

ACO Collaboratives

Undaunted by Uncertainty



AMGA

American Medical Group Association

Meetings

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The Next Steps in an Evolving Journey

“When the ACO regulations came out, the negativity was felt from one end of the country to another,” said Julie Sanderson-Austin, R.N., AMGA consultant, quality management and research and American Medical Group Foundation (AMGF) director. A strong response would have to follow. So in May, AMGA turned its focus to gathering and submitting comments. (Read more at www.amga.org/Advocacy and in the May 2011 *ACO Regulatory Review* meeting report.)

Undaunted, providers were moving forward with core ACO principles under a variety of frameworks and approaches. This event, the first that brings both AMGA ACO Collaboratives together, featured updates from the field and insights from industry. Integrating care, aligning incentives, engaging employers, and expanding networks—through sharing knowledge on these topics and more, participants showed they were determined to succeed whatever the regulatory climate.

Regulatory Update: Spending Cuts, Pioneers and More

— George H. Roman, Senior Director, Health Policy, AMGA

Already complex and contested, ACO regulations are now complicated by yet another factor: looming budget cuts. Heated debate on the U.S. deficit and the debt ceiling cast scrutiny on everything from Medicare to Medicaid Federal Medical Assistance Percentages, prepayments for power wheelchairs to reimbursement formulas for advanced imaging. The only thing that’s certain, said Roman, is that anything is potentially on the table for cutbacks.

Meanwhile, four days after AMGA wrote the Centers for Medicare and Medicaid Services (CMS) that 93 percent of members surveyed would not participate in the ACO program as written and submitted a detailed list of concerns, the Center for Medicare and Medicaid Innovation (CMMI) announced the Pioneer ACO Program.

The Pioneer ACO Program “exhibits more flexibility and casts an eye to the real world,” said Roman. Although it will use the same quality measures as the proposed final ACO rule, the ACO Pioneer model will incorporate a greater shared savings percentage (60-70%), a greater maximum payout (10-15%), a flat MSR of 1%, no withholding requirements, and losses capped at 10-15%. CMS will allow cost-based dynamic risk adjustment based on costs and levels of risk sharing and will provide claims-level data with identified beneficiaries. Participants sign up for a three-year term with two optional one-year extensions and can drop out of the program by the end of the year.

What’s next for the ACO regulations? Based on what he’s heard on the Hill, Roman said he expects CMS to issue the final ACO rule before the end of the year. If issues still exist with the latest regulations, “AMGA will pursue a legislative fix.” Regardless of these issues or how many providers choose to participate—Roman said he has heard of 10 so far—ACOs will be law by the time the calendar flips to 2012.

Part I: Dispatches from the Field

“Your challenges are very similar, no matter where you are in the spectrum,” said Sanderson-Austin, introducing groups who shared their stories, stumbling blocks, and secrets for success. Discussions covered population health, predictive analytics, Pioneer ACO plans, and more.

Advocate Physician Partners – Seeking Consistency Across Practices

— Lois Elia, Vice President, AdvocateCare

Overview: Within the Advocate Physician Partners (APP) integrated delivery system, AdvocateCare is a newly formed structure for delivering care and managing shared savings across the continuum of practices. “We are really integrating a lot of best practices that we currently have in the system,” said Elia. However, she added, without the foundation provided by APP, which handles managed care and contracting, “I don’t think we’d be able to jump on this.” She cited in particular the challenge of implementing tactics at one- or two-doctor practices.

Highlights of current activities: Advocate has contracted with one commercial payer for global risk and shared savings—an opportunity to bend the cost curve and gain other benefits. Advocate has also signed a non-binding letter of intent to become a Pioneer ACO and has decided not to move forward with the classic shared-savings ACO model at this time.

According to Elia, Enterprise Care Management has been implemented to ensure coordination and continuity among its care managers who work with high-risk patients. Using consultant guidance and the Project Activation Management System (PAMS) model developed at Harvard University, the team developed strategies, tactics, and metrics. “We’re breaking down silos” in outpatient care, mandating the use of hospitalists, and revamping the inpatient side through new job descriptions focused on transition planning. Strategic alliances also are crucial. “We only want to partner with post-acute providers who have great outcomes,” Elia noted. Advocate has signed a contract with MinuteClinic for referral and access opportunities, a move met by mixed reviews from physicians.

Lessons learned: In these improvements, said Elia, Advocate overestimated its ability to balance the interests of key stakeholders (who must be engaged early on), quickly standardize processes, and implement needed systems—and underestimated the time required to build needed infrastructure and adequately manage performance measures. It has been a cultural transformation, she said. “I’d be lying if I said we had a unified perspective on pace and speed.”

Questions/challenges: Can we really drive this improvement while living in two worlds? Elia asked. The model chosen by Advocate balances backfill with shared savings, with a focus on cost reduction. Asked whether Advocate is considering making the model scalable after the concept is proven, Elia said it’s too early to consider such a move. The next step will be testing with the Advocate employer group.

Atrius Health – Strategic Partnerships Are Key

— Marci Sindell, Chief External Affairs Officer, Atrius Health

Overview: Atrius Health is an alliance of five medical groups of varying size brought together by Harvard Vanguard Medical Associates, with a sixth clinic joining soon. “In a lot of ways, we are an ACO,” Sindell noted. “[But now] the things we’ve been doing for a lot of years will now be regulated, legislated and certified, and there will be fewer degrees of freedom.” About the ACO regulations, she remarked, “We think the Medicare Shared Savings Program has too much risk. You might as well put your savings in Vegas.”

