Health System Restructuring: Building Blocks in the Hudson Valley

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Agenda

- Revisiting the ACO Concept
- THINC Pay for Performance and Medical Home Project
- ACO Attributes and Challenges
- Opportunity in the Hudson Valley: Health System Restructuring
Nature of the Problem

• Current health care reimbursement structures reward volume rather than value and do not encourage coordination or collaboration across unaffiliated organizations.
What is an ACO?

Many descriptions – so a working description:

• An ACO is a way of formally bringing together a set of non-affiliated providers, ideally including primary care physicians, specialists, community health centers, and hospitals, and holding them accountable for the cost and quality of care delivered to a defined population of patients.
Some ACO Capabilities

- Ability to provide and coordinate care across different institutional settings, including ambulatory and inpatient care.
- Sufficient size to support comprehensive, valid, and reliable performance measurement.
- Health information infrastructure to facilitate the necessary performance measurement and care coordination.
- Leadership, particularly clinical leadership, to enable changes in culture and clinical coordination.
HUDSON VALLEY INITIATIVE
Partnership of three organizations

THiNC
Taconic IPA
MedAllies
Based on three shared ideas

- Health care should be patient-centered, coordinated and accessible
- Financial models used to pay for health care should result in lower cost and increased quality
- Health information technology should be used as a tool to improve patient care and community health
With a shared vision

- To improve the quality, safety and efficiency of health care in the Hudson Valley through improved care delivery models enabled by health information technology.
Hudson Valley Building Blocks

• **Health plan involvement and a community-wide data set**
  – Six commercial health plans have partnered with THINC in a pay-for-performance/medical home project
  – These plans are paying an estimated $1.5 million in incentives this year
  – Also populating a multi-year claims data set to enable quality and cost outcome analysis.
Hudson Valley Building Blocks

• Medical home recognition of 236 providers.
  – THINC’s pay for performance and medical home project, 236 primary care providers have received NCQA Level 3 recognition for patient centered medical home.
  – This gives the Hudson Valley community an unusually high concentration of NCQA PCMH providers.
Hudson Valley Building Blocks

- **Electronic Health Record (EHR) adoption rate of 37% (43% among primary care providers)**
  - THINC, under a HEAL 1 grant from the New York State Department of Health, has supported the implementation of more than 600 EHRs in the last three years, a significant factor in area’s high rate of EHR adoption.
Hudson Valley Building Blocks

- **Six years of experience with Health Information Exchange (HIE).**
  - The Hudson Valley’s first HIE has been operational since 2004 and has helped providers achieve demonstrable gains in quality of care.
  - An enhanced HIE will go live in late 2010 to enable exchange of structured data between EHRs to support coordination of care.
Project Participants

236 primary care physicians in Hudson Valley

- 11 groups; 3 FQHCs, 8 physician practices; 51 sites
- Physician practices run from solo practitioners to primary care physicians in multi-specialty groups of 100+

Six health plans

- Provide claims data to data aggregator for quality profile and utilization metrics
- Pay incentives after quality profile is issued
- Participate actively in project design via THINC Quality Cmte

• IBM, as employer, has supported this project and is also making incentive payments
Project Management

THINC
• Use THINC Quality Committee to ensure collaborative process for development of project goals and implementation
• Manage project and all deliverables
• Work with health plans to determine payment process and triggers

Taconic IPA
• Intensive planning for and leadership of medical home transformation initiative
• Physician recruitment

Cornell
• Conduct evaluation, data gathering, develop and administer surveys, analysis, etc.

ViPS
• Data acquisition and analysis

MedAllies
• Development of the quality profile
Lesson Learned: double or triple your time estimate

- 2.5 years of planning work (2006 to 2008)
- 10 months of intensive medical home transformation work (2009)
- 19 months to complete health plan data contracts and acquire data (2009-10)
- 6 months to complete data analysis, and issue quality profile and incentive payments (2010)
Quality Profile

• Will include:
  – 10 HEDIS measures
  – NCQA PCMH recognition level
• Pilot in first year, then if viable, use as basis for incentive payments in following years
• In subsequent years:
  – planning to add EHR-based, clinical quality measures
  – Will also review and validate utilization data generated from project
Incentive Payments

- 2009 incentive payments were issued in Q2 2010 following NCQA decisions
- Aggregate health plan incentive pool around $1.5 million
  - Allowed variation -- payment approach or pmpm varies among health plans
Project Evaluation

- Working with Rainu Kaushal, MD, MPH, and Lisa Kern, MD, MPH, at Weill Cornell Medical College to conduct a robust academic evaluation of project
- Goal is to determine incremental effects of medical home incentives and EHRs on quality and costs
- Three-group study with before-and-after evaluation looking at quality measures, utilization and patient and physician satisfaction

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Evaluation

- Will draw on five years of data, attributed to physician level
- Includes 17 utilization measures as well as quality measures
- Just completed baseline physician and patient satisfaction surveys – analysis is underway
  - High levels of patient satisfaction and physician satisfaction
  - Both patients and physicians noted issues about coordination of care
- Evaluation design should produce results to inform policy debate as well as participant health plans’ decisions about value of medical home
Year 2

