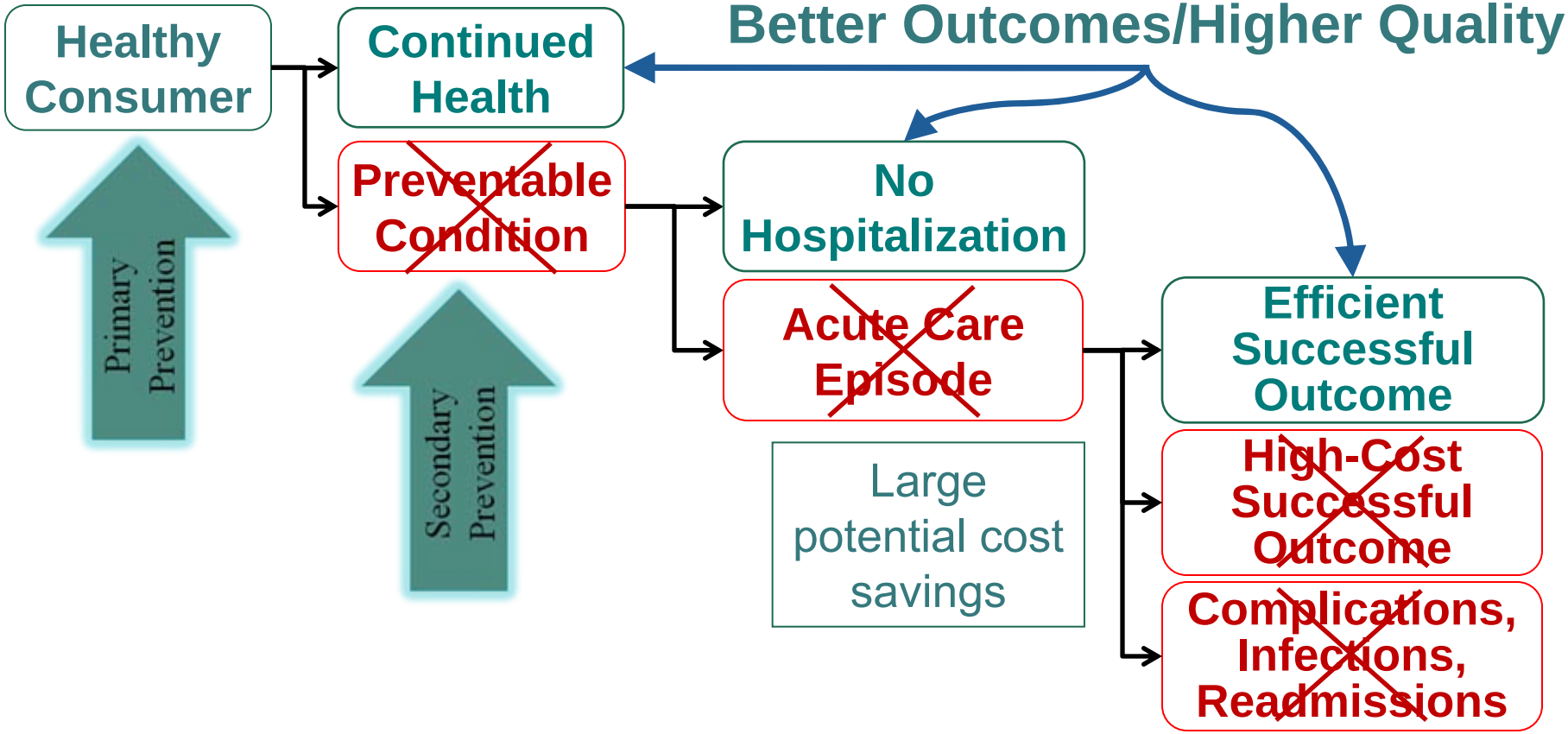
Accountable and Coordinated Care: What we've learned so far

Susan DeVore
President and CEO
Premier healthcare alliance

We began with the end in mind: What are we trying to incent?



Model courtesy of Harold Miller and the Center for Healthcare Quality and Payment Reform

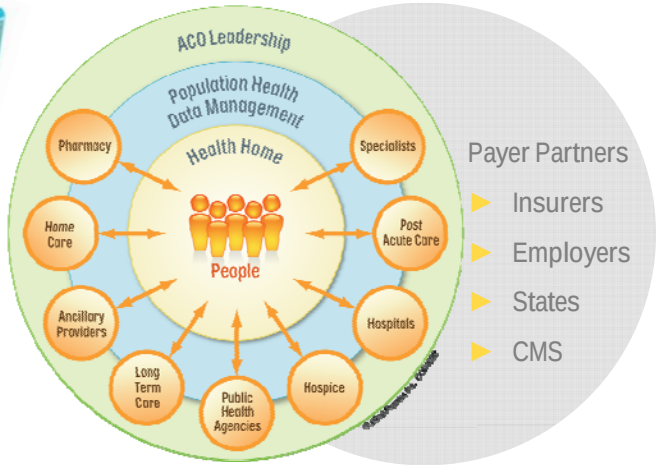
What we knew when we started

Significant **collaboration** between physicians, hospitals, payors and others would be critical.
Care delivery would need to be transformed.
Payment models would need to be **aligned** to care delivery transformation.
Transitional models would be required.
A design for one payor (Medicare) wouldn't work…we need **systemic change for all patients and all payors**.
Multiple models based on geography and history would emerge.
Advanced **measurement and technology** would be needed.
Legal and trust barriers would be challenging.
The typical **consumer** will likely be both **cynical and confused**.

Our journey to high performance health care

Systematic improvement (Inpatient/outpatient value)

Population total value



Process Improvement (Evidence-Based Care)

We have to get the “hospital” house in order

- Total Inpatient Cost per Case Mix Adjusted Discharge
- Waste report and focus on appropriate utilization

Evidence-Based Care Performance % “All or Nothing”

