

Creating High-Performing Care Organizations

AMGA National Summit on ACOs

***Where Are We Now?
Where Are We Going?***

September 29 – October 1, 2010
Westin Diplomat • Hollywood, FL

AMGA

AMERICAN MEDICAL GROUP ASSOCIATION

Creating High-Performing Care Organizations

Accountable Care Organizations: Where Are We Now? Where Are We Going?



“My father would have laughed at the concepts of medical home and patient-centered care. He’d say, ‘what other kind of care is there?’”

— Donald Berwick, M.D.

Administrator of the Centers for Medicare and Medicaid Services

“It’s not the usual IQL,” said AMGA President Donald W. Fisher, Ph.D., introducing the first entirely ACO-focused Institute for Quality Leadership (IQL) meeting, the culmination of several years of AMGA involvement in accountable physician practices, patient-centered care, and the ACO concept.

Keynote speaker Donald Berwick, M.D., administrator for the Centers for Medicare and Medicaid Services (CMS), related his first encounters with patient-centered care: watching his father as a rural doctor and being part of a care team at Harvard Community Health Plan that delivered an effective diagnosis within 10 minutes that saved an asthmatic child a trip to the hospital. “That’s integrated care—what everyone in America could have and should have.”

As CMS fleshes out the ACO details of the 2010 Affordable Care Act, Berwick said he sees efforts coalescing under the Triple Aim:

- Better care for individuals through improving safety, effectiveness, patient control, timeliness, efficiency, and equity
- Better care for populations through focusing on the environment, nutrition, and health choices
- Better conservation of resources—in other words, “lowering the social cost without harming a hair on anyone’s head”

But how does evolving policy translate into strategically smart decisions and operations? Audience members posed questions about aligning reimbursement models, working with payers and hospitals, leveraging resources, and more, setting the stage for the sessions to follow.



2010 Acclaim Award Recipient: Group Health Physicians



Group Health implemented the medical home model system-wide, redesigning EMRs and increasing patient access. Efforts resulted in a 30 percent increase in virtual visits, patient savings of \$10 a month in co-pays, and improvements in hospitalization rates and patient and staff satisfaction.

The American Medical Group Foundation also recognized:

- **Dreyer Medical Clinic/Advocate Health Care** in improving quality of care across populations served
- **HealthPartners** in improving cultural competencies and health disparities
- **Sharp Rees-Stealy** in improving the healthcare experience for patients



“If we don’t get the governance and financial systems right, the rest of this won’t work.”

— Robert E. Nesse, M.D., Chief Executive Officer, Mayo Clinic Health System

General Session Highlights: Change Begins with the Business Model

Robert E. Nesse, M.D., Chief Executive Officer, Mayo Clinic Health System

As organizations move towards becoming an ACO, what type of governance works best? Answering this question starts with examining how the ACO concept is changing health system business models and the entire structure of care delivery.

From individual focus to a “union of forces”

The United States is moving towards a future of fewer dollars and more people needing care; it is predicted that 70 percent of the population will be covered by government insurance, such as Medicare and Medicaid, in ten years. Not only does the Patient Protection and Affordable Care Act broaden access to public programs, it introduces new payment models. For many deliverers of health care, reimbursement will decrease as the number of public patients—and the demands for transparency—increases.

Because of these complexities, a fragmented approach to care by region or community will no longer work, particularly in the areas of knowledge-sharing and financial operations. Instead, elements of the health system will need to seamlessly align in areas such as reimbursement, patient data, and responsibility for the value of care.

From fixed locations to flexible systems

Current health delivery business models are centered around a single facility, like a hospital or office. The new ACO model, on the other hand, focuses on using portable information to serve a system. To combat the long-held perception of the clinic being synonymous with its headquarters, Mayo Clinic is incorporating efforts in the areas of quality reporting, shared efficiencies, and system alignment among its growing network of facilities.

Consolidation, contracting, and constant change

Managing the financial risk of outcome-based payment, accommodating for disruptions in the delivery of the highest-margin care—these are just the beginning of the governance challenges aspiring ACOs should be prepared to address. Others include:

- **Capacity:** The shortage of services such as primary care—key to an ACO’s operations—may drive organizations to acquire more health systems to add capacity. Nesse anticipated significant consolidation and competition over the next five years.
- **Structure:** Contracting around payment and care, rather than taking an ownership approach, may be a more effective structure for groups forging alliances with others to become an ACO.
- **The need for flexibility:** Because organizations must take steps toward becoming an ACO as policy is being written, any business model should be broadly applicable and adaptable.

