Strategies for Success in ACO

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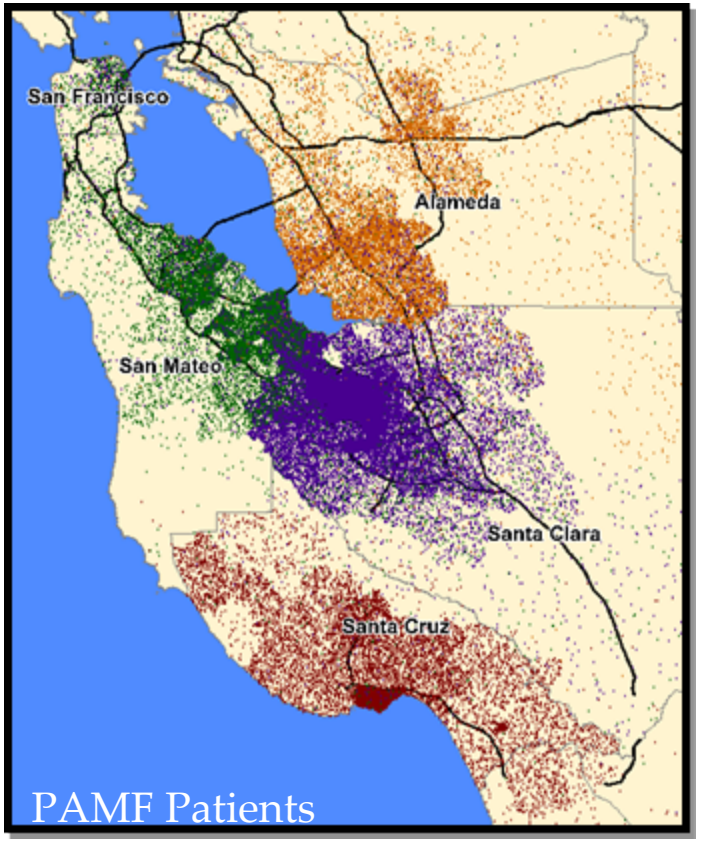
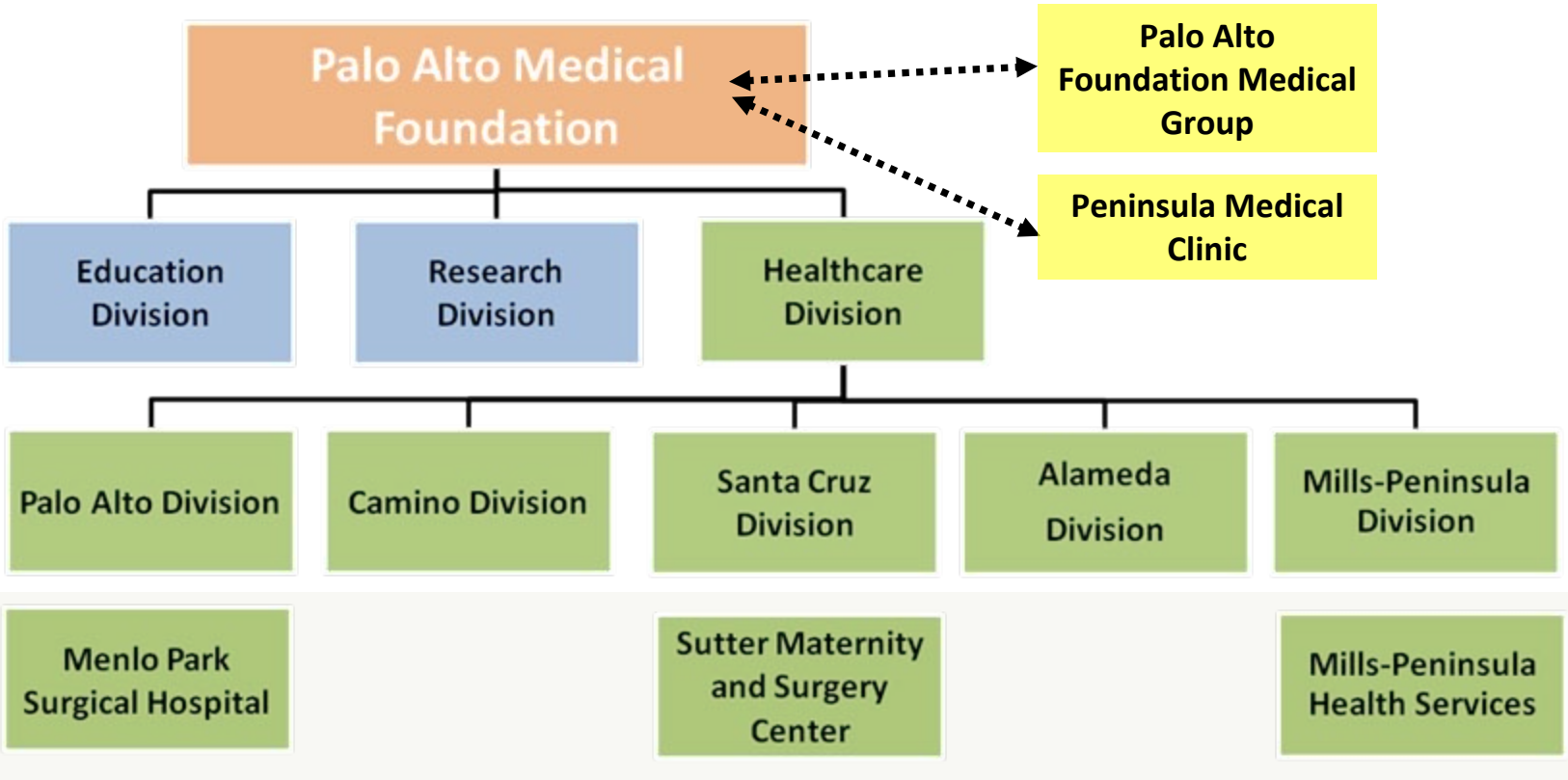
Palo Alto Medical Foundation

Vision: To lead the transformation of health care to achieve the highest levels of quality, access and affordability.

