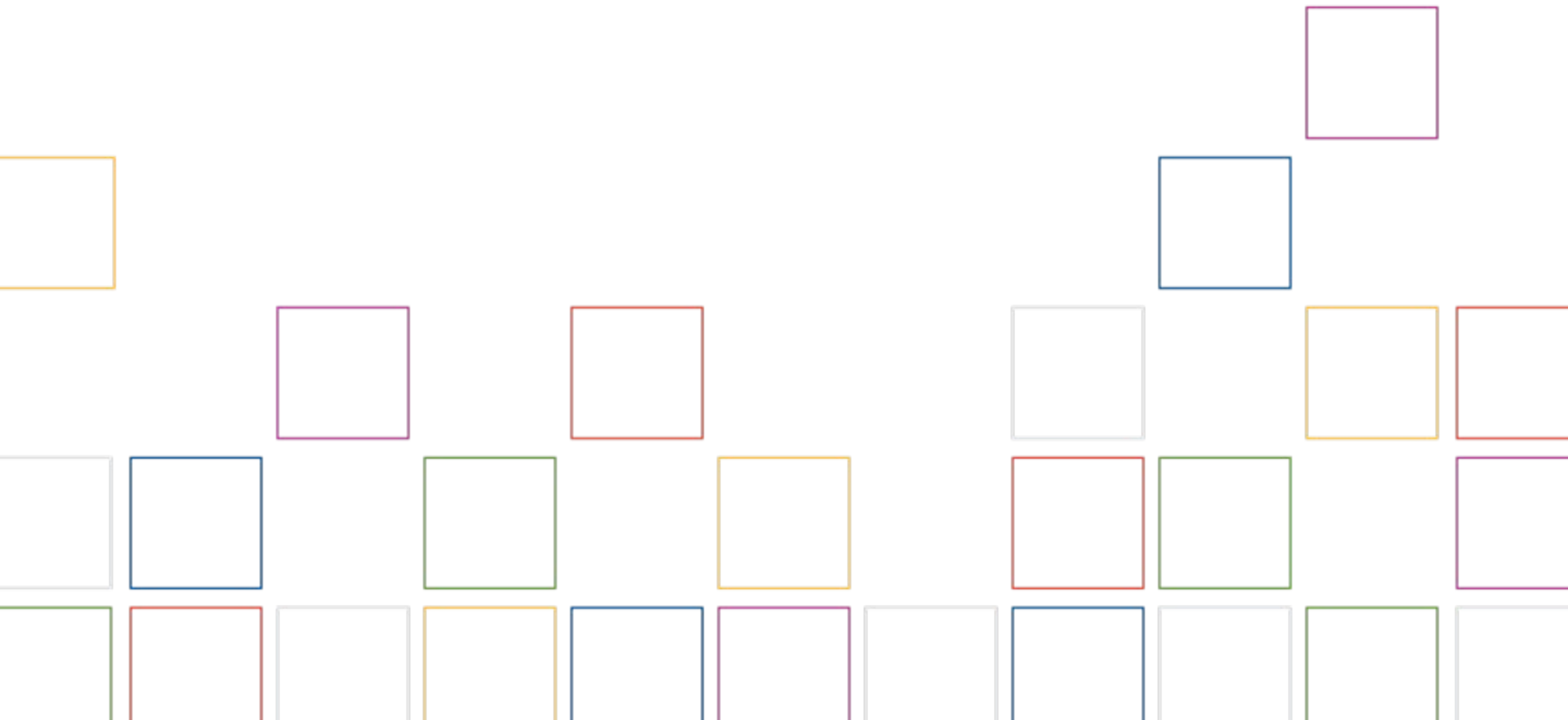
Enter full risk for Medicare HMO and commercial starting in Year 4:



