Managing an ACO in a Primary Care Network

Jan Maisler, MSN

VP, Physician Performance Services

Renaissance Health Network

Medical Home Expert

Who We Are

- 250 internists and family physicians

- Managed over 100K lives for IBC for 12 years and now 30K Medicare lives as a Pioneer ACO

- Composed of all privately owned practices ranging in size from one to thirty doctors

What Our Model Is

Secondary Drivers

Develop and deploy method to collect risk data on all patients

Identify patients in long-term care settings

Identify patients with gaps in care and outcomes outside of clinical goal

Update clinical registry with CMS measures, logic, and support for P4P program

Develop data interfaces; educate practices on program requirements

Develop data streams for inpatient care notification

Hire staff for care coordination and panel management requirements of population

Deploy time-tested care coordination strategies and develop new ones based on the needs of this population

Primary Drivers

PCP identification of high risk patients

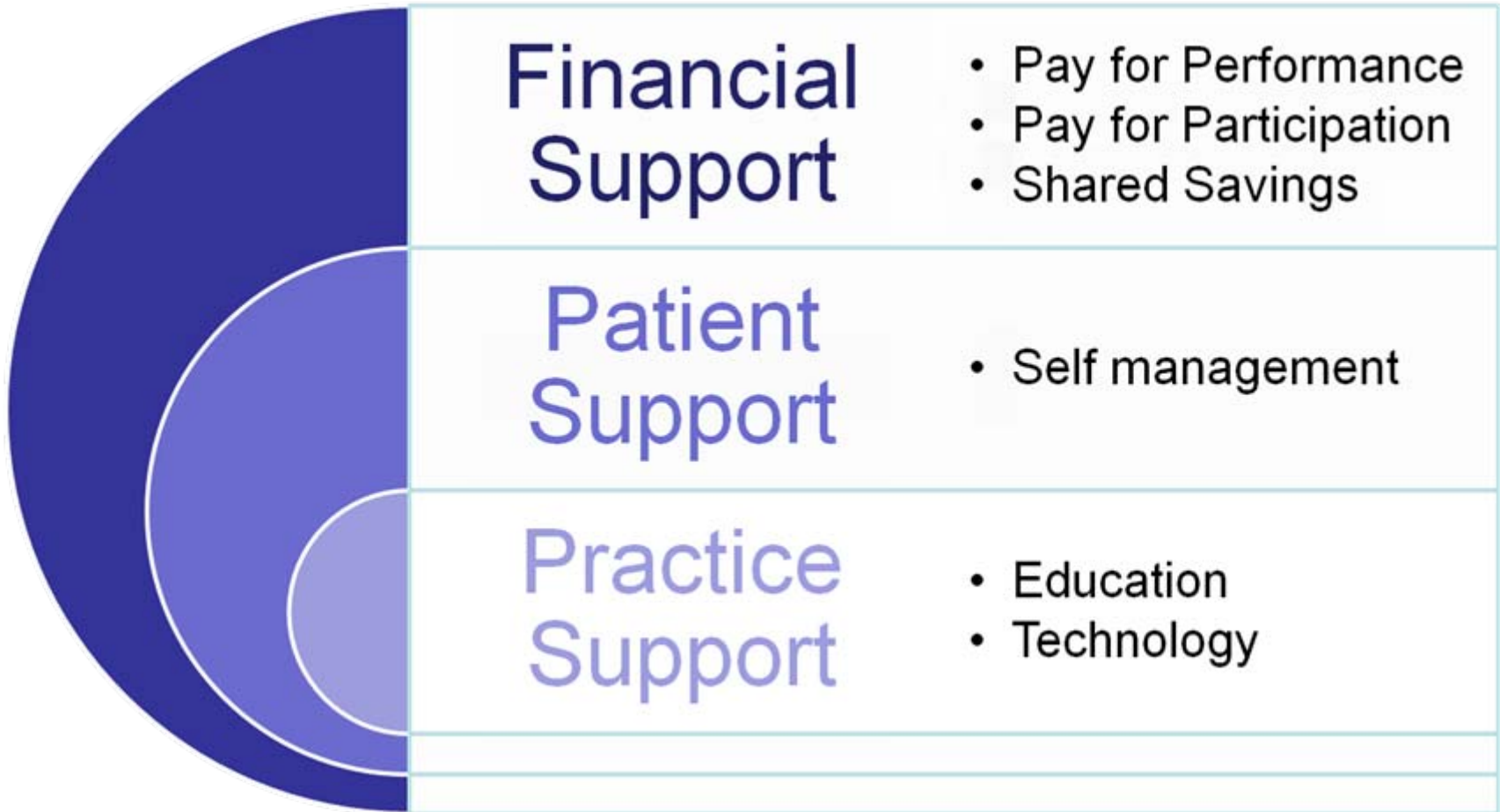P4P for PCPs to improve care of chronically ill patients

Telephonic mgmt of transitions, high risk, and chronically ill pts.

