“The purpose of this collaborative is to share ideas and concerns and work through solutions together.”

— Julie Sanderson-Austin, R.N., Vice President of Quality Management and Research, AMGA

In October 2010, AMGA’s ACO Development Collaborative first presented in-depth workshops on the accountable care organization (ACO) concept. The January 2011 ACO Implementation Collaborative engaged a new group in sharing and learning. Because the Centers for Medicare and Medicaid Services (CMS) had not yet released regulatory guidance fleshing out Section 3022 of the Patient Protection and Affordable Care Act (PPACA), myriad questions were asked and addressed on moving forward in an informed fashion.

What are the opportunities to start building new compensation models? How does one improve capabilities in population health? “These are some of the areas that are not detailed in the broad legislation that came out,” said Sanderson-Austin. We also need to understand how to measure the complete patient experience, beyond an office visit survey, and collect other valuable feedback on the impact of new care processes and business relationships. Sanderson-Austin introduced a pilot project to develop such a tool—a collaboration between AMGA and Press-Ganey, two traditional competitors in the healthcare benchmarking space. “This is the kind of partnership you all will need to enter into,” she said.

Participants represented 16 health systems from cities like Detroit and broader geographic areas in the Pacific Northwest. They heard successes and challenges from the field, learned implementation tips in areas such as population health and physician compensation, and gleaned insight into policy possibilities and payer perspectives.

AMGA Resources

A self-moderated listserv is available to keep participants connected between meetings. AMGA also has created a dedicated, password-protected area on its website, www.amga.org, where ACO Implementation 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 monthly educational webinars
— George H. Roman, Senior Director, Health Policy, AMGA

Once the CMS guidelines are released, AMGA’s public policy team will be working “day and night” to digest them and outline the most critical issues for participant response and feedback, said Sanderson-Austin. In the meantime, Roman delivered perspectives on what the rules might contain and areas aspiring ACOs should pay attention to moving forward.

“As soon as the rules come out, we need to hear from you quickly where the surprises are.”

— Wendy Oberdick, Holston Medical Group

Where do ACOs come from? A brief history

The ACO concept responds to a convergence of factors, including increasingly unsustainable healthcare costs, the impending influx of baby boomers into the Medicare system, and an overall shift from volume to value. For many, its beginnings truly coalesced at a 2006 MedPac committee meeting.

From 2005 to 2010, the CMS Physician Group Practice (PGP) demonstrations engaged 10 physician group practices, integrated delivery systems, and others with 250 or more physicians to test the use of incentives and rewards, foster coordination between Medicare Parts A and B, and encourage investment in efficiency and processes. In 2008, the Newt Gingrich-created Center for Health Transformation asked AMGA for insights from PGP demo participants, and key legislators and staffers asked AMGA for input on language that ultimately became Section 3022 of the PPACA.

Since then, AMGA has been heavily involved in creating momentum and a case for a separate ACO funding model, and interest in the ACO model has spread. “The private sector might even get ahead of the federal government in this idea,” said Roman.

The Law Right Now—Do You Qualify?

To be considered an ACO under current regulations, a medical group, individual practice association, hospital with joint ventures, or “anyone else the Secretary deems appropriate” is required to have:

- A formal legal structure that allows for receiving and distributing payments
- Sufficient primary care capacity to manage at least 5,000 Medicare beneficiaries
- The appropriate leadership and management structure
- Processes that promote evidence-based medicine, report quality and cost measures, coordinate care, and take a patient-centered approach
- Commitment for a three-year term
How Will Rules in Washington Impact Reality on the Ground?

Roman discussed issues in play against observations and challenges that emerged from the PGP demos, including:

**Attribution:** The PGP demo project used retrospective attribution. Whether this or prospective attribution is chosen, CMS has expressed a preference for assignment rather than enrollment and will have a low tolerance for “cherry picking” as ACOs drive the role of primary care.

**Quality measures—**which and how many**?** Roman said he anticipates national quality measures (NCQA, NQF) that include ambulatory and hospital care and that may be changed or augmented moving forward. He cautioned that PGP demo participants flagged reporting as “doable but challenging,” and many said reporting would have been overwhelming if all 32 metrics had been required from the beginning, rather than phased in.

**Thresholds:** In the PGP demo, one large system asserted that the current savings requirement on top of its “already too efficient” operations set the bar too high. Because of the proposed 95 percent confidence level, the threshold is population-dependent. Some groups may need to save even a greater percentage than the 2 percent total savings above the local trend line before qualifying for shared savings.

“**To Be or Not to Be an ACO**”

When deciding if and how to answer this question, Roman advised participants to seriously ponder the following questions:

- Is what you know about the ACO requirements so far attractive enough for you to voluntarily participate?
- Do you have the infrastructure, especially in primary care, to become an ACO? What would it take to get there?
- Are you prepared for seven-figure maintenance expenditures that are not considered in the current reimbursement methodology?
- Are you prepared to tackle rigorous reporting requirements?
- Do you have the necessary culture and commitment?
Sutter Health: Exploring the ACO Model

— Jeff Burnich, M.D., SVP and Executive Officer, Sutter Medical Network

Among the largest not-for-profit health systems in the nation, Sutter Health serves more than 100 cities and towns through nearly 5,000 physicians, 24 hospitals, and five IPAs. Recognizing Medicare as “a bubble that will burst,” Sutter moved toward integrated delivery and is exploring the ACO model. Today Sutter hospitals perform in the top 10 percent of CMS quality indicators and Sutter is ranked as California’s leading health system based on quality and patient satisfaction.

Keys to Success So Far

- **Clinical integration that’s mindful of culture and data:** After ensuring a good cultural fit with this multispecialty group, Sutter engages new physician practices into an aligned agreement with 29 pay-for-performance measures. “It’s ‘raise all boats’ to help people improve,” said Burnich. “All measures go up over time because we’re transparent.”

- **Using IT to share and connect:** Sutter uses technology systems like Ingenix Impact Intelligence to address variations across physician practices and Epic to improve quality of patient care. More than 400,000 Sutter patients get personalized health information, most lab results, and messages from their care team through the MyHealth online patient portal.

- **Calculated risk management:** Sutter takes a strategically cautious approach. As one example, because the health system has recently been able to view costs in pharmacy services, leadership now feels comfortable taking on risk in this area.

Collaborative Thinking

Participants asked Burnich how Sutter was addressing:

- **Behavioral health:** “I think you need to develop awareness, then tools such as screening, to manage it.” He added that over-diagnosis is a problem.