Summary

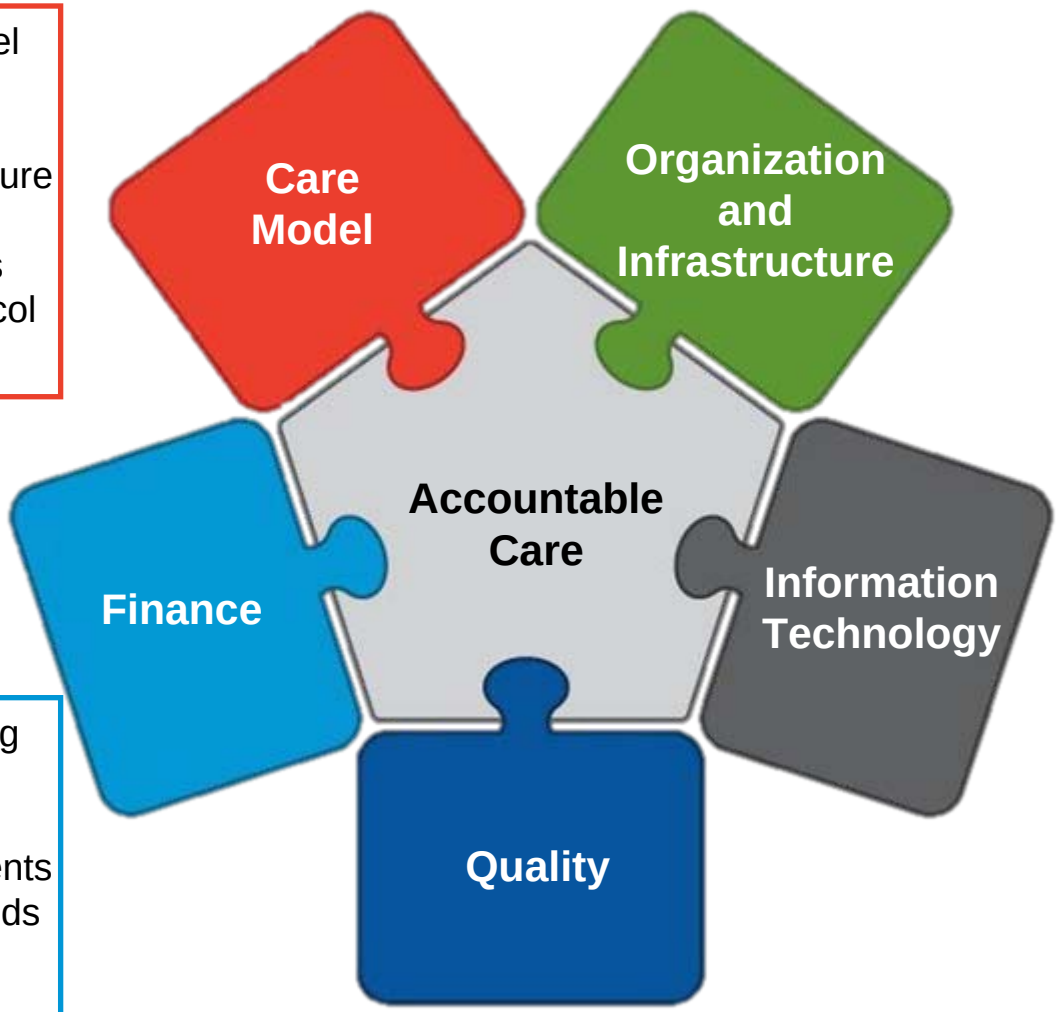
- The transition to population management should be built around a well thought out payer strategy.
- Start with low risk payer segments until the system is comfortable with the effectiveness of the care management capabilities.
- Systems and hospitals should consider moving to case rates (reimbursement) for commercial ACOs to minimize the impact of reduced utilization.
  - Reduce ALOS and maximize profitability per case.
- Increasing market share will also be critical.
- Full risk should be the end game.

Conclusion



Key Components

- Clinical care model spanning the full continuum of care
- Clinical infrastructure and leadership
- Clinical guidelines
- Process for protocol development