Observed to Expected Mortality Ratio

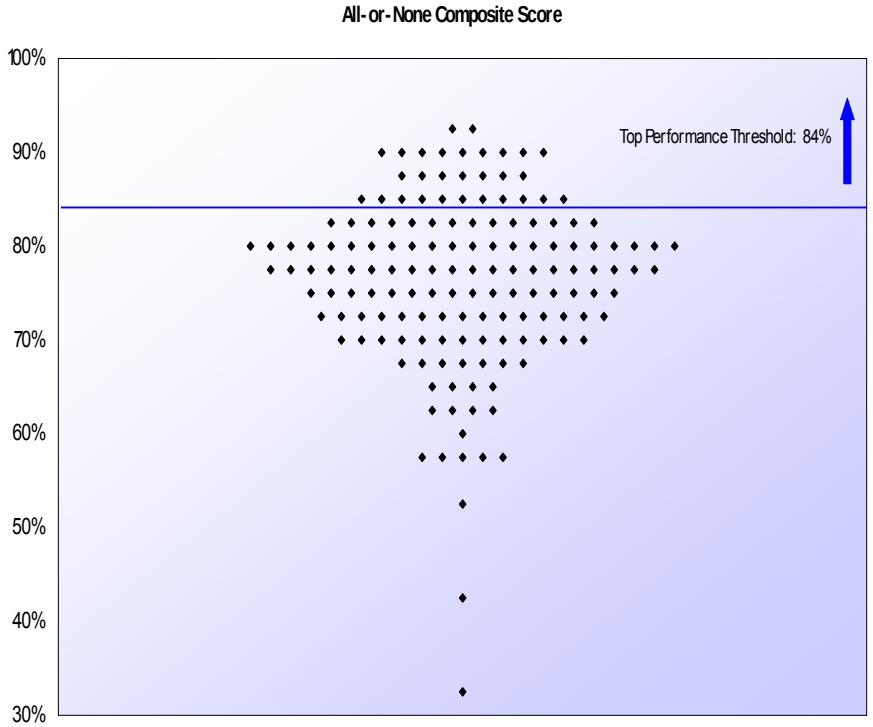
Composite Harm Index

HCAHPS Top Box Global Measures Composite, stratified by demographics

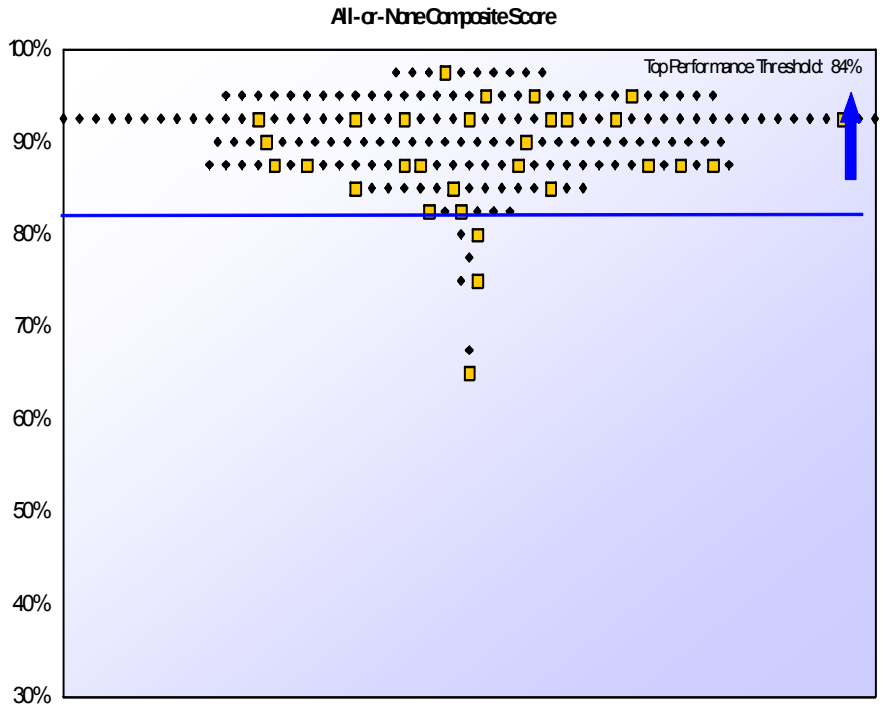
Reduce Preventable Readmissions

Improving “perfect” compliance with the evidence

Baseline (3Q 2006 – 2Q 2007)