Highlights of current activities: Atrius Health has submitted a letter of intent to CMMI regarding the Pioneer ACO Program and is evaluating the likely ROI compared to other possible investments in quality initiatives. Priorities for improvement include:

- ▶ Decreasing costs by 6.5 percent in a year, using Lean techniques, based on a target of 20 percent savings over three years
- ▶ Reducing overuse and practice variations
- ▶ Lowering hospital admissions

In a news-making partnership shift, Atrius Health moved its tertiary and urban care from Brigham and Women’s Hospital to Beth Israel Deaconess Medical Center. According to Sindell, Beth Israel “really understands that when we send our patients there, we want our patients back.” Joint efforts between Beth Israel and Atrius Health include creating an IT interface—the “magic button”—that allows clinicians to see patient records on a read-only basis. The two organizations are also beginning to work toward improvements in risk management and care management.

Lessons learned: Atrius Health has discovered that prepaid global risk programs afford more flexibility than fee-for-service programs, Sindell said. In managing partnerships from start to finish, her team has realized the crucial role of expectation management when developing physician compacts, the power of Lean processes when working with frontline staff, and the importance of managing risk in an environment of patient choice.

Questions/challenges: Under universal coverage, 98 percent of the Massachusetts population is insured, yet affordability remains a real concern, Sindell said, as do state “integrated care organization” laws overseeing transparency, quality, and cost. In daily operations, she said, Atrius Health is challenged to make the job of primary care provider more “doable,” improve patient experience in a large system, and manage relationships among 30 different facilities.

Crystal Run Healthcare – Early Adopters Expanding Services

— Gregory Spencer, M.D., Chief Medical Officer, Crystal Run Healthcare

Overview: Since Crystal Run was an early adopter of the medical home concept and received accreditation by the Joint Commission several years ago, the achievement of Level 3 medical home certification “wasn’t such the trauma it could be,” Spencer said. “But we need to do more than that moving forward.” This included building additional infrastructure to handle things such as claims-based data and expanding the breadth and depth of services.

Crystal Run has experienced significant growth through physician hiring and has had merger discussions with 12 other medical groups. “We’re definitely in the top ten of large groups in New York,” Spencer said, “and we’re being careful about that and looking at the reasons people want to merge with us.”

Highlights of current activities: Crystal Run has submitted a letter of intent to the Pioneer ACO Program at CMMI and is working on maintaining its Level 3 certification through 2012. An online patient portal was set up, but patient and physician use did not show “the great uptake we’d hoped it would be.”

Crystal Run is working on practice redesign, said Spencer, striving for a greater understanding of its population in order to reduce the cost of care, improve care management, and increase proactive care. Guided by a model developed by Geisinger Health System, nurses are helping to close care gaps and are transitioning to case management. Team-based care is being expanded, with the medical home as the center. Care managers continue to be embedded at the point of care, including primary care sites, and are handling more high-risk, complex conditions. Crystal Run has considered embedding them at local hospitals for discharge coordination, but there is “some tension due to past issues,” according to Spencer.

To improve proactive care, Crystal Run is using claims-based predictive modeling and analytics to identify at-risk population, exploring tools for analyzing data from electronic health records and seeking to expand the data warehouse. “There is a lot of population data in the EHRs,” Spencer said, “but payers are extremely reluctant to give up claims data.”

Lessons learned: Establishing teams and bundles for care management “seems to hold great promise,” Spencer said; however, “no one has all the answers.” After “the best quarter in the history of the whole practice,” he said, “we think the ACO is not an end state but a journey.”

Questions/challenges: Are there any validated predictive analytics based on EHR data, not just claims? Spencer asked. How do other healthcare systems identify high-risk patients in order to target proactive care? And how do other systems approach payers to obtain claims data and risk contracting?

Henry Ford Health System – Clinical Integration in a Challenging Market

— Kathleen Yaremchuk, M.D., VP of Clinical Health System Performance, Henry Ford Health System

Overview: “When the rest of the U.S. was in a recession,” Yaremchuk said, “we were in a depression.” The geographic area Henry Ford Health System (HFHS) serves suffered a population exodus, leaving behind patients (many elderly) with expensive-to-treat diseases. “Despite all that,” she said, “we managed to pull through.”

HFHS has “lived under ACO rules for a long time,” Yaremchuk said. The system’s history with capitation includes full-risk capitation with its Health Alliance Plan HMO members since 1986, the Patient-Centered Medical Home (PCMH) program through Blue Cross/Blue Shield and the Medicare Advantage program.

Highlights of current activities: As a preamble to forming an ACO, HFHS adopted a strategy of clinical integration, aligning community physicians with the care practices at the system’s hospitals. The approach was approved by the Federal Trade Commission in December. Under this initiative, a physician-led board of trustees is using HFHS’s experience with capitation and Medicare Advantage to launch a successful ACO.

Each physician will have at least five quality measures to meet, and Crimson software is used to review claims and quality and return report cards to physicians. Because many physicians didn’t have EHRs, Yaremchuk said, “trying to get everyone to share data has been a challenge.”