- Consists of about **1,300** primary care and specialty physicians along with **7,000** employees
- Serves approximately **760,000** patients
- Operates **50** Clinics and **3** Acute Care Facilities
- Is a physician-led multi-specialty group practice
- Has a mission of providing health care, education and research
- Is proudly not-for-profit



PAMF Structure



PAMF has 36 clinic locations from Watsonville to Palo Alto to Fremont to Dublin to Daly City and covers Santa Clara, San Mateo, Santa Cruz and Alameda Counties

History of Innovation

- Early adoption of multi-specialty group structure to support primary care
- Pioneer in electronic health record
- Integrated clinical delivery structure
- Primary Care Medical Home
- Dr. David Druker Center for Health Systems Innovation
- Focus on interventions that achieve:
  - Affordability
  - Demonstrable quality: consistently top P4P rating by IHA
  - Excellent service

David Druker Center for Health Systems Innovation
New perspectives on health

PAMF Initiatives

David Druker Center for Health Systems Innovation

New perspectives on health

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Variation Reduction

PAMF Champion

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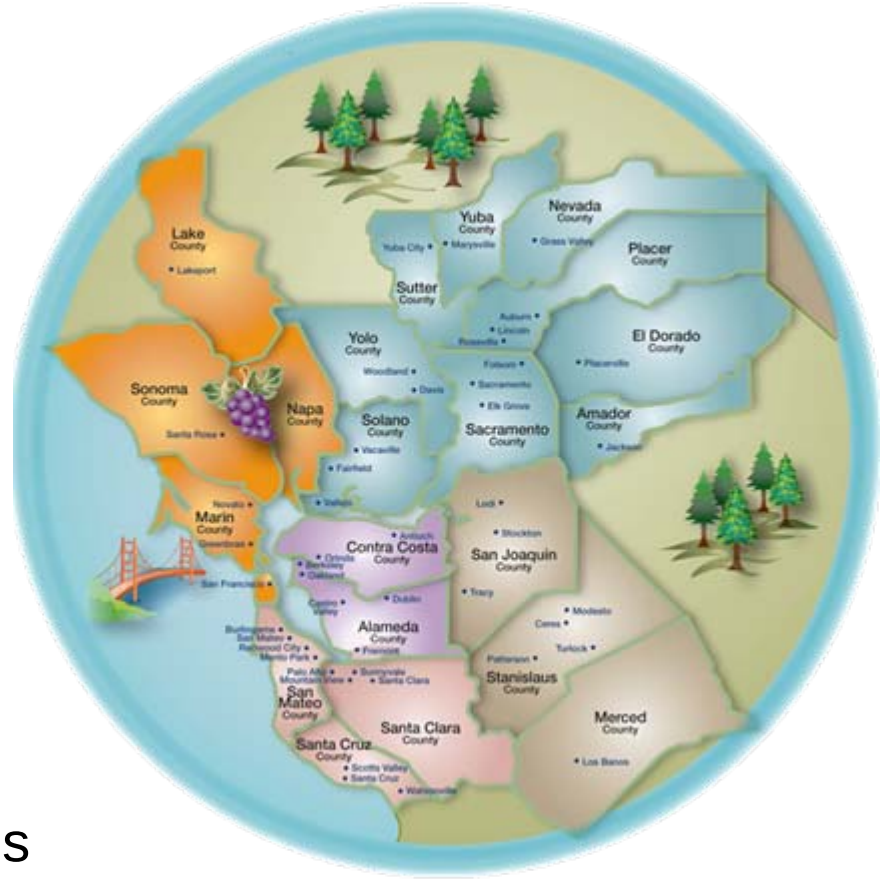
Part of a Larger System

The **Palo Alto Medical Foundation (PAMF)** is a part of the **Sutter Health** System:

- A not-for-profit integrated delivery system serving Northern California
- 24 hospitals and hundreds of clinics
- Over 5,000 aligned physicians
  - Medical Foundations and IPAs
- Almost 50,000 employees
- Physician and nurse training programs
- Medical research facilities
- Home health, hospice ancillary services



A Changing Market

- Patients increasingly complaining about cost
- Blue Shield's decision to regionalize total joint replacement
- Stanford
  - Stop offering commercial HMO
  - Set up their own network
- UC Blue and Gold network excluding PAMF
- Uncertainly of the effect of Covered California

PAMF's
Response to the Changing Market

- To create **aligned incentives** between the employer, health plan, physician organization and possibly the hospital that focuses on reducing the total cost of care and improving quality
- To **reduce total health care** costs upward trend for purchasers
- To **foster transparency** in cost and quality information between the parties
- To create a multi-year plan to reach a premium level that is more **competitive with Kaiser** than we are today
- Shared Savings to be **upside only** at this time

Readiness Assessment

- Willing organization: how willing is your organization to adopt total cost of care?
- Can you potentially be more affordable? Do you have a methodology in place to reduce costs?
- Do you have a Quality infrastructure?
- Robust E.H.R.
- Analytics capacity