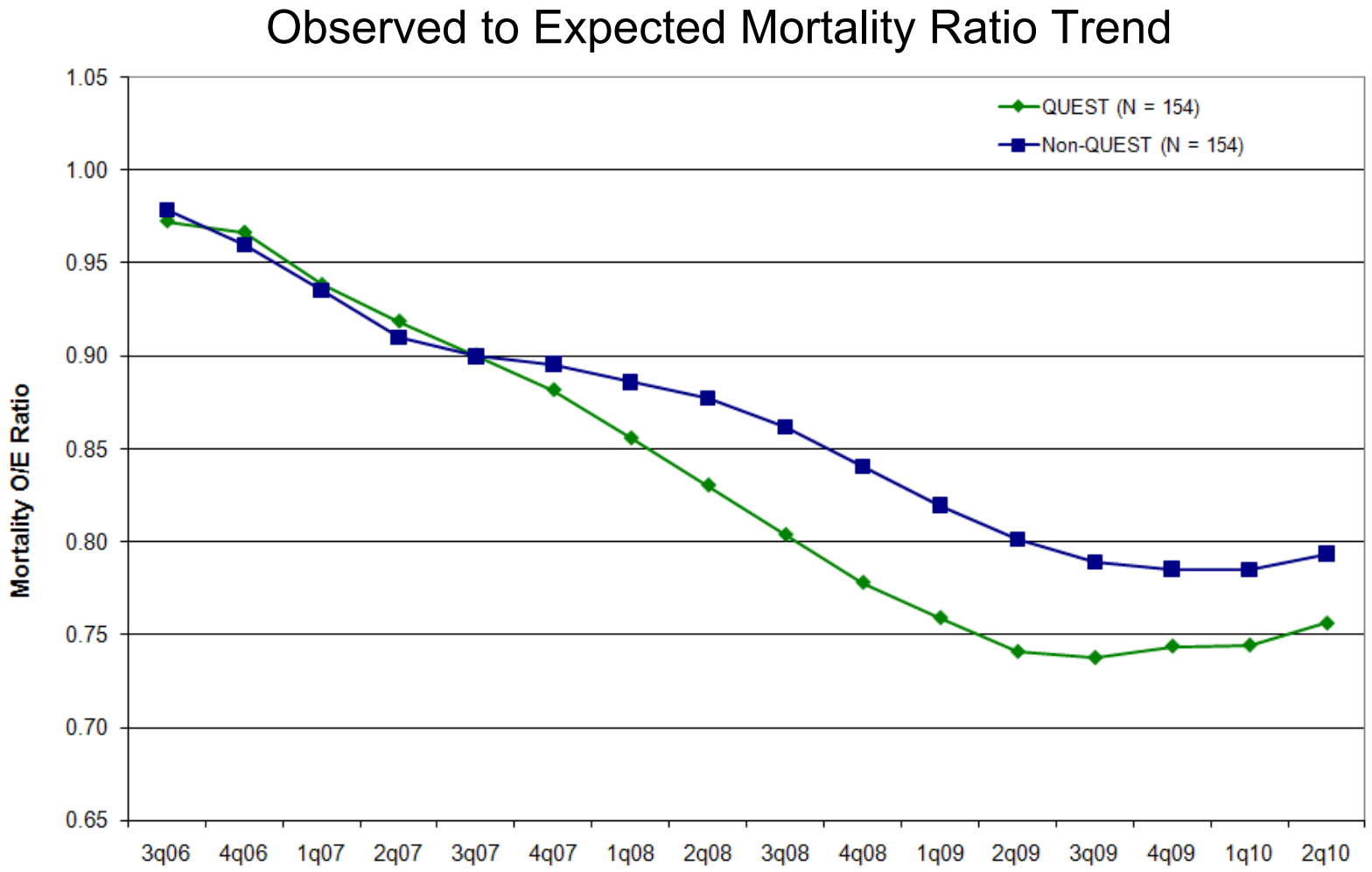


3Q 2009 - 2Q 2010

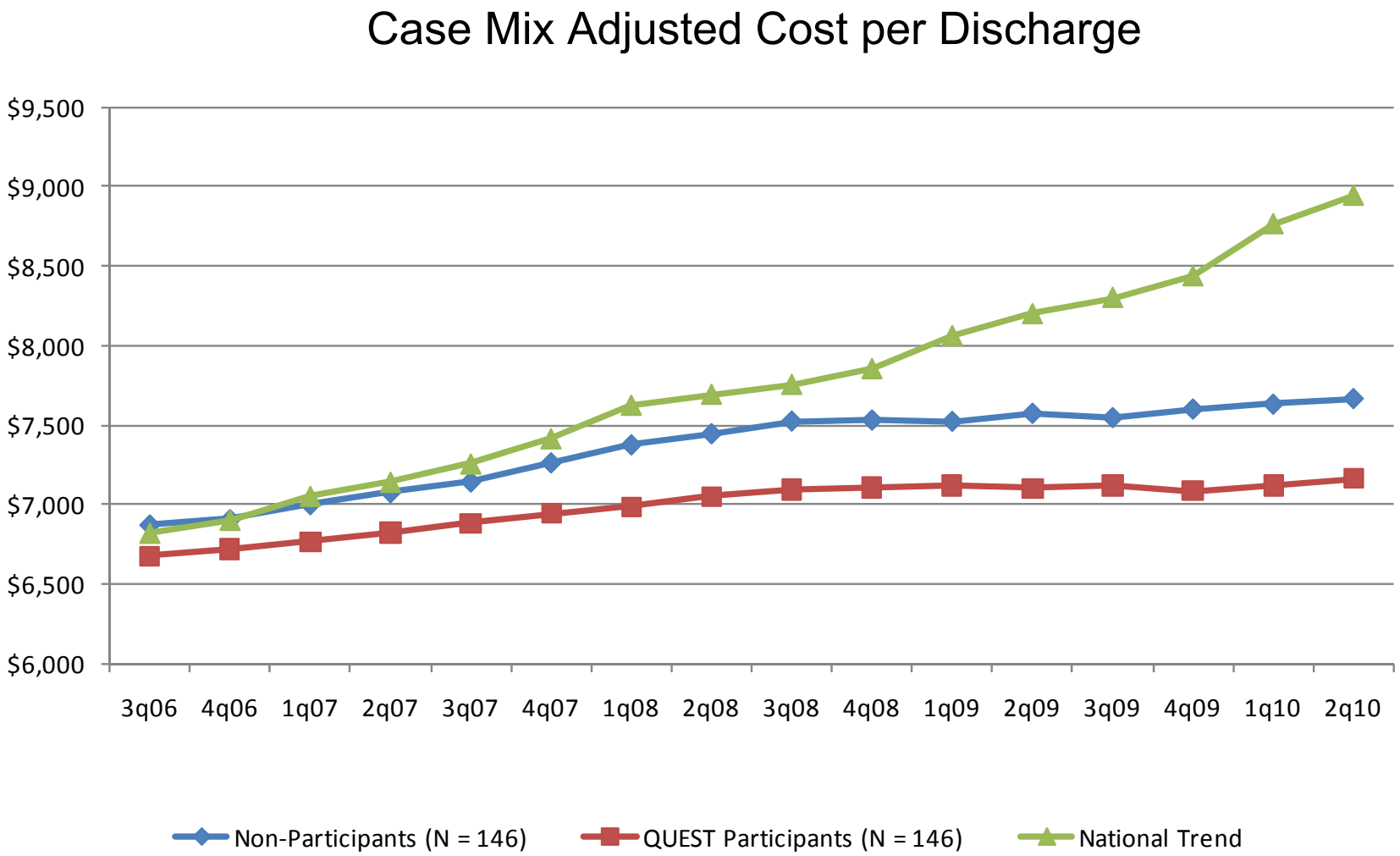


95% of QUEST Hospitals in the Top Performance Threshold

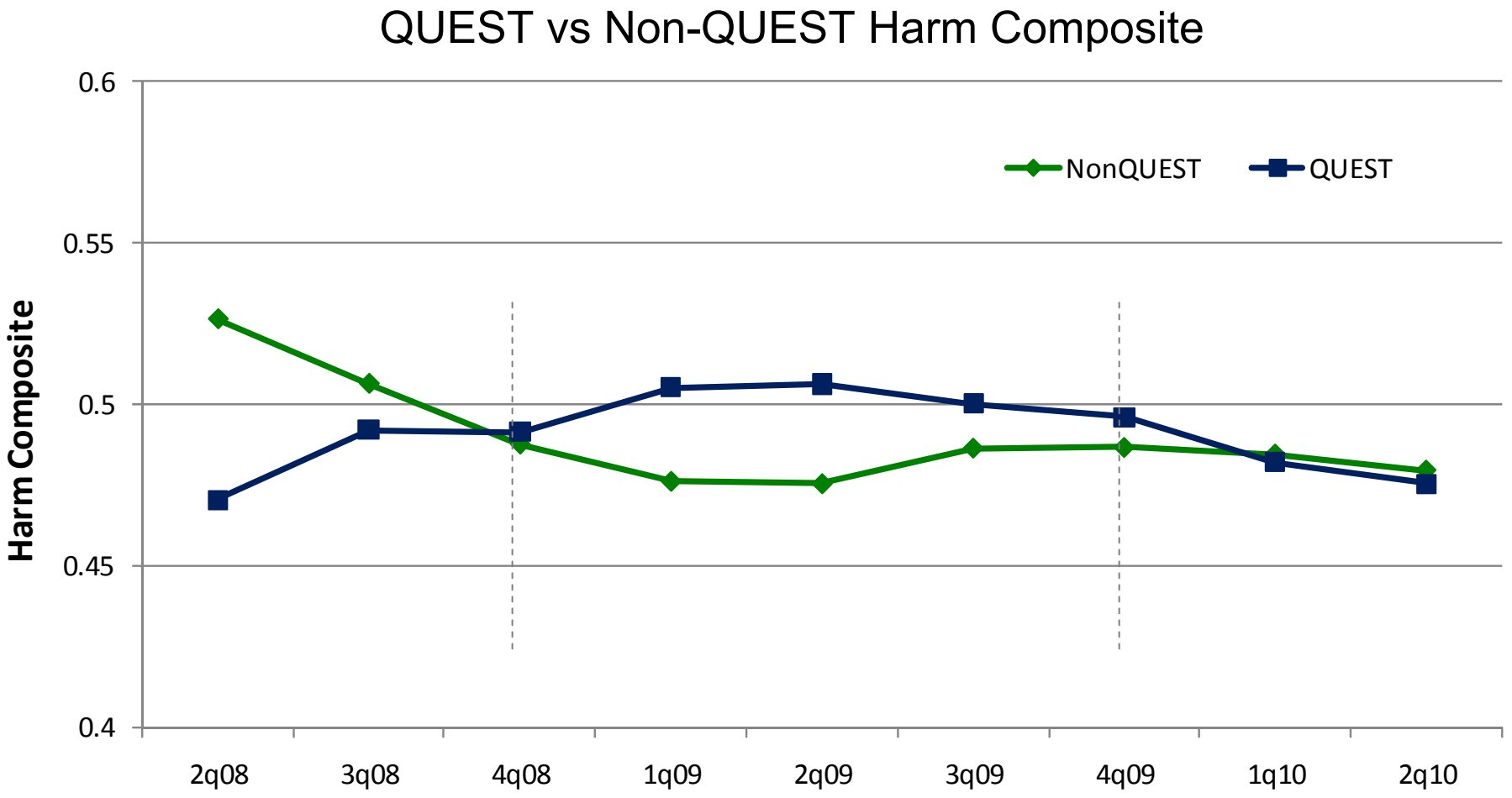
Improving patient care and decreasing mortality



