Accountable Care Organizations:

Advanced Readiness Assessment

The First of Six Conference Calls for VHA, Inc.

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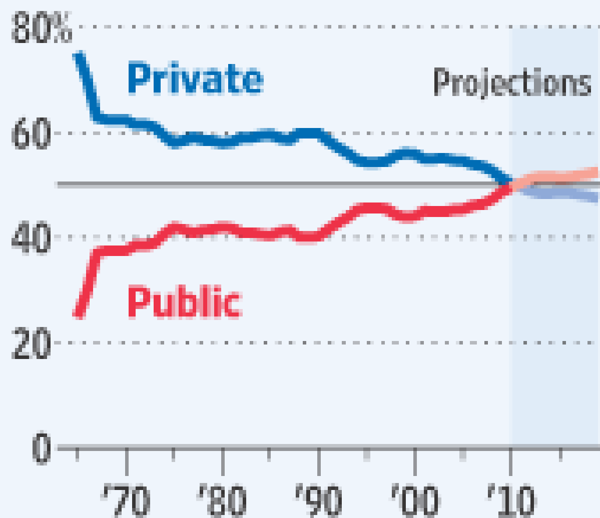
Leading Constructive Change

Boston • Cleveland • Dallas • Denver • Miami • San Francisco • Washington, D.C.

The Growing Crisis – How Can Providers Help?

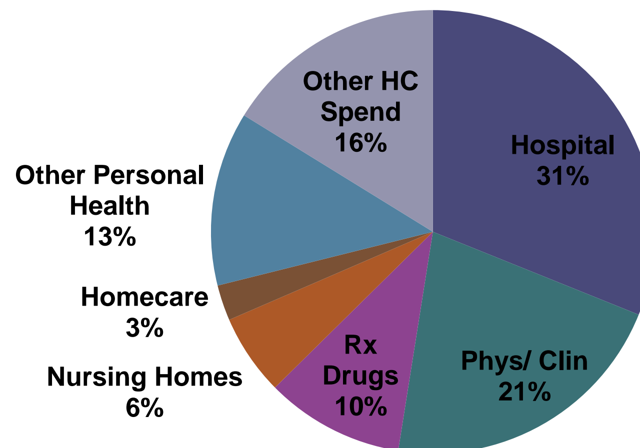
Healthcare expenditures projected to be 19% of GDP in 2010



$2.3 Trillion Health Care Expenditures '08
$1.1 Trillion (47%) - Public Payments

Public expenditures for healthcare projected To exceed 50% of total in 2010!

USA 2007
Healthcare Expenditures



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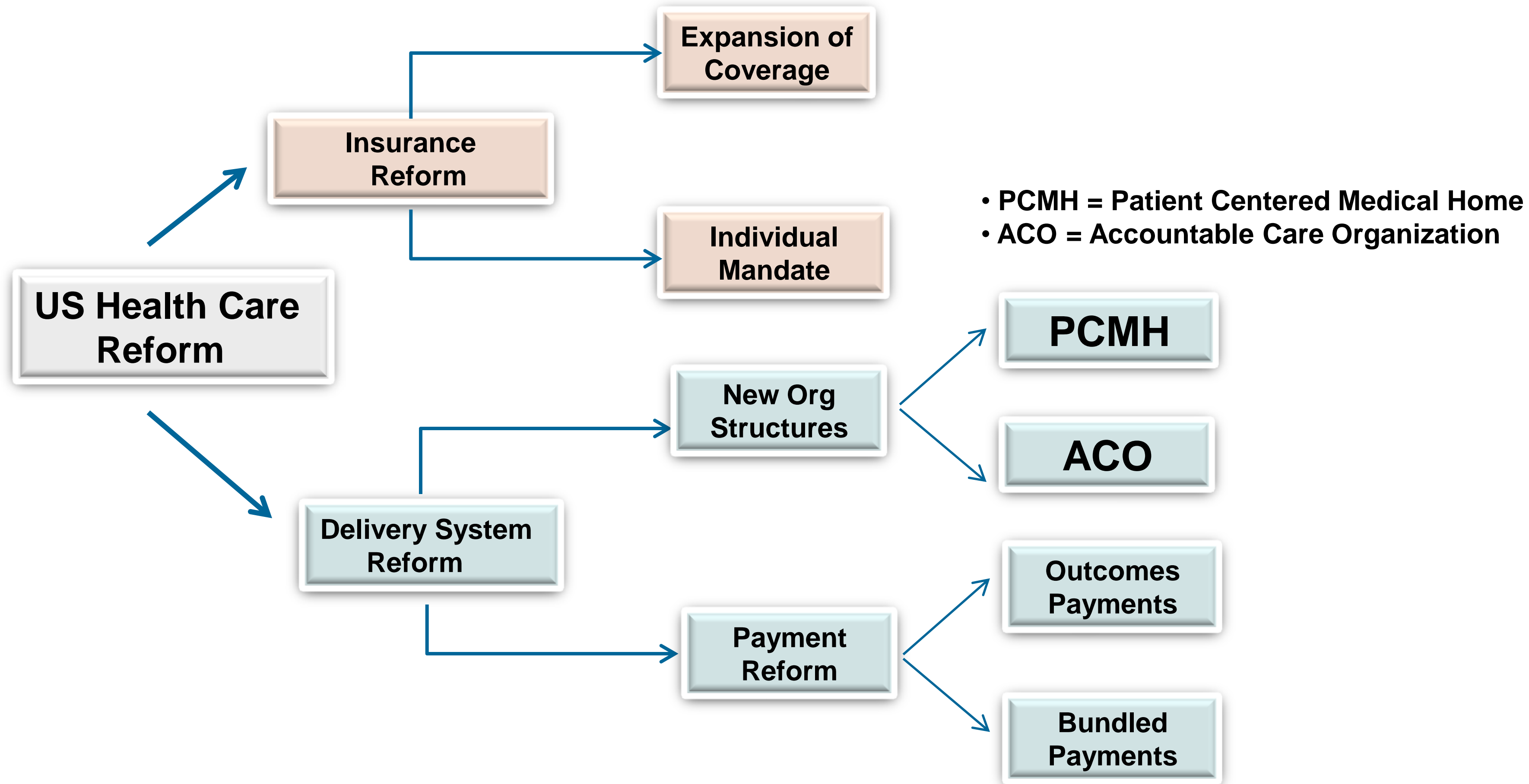
US Health Reform 2010