Yesterday’s Business Model:

- Provider-centered
- Price driven
- Commonly disconnected
- Slow to innovate
- Care reactive and episodic
- Paper-based
- Outcomes ignored
- Costs tend to increase overall

Today’s (and Tomorrow’s) Model

- Patient-centered
- Value driven
- Knowledge-intensive
- Facilitates rapid innovation
- Proactively, holistically oriented
- Technology-based
- Outcomes measured, accountable
- Costs remain stable or decrease overall

Breakout Session Highlights

Billings Clinic: Keys to governance success include having a real, relevant, and meaningful vision and making sure that privileges and accountability are understood across the organization.

Lehigh Valley Physician Group: By moving toward a Clinical Practice Council—the central hub connecting elements from surgery to specialties—Lehigh Valley Physician Group achieved clinical integration that improved referrals and standardized processes that improved performance and facilitated the drafting of the group’s Clinical Practice Guidelines.

St. John’s Health System: Strategic planning and compensation takes into account the following factors in the following order: physician satisfaction and engagement, employee satisfaction, patient satisfaction (the natural end result of the first two factors), quality improvement and transparency, and business performance.

Aligning Incentives



“To make meaningful change, you have to give people data and information.”

— Karl Ulrich, M.D., President and Chief Executive Officer, Marshfield Clinic

General Session Highlights: The CMS Demo as Kick-start to an ACO

Karl Ulrich, M.D., President and Chief Executive Officer, Marshfield Clinic

As one of 10 CMS demo sites, Marshfield's goals included improving efficiency and quality on 32 metrics; improving coordination between Part A and Part B expenditures; aligning reimbursement with quality; and rewarding improved health outcomes.

Making it work: Insights and ideas

- Meaningful change begins with secure, sharable data: Marshfield's CattailsMD is the first internally developed U.S. ambulatory electronic health record (EHR) to earn Certification Commission for Healthcare Information Technology® (CCHIT) certification.
- Give people time to change: Data tracking physician outcomes was blinded for the first few years. This removed stigma and allowed physicians time to improve if needed.
- Hire a “designated dashboard driver” to monitor the EMR and the intervention list.
- Change requires training: Marshfield paid doctors for training and made it convenient through computer-based delivery.
- Change applies to all: Fee-for-service Medicare patients aren't singled out.
- Even small rewards work: Marshfield gave a \$2,000 bonus to physicians who could begin the process of moving to quality metrics.
- Work incrementally: All-or-nothing approaches can fail. Ensure that even those who do not meet all the metrics get some kind of reward.
- Thoughts on future remuneration: Remuneration can range on a continuum, from fee-for-service, to fee-for-service plus shared savings, to pay-for-performance, to capitation.

Typical challenges and how to meet them

- Motivation: When presenting change to stakeholders, accentuate the rewards.
- Sunk costs: Payback is not always direct, measurable, or easily anticipated; organizations must recognize that in some ways they are taking a gamble.
- Data: 3,500 mobile convertibles ensure “information goes where the doctor goes.”

Success stories and results

- Marshfield was able to move 7,000 patients to clinics set up solely for anticoagulation difficulties. Readmission and compliance rates improved.
- A 24/7 nurse line, through which nurses could answer questions and schedule next-day appointments, resulted in an ER utilization decrease of about 50 percent.
- Working with the state, Marshfield developed a telepharmacy for rural areas.
- The EMR allowed several ways to drill down on information and created alerts when needed. Physicians could contact patients who had fallen behind on tests and give patients and families a printout that listed all medications and procedures, improving patient engagement.

Breakout Session Highlights

Wellstar/Humana: Physicians wanted to engage in the patient-centered medical home model, but were concerned that they were too busy. The Wellstar partnership with Humana leveraged resources without adding support costs. In 21 months, all patient satisfaction factors either improved or stayed the same; ER visits decreased by 15 percent and ER expenses by 17 percent.

Geisinger Health System: By its third year in the CMS demo project, Geisinger was saving \$7 million and had reached 100 percent on quality levels. Making delivery proactive, keeping a healthy relationship with the health plan to provide data and expertise, and using HIT to engage all sides were cited as success factors.

