

# ACO Development Collaborative

*Sharing Insights, Strengthening Capabilities*



**AMGA**

American Medical Group Association

**Meetings**

October 1–2, 2010 Hollywood, Florida

## “This is about redesigning the delivery system to compete in a new world.”

—Donald W. Fisher, Ph.D., CAE, AMGA President and Chief Executive Officer

**T**his first meeting of the ACO Development Learning Collaborative launches a year of hands-on collaboration among healthcare providers nationwide in navigating this model’s complexities. How can new regulations translate into reality on the ground in a way that benefits both providers and the patients they serve?

To find the answers, said Julie Sanderson-Austin, R.N., event chair and AMGA vice president of quality management and research, “we need to begin to think of ourselves as a community that can share ideas, cast ideas, and not be afraid to fail.”

The Collaborative represents health systems of all sizes, structures, and stages in the journey towards ACO-ready operations. Arch Health Partners in California, for example, has been successfully operating under a capitation, rather than fee for service, system for 20 years. Its latest initiative: building a billion-dollar “hospital of the future.” HealthPartners Medical Group in Minnesota just received National Council of Quality Assurance (NCQA) certification and currently is integrating financing and care delivery systems. Participants shared reasons for interest and participation:

- ▶ “We want to learn how to do this with community-based physicians and learn about the economics with this related to risk,” said David R. Posch, M.S., Vanderbilt Medical Group
- ▶ “Six years into a 10-year strategic plan, we’ve been invited to join a physician health organization. Should we join or should we go independent?” asked Robert E. Matthews, PriMed Physicians
- ▶ “Seventy percent of our revenues come from Medicare and Medicaid. That’s where the interest in ACO comes from,” said Michael Dowling, Montefiore Medical Center

In general sessions and workshops, participants learned about measuring and reporting tactics and legal labyrinths. They talked about different ways to achieve clinical integration, such as leveraging technology, incorporating Lean Six Sigma principles, and successfully bringing in services like mental health and end-of-life care. They used interactive exercises to explore barriers to collaboration and gained insight into the employer perspective through hearing firsthand the strategies of two major corporations.

Highlights from this intensive day and a half of meetings follow. Complete presentations are available to collaborative participants at [www.amga.org](http://www.amga.org).

# Understanding the Payer/Employer Perspective

**“Employers will not be able to continue to provide health care unless (the cost) curve goes down.”**

– Melissa Miller, NextEra Energy

In the United States, 70 million active employees and 89 million dependents receive health insurance through their employers. Which ones should ACOs target for partnerships in these crucial beginning stages? How can ACOs and employers work together? How are forward-thinking payers approaching today’s challenges of balancing costs and care?

**“I need employees to be healthy, at work, and able to do their job every day.”**

– Chuck Reynolds, The Benfield Group

## **When Providers Meet Employers: How Emerging ACOs Can Pick the Right Partners**

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With this perspective in mind, said Reynolds, employer approaches toward purchasing benefits tend to be either tactical (price-driven, “they don’t want to hear about quality”) or strategic (value-driven, with a focus on analytics). Their financial/economic orientations span a continuum from siloed to integrated. Perhaps not surprisingly, the ideal employer-partner for an early-stage ACO thinks strategically and prioritizes the best-total-value view in decision-making. Other traits include:

- ▶ A longer-term view of employee health
- ▶ A focus on integrated data analysis (e.g., health risk assessment data, wellness usage data, connections across health, performance, and job longevity), as opposed to a siloed view of costs
- ▶ Benefit design that’s evidence-based with a complete risk-reward picture

This segment represents 10 percent of employers: “It’s a minority, but a very important one since they will be taking the lead.” However, ACOs may also have luck working with the additional 40 percent who take a strategic approach. Even if the financial orientation is more siloed, these employers’ long-term view is congruent with the ACO model.

## Collaborative Thinking

Participants shared the following as challenges and concerns that might merit further discussion:

- ▶ **Service outside of cities:** Smaller clinics, such as Physicians of Southwest Washington, asked if providing “big city-levels” of care to smaller, rural areas was costlier, as fewer resources are available. Miller said that NextEra wasn’t seeing cost increases. However, she and participants agreed that employee access is key. “If they can’t get to a coordinated care center, all these investments go down the drain,” said Melanie Fagan with Robert Bosch Healthcare.
- ▶ **Short-term opportunities:** Mention of long-term prevention tools like fitness centers spurred questions about health interventions that generate more immediate results—and savings. “We don’t have 10 to 12 years to wait to get paid,” said Robert Dittus, M.D., with Vanderbilt Medical Group.
- ▶ **Shared sacrifice:** Martin Hickey, M.D., from Alegent Health Clinic mentioned to the panel that they could achieve savings of 15 to 20 percent by working with a limited network, such as an ACO. “Are you willing to go to your employees with ‘this is the only place you can go?’” GE’s Jones responded that health care is personal. “As soon as you start restricting, it’s a demotivator. They suspect it’s profit-driven and not care-driven.”

## NextEra Energy: What One Company Is Doing to “Prevent the Event”

Melissa Miller, Director, Employee Benefits and Services, NextEra Energy

A Six Sigma company, NextEra Energy incorporates quality processes in everything it does, including health care. It takes a prevention-focused, long-term approach with its employees, many of whom stay with the company 10-40 years.

With a focus on facilitating access to the health services its employees need when they need them, NextEra supports its employees with:

- ▶ Three primary care centers with services including EKGs and physical therapy
- ▶ Onsite care centers offering cholesterol and BMI screenings, flu shots, and nutritional and behavioral coaching (mental health is part of NextEra’s holistic approach)
- ▶ Coaching hotlines, plus traveling nurses (NextEra is studying the value and usage patterns of employees who use mobile health services)
- ▶ More than 60 fitness centers nationwide (“They may not benefit us right away, but we expect them to in 5 to 10 years”)
- ▶ Cafeterias with healthy eating stations and notes on nutrition

Miller said that NextEra shares the ACO model’s outcomes-based orientation. It’s piloting a tool that evaluates cost and quality across facilities, and employee incentives are continuing to move towards rewarding health-enhancing behavior. However, she expressed concern about losing bargaining power when dealing with large groups of physicians.

## **GE: HealthAhead and an Innovative Pilot in Cincinnati**

Earl Jones, III, Senior Vice President and General Manager, eHealth, GE Healthcare

Jones presented three facets of GE's HealthAhead employee initiative:

- ▶ **Cost and quality**, making active consumers out of employees and giving them the transparency they need to manage their health care
- ▶ **Prevention**, such as certified wellness centers and wellness tools for employees and their families
- ▶ **Partnerships**, like those in GE's pilot city of Cincinnati, that engage government, employees, and GE's employer peers to "tease out best practices" and "change the paradigm of large-city health care"

In Cincinnati, GE accelerated the use of technology, streamlined administrative processes, tied provider payment to results, and launched pilots in areas including childhood asthma, diabetes, and cardiac conditions. Non-emergent ED visits, hospital readmissions, and hospital-acquired infections decreased by 50 percent and ambulatory admissions decreased by 25 percent.