Two-Pronged approach to Redesign of the US Health Care System



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Guide to the Presentation

New Organizational Structures

Payment Reform

Strategic Direction

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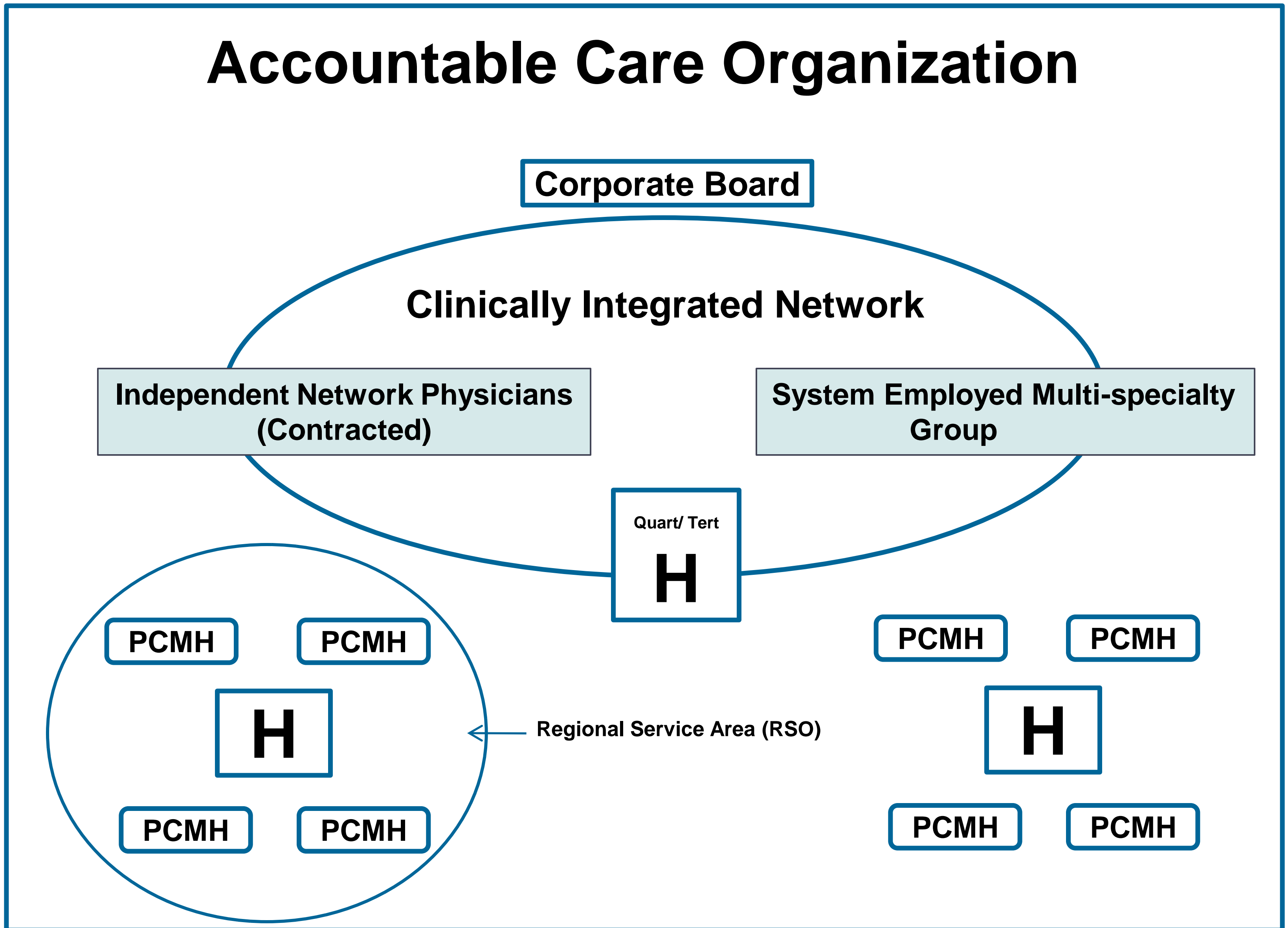
Vision of a "Generic" ACO



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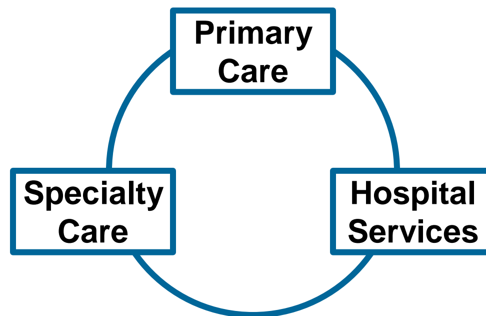
ACO Definition

*An ACO is a **provider-led organization** whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population*

Multiple forms of ACOs are possible, including:

- Large integrated delivery systems (IDNs)
- Physician–hospital organizations (PHOs)
- Multispecialty practice groups with or without hospital ownership
- Independent practice associations (IPAs)
- Virtual interdependent networks of physician practices



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ACO will Change Executive Focus

Current Incentives give Hospital Leaders little reason to focus on what's happening above the falls……