HFHS has also submitted a letter of intent to the Pioneer ACO Program. Yaremchuk said that, based on the system’s experience with commercial capitation and Medicare Advantage, “we have the knowledge base” to maintain financial viability. The goal: recognition of HFHS as a provider of high-quality care and bending the cost curve while serving a diverse population.

Lessons learned: The right infrastructure is essential to accommodate patient-centered team care, panel managers for patient outreach, case managers for chronic conditions, and a patient registry, Yaremchuk said. High-quality care has been fundamental to success in the capitation environment, as has physician education in areas such as coding, copays, benefit design, and decision-making surrounding medical necessity. To survive capitation, Yaremchuk said, “Live within your budget. It’s a matter of educating employers on what’s a reasonable benefit.”

Questions/challenges: Among the challenges cited by Yaremchuk are the “670-plus benefit plans we have to figure out how to administer” and the task of collecting quality data from socioeconomically challenged areas. Also, when a significant portion of the population lacks insurance, “you have to be careful, because you can’t make it up in volume.” Access is an important issue; HFHS strives to provide service on Saturday and during early and late hours at its clinics. Population monitoring can be difficult, as data from insurers can lag as much as 12 months. As for Medicare Advantage patients, Yaremchuk said, “The idea of being an ACO and responsible for this population keeps us awake at night.”

Holston Medical Group – Performance Measurement and Payer Partnerships

— Owen Poole, President, CMD9, Holston Medical Group

Overview: Holston Medical Group (HMG) covers Smith County, Tennessee, where some patients must drive an hour to the nearest provider. “We have everything you typically see in a multispecialty group except cardio,” said Poole. “We see ACOs as tightly wrapped with patients and medical home,” he said, although HMG has not implemented the medical home concept in all its offices yet.

Highlights of current activities: “We don’t have the size and scope to become an ACO. We do have good relationships with managed care,” said Poole. To measure performance, “HMG has had to become a bit of an opportunist,” he said. For instance, to build its own registry, HMG started with claims data—“accepting all its faults”—and queried its own database to identify gaps in care, obtaining underwriting support from Blue Cross for the registry infrastructure. “We always try to ask for things they’re capable of doing and they want to do.”

New initiatives include:

- ▶ Capturing data on the front end to avoid gaps
- ▶ Reworking quality targets to be more appropriate and clear to managers
- ▶ Building into contract negotiations a commitment to “visit” in the contracting offseason
- ▶ Negotiating more supportive relationships with referral sources
- ▶ Using Skype to expand virtual reach to the population

In the area of compensation, HMG is creating relative value unit “lookalikes” as a proxy for value-based reimbursement. However, quality metrics and financial performance also have to come together to create behavior change. “The real issue,” Poole said, “is how you sustain it.”

Lessons learned: HMG has found process buy-in to be as important as process management and that all meaningful gains must involve payers. In addition, because there will always be noncompliant patients, it’s important to budget for the resulting costs.

HMG has worked with its managed care partners on a number of issues, including capturing bidirectional data and deploying nurse practitioners to patients’ homes in response to access issues. “Everybody’s a partner, and we’re progressively becoming more dependent,” Poole observed.

Questions/challenges: Sticky issues include determining the critical mass required for HMG to change its market share and addressing the eventual need for a capital partner. Like many others, Poole cited the need for culture change: “Doctors have had to step up and become good administrators.”

ProHealth Physicians – Integrating Processes, Building Capacity

— Bethany Kieley, Director, Practice Operations, ProHealth Physicians

Overview: With 268 primary care physicians and nine specialists providing care to 10 percent of Connecticut’s population, ProHealth Physicians has made “great progress” over the past eight to nine years. For example, the group’s risk management tactics reduced malpractice premiums by 50 percent. Today, its fee for service (FFS) market is in a state of change. According to Kieley, employers and payers are driving payment reform, and “every hospital is buying up doctors” and beginning to build their own ACO platforms and strategies.

In response to these competitive dynamics, ProHealth plans to develop capacity for population management, increase clinical integration with specialists, and form a larger, physician-owned entity. This entails evolving its PCMH into a more continuous system of care management that can improve quality and decrease costs and leveraging the reputation, brand, and market share that has contributed to its success so far. “We’re the organization the payers come to first with a new idea,” said Kieley.

Highlights of current activities: ProHealth has completed a capital development plan to support its plans for population management and physician and provider growth—the foundation of ACO shared savings. To create a more comprehensive care strategy and workflow, it is implementing the PCMH model at all sites—70 sites have been submitted for National Committee on Quality Assurance (NCQA) PCMH Level 2 recognition so far—and is working with the State of Connecticut, Anthem, and UnitedHealthcare on a pilot PCMH for 17,000 members.

To begin to develop the infrastructure for population management, ProHealth has implemented Allscripts across its sites and upgraded its EHRs. Despite a sophisticated data repository, “we’re behind the curve in data sharing,” Kieley said. Rather than pursue the CMS or Pioneer ACO models, ProHealth is looking at commercial gain-sharing through either a hospital-driven or a doctor-driven ACO. The determining factor: Who will deliver care best?

Lessons learned: Be creative, advised Kieley, citing ProHealth’s solution to the following dilemma: Is it better to build or buy population health management capacity? Finding its capital development plan “almost completely unaffordable” for a primary care physician organization to support, ProHealth discovered alternatives in the private sector. Now the group is talking about ACO solutions with Aetna and Cigna, which are providing care management and services under a private label arrangement so providers “don’t need to invest millions.”