# Navigating the Legal Labyrinth

## The Perils of Privacy

For an ACO, access to medical information through EMRs and IT systems is critical for quality care and savings. But at the state level, an employee's lost laptop can trigger a legal meltdown. The advice? Examine your state's progress on privacy statutes.

## Watch Your Language

Several common healthcare terms take on a different meaning when used in the ACO environment: "Fair market value" and "commercially reasonable standards" will be difficult to determine in the new payment environment, and "identifiable services" doesn't take into account the new healthcare delivery model.

Craig Kelinson, In-House Counsel & Director of Risk Management, The Iowa Clinic, P.C.

**"There are legal hurdles, but don't be deterred. The federal government wants you to do this, and they are working on these hurdles."**

— Craig Kelinson, The Iowa Clinic

As with the operational and financial aspects of the ACO model, many of the legal elements are unclear or in flux. As a group moves toward ACO status, it should have a legal foundation in place and be ready for challenges from conflicting and changing laws and interpretations.

## What Prospective ACOs Need to Move Forward

- ▶ A formal legal structure to receive and distribute the shared savings
- ▶ A sufficient number of primary care professionals to serve assigned beneficiaries, often achieved through partnerships or joint ventures
- ▶ Leadership, supported by the ability to make a three-year commitment
- ▶ Sufficient information to address inquiries by federal agencies. For instance, do you have enough healthcare professionals to support beneficiary assignments? Do you have a system in place for shared savings payouts?
- ▶ Management and clinical administrative systems able to accommodate the change
- ▶ Defined processes for evidence-based medicine, coordinated care, and reporting data to evaluate quality and cost measures

## Watch for Red Flags

The following are examples (but not an exhaustive list) of the terms, regulations, and considerations ACOs should pay close attention to:

- ▶ **Gainsharing arrangements:** Although these have been identified as low risk, under current law, these arrangements may implicate fraud and abuse violations.
- ▶ **Coordinated care:** Care coordination—in addition to bundled payments among hospitals, doctors, and payers—can appear like anticompetitive behavior or antitrust violations, especially between providers and facilities that are not otherwise integrated.
- ▶ **Stark (self-referral), anti-kickback, and Civil Monetary Penalty regulations:** Significant confusion and conflict still exist as to whether ACOs will trigger these regulations.
- ▶ **Participation in more than one ACO:** This may end up appearing collusive.
- ▶ **Shared savings and distributed incentive payments:** These may be regarded by states as fee splitting and therefore subject to limitations.
- ▶ **Global bundled payments:** Risk exists that state insurance regulators will regard ACOs as managed care or health plans.
- ▶ **Not-for-profits:** Scrutiny of money flows between for-profit and not-for-profit entities has increased. Physician payments under incentive plans can impact tax-exempt status.

## Collaborative Thinking

Participants shared the following as challenges and concerns that might merit further discussion:

- ▶ **Clinical vs. financial integration:** For financial integration, you must share risk. With clinical integration, a specific practice of ACOs, you don't. Currently, 30 percent of payment or compensation needs to be at risk to be considered financial integration.
- ▶ **Keeping up with oversight:** With so many agencies involved, it can be hard to tell who is "running the show." For instance, anti-kickback and Stark regulations are administered by the Department of Health and Human Services and the Office of the Inspector General. On the positive side, agencies are interacting on the issues.

# Exploring Three Approaches to Clinical Integration

Advocate Physician Partners (APP) offered the following definition of *clinical integration*: “A structured collaboration among APP physicians and Advocate Hospitals on an active and ongoing program designed to improve the quality and efficiency of health care. Joint contracting with fee-for-service managed care organizations is a necessary component of this program in order to accelerate these improvements in healthcare delivery.”

However, a number of paths exist for health organizations to follow to this goal. Here is a look at how three different organizations approached clinical integration, highlighting the major lessons learned at each.

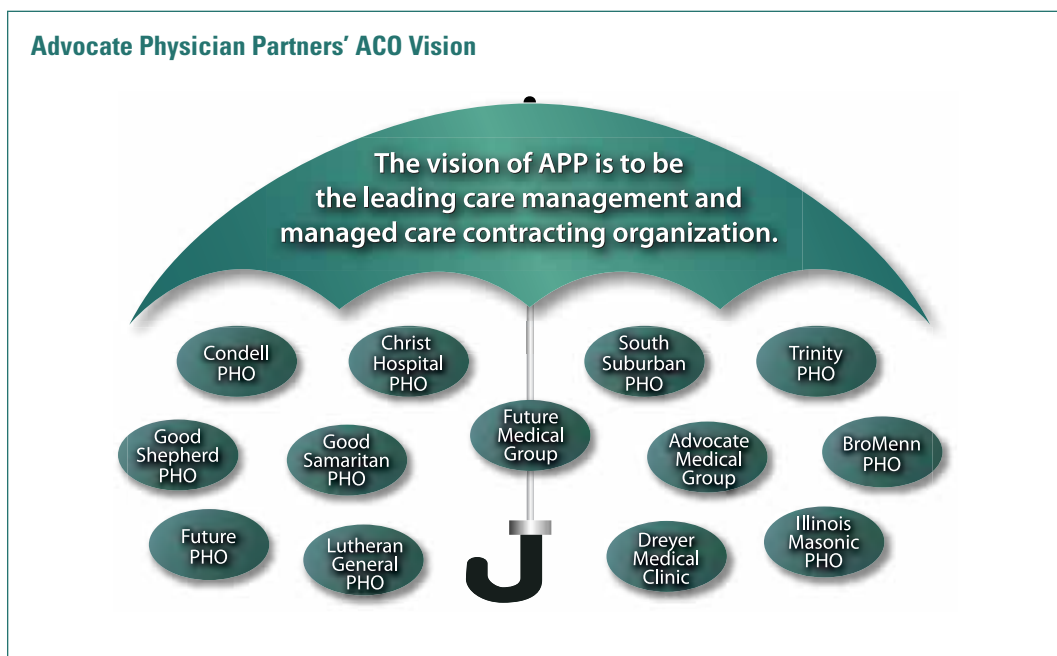
## Advocate Physician Partners: Keeping Up with an Evolutionary Process

Mark Shields, M.D., Senior Medical Director, Advocate Physician Partners

“Clinical integration helps you create the ACO culture.”

— Mark Shields, Advocate Physician Partners

Advocate used incentives as a catalyst for change and a means to ramping up to the ACO model. Here, working with private carriers posed major challenges. Clinical integration allowed physician networks to assert themselves in collective negotiations with preferred provider organization (PPO) health plans.