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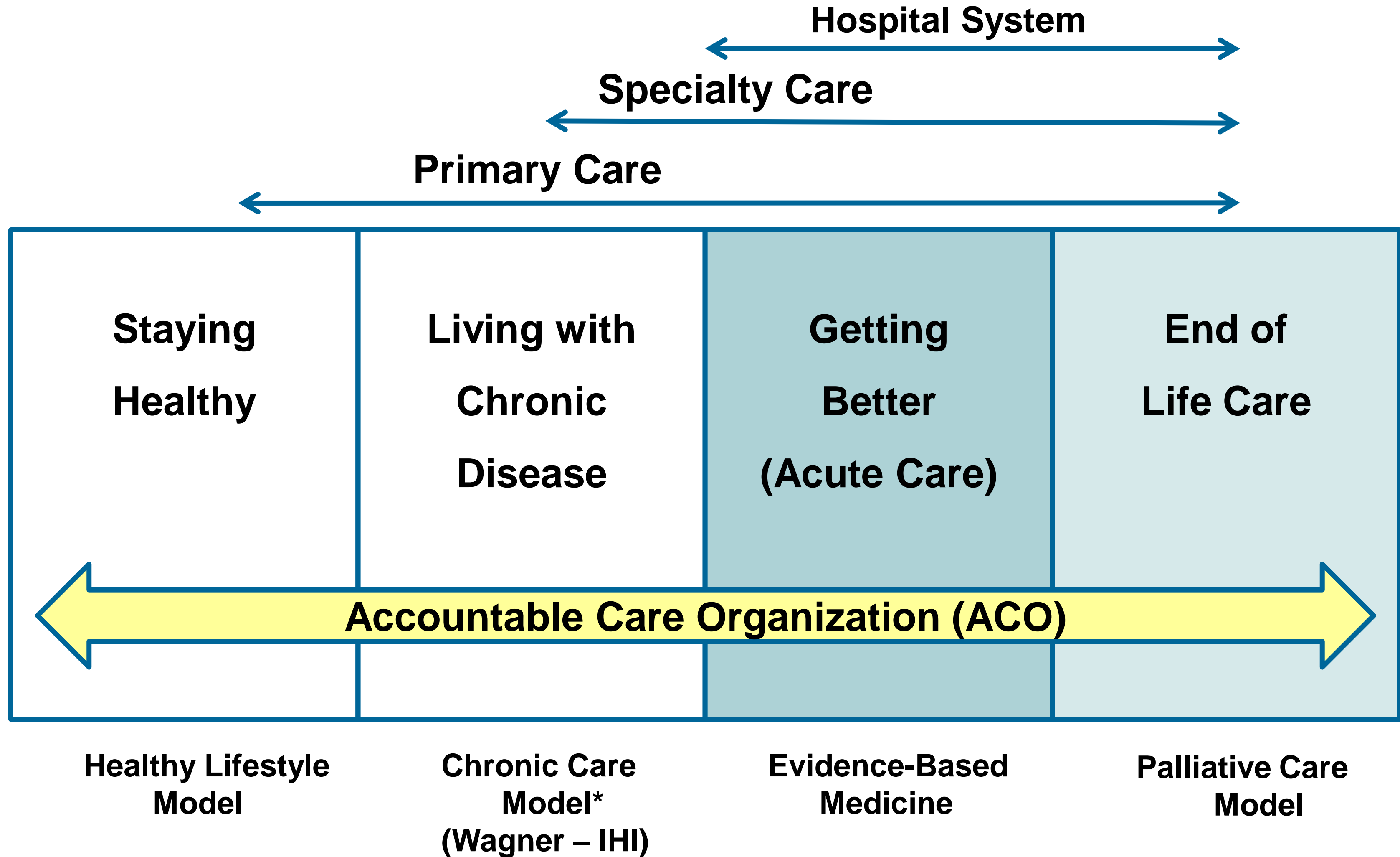
Hospital System – Narrow Focus

Hospital Systems' leadership/ business model not prepared to function as an ACO



* Medical Home

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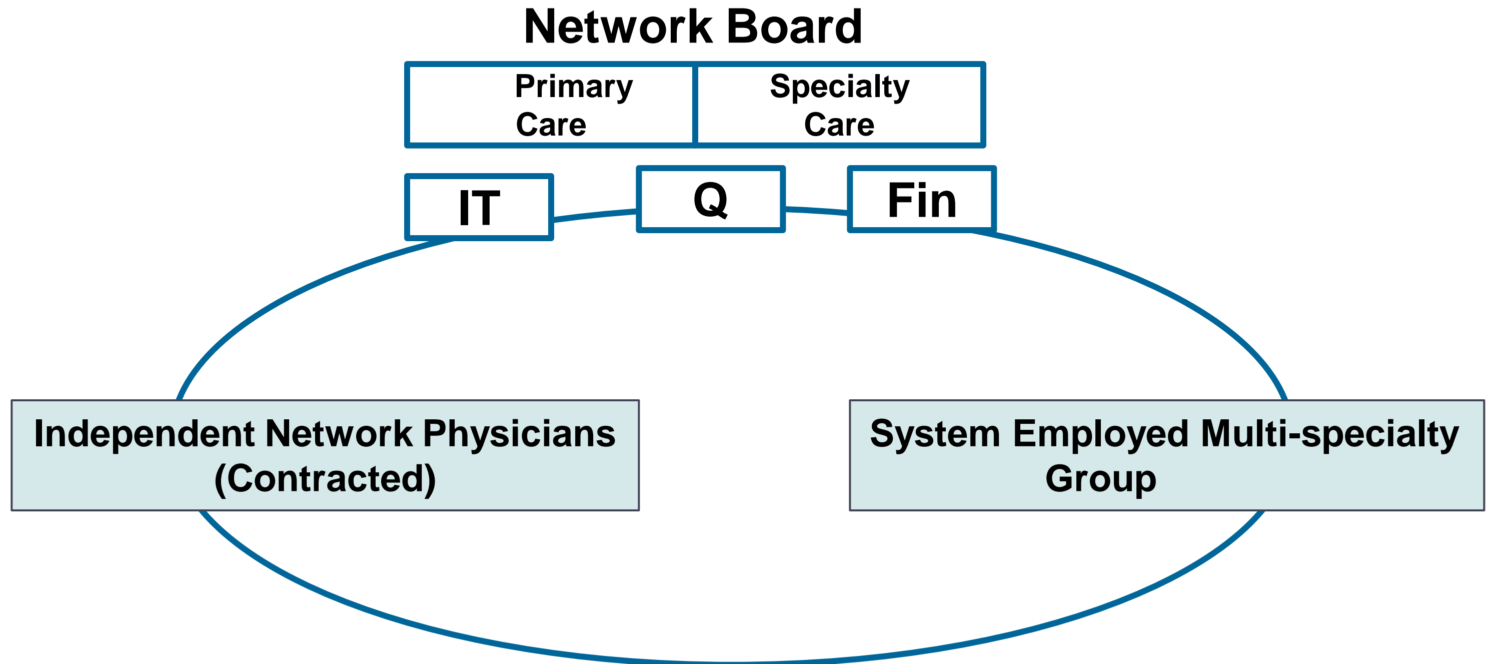
Clinically Integrated Network

One Structure to Spread Accountability across the Continuum of Care



Requirements of a CIN physician:

- To follow evidence based guidelines created by peers
- To be subject to education/discipline/expulsion
- To serve on one year quality assurance council (or other key committee)
- To invest in and adopt necessary connectivity technology (EMR, etc.)