Questions/challenges: As ProHealth moves forward in addressing today’s challenges, new questions are emerging, said Kieley. Many relate to growing and managing the physician network. How can struggling doctors be transitioned out of the system? How can the 9-to-5 model many doctors want be reconciled with the need to attract more patients to the network? Kieley said she was intrigued by the structure used by Advocate Health Partners as well as the possibilities presented by clinical integration. And does this generation of doctors want to own a practice or be employed by one?

Sutter Health – Tools for Accountability

— Rosemary Jordan, M.P.H., M.P.P., Regional Director, Network Development, Sutter Health West Bay Region

Overview/background: Sutter Health’s more than 5,000 doctors provide care in more than 100 communities throughout northern California. As its physician network has grown, the provider has worked to increase clinical integration and reduce variation across practices. Other initiatives to transform care include patient-centered medical home teams and an advanced illness management program. The strategy, says Jordan, is to build an “accountable integrated care delivery system for the future.”

Highlights of current activities: Sutter Health has a long history of active patient councils and focus groups but until now has had no way to “hard-wire” patients’ voices into the institution. It is now creating a campaign to personalize care through listening to patients, enhancing their access to services, using data analysis to educate and add value, and rightsizing the number of face-to-face visits to deliver a better experience.

This campaign involves coaches, who make patients part of the care team, and tools that give patients the ability to be accountable for their care. For example, Sutter Health is redesigning interactions to work across new technologies, from mobile education to phone messaging to biometrics. Sutter Health is also using a 3D “n-dimensional” model to explore how to leverage data in ways that lead to better management of care. This model looks at an often-overlooked aspect of health determinants: the patient’s social environment, including level of risk, social isolation, and financial independence. Such data segmentation can help Sutter Health devote limited resources to the people most able and likely to activate change.

As its network grows, Sutter Health is pilot testing new programs. However, impressive infrastructure and results in one area haven’t always been replicable in other areas, Jordan said, so her team is also focusing on improving consistency. Lean and other tools are used for process improvement and to “bond people to our brand” across systems and locations.

Although Sutter Health has submitted a letter of intent to the Pioneer ACO Program, it continues to monitor both the Shared Savings Program and commercial opportunities.

Lessons learned: Think broadly, said Jordan, calling interdisciplinary perspectives “paramount.” To augment its own capacity, Sutter Health has found value in identifying and leveraging internal subject matter experts and identifying like-minded external partners. Meanwhile, introducing accountability initiatives in increments has proven helpful for moderating both start-up costs and impacts on staff and patients.

Challenges/questions: For other providers personalizing care delivery, Jordan asked the following: How do you evolve your organizational culture to support care accountability? What are your greatest IT-related challenges (and how do you overcome them)? And what strategies do you apply to build patient empowerment and participation in the care plan?

Swedish American Medical Group – Data-Driven Solutions

—Thomas Schiller, M.D., President, SwedishAmerican Primary Care Group, Swedish American Medical Group

Overview/background: Since Swedish American Medical Group (SAMG) started in 1994 with just 23 providers, it has morphed into a multispecialty group with 110 providers in 17 locations, including 2 hospitals. The PCMH is integral to SAMG's efforts. "It's going to be about data," Schiller said—and this goes beyond claims data. The group's recent affiliations with Anceta and Humedica will enable SAMG to mine data to identify high-risk patients and their needs.

Highlights of current activities: SAMG is not participating in either ACO option. "We're a little too small to be an ACO, so our only option is to join forces," said Schiller.

As one example, SAMG is trying to get a handle on costs by partnering with a local business coalition to pilot the PROMETHEUS™ payment model. "We're looking at what we're doing and what it's costing us," said Schiller. In reporting performance across multiple metrics—3 conditions and 12 measures—SAMG aims to identify potentially avoidable complications.

SAMG is moving toward bundled payments; however, its relationships with 20 third-party administrators make data collection a challenge. A partnership involving Coventry's CMS-approved ACO model allows SAMG to offer case management and care coordinators who can contact Medicare Advantage enrollees. These 7,000 enrollees may not be a big number; however, it's "a good opportunity to get our feet wet," Schiller noted.

Lessons learned: Getting everybody on board has been key, said Schiller. Given the amount of work involved in developing an ACO, effective coordination also has been a pre-requisite.

Challenges/questions: Not only does Rockford, Illinois, where SAMG has its headquarters, have the highest unemployment rate in the state—just under 14 percent—providing care for self-pay patients through a federally qualified health center in conjunction with Medicaid makes it difficult to come out far ahead, said Schiller. Adding to the challenge: Even though SAMG is the market-share leader, potential mergers and acquisitions among competitors mean that it "can very quickly become the small player in the community."

Vanderbilt Medical Group – Medical Home and Population Health

— David Posch, Chief Operating Officer, Vanderbilt Medical Group

Overview/background: With the largest health IT department in the world and 500 biometric scientists providing clinical decision support, Vanderbilt Medical Group's strengths lie in areas such as research, education, and tertiary treatment protocols. "What we're not good at," said Posch, "is thinking in terms of population health and medicine."

The group's strategy covers programming, cost performance, and networking. It is working on developing medical home and care management tools and techniques for provider networks and fine-tuning medical home programming. Plans also include improving access and standardizing care in ambulatory settings, launching bundled payment packages for high-opportunity interventions, improving the fiscal performance of its employee health plan, and exploring the feasibility of a regional network.