For health systems following this path, Shields recommended starting with a local carrier likely to understand the full value of an ACO and sharing the goal of reducing cost of care for a population of patients over time. He also recommended using the same metrics across all payers and starting these initiatives with a few local employers, using them as leverage to attract local insurers. Once a lead employer and insurance company are on board, others will follow.

Incomplete data and technical issues created bumps in the road; however, working through antitrust-related obstacles yielded significant insights for Advocate to share. To navigate the new ACO environment, Shields recommended bringing in an astute antitrust lawyer early in the process. He also shared his impression that the Federal Trade Commission (FTC) does not want to stifle innovation and can acknowledge there are many ways to get to the same end. An organization doesn't necessarily have to show results all at once, but it must prove that it has the structure and programs in place by which to achieve them.

Also, aligning with hospitals to leverage IT and more is important to both the physicians and the hospitals. But the most important part of making it work was addressing the culture, Advocate learned. The more the change is physician-driven, the more successful it will be, Shields said. Getting the culture change right might even be more important than getting compensation right.

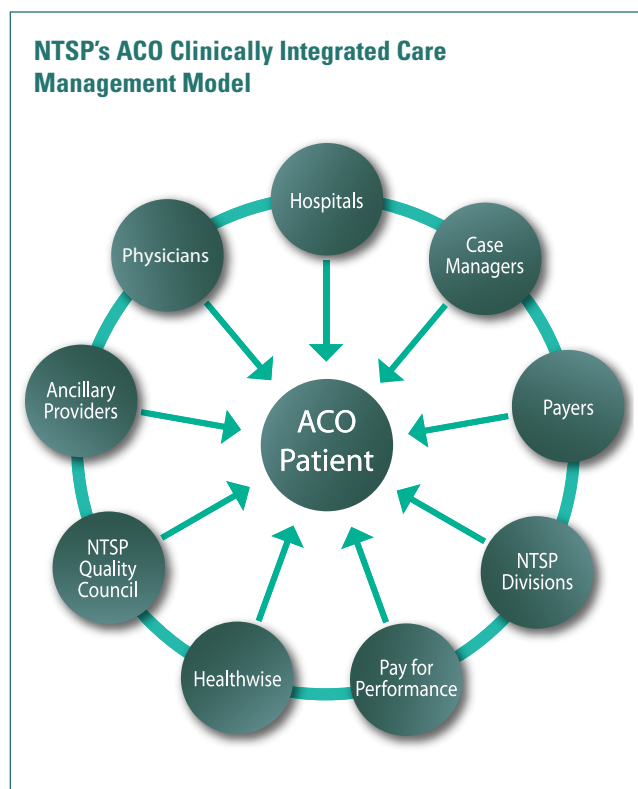
## **Leveraging Technology: North Texas Specialty Physicians Shares the Data**

Karen Van Wagner, Ph.D., Executive Director, North Texas Specialty Physicians

North Texas Specialty Physicians connects 1,700 physicians and 1.5 million patients across systems with its Sandlot Community Health Information Exchange. In its efforts to achieve clinical integration, North Texas looked at “whatever enhances the doctor-patient relationship” and focused on using IT to increase the quality there.

Sandlot allowed North Texas physicians to transform the model of care. The regional system connects 1.5 million patients, with 300 physicians putting data into the system in about 50,000 transactions per day. The motivation, Wagner said, was that doctors realized “it’s no longer acceptable for me to practice medicine and not know the lab tests, what the other doctor did, or the ER activity—it’s just not the way I want to practice anymore.”

North Texas pays for the hosting and training elements of Sandlot. A CareWizard offers point-of-care prompts that show what tests have been ordered, contraindications, and more—and will be available on iPhone. Although IT specialists are currently building a data warehouse and working on developing true interoperability and continuity of care record transmission, Sandlot’s current capabilities—such as secure messaging, electronic referrals, prompts, and registries—are already yielding results.



## Collaborative Thinking

Participants shared the following as challenges and concerns that might merit further discussion:

► **New technology:** North Texas found that “adoption is about workflow” and designing and testing systems with doctors to be another critical element to adoption. The question to be asked is: Who is doing the work, and does the IT support that? North Texas predicted the next generation of compliance tools will be guided by doctors’ standing orders to get patients into their offices for care.

► **Working across silos:** Finding common ground takes some work. The key is to determine as an organization the interventions you wish to focus on, then letting success breed success. Also, realize that when information crosses silos, culture is also affected.

One immediate time and resource savings was seen in prescriptions, of which 40 percent typically need a human touch. With e-prescription programs, this number drops to 4 percent. In the ER, CT scans dropped from 25 percent to 14 percent.

## Applying Lean Principles: Everett Clinic Pulls Together

James Lee, M.D., Associate Medical Director,  
Coordinated Care, The Everett Clinic

This 440-provider multispecialty medical group was able to solve multiple problems through its transformation to a “Lean principle shop.” It had found that from decision to admit to discharge follow-up, the experience was fragmented and had redundancies. Using Six Sigma Lean methodology and focusing on transition points of patients helped realize significant improvements.

Everett witnessed one notable outcome in the area of geriatric extended care. Previously, Everett’s nursing home services were high in cost, low in efficiency, and variable in quality, with no electronic health records and an annual loss of 86 percent in operating income. In keeping with Lean principles, the group reduced facilities from nine to five, based on patient flow and quality of care. Creating more patient information about provider coverage helped as well. Remote electronic health record and billing capability helped Everett improve operating income by 30 percent.

Imaging had also been identified as a critical issue. Here, partnership was key to improvement. Everett worked with orthopedists on a survey of important factors and built into its EMR order set exact specifications for clinical criteria for ordering imaging. Doctors now can review these with patients right in the office—and patients will see why they may or may not need a particular CT, for instance, and how much it will cost.

Results included a more than 60 percent decrease in lumbar scans and cardiac imaging down 50 percent.

**Date: October 1, 2007**

Plain films must already be obtained for all indications.  
(Standing 30 degrees AP flexion view should be obtained when possible.)

## MRI Knee Appropriateness Checklist

Only one "yes" box necessary to schedule exam

	YES	NO	ICD-9
<b>1. Persistent knee pain after 6 weeks of physical therapy</b>  <i>Patello-femoral pain is more common than a meniscus tear or a ligament tear. The treatment for this problem is physical therapy that includes quadriceps strengthening, stretching, modalities, and patella taping.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>2. Suspect acute meniscus tear</b>  <i>The patient must have one of the following: joint line tenderness, positive McMurray test, joint effusion.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3. Suspect ligament tear</b>  <i>The patient must have one of the following: laxity to varus or valgus stress, positive lachman test, positive pivot shift test, positive drawer test, hermarthrosis by aspiration.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>4. Evaluation of mass or tumor</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5. Suspect infection</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>6. Locked knee</b>	<input type="checkbox"/>	<input type="checkbox"/>	

**Physicians:** Patient who qualifies under one or more of the above indications meets the appropriateness guidelines for an MRI exam. Please see your FMD with issues or concerns regarding the checklist criteria. Call ext. 3400 and a radiologist can assist you with technical questions.