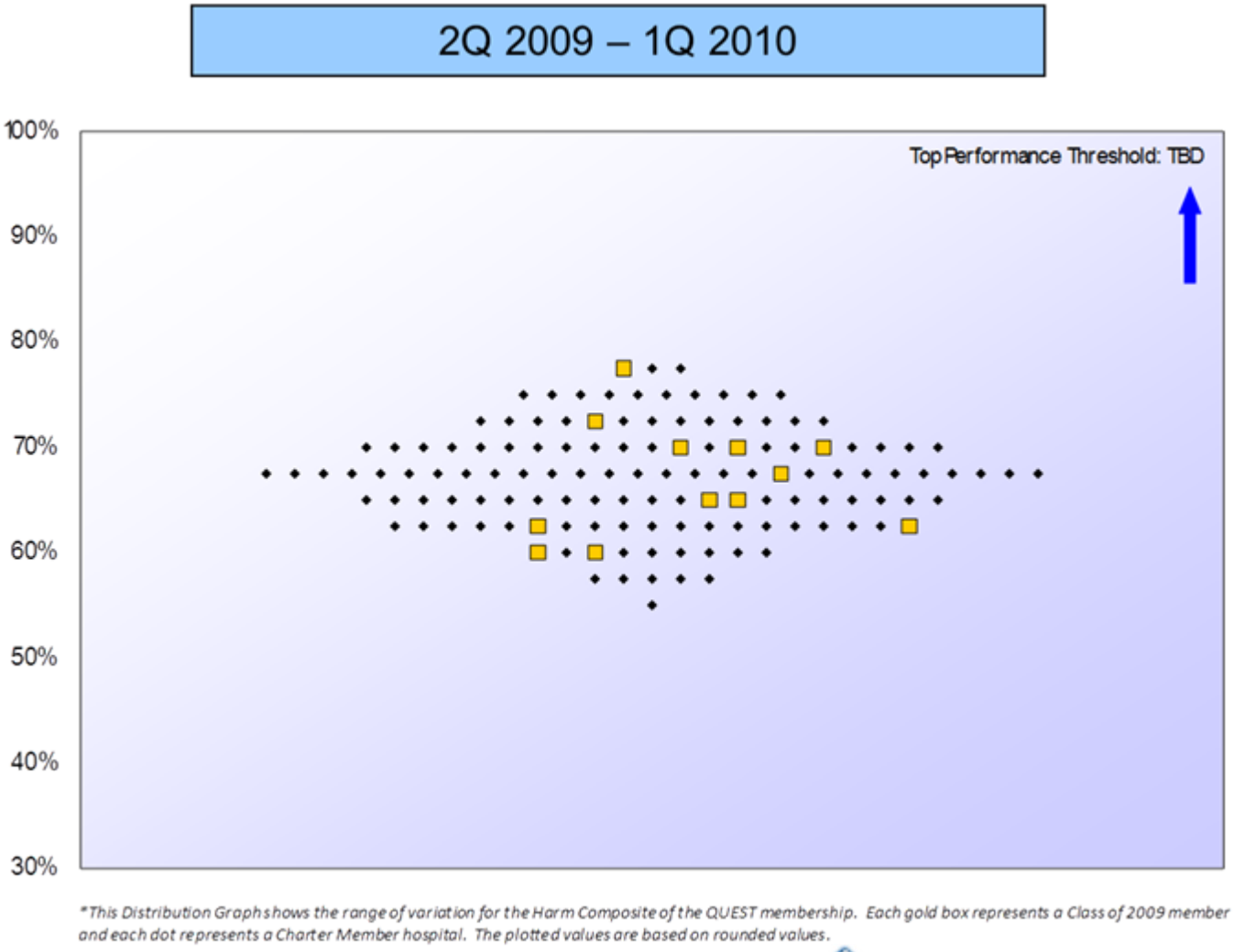
Bending the cost curve



Reducing harm



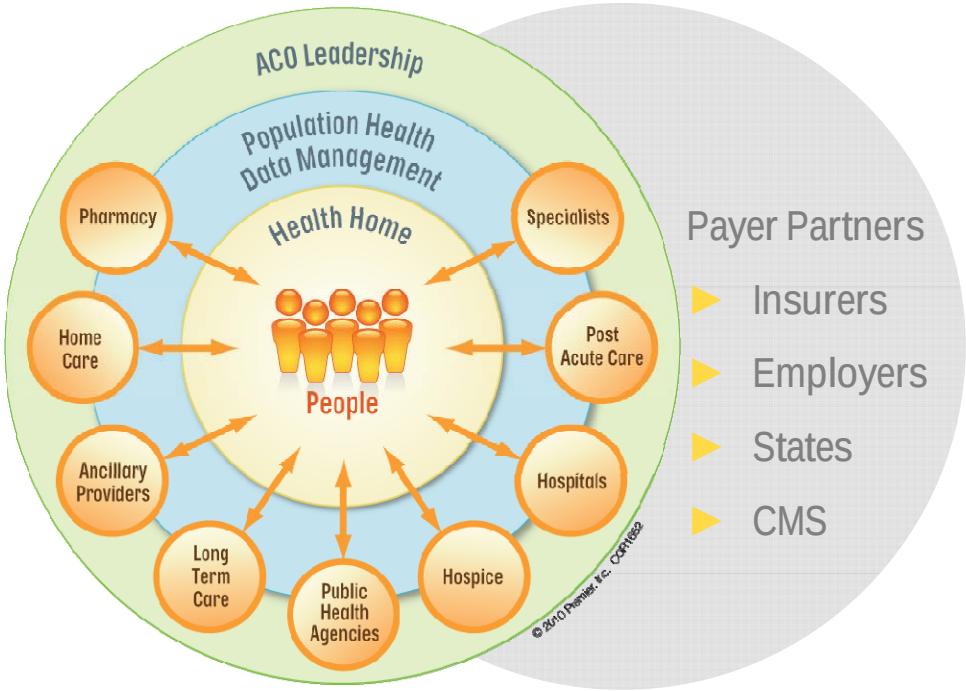
Improving the patient experience will be a lot more difficult



*This Distribution Graph shows the range of variation for the Harm Composite of the QUEST membership. Each gold box represents a Class of 2009 member and each dot represents a Charter Member hospital. The plotted values are based on rounded values.

We had to share or build additional accountable care capabilities

- Accountable care capabilities framework
- Collaborative sharing
- Alternative care delivery models
- Core component guidebooks
- Clinical integration and physician alignment models
- Data and information
- Payor contracts, legal guidance
- Financial models
- Payment model impact analysis

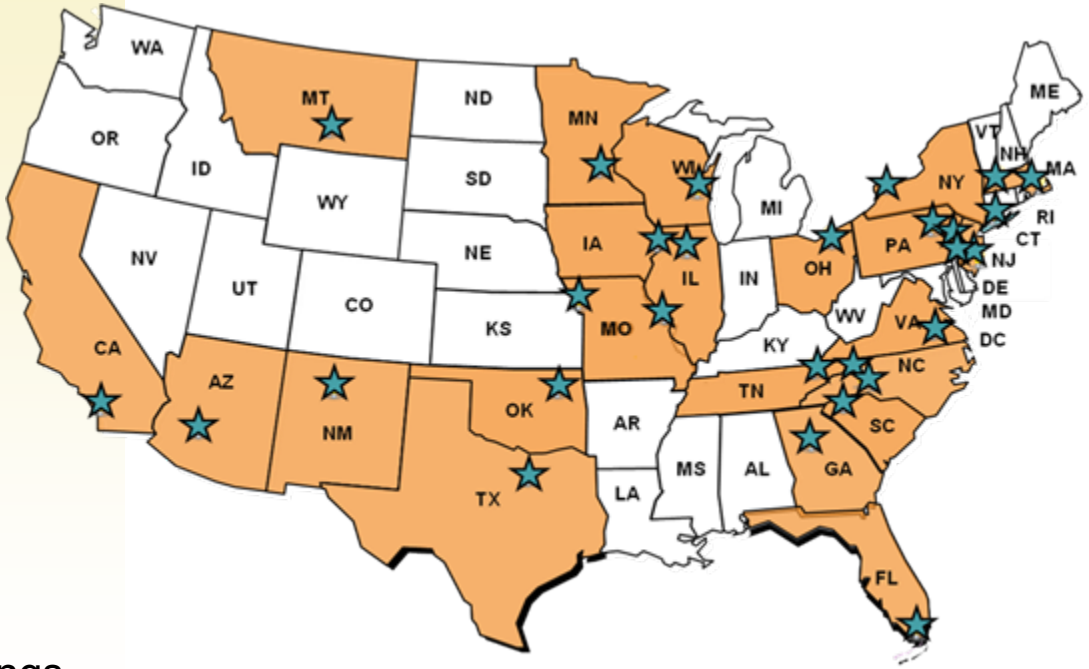


Innovative care delivery early adopters

IMPLEMENTATION COLLABORATIVE

- Ready to begin implementing
- Executive sponsorship & participation
- Payer partner participation and transparency
- Physician network & sufficient population base (5,000 equivalent Medicare lives)
- Transparency and acceptance of common cost/quality metrics (QUEST, HEDIS, others)
- Population health data infrastructure (EHR, HIE, Payer)
- Participation in work groups and meetings
- ACO contracting vehicle (legal entity)

