ACOs: A Vital Step in the Transformation of Our Health Care System

Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
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<tbody>
<tr>
<td>8:30 – 9:30</td>
<td>Welcome and Creating a Shared Vision</td>
</tr>
<tr>
<td>9:30 – 10:30</td>
<td>Focus on Finance</td>
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<tr>
<td>10:30 – 10:40</td>
<td>Break</td>
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<tr>
<td>10:40 – 12:00</td>
<td>Focus on Data</td>
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<tr>
<td>12:00 – 1:00</td>
<td>Lunch</td>
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<tr>
<td>1:00 – 1:15</td>
<td>Faculty Panel</td>
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<tr>
<td>1:15 – 2:15</td>
<td>Engaging Patient and Community</td>
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<td>2:15 – 2:25</td>
<td>Break</td>
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<tr>
<td>2:25 – 3:25</td>
<td>Engaging Providers and Care Settings</td>
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<tr>
<td>3:25 – 3:50</td>
<td>Faculty Reflections</td>
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Session Objectives

- Identify common challenges to running a successful ACO and ways to meet them
- Discover opportunities to accelerate their efforts to achieve cost-and quality-related improvements at scale
- Engage in active peer sharing and learning

Faculty

- Al Kurose, MD, FACP – President & CEO, Coastal Medical
- George Kerwin, FACHE – President & CEO, Bellin Health
- Peg Bradke, RN, MA – VP, St. Luke’s Hospital
- Trissa Torres, MD, MSPH, FACPM - SVP, IHI
Objectives

- Understand the IHI High-Impact Leadership Model.

- Using IHI’s High-Impact Leadership Framework, trace Bellin’s journey toward managing the health of people in its market.

- Evaluate where your organization is on this journey, and define how you can improve your ability to manage the health of people you serve.
IHI HIGH-IMPACT LEADERSHIP FRAMEWORK

Driven by Persons and Community

Life and Health Cycle

- Screening
- Chronic Conditions
- Prevention
- Acute Crises
- Birth, Growth and Development
- DIYing with Dignity

- Planned Care
- Nurse Coaching
Driven by Persons and Community

Determinants of health

Driven by Persons and Community
IHI HIGH-IMPACT LEADERSHIP FRAMEWORK

Create Vision and Build Will

MISSION
Bellin Health is a community-owned not-for-profit organization responsible for the physical and mental health of people living in Northeast Wisconsin and the Upper Peninsula of Michigan.

We exist to serve others through patient care excellence and innovative programs designed to positively impact health in our region. We are steadfast in our commitment to providing compassionate, safe and reliable care, while continually improving the value we provide to customers and communities within our region.

Our innovations and never-ending pursuit of improvement will drive the evolution of healthcare delivery in our region, and influence other organizations.

VISION
The people in our region will be the healthiest in the nation, resulting in improved vitality and economic well-being in the communities we serve.
IHI HIGH-IMPACT LEADERSHIP FRAMEWORK

Create Vision and Build Will
Driven by Persons and Community
Develop Capability
Deliver Results
Shape Culture
Engage Across Boundaries

Develop Capability

Serving a Market of 636,682 people

Bellin Hospital, a 220-bed community hospital with proven excellence in heart and vascular care, orthopedics and sports medicine, family programs and services, cancer care, and minimally invasive procedures including robotic surgery

Bellin Health Oconto Hospital, a 10-bed critical access hospital in Oconto

Bellin Medical Group and Bellin Health Northshore, a 114-member primary care group with 32 clinics sites and proven excellence in disease management and wellness care

Employer Clinics, 115 clinics located within employer facilities

FastCare Retail Clinics, 4 retail clinics located in grocery and discount retail stores

Physician Partners, LTD, more than 160 independent specialty physicians and mid-level providers

Bellin Psychiatric Center, a dominant provider of in- and outpatient behavioral health services, staffed by 7 psychiatrists, 4 psychologists and 21 therapists

Unity Hospice, providing hospice and palliative care services
Develop Capability

KEY TOOLS
- Electronic Medical Record (EMR), enterprise-wide using Epic software
- Patient Registry, CareManager software integrated into the EMR
- Health Risk Appraisal from Healix integrated into the EMR
- Navigation Platform

Navigation Platform
Develop Capability

MANAGE POPULATIONS TO ACHIEVE THE TRIPLE AIM

AIM

100% of cost, health & experience targets are met according to the aligned agreements we enter into with each Partner where Bellin has risk for an attributed population

PRIMARY DRIVERS

- High Functioning Patient Care
- Knowledge of Population
- Connected Experience Across Continuum
- Medical Utilization Management
- Partner Relationship Management
- Engaged & Activated Consumer