Eighty percent of employers in Vanderbilt's market are self-insured and actively interested in a provider-driven approach. However, because Tennessee is primarily a FFS market, the group sees too much risk in Medicare ACOs. Vanderbilt is nonetheless focused on delivering value-based care, said Posch, by recrafting what it does to produce greater value, focusing on coordinating care across a continuum, and actively engaging patients and families.

Highlights of current activities: Five broad efforts currently under way involve bundled payments, medical home, network development, health plan cost containment, and clinic redesign. Vanderbilt is looking at where the highest costs are so it can value-engineer those areas first and drawing on its research expertise to create care management tools and techniques for provider networks. In an effort Posch described as "not for the faint at heart," an HIE is being developed for the central Tennessee region that will be the backbone linking area hospitals and physicians.

In the area of acute care, the group is targeting chronic diseases to fundamentally reengineer every part of the first six months of care. The goal: to establish a control care process and wrap an economic package around it that "we'd be willing to go into risk for," said Posch. "We want to make sure we have an elegantly designed process that solves the problem of lack of coordination. We're learning the issues of patient engagement, particularly care transitions and the use of care coordinators." Vanderbilt is developing a medical home from a primary care base, with tools and techniques that are scalable and can be spread among practices. It is aiming to gain significant control over certain chronic conditions and achieve key milestones within eight-week timeframes.

In response to escalating employee health plan costs, Vanderbilt started with pharmacy costs, applying research findings to more effectively manage acute care episodes, medication utilization, high-risk/high-cost patients and changes in wellness and behavioral patterns. Drawing from private sector examples, the group set up a medical home approach, using an algorithm to identify potential "train wrecks" over a 12-month period and get those patients under ambulatory care management. After identifying the acute syndromes that affect members the most, Vanderbilt is redesigning care processes.

Lessons learned: In a closed staff model, Posch pointed out, it's easy to manage costs. In an open network, things get complicated fast. A key problem is geographic access. "Do we have providers where employees live? In areas without, let's get them into a network."

Furthermore, change takes time because everything is connected. "The dominos are stacked." Many initiatives—such as IT, meaningful use, ICD-10, and clinical integration—require significant cultural shifts, and implementing them can generate a "perfect storm" of activity. After picking the low-hanging fruit, Posch observed, the work gets much harder. Critical patient engagement is often elusive, clinical integration is an evolutionary process, and initiatives such as medication cost containment and changing FFS expectations tend to take longer than anticipated.

Challenges/questions: Vanderbilt's questions were both sweeping and specific: How do we develop the infrastructure of an advanced medical home and improve access within the organization? How do we improve health and wellness initiatives and administer bundled packages for problems like back pain and depression?

Posch also cautioned participants to identify "silly incentives" that don't align in terms of plan design. For example, copay incentives make people with chronic disease think twice about whether to see a doctor; however, those are the very people who should come in.

HealthPartners – Achieving Triple Aim Results

— Sue Knudson, Vice President, Health Informatics, HealthPartners

“In Minnesota, HealthPartners is doing the work everyone is wanting to do,” Sanderson-Austin said in her introduction of HealthPartners, which has achieved a top 20 NCQA insurance ranking, medical home recognition, and recognition in its region as a “best place to work.” In addition, the provider has met its margin targets for the past nine years while improving physician satisfaction. “Culture is really the linchpin in how we get this done,” said Knudson.

How did HealthPartners achieve such transformative results in health, experience, and affordability?

- 1. Set goals—and aim high:** “We want the best local and national outcomes at the best cost,” said Knudson. HealthPartners just retired its five-year goals for 2010 and is now working toward “lofty” ones for 2014.
- 2. Redesign care:** The revamped care model is clinic- and hospital-led, with standardized IT and processes and publicly reported measures. The focus:
 - A. Reliability (consistency across the continuum)
 - B. Customization (segmented interventions to reduce disparities in areas such as mammography screenings)
 - C. Access (making care and information convenient and easy).

“Everyone on the team knows where a patient is in the plan,” she said. “It’s really done a lot to build trust and confidence.”

- 3. Proactively identify and engage high-risk populations:** Across the delivery system, her team uses informatics, claims and risk assessment data, care team referrals, and a consistent approach to identify and stratify patients. Patients then are engaged through face-to-face interactions, proactive outreach, and detailed action plans.
- 4. Support healthy lifestyle choices:** HealthPartners measures behavioral characteristics through health assessments and a patient satisfaction survey, directing patients to wellness programs and services accordingly. “Here’s where the big gains are,” said Knudson.
- 5. Provide actionable data:** Once a year, HealthPartners conducts a full assessment of total cost of care—from providers and community partners to pharmacy and lab work to ancillary care. Its measurement system—similar to ACO benchmarking, using Johns Hopkins methodology—demonstrates one group’s performance to the next and calculates cost-of-care dollar savings right down to the number of scans involved for every point of improvement.
- 6. Transparently report results:** In addition to its internal reporting methods, HealthPartners gives consumers the ability to view provider ratings, conveniently coded with dollar signs and stars.
- 7. Align compensation, payment, and plan design with Triple Aim goals:** HealthPartners started its Partners in Excellence incentive program in 2007. Today two-thirds of its members receive care from a provider with a total cost of care agreement.