Everett Clinic: Through its participation both in the CMS demo project and in a pilot requested by employer Boeing, The Everett Clinic discovered physician/nurse and behavioral health team-ups to be crucial, aided by pharmacy data on compliance and a patient portal to the EMR.

University of Utah Health Care: A “health neighborhood” leveraged the resources of a large system. Key to success was bringing everyone onto the same EMR, from specialists on the main campus to community clinics.

Humedica MinedShare™ Ambulatory and the Anceta Comparative Data Warehouse: Organizations can use comparative data from a national data warehouse to propose value-sharing arrangements with payers and use ongoing reports to maximize improvement and report results for possible enhanced payment.

Care Coordination



*“It’s not about ‘we need smarter cardiologists.’
It’s about ‘we need a better system.’”*

*— John Cochran, M.D., Executive Director,
The Permanente Federation*

General Session Highlights: Success Stories and Strategies

John Cochran, M.D., Executive Director, The Permanente Federation

Improved care coordination in targeted areas helped Kaiser Permanente achieve top NCQA ranking for its healthcare delivery system reform and integrated care delivery.

Cardiac care service

Within 24 hours of discharge, all CAD patients admitted with an acute coronary event were enrolled in a three- to six-month educational and case management cardiac rehabilitation program. This focused on smoking cessation, diet and exercise, psychological support, and use of cholesterol-lowering medications. Overall incidence of mortality decreased 89 percent, with an estimated 280 emergency interventions prevented annually. Cochran attributed success to:

- Coordinating change in lifestyle advice and other guidance among nurses, pharmacists, cardiology rehab specialists, and primary care leadership
- Using IT to integrate data, measurement, and performance improvement
- Assigning a clinical specialist to manage medication regimens
- Sharing all patient interactions, medication orders, and lab tests recorded in the emergency room with the care team
- Leveraging patient registries, coordinating outreach capabilities, and providing measurement and integration across all levels

Breast cancer screening

Kaiser Permanente designed a comprehensive outreach campaign for all women meeting Healthcare Effectiveness Data and Information Set age criteria for mammograms who hadn’t been screened in the past 18 months. As a result, southern California ranked number one nationally in breast cancer screening by NCQA, and all Kaiser Permanente regions were at or near 90th percentile. Time screening result and diagnosis decreased from 19 to 9 days. Cochran attributed this success to:

- IT systems that combined multiple data streams, including a “missed opportunity” log
- A vigilant system of monitoring the information, such as the automatic, IT-enabled identification of patients needing mammogram
- Trust among colleagues to keep the conversations going

Essential Elements for Effective Care Coordination

- Aligned culture and mission
- Aligned incentives
- Integrated IT, performance improvement, and reporting systems
- Adherence to clinical guidelines and evidence-based medicine
- A focus on primary care and total patient health
- Physician leadership

Breakout Session Highlights

Advocate Health Care: Advocate found that it didn’t need a fully installed EMR to be successful in coordinating care. Elements that were vital in the process: joint contracting, metrics such as report cards, and integration of office staff in pivotal roles.

Intermountain Medical Group: EMRs helped Intermountain integrate mental health services into operations, enabling care managers to detail tasks, set up appointments, summarize assessments, and outline next steps in the patient’s centralized clinical record.

PriMed Physicians: PriMed achieved breakthrough outcomes in managing hypertension through a five-step, Six Sigma-inspired process: training, establishing baseline performance, identifying the “spines” (challenges) along the fishbone, designing processes, and using statistics to address controversies.

Virginia Mason Medical Center: A collaborative pilot project with Boeing used an ambulatory ICU and proactive outreach to reduce hospital days and imaging and lab services for the most expensive 20 percent of Boeing care users.

Organizational Structure



“Culture trumps strategy.”

— Mark Werner, M.D., Chief Medical Officer,
Carilion Clinic

General Session Highlights: Addressing Behavior and the Business Model

Mark Werner, M.D., Chief Medical Officer, Carilion Clinic

Moving from the typical structure of health delivery, centered around the individual actions of good clinicians working hard, to the team approach of the ACO model requires a look at both the culture and the business model. Focusing on either one alone won't result in success.

How can you change physician behaviors?