CI Programs Should Include

Mechanisms to monitor and control utilization of healthcare services that are designed to control costs and ensure quality of care.

Significant investment of **capital**,

(both monetary and human),

in a necessary **infrastructure**

and a capability **to realize the claimed efficiencies.**

Strategic selection of network physicians

(who will further efficiency objectives).

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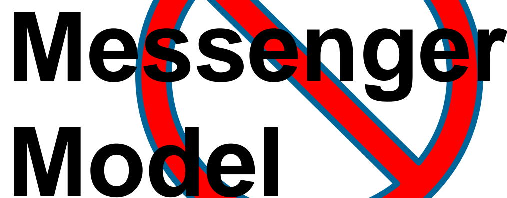
Clinical Integration – Strong Legal Underpinning

Clinical Integration is not the 1990's "messenger model", and has been well defined in FTC and DOJ writings



Clinical Integration

"... an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.

This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies."

FTC/DOJ - Statements of Antitrust Enforcement Policy - 1996

4 Indicators of CI

What the FTC is looking for…

- The development and adoption of clinical protocols
- Regular care reviews based on the application of protocols
- Mechanisms that will ensure physician adherence to protocols
- The use of common IT to ensure the exchange of relevant patient data

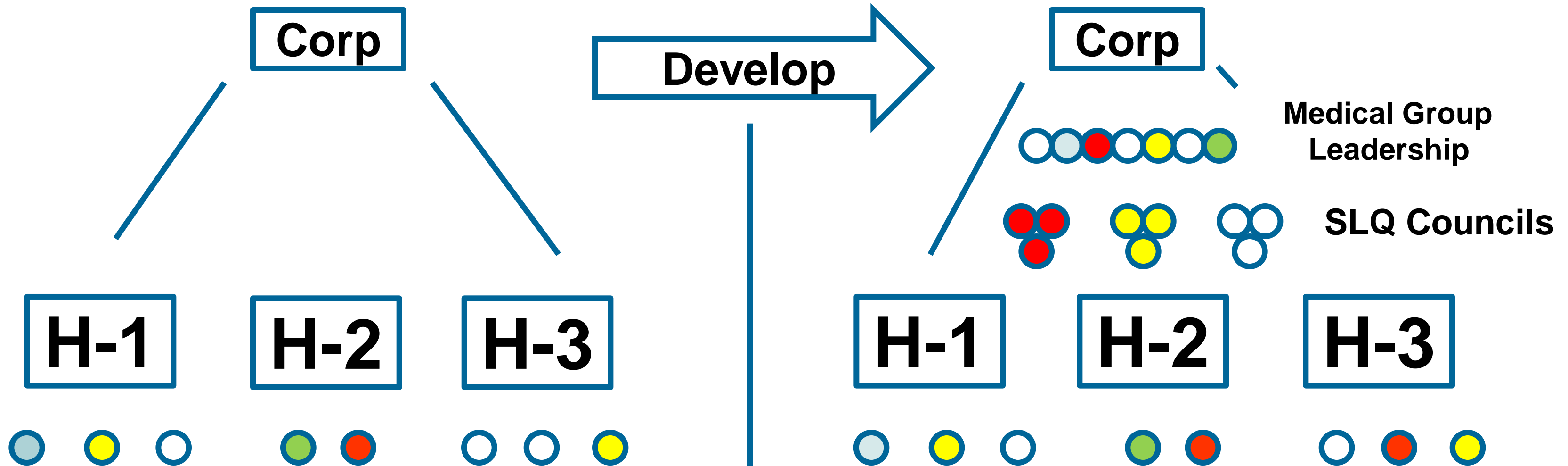
Engage Your Physicians (Leadership/ Committees)

Create Physician Directed System-Level Structures

Current systems often have only a CMO or MSO leader functioning at Corporate

Consider organizing your employed physicians at the System Level

- Medical Group/ Leadership
- Specialty Service Line Quality Councils



Anticipate resistance from:

- Hospital Presidents and SL Leaders
- Independent Medical Staff Leaders

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Engage Your Physicians (Leadership/ Committees)

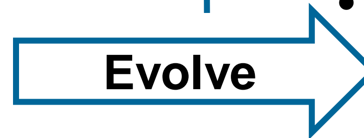
Create Physician Directed System-Level Structures

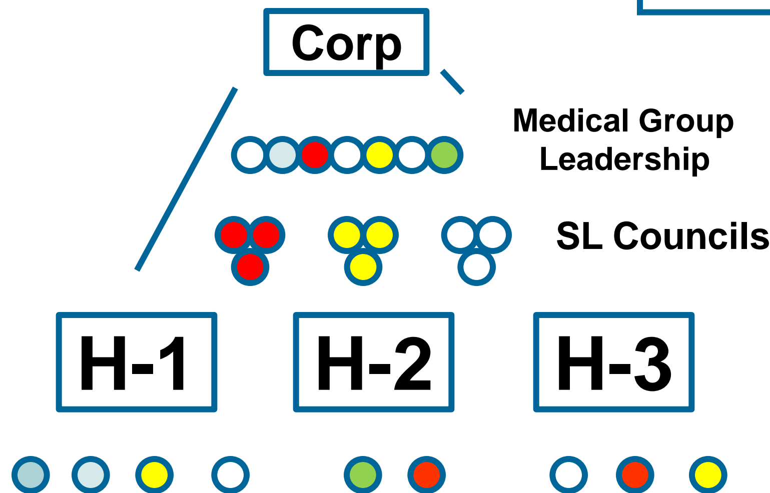
Consider organizing your employed physicians at the System Level