- Physicians want to pursue enhanced coordination of care initiatives
  - IHI Triple Aim and Johns Hopkins’ Guided Care Curricula
- Will do an intensive review and validation of data regarding utilization with physicians and health plan participants
- Will repeat both patient and physician satisfaction surveys to look for changes
ACO ATTRIBUTES AND CHALLENGES
Goal: Change Both Reimbursement and Structure of Care

- Not just a different way to reimburse
- Goal is to achieve a different structure of care supported by a different system of reimbursement
ACO Hierarchy of Physician Needs

Specialists (Episodic)

Specialists with long term relationship with patient

Primary care provider coordinating care

Episodic specialists could be part of multiple ACOs
The Everest Analogy

A little more like climbing Everest

1. Climb and stop to acclimatize
2. Back to base camp
3. Climb farther and stop to acclimatize
4. Back to base camp
5. Climb even farther and stop to acclimatize
6. Back to base camp
7. Only then to you make your first summit attempt

Have to create capacity -- this is a long term, stop, regroup and then go proposition
The Escalator Analogy

- Policy makers understand the significant organizational, infrastructure and legal hurdles for ACOs.

- Want to design ACO models that create the ability for creditable organizations to get on first step and then rise up and embrace levels of complexity.

- Right concept – but this is not a glide path upward. Dangerous to underestimate the financial, time, intellectual and emotional commitment needed.
Need HIT Tools

• Need stable EHR implementations to enable population management, closed loop referral tracking, real time quality measurement

• Need health information exchange to enable coordination of care – referral, consult, discharge, etc.
  – Not just what happens within ACO but need to be able to reach providers when patients seek care elsewhere

• Need robust data systems to manage attribution, quality measurement and cost tracking across organizations
Data to Manage Quality and Cost

• Critical issue of “real time” data
  – Need timely attribution of patient population to be able to manage and improve care
  – Need agreed upon methodology

• Payor data is critical – but there is great difficulty in producing multi-payor claims data sets

• Clinical data is critical – but EHR systems are still evolving

• Do not underestimate technical, organizational and political barriers to managing data and producing measures
Proactive Stance Toward Patients

• Medical home model seeks to drive to some key issues that patients want:
  – whole person care and coordination of care
  – communication, patient support and empowerment
  – ready access to care, telephone, email and evening access

• Despite common beliefs, do not think that patients necessarily want more care or more costly care

• But patients should know if their provider is participating in an ACOs
Disadvantage: Small Provider Groups

- For ACO demo, PPACA set a minimum of 5,000 Medicare beneficiaries
- A typical PCP cares for 2,000 patients and usually a quarter to a half are Medicare patients
- Implies that at least 10 primary care physicians would need to be in an ACO to meet this standard
- However, in the Hudson Valley, only about one-third of primary care physicians practice in groups that large
- Leaves a large set of small practice providers that may not be able to manage infrastructure and necessary collaboration for ACOs
OPPORTUNITY IN THE HUDSON VALLEY: HEALTH SYSTEM RESTRUCTURING
Hudson Valley Trajectory to Health System Restructuring: Achieving Real Care Coordination and Outcome Measurement

- HIT Infrastructure: EHRs and Connectivity
- Primary Care Capacity: Patient Centered Medical Home
- Operational Care Coordination: Embedded RN Coordinator and Health Plan Care Coordination
- Value/Outcome Measurement: Reporting of Quality, Utilization and Patient Satisfaction Measures
- Value-Based Purchasing: Reimbursement Tied to Performance on Value (quality, appropriate utilization and patient satisfaction)

Achieve Supportive Base for ACOs and Bundled Payments with Outcome Measurement and Health Plan Involvement
Build on the Base

• Transparency of Outcomes and Value Based Purchasing
  – Get an intensive care coordination program in place – inspired by and trained by Geisinger
  – Pair with outcome data measuring value – quality and utilization measures and patient satisfaction
  – Galvanize health plan payment to support both care coordination and an outcome-based incentive paid based upon value delivered
ACOs

- Support groups well positioned to undertake ACO
  - A number of high performing multi-specialty groups will be ready and able
- Provide quality measure and utilization data to these ACOs and a comparison of performance to community
- Seek to foster a multi-payor approach building on THINC’s P4P-MH project
  - Some commonly agreed-upon principles for ACO operation in the region would facilitate the willingness of commercial payers to participate alongside Medicare
  - Emphasize primary care and care coordination aspects of ACO-driven care restructuring
Alternatives for Small Practices

- Small practices can definitely participate in value-based purchasing
  - But ACOs may be beyond reach because of infrastructure demands
- Some of these groups, however, provide high quality, high value primary care
  - We want small physician practice to step forward and manage the pieces of care that they can
- Terrific opportunity to focus on managing cost and quality for one set of procedures or a diagnosis - a proto-ACO
- … And set up base camp at Everest
Questions

Please feel free to reach out with questions

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