- **Benchmarking:** Burnich advised participants to be prepared to compare total costs of care against a national average, not their own historic figures.

- **Sharing knowledge across a large system:** Sutter maximizes the efforts of its small staff by communicating through dashboards, print and online outreach vehicles and empowering five regional group leaders to get the word out on the ground.

- **Engaging physicians without violating Stark:** Anti-trust law prohibits donations. However, intellectual capital is one way to get over this hurdle; Sutter lends out to physicians the datasets, best practices and other intellectual capital developed over a decade using Epic.
Collaborative Thinking

Freed and Rutherford talked to participants about:

- **Whether success could be attributed to the targeted population demo or overall efforts in chronic care:** According to Freed, the demo project gave WVMC the opportunity to look at overall approaches to chronic care, improve case management and constantly ask the question, “How can we do this better,” said Freed.

- **What they’re working on now:** WVMC is moving case management into physician pods, working through process measures and building data sets and registries nurses can easily display for patients who are coming in. WVMC is also piloting a 5 percent at-risk compensation system for the first time.

- **What the demo experience taught them about the case manager role:** WVMC learned about the necessary skill sets, the capacity for patient assignments, training resources, and how they can identify where patients are in the change readiness continuum to start taking charge of their health.

**What Sutter needs to move forward:** Burnich cited the need for data systems to cover a population and actuarial experience beyond registries. “You have to really know who’s in there and the risk they bear,” he said. Also required: CMS-ACO infrastructure to support care managers in the practices, especially for patients with high-volume, high-cost chronic diseases. This will be an investment of millions even though the shared savings might not be seen for months or years.

Furthermore, because most health care is episodic at Sutter, with nearly half (45 percent) of patients leaving the hospital without substantial follow-up, the group also needs systems in place to facilitate smooth transitions of care across all practice settings, including behavioral health.

---

**Wenatchee Valley Medical Center: Chronic Care Provides an ACO Foundation**

— Peter Rutherford, CEO and Chairman of the Board; Stuart Freed, M.D., Medical Director and Board Member, Wenatchee Valley Medical Center

Wenatchee Valley Medical Center is a for-profit multispecialty physician group with eight sites serving 150,000 patients—including a population costing 2.5 times more than the average Medicare patient—across 12,000 square miles in the Pacific Northwest. Participation in a CMS Care Management for High-Cost Beneficiaries demonstration project gave WVMC the opportunity to explore comprehensive care management strategies and tools that resulted in decreased clinical care costs and improved patient outcomes.
Keys to Success So Far

- **Robust case management:** In addition to WVMC’s 20 years of experience and staff with strong leadership experience, the medical center already has a reliable Epic medical records system and mature IT system in place. WVMC leadership is committed to rolling out Epic across the entire group. “We see the power of medical records systems,” said Freed.

- **The Health Buddy® program:** Health Buddy equipped selected patients with chronic conditions with in-home devices for education and monitoring and regular communication with a care manager. In addition to giving patients “the peace of mind that someone is looking out for you,” WVMC reduced the number of inpatient visits, emergency room visits, and nursing home days. ER visits decreased by 17.71 percent.

- **Physician and staff engagement:** Aligning salary to patient care entails moving from a culture of “how much do you produce?” to “how well do you do?” said Freed. In one example of facilitating this shift, WVMC gives each department the opportunity to develop—and personally invest in the performance of—a grassroots improvement project.

What WVMC needs to move forward: The medical center continues to grapple with high fees for service. “There’s still not a lot of experimentation from payers,” said Freed. And already-low Medicare payments mean they’re already “running lean. There’s not a lot of room to win the [shared savings] game.” Increased visits are where WVMC is hoping to get some of the costs back.

Riverside Health System: Using the ACO Model to Align Parties, Adapt to Market Challenges

— Barry L. Gross, M.D., Executive Vice President/Chief Medical Officer, Riverside Health System

Headquartered in central Newport News, Virginia, Riverside Health System is challenged by a large geographic area of coverage and highly competitive market. Competitors are mostly large primary care groups; the region has seen a dramatic trend of shrinking independent practices.

Starting in the 1980s, Riverside has been adding employee physicians (responding to the purchase of a hospital with no doctors) and adding practices because “primary doctors were having trouble surviving. This was the only legal way we could help them,” said Gross. Today, Riverside is working to stay competitive and align divergent practices and protocols as it moves to the ACO model.

Keys to Success So Far

- **Insurance industry experience:** Several Riverside executives come from the health insurance industry, giving the health system a solid foundation of industry experience and strong relationships with payers, such as Anthem.

- **Robust care management:** Riverside top-level management backs its commitment to care management with IT and other resources. For example, a centralized call center allow doctors to utilize all available resources, moving patients to the appropriate hospitals or facilities and referring them to the right specialists within the health system.
Strong information systems: Riverside already has reliable IT capabilities in place with Centricity, which connects roughly 370,000 active patients and 600,000 charts.

What Riverside Needs to Move Forward

A multitude of compensation plans, a dearth of in-house actuarial experience, and insufficient experience managing disease registries and chronic disease care have slowed Riverside’s progress, according to Gross. A larger paradigm shift also is needed. Gross said they’ve worked with doctors to try and align the employment contract methodology to highlight care over quantity, but it’s not always easy. “They have a hard time with that because their mortgage is on the line.” And despite an already robust network of experienced physicians, he said that Riverside needs more leaders who understand that the siloed approach is no longer valid. “We need that mentality to change.”

Collaborative Thinking

Participants asked Gross about:

- **Communicating between hospitals and interoperability:** Although Riverside has created a system that automatically lets physicians know there’s a Centricity chart for an incoming patient, “we’re not there,” said Gross. Although Sorian® has been installed at different hospitals, a disparate system still exists in the ER rooms.

- **Structuring compensation:** Riverside ties 20 percent to service and quality, with the components determined by the medical board.

- **Addressing management gaps:** “We pride ourselves on being a lean organization,” said Gross. However, the ability to move patients across the system is critical to success, and Riverside needs more management integration and leadership centered on that concept. The major challenges lie across the care continuum, he said.
Reducing Total Cost of Care through Practice Redesign

— Shawn Wagoner, Engagement Director, Carol Corp; and Dave Moen, Medical Director Care Model Innovation, Fairview Health Services

Fairview Health System’s “difficult but successful” road toward practice redesign ultimately ended up with the network operating eight points below the market median for quality of care.