**Patients:** These questions are designed to assist us apply best practice principles in providing your care.

**MA/RN:** Please advise the scheduler the YES indication(s) above when calling to schedule the MRI exam.

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# Getting Relationships Right for Successful ACO Development

Jack Silversin, D.M.D., Dr.P.H., and Mary Jane Kornacki, AMICUS, Inc.

An older, experienced physician was sitting in the doctor's lounge, talking to no one in particular. "You know, I used to know how to admit a patient. I used to know how to order things for my patient. I used to know how to discharge a patient. And now I found out that I don't know how to do this anymore. I've spent my whole life doing this and being good at this, and now I'm told that I don't know how to do it."

This story, told by Dr. Peggy Naas, vice president of physician strategies at VHA Inc., encapsulated many of the challenges faced in moving to an ACO model.

"I have huge respect for what doctors do and I have huge empathy for the changes they're being asked to make," said Jack Silversin, a faculty member at the Harvard University School of Dentistry and nationally recognized speaker on physicians and change.

## **Cultural Challenges in the Current Landscape**

- ▶ Moving from a world of electives to a world of commitments.
- ▶ Specialties and primary care have their own subcultures—and communications among them have not always been respectful.
- ▶ Market forces are breaking up and causing competition within natural networks and collegial relationships.
- ▶ Financial incentives don't get us to work collaboratively.
- ▶ In the real world, we don't talk to each other. We sit in our silos and talk about each other.
- ▶ In times of change, people are more concerned with survival of self.
- ▶ Doctors feel like their "compact," the unwritten terms of the deal by which they operate (autonomy, entitlements, protection in exchange for bringing in patients and doing a good job), is being violated.

## **Technical vs. Adaptive Change**

According to Ronald Heifetz, a recognized scholar on adaptive leadership, people often believe their mission is solving a technical problem—for which well-defined, tested solutions with a clear path to implementation exists—when, actually, the problems fall within the "adaptive change" category. These complex problems, like those encountered when making the cultural shift to an ACO, involve feelings of loss and sacrifice; and solving them requires learning new ways of thinking and transforming existing habits and assumptions.

## The “Broken Squares” Exercise

To demonstrate the difficulties of entering an ACO collaboration, Silversin and Kornacki divided participants up into groups of six to eight and gave each person an envelope with some, but not all, of the pieces needed to create a square. The only way to complete the puzzle was to have a fellow participant glance across the table, notice the need and contribute the crucial piece. Participants were not allowed to talk, point, or proactively communicate through verbal or non-verbal gestures.

Every group completed the exercise through different means. However, Silversin noted a common reaction—the emergence of individually focused, “I could but I won’t” behavior. This emerged even though nothing really was at stake in this exercise.

“I don’t think we see conceptually that we’re interdependent. In times of scarcity, it’s hard to get people to break things up,” he said.

“You would break it up if success depended on the whole table,” said Al Diaz from Harbin Clinic.

## Avoiding Common Engagement Pitfalls

Many snags can emerge when engaging people in a complex change process, like the transition to an ACO. They may feel the process is for show only because they saw previous input ignored. They may mistakenly believe that all input will be incorporated in a final decision, or that nothing will be able to progress or change until consensus is reached.

**Getting beyond baggage.** Unspoken grudges and disagreements among group members can create an atmosphere of reticence. Acting curious, not defensive, gives people the opportunity to air and resolve issues in a safe environment.

### Questions to break the ice when engaging new, and potential, ACO partners:

- ▶ How do you see your strengths, weaknesses, opportunities and threats?
- ▶ How do you see other ACO members’ SWOT?
- ▶ How do you think others perceive you?

## For a Fair Engagement Process:

- ▶ Make clear what, if any, “givens” (things not amenable to change) need to be on the table.
- ▶ Define what is open for input and can be influenced or changed.
- ▶ Determine how the decision will be made—and by whom.
- ▶ Decide how you will explain the decision—and why input was or was not used.

## Responsibilities of ACO Member Groups:

- ▶ Implement agreed-upon, evidence-based guidelines
- ▶ Invest time in making the ACO successful
- ▶ Be open to feedback

**Achieving productive dis-equilibrium.** Silversin said that low anxiety levels tend to concern him more than higher ones. “Sometimes we dial down people’s anxiety because it’s just too painful to see.” It’s better to dial up the energy, share information bit by bit, giving people the chance to discover it, and ward off the temptation to protect people too much. “Sometimes it’s okay not to end on an up beat, because that anxiety is motivational.”

**Fighting off change fatigue.** Many experienced doctors remember the 1990s and the threat of managed care that never really materialized. The difference today: “We’re basically going to go bankrupt if things don’t change,” said Silversin. Here, communicate the context for decisions and why change is in everyone’s best interest.

**Avoiding “analysis paralysis.”** Keep moving by realizing you don’t have to go the whole way at once or achieve perfect collaboration. “It’s not a love-in, it’s a respect-in.”

## Eight Tips for Change Leaders

1. Clearly and frequently communicating “here’s how things are going to be different” makes a difference in the time and effort needed to implement change.
2. In any relationship that’s not working, each party is responsible for talking about the pieces they own.
3. Positive spin and “happy talk” can spur resistance. Don’t minimize people’s emotional reactions.
4. Ask what a shared vision of success will look like.
5. Ask yourself how you will make decisions that people will think are fair.
6. Examine how your own behavior might need to change for success.
7. Remember that when you see something and don’t comment on it, that makes it okay.
8. Once you’ve acknowledged everyone’s contributions, winning is about moving on.

# Creating and Sustaining Leaders Organization-Wide

Jeffry G. James, CEO, Wilmington Health Associates

**“Through all of this information sharing, cultivating leaders, changing culture, we need to move the curve to keep up with the changes coming in health care.”**

—Jeffry G. James, Wilmington Health Associates

According to James, it’s going to take leadership—cultivated from the bottom up—for healthcare organizations to weather the changes that lie ahead. To create and sustain effective leaders from within, organizations must fully understand engagement and culture.

## **What Is a Leader? A Checklist**

Leaders exist at all levels of the organization. How can you spot one in your organization?