IHI HIGH-IMPACT LEADERSHIP FRAMEWORK

Create Vision and Build Will
Driven by Persons and Community
Deliver Results
Develop Capability
Shape Culture
Engage Across Boundaries
Deliver Results

IHI HIGH-IMPACT LEADERSHIP FRAMEWORK

- Create Vision and Build Will
- Driven by Persons and Community
- Develop Capability
- Deliver Results
- Shape Culture
- Engage Across Boundaries
IHI HIGH-IMPACT LEADERSHIP FRAMEWORK
ACOs: A Vital Step in the Transformation of Our Health Care System

Leveraging Financial Models to Achieve Cost and Quality Improvements: Payment Models
Business Case

The Pace of Volume to Value

Why Slower
- The market is not ready today
- Physicians are not ready
- We don't have all the competencies
- Payment models are not fully developed
- Employers will wait for government action

Why Faster
- Most insurers have told us they are ready and willing
- A weaker economy
- PCPs are ready
- We have some competencies and can get the others
- We may get to establish the payment models
- Employers will move faster than the government
Continuum of Relationships and Payment Options

<table>
<thead>
<tr>
<th>Continuum</th>
<th>Options</th>
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<tbody>
<tr>
<td>Full Capitation</td>
<td>Exploring</td>
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<tr>
<td>Shared Savings</td>
<td>Pioneer / Employers / Payers</td>
</tr>
<tr>
<td>Bundles</td>
<td>Employers / Payers</td>
</tr>
<tr>
<td>Medical Home</td>
<td>Employers / Payers</td>
</tr>
<tr>
<td>Pay for Performance</td>
<td>Employers / Payers</td>
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</table>

Fee for Service

Example: Pay For Performance
### Estimate $$ of CMS Value Based Purchasing Programs

#### Program Type

<table>
<thead>
<tr>
<th>Program</th>
<th>Type</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Total At Risk</th>
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<tbody>
<tr>
<td>Inpatient Quality Reporting</td>
<td>Penalty</td>
<td>-</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
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<td>1.25%</td>
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<tr>
<td>Hospital Acquired Conditions</td>
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<td>3%</td>
<td>3%</td>
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<td>Meaningful Use*</td>
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<td>-</td>
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<td>1.6M</td>
<td>848</td>
<td>251</td>
<td>48K</td>
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<td>Medicaid Pay for Performance (State Program)</td>
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<td>1.5%</td>
<td>1.5%</td>
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#### Program Type

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<tr>
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<th>2014</th>
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<th>2017</th>
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</thead>
<tbody>
<tr>
<td>ACO Shared Saving</td>
<td>Incentive</td>
<td>-</td>
<td>1.1M</td>
<td>1.3M</td>
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<td>+$2.4M</td>
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<td>Physician Quality Reporting System (PQRS)*</td>
<td>Incentive</td>
<td>-</td>
<td>+.5%</td>
<td>+.5%</td>
<td>-1.5%</td>
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<td>-$85K</td>
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<tr>
<td>Ambulatory Surgery Centers</td>
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<td>2%</td>
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<td>1.5%</td>
<td>1.5%</td>
<td>1.5%</td>
<td>-$288K</td>
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</table>
Government Quality-Based Program

**$ At-Risk Estimates**

2013 - 2017

<table>
<thead>
<tr>
<th>Penalties</th>
<th>Incentives</th>
<th>Total at Risk</th>
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</thead>
<tbody>
<tr>
<td>$10.5M</td>
<td>$5.0M</td>
<td>$15.5M</td>
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</table>

- Reporting = $4.3M
- Performance Based = $6.2M
- MU = $4.9M
- PQRS = $54K
- Pioneer ACO is not in this calculation.

Example: Medical Home
Blue Cross Blue Shield of Michigan (BCBSM) is offering an incentive for physician’s and practices to become Patient Centered Medical Home (PCMH) certified. The goals of their model include:

- Ensuring effective communication, coordination and integration with PCMH practices, including appropriate flow of patient information.
- Providing appropriate and timely consultations and referrals that complement and advance the aims of the PCMH practices.
- Clearly defining roles and responsibilities of primary care physicians and specialists in caring for the patient.

BCBSM requires that practices meet a minimum of 40 criteria measures that support the goals listed above. Bellin Health Escanaba and Iron Mountain have met this criteria as supported by an independent contractor, Mark Dougherty of Medical Advantage Group, hired by BCBSM to consult with us and conduct a site visit to validate the we do meet a minimum of 40 criteria measures. Mark Dougherty conducted his site visit in September 2014 and advised that he will submit our nomination in January 2015. BCBSM will officially announce practices that are approved for certification in June 2015. Once certified as a PCMH, Bellin Health Escanaba and Iron Mountain will receive a 10% uplift in reimbursement on all claims.