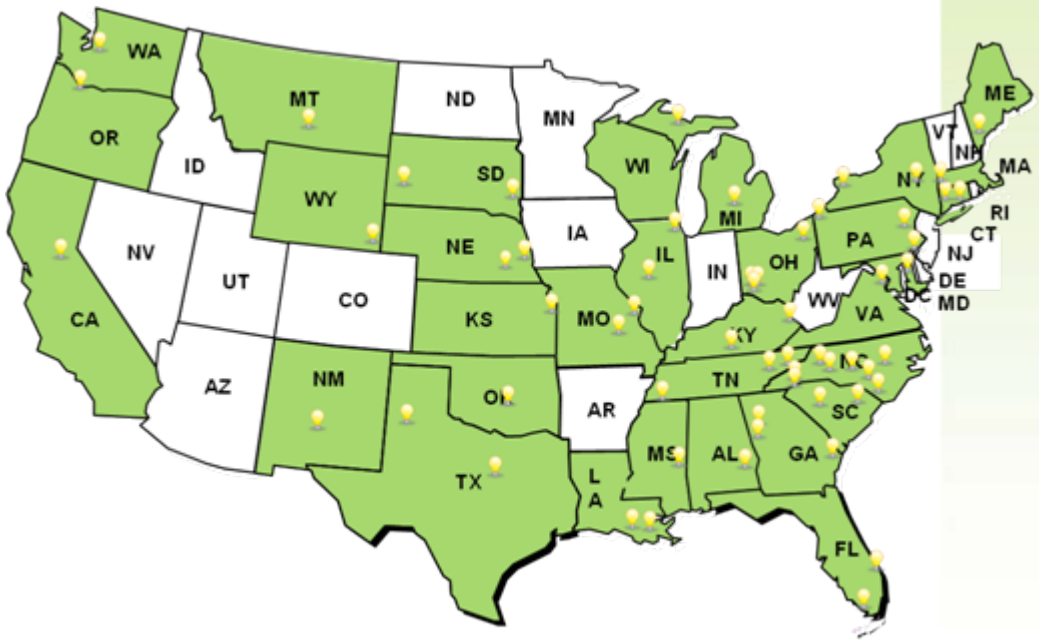
Accountable Care
> IMPLEMENTATION COLLABORATIVE



29 systems representing 120+ hospitals, 5,000+ MDs and more than 1.5M accountable care covered lives

Those building for the future

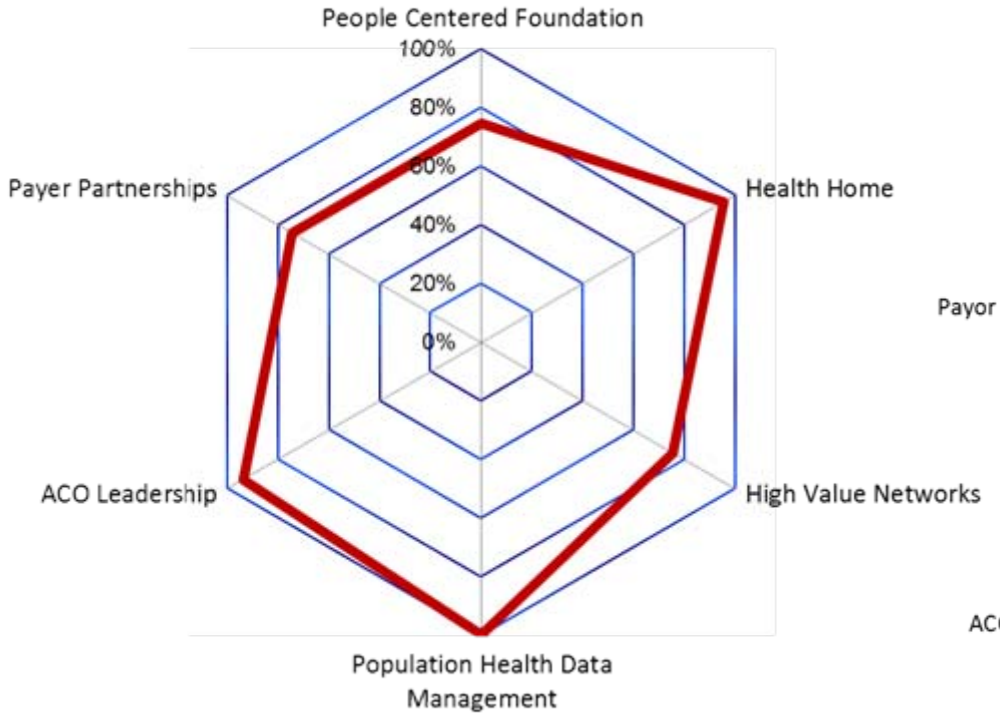
Accountable Care
> READINESS COLLABORATIVE



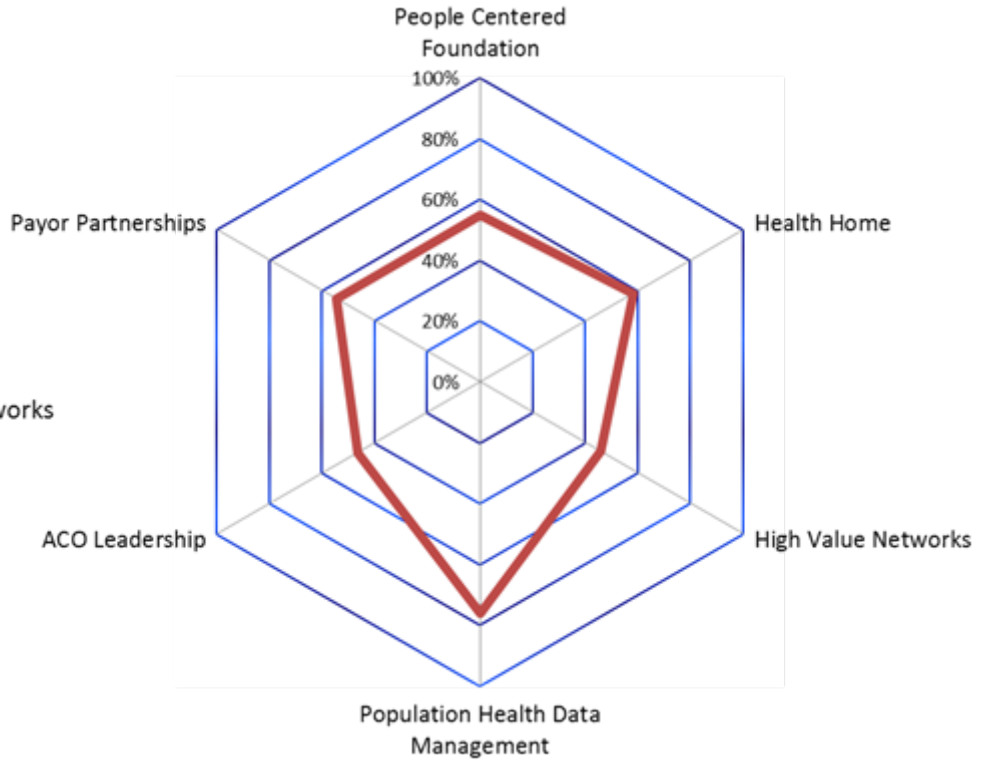
READINESS COLLABORATIVE

- Capabilities assessment to pinpoint focus areas
- Participation in monthly webinars focused on execution strategies (including members of Implementation Collaborative)
- Online portal of ACO content including toolkits, methodologies, and related content
- Preparation to collect population-based measures
- Milestones to keep on track to join the ACO Implementation Collaborative