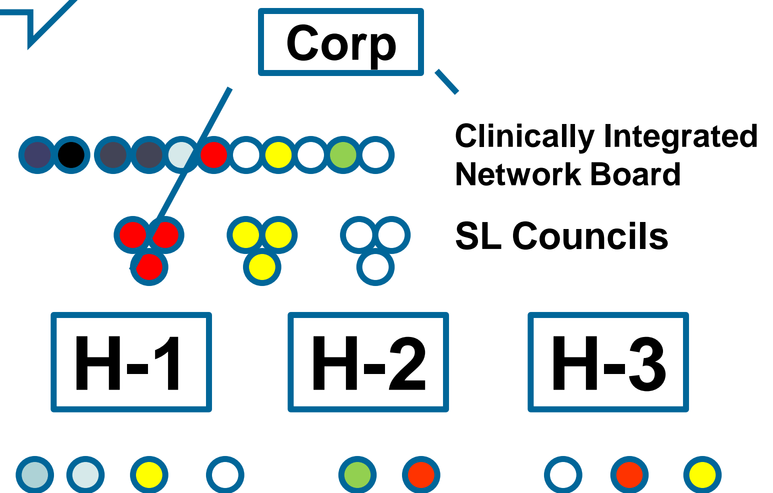
- Medical Group/ Leadership
- Specialty Service Line Quality Councils

Evolve into a CIN Board at System Level

- Medical Group / Leadership
- Specialty Service Line Quality Councils
- Independent Physician Members







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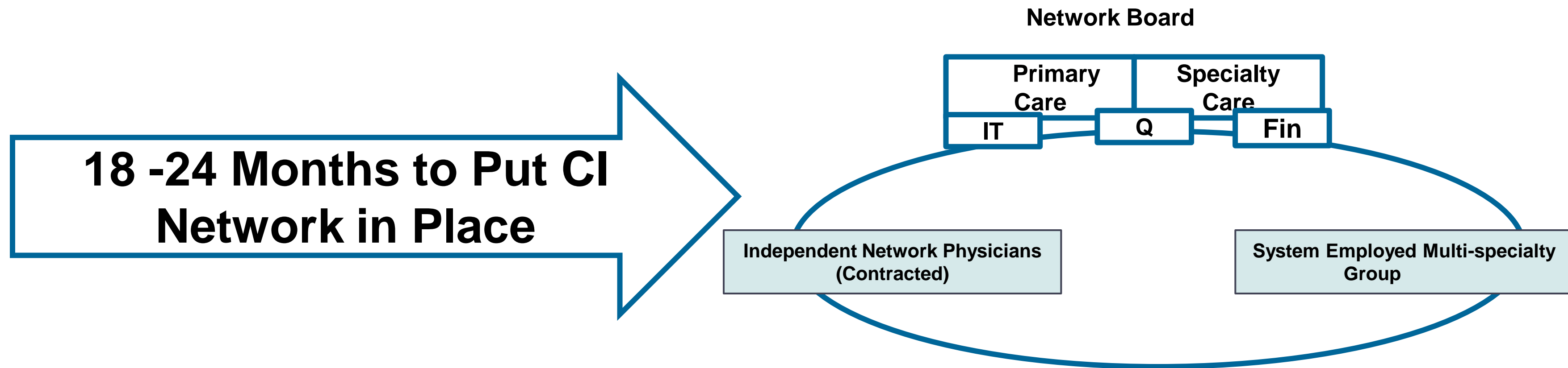
Clinically Integrated Network

Creating a CIN will have impact on all components of the Health System



Notes

- *EMR deployment a major benefit, but not required to start*
- *Does not require specialist "splitters" to be exclusive with network*
- *Funding sources: Payors, Health System, and Professional Fees*
- *Networks start with Primary Care Measures (small number) and expand*
- *Pay-for-performance incentives work in the FFS environment*
- *Physician alignment with Health System is part of the ROI of the IT investment*

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Measures – Clinically Integrated Network (CIN)

Clinical Integration Requirements	Criteria	SCP/ PCP	Finc Inc	Measure	Op Def	Data Repositories	Primary Resources
***e*ICU participation**	• = or > Level 3 at Primary Hospital	All	MD PHO	% Signed Agreements (Y/N) % Uses (Y/N)	• Signed agreement • Number of physicians with signed agreement at Level 3 or > /Number of AHP physicians • Number of AHP days covered by eICU at Level 3 or 4 /Number of AHP days in covered eICU beds	• Agreement • Utilization	• *e*ICU database
Hospitalist Program participation	• Signed Agreement • Measures of effective patient management (ALOS by PHO and MD)	PCP	PCP PHO	% Present (Y/N) Hospitalist vs Non-hospitalist outcomes	• Signed agreement • Number of AHP PCP physicians with signed Hospitalist agreements /Number of AHP PCP physicians • Number of AHP PCP hospital days covered by hospitalist /Number of AHP hospital days	• Agreement	• Hospitalist registry
Supply Chain initiative partipation	• Active use of SCI for Ortho and Cardiology	All	PHO Hosp	% Complaint Utilization (Y/N)	• Number of implants used on Supply Chains preferred listing /Total Number of implants placed by AHP physicians.	• SCI/ Lawson data	• SCI • DSS
CareConnection including CPOE	• Access (3/04 Christ) • Utilization	All	MD PHO	% Signed access agreement # sign-ons, patient or Minutes used	• Signed agreement • Number of physicians signed with access CareConnection agreements /Number of AHP physicians • Number CareConnection access minutes /Number of AHP physicians • Number of AHP orders entered by physicians using CPOE /Number of AHP physicians with CareConnection agreements	• Access Agreement • CareConnection reports • Care Connection reports	• CareConnection
Formulary usage (inpatient)	• Adherence to Formulary	All	MD	% Formulary compliance	• Number of formulary medications fille /Number of medications filled	• PharmNet reports	• Dir of Pharmacy – Pham
Generic usage (outpatient)	• Generic Utilization by ordering physician	All	MD	% Generic filled by MD	• Number of prescriptions filled by generic medications /Number of prescriptions filled	• Pharmacy reports	• PBM • MCO • AHHC PCS –

EXAMPLE

Patient-Centered Medical Home (PCMH)

A Second Structure to Strengthen Care Coordination across the Continuum

- PCMH: Joint Principles of the AAFP, AAP, ACP, AOA:

Principles (2007)	PCMH	PCP*	Urg Care	ED**
Personal Physician	*Yes*	*Yes*	*No*	*No*
Physician-Directed Medical Practice	*Yes*	*Yes*	*Yes*	*Yes*
Whole Person Orientation	*Yes*	*+/-*	*No*	*No*
Care is Coordinated and/ or Integrated	*Yes*	*+/-*	*+/-*	*+/-*
Quality and Safety	*Yes*	*?*	*?*	*+/-*
Enhanced Access to Care	*Yes*	*+/-*	*Yes*	*Yes ++*
Payment Reform (to Recognize Services Provided)	*Proposed*			

•PCP = Current Model under FFS

•ED = Offers Access to Specialists and Diagnostics not Available to other Models

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Patient-Centered Medical Home (PCMH)

A Variety of PCMH Models and Criteria for Accreditation (NCQA, BTE, etc.)