Additionally, we have the opportunity to receive incentive funds based on HEDIS (quality) measures which are reported to our practice semi-annually. In October, Bellin Health Escanaba and Iron Mountain received a $23,000 check based on our physician’s scores.
Where the Medicare Accountable Care Organizations Are

Pioneer Example:
A framework for intentionally managing a population that is the foundation for managing any population.
Characteristics of Medicare Pioneer ACO

- Medicare “Fee for Service” program
- ACO consists of Bellin, ThedaCare, and many independent physicians within the respective markets
- Members are assigned based on attribution methodology
- Shared savings program with risk for total cost of care
- Quality metrics determine the amount of shared savings
Example:
Full Capitation
Lessons Learned

- Focus on the Customer and Value Creation
- Pioneer Pilot – Lead or Watch – we choose lead
- Experiment with Payer Strategies
- Consider a Super ACO Strategy
- Bring others along – FFS is deeply embedded and change will be transformational

Leveraging Financial Models to Achieve Cost and Quality Improvements: **Compensation Models**
Coastal Medical

- 84 Physicians + 30 AP’s, mostly primary care
- 21 sites in Rhode Island; 120,000 patients
- Formed in 1995; ACO in January 2012
- Ancillaries: lab, imaging, billing, realty
- Shared Savings Contracts with all major payers
- Physician compensation (average) comprised of
  - 80% FFS / 20% non FFS in 2014
  - 70% FFS / 30% non FFS in 2015 (projected)
- Historical context: Most docs started in small independent practices

Coastal: Early Success as an ACO

- Multi-payer approach
- **MSSP: outperformed benchmark by 5.4%, saved $7.2 million**
  - Commercial
  - Medicare Advantage
- First mover advantage
  - Modest success to date
**Elements of Value Based Contracts at Coastal**

- Pay for performance (PMPM)
- Pay for process (PMPM)
- Stipends to support team based care
- Infrastructure support (PMPM)
- Shared savings (% of savings vs. benchmark)
- Bundled payment
- Risk models
- Full capitation

Layered on top of FFS...

All incentives, no penalties

**Compensation Formula**

- Today FFS dollars still flow intact to physician’s P&L

- Incentive formula for non FFS dollars:
  - Quality performance
  - Documentation
  - Generic prescribing
  - Quality improvement workflow
  - CME

*We are redesigning the compensation formula right now*
Payment Model vs. Comp Model

- Our comp model at Coastal today reflects our payment model
- But…The comp model *should* be built on rational incentives
- But…Physicians feel they *own* every dollar of FFS revenue
- So…Change has to be incremental

Staffing is also a Challenge

- Pod offices are profit centers for the docs
  - Available revenue to physician P&L is reduced by pod expenses
- This creates an incentive to minimize staffing
- But…offices in an ACO need more staff for quality measurement, reporting, and improvement
- Economic effects of improving quality performance are pooled at the organization level
- Economic effects of increasing staffing are more immediate and personal
Conclusions

- Comp models need not be tightly linked to payment models
- A comp model with rational performance incentives is optimal
- We need a solution for the staffing challenge
- We need to progressively weaken FFS over time

Leveraging Financial Models to Achieve Cost and Quality Improvements: *Working Capital*
New Infrastructure for the ACO

- Chief Medical Officer
- Directors: Analytics, Practice Management
- Staff: analytics, IT, communication, EMR trainers
- 17 Nurse Care Managers embedded in practices
- 2 Nurse Care Managers in hospitals, one in SNF's
- 6 Clinical Pharmacists and 2 Pharmacy Techs
- New Analytics and Care Registry Platform

*We are building a new set of core competencies*

Incremental Costs as an ACO

Coastal's Advanced Payment Model experience: a cost experiment:
- ~10,000 patients
- $1.2 M per year of approved expenditures
- For every $6 saved:
  - $3 retained by CMS as their 50% share
  - $2 used by Coastal to cover incremental costs
  - $1 kept by Coastal for reinvestment or distribution
Sequencing

- Find opportunity
- Look at cash flow

Finding Opportunity as a Nascent ACO

- What does our performance look like?
  - Quality
  - Cost
- What current assets and competencies can we bring to bear?
- Which initiatives should we implement first?
- What are the infrastructure and workflows we need to support those initiatives?
Looking at Cash Flow

- How much will our new initiatives cost?
- How long will it take until they start to impact cost?
- When can we expect a significant impact on Total Cost of Care?
- Will our performance on quality allow us to access shared savings?
- When will an impact on TCOC produce an actual revenue stream?
- How much money do we need to get us to that point?