The journey involved a five-phase care package process. First Fairview identified opportunities to improve quality and reduce costs. “Use your own performance data to see what’s going on,” said Waggoner. Analysis of patients with diabetes and medication management led Fairview to the area of blood pressure control. Clinical delivery innovations followed, such as a “diabetes care package” outlining interventions and standard processes, as did new clinical workflows and tools, including diabetes cost and quality dashboards that made key metrics easy to grasp and transparent. Fairview engaged clinicians at every stage, from initial design through education and training.

Results and challenges: From 2008 to 2010, Fairview clinics involved in practice redesign saw quality of care metrics go up from 37.2 percent to 43.6 percent—and could compare this performance against that of Fairview clinics that did not participate in the practice redesign. Achieving these results required overcoming a significant challenge—cultural resistance to the disequilibrium that’s inherent with any change.

Tips for Implementation Success

- **Physician training in adaptive (not technical) leadership:** Fairview trained 200 physicians in adaptive leadership, using curriculum from the Harvard Kennedy School of Government, and is starting its own “leadership academy” for the network. Said Moen, “We need to work together to learn the language of leadership and be honest about what we need to learn, unlearn, and do to be active participants in change.”

- **Data-driven processes:** Fairview described its care package process as “data driven, physician led.” Timely, relevant information gives clinicians the power to think about what they would do differently.

- **Protocol oversight:** Fairview supplements its dashboards and workflows with “lots of conversations” to keep people accountable. “We want this to be a team-based, shared accountability activity with dialogue among accountable team members,” said Moen.

- **Aligned incentives:** According to Moen, when everyone is talking about the bucket of savings and who’s going to get what, parties such as physicians, hospitals, and clinics realize they have to work together differently. With this incentive, they begin to connect the dots and begin to create care management systems that fill in the gaps.
A Simple Step. Substantial Savings.

When Fairview asked physicians what bothered them most, a frequent answer was the 90 minutes a night of “take-home work,” such as lab follow-up and documentation. To address this complaint, Fairview examined its e-mail communication model. A staggering 30 percent of all clinic communication was ending up in physicians’ e-mail boxes. Practice redesign alleviated the burden by:

- Embedding receptionists and schedulers into the care team
- Scheduling daily “huddles” for the care team to exchange information and adapt to tasks coming into the office
- Using an automated tool, rather than personal physician phone calls, to inform patients of lab results

Demonstrable outcomes: Moen advised getting “points on the board” early, to energize people both inside and outside the network. Not only did shared successes help address the questions “Why are we spending doing this?” and “Why are we spending money?” Fairview’s early efficiency results helped attract a million-dollar payer partnership and the interest of several area Fortune 500 employers.

Lessons Learned from the Primary Care Medical Home Model

— John Wendland, PCMH Project Manager, Carilion Clinic

Although a health system cannot legally be a medical home and ACO, both share similarities. For instance, the medical home model is a response to high healthcare costs and focuses on care that is accessible, continuous, comprehensive, patient- and family-centered, coordinated, compassionate, and culturally effective.

At Carilion, chronic illness expenses were escalating, and preventive care was falling through the cracks. To address this, in 2009 the clinic implemented a primary care medical home (PCMH) model concurrently at 28 sites. The goal: to better serve patients and to seize evolving payment opportunities.

The PCMH model, in strengthening relationships between office staff and physicians and between individual patients and their medical home, created an environment of continuous, coordinated, and comprehensive care. Concurrent, multiple-site implementations facilitated shared learning in program management. Yet the model is still struggling for fiscal viability.
Results and challenges: Nearly all participating sites have met goals for diabetes test frequency. One of the strongest results is a nearly 140 percent rise in BMI testing. Through extended hours and weekend and holiday coverage, patient access improved. Forty percent of Carilion medical home visits are same-day appointments. Because patients connect to their medical home through an online portal, use of online services tripled from 2009 to 2010.

However, Wendland expressed concern that the transformation is not happening as fast or fully as he’d like. “Physicians are more satisfied in patient management, but they are still in a fee-for-service environment.”

Tips for Implementation Success

“There’s a normal distribution of physician attitudes: about 2 percent are early adopters, who are fired up to try it—and on the other end are curmudgeons who want nothing to do with it. So the 95 percent in between are the ones to focus on.”

— John Wendland, Carilion Clinic

Get physician buy-in: In a culture where change comes slowly, introducing the PCMH model with patience and flexibility was crucial, as was fighting change fatigue. For instance, Carilion had introduced the Epic EMR a few years before implementing the medical home, and many sighed at having to do yet another major system overhaul. Carilion also experienced resistance to policy changes and to consolidating into part of a larger corporation.

The Power of Research Partnerships

For organizations seeking to improve quality and implement new systems of care, partnerships with research institutions yield numerous benefits. Research institutions can provide tools and techniques, capture data and changing knowledge, enable better information and best-practice sharing, and more. Partnerships spur staff creativity and enable professional development and funding opportunities.

Carilion partners with many medical home researchers to improve its internal operations and advance the model. It enlisted Virginia Tech as its primary research partner, gaining access to technology, statistics, and models from the business school and insights from the manufacturing systems group and the health policy research group in Washington, D.C.
Motivate leaders: Carilion let early adopters and other motivated people lead, whether they were officially the practice leader or not, and published performance metrics to exert positive peer pressure. These metrics are supported by regular chart audits and clear communication to physicians that medical directors will be brought in to counsel those who aren’t getting on board. “The fact that we announce it means we rarely have to use it,” Wendland said.

Empower staff: Carilion outlines goals, then lets staff determine how to reach them using established workflows and methods. “It’s very important not to be prescriptive and say that everybody’s got to do it the same way,” Wendland said. “Patient care trumps all.”

Optimize resources: Carilion ensures that everyone “works to the top of their license.” Nurses are doing more than they used to, including refill protocol and documentation entry. “A lot of the burdens in medical home have simply been transferred to nursing,” Wendlund said. Carilion also encourages, but doesn’t require, templates for clinically important conditions but notes that revenues increase for those who do use them, simply because of the better coding practices.

Share responsibility: Once each day, all members of a Carilion care team huddle for a seven- to 10-minute meeting to see what incoming patients need. “Assume all patients are your patients—not just the ones who show up for appointments,” said Wendlund, adding that, if you follow that assumption, there are some things you start doing, such as contacting patients who haven’t been in. After one care coordinator made 360 such “cold calls,” 30 percent of these patients were seen by the practice, compared with the average call response of 3 percent.

Prepare for plateaus and dropoffs: Be ready to see a big change at the beginning, Wendlund warned, and when that change starts tapering off, add in more conditions to work with. Also be prepared for initial results that might seem negative but that are only temporary. For example, the addition of care coordinators may initially result in poorer performance numbers because more untreated diabetics and people with hypertension will be entering the practice.