Why were we not a Medicare Pioneer ACO

- PAMF's strength is in ambulatory care
- Primary cost savings in Pioneer center around hospital costs
- No willing hospital partner
- Chose not to participate

Strategic Decision

Develop commercial ACO model

- Physicians out of habit of managing populations
- Wanted to focus on vast majority of patients, not subgroups: Committed to doing this for all our patients
- Chose to focus more on commercial sphere

Components of an ACO

- Contracting: willingness to be flexible
- Population Management components
- Quality outreach processes
- Variation Reduction
- May or may not need hospital partner

Contracting

- 2 different methodologies of payment
  - Savings model based on actuarial budget
  - Savings based on performance against local market trend
- 2 different types of contracts
  - Negotiated contract
  - Take it or leave it (Cigna, Medicare)

Attribution

- Typically based on patient with 2 visits in primary care within last 18 months
- Model developed for Medicare Pioneer ACO
  - At PAMF, 90% of Medicare HMO patients have visit within given calendar year
  - However, only 50% of commercial HMO patients have visit in a given year
- Means patients added to denominator as soon as second visit bill received
- Watch out for non-billable electronic encounter
  - Sutter Health study shows 11% of pts only have electronic contact in given year
- Some provisions require patients to be present at both beginning and end of contract period

Population Management

- Difference between utilization of HMO and PPO populations
  - Average LOS for HMO approximately 1 day less than PPO, even with same care team
  - Utilization of Ancillary services higher in PPOs
- Approach: Apply all successful HMO strategies to manage PPO population
  - Hospitalization
  - Pre- and post-procedure management
  - Pharmacy: Generic prescribing
  - Case Management

Case Management Focus Areas

- Care Coordination
- Health Maintenance (Preventative)
- Medication
- Advance Directives
- My Health On Line (Email within chart)
- Social/ Cultural
- Mental Health/ Behavioral (PHQ2 & 9)

Case Management: Creating standard work

- Inpatient review
  - Focusing on 1-2 day stays: can they be done as outpatient procedures
  - What is needed to prevent another admission
- Transition of care
  - Informing the PCP
- High Risk patient engagement
  - Need cooperation of the PCP office

Standard Care Plan

Name:	DOB: 03/08/1956	MRN:	Referral Source: Hi Risk Patient UHC health plan.
DX 1st: ESRD,	2nd: Neuropathy,	3rd: Asthma & HTN	**Care Team:** Dr. A Dowse, PCP, Dr. S. Zarghamee

Focus	Problem	Potential Solutions	Outcomes/ Dates
Care Coordination	1.Last PCP appt 2009 2.Gyn Appt regarding Surgery for Pelvic mass	Communicate with Davita Dialysis San Jose Contact PCP; Preventative care deficits, Coordinate pre visit labs, and appts. Contact Gyn: Schedule appt	
Preventative Care	1. Pneumococcal Vaccine 2. Universal Hiv Screening 3. Pap Smear 4. Colorectal Cancer Screening 5. Discussion Mammogram 6. Thyroid Hormone (Tsh)	Work with patient and family to educate on benefits to health maintenance Identify barriers that prevent routine health maintenance Enroll in PAMF programs for education	
Medication	Polypharmacy: 20 meds Multiple providers	Review list; Talk with pharmacist, & SW at Davita Dialysis Speak with patient, reconcile meds Identify patient concerns Forward review to PCP and Nephrologist Assist with communication between patient, PCP and Nephrologist	
Advance Directives	No Directive on file	In basket message to PCP and Nephrologist-query, who will be responsible for completing the Advance Directive. Offer assistance, resources	
My Health Online	Not Active; code expired	Give patient information on benefits, CM would assist patient and **family** with establishing access	
Social/ Cultural Supports / Barriers	Has established support system; Husband involved	Communicate with Dialysis SW to clarify if patient has accessed all available community support	
Mental Health	Chronic Dialysis-no advance directive	Initiate communication. Coordinate with SW at Davitas	
Programs Referred to	Community Refer to UHC Chronic Disease Management	Under review with Dialysis SW	
CM Remarks	Establish with the patient and caregiver agreement to CM support and clarification of patient goals. Patient identifies WHO to call, WHEN to Call MD and Emergency Services Confirmed the patient has CM name and contact information with agreed upon date and time of next call. Potential actions based upon review of chart		