NCQA Medical Home Certification:

- 500 Practices with 4,600 Physicians have received certification (Dec. 2009)
- Revised criteria to be released first quarter 2010
- Current Criteria:
  - Access and communication
  - Patient tracking and registry functions
  - Care management
  - Patient self-management support
  - Electronic prescribing
  - Test tracking
  - Referral tracking
  - Performance reporting and improvement
  - Advanced electronic communications

Gatekeeper	PCMH
PCP Assignment	*PCP of Choice*
Specialist by Referral Only	*Open Access to Specialists*
PCP at Financial Risk for Cost	*PCP Paid for Quality Outcomes*

What's your "Primary Care IQ" in the C-Suite?

How prepared is your team to lead across the full continuum?

- What are the elements of your current primary care strategic plan?
- What primary care clinical quality metrics are you measuring and reporting?
- What PC non-clinical performance metrics (KPIs) do you track? How do they compare to benchmarks?
- How do your PC practices perform? Are they NCQA credentialed? Do you know the NCQA criteria for credentialing?
- Do you know your customer experience metrics? Access statistics?
- Do you claim your primary care practices? Or are they a "stealth" practice?
- Do they have a name? Are they branded? Are they identified with the system?
- Are you tracking and reporting ambulatory sentinel events?
- Are your PCPs paid at market rates? Do they have payment tied to quality or service performance?
- Does your primary care group have a leader? A leadership council?
- Are there primary care physicians on your Board? Is there a system primary care medical director?
- Does each practice have a lead physician?
- Are you preparing for or piloting a PCMH?

Benchmark Your Primary Care Practices

OnLine Practice Assessment

Evaluate Practices Performance across the 9 Core Competencies

- *Access to Care and Information (15 questions)*
- *Practice Management (32 questions)*
- *Practice-Based Services (10 questions)*
- *Patient-Centered Care (10 questions)*
- *Practice-Based Team Care (13 questions)*
- *Quality and Safety (16 questions)*
- *Health Information Technology (15 questions)*
- *Care Coordination (10 questions)*
- *Care Management (12 questions)*

- http://www.transformed.com/surv/intro.cfm?assetID=30

Guide to the Presentation

- New Organizational Structures
- Payment Reform
- Strategic Direction

Types of Value-Based Payment Systems

Value-based payment comes in three "flavors," each of which has advantages and disadvantages.

Type of Reimbursement	***Advantages***	***Drawbacks***
Pay-for-Performance	• Clarity, simplicity • Promotes focused innovation	• Suitable for quality more than cost • Potential for conflicts between payers and payees • Lack of breadth reduces impact • Must be large enough to capture attention
Gain-Sharing	• Simplicity, flexibility • Promotes innovation, collaboration between payers and payees	• Lack of predictability / defined targets • Complexity of navigating around regulatory restrictions • Difficult to sustain – zero-basing problem
Bundled Payments	• Flexibility • Promotes innovation, learning	• Complexity • Easy to overreach (e.g., global cap) • Difficult to update for changes in technology, economics

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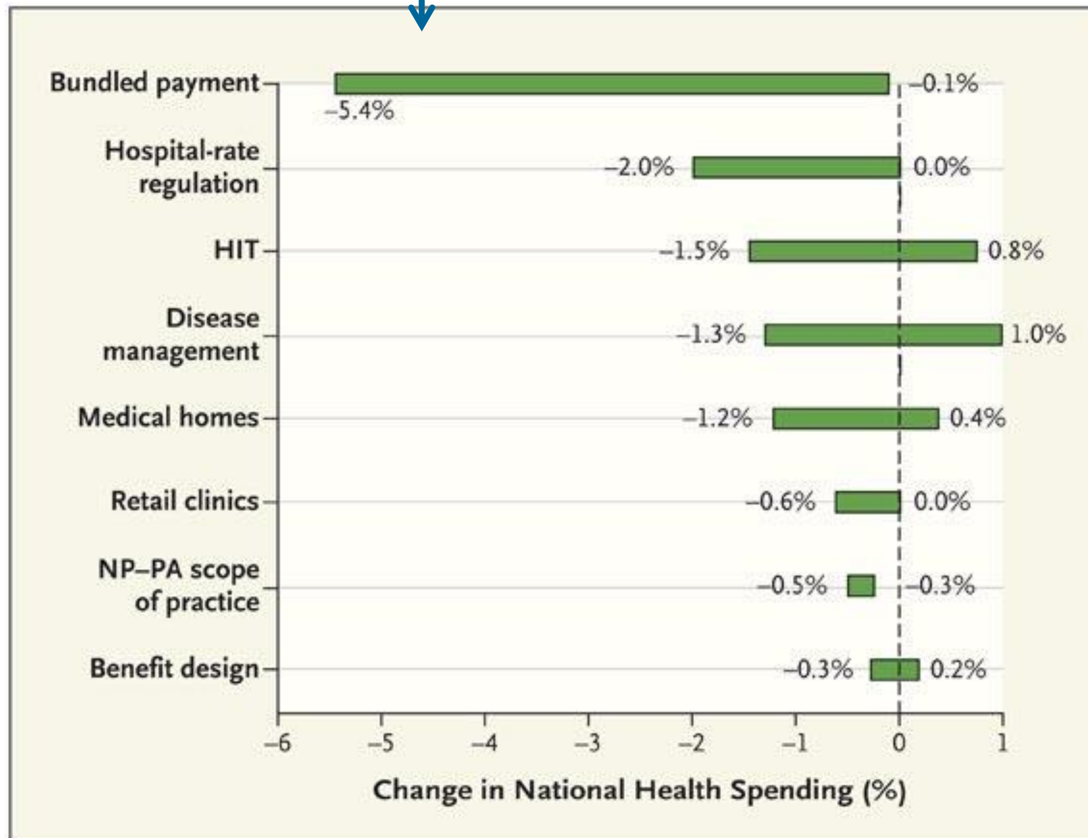
"Bundled Payments" Offer Greatest Impact on Cost Trends