Aim and Outcome

1. Better outpatient management of chronically ill patients

2. Better care coordination across transitions

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How We Do It

Financial Support
- Pay for Performance
- Pay for Participation
- Shared Savings

Patient Support
- Self management

Practice Support
- Education
- Technology

What Our Doctors Have Learned

Tenets consistent with Medical Home

- Population Management
- QI processes
- Working in teams and using tools
- Result sharing
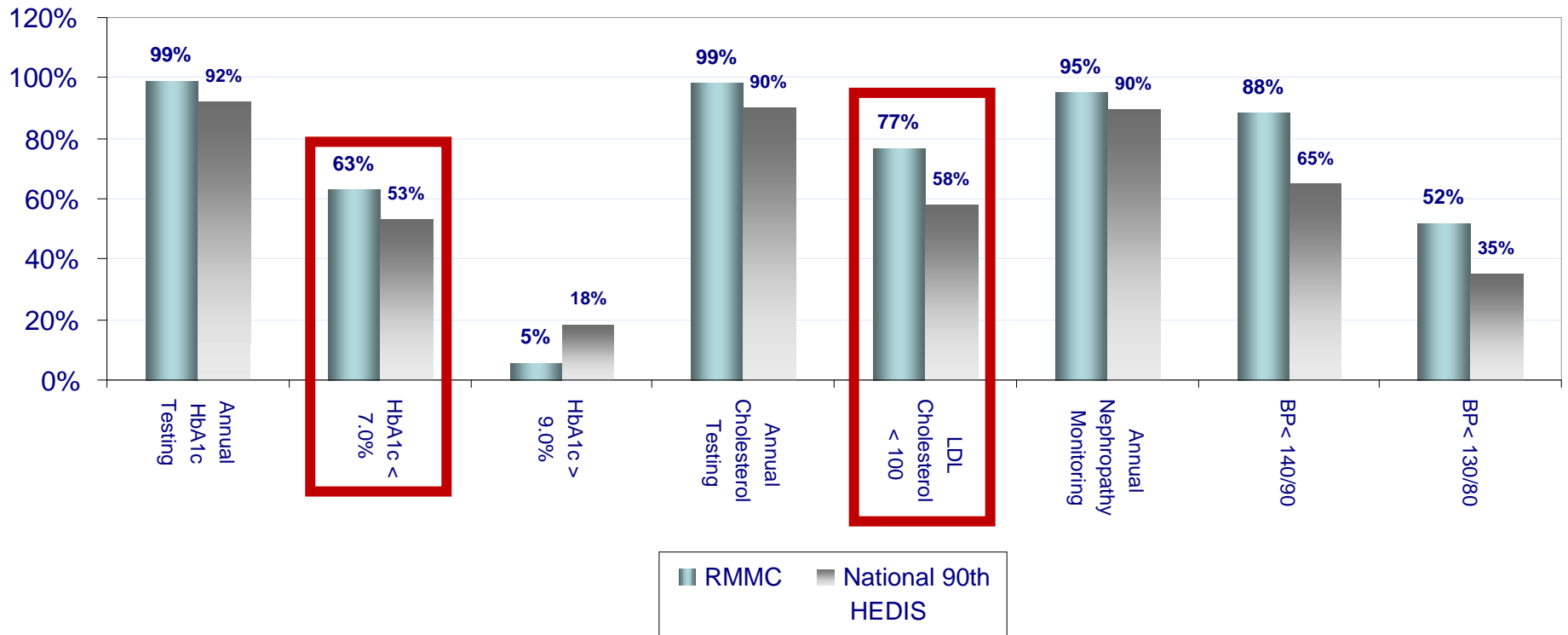- Helping patients change their health behaviors

What We've Demonstrated in Commercial Populations

- With proper incentive and support, doctors can change how they practice and engage fully in quality improvement and population management

- These changes can produce significant improvements in outcomes for patients with chronic illness

- These improvements can lead to lower overall costs

HMO DM Medicare

HMO Medicare Diabetes

Chart showing RMMC vs National 90th HEDIS percentages by measure:

Measure	RMMC	National 90th HEDIS
Annual HbA1c Testing	99%	92%
HbA1c < 7.0%	63%	53%
HbA1c > 9.0%	5%	18%
Annual Cholesterol Testing	99%	90%
LDL Cholesterol < 100	77%	58%
Annual Nephropathy Monitoring	95%	90%
BP< 140/90	88%	65%
BP< 130/80	52%	35%

Legend: RMMC, National 90th HEDIS

Renaissance Medical Management Company Results

Line of Business	2006	2007	2008	2009	2010	2011	Cumulative
Comm. Non-POS	$5,881,918	$5,237,061	$4,990,848	$6,994,637	$2,543,505	$3,867,355	$29,515,324
Comm. POS	$3,193,915	$3,567,663	$1,347,169	$1,424,996	$2,496,039	3,220,075	$15,249,857
Medicare MAPD	$3,551,194	$1,572,367	$4,463,047	$8,068,123	$4,308,051	3,230,633	$25,193,415
Dual- Eligible	($1,008,490)	($245,661)	($1,168,432)	$256,731	$ N/A	$ N/A	($2,165,852)
Total Gain	$11,618,537	$10,131,430	$9,632,632	$16,744,487	$9,347,595	$10,318,063	$67,792,744