---

A New Recruit to the Care Team: Care Coordinators

A new role in many PCMH and ACO systems is the care coordinator. Care coordinators handle patient transitions across the system, such as contacting patients discharged from the hospital to arrange follow-up care. They create care plans for patients and check in by phone to track progress. Care coordinators are kept in the loop on all aspects of daily office operation and patient care, so they are in an ideal position to watch for efficiencies and redundancies in communications and quality care processes.

Because the care coordinator needs to suggest courses of action for others on the practice team, the care coordinator role can be a difficult one for a practice to absorb. It can also be a difficult role to hire for, given the importance of experience and motivation in fulfilling daily responsibilities. Carilion does not usually recruit recent graduates for care coordinators and also looks for experience with the populations Carilion serves.

“It might be more economical to do care coordination remotely, at the central office, with just a few over the computer and the phone,” Wendlund said. “But it seemed really important to us to maintain these personal relationships.”
The World Looks Different Now: Managing Health Disparities

“We thought we were doing a wonderful thing by translating our brochures—only to find out we were missing the mark because health literacy itself was at a far lower level than we had realized.”

— Robert Van Why, Senior Vice President of Primary Care and Practice Development, HealthPartners

“Minnesota: It’s not just Scandinavians anymore.” Today Minnesota has the largest Hmong population in United States and the largest Somali population in the world outside Somalia. In the Minneapolis/St. Paul area alone live 80 percent of the state’s foreign-born residents. Adding to the challenge, one in five of new immigrants since 2005 have been refugees fleeing persecution—meaning their healthcare needs can be at crisis levels. Many have been without health care for some time. Behavioral health and language barriers create obstacles as well.

Yet an organizational assessment revealed limited knowledge of work related to health disparities, limitations in data collection to identify gaps, staff and leadership that did not reflect the communities served, and insufficient resources for almost three-quarters of providers. Patients’ families and friends were serving as interpreters, for instance.

HealthPartners launched pilot programs to track and address disparities, shaping and customizing programs based on feedback, standardizing patient processes, and incorporating disparities information and care into the EMR. Three areas emerged for focus: Optimal diabetes care, mammography, and colorectal screening. Nearly all minorities have a type 2 diabetes prevalence two to six times higher than that of the white population, and Latinos are more than twice as likely to develop diabetes than are non-Latino whites. Fewer African-Americans than whites are likely to get mammograms or colorectal cancer screening.

Results and challenges: Pilot sites offered walk-in mammography, which resulted in more than half of the walk-in patients getting mammograms. Simple tactics increased engagement. For instance, desk workers in the waiting area would ask patients to deliver pink ribbons down the hall to the mammography area, giving them a sense of responsibility and accountability. In the second pilot cycle, the program spread to all sites, and outreach calls to patients due for screening were added. In 2010, HealthPartners performed almost 5,000 mammograms, with almost half for high-risk women targeted by the disparities improvement system.

Moving the numbers on colorectal screening has proven more difficult. HealthPartners is testing race- and ethnic-specific videos encouraging this screening and addressing other disparities. To address the diabetes discrepancies, HealthPartners is exploring onsite testing rather than using a central lab.
Asking for Sensitive Information

Accurate data is essential to addressing health disparities and providing better care. HealthPartners uses the following script:

“We want to ask you about your race and country of origin. If you answer, you will help us provide the best care to all of our patients. We will use this information to help our doctors and nurses give you better care. We will keep your information private and confidential.”

HealthPartners experienced greater success when this information was gathered at the appointment by a doctor or nurse rather than over the phone or when a patient was making an appointment. Whatever tactic is used, members of the care team should assure patients that the information is private and will be used only to improve care.

Tips for Implementation Success

- **Committed leadership:** At HealthPartners, a consumer board of directors makes health disparities a priority, and management goals include recruiting and hiring people who reflect the community demographics.

- **A commitment to communication:** Interpreters in the health system often can get more accurate information than family and friends. Interpreters can also help patients with low health literacy understand pamphlets and other health information and assist physician efforts to emphasize the importance of testing in patient conversations.

- **Consistent data:** HealthPartners used the same electronic system for all staff and clinics to collect data and generate reports.

- **Cultural competency training:** HealthPartners educated staff on patients’ diverse beliefs, practices and ways of using the healthcare system. For instance, some in the Hmong community feel that having blood drawn can weaken the body, which is important to know for diabetes and other testing.

- **Outside resources/partnerships:** Working with state-level resources, HealthPartners created a panel charged with reaching out and meeting with community groups to research health beliefs that stand in the way of patients getting recommended medical tests.

- **Volunteers:** At HealthPartners, more than 100 “equitable care fellows” work all locations to oversee disparity issues and serve as bridges between patients and resources. HealthPartners supports them with training and a monthly newsletter on equitable care.
Practice-Based Population Health: What ACOs Can Learn from Employer-Based Programs

— Richard Hodach, M.D., Chief Medical Officer, Phytel, Inc.

Richard Hodach knows employer-based population health programs can work. After 12 years behind the scenes, the former neurologist has witnessed the patient-centered model’s success firsthand. Participants respond favorably to regular check-ins, dedicated nursing, specialized health care, and more. And research shows the programs result in reduced costs, happier employees and more profitable companies.

Today with Phytel he’s helping aspiring ACOs identify care gaps, integrate EMRs, and develop practice management systems that address the population health management component of operations. Hodach said that the healthcare community hasn’t begun to realize the full benefits of employer-based programs. Physicians tend to dismiss employee-based population health programs as yet another insurance company offering.

Yet employer-based programs have been doing population health management for over a decade. They also embrace practice-based population health because of financial accountability and in order to minimize risks and increase loyalty, retention, and engagement. And today’s physicians have the opportunity to take a leadership role in population health management by engaging these tools, tactics, and best practices.

Results and challenges: Hodach talked about an organization he’s working with that’s going down the path to becoming an ACO. “We’re seeing a significant time spent researching into every patient. It won’t be very scalable.”

Why is scalability important? Today’s primary care physicians see 30 patients a day. Tomorrow’s primary care physicians in ACOs will be responsible for about 2,500 patients, with only a small number presenting at the office. To successfully make this leap, providers will need to assess patients differently. They will need to prioritize patients differently. And they will need to manage the population differently.

For ACO population health management, different groups of patients—for example, patients with chronic diabetes—will require different levels of care and communication. Population management plans will need to incorporate high, medium, and low levels of intervention based on different filters. Stratification of patients can help providers think about population in manageable chunks. And technology will be a big part of this in the future.