Some are more advanced than others

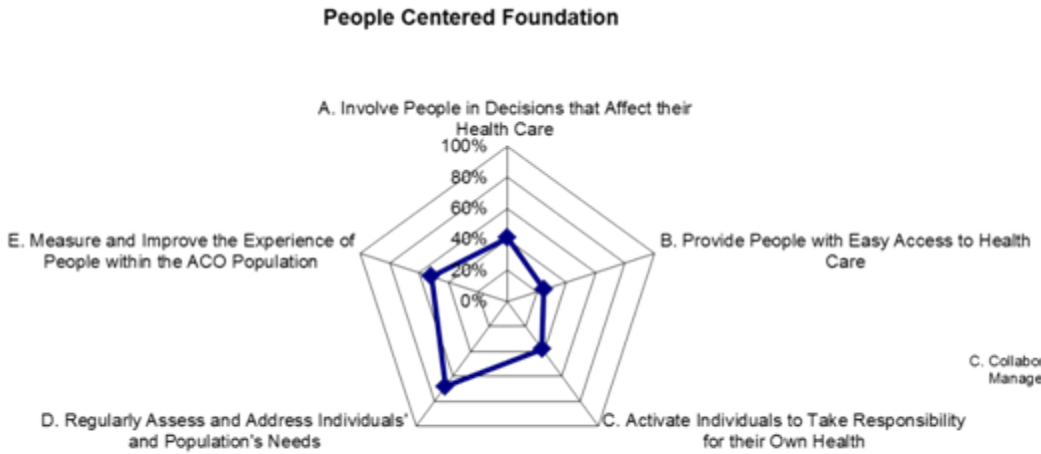


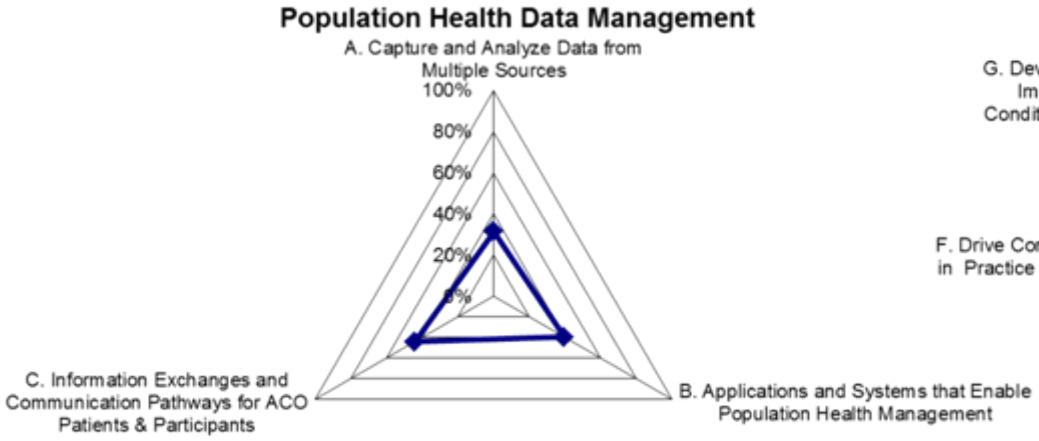
More integrated system

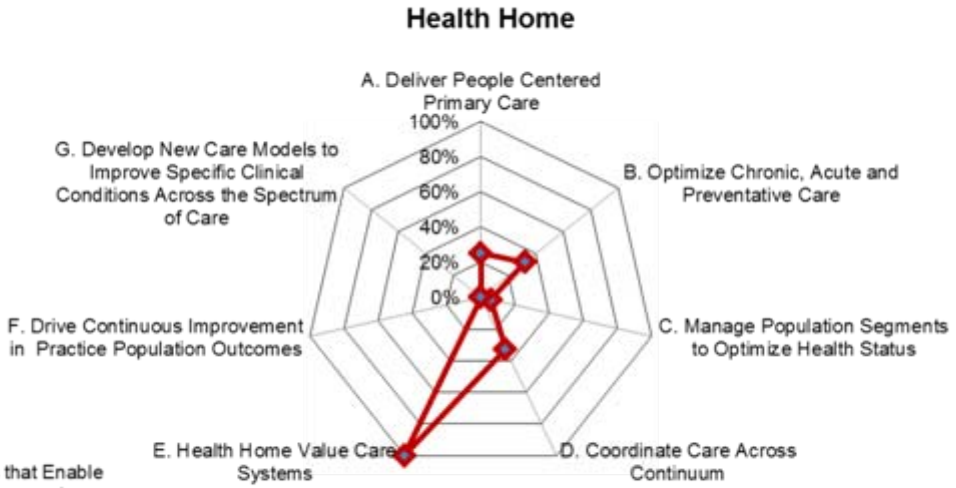


Less integrated system

And some have well developed component parts







The models are different

Model	Characteristics
Integrated delivery systems/networks (IDN)	• Own hospitals, physician practices, perhaps insurance plan. • Aligned financial incentives. • E-health records, team-based care.
Multispecialty group practices	• Usually own or have strong affiliation with a hospital. • Contracts with multiple health plans. • History of physician leadership. • Mechanisms for coordinated clinical care.
Physician-hospital organizations (PHO)	• Nonemployee medical staff. • Function like multispecialty group practices. • Reorganize care delivery for cost-effectiveness.
Independent practice associations (IPA)	• Independent physician practices that jointly contract with health plans • Active in practice redesign, quality improvement.
Virtual physician organizations	• Small, independent physician practices, often in rural areas. • Led by individual physicians, local medical foundation, or state Medicaid agency. • Structure that provides leadership, infrastructure, resources.

*Source: Article by Stephen M. Shortell and Lawrence P. Casalino

Payor and Employer partners are at the table
(representative list)

Provider-sponsored Plans

Geisinger Health Plan

Presbyterian (NM) Health Plan

Health New England (Baystate)

SummaCare (Summa)