Related Concerns

- Mission
- Hearts and minds
- Market and non-market strategy
ACOs: A Vital Step in the Transformation of Our Health Care System
Using Data to Drive Performance Improvement: Bellin Health

Manage Populations to Achieve the Triple Aim — DRIVER DIAGRAM (as of 9/23/2014)

100% of cost, health and experience targets are met according to the aligned agreements we enter into with each Partner where Bellin has risk for an attributed population.
Knowledge of the Population – Driver Diagram (as of 9/23/2014)

Build a knowledge based data system based on Specifications for the “Brain” to be able to deliver information needed for decision making at 3 levels

- Provide the system with knowledge of the population at the Executive Level
  - Specs for each level Scorecard
- Provide the system with knowledge of the population at the Mezzanine level
  - Specs for each level Scorecard
- Provide the system with knowledge of the patient at the Point of Care
  - Specs for each level Individual Care triggers
- Provide Scorecards for Strategic Partners based on aligned agreements
  - Specs for Scorecard

Medical Management – DRIVER DIAGRAM (as of 9/23/2014)

Ensure effectiveness of onsite care teams by analyzing data and results in a timely manner, adjusting key processes to meet 100% of cost, health and experience targets

- Identify and Acquire Claims and Clinical Data
  - Accurate Data
  - Sensitive Data
  - Specific Data
  - Timely Data
- Analyze Clinical and Claims Data for Variation and Trends
  - Summary Dashboard
  - Clinical Benchmarking
  - Cost of Care Benchmarking
  - Pharmacy Opportunities
  - Manage Adherence to Defined Protocols and Practices
- High Risk / High Cost Management
  - Case Management Protocols
  - Case Management Competency
  - Predictive Analytics
- Partner with Operations to Manage the Clinical Aspects of the Onsite Care Team
  - Provider Scorecard
  - Feedback Long From Strategic Level to Care Team
  - Feedback Long From Mezzanine Level to Care Team
**Detailed Specs**

### Bellin Health ACO IT Assessment

**Objective:** To provide a matrix of potential internal and external alternatives to meet Bellin’s ACO IT requirements in order to guide wise executive investment decision-making

### 1.0 ACO IT Components

#### 1.1 Cost of Care Insights (Claims-Based)

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<th>Description</th>
<th>Requirement</th>
<th>Feasibility</th>
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<tr>
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<td>In-place Today</td>
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#### 2.0 Analyze Clinical and Claims Data from Variation and Trends

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<th>Feasibility</th>
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<tr>
<td>2.2</td>
<td>In-place Today</td>
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#### 3.0 External Benchmarking

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<th>Requirement</th>
<th>Feasibility</th>
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### Quadrant Analysis - YTD

#### Bellin Health: 2013 Q2-Q4 and 2014 Q1 Cost-Risk grid

- **PMPPM/Enrollee = $409**
- **Total Cost = $5.16 MM**
- **Clinical Risk: 4.1%**
- **Enrollees = 1,050 members**

#### Quadrant Analysis

- **High Clinical Risk, High Cost**
  - **“Hidden Opportunity”**
    - 189 members
    - $194,440
    - Clinical Risk: 7.80
    - PMPPM:$86
  - **“Critical”**
    - 110 members
    - $1,934,994
    - Clinical Risk: 8.87
    - PMPPM:$1466

- **High Clinical Risk, Low Cost**
  - **“Unknown / The Healthy”**
    - 573 members
    - $400,914
    - Clinical Risk: 2.31
    - PMPPM:$58

- **Low Clinical Risk, Low Cost**
  - **“Frequent Utilizers”**
    - 178 members
    - $2,627,347
    - Clinical Risk: 2.69
    - PMPPM:$1230

- **Low Clinical Risk, High Cost**
  - **“Critical”**
    - 110 members
    - $1,934,994
    - Clinical Risk: 8.87
    - PMPPM:$1466
Marriage of Clinical and Claims Data for Population Risk Analysis...