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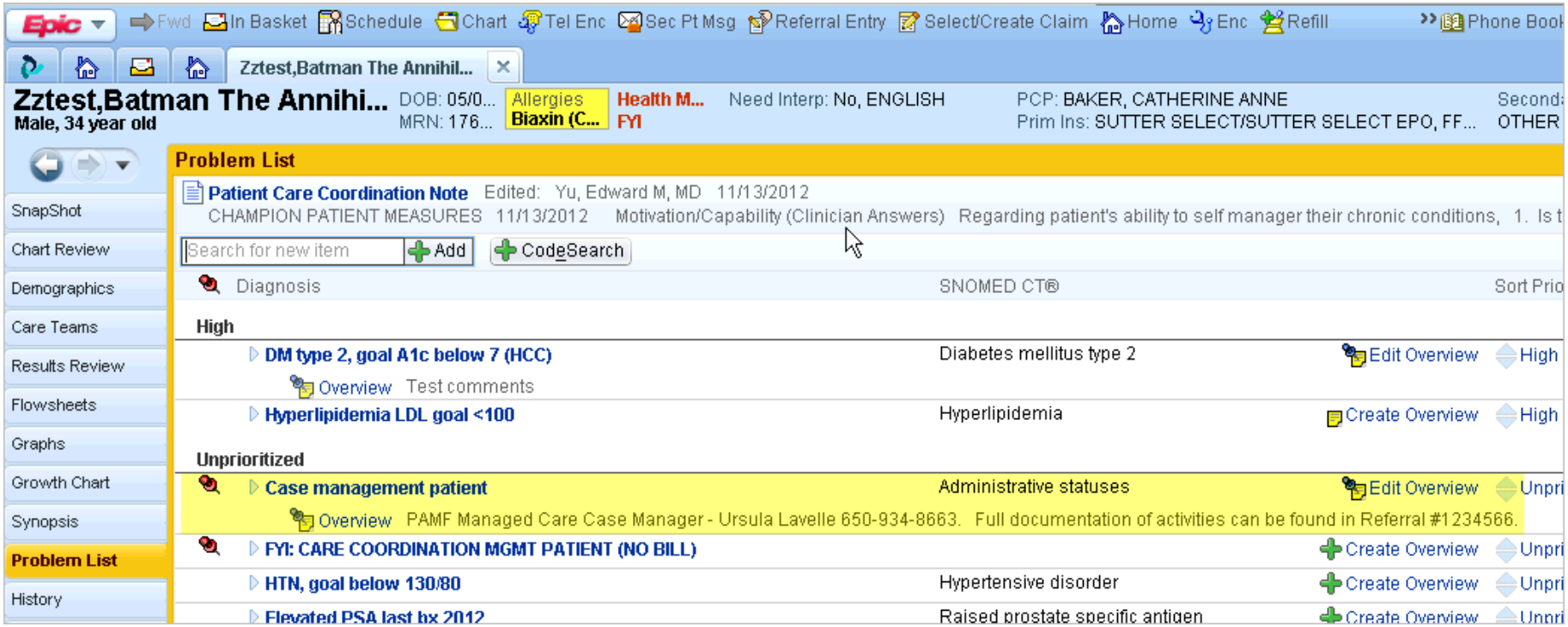
Identification – Problem List



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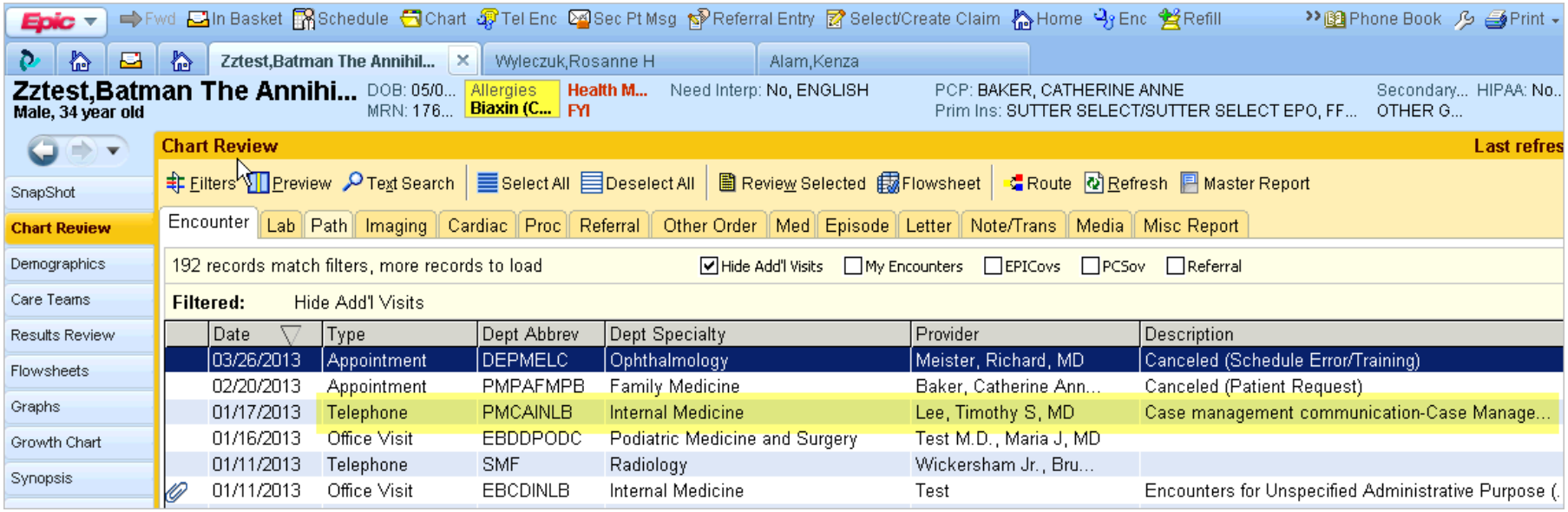
Documentation: Telephone Encounter in Chart Review



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50% Spent on 5%

- Expand RN case management beyond traditional areas but still we needed to look at high cost cases
  - Traditional telephonic case management ineffective
  - Does no good to close the barn door after the horse is gone
  - Population Management analysis of high risk cases
    - 40% of cases were felt to be "preventable" with DM most common dx; 10% asthma
    - 48% of the 60% of "non preventable" were oncology with 35% of these from breast cancer
    - Action items: increased breast screening in this population; align this population with PAMF asthma program