RHN
Pioneer ACO Experience

Why We Applied for Pioneer

- Leverage our learnings
- Remain on the front line of new care delivery systems and new reimbursement methodologies
- Benefit our patients and hopefully help our health care system learn and improve
- Organizational benefits

Achieving ACO Success

Ingredients for Success	
• Need to be Patient-centric and provide an excellent experience	**Among others, these are critical success factors**
• Ability to provide excellent care for populations	
• Engaged, aligned, incented physicians	
• Data and data management	
• Leadership and support	
• Programs to help manage the cost of care	

Managing the Costs of Care by Situation

- Hospital care
- Managing chronic illness; health coaching
- Prevention
- Care coordination and management of transitions of care
- End of life care
- Long term care and home care

ACO Programmatic Focus

Right Patient:	**Right Focus:**	**Leadership and Support:**
Predictive Model, Transitional Care, Health Coaching	High-value chronic conditions, Preventive measures	Education, Process improvement, Data

Addressing the Hospital Challenge

- Cornerstone Program: Transitional Care to newly discharged patients to help avoid preventable re-admissions

- Program driven by daily census reports

- 10 Hospitals accounted for 70% of our admissions over past 3 years

- Outreach for collaboration

- Take what we get; Go with what we have

Predictive Modeling

First Rule of Predictive Modeling

"All models are wrong, but some are useful."
George Box

Predictive Models are tools. For them to be useful, they must be:

- Made of the right materials.

- Made well and be tested for functionality.

- Used with the proper functions in mind.

Risk Stratification

HEALTHWAYS   ACO

Home > Patient Data Entry

Patient List

[Activate Filter] [Print]

Patient Name	DOB	LOB	Patient Status	Cohorts	At Goal	Not at Goal	Incomplete
Angelos, Marian	01/30/1924	ACO	Not at Goal	ABA, CBP, CHF, DEP, HTN	CBP, CHF, DEP, HTN	ABA	
Balle, Ann	05/11/1934	ACO	Not at Goal	CAD, CDC, IVD, MAM	MAM	CAD, CDC, IVD	
Broderick, Mary	12/27/1928	ACO	Incomplete	FR, HTN, IMI, IMP	IMI, IMP	HTN	FR
Bugenhagen, Helen	10/18/1920	ACO	Not at Goal	CBP, CDC, CHF, CRC, DEP	CHF, CRC, DEP	CBP, CDC	
Crane, Karen	07/18/1952	ACO	At Goal	CDC, HTN, IVD, TSC	CDC, HTN, IVD, TSC		
Drake, Lois	06/23/1932	ACO	At Goal	ABA, CHF, DEP, TSC	ABA, CHF, DEP, TSC		
Endy, Yolanda	05/12/1919	ACO	Incomplete	ABA, CHF, DEP, FR, HTN, MAM	CHF, FR, HTN, MAM	ABA	DEP
Greenberg, Gerardett	11/26/1955	ACO	Incomplete	CBP, CDC, CHF, DEP, HTN	CHF	CBP, CDC, HTN	DEP
Gruver, Rose	03/18/1934	ACO	At Goal	ABA, CHF, FR, TSC	ABA, CHF, FR, TSC		
Hagner, Marybelle	01/15/1926	ACO	At Goal	ABA, CAD, CBP, CDC*, CHF, FR	ABA, CAD, CBP, CHF, FR		
Kiefer, Jonathan	10/01/1931	ACO	At Goal	CAD, IVD	CAD, IVD		
Lawson, M Anita	01/28/1926	ACO	Incomplete	CBP, CDC, CHF, IVD, MAM	CBP, CHF, MAM		CDC, IVD
Lorie, Agnes	02/08/1920	ACO	Incomplete	CDC, CHF, CRC, DEP, FR	DEP, FR		CDC, CHF, CRC
Mckeehen, Elizabeth	09/19/1934	ACO	Incomplete	ABA, CBP, CDC, DEP, FR, MAM, TSC	ABA	CBP	CDC, DEP, FR, MAM, TSC
Napolitano, Marilyn	11/06/1946	ACO	Incomplete	CAD, CDC, CHF, CRC	CAD, CHF		CDC, CRC

* Patient has one or more exclusions for these cohorts.

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Did our Tools Support Us?

Definite Quality and Patient-Centric Focus

- Early targeting for patient outreach

- Collection of ~70% of data ahead of requirement to support

- Focus on important clinical outcomes

Lessons Learned

- Patience is a virtue

- Some learnings transfer; others don't

- Control what is within your reach, but extend your reach

- Don't expect others to share your enthusiasm or cooperate altruistically

- Pick your partners carefully

Thank you