Plus Administrative and Census Data
# Work List for Care Management & Outreach

## Using Data to Drive Performance Improvement: Coastal Medical

| Patient | Work Date | Age | PCP     | Cmsen Count | Ambulatory Payment (-) | Acusent Payment (-) | Total Payment (-) | Total Costs | R/Aug Chose Risk | %Max Outside Risk | %Max Outside Risk | %Max Outside Risk | %Max Outside Risk | %Max Outside Risk | %Max Outside Risk | %Max Outside Risk | %Max Outside Risk |
|---------|-----------|-----|---------|-------------|------------------------|---------------------|--------------------|--------------|----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| J       | 12/2/2014 | 62  | LEMAHLE, DANIEL | 6891        | $12,953.40            | $1,738.33           | $14,291.73         | $893,252.75 | 52.00%         | 60.00%          | 27.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          |
| J       | 12/12/2014 | 65  | RANSOM, ALONSO W | 473         | $2,085.95            | $0.00               | $2,085.95           | $67,387.04 | 52.11%         | 60.00%          | 27.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          |
| J       | 01/31/2015 | 62  | GUNDERSON, LISA M | 421         | $2,665.46            | $910.02             | $3,575.48           | $98,688.13 | 52.17%         | 60.00%          | 27.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          |
| J       | 01/31/2015 | 61  | HUGHES, ALI W    | 4902        | $1,770.89            | $0.00               | $1,770.89           | $74,377.27 | 52.00%         | 60.00%          | 27.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          |
| J       | 01/31/2015 | 66  | SMITH, JAYSON W | 362         | $1,057.49            | $141.32             | $1,202.81           | $84,924.67 | 52.85%         | 60.00%          | 27.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          |
| J       | 01/31/2015 | 66  | LENA, JOSE MIGUEL | 347         | $1,089.81            | $0.00               | $1,089.81           | $76,631.40 | 52.00%         | 60.00%          | 27.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          |
| J       | 01/31/2015 | 52  | HAWKINS, MELISSA | 317         | $1,710.65            | $0.00               | $1,710.65           | $71,655.50 | 52.18%         | 60.00%          | 27.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          | 30.00%          | 58.00%          |
Coastal Medical

- 84 Physicians + 30 AP’s, mostly primary care
- 21 sites in Rhode Island; 120,000 patients
- Formed in 1995; ACO in January 2012
- Shared Savings Contracts with all major payers
- Historical context: Most docs started in small independent practices

How We Use Data at Coastal

- Volume and Complexity of Quality Work is Increasing
- Blue Cross Data: P4P, Shared Savings Quality Gating, and Comp
- Pattern Recognition in Total Cost of Care Reports
- Identifying High Risk Patients
- Focus on Specific Specialties
- Use of CAHPS Results
- A Look Forward
Volume and complexity has risen

By 2014, many similar measures across the programs, all with slightly different specifications:

- 11 BMI-related metrics
- 7 HbA1C measures
- 6 mammo measures
- 5 BP control measures
- 4 DM Nephropathy measures
- 4 BP Control measures

Number of Performance Based Clinical Quality Measures by Year

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<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>35</td>
<td>35</td>
<td>55</td>
<td>96</td>
<td>134</td>
<td>142</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BC Quality Measures Used for P4P, Shared Savings Quality Gate, Comp

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q4 2011</th>
<th>Q4 2012</th>
<th>Q4 2013</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM - HgbA1c &gt; 9</td>
<td>20%</td>
<td>20%</td>
<td>16%</td>
<td>&lt;20%</td>
</tr>
<tr>
<td>DM - HgbA1c &lt; 8</td>
<td>68%</td>
<td>69%</td>
<td>73%</td>
<td>65%</td>
</tr>
<tr>
<td>DM - LDL &lt; 100</td>
<td>51%</td>
<td>52%</td>
<td>61%</td>
<td>50%</td>
</tr>
<tr>
<td>DM - BP &lt; 140/90</td>
<td>N/A</td>
<td>79%</td>
<td>82%</td>
<td>75%</td>
</tr>
<tr>
<td>Tobacco Use Assessment</td>
<td>87%</td>
<td>98%</td>
<td>99%</td>
<td>95%</td>
</tr>
<tr>
<td>Tobacco Cessation Intervention</td>
<td>81%</td>
<td>88%</td>
<td>92%</td>
<td>80%</td>
</tr>
<tr>
<td>Adult BMI - Age 18-64</td>
<td>53%</td>
<td>55%</td>
<td>73%</td>
<td>45%</td>
</tr>
<tr>
<td>Adult BMI - Age 65+</td>
<td>67%</td>
<td>69%</td>
<td>78%</td>
<td>45%</td>
</tr>
<tr>
<td>Fall Risk Screening</td>
<td>72%</td>
<td>77%</td>
<td>84%</td>
<td>65%</td>
</tr>
<tr>
<td>HTN: BP Control (&lt;140/90)</td>
<td>N/A</td>
<td>79%</td>
<td>80%</td>
<td>68%</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>77%</td>
<td>85%</td>
<td>94%</td>
<td>50%</td>
</tr>
</tbody>
</table>
Pattern Recognition in Total Cost of Care Data

- Type of service
  - Inpatient/Outpatient/Physician/Pharmacy
  - Facility vs. professional

- Site of service

- By specialty

Costs by Specialty (from ETG Data)

- Orthopedics 18%
- Cardiology 11%
- GI 10%
- Mental Health 8%
- Neurology 6%
- Endocrine 6%
- Preventive 5%
- Dermatology 5%
- Pulmonary 5%
- GYN 5%
High-Risk Patient Identification