Tips for Implementation Success

- **Address weaknesses:** Typical areas for providers include a lack of experience with risk-based reimbursement models; a lack of reportable, stratified, actionable data across patients; care teams that focus on visit management, not the total population; and absence of a patient communication/engagement platform.

- **Turbo-charge your technology:** You can’t do it without automation, said Hodach. Practice-based population health management requires more than the EMR. You need multiple data sources operating on a seamless, ongoing basis. The right monitoring technologies could help one nurse keep track of 200 to 250 patients. And the right tools can add power to care management and reporting.

- **Automate outreach:** Consider how you’re going to reach out to patients via telephone, e-mail, mail or text messages and how to tailor communications to get patients to become part of care process.
**Enhance education:** Web and smartphone apps can supplement office visits in administering the repeated reminders and coaching required for behavior change.

**Physician Compensation: Defining Value, Developing Strategies**

— Robert J. Erra, President; Jim Rice, Executive Vice President; Toni Dolby, Senior Vice President, Integrated Healthcare Strategies

Integrated Healthcare Strategies advises healthcare organizations on executive recruiting, employee compensation, performance management, human resources management, and labor relations. According to Erra, ACO success depends upon designing and managing new strategies and systems to move money for value delivered. The operative word—value—is where the complications arise.

**Results and challenges:** A long-held tradition of whoever produced the most earned the most becomes outdated in a system where value delivered is based on *quality* not *quantity*. The result is nothing short of a paradigm shift.

- **Primary care physicians** become the primary distribution system for the ACO.
- **Subspecialists and surgeons** shift from high producers to ACO care managers using more efficient ancillary services and fewer procedures.
- **Hospitals** shift to ambulatory care and reduce bed occupancy.

The value proposition in the ACO is changing, Erra maintains, and physicians are in a unique position to redefine it.

“How do we want to pay for the value we are receiving?” he asked. “Whom do we value? How much do we value pediatrics? More or less than we value internal medicine? And how do we determine the pay for each? What about subspecialists? Do we need 5 cardiologists or 1.5?”

In an interactive exercise, participants shared their most important assertions for setting up an ACO compensation system:

- Physicians have to be at table, both employed physicians and independents.
- Payment must be balanced with performance management infrastructure.
- Tying physician engagement and alignment with compensation is only one aspect of the issue.
- Clear measures must be followed.
Tips for Implementation Success

Start with a philosophy: Answers will only grow out of a careful and consistent compensation philosophy. Yet, when asked, few participants could explain what a compensation philosophy was. And fewer still actually had an established tool in place to set pay for administrative and clinical work. According to Erra, a compensation philosophy needs to be reflected in strong management (including physician leaders) and strong governance and include administrative and clinical work.

Add your benchmarks: Research salary data for similar jobs at like-sized institutions. But don’t be surprised if you don’t find an exact match, Erra said. “If you’ve seen one compensation plan, you’ve seen one compensation plan,” he warned. Also recognize that ACO income could be a small part of a physician’s practice or hospital’s volume.

Know your regulations: ACO compensation will need to adhere to a variety of compliance regulations surrounding not-for-profit, self-referral, and Medicare fraud and abuse issues. Defensible compensation and compliance requires:

- Detailed job descriptions
- Routine and accurate time reporting (for staff who are not full-time)
- Annual performance appraisals

<table>
<thead>
<tr>
<th>Medicare ACO Illustration: Compensation Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Members</td>
</tr>
<tr>
<td>Annual Payment per Member</td>
</tr>
<tr>
<td>Total Payment to ACO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPENSATION ALLOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
</tr>
<tr>
<td>Clinical Services</td>
</tr>
</tbody>
</table>
### Medicare ACO Illustration: Allocation Pools

#### CLINICAL SERVICES

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
<th>Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health, Skilled Nursing</td>
<td>17%</td>
<td>$8,400,000</td>
</tr>
<tr>
<td>Hospitals</td>
<td>48%</td>
<td>$24,960,000</td>
</tr>
<tr>
<td>Physicians</td>
<td>20%</td>
<td>$10,400,000</td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
<td>$7,800,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>$52,000,000</strong></td>
</tr>
</tbody>
</table>

#### PHYSICIAN ALLOCATION

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
<th>Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>20%</td>
<td>$2,080,000</td>
</tr>
<tr>
<td>Subspecialty &amp; Surgery *</td>
<td>80%</td>
<td>$8,320,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>$10,400,000</strong></td>
</tr>
</tbody>
</table>

*Actual tables can be utilized to allocate the pools by specialty

### Medicare ACO Illustration: Allocation Percentages

#### SAVINGS ALLOCATION SHARE PERCENTAGES

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>60% Hospital, 40% Physicians</td>
</tr>
<tr>
<td>Physician Specialty</td>
<td>100% Specialty Physicians</td>
</tr>
<tr>
<td>Other, Skilled Nursing, Home Health</td>
<td>50% Hospital, 50% Patients</td>
</tr>
</tbody>
</table>

Payment of Savings to Physicians as: Additional Compensation, Contribution to a Retirement Plan, Deferred Compensation
Value-Based Networks for Physician-Organization Alignment

— Shawn Wagoner, Engagement Director, Carol Corporation; and Thomas Bartrum, Shareholder, Baker Donelson

With Carol Corp., Wagoner delivers guidance to providers moving toward the ACO model. Bartrum’s practice at Baker Donelson focuses on healthcare regulatory matters. The two presented three fundamental questions that frame the issue of physician and organizational alignment:

- What are you trying to accomplish with a value-based network (VBN)?
- Who will own, govern, operate, and participate in the VBN?
- How will the VBN create and share value?

**Step 1. Gauge your readiness for alignment:** Wagoner advised that organizations assess their readiness in terms of clinical and financial performance, management, physician leadership, clinical integration, value-based payment, data infrastructure, and primary care. “Can you identify opportunities?” he asked. “Can you tie them to action that translates into rewards? Do you have the tools to perform?” In addition, is your value proposition financially and clinically relevant to providers?

---

**Gauge Provider Willingness to Embrace VBN Models**

Is the provider willing to engage? **Critical: Does the provider believe in the “burning platform” to embrace a VBN approach to care?**

- Financially Relevant
  
  “To drive major improvements, performance-based payments must exceed 10% of total provider income.” — Arnold Milstein, M.D., M.P.H.

- Clinically Relevant
  
  Does the provider believe the model will foster clinically meaningful and actionable activities that are within the provider’s span of control?