- Acknowledge the ambiguity of the ACO journey.
- Create an atmosphere of participatory problem-solving. Treat physicians as owner/managers and get their input.
- At the same time, realize the granular level at which people need guidance. Continually clarify the vision and goals and translate these into accountable steps.
- Don't be afraid to reorganize. People will need to learn new skill sets and processes.
- Examine how integration plays out across operations—for instance, when a congestive heart failure patient arrives for elective surgery.
- Organize around patient, not institutional, needs.
- Establish a shared ACO vision up to the board level.

How do you change the business model?

- Start evaluating underlying cost structure. If you had to reduce cost structure by 15 percent over next 15 years, how would you do that?
- Structure your groups. Carilion established interdisciplinary centers rather than specialty practice areas and created a physician-group executive leadership team.
- Focus on your foundation: primary care, chronic disease management, quality outcomes.
- Realize that some metrics (primary care panels, NCQA and HEDIS outcomes, avoidable hospitalizations) will become more important and others less so.
- Build the capacity to manage risk.
- Develop capability to work across providers. Each has its own measurements, needs, rules, and IT systems—how will you handle these differences?
- Be prepared to manage revenue reductions, especially in the areas of hospitals and specialists, and realize that all the savings won't come back to you.
- Include performance bonuses for staff in key areas, such as scheduling, registration, and pediatrics.
- Create a balanced scorecard for measuring physician performance and base incentives.

What Physicians Need to Lead

- Communication skills
- Behavior/performance management
- The ability to work in teams across the organization
- Business and finance knowledge
- Quality improvement training
- Practice management training
- Knowledge of healthcare trends
- Guidance in change management

Breakout Session Highlights

Cleveland Clinic: Physicians here undergo multiple forms of evaluation, including short-cycle access and productivity metrics (available online), quarterly quality evaluations, and an annual self-evaluation and sit-down session with the department chair.

Dean Health System: Dean Health System uncovered savings by switching to 90-day prescriptions and discovering that not all cardiac cases needed to be managed in a hospital.

Northwest Physicians Network: Alignment here is supported by an infrastructure of electronic tools and care coordination systems, strong relationships, and a sense of “citizenship” across the ACO community.

Spectrum Health Medical Group/ECG Management Group: Challenges—and questions—arise with global compensation that accounts for all services. Which ancillary services should you keep or get rid of? Do you employ your doctors, contract them through PSAs, or use a mix?

Western Washington Medical Group: Capital strategies need to be aligned between the hospital and medical group. Here, the medical group has the same level of independence to spend (up to \$10 million) as the hospital, giving the group the freedom to also invest in resources.

Moving from Volume to Value



“What’s different today is we now have a federal requirement that everyone has health insurance—fueling a sea change in public accountability.”

*— Richard Maturi, Senior Vice President,
Health Care Delivery Systems, Premera Blue Cross*

Payment Reform from Three Perspectives

According to Martin Hickey, M.D., chief accountable care officer of Alegent Health Clinic in Omaha, Alegent’s marketplace reflects several nationwide trends:

- Competition: Two large medical centers serving community
- Excess capacity: Hospital occupancy at only 40% to 60%
- Collaboration: PHO of 300 academic physicians, 600 independents

How can health groups adapt moving forward? “Data and transparency—to see outcomes—are critical as we move from volume to value. And, if physicians aren’t intimately involved in the formation of a competing ACO, it won’t succeed.”

Nicholas Wolter, M.D., CEO of Billings Clinic and former commissioner of the Medicare Payment Advisory Commission, pointed to the need to refine fee-for-service payments, create penalties for nonparticipants, and incentivize physicians, particularly those in small practice. He talked about how his five years of experience with the PGP demo project underscored the importance of the following factors:

- Attribution
- Beneficiaries
- Comparative groups
- Performance feedback
- Risk adjustment
- Infrastructure
- Shared savings

Richard Maturi of Premera Blue Cross predicts that government will step in to regulate healthcare costs at the provider level in the next five years—not 15 or 20. To head off federal officials at the pass, he said, the healthcare industry needs a commercial payment model that can be quickly brought to scale without having to completely retool the transaction payment structure.

Audience questions focused on on-the-ground aspects of implementation, such as:

- How big do incentives have to be, and where does the money come from?
- What incentives can be presented to hospitals for buy-in into the ACO model?
- How will the success of the ACO model impact the compensation of specialists, who right now earn much more than primary care physicians?