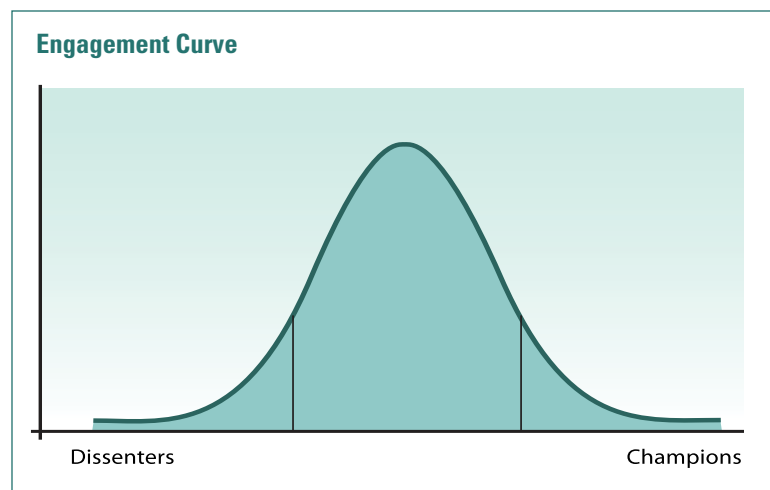
- ▶ Leaders influence a group of people toward the achievement of a goal.
- ▶ Leaders reflect the organization’s culture.
- ▶ Leaders beget leaders.

## **The Rules of Engagement**

Leaders are grown through engagement. Employees in any organization engage in their work at different levels; a typical breakdown might be:

- ▶ 13 percent of employees are actively disengaged
- ▶ 76 percent of employees are disengaged
- ▶ 11 percent of employees are actively engaged

The result is a bell-shaped curve—with a small group of champions at one end (the ones you want to cultivate), a small group of dissenters at the other (the ones you want to keep an eye on), and a large group of employees in the middle who are neither extreme (the ones you want to engage more actively in the ACO mission).



## Cultivating Leaders Begins with Changing Culture

Organizational culture is the foundation of an organization's strategies. It is the culmination of shared experiences and stories, constantly in flux, and difficult to change. In any healthcare organization, the established culture will define its:

- ▶ Overall mission/success
- ▶ Leadership structure
- ▶ Core values
- ▶ General spirit
- ▶ Level of innovation
- ▶ Employee work model
- ▶ Community fit

From the increased focus on quality to the team-based approach to care to new payment systems, all aspects of moving to the ACO model require cultural transformation. And this takes time.

In James' words:

**“You can change your strategy overnight,  
but you can't change your culture overnight.”**

## Cultivating Leaders at Wilmington Health Associates

**Stage One (Fall 2008):** This early stage took an operational focus—developing strategic pillars and tactics tied to the organization's mission and values. The primary goals were to gain trust, establish core competencies, and demonstrate movement. To engage staff and build leaders from the bottom up, Wilmington Health concurrently improved employee benefits and training, drafted new communications plans, and opened channels for an ongoing dialogue about the changes to come.

**Stage Two (Spring 2010):** This stage focused on implementation and training the entire staff to get everyone on the same page.

As Wilmington Health moves into the next stage—core process redesign—leaders will continue to take the pulse of the organization. With change, too much or too fast can be hazardous.

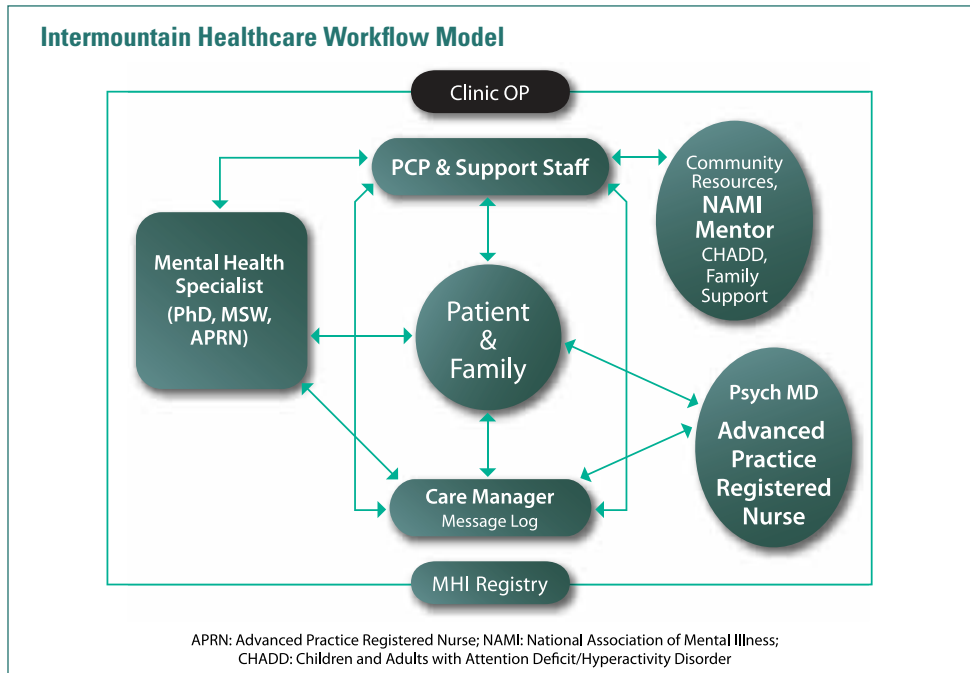
# Mental Health and End-of-Life Care: Successfully Integrating Two Crucial Pieces of the Care Puzzle

## 10 Years of Mental Health Integration at Intermountain Healthcare

Brenda Reiss-Brennan, M.S., A.P.R.N., CS, Mental Health Integration Director, Intermountain Healthcare, Primary Care Clinical Program

ACOs increasingly are looking to integrate mental health services into the mix: demand is high and inclusion aligns with many key ACO principles, such as integration of care and a focus on the whole patient. But how do you effectively (and cost-effectively) incorporate mental health integration (MHI) into the ACO model?

With 130 clinics, Intermountain takes to heart the importance of strong teams—with primary care champions and operational champions at every location. A full-time psychiatrist is not required at every MHI clinic. Instead, a psychiatrist might move from one clinic to another in a single day, spending three to four hours at each. Building on its “healing for life” brand positioning, all staff members are trained and cross-trained to treat any patient with any condition coming into primary care. And, Reiss-Brennan pointed out, most present multiple physical and mental conditions, such as diabetes and depression.



In addition to managing for complexity and compliance, managing coproduction—engaging patients and families as active members of healthcare teams—is essential to achieving both cost savings and quality care. Coproduction is a concept commonly used in Europe based on reciprocity. With coproduction, health care is a two-way exchange, and a patient and his or her family are encouraged give something back to the process.