- **Historical**
  - High ED utilizer (payers)
  - High # of gaps in care (registry)
  - Patients in Transition
    - (hospital daily census reports)
    - (HIE alerts)
  - Patient/family request for help
  - Physician referrals

- **Predictive**
  - High-Risk Patient List based on payer analytics
  - In house analytics just coming on line
    - (drillable provider dashboards marrying claims + EMR data)

CAHPS

- Transparency: Composite performance score for each site, rankings
- Interventions where indicated in specific offices
  - Site assessment
  - Coaching
  - Workflows
- Identify areas needing system wide improvement
A Look to the Future

- More centralized quality staff
- More centralized authority
- No more “fire drills”
  - Performance monitoring 52 weeks a year
- More standardization of workflows
ACO’s: A Vital Step in Transforming of Our Health System

Monday
December 8, 2014
Engaging Communities and Patients to Get to Outcomes

Determinants of Health and Their Contribution to Premature Death

Adapted from: McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(3):78-93.
## Engage Across Boundaries     Achieve Brown County

<table>
<thead>
<tr>
<th>Vision</th>
<th>Brown County is a collaborative, thriving, inclusive community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission</td>
<td>Create a coordinated, accountable and connected community that prepares all children and youth to become engaged, successful adults which will result in a vibrant and sustainable Brown County.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goals</th>
<th>Every child is prepared for school.</th>
<th>Every child succeeds in school.</th>
<th>Every youth is connected to and engaged in education/training/employment pathways.</th>
<th>Every youth attains post-secondary, continuous education or career training.</th>
<th>Every youth is equipped to become an effective and engaged citizen.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Age Range</th>
<th>0-4</th>
<th>5-18</th>
<th>10-18</th>
<th>18-24</th>
<th>18-26</th>
<th>5-26</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Children are developmentally ready to enter kindergarten.</th>
<th>Children meet grade-level expectations.</th>
<th>Children are supported outside of school.</th>
<th>Youth create and regularly assess their post-secondary and career plans.</th>
<th>Youth attain a college degree within 6 years.</th>
<th>Youth attain industry-, government-, or military-recognized license/certification.</th>
<th>Young adults are gainfully employed.</th>
<th>Children, youth and young adults contribute to community in a positive way.</th>
</tr>
</thead>
</table>

| Contributing Indicators | Children entering 5K with age-appropriate: | + 3rd grade reading scores | + 8th grade math scores | + Dropout rate | + 9th and 10th graders | + Detentions, suspensions and expulsions | + Parent and their child develop a career/collage pathway | + Student participation in a work-based learning program | + FAFSA submission by high school seniors | + Adults completing one or more years of post-secondary education or vocational training | + Adults earning an industry, government, or military certificate/license by age 24 | + Young adults self-sufficient by age 26 | + Youth engaged in the labor force by age 24 | + Adults holding stable employment for at least one year | + Adults engaging in household formation, including homeownership | + High school students avoiding risky behavior | + Secondary students engaging in volunteer service | + Children and young adults age 5-26 involved in community organizations |
|------------------------|-----------------------------------------------|-----------------------------|-----------------------------|---------------------|-----------------------------|----------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|

- Language, literacy and thinking skills
- Social and emotional behavior
- Gross motor skills

### Working outside our boundaries
What experiences can you share about working outside healthcare boundaries?

Partnering with Patients
“Patient-centered care focuses on the patient’s needs and concerns as the patient defines them.”

Picker/Commonwealth
Patient-Centered Care Program
What Matters?

Enhancing conversations between patients and clinicians from -- “What’s the matter?” to also including “What matters to you?”

Shared Decision Making — The Pinnacle of Patient-Centered Care
Michael J. Barry, M.D., and Susan Edgman-Levitan, P.A.

n engl j med 366;9 nejm.org march 1, 2012

Genesys HealthWorks/Genesee Health Plan
Health Navigator Outcomes for Uninsured Population

<table>
<thead>
<tr>
<th>HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Behavior Improvements</td>
</tr>
<tr>
<td>• 53% of people who did not eat adequate amounts of fruits and vegetables, now eat adequate amounts</td>
</tr>
<tr>
<td>• 53% of people who reported no regular physical activity, now are physically active</td>
</tr>
<tr>
<td>• 78% of people who were physically active at baseline, maintained their physical activity</td>
</tr>
<tr>
<td>• 17% of smokers quit smoking</td>
</tr>
<tr>
<td>• 85% of patients who were not taking their medications regularly, now do take medications at prescribed intervals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of patients engaged in Self Management Support who report one or more visits to the ER in the past 6 months</td>
</tr>
<tr>
<td>Baseline</td>
</tr>
<tr>
<td>2006</td>
</tr>
<tr>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXPERIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Thank you so much for everything you have done for me. You will be blessed for using your whole heart to help people. I am glad you are on my team.”</td>
</tr>
</tbody>
</table>