Quality Program

- Must haves:
  - Ready flow of patient-specific information
  - Focus at patient level to identify all overdue items
  - Workflow that starts with capturing overdue items at time of routine visits
  - Robust E.H.R. to send automatic reminders
  - Standard work for staff to send reminders
  - Central processes as a safety net

Challenges in PPO Population

- No standard quality measure set
  - Contracts may come with dramatic increase in number of quality measures (Cigna 25+ new measures)
  - Variation in specifications
  - No standard benchmarks (may dramatically affect financial return to group)

Challenges (continued)

- Data flow
  - Attribution methodology rests on billing data
    - Introduces 1-2 month lag in information
  - However, Health Plans are only ones with all information on PPO patients
    - PAMF patients get mammograms and paps from non-PAMF providers
    - Risk is reminding patient for test they have already completed (patient annoyance)
  - No standard length of time required for patient to be eligible for quality measures
    - Often not notified until February that patients were added for December, leaving no time for outreach

Variation Reduction

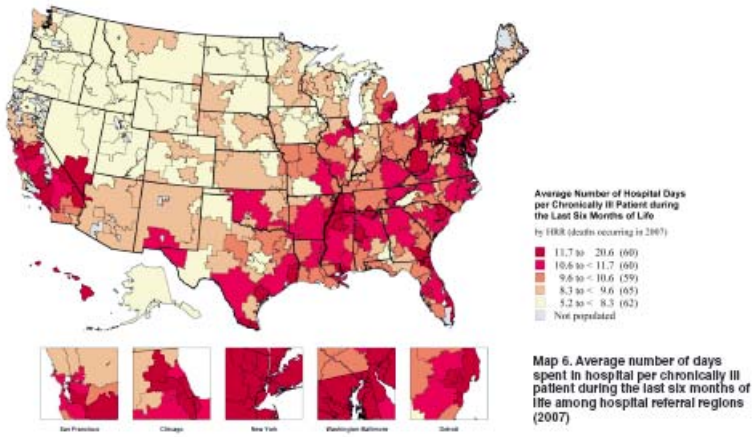
- Overview of how we do it
- Examples
  - Oncology
  - Spread of standard from breast CA to lung CA
  - Epidurals
  - Urine cultures

VR @ PAMF

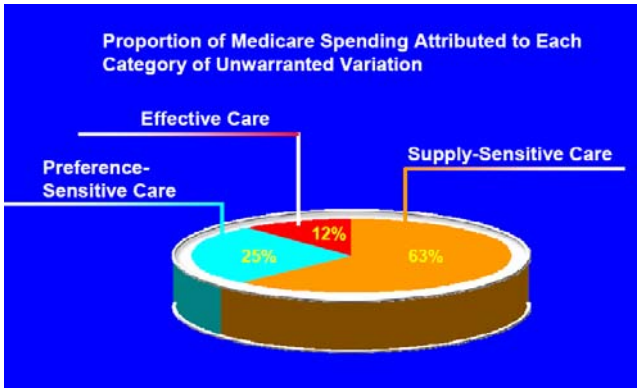
- 2003: Moneyball and Managed Care
- 2004: Aetna and Sutter
- 2005: First ETG data
- 2006: Pilot projects at Camino
- 2007: Aetna Review
- 2008: Merger of Groups and decision to spread VR Foundation wide

Unwarranted Variation

- First reported by Wennberg in 1972
- Geographic variation
- Types of variation
  - Effective care and patient safety
  - Preference-sensitive care
  - Supply-sensitive care



Map 6. Average number of days spent in hospital per chronically ill patient during the last six months of life among hospital referral regions (2007)



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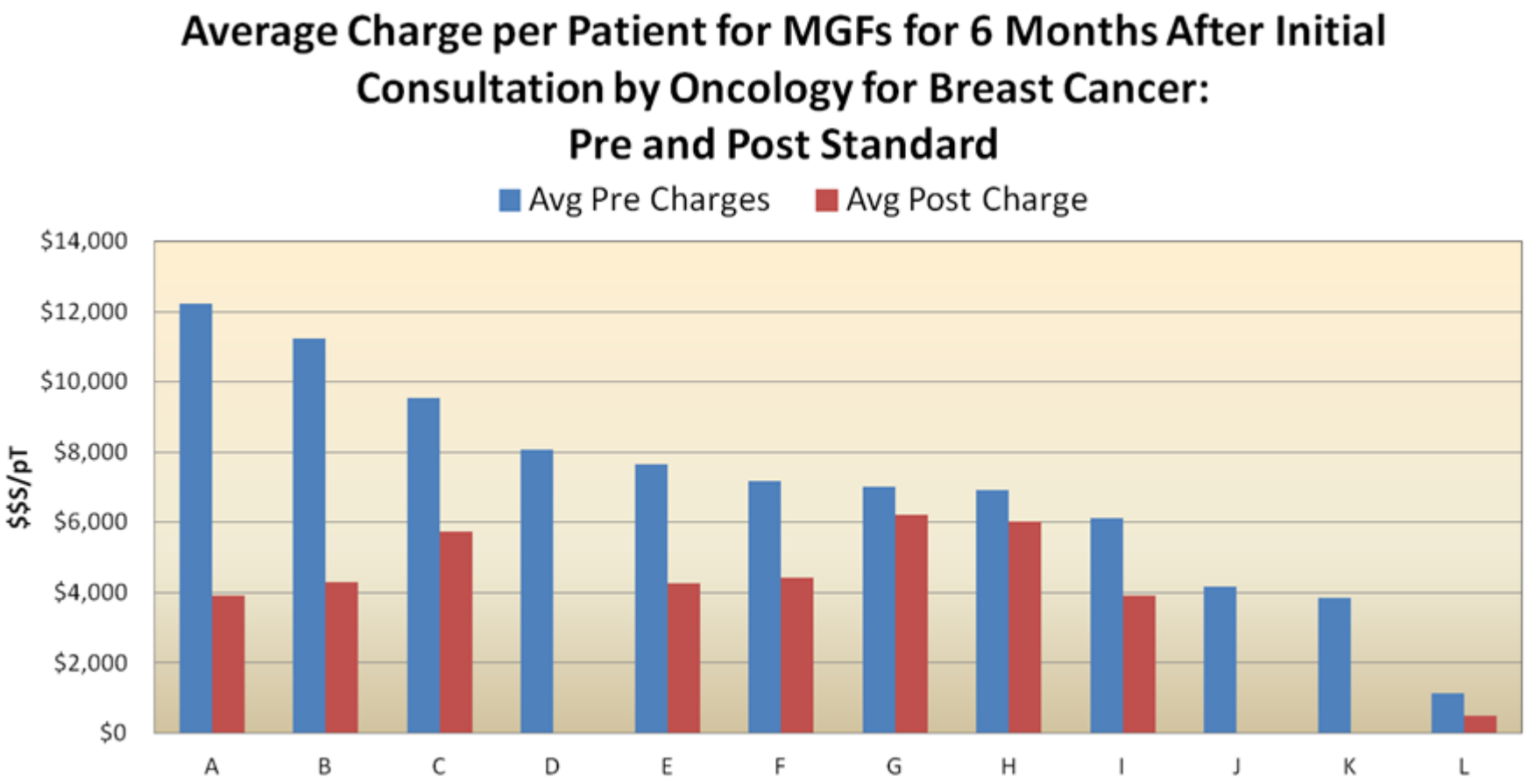
The Essence of VR