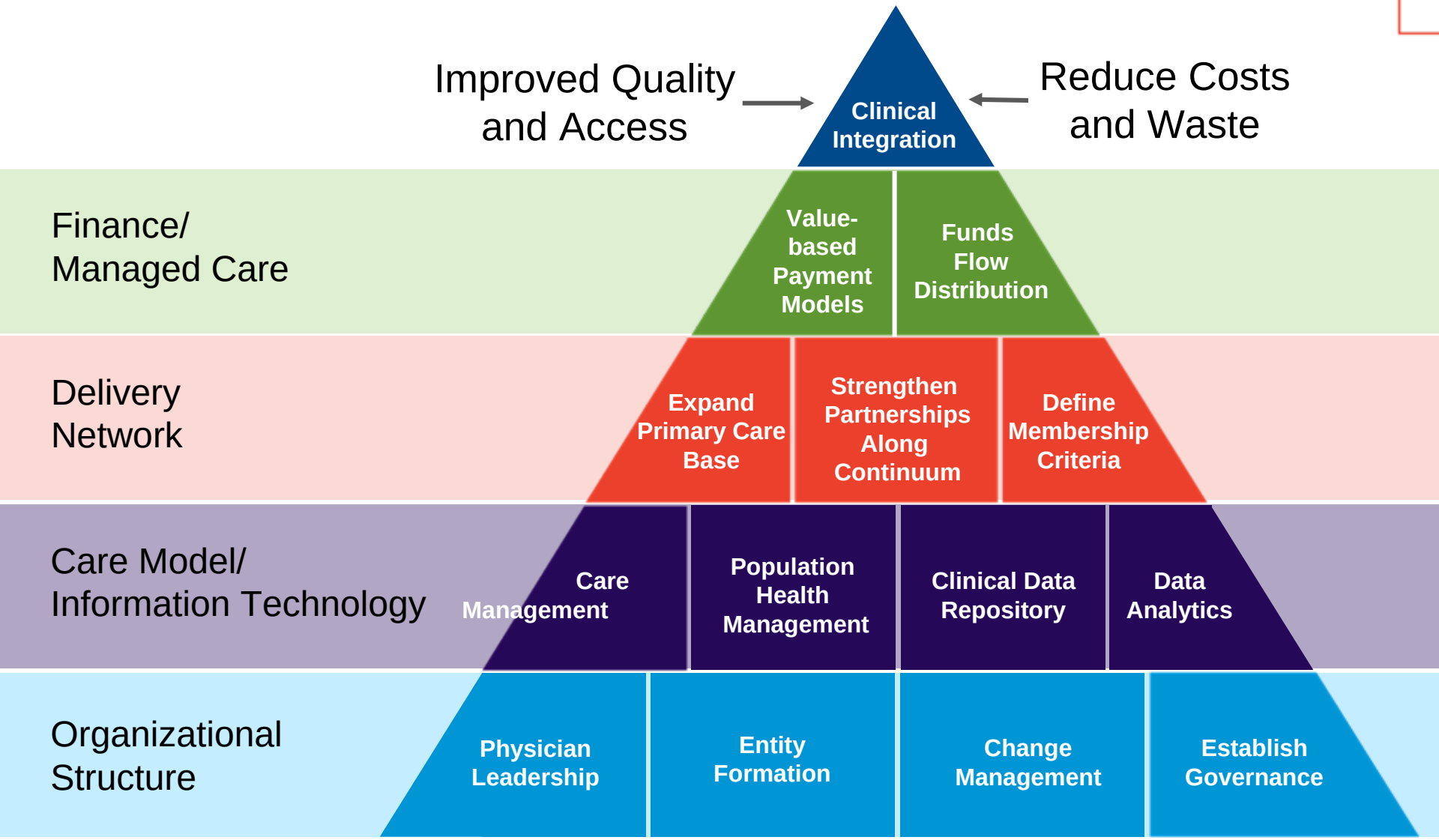
- Functional scope
- Ownership structure
- Leadership
- Decision-making
- Operational structure

- Financial operating model
- Resource and staffing requirements
- Capitalization needs

- IT infrastructure to connect key data sources across the continuum
- Centralized data repository
- Analytics capacity to report quality across the network

- Key operational performance metrics
- Clinical quality outcomes
- National standards, benchmarking

Clinical Integration Building Blocks



Top 10 Ways to Achieve ACO Success

10 Maintain focus

9 Adapt and embrace new ideas

8 Behave as though neither the hospital nor the physician is at the center – the patient is

7 Reward even minor successes

6 Invest in physician and other clinical leadership

5 Keep it simple

4 Recognize that technology is your friend, but it's not the answer to everything

3 Know thyself: find partners if you need them

2 Evaluate performance based on fact, not fantasy

1 Listen