FIFTH NATIONAL MEDICAL HOME SUMMIT
MINI-SUMMIT V

The Medical Home: Road to an ACO

A Medicare Shared Savings ACO Model

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About Carilion Clinic

- Profile
- Education and Research
- Medical Homes
- P4P Programs

Profile

Carilion Clinic is a multi-specialty group of 600 physicians located in Roanoke, VA. It serves one million residents in southwest Virginia and southern West Virginia. Over 11,000 employees staff 160 facilities, including eight not-for-profit hospitals. Annual revenue is $1.3 billion.

Carilion Roanoke Memorial Hospital

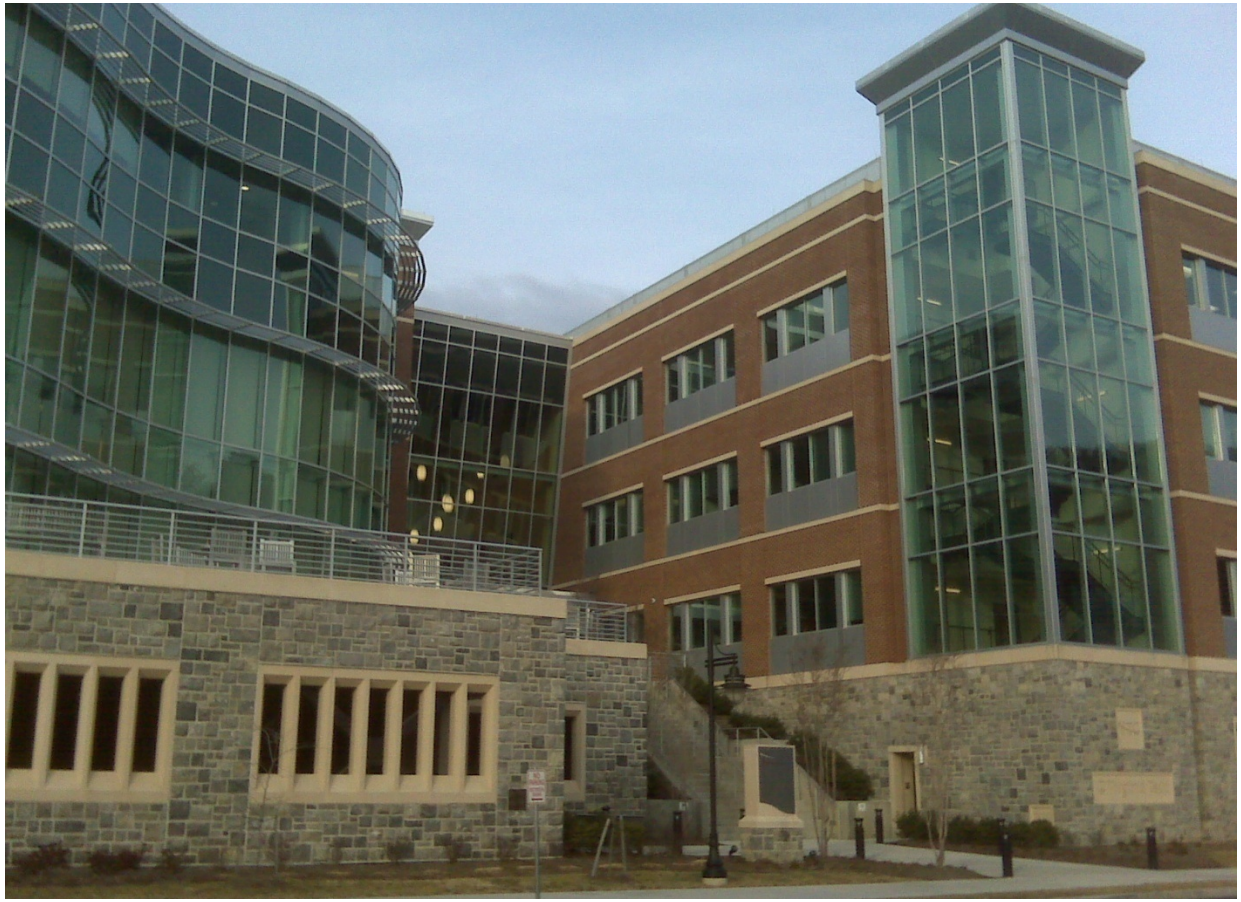
Education and Research

Virginia Tech Carilion School of Medicine

Jefferson College of Health Sciences

Offers 14 residency and fellowship programs

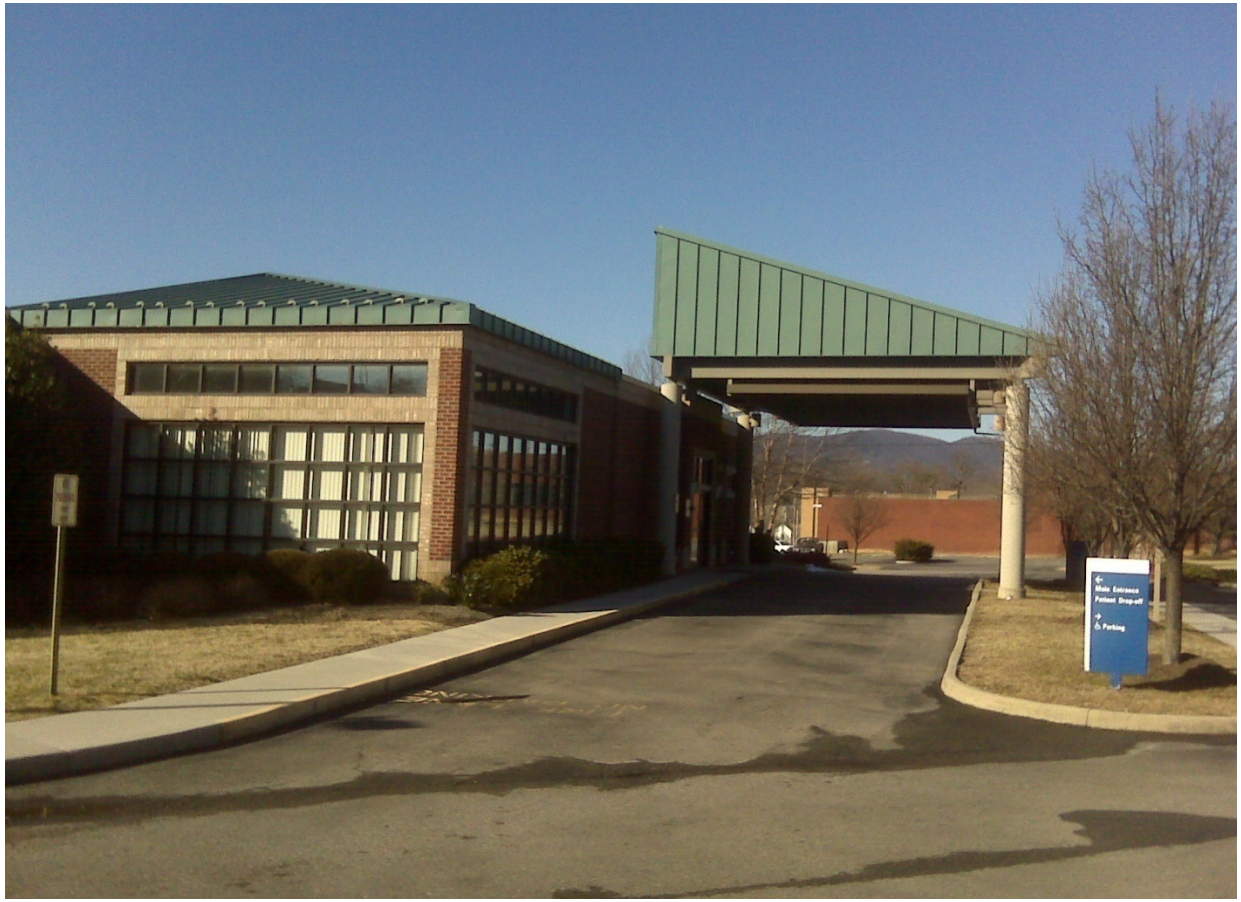
Virginia Tech Carilion Research Institute