- This is a physician engagement process
  - At first let physicians choose their own topics
  - Can later direct them to most common or most costly topics (top 10 lists)
- Give physicians their variation data
  - Initiating event
  - Not looking for perfect data
- Stimulate the discussion
  - Ask simple questions
  - Create a local standard

Reduction in Variation



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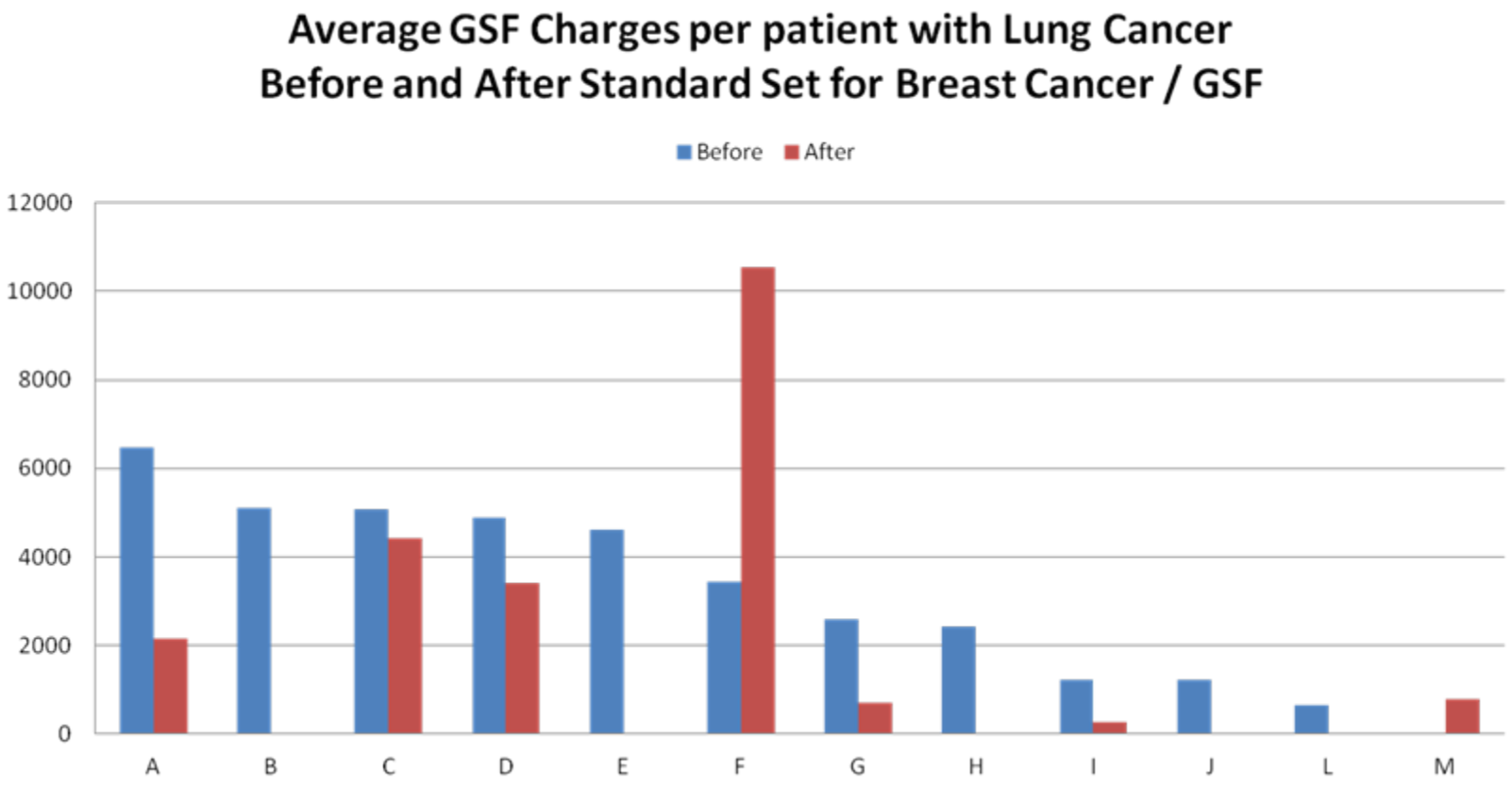
Self Spreading of Concept