Estimated Cumulative Percentage Changes in National Health Care Expenditures, Given Implementation of Possible Approaches to Spending Reform (2010-2019)



Source: Hussey P et al. N Engl J Med 2009;361:2109-2111

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Health Care Reform – Senate Bill Demonstration Projects

Demonstration (Pilot) Projects likely to proceed despite political uncertainty of reform

Senate Bill H.R. 3590	Funding	Dem Project	Description	2010	2011	2012	2013	2014	2015	2016	2017
Sec. 2704	Not Spec	Evaluate Integrated Care Around a Hospitalization	Bundled H-P payments for inpatient care								
Sec. 2705	Not Spec	Medicaid Global Payment System	Global Capitation for Medicaid (5 states)								
Sec. 3022	$4.9 B (est)	Medicare shared Savings Program	Payment to Providers forming an ACO						???		
Sec. 3023	Not Spec	Payment Bundling Pilot (Episodes of Care)	EOC - 3/30 days around hospitalization								
Sec. 3025	$7.1 B	Hospital Readmission Reduction Program	Payt adjustment for 3 conditions			1-Oct			1-Oct		
Sec. 3027	$1.6 M	Extension of Gainsharing Demonstration	Extends current gainsharing projects		30-Sep						
Sec. 1151	$15 M	Post-acute Care Services Bundling	Hospital and post-acute care provider								
Sec. 1236	Not Spec	Use of Patient Decision Aids	Enroll 30 eligible providers ; ed aids	Not specified							
Sec. 1301	$45M	Accountable Care Organization Pilot	Partial Capitation/ Performance Models								
Sec. 1720A	Not Spec	Accountable Care Organizations	Enact prgrams from 1301	Not specified							

Note: Medical Home Projects in progress

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Example: West Coast Value-Based Payment System

A value-based payment system being evaluated by a West Coast health system aligns incentives around the needs of specific customer segments.

Customer Segment	***Basis of Payment***	***Paid to Whom?***
Casual Immediate	• Wellness capitation payments • Quality bonuses	"Medical home" – Wellness Center
Routine Healthy	• Primary care capitation payments[1] • Quality bonuses	"Medical home" - e.g.: • Medical groups • PCPs
Intense Immediate	• Episode-of-care payments[2] • Quality bonuses	Hospitals / Specialists
Chronic conditions ("Big Five" initially)	• Chronic disease capitation payments • Episode-of-care payments[2] • Quality bonuses	"Medical home" – could be: • Medical groups • Specialists • PCPs • Others – e.g., disease mgmt companies, specialty HMOs Hospitals / Specialists
Frail elderly / End-of-life	• Bundled capitation payments • Episode-of-care payments[2] • Quality bonuses	"Medical home" – could be: • PCPs, esp. geriatricians • Hospice • Senior housing / Asst living • SNFs Hospitals / Specialists

Notes: (1) Including primary care reimbursement for defined episodes of care
(2) One option: Contact cap to specialists; APR-DRGs to hospitals; APCs to O/P centers

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Guide to the Presentation

New Organizational Structures

Payment Reform

Strategic Direction

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Health System Strategic Approach to Reform

CEO and Board to set a Direction – Lead time for Change is Significant

Option #1 **- *Defend the Current Model***

- *Actively strengthen the hospital position in the market through acquisitions, pricing, contracting to prevent the incursion of managed care, employer or physician initiatives to change the market*

Option #2 **- *Wait for a Mandate***

- *Maintain and continue to invest in current hospital volume-based model (beds and towers) waiting for payment reform to be adopted before announcing or acting on the need for a business transformation*

Option #3 **- *Hedge your bet***

- *Maintain and invest in the current hospital volume-based model but (quietly) begin investing some profits in building infrastructure and capabilities that will support a business transformation if so required in the future.*

Option #4 **- *Begin the transformation***

- *Decide to fundamentally change the organizations relationship with both physicians and payers, and begin restructuring the leadership and decision-making processes of the organization to manage care across the continuum. Major commitment to primary care through investment in a primary care network.*