Virginia Tech Carilion School of Medicine

Medical Homes

In 2009, Vinton Parkway Physicians became the first NCQA Level 3 site in Virginia. Carilion Clinic's Department of Family and Community Medicine currently has 27 recognized medical homes staffed by 141 providers and 24 care coordinators managing 185,000 patients.



Vinton Parkway Physicians

P4P Programs

2012
CMS Medicare Shared Savings Program ACO

2013
Anthem PC2 value-based reimbursement program

Additional P4P agreements with Aetna, UnitedHealthcare and Optima Health

Carilion Clinic Riverside

Carilion Clinic
Medicare Shared Savings Program
ACO

- Chronology
- Requirements
- Attributes

Chronology

The Carilion Clinic Medicare Shared Savings Company, doing business as Doctors Connected, is the end product of a six-year evolution in Carilion's organization, primary care delivery, and health information technology.

2006 Formation of physician-led clinic
2008 PCMH adopted as primary care model
2009 Brookings-Dartmouth ACO Learning Network; Vinton practice receives first NCQA Level 3 recognition in Virginia; Epic EMR introduced in primary care
2010 Five family medicine practices are recognized
2011 Carilion and Aetna launch ACO; four family medicine and one internal medicine site are recognized
2012 Carilion forms Doctors Connected ACO; CMS approves Carilion Clinic as a Medicare Shared Savings Program ACO;11 family medicine, three internal medicine and two pediatric clinics are recognized
2013 Anthem selects Carilion for participation in PC2 value-based reimbursement program; 15 practices begin transition to medical home model

Requirements

On November 2, 2011, CMS fulfilled provisions of the Affordable Care Act and published the final rule for the Medicare Shared Savings Program in the Federal Register (42 CFR Part 425). A brief summary of the188-page rule appears to the right.

- Participation is voluntary
- Incentive system based on population management, cost reduction, and fulfillment of 33 quality measures
- Focus on primary care groups, but includes integrated health systems like Carilion Clinic
- Two program options associated with risk assumption
- Performance benchmarks based on annual updates
- Retrospective attribution of beneficiaries
- Patients retain right to select their PCP
- Relief from antitrust prohibitions granted in expedited reviews

ACO Attributes

The Board of Directors and physician leaders of Doctors Connected are formally committed to nine pillars of care delivery in the ACO. These elements will provide Carilion's 50,000 beneficiaries with comprehensive, coordinated, continuous patient-centered care and lead to the realization of shared savings.

- Physician management
- Clinical integration
- Medical home model of care
- Enterprise Data Warehouse (EDW)
- Beneficiary Forums and Hotline
- Disease Registries
- Care Transition Management
- MyChart Online Portal
- Partnerships with commercial insurers

How Adoption of the Medical Home Prepared Carilion for Payment Reform

- Office Culture
- Electronic Medical Record
- Population Management
- Clinical Practice
- Continuous Improvement
- Patient Experience

Office Culture

We have combined medical home principles with lean concepts to create a more efficient and effective model of primary care.

The transition to the medical home encouraged us to…

- Enhance the level of staff engagement
- Align responsibilities with skills
- Standardize and balance work
- Provide adequate resources
- Create a collegial office environment
- Accept continuous change as a component of achievement

Electronic Medical Record

HIT has provided the backbone required to fulfill P4P requirements and ACO design intent.