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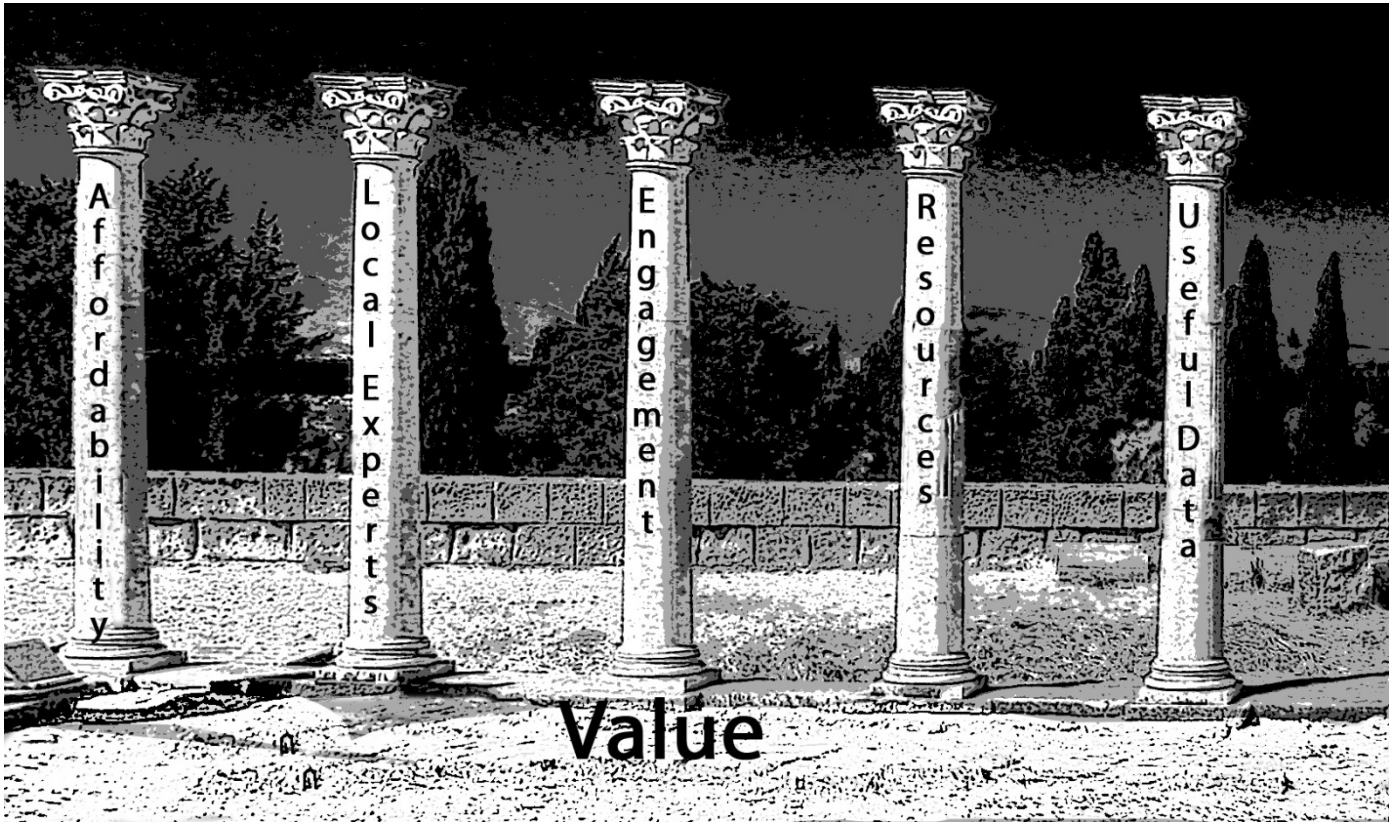
VR : It’s Not About the Data



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Get physicians in the same room

- Bring small groups of physician peers together
- Create safe environment
- Its about the dialogue
- Collaboration produces best outcomes

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Guideline Development vs. Variation Reduction:

Guideline Development

- Choose Topic
- Review clinical evidence
- Discuss topic from a distance (What should one do?)
- Evaluate strength of evidence
- Address all aspects
- Adhere to national guidelines
- Spread: MD Education
- Follow up: Little or none
- Result: Inconsistent adherence to guideline

Variation Reduction

- Un-blinded data showing variation
- Include both cost and quality data
- Trigger conversation between MDs about variation (What do you do?)
- Often data free zone: Rely on “expert opinion”
- Focus on root cause
- Allow MDs to differ from national guidelines based on local population
- Spread: Repeat process of MD engagement
- Follow up: Individualized data showing change
- Result: Guidelines that transfer to other topics