Legal Issues Update: What to Watch for in ACO Creation and Implementation

Foley & Lardner provided insight on overlaps and ambiguities related to:

- **Joint contracting:** To avoid anti-trust scrutiny, ACOs should be prepared to show that joint contracting is necessary to achieving goals.
- **Fraud and abuse:** Laws designed for a fee-for-service environment preclude payment for referrals. In light of these, ACOs may need to consider fee-for-service agreements, distributions to equity owners and participants, and the structure of physician contracts.
- **Compensation and shared savings:** Shared savings may be disallowed under anti-kickback statutes or the Stark law, which largely prohibit and severely limit self-referrals for ancillary services. As payment mechanisms emerge, such as gain-sharing programs or exceptions for academic medical centers, aspiring ACOs should examine the way these laws apply.

Challenges and Concerns

Moving Forward



“What’s going to keep you up at night?”

In this concluding roundtable session, AMGA President and CEO Dr. Don Fisher presented this question to audience members and panelists Dr. Martin Hickey with Alegen Health Systems, Dr. Robert Nesse with Mayo Clinic, and Dr. Karl Ulrich with Marshfield Clinic.

Participants throughout the workshop had expressed general support of the ACO concept; however, factors like attribution, shared savings, and delayed results had some expressing hesitation and concern for how policy would play out on the ground. Within the overarching umbrella of “Should I become an ACO? How do I become an ACO?” topics on participants’ minds included:

- **How to reconcile the ACO model’s long-term returns with necessary savings in the short term:** With an ACO model, return on services can take eight to ten years to really show in the system. Yet groups considering the ACO path want and need to see returns in two to five years. One suggestion: pursuing both paths at once—for instance, tackling effective care management of patients in the top ten percent for comorbidity, where returns can start to be seen within months, while concurrently pursuing longer-term efforts in the areas of preventative care.
- **How to bring in ACO-required services:** Many aspiring ACOs, for example, currently don’t handle Part A. Is adding capacity best accomplished through buying services or pursuing partnerships? For groups considering the latter, having informatics, case management resources, or a certain number of physicians (say, 100) can strengthen negotiating power.
- **How to manage the repercussions of healthcare reform’s increased access:** With healthcare reform, millions of uninsured will be pushed into Medicaid. For organizations that serve as safety net hospitals, this could have significant cost implications. Although reimbursement specifics vary by state, participants were cautioned to look out for a possible industry-wide reaction from insurers: the motivation to pay providers less.

- **How to manage attribution issues and share the savings:** Participants also were cautioned to be prepared for attribution issues in their groups. These can be an opportunity for finger-pointing; for instance if a patient hasn’t yet been seen by a primary care physician but gets a huge workup in the ER.
- **How to find the optimal mix of primary care physicians vs. specialists:** An ideal ratio might be 40 percent primary care and 60 percent specialists; however, every group is different and must find the best solution for its situation. Nursing providers (a new position for employees with a doctorate in nursing) also can be brought in to support the work of primary care physicians.



- **How to manage patient expectations when using physician extenders:** Physician extenders are being used more and more due to the shortage of primary care physicians. Yet, does this impact patient satisfaction? How do people react when they expect to see a doctor but meet instead with a nurse practitioner? According to Nesse, the level of expectation depends on the type of care needed and an overall sense that a physician could be called upon if necessary. In retail clinics, he said, people come in for a specific set of commoditized services, delivered quickly and conveniently. “They thought (the use of physician extenders) was fine if they sensed the care was coordinated.”

IQL 2010 Presenters

Craig Anderson Sr., Senior Partner, Charis Health

Donald Berwick, M.D., Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

Carole Black, M.D., Chief Medical Officer, Valence Health

Frederick J. Bloom Jr., M.D., M.M.M., Assistant Chief Quality Officer, Geisinger Health System

David L. Bronson, M.D., FACP, President, Cleveland Clinic Regional Hospitals

A.G. Breitenstein, J.D., M.P.H., Vice President & General Manager, Provider Markets, Humedica

Lawrence Casalino, M.D., Ph.D., Chief, Division of Outcomes and Effectiveness Research, Weill Cornell Physician Organization