Genesys HealthWorks, 2012
Changing the Cultural Norm

A national campaign encouraging everyone to have a conversation about their wishes for end-of-life care

Collaboration to ensure health care systems are ready to receive and honor wishes for end of life care

Judy (Trevor’s Grandma)

Age 74
Generally healthy and active
Walks regularly, plays tennis and golf
- Eats a balanced diet
- Never smoked
- Blood pressure controlled

Lab result: elevated cholesterol
What if.... every clinician, staff member and community health worker routinely asked -- "what matters to you?"– and listened attentively at every encounter with individuals and their family members?

What would we learn?

What successes have you had in partnering with patients?
http://www.ihi.org/offerings/ihiopenschool/resources/Pages/TrevorAndThePerksOfDiabetes.aspx
http://www.youtube.com/watch?v=cMGgoInt1Mo

Trevor@trevortorres.net
Free eBook: 24 Reasons Diabetes is Awesome!

Institute for Healthcare Improvement

Session M20

BREAK
ACO’s: A Vital Step in Transforming of Our Health System

Engaging the Team in Care Redesign

Al Kurose, MD MBA FACP
President and CEO, Coastal Medical
“Coastal 365”

- Began as urgent primary care clinic on Saturdays
  - Sundays, holidays later; then weeknights
- Designed to serve mission and strategy
  - Never viewed as a profit center
- Initial fear of providers was loss of FFS visits
- Attracting experienced PCP’s to work was crucial
- Better patient care (weekend f/u’s) was a selling point
- Communication on parallel tracks was vital
- Adding weeknights was a new challenge

Coastal 365: Results

Coastal MSSP ACO Utilization Trend

*For 12 mos. ending 3/31/14, compared to 2011:*

- ER visits decreased by 15%
- Hospitalizations decreased by 29%
- 30 Day Readmissions decreased by 23% (to 13%)

*We believe better access played a major role here*
“Brand to Generic”

- Pharmacist driven telephonic initiative to change Rx
- **Data** was important because variation was high
- **Flexible approach** with individual physicians early on
- **Comparison to peers** was powerful
- Early push back – and then a tipping point
- **Aligned business model** helped
- **Credibility on quality** of care was crucial
  - P&T Committee was carefully designed
- **Patient acceptance** was crucial

---

**Brand to Generic: Results**

- For just one branded statin drug:
  - 425 interventions
  - $765,000 in annualized savings

- Total annualized savings for pharmacy initiatives
  - $1.2 M in 2013
What Has Worked for Us

- Involve team members at every level from the outset
  - Use facilitated brainstorming
  - Communicate using parallel tracks
- Be strategic about physician leadership opportunities
- Take an incremental approach
  - Use pilots, be patient
- Pay close attention and be willing to change the plan
  - Debrief, audit, and survey; tinker and experiment; abort if needed
- Celebrate success!

Care Redesign: A Few Insights

- It’s crucial to include the people who do the work
- *Early* participation breeds ownership and advocacy
- Patience with an incremental approach pays off
- Trust goes a long way
- Process change drives culture change
Physician Buy-In

- Providers support initiatives that improve patient care
- Providers support initiatives that patients like
- It is easier for providers to support initiatives that staff are buying into from the beginning
Engaging Care Setting in Redesign

Peg Bradke  RN MA
Unitypoint-St. Luke’s
Cedar Rapids, Iowa

ACO’s: A Vital Step in Transforming of Our Health System

St. Luke’s Hospital – UnityPoint Health System

• Private hospital – Cedar Rapids, Iowa
• Affiliate in the UnityPoint Health System
• Licensed for 500 beds with more than 17,000 admissions
• Truven Top 100 Hospital - 4 years; Heart Hospital - 5 years
• Mayo Clinic Care Network - 2014
• Iowa Recognition for Performance Excellence Gold Award - 2010
• Magnet Re-designation - 2014
Our Mission:

“To give the healthcare we’d like our loved ones to receive”

It represents goals that are aligned with healthcare reform: providing better value for decreased costs.