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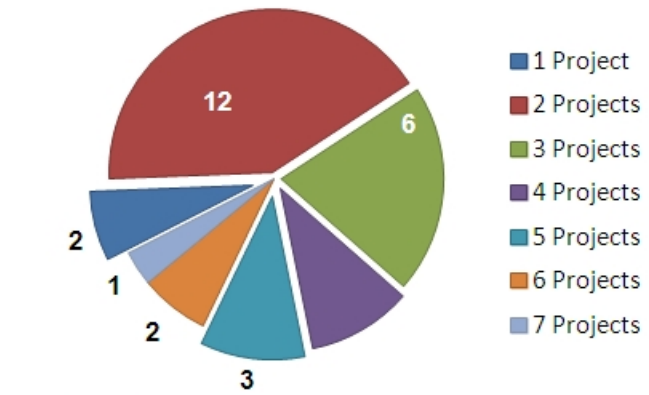
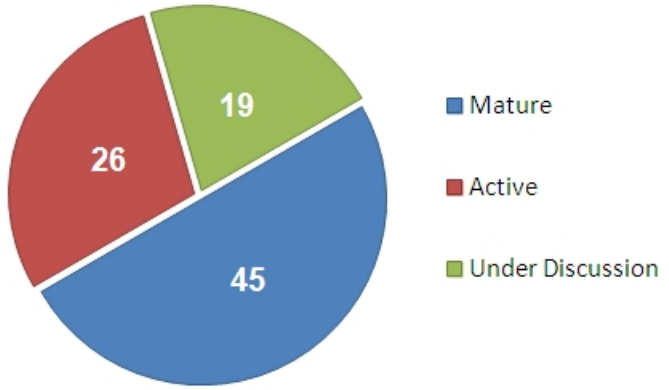
VR Results

- $46 Million in savings
- 90 projects

Total Patient Savings	$ 46,790,523	Cummulative Unique Pt. Affected by VR (2008 - 2013)	217,024



Number of Specialties



Number of Projects

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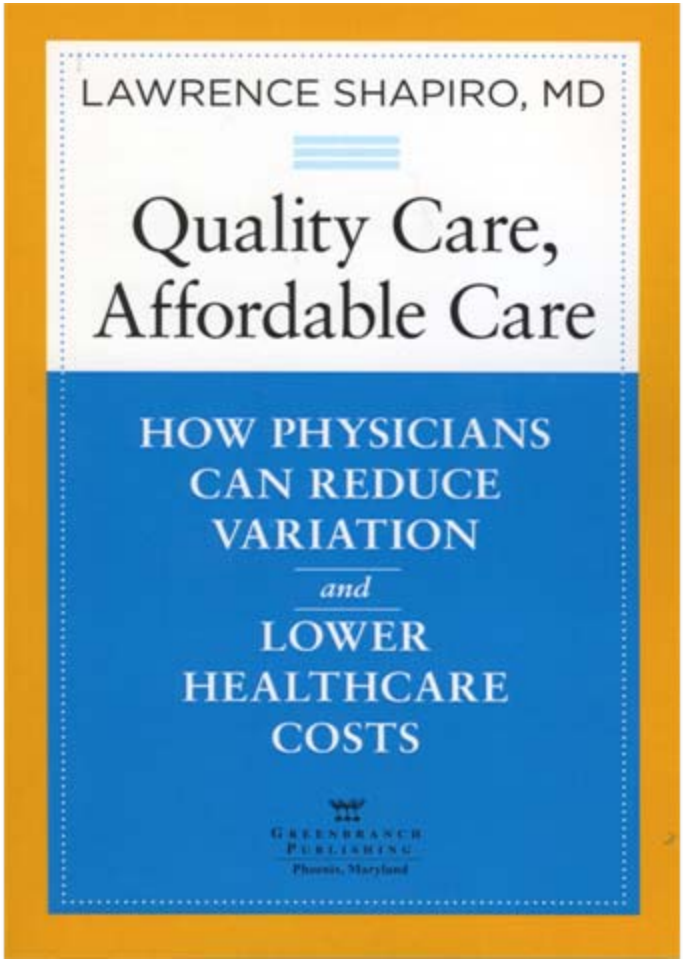
Want to Know More?



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Check List for ACO

- **Identify pool of patients**
- **Data is reviewed regarding the PMPM**
- A **Baseline Budget**
- **Operating Committee** is established between health plan, hospital and physician group to work together to improve performance
- **Claims are paid against the budget** using agreed upon rates
- **Shared Savings to be upside only;** some providers may be willing to explore downside risk

Clinical Improvement Initiatives

Inpatient PPO management as if they were HMO

Variation Reduction

- Outpatient procedures
- Advanced imaging

P4P for PPO population

Increased enrollment in MHOL

Coordinate Disease Management,

- Eliminate duplication
- Utilize predictive modeling
- Health risk assessment data sharing
- Use population management model for high risk patient

Readiness Assessment

- Willing organization: how willing is your organization to adopt total cost of care?
- Can you potentially be more affordable? Do you have a methodology in place to reduce costs?
- Do you have a Quality infrastructure?
- Robust E.H.R.
- Analytics capacity

Important Differences between HMO and ACO

- In HMO, attribution is prospective, in ACO it's retrospective
- In HMO, financial information can be verified
  - Plan has to give group risk pool report
  - ACO generates "black box" savings report because of anti-trust issues
- Patient knows they are in an HMO; not clear to patient that they are part of ACO

What's next for ACO development at PAMF?

- Consideration of physician payment methodology
- Cooperation on attribution methodology
  - Include patients only seen electronically
- Increased awareness of all physicians to Total Cost of Care
  - Development of different financial reporting
  - Include ACO metrics in addition to RVU and EBIDTA