Group Health Physicians – Post-Acute Transitions in Care

— Bruce C. Smith, M.D., Service Line Chief for Continuing Care, Group Health Physicians

To battle climbing inpatient costs, Group Health Physicians set up a medical home and redesigned specialty care. Despite growing enrollment, the provider saved \$51 million. The secret: easing the transition to post-acute care every step of the way.

Step 1: Preadmission: Discovering roughly 25 percent of admissions to be “social admissions” that required placement in other care settings, Group Health partnered with extended-stay facilities and ramped up its staff and resources. This not only yielded an accurate picture of next steps but provided the ability to swiftly act upon it. Group Health also delivered education in advanced illness management. Previously reticent doctors were trained to talk directly and overtly about diagnoses with chronically ill patients and family members, empowering the latter to make plans for moving forward.

Step 2: The hospital: Having urgent care teams, Epic, and administrative staff, including discharge planners, at all hospitals helped Group Health “right-size the stay.” Within each hospital, Group Health instituted standardized work processes, daily huddles, transition coaching using Eric Coleman’s “Four Pillars” model, and health summaries presented when a patient was discharged.

Step 3: The nursing home: Group Health worked with its nursing home partners to increase access, so patients wouldn’t have to wait days to be admitted. Upon admission, patients now find teams of nurse practitioners and physicians waiting for them, with transition plans for the next phase starting almost immediately. Group Health actively tracks patient rehabilitation levels, functional status, and nursing home performance and, when needed, helps fill IT gaps with systems to document Epic-compatible systems (to keep care consistent), laptops, and DSL lines.

According to Smith, ingredients for success included:

Lean/Kaizen training, ongoing monitoring, and continuous process improvement. “Once it’s part of your culture and DNA, it really works,” Smith said.

Advanced illness management training. Physicians learned how to talk about end-of-life planning and were given decision support tools. “This was worth taking everyone offline for a day,” said Smith.

Metrics. Hospitalist teams (and many specialists) have committed to doing medication reconciliation in Epic, which Smith cited as the key to transition and quality of care. In addition, Group Health is using senior metrics to gauge a patient’s functional level upon admission, is rigorously tracking patient length of stay, and is sending out patient surveys one to two weeks after discharge to gauge satisfaction and ensure that patients understand medication and other health plans.

Shared metrics, goals ease payer partnerships: Shields sees the move towards a single industry standard of metrics as one of the key contributions of the ACO regulations and something that will make negotiations with insurance companies easier. Shared goals and shared savings—saying “We want to work with you to eliminate waste and produce a price-competitive product”—facilitated Advocate’s partnership with Blue Cross, the biggest payer in its market, Shields said. He added that the Enterprise Care Management infrastructure this partnership has made possible has been core to delivering care.


Advocate Health Care – Managing Quality Across a Physician Network

— Mark C. Shields, M.D., M.B.A., Vice President, Advocate Health Care

With 3,800 physicians, most in independent practice, Advocate Health Care is in a favorable position. It is one of few providers with Federal Trade Commission approval to move ahead with the model, and it contracts with all payers in marketplace. Shields talked about why a provider might want to work through a physician network—and the secrets to making it work.

Culture: “Getting the culture right first is absolutely essential,” said Shields. To strengthen a sense of “shared identity” among “the few, the proud, the elite,” Advocate has ramped up its membership requirements and supported its doctors with comprehensive education, coaching, IT tools, and feedback. When Advocate recognized exemplary physicians with a simple paper certificate, those who did not receive the certificate “almost had a riot,” said Shields. “Physician pride is very important. You want to use it to your better purposes.”

Governance: In 2005, Advocate brought in an outside director to help review and revamp its governance structure. Today all doctors are organized around local physician-hospital organizations (PHOs), which each have their own boards and are heavily focused on clinical integration and outcomes. Local governance is supplemented by a part-time local medical director and a PHO director. Advocate supports these leaders with a formal orientation that includes fiduciary responsibilities and leadership development training: “Just because a doctor is a good physician doesn’t mean he or she will be effective working on a quality committee.” Doctors are also compensated \$150 an hour for the time of the meeting plus an hour for prep. “It’s peanuts compared to the impact it has,” said Shields.



Infrastructure: According to Shields, effective infrastructure allows multispecialty groups to really drive effectiveness. Advocate's efforts towards strengthening its infrastructure include clinical integration, disease registries, and performance metrics, announced via "doctor report cards" and supported by patient education. Advocate also has enlisted physicians in a mandatory program to reengineer their practices and maintain their certifications. In addition, Advocate's quality committee is developing protocols for pharmacists and doctors to work together in areas such as medical care management coaching.

Incentives: "Chlorophyll is not the only green catalyst," said Shields. At Advocate, 70 percent of incentives depend on individual performance and 30 percent are tied to preferred provider organization (PPO) performance. Internal and external transparency is key to success. Advocate publishes a "Value Report" that employers and insurance companies can access online, and physician performance is evaluated against metrics designed by the quality committee and endorsed by the board of directors.

Part II: It's About the Value

Measurable value speaks for itself as a powerful argument for change. These sessions explored ways to build value through models and partnerships.

Developing the Economic Model for Success

— Richard Ward, M.D., President, Reward Health Sciences

Underlying every successful ACO is a forward-looking, carefully constructed financial model. Ward shared insights gained from his work with Reward Health Sciences, a consultancy and IT developer dedicated to partnering with physicians and hospitals to create ACOs.