Billings Clinic

First Health

Private Plans

Anthem/WellPoint

Cigna

Coventry

HealthSpring/Bravo

Medica

United

Aetna

BCBS MT

HMSA

Horizon BCBS

New West

BCBS MA

Government Payors

CMS

State Medicaid plans

S-CHIP plans

VA

Employers

IBM

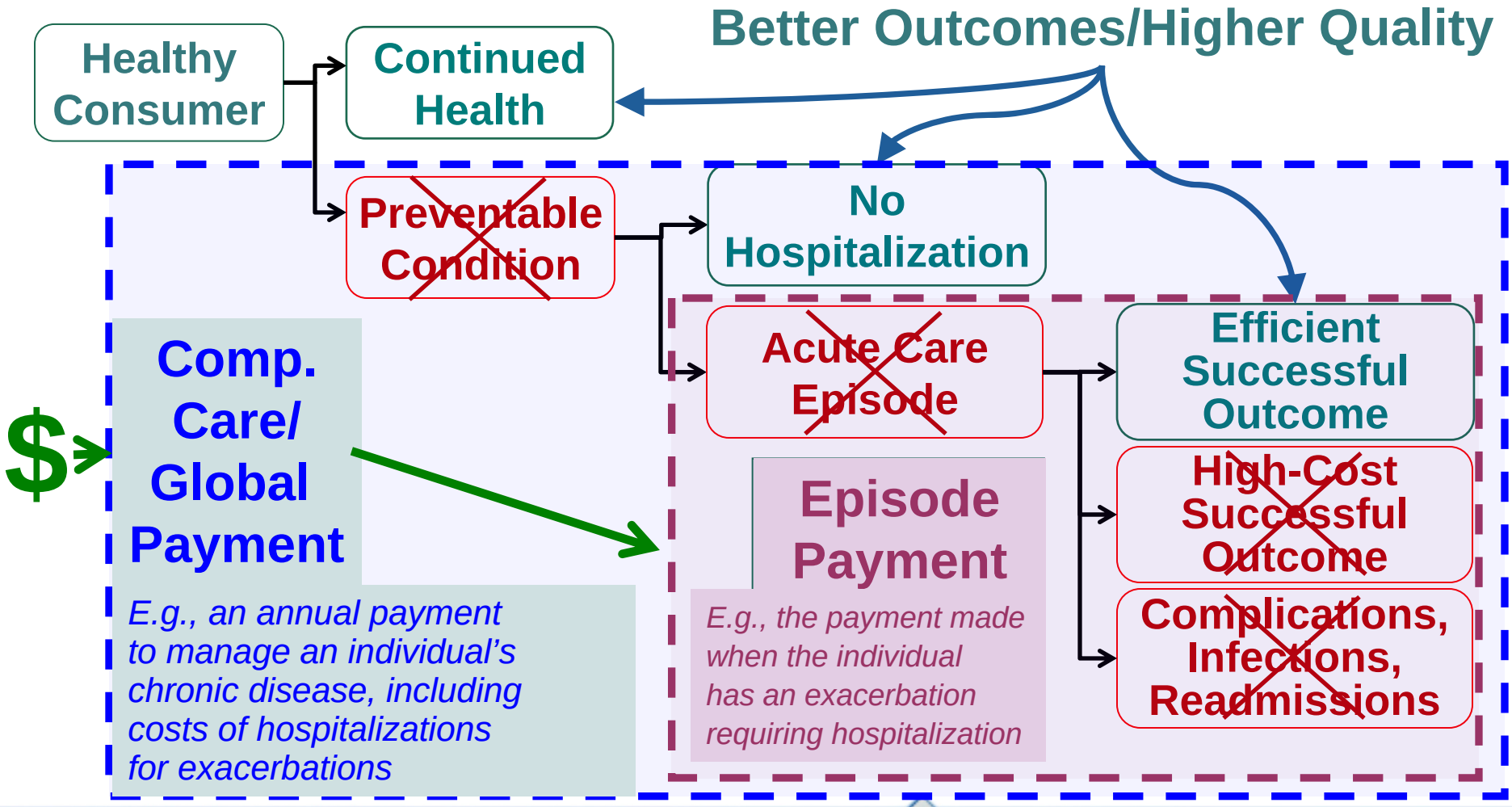
Caterpillar

Eastman Chemical

UNITE HERE Local 54 representing:

- Trump Entertainment Resorts, Inc.
- Harrah's Entertainment
- Hilton Hotels Corp.
- MGM Mirage

Payment models in action



Model courtesy of Harold Miller and the Center for Healthcare Quality and Payment Reform

Clinical coordination/integration models in action

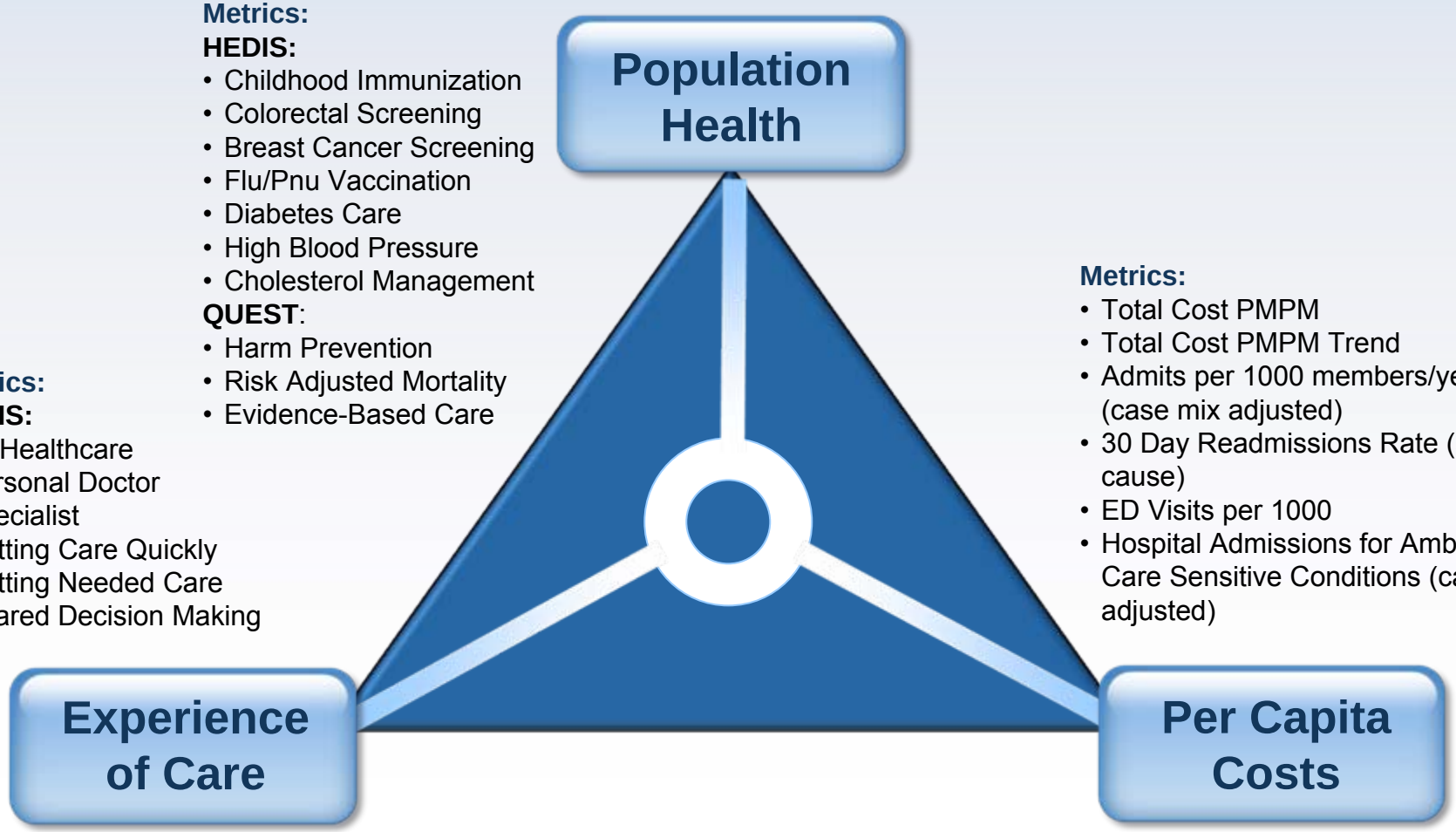
- Long Island Jewish (NY): Continuum of care patient experience monitoring
- Billings Clinic (MT): PCP/SNF care coordination program
- McLeod (SC): Rover nurse program
- Atlanticare (NJ): Special Care Center
- Geisinger (PA): ProvenHealth and ProvenNavigator programs
- Presbyterian (NM): Integrated behavioral health
- Greater Newport Physicians/Hoag (CA): continuum of care analytics and aligned financial incentives
- Presbyterian (NM), Bon Secours (SC): Integrated diabetes CoC model

Accountable Care Phase 1 measures

Metrics:
HEDIS:
- Childhood Immunization
- Colorectal Screening
- Breast Cancer Screening
- Flu/Pnu Vaccination
- Diabetes Care
- High Blood Pressure
- Cholesterol Management

QUEST:
- Harm Prevention
- Risk Adjusted Mortality
- Evidence-Based Care

Metrics:
HEDIS:
- All Healthcare
- Personal Doctor
- Specialist
- Getting Care Quickly
- Getting Needed Care
- Shared Decision Making



Metrics:
- Total Cost PMPM
- Total Cost PMPM Trend
- Admits per 1000 members/year (case mix adjusted)
- 30 Day Readmissions Rate (all cause)
- ED Visits per 1000
- Hospital Admissions for Ambulatory Care Sensitive Conditions (case mix adjusted)

The term triple aim is a trademark of the Institute for Healthcare Improvement

Planning for the evolution of measurement

- Joint national meeting June 7-8, 2011 to iterate next phase of accountable care measurement
- Co-sponsored by Premier, Dartmouth, NQF, AAFP, National Partnership for Women and Families
- Objective is to address limitations of current measurement and identify standards of measurement that assess outcome and value, not just process or outputs.