- Financial Participation
  
  Ultimately, what is the provider’s appetite for financial risk?

Yes, but does the provider have the capability to assume risk?
Step 2. Look at the legal issues: In addition to compliance with Stark laws, anti-kickback provisions, and relevant state laws, Bartrum cited anti-trust as the major legal issue ACOs face when evaluating structures and partnerships. “Can you do this, or is it price-fixing among competitors?” While additional guidance is expected from the Federal Trade Commission, the agency has this three-part test:

- Can you demonstrate that the network’s clinical integration program is “real”?
- Are the initiatives designed to achieve likely improvements in health care?
- Is joint contracting with fee-for-service health plans “reasonably necessary” to achieve the efficiencies of the clinical integration program?

Step 3. Choose your structure: Start by determining where the payment is coming into the system, and where is it going. Because no general template exists, each organization will be a hybrid, evolving over time. A health system might itself serve as the network or it might form a separate, wholly owned subsidiary or a joint-ventured subsidiary to serve as the network.

When developing your network, consider:

- Whether or not to be tax exempt
- How to structure the board to achieve broad participation
- How to structure compensation, including working with physicians on the cost impact of their decisions

Collaborative Thinking

- Results along the continuum: Wagoner showed that performance bonuses were higher for physicians with lower case rates but that improvement bonuses were higher for physicians with higher case rates.

- Getting buy-in from physicians who are “doing the right thing”: Wagoner advised rewarding physicians for “absolute performance,” noting that an ACO would be more likely to refer patients to the physicians with the lower case rates.

- Referrals, agreements and contracts: Can I refer patients to a particular group that adheres to certain standards without having a legal agreement? one participant asked. Bartrum replied that some commitment from them to live up to care protocols is needed. However, “if you’re not sharing risk, there’s no reason for a contract.”

Step 4. Engage with providers: Providers will ask, “What do I get if I join you on this journey?” Wagoner advises that you think about how you will communicate your value proposition to specialists as well as primary care physicians. For example, Continuum Health Partners in New York City engaged specialists in a bonus program that rewards resource stewardship and quality. The resulting savings added $21.4 million to the margin, and the physicians received incentive payments (subject to quality and performance thresholds) totaling $1.8 million. Bartrum added that this program does comply with the Stark law, under its risk-sharing provisions.
Model Review: Pros/Cons

<table>
<thead>
<tr>
<th></th>
<th>Health System as Network</th>
<th>Network as Health System JV</th>
<th>Network JV (w/ MSO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Alignment</td>
<td>Quick dissemination (top-down); cultural barriers may impede progress</td>
<td>Moderate structural integration allows for moderate alignment</td>
<td>Phy. advisory board and close utilization of centralized MSO</td>
</tr>
<tr>
<td>Performance Measurement</td>
<td>Depends if quality improvement written into contracts; distributive fairness</td>
<td>Subject to “small p” “big H” contention</td>
<td>Centralized reporting and analysis requires participant buy-in; distributive fairness</td>
</tr>
<tr>
<td>Incentive Alignment</td>
<td>Requires strong culture of physician ownership of clinical performance in lieu of quality improvement bonuses</td>
<td>Depends on structure; often one party (Hospital seen at odds with physician)</td>
<td>Centralized reporting and analysis requires participant buy-in; distributive fairness</td>
</tr>
<tr>
<td>Network Contracting</td>
<td>Depends on degree of integration</td>
<td>Depends upon degree of integration</td>
<td>Assuming clinical integration, flexible model allows for broad yet select network</td>
</tr>
<tr>
<td>Physician/Hospital Network</td>
<td>Closed or semi-closed system; expansion through acquisition</td>
<td>Semi-closed system</td>
<td>Flexible; participants may or may not take ownership stakes</td>
</tr>
<tr>
<td>Physician/Hospital Network</td>
<td>Central authority; but requires physician leadership</td>
<td>Historically fragmented</td>
<td>Requires sharing</td>
</tr>
<tr>
<td>Investment/Capital</td>
<td>“Bricks &amp; Mortar” investments; tight capital controls</td>
<td>Investment in development of JV; analytic and CI investments</td>
<td>Analytic and CI investments; advisory board compensation (can provide physician investment opportunity in limited risk MSO)</td>
</tr>
</tbody>
</table>

Extrapolate Continuum Results: Impact to Surgeons and System

<table>
<thead>
<tr>
<th></th>
<th>MD A</th>
<th>MD B</th>
<th>MD C</th>
<th>MD D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Year Case Rate</td>
<td>$27,626</td>
<td>$34,807</td>
<td>$48,983</td>
<td>$51,561</td>
</tr>
<tr>
<td>Rate Year Case Rate</td>
<td>$27,626</td>
<td>$32,413</td>
<td>$37,200</td>
<td>$51,561</td>
</tr>
<tr>
<td>Performance Bonus</td>
<td>$418</td>
<td>$335</td>
<td>$251</td>
<td>$0</td>
</tr>
<tr>
<td>Improvement Bonus</td>
<td>$0</td>
<td>$209</td>
<td>$837</td>
<td>$0</td>
</tr>
<tr>
<td>Total Bonus Per Surgery</td>
<td>$418</td>
<td>$544</td>
<td>$1,088</td>
<td>$0</td>
</tr>
<tr>
<td>Total Savings Per Surgery</td>
<td>$0</td>
<td>$2,394</td>
<td>$11,783</td>
<td>$0</td>
</tr>
<tr>
<td>Bonus for 100 Surgeries</td>
<td>$41,800</td>
<td>$54,400</td>
<td>$108,800</td>
<td>$0</td>
</tr>
<tr>
<td>Savings for 100 Surgeries</td>
<td>$0</td>
<td>$239,400</td>
<td>$1,178,300</td>
<td>$0</td>
</tr>
</tbody>
</table>

- Total amount paid in bonuses to surgeons = $205,000
- Total savings obtained = $1,417,700,000
- Total improved contribution to system’s margin = $1,212,700
A Four-Month Plan to Get Focused

Wagoner offered a 120-day work plan for "how to get the right people in the room and what things these people need to focus on." To determine required deliverables in the areas of strategy, structure, and staffing and set specific milestones for completion, he recommended assembling a temporary work group with expertise in:

- Legal issues
- Operations
- Clinical operations (care management knowledge is a plus)
- Information systems
- Payer contracting
- Human resources

Where Are Commercial Insurers Coming From?