Cause and effect: Groups looking at gain-sharing to reduce costs first need to understand the mechanisms and actions that will yield the biggest bang for the buck, said Ward. For instance, many health systems invest in HIEs or other IT systems to reduce service duplication. However, this tactic often generates “relatively small effects, if you do the math.” For greater impact, he advised also looking at relationships in the areas of:

- ▶ Lean process improvements, which can reduce the resources required per clinical service
- ▶ Patient self-management
- ▶ Care coordination, especially over time, to reduce the rate of avoidable clinical events
- ▶ The referral influence of primary care providers
- ▶ Provider consolidation, which can increase market power and pricing potential

Structural dilemmas: Health groups also need to understand how to negotiate the “many to many” relationships among plans and providers, Ward said. One party’s cost savings often represents another party’s revenue loss. For example, a hospital that acquires a primary care provider practice may want doctors, the “natural owner” of the patient, to speed up their work, which reduces their revenues.

Specialist integration also demands a strategic eye and deft touch. Those in areas like oncology, focused on length of stay, might naturally align with hospitals while those in chronic disease, with a focus on transitions, might be a better fit for a patient-centered medical home. “There are models that are emerging that are making sense,” said Ward. Furthermore, groups need to understand that health plans often resist co-investments in IT and other improvements if their competitors will benefit (especially if these competitors did not chip in). Partnering with a nonprofit with a social mission, like one of the “Blues,” can be one solution, suggested Ward.

Health information technology: This is an ACO’s “No. 1 financial investment,” said Ward. Rather than merely strive towards paperless and painless operations, today’s IT systems are all about increasing the accessibility, exchange, security of data, and transforming processes. What are the IT capabilities needed to implement a patient-centered medical home or a population health model? What outcomes data can you capture to help you plan care, implement best practices, assess cost and quality, and inform the next iteration of planning?

Answers can be found through care execution tools, which help doctors and clinicians make changes to the process as they innovate. Ward cited data registries, which put the power in the hands of the clinical leader. To find the best tools and processes, he suggested that providers explore what other industries have done in the areas of workflow automation and business process management. Even across sectors, the fundamental purpose remains constant: To create an IT framework that allows users to do a job comprised of constantly changing requirements, make improvements and determine if the improvements worked.

Analytics: This key ingredient to health IT is the logic that gives data meaning, particularly essential when “things that seem quite intuitive end up, upon analysis, not really working at all,” said Ward.

According to Ward, “We need more models,” particularly when asking where care centers should be located and whether care interventions should be done for everyone. “You have only a limited amount of resources to work with to get the optimal results. And you need people who understand this and are passionate about this. You need to build up that core competency in your organization.”

Tips for model ACO success

According to Ward, analysis used to support strategic planning should:

- ▶ Show how all the pieces fit together and constrain analyses to believable truths
- ▶ Account for random variation, uncertainty and “missing” values — e.g., what doctors didn’t say in a satisfaction survey
- ▶ Use “raw” data (cleaning-up often results in misleading findings)
- ▶ Bring in sophisticated statistical approaches for highly rigorous analysis
- ▶ Look forward, not just in rear-view mirror

Succeeding in Delivering Value-Based Care

— Matthew Wiandt, Vice President, Provider Solutions, Carol Corp.

The transition to value-based care can be simple as a move to diagnosis-related group payments or as complex as trying shared savings with a payer, said Wiandt. However extensive the journey, getting started begins with questions involving comparison and quantification, such as:

- ▶ What's the health risk status of your patients compared with those in the community (including the risk of the patients who access care down the street)? And have you fully recorded it? (If not, you might not appear as rigorous in the marketplace, Wiandt cautioned.)
- ▶ How does your utilization compare with others? Transitions can be easier in states with low usage levels, such as Iowa, than in high-usage states like Louisiana and Florida.
- ▶ Have you conducted a total contract value analysis? "You might be surprised about who turns out to be your best payer," said Wiandt.

Changing care—whether this be to population-centered delivery, or to a value chain that doesn't hurt an existing fee-for-service system and builds future capabilities—incurs change operation-wide. Your payment systems will have to accommodate total cost of care, said Wiandt. You will need to change how you manage patient risk and help patients navigate the care path. And you will need to think about engagement; because it will be challenging for patients to wrap their minds around "less care, more quality." For acute issues, patients really want to be seen.

Mapping—and making—the transition: Wiandt advised that groups spend time on a financial model to see what that transition will look like in terms of investment and contract needs, spending per person, and leading indicators in the marketplace. This allows funding sources for investments to be developed early in the process. It also strengthens a group's ability to establish stop-loss and aggregate loss measures while working with payers and to make its transition as quickly as possible, rather than generate savings first and then have to share them.

For a framework, Wiandt suggested creating a roadmap around a series of targets. For example, a provider might establish leakage for currently attributed patients to determine how many can be kept within the practice. Wiandt also recommended identifying unprofitable care, such as uninsured care, and leveraging this risk management opportunity for building new patient care capabilities, from interventions to outreach strategies. "Even though you don't want to practice different care for different patients, this will help you understand profitability," he said. He also suggested finding the points when your organization thinks that increasing costs might increase revenues. Then you have an idea on the initiatives you could get started on now, as well as projects to prototype ahead of time.

Collaborative thinking: Participants wanted to know more about enhancing medical home in contracting. To effectively balance having "one foot on the dock and one foot on the boat," Wiandt suggested starting with an investment in a small area that can be diffused as you go.