F. Douglas Carr, M.D., M.M.M., Medical Director, Education and System Initiatives, Billings Clinic

John H. Cochran, M.D., FACS, Executive Director, The Permanente Federation, Kaiser Permanente

Carolyn Cone, Program Manager, Virginia Mason Medical Center

G. Patrick Connors, FACHE, Chief Executive Officer, Holzer Clinic

William A. Conway, M.D., Senior Vice President and Chief Quality Officer, Henry Ford Health System

Christopher Corbin, M.B.A., Program Manager, Clinical Guidance Organization, Humana

John Cuddeback, M.D., Ph.D., Chief Medical Information Officer, Ancuta

Julie Day, M.D., Medical Director for Quality, University of Utah Health Care: Community Clinics

Marcia L. Delk, M.D., M.B.A., Senior Vice President Medical Affairs, Chief Quality Officer, WellStar Health System

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

Albert W. Fisk, M.D., Chief Medical Officer, The Everett Clinic

Seth Frazier, Vice President, Transformation, Geisinger Health System

C. Frederick (Fred) Geilfuss, J.D., Partner, Foley & Lardner LLP

Ingrid Gerbino, M.D., FACP, Section Head, Virginia Mason Medical Center, Lynnwood

Thomas R. Graf, M.D., Chairman, Community Practice Service Line, Geisinger Health System

Joshua D. Halverson, M.H.A., Senior Manager, ECG Management Consultants, Inc.

Jacqueline R. Hayes, R.N., B.S.N., Executive Director of Clinical Services, WellStar Physicians Group

Martin Hickey, M.D., M.B.A., Chief Accountable Care Officer, Alegent Health Clinic

Karen Hohenstein, Director, Navigant Consulting, Inc.

Sheila Johnson, R.N., M.B.A., Director of Clinical Performance, Dartmouth-Hitchcock Clinic

Scott Kronlund, M.D., Chief Medical Officer, Northwest Physicians Network

Linda Leckman, M.D., FACS, Vice President, Intermountain Healthcare and Chief Executive Officer, Intermountain Medical Group

Abe Levy, Chief Medical Services Officer, Mount Kisco Medical Group

Robin L. Lloyd, M.P.A., Executive Director, Ambulatory Services & Community Clinics, University of Utah Health Care

Rick MacCornack, Ph.D., Chief Systems Integration Officer, Northwest Physicians Network

John M. MacKeigan, M.D., Chair of the Board/Chief Medical Officer, Spectrum Health Medical Group

Robert E. Matthews, Executive Director, PriMed Physicians

Richard A. Maturi, Senior Vice President, Health Care Delivery Systems, Premera Blue Cross

Robert E. Nesse, M.D., Chief Executive Officer, Mayo Clinic Health System

Mike Nugent, Director, Navigant Consulting, Inc.

Max Reiboldt, CPA, President/Chief Executive Officer, Coker Group

Douglas Romer, M.D., Family Practice Physician and Chairman of the Board, PriMed Physicians

Mark C. Rumans, M.D., Physician in Chief, Billings Clinic

Lee Sacks, M.D., Executive Vice President, Chief Medical Officer, Advocate Health Care and President, Advocate Physician Partners

Craig Samitt, M.D., Chief Executive Officer, Dean Health System

Michael Sheinberg, M.D., Associate Medical Director, Medical Quality, Lehigh Valley Physician Group

Mark Shields, M.D., Senior Medical Director, Advocate Health Care

Donn E. Sorensen, M.B.A., FACMPE, Executive Vice President, St. John's Health System

Jerry Tillinger, M.B.A., M.H.A., CEO, Western Washington Medical Group

Karl Ulrich, M.D., President and Chief Executive Officer, Marshfield Clinic

Barbara A. Walters, D.O., M.B.A., Senior Medical Director, Southern NH Community Group Practices, Dartmouth-Hitchcock Clinic

Jay Want, M.D., Chief Executive Officer, Physician Health Partners

Mark Wendling, M.D., Associate Medical Director, Performance Improvement, Lehigh Valley Physician Group