— Rich Maturi, Senior VP, Healthcare Delivery Systems, Premera, Blue Cross Blue Shield

According to Rich Maturi, payers are looking for providers who think: “We have to do it. We’re willing to experiment, take some risks, put bounds around the risks, and learn how to work together.”

Although health plans and providers don’t really have a history of collaboration, they will need to start soon, said Maturi, or else government will regulate solutions to the double-digit premium increases that are longer politically acceptable. The task on the provider side: to bend the healthcare cost trend by increasing quality and decreasing costs. The task on the payer side: developing a quickly scalable commercial payment model to support it. This is the challenge that Premera—a 100-percent commercial, fee-for-service, PPO regional health plan with 1.7 million members—has grappled with for the past decade.

Future Provider Payment Scenarios
A three-phase evolution: While much of the ACO model’s history ties in with that of Medicare, Premera’s evolution into its current performance-based payment model has been very different, with each step marked by challenges:

- **Pay for performance:** Incremental pay-for-performance tactics spurred concerns about putting expected income at risk, quality measures where the savings couldn’t be tracked, and attribution. Especially with the self-insured, medical groups wondered, “Was that really my patient?”

- **Non-FFS payment model pilots:** Because underlying infrastructure remains FFS, these pilots incur significant administration and infrastructure expenses. Adding to Premera’s challenge: Washington state law deems any provider that takes capitation and markets directly to employers to be a “health insurer” that must deal with reserves and taxes.

- **Global performance-based FFS:** Health reform’s lack of cost controls present the business case for moving to the ACO model. Under Premera’s current model, reductions in the overall healthcare cost trend for attributed patients are shared with providers through increased payment levels.

Premera and the payment scenarios of the future: On the continuum of regulated vs. negotiated payments and performance-based vs. FFS plans, Premera’s current global performance-based fee-for-service model sits squarely in the market-based, FFS quadrant.

One advantage to Premera’s global performance-based FFS model is scalability. “As soon as we and a provider group get to an agreement, we can get a product, a plan design. We don’t have to write new agreements, and the provider group can focus on what they want,” said Maturi. With details on attribution, measuring for risk adjustment, and shared savings still being determined, Premera’s payment scenario is a work in progress. However, this work has sped up to meet the accelerated demands of the landscape. “Our development cycle will be annual rather than every five to six years.”

---

**Collaborative Thinking**

Participants asked Maturi about:

- **Attribution:** Is Premera attributing to the primary doctor or aggregating spending to specialists such as cardiology and oncology? Both, said Maturi. Premera attributes to the practice, the entity level for performance. If a patient shows up under both a specialist and primary care, the attribution goes to the physician seen most frequently.

- **Benchmarking:** For global payments, should providers benchmark on historic costs? Premera looks at regional network average trends, said Maturi, seeking stable relativity between groups and these trends.

- **Reconciling the disconnect in provider and payer concepts of “cost”:** According to Maturi, payers are looking to providers to reduce costs as they see them—for example, long-term actions to reduce the disease burden. Payers will help by changing the incentive structure and by providing support in the forms of actionable data, assistance with the care management processes, and solutions for small providers.
Engaging Payers, Aligning Goals

— Michael Nugent, Managing Director, Healthcare Practice, Navigant Consulting

“Challenge your organization: Why are we really talking about payer alignment? Those who are really serious want to promote growth and value.”

— Michael Nugent, Navigant

With Navigant, Nugent advises a wide range of healthcare payers, providers, and manufacturers on corporate strategy, reimbursement, product, and operational matters, including shared risk, tiered network, and pay for performance structures for some of the nation’s top payers, providers, and manufacturers. According to Nugent, alignment happens at different levels: administrative, payment, and clinical, as well as the internal alignment that surrounds an organization’s “end game.”

But “not all alignment is created equal,” he said, and strategic alignment is “where the conversation needs to start.” Partnership attempts will fail if partner goals and strategies are not mutually understood.

**Step 1. Evaluate savings opportunities:** Consider population, provider, payer, product, and geography. Determine your desired “end game.” Is it the status quo? In this case, you will need to think about maintaining historical rate and volume increases. Is it a growth and value strategy? In this situation, think about how to align system models to what patients will pay extra for. What’s the critical mass necessary to get hospitals, purchasers, and others interested?

**Step 2. Define the “capture” strategy:** First ask where the savings will come from. Then ask how the savings should be shared. Identify the population for a pilot project, the providers you wish to use, and the quality and savings targets you wish to reach. As you do so, be mindful of your market vs. national norms.

**Step 3. Approach your top payers:** Ideally, do this ahead of your competitors, senior management to senior management, but only when you can say “we’ll deliver X for Y”—your value proposition.

**Step 4. Have a contingency plan:** New lives and member growth can allow you to put some reimbursement at risk. But if you are already a sole community provider, growth may not be as great as you think. If growth doesn’t materialize, to maintain current margins, you must reduce variable cost about 5 percent for every 1 percent reduction in reimbursement or volume.
Lessons/Observations

Keep your opportunities in perspective using national data

Spending for DME and home health varies widely in contiguous Florida counties

<table>
<thead>
<tr>
<th>Area</th>
<th>DME spending per capita</th>
<th>Home health spending per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Florida county</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broward</td>
<td>$394</td>
<td>$321</td>
</tr>
<tr>
<td>Collier</td>
<td>$207</td>
<td>$202</td>
</tr>
<tr>
<td>Miami-Dade</td>
<td>$2,043</td>
<td>$828</td>
</tr>
<tr>
<td>Monroe</td>
<td>$237</td>
<td>$210</td>
</tr>
<tr>
<td>National</td>
<td>$263</td>
<td>$282</td>
</tr>
</tbody>
</table>

Note: DME (durable medical equipment). Spending data are annualized for beneficiaries with either Part A or Part B coverage for at least one month during 2006. The results are not adjusted for differences in beneficiaries’ health status or prices.


Negotiate the “Balancing Act”

- Fee schedule trims
- Use rate reductions
- Steerage to lower cost sites of care
- Direct investments in cost-saving technologies
- Shared savings
- New lives
- Backfill
- Admin cost savings
Are You Ready?

To ensure your organization is fully prepared for negotiations, first ask yourself:

- What do I approach the payer with?
- When do I approach the payer?
- How do I approach the payer?
- Which payers do I approach?

Next Steps

**Keeping the Collaboration Alive**

“What did you hope to learn from the collaborative?” Julie Sanderson-Austin asked participants in the closing session. “What are areas we still need to develop?”