According to Reiss-Brennen, with MHI, patients are happier and feel that their concerns were heard and addressed. To evaluate MHI effectiveness, Intermountain compared clinic performance at similar practices, five integrated and eight non-integrated. Approximately 54 percent of MHI patients were less likely to visit an ER one year after an initial diagnosis. Savings were reported in the areas of in-patient medical costs and specialty services, such as in-patient psychiatric service. Overall per-patient savings for service lines directly affected by MHI totaled more than \$400 in 2005 dollars.

## Is Your Organization Equipped for MHI?

Representative resources and metrics indicate that ACOs considering or implementing MHI should evaluate the following within their organizations:

- ▶ **Structure:** Staffing per population by provider type, proportion of staff trained in MHI, and number of actively engaged community partners
- ▶ **Process:** Depression detection rate, proportion of returned MHI packets, average time to initial appointment for MHI referral, percent change in number of patients in registry
- ▶ **Outcome:** Patient satisfaction, provider satisfaction, change in number of visits with MHI diagnosis

## Five Key Components for MHI Success:

1. Leadership and cultural integration
2. Workflow integration
3. Information system integration
4. Financial and economic integration
5. Community resource integration

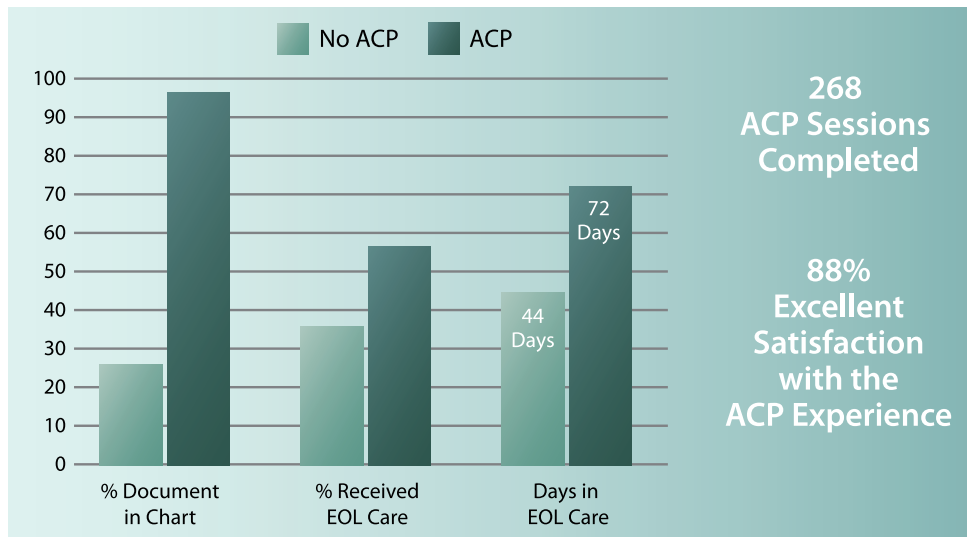
## How Patient-Centered End-of-Life Interventions Increase Quality and Save Money

Sandra Schellinger, R.N., M.S.N., NP, Director, Palliative Care, and Eric Anderson, M.D., Medical Director, Palliative Care, Allina Health System

According to Schellinger and Anderson, hospice care traditionally is underused in the current healthcare model and largely brought in for end-of-life situations among the old and frail. Furthermore, there's generally been little consistency in how different players (such as hospitals, clinics, nursing facilities, primary care physicians, hospice, palliative care, senior care center) communicate or document patient needs or wishes in the area of end-of-life care.

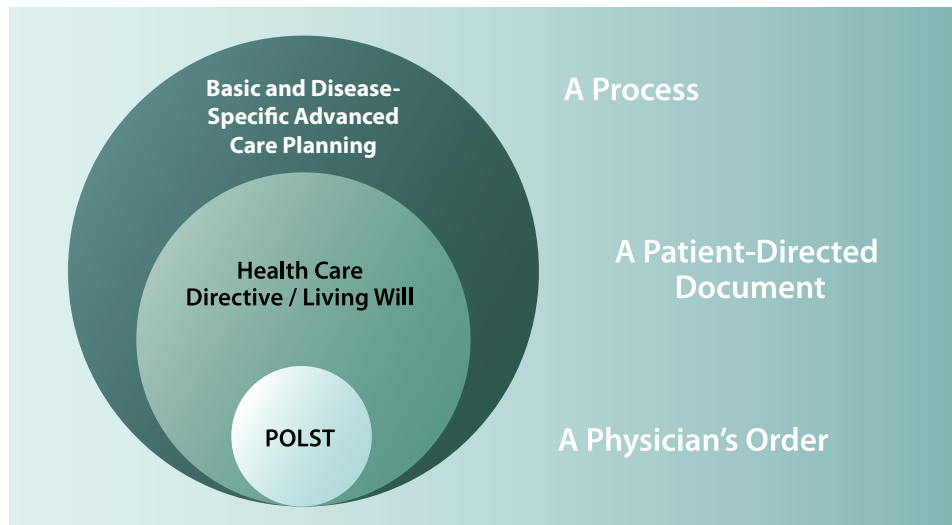
Schellinger and Anderson talked about Allina's efforts to move from disease-centered to patient-centered care and move end-of-life care decisions much farther upstream to put hospice and palliative care into play much sooner. Getting patients into the right kind of care can affect not just quality of life during these important final days but also the cost of care for the system, as palliative and hospice care can be less expensive than hospital care.

### Initial Outcomes of Advanced Care Planning Sessions



It's a change in mindset to move from advanced care directives to the process of advanced care planning. A change in ICU culture may be required. Also, health systems should understand that many of the issues surrounding end-of-life care are not medical but rather psychosocial. For example, patients need to be listened to and understood. The current model doesn't allow for that. In Allina's model, chaplains and trained professionals across the spectrum fill this important role.

### Spectrum of Advance Directives



POLST: Physician Orders for Life-Sustaining Treatment

Allina's next steps include external efforts to educate and engage its community on these issues. By 2015, it hopes to have all patients introduced to advanced care planning. According to Schellinger and Anderson, advanced care interventions using palliative care and hospice care have the potential to save \$135 million a year in Minnesota.

## Is Your Organization Ready for End-Of-Life Care Integration?

Here are five key ingredients:

- ▶ **Roles and responsibilities:** End-of-life care is not just the doctor's responsibility. Everyone on the healthcare team has a role in initiating advanced care planning before a medical crisis.
- ▶ **Training:** Staff must be equipped with the right skills to help patients plan.
- ▶ **Education:** Detailed follow-up conversations and informed patients are crucial to arriving at the most appropriate end-of-life care options.
- ▶ **Centralization of patient information:** This involves a "front page" via charts and/or computer systems where the advanced care plans are immediately available to be followed by caregivers in clinics, in the ER, or at any location. When one link breaks, the whole process falls apart.
- ▶ **Regional consensus/culture:** This model of advanced end-of-life care requires a shared vision. And, the details of an organization's strategic partnerships will need to align with this vision. For example, for reimbursements to work, ACOs will need to negotiate for services to be delivered earlier in the life cycle.