Mark Werner, M.D., Chief Medical Officer, Carilion Clinic

Jennifer L. Wilson-Norton, Director of Pharmacy, The Everett Clinic

Nicholas Wolter, M.D., Chief Executive Officer, Billings Clinic



IQL 2010 Presenting Organizations at a Glance

Advocate Physician Partners

Elmwood Park, IL
IPA
200 Satellites
2,100 FTE Physicians

Alegent Health Clinic

Omaha, NE
IDS
44 Satellites
200 FTE Physicians

Billings Clinic

Billings, MT
IDS
9 Satellites
220 FTE Physicians

Carilion Clinic

Roanoke, VA
IDS
75 Satellites
600 FTE Physicians

Cleveland Clinic

Cleveland, OH
Academic/Faculty Practice
15 Satellites
1200 FTE Physicians

Dartmouth-Hitchcock Clinic

Lebanon, NH
Academic/Faculty Practice
30 Satellites
605 FTE Physicians

Dean Health System, Inc.

Madison, WI
Group Practice
60 Satellites
363 FTE Physicians

The Everett Clinic

Everett, WA
Group Practice
6 Satellites
318 FTE Physicians

Geisinger Health System

Danville, PA
IDS
60 Satellites
800 FTE Physicians

Henry Ford Medical Group

Detroit, MI
IDS
30 Satellites
1,020 FTE Physicians

Holzer Clinic, Inc.

Gallipolis, OH
IDS
10 Satellites
140 FTE Physicians

Intermountain Medical Group

Salt Lake City, UT
IDS
130 Satellites
626 FTE Physicians

Lehigh Valley Physician Group

Allentown, PA
IDS
60 Satellites
500 FTE Physicians

Marshfield Clinic

Marshfield, WI
Group Practice
65 Satellites
768 FTE Physicians

Mayo Clinic – Jacksonville

Jacksonville, FL
Group Practice
274 FTE Physicians

Mayo Clinic – Rochester

Rochester, MN
Group Practice
3 Satellites
1544 FTE Physicians

Mayo Clinic – Scottsdale

Scottsdale, AZ
Group Practice
4 Satellites
350 FTE Physicians

Mayo Clinic Health System

Various Locations
Group Practices
64 Satellites
2,627 FTE Physicians

Mount Kisco Medical Group

Mount Kisco, NY
Group Practice
15 Satellites
205 FTE Physicians

Northwest Physicians Network

Tacoma, WA
IPA
1 Satellite
391 FTE Physicians

The Permanente Federation

Various Locations
Individual Group Practices
400 Satellites
16,929 FTE Physicians

Physician Health Partners

Denver, CO
IPA
250 FTE Physicians

PriMed Physicians

Dayton, OH
Group Practice
18 Satellites
48 FTE Physicians

Spectrum Health Medical Group

Grand Rapids, MI
IDS
18 Satellites
525 FTE Physicians

St. John's Health System

Springfield, MO
Group Practice
70 Satellites
560 FTE Physicians

University of Utah Community Clinics

Salt Lake City, UT
Academic/Faculty Practice
91 FTE Physicians

Virginia Mason Medical Center

Seattle, WA
Group Practice
7 Satellites
363 FTE Physicians

Weill Cornell Physician Organization

New York, NY
Academic/Faculty Practice
2 Satellites
750 FTE Physicians

WellStar

Marietta, GA
IDS
65 Satellites
263 FTE Physicians

Western Washington Medical Group

Everett, WA
Group Practice
6 Satellites
55 FTE Physicians

For more information on AMGA and ACOs, visit the ACO Resource Center at www.amga.org.

IQL 2010 Contributors and Exhibitors

Platinum Host



Gold Contributors and Exhibitors



Life is our life's work.®



AMGA Accountable Care Organization Principles

I: Multispecialty Medical Groups and Other Organized Systems of Care Make the Strongest Foundation for ACOs

II: ACOs Must Be Physician-led

III: Accountability for Healthcare Services

IV: ACO Incentives Must Be Aligned to Foster Voluntary Participation

V: ACOs Must Have a Primary Care Core

VI: ACOs Should Be “Learning Organizations”

VII: ACO Core Values and Attributes

Core Values

- Quality
- Patient-centered care
- Care coordination
- Accountability
- Innovation
- Physician self-governance
- Leadership development

Attributes

- The organization is a physician-led, multispecialty group medical practice or other physician-led organized system of care
- The organization has a stable governance structure
- The organization has a centralized administration
- The organization has an infrastructure necessary to be accountable
- The organization is quality driven



One Prince Street
Alexandria, VA 22314-3318
www.amga.org