Participants were not shy about suggesting areas they’d like to see explored more in future events and exchanges. These included:

- **IT guidance** for aggregating, sharing and protecting data
- **Compensation methodology details** that are more “in the weeds,” such as how people are transitioning from straight RVU and maintaining physician salaries
- **Collaboration tips** for working with the range of post-acute care providers and/or many small providers
- **How to engage patients in self-management** in areas such as obesity
- **How to educate patients about the ACO concept,** particularly in light of negative focus group feedback on terms like “medical home” (which sounds like a place people go to die)
- **Templates** for a common lexicon and benchmarking process
- **More case studies** on topics such as staffing, implementation, ACOs in rural areas, self-funded ACO systems, independent hospitals and medical home systems that are collaborating with private payers around the ACO model
AMGA ACO Implementation Collaborative

Meeting Presenters
Thomas Bartrum, Baker Donelson
Richard Bennett, R.N., Wenatchee Valley Medical Center
Jeff Burnich, M.D., Sutter Health
Toni Dolby, Integrated Healthcare Strategies
Bob Erna, Integrated Healthcare Strategies
Stuart Freed, M.D., Wenatchee Valley Medical Center
Barry L. Gross, M.D., Riverside Health System
Richard Hodach, M.D., Phytel Inc.
Rich Maturi, Premera Blue Cross Blue Shield
David Moen, M.D., Fairview Health Services
Michael Nugent, Navigant
Jim Rice, Integrated Healthcare Strategies
George H. Roman, AMGA
Peter Rutherford, M.D., Wenatchee Valley Medical Center
Robert Van Why, HealthPartners
Shawn Wagoner, Carol Corp
John Wendland, Carilion Clinic

AMGA ACO Implementation Collaborative Members

Crystal Run Healthcare, Middletown, NY
Scott Hines, M.D., Dept of Endocrinology, Medical Specialty Division Leader
Betty Jessup, R.N., B.S.N., Director of Quality and Patient Safety
Jonathan Nasser, M.D., Internal Medicine & Pediatrics; Division Leader, Department of Pediatrics
Gregory Spencer, M.D., Chief Medical Officer

Esse Health, St. Louis, MO
Mary Calzaretta, Corporate Counsel
Mike Castellano, Chief Executive Officer
Mike Fedak, M.D., Executive Committee Member
Susan Kendig, Attorney at Law
John Rice, M.D., Chief Medical Officer

Harvard Vanguard Medical Associates, Newton, MA
Emily Brower, Sr. Director, Clinical Improvement Ventures
Tom Denberg, M.D., VP, Quality and Safety
Kathy Keough, Government Relations Manager
Richard Lopez, M.D., Chief Physician Executive
Kim Nelson, Chief Legal Officer
Marcy Sindell, Chief External Affairs Officer

Henry Ford Health System, Detroit, MI
Charles Kelly, M.D., Sr. VP & Chief Medical Officer
Michelle Nelson, Director Managed Care HFMG
Jonathan Schwartz, M.D., Medical Director, Managed Care HFMG
Matthew Walsh, VP of Operations

Holston Medical Group, Kingsport, TN
Steve Adkins, M.D., CMID
Scott Fowler, J.D., M.D., President
Richard Gendron, M.D., Vice-President
Steve Lauhoff, COO
Robert Lee, M.D., Medical Director
Wendy Oberdick, M.D., Family Physician
Owen Poole, President, CMD9
Eric Schwartz, M.D., Hospitalist

Mercy Medical Group, Sacramento, CA
Parag Agnihotri, M.D., Medical Director,
Care Management Mercy Medical Group
Khuram Arif, M.D., Chair, Dep. of Pediatrics
Adam Berman, M.P.A., M.A., Vice President
Ben Balatbat, M.D., Chair, Dept. of Internal Medicine
Greg Cooper, D.P.M., M.B.A., Chief Medical Officer, Mercy Medical Group
Jag Gill, FACHE, FACMPE, President & CEO, CHW Medical Foundation
John Gisla, M.D., Chair, Dept. of Family Practice
Dag Jakobsen, Chief Operating Officer, CHW Medical Foundation
Dean Rinard, M.D., President, Mercy Medical Group

Mount Carmel Health Providers, Columbus, OH
Sloan Albert, President & COO
Douglas Finnie, M.D., Medical Director
Jean McKee, M.D., Strategy Committee Chair
Jay York, Director

MultiCare Health System, Tacoma, WA
Christa Able, Director, Payor Contracting
Andrew Baron, M.D., M.B.A., FAAP, Medical VP, Primary Care Services
Theresa Boyle, Sr. VP, Strategy & Business Development
Florence Chang, Sr. VP Clinical Support Service & Chief Information Officer

Prism Physicians, Cincinnati, OH
Bob Matthews, Executive Director

Princeton Medical Group, PA, Princeton, NJ
Susana Gummel, Assoc. Director/Chief Financial Officer
Joan Hagadorn, Chief Operating Officer
Fong Wei, M.D., President/CEO

ProHealth Physicians, Farmington, CT
James Cox Chapman, M.D., Sr. VP & Chief Medical Officer
Bethany Kielea, Director, Practice Operations
Karen Leibiger, Sr. VP, Practice Operations
Cheryl Lescarbeau, VP, Clinical Performance and Marketing
Phil Pin, Sr. VP & Chief Financial Officer

Riverside Medical Group/Riverside Health System, Newport News, VA
Wade Broughman, Executive Vice President/CFO
William B. Downey, Chief Operating Officer
Barry L. Gross, M.D., Executive Vice President & Chief Medical Officer
Terri Kennedy
John Stanley, Senior Vice President

Sutter Health, Sacramento, CA
Lori Bloomfield, VP, Sutter Medical Network
Jeff Burnich, M.D., SVP & Executive Officer, Sutter Medical Network
Cyndi Kettmann, Senior Policy Advisor
Michael van Duren, M.D., M.B.A., CMO, Sutter Physician Services
Don Wreden, M.D., President, Sutter Medical Group

Swedish American Health System, Rockford, IL
Albert Ferrabone, Manager, Clinic Quality
Steven Lidvall, M.D., M.P.H.
Thomas Schiller, M.D., President

Wenatchee Valley Medical Center, Wenatchee, WA
Richard Bennett, R.N., Assistant Administrator
Stuart Freed, M.D., Medical Director
John Hamilton, COO, Central Washington Hospital
Steve Jacobs, CFO, Central Washington Hospital
Jay Johnson, Associate Administrator
Peter Rutherford, M.D., CEO and Chairman of the Board

White-Wilson Medical Center, Fort Walton, FL
Alan Gieseman, CEO
Karl Metz, M.D., Medical Director