# Care Coordination: HealthPartners Medical Group Shares Five Key Lessons Learned

Beth Averbeck, M.D., Associate Medical Director, Primary Care and Bob Van Why, Senior Vice President, Primary Care and Practice Development, HealthPartners Medical Group

HealthPartners is working to become integrated after a merger with a county hospital. The Minnesota not-for-profit organization offers care delivery, transitional care, and a number of nursing homes, with more than 11,000 employees, 400,000 active patients, and about 750 physicians. The multi-payer system also has about 15 percent Medicaid and 25 percent Medicare and is beginning to explore alternative payment models. HealthPartners emphasized that, as one of four systems that dominates the market in the area, it experiences substantial competition, but also a great deal of collaboration.

- ▶ **Lesson 1:** Align all efforts toward an overarching goal. For HealthPartners, this is the Triple Aim: Health, experience, and affordability. Focusing on this led to HealthPartners' goals of optimizing care, eliminating care disparities, and increasing physician and employee satisfaction.
- ▶ **Lesson 2:** When standardizing processes, leverage IT and best practices. As one example, patients now receive notification of every test result by their preferred method of contact—letter, phone call, or online—after each visit. To achieve this, HealthPartners created a standardized process based on best practices and used its IT systems to handle the information and implementation. Now, more than 90 percent of HealthPartners' lab results are released online within 24 hours.
- ▶ **Lesson 3:** Implement a framework of continuous improvement. HealthPartners found that inconsistent performance was linked to inconsistencies in standards in every area, from benchmarking to IT platforms. For instance, an EMR platform was put in at two clinics, with no appreciable quality improvement. After looking for gaps and redesigning systems, the group is outperforming community standards in 12 of 13 areas.

## HealthPartners' Cultural Assessment Question List

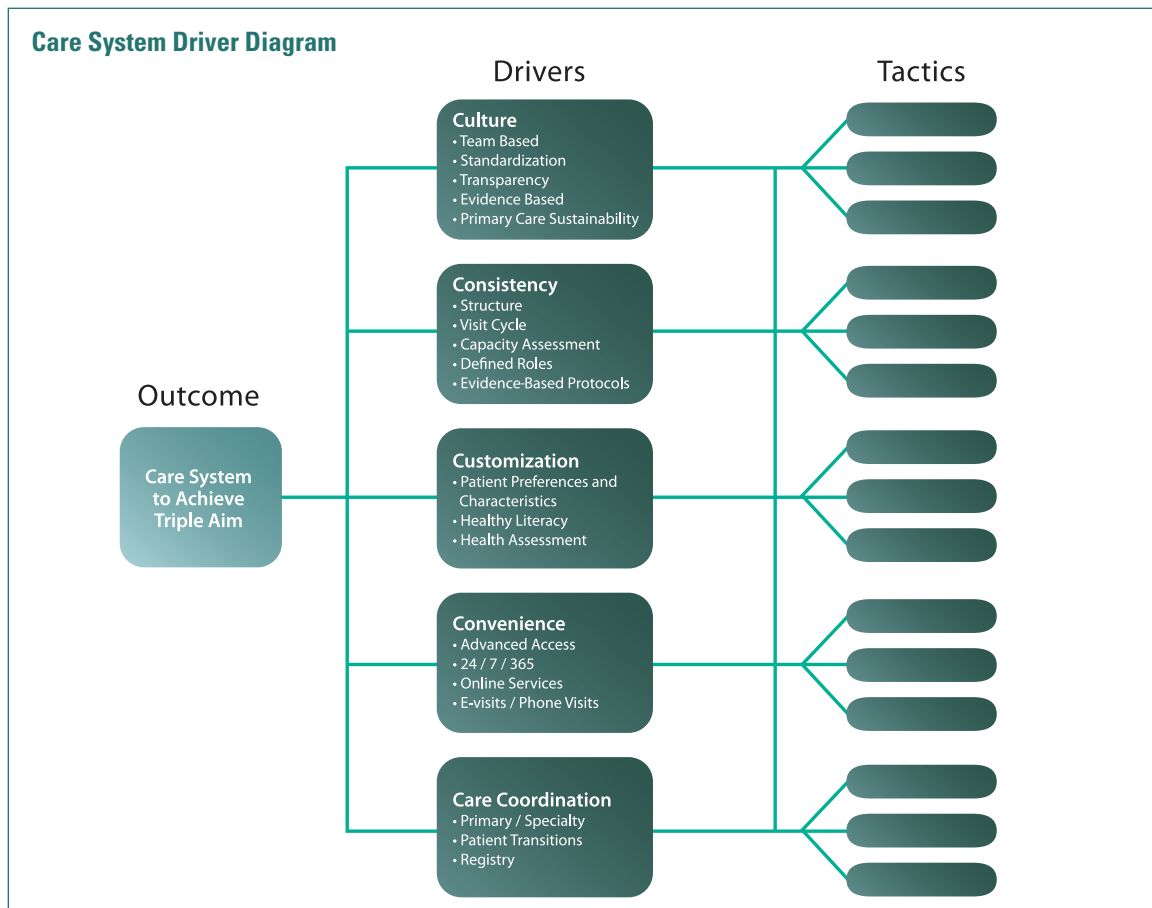
- ▶ What is your case for change?
- ▶ How do you involve your physicians and staff in developing and supporting your strategic plan and goals?
- ▶ How do you communicate goals and measures throughout your organization?
- ▶ Is it physician-centered or patient-centered?
- ▶ How do measures and/or anecdotes drive change?
- ▶ What do you reward and recognize?
- ▶ What is your approach to improvement?

► **Lesson 4:** Acknowledge the importance of culture—think drivers, then tactics. As one example in the health-care world, a healthy lifestyle is a driver and a balanced diet and exercise are tactics. According to Averbeck and Van Why, groups often put the tactics before the drivers. HealthPartners recognized this when, after a merger, it realized that the organizations needed to start over by addressing drivers to build a new culture. The key tactics it used for culture change were communication and teamwork.

HealthPartners found that culture change contributed directly to better patient care. After healthcare teams and care standardization were instituted, the organization saw improvements in breast cancer detection and controlling diabetes.

► **Lesson 5:** Keep measurement transparent. According to Averbeck and Van Why, the presence of measurable, transparent data means that organizations examine assumptions and base changes on realities. For instance, HealthPartners followed physicians and timed all care team activities. The organization found that physicians had only about 2 percent of free time in their 11-hour days, revealing that the system was working close to capacity and efficiencies would have to be found in other areas, such as patient registry improvements.