Current State - Post-Acute Care Nationally

- PAC contribute to 40% of the spending
- 40% of Medicare patients utilize PAC services
- Medicare per capita spending on post-acute services has grown at 5% a year or faster in 34 of the nation’s 50 most populous hospital market’s in recent years
- PAC shows the greatest variation in spending compared to acute and ambulatory: $60 PMPM to $450 PMPM
St. Luke’s Post-Acute Strengths

- St. Luke’s owns a large part of Care Continuum
- Strong history in IRF and LTACH with strong clinical outcomes
- Organizational structure that supports a Post-Acute Service Line strategy
- Working in tandem with Population Health Strategy
- Physician-driven with strong Medical Directors
- Alliance with UnityPoint Clinics
- Established ARNP’s in three nursing facilities
- Accredited Home Care, Inpatient Rehabilitation Unit, Palliative Care, Hospice and LTACH

UnityPoint-St. Luke’s Post-Acute Vision

*We will give the care we would like our loved ones to receive by re-envisioning care beyond the hospital walls*

<table>
<thead>
<tr>
<th>Today</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-acute services after a hospital stay</td>
<td>Pre and post acute services to minimize days spent away from home</td>
</tr>
<tr>
<td>Confusing path to the road to recovery</td>
<td>Evidence-based, seamless pathways starting in the medical home with engaged consumers and families</td>
</tr>
<tr>
<td>Care within the hospital walls</td>
<td>Care in the home, wherever that home may be</td>
</tr>
<tr>
<td>Partner in end-of-life planning</td>
<td>Partner in life-long healthcare planning (goals, medical wishes, and financial planning)</td>
</tr>
<tr>
<td>Expertise in sites of care</td>
<td>Well coordinated expertise wrapped around the consumer and family</td>
</tr>
<tr>
<td>Consumers come to us</td>
<td>We go to our consumers through virtual care delivery when appropriate</td>
</tr>
</tbody>
</table>
Looming Threats for Post-Acute Care

- Broadening readmission penalties for acute providers extending into post-acute care.
- Discussion of site-neutral payment for comparable services.
- Due diligence in obtaining publicly available information to make decisions.
- Finding a way to manage non-homebound patients.
- Connectivity and engagement strategies.

Care Coordination Strategies

- Manage the patient/consumer in the lowest cost setting.
  - Manage PMPM costs.
  - Keep patients in their home as long as possible.
  - Utilize established criteria to match patient to appropriate site of care.
  - Improve understanding of different post-acute sites and levels of care to all providers.
  - Reduce duplication across the continuum and achieve appropriate utilization and consistent placement.
ACO’s: A Vital Step in Transforming of Our Health System

SNF Profiling

- Ownership/Partnerships/Other facilities owned by parent company
- Licensure (Medicare/Medicaid)
- Levels of Care; Capacity; Staffed Beds; Avg Census
- Medical Director
  - At least one MD, NP or PA in building 3 or more days per week
- Other Contracted/Joint Ventures
- Connections with UnityPoint
SNF Profiling – Ease of Access

• Patient referrals/admissions accepted seven days per week
• EHR
• Pharmacy coverage
• Participating insurance products
• Willingness to accept patients on weekends/off-shift

SNF Profiling – Quality Ratings from Nursing Home Compare.gov

• Overall
• Quality
• Fines reported
• Payments denied

Is there a formal patient satisfaction measurement tool in place in the facility?
Collaborative Assessment

• Willingness to participate in quality, care coordination, admission criteria and ability to meet patient care need.
• Willingness to be part of Population Health efforts and Population Health work.
• Willingness to accept patients with high-cost medicines, Behavioral Health diagnosis, high-risk treatment (e.g., PD/HD).
• Willingness to improve metrics and financial status.
• Willingness to commit to staff training and education in regard to performance metrics/VBC.

SNF Profiling - Other

• Availability of private rooms
• Utilization of Interact tools
• Compatible with Mission/Values
• Current financial status
• IPOST-Certified/Palliative Care-Certified
• Reputation
Provider Alignment Strategies

- Develop life-long relationships starting in the Patient-Centered Medical Home
  - Establish Physician Champions for Post-Acute
  - Merge Post-Acute work with Patient-Centered Medical Home

Post-Acute Metrics:
Home Care, Skilled, Inpatient Rehab  CCH

- Per member, per month
- LOS
- Percentage of in-network care
- Patient experience
- Readmission/ Hospitalization rates from post-acute site
- ED visits from post-acute sites
- Percentage of patients with a follow-up visit from post-acute site at discharge
- Percentage of patients identified Goals and Plan of Care
- Medicare Compare reports
Sustainability Strategies

- Keep care within the System
  - Education on our network and what care within the system means and why it’s important.
  - Be the low-cost/high-quality provider so we are the patient’s choice.
  - Balance referral of our own partners while upholding patient choice.
  - Monitor referral management and address outmigration.
  - Become positioned well to attend to the dual population.

Questions?

Peg Bradke, MA RN
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UnityPoint Health - St. Luke’s Hospital
Cedar Rapids, IA
Peg.bradke@unitypoint.org