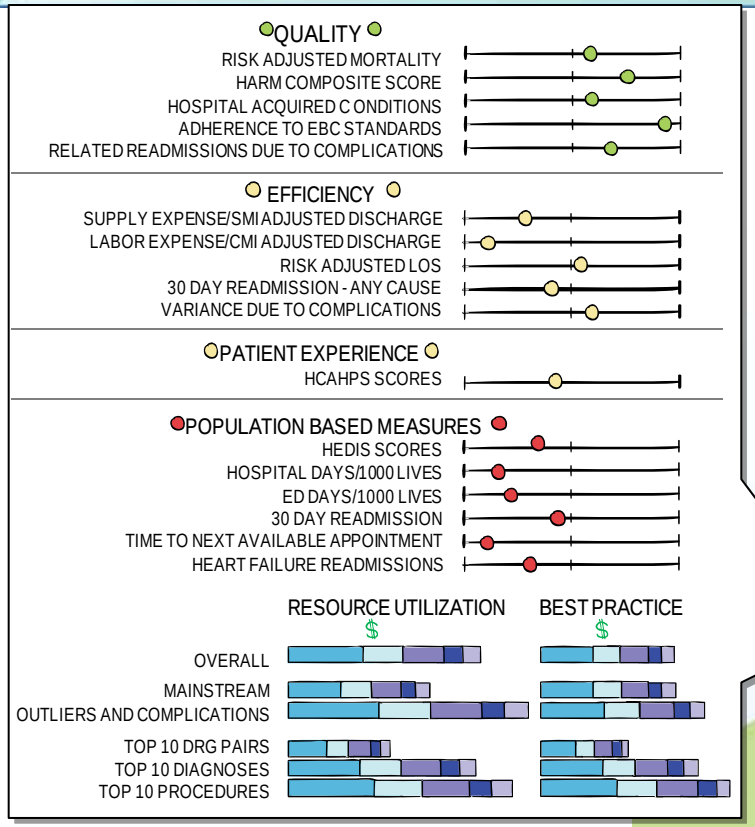
Learnings thus far

- **Managing populations** requires fundamental change within most healthcare systems.
- Fundamental **transformation will be clinical**
- **Physician leadership** is pivotal
  - Care models are **critical building blocks** to an ACO
- **Executive leadership** is vital.
- Keys to success include a **primary care foundation**, plus strong informatics and IT.
  - **Variability** of models is a given…**flexibility** and innovation is **market driven**.
- **Shared learning** collaborative is both a motivator and supportive structure
- Private payor **readiness** to alter reimbursement and share data to support ACO model varies widely.
- **Unknowns** are plentiful…public and private sector have a lot to learn to effectively transform health care

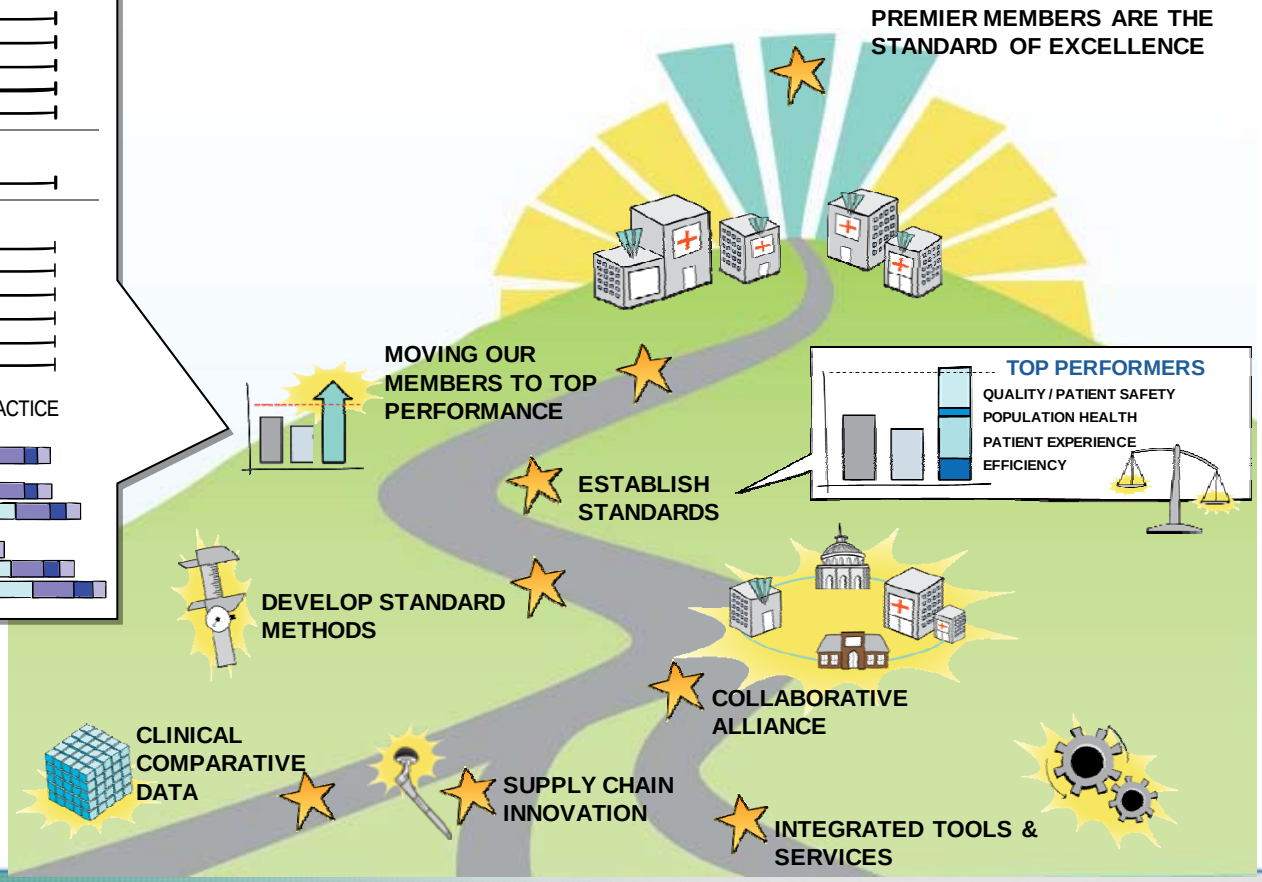
Challenges thus far

- **Population measurement** capabilities
- True partnerships require **paradigm shift for both provides and payors**
- **Resistance to change** with regard to care delivery patterns and compensation incentives
- Achieving the Triple Aim™ of success requires ability to address **clinical AND social determinants of health**, including stronger alignment with public health organizations.
- Agreement on **core measures of success** that are common across the industry.
- **Managing expectations** of all stakeholder groups – collaborative members, government, private payors, etc. – to ensure success at a reasonable and sustainable pace.
- Ensuring that learning from collaboratives appropriately informs **reform rules and regulations**.
- Patient opposition to **disruption of status quo**
- Inadequate information to **evaluate performance**

We cannot slow down, back up or stop on our journey to high performance



MISSION:
To improve the health of communities.



Why all this matters