HealthPartners also discovered that transparency was more important than changes in the compensation structure for many physicians. Averbeck and Van Why explained that transparency is essential to making teamwork operate and to communication. It allows everyone in the organization to see what changes are working and which ones aren't, so the effort for improvement gets full buy-in.



# Measurement and Reporting: Capturing the Movement of Data and Linkage of Activities

David Nerenz, Ph.D., Henry Ford Health System and Steven Bernstein, M.D., M.P.H.,  
University of Michigan

If a doctor documents a drug allergy, where else does that information go? How many times do activities that are supposed to coordinate clash—for example, in the case of duplicative tests?

How an organization measures the essential flow of information is core to the ACO concept, and, thanks to technology, “we can track and measure things today that we could not track 20 to 30 years ago,” said Nerenz. Measurement is an area of focus for payers and accrediting bodies and an area that’s in flux with CMS and others. According to Nerenz, opportunity exists to have a voice in what measures will be used in the context of ACOs. “This is the time to start advocating for the measures you like to influence upcoming decisions,” he said.

Things an ACO can measure include:

- ▶ **Coordination:** Measuring the synergy of action between two sites or domains of care (for example, doctor’s offices and hospitals) is vitally important due to the complexity of an ACO’s multiple providers, steps, and processes. Organizations can link to or build upon valid measurement sets developed by the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, CMS, and NCQA. They can use surveys to gauge coordination of a care event from the patient point of view or get physician insight into the overall care experience. Technology, such as computerized care plans, also can play a helpful role.
- ▶ **Accountability:** In this area, ACOs should recognize that not all quality of care measures are useful as vehicles to improve quality; indeed, some are only loosely related to patient outcomes.
- ▶ **Time lapses:** Measuring the time between initial diagnosis and first treatment is pivotal because it often involves many things happening in between (biopsies, staging, consultations) and a high level of patient fear. Highly coordinated care, delivered through an integrated health team, can shorten the waiting time for patients.
- ▶ **The absence of information:** This includes errors of omission—for example, failure to follow up on a lab test due to lack of communication. An ACO may find it helpful to measure the number of times a needed action did not occur and investigate the “why.” Why is the patient in the clinic or hospital? Why was the test ordered?

Throughout the measurement process, organizations will need to be aware of the minimum sample sizes needed for reliable measurement; take into account factors such as variability across ACOs, stability, or change over time; and watch for correlations among measures within the same organization.

**The challenge of measuring for efficiency:** Efficiency can be defined as sum costs set against an event—in other words, what it takes to make something happen. Even though efficiency deals with ratios of inputs to outputs, measuring for it generally is more difficult than measuring for care coordination: the definition of *efficiency* varies for payers, hospitals, and others; the measures are not those used right now in real-world organizations; and a quality dimension (is this action good or appropriate?) often is not included.

Further complicating matters is the presence of multiple desirable end points common for many healthcare scenarios. Has surgery been completed? Has the patient’s condition improved? Is the patient satisfied with the care experience?

## Next Steps

### Using IT to Coordinate Care at the University of Michigan

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The University of Michigan Faculty Group Practice was one of two CMS PGP demonstration sites to be successful in its first four years and get money back from Medicaid.

Throughout the demo, the University of Michigan practice leveraged IT toward:

- ▶ Improved documentation
- ▶ Standardized action plan templates for chronic conditions like asthma
- ▶ Decision support
- ▶ Delivery system design

Creative use of IT tools and processes included:

- ▶ A Computer Assisted Terminal Interview used by 21 health centers to improve preventive services across the health system
- ▶ An Interactive Voice Response system to link patients with providers and informal care-givers for the management of chronic diseases like chronic heart failure, diabetes, and depression
- ▶ Automated appointment reminder letters to registry patients
- ▶ Patient take-home educational sheets that blend health data with helpful tips to encourage preventive care

### The effect of changes and evolution in the EMR landscape on reporting:

ACOs *can* use a home-grown system to improve reporting and documentation. But they will *need* a certified system like one developed by Epic, Phytel, GE, or Allscripts to get Medicare incentives, said Bernstein. Home-grown systems won't cut it. Any system will need to report on quality, cost, and patient satisfaction. Given these requirements, Bernstein predicted consolidation among major EMR players.

Bernstein also sees data transparency as something ACOs will need to consider when making an EMR investment. By 2013, a wealth of performance data will be made public through CMS's Physician Compare and Hospital Compare websites. ACOs will need to take the data and reporting needs of these systems into account when making their infrastructure investments.

Amid all the technology bells and whistles related to EMR systems, attention also must be paid to the statistical validity and reliability of the data entered into it. Bernstein cautioned, "Public reporting is an important element for all of us. As more and more ACOs emerge, how do we establish ourselves as the best for patients or employers? We must do everything we can to make sure that reporting is accurate."

### Tips for Building and Adapting Reporting Systems

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- ▶ Be inventive with the tools you have. For instance, Bernstein's groups compiled 15 paper Asthma Action Plans into one electronic template that won a 2008 Environmental Protection Agency National Asthma Leadership Award.
- ▶ Make reporting systems valuable for staff by tailoring them to specific areas and levels of your practice.
- ▶ Pay sufficient attention to delivery system design. "You can have all the IT you want, but if you don't get your systems revised, it's not going to work," said Bernstein.
- ▶ Equip your staff with the necessary skills.
- ▶ Don't downplay the importance of governance, leadership, and culture. "Culture has to be there, or it will be all for naught," said Bernstein.

# What's on the Mind of the Collaborative?

In the final wrap-up session, participants expressed interest in case studies—learning from their peers' experiences in the implementation stage—and knowing what their colleagues would be tackling first, so that people moving in same direction could connect work together. The overarching areas of interpreting data, producing reliable, quality results, and shifting cultures towards effective transitions were identified as common priorities. Participants also shared more specific areas of concern, such as:

- ▶ How the language of the regulations will be interpreted, for example, in terms of multipayer arrangements
- ▶ Legal protection that should be on the radar, such as the need for federal tort coverage
- ▶ Attribution, population sizes, and thresholds
- ▶ Technology best practices and guidelines, such as the use of Epic by large groups
- ▶ Encouraging employers to move certain services (and fees) from third parties to ACO systems

## **Tools to Keep the Learning Active**

A dedicated, self-moderated listserv is available to keep participants connected between meetings. AMGA has created a dedicated, password-protected area on its website, [www.amga.org](http://www.amga.org), where ACO Collaborative participants can find:

- ▶ The latest ACO news
- ▶ Reference materials and articles
- ▶ Legislative and regulatory updates
- ▶ Information on CMS public meetings
- ▶ Content posted in advance of the Collaborative's regularly scheduled calls/webcasts

During the year of collaboration, Press Ganey will be developing a patient experience survey specifically for the ACO Collaborative, going beyond the visit to encompass factors in the integrated care model such as admissions and registration.

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