Leveraging the EMR in conjunction with medical home implementation allowed us to…

- Facilitate a team approach to care
- Provide clinical support at the point-of-care
- Manage discrete populations
- Mitigate documentation frustration
- Promote higher coding
- Use common datasets for measurement and improvement

Population Management

We identify vulnerable, high-risk patients–and candidates for in-patient readmission–allocate care coordination and extensivist resources and apply proven case management methods to produce gains in health and declines in utilization.

The medical home demanded a more sophisticated and comprehensive approach that led us to….

- Focus on at-risk and high-risk populations
- Identify preventive and chronic care needs
- Implement pre-visit planning and office protocols
- Coordinate care across the healthcare continuum
- Provide context for health coaching
- Manage transitions in care

Table 1. Care Coordinator Activity
2010-2012

Source: Clinical Informatics, Care Coordinator Activity Reports

Care Coordinators	Patient Telephone Contacts	Face-to-Face Health Coaching Encounters	Transition Follow-Up Contacts
24	78,800	9,700	14,900

Table 2. Care Coordinator Impact on Diabetes Control 2009-2011

Source: VTC and Virginia Tech Department of Statistics, PCMH Outcomes Study

Intervention	HbA1c %	LDL mg/dL	BMI %	DBP mm/hg	SBP mm/hg
Without Care Coordinator Health Coaching n = 30,000	-0.0750	-9.5364	-2.8310	-2.1434	-2.8310
With Care Coordinator Health Coaching n = 2,800	-0.6200	-14.267	-5.0746	-3.8121	-5.0746

Clinical Practice

We pursue patient safety and desired health outcomes by drawing on physician and clinic resources, evidence-based medicine, and health information technology.

We have refined our approach to clinical practice as a result of the medical home, adding processes to…

- Integrate care across clinic departments and disciplines
- Standardize clinical documentation
- Embed clinical guidelines, best practice and preventive care alerts in the EMR
- Assess patient barriers to self-care
- Conduct longitudinal studies of patient performance against care plan objectives
- Implement a comprehensive medication management program

Continuous Improvement

We have strengthened our capabilities through staff training, process standardization, and performance measurement, and continuous quality improvement.

Medical home standards require performance measurement and improvement, in fulfilling this quality mandate we created a structured approach to…

- Improve clinical and service performance
- Match our performance against national benchmarks
- Drive out complacency and replace it with a healthy sense of competition
- Promote transparency and accountability
- Incorporate the use of recognized quality disciplines
- Create an institutionalized culture of continuous improvement

Table 3. Comparative Clinical Measures
2009 vs. 2012

Source: Clinical Informatics, Ambulatory Performance Reports

MEASURE	JAN 2009	DEC 2012	PERCENT CHANGE
Persistent asthmatics on controller meds	69.57%	92.93%	33.56%
Diabetics with HbA1c test in last six months	76.12%	91.17%	19.77%
Hypertensives with BP controlled 140/90	58.34%	65.61%	12.46%
Pneumo vaccination for patients ≥65 yrs.	62.22%	77.82%	25.07%
Breast screening female patients 40-69 yrs.	58.04%	66.52%	14.61%

Patient Experience

We have attempted to fulfill the expectations of healthcare consumers by transforming the delivery of care from a series of episodic treatment encounters into an authentic practice/patient relationship.

The medical home's emphasis on patient satisfaction launched a reexamination of our interaction with patients and families and prompted us to…

- Engage patients as active partners in improving their health
- Emphasize patient/provider continuity
- Improve telephone responsiveness
- Expand patient access to providers
- Coordinate clinical activities
- Open four urgent care centers
- Promote use of a secure web portal
- Solicit patient feedback

Conclusion

We began our medical home journey with three strategic objectives: 1) provide better patient care, 2) address the crisis in primary care, and 3) position ourselves to seize evolving payment opportunities. Our four-year experience with the patient-centered medical home has provided us with the tools and confidence to accept the challenges of a pay-for-performance reimbursement environment, including participation as a CMS Medicare Shared Savings Program ACO. We think differently and work differently than we did before. We are ready.