Other questions involved designing data and analytics. Do you raise capital yourself for IT or partner with a payer who might have systems developed over time? In most markets, payers are taking a wait-and-see attitude, said Wiandt. If they start paying for quality in ways competitors are not, it will ultimately affect their premiums and rates compared with others. He offered the following guidelines for successfully approaching, engaging, and working with payers:

- ▶ Approach people outside of your usual payer contacts in a timeframe that is off cycle from regular contract negotiations
- ▶ Ask yourself “what value proposition can I make that’s better?”
- ▶ Think about what you could take on—e.g., administrative complexity or care management dollars
- ▶ Try suggesting a partnership, product, or service that “gets the market started”

Bridging the Value Gap: Value-Driven Opportunities for Providers to Partner with Employers

— Jack Nightingale, M.P.A., Vice President, and Chuck Reynolds, M.S., President, The Benfield Group

Nightingale compared today’s healthcare landscape to a rugged topographical map. Within each market, ravines represent gaps in health status, quality, and value, with one side excelling and the other struggling. Also separated by a chasm: employers and providers, often reaching out trying to find a partner in vain. In some markets, there’s a bridge, said Nightingale, in others, frustration due to misaligned incentives and lack of communication. His goal: to provide information and insight to help participants more effectively partner with employers in ways that provide value.

Step 1: Choosing the right employers to engage: While a multinational like GE might have tremendous nationwide buying power, in a health provider’s more immediate radius, the ones who could “really move the needle” might be a school district or the local government. Nightingale also advised that “bigger is generally better, but smaller can be less complicated.”

Partnership readiness can be evaluated across two continuums: tactical/strategic in their planning styles and siloed/integrated in their view of value and care delivery. Employers falling under the categories of strategic and integrated are ideal—and also rare, said Nightingale. Strategic and siloed is the more likely workable combination. A tactical/siloed employer will be motivated primarily by immediate cost savings, he cautioned.

Step 2: Finding out what’s on their radar screens: Only research and conversations will pinpoint specific needs within a market; however, some challenges appear to be universal. These include controlling the cost and productivity impact of conditions such as depression and cardiovascular ailments, engaging employees in long-term wellness efforts such as weight loss and smoking cessation, and avoiding the “Cadillac tax.”

“Consumerism”—developing employees to be smart healthcare consumers—is by far the number one trend, according to Nightingale, followed by transparency, health reform, care coordination, and total value measurement. The employer drive towards consumer-directed health care has big implications for providers, Nightingale said. Most employees today are naïve, presenting both a challenge and a value proposition opportunity. Can you help them:

- ▶ Manage high-cost populations in a more intensive or effective way?
- ▶ Deliver superior care at the worksite?
- ▶ Empower employees and dependents to be more effective consumers?

Step 3: Engaging stakeholders: Once you’ve identified your potential place in an employer’s supply and value chains, Nightingale advised, create demand for a partnership with a good story. Identify the problem, describe the impact, and build your evidence over time. Although this approach is simple, the account management should be sophisticated, comprised of outreach to both direct decision-makers and intermediaries through seasoned executives. “Don’t just put your key customers in the hands of a 20-something intern,” Nightingale advised.


Demonstrating Value to Employer Purchasers with Health and Productivity Metrics

— Thomas Parry, Ph.D., President, Integrated Benefits Institute, and Chuck Reynolds, M.S., President, The Benfield Group

CFOs today—motivated into compliance-driven strategies thanks to developments such as health reform and the Cadillac tax—no longer see health benefits as a “cost of doing business.” Realizing that managing costs by managing claims is a dead end, the focus today is on trying to get and provide value. Key to defining value is answering the following question: What do “health costs” really entail? Under the old view, medical claims plus pharmacy costs comprised the full picture. The expanded view encompasses financial lost productivity, including absence costs (paying wages for people not to come in when they’re sick) and lost productivity due to “presentee-ism” (people not functioning at full capacity).

Getting a handle on financial lost productivity demands a broader understanding of 27 chronic health conditions, such as depression, fatigue, and heart troubles, that affect employee performance. According to Reynolds, typically nine out of ten employees identify at least one of these conditions as impacting their work—resulting in three percent to four percent lost productivity every single day they’re on the job.

Although employers intuitively understand the impact of financial lost productivity, they haven’t yet been able to put their arms around the numbers, said Reynolds. “I’ve never seen employers more interested in and focused on data than I’ve seen them today.” Yet they’re inundated by data in some areas and have none in others, victims to slicing data into segments.



What is the secret to talking to employers about the issue of metrics and making these real and helpful to them? First, move “from ROI to VOI”— from conducting analyses to thinking of health as value. Then “think top down” with a focus on populations, not diseases. Reynolds suggested using a dashboard to track over time 10 key dimensions in population health: financials, program participation, biometric screenings, health risks, utilization, preventative care, chronic conditions, lost work time and productivity, and employee engagement. If you bring the data and metrics, you can become a valuable partner who will be very hard to displace, said Reynolds.

But quantifying lost productivity and population health is just the beginning. The session concluded with participants asking how they could work with employers to share data in the current siloed marketplace, better manage absences under the Family and Medical Leave Act (which currently allocates 12 weeks of leave even when an employee might be ready much sooner), and bring employees back to work more effectively after disability leave.

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