Option #5 **– *Lead the Transformation***

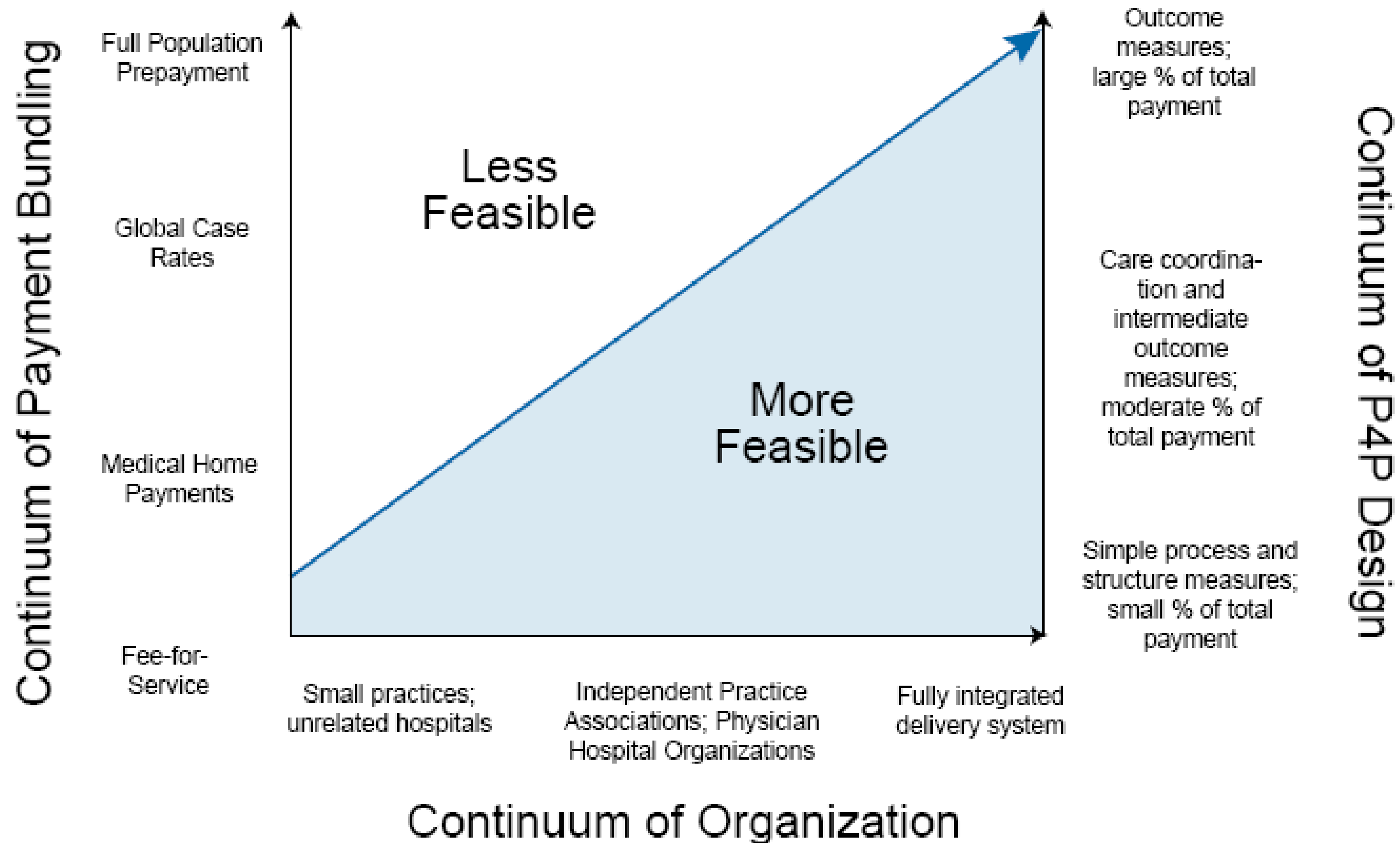
- *Announce the current model "dead" and set a new direction by aggressively building the new organization capable of offering bundled pricing of services, managing chronic disease in the ambulatory setting, and contracting with payers for quality premiums, a share of savings, and risk contracts. Embrace the opportunity (strategic).*

Option #6 **- *Find a Niche***

- *Recognize that transformation into an ACO is too great a change for the organization to achieve, and pursue a niche that can provide a unique service to the market.*

Strategy Linked to State of Market and View of Future

A health system's strategic path with physicians should be dependent on both the state of the market and your view of the future



Source: The Commonwealth Fund, 2008

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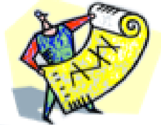
Getting from Here to There

How to get from A to B?

Paralyzed by the Crevasse



FEE FOR SERVICE

- A system we know - all about "heads in beds"
- Low margin, but it works
- Contribution margin analysis always puts hospital at center
- Need only to provide a great operating environment for MDs – not true integration

Whither Margins?

BUNDLED PAYMENT

- Seems so "90s"
- Got burned on this 15 years ago
- How much of this business will there be?
- Will our system really get the upside of keeping patients out of the hospital?

Hospital Leadership Dilemma? – or Not

For some systems, no immediate organizational imperative to change

What to do if you have <u>no burning platform</u>, but everything around you is on fire?

- *Hospital record profits '09*
- *Demand (disease) rising*
- *No new competitors*
- *Specialty hospitals on hold*
- *Insurers weak*
- *Physicians disorganized*
- *Private practice failing*
- *Primary care withering*
- *Consumer choice limited*

Hospital Plan

Build more towers and beds?
Hire more specialists?
Open (provider-based) urgent care centers?
Build free-standing EDs?

Accountable Care

Hospital Systems have a steep ambulatory care learning curve

Is an Emergency Hospital Admission a…

OR

Good Thing!?......
- Fill a bed, take x-rays, do a procedure

$$$$$

..an Ambulatory Sentinel Event?

- Missed appointment?
- Unable to get into clinic?
- Failed to fill prescription?
- Unable to get Rx refill?
- PC / specialty miscommunication?
- Patient misunderstanding
- Failure to listen to patient?
- Missed lab or xray report?

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Physician Integration Strategies

Approach to Crossing the Crevasse

- Develop and grow the employed (multi-specialty) group
- Create a Clinical Integrated Network (CIN)
- Build patient centered medical homes (PCMH)
- Find Insurance Partners

21st Century Healthcare System

Insurance Partners (Payment Reform)

Clinically Integrated Network

Multi-Specialty Group (including Prim Care)

Hospital System

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ACO Readiness

Category	Assessment
Governance	*Evidence the Organization's governing body and Leadership are ready and capable of directing the changes necessary to transform the business model.*
Executive Leadership	*Evidence the Executive Leaders (including Hospital Leaders) can articulate the need for a business model transformation and are prepared to move forward with a new business model.*
Clinical Leadership	*Evidence the organization values and actively promotes physician leadership , perspective and input at the highest levels of the enterprise. Evidence that System Clinical Leaders are ready and capable of leading a business model transformation.*
Organizational Design	*Evidence the organization has been designed to promote physician and patient (customer) input into both business and clinical decisions at all levels of the system.*
Primary Care	*Evidence the hospital system and specialty providers recognize the critical role of primary care in and ACO, and support the development of PCMHs and PC payment reform*
Physician Network	*Evidence the Organization understands the need to organize and align primary and specialty physician practices into a broad network and understands the key support role the hospital system can play.*
Care Management	*Evidence the organization has the clinical leadership, understanding and support systems to adopt promote evidence-based medicine and implement best practices across the care continuum.*
Quality Management	*Evidence the organization leadership, skills and processes to effectively measure, report and manage clinical quality across the continuum of care.*
Strategic Alliances	*Evidence the organization has reached out to other systems and consortiums to share information, learn and develop best approaches to common issues in achieving the triple aim of greater access, improved quality and cost containment*
Information Technology	*Evidence the organization has invested in the information technology leadership and systems necessary to support the system business transformation.*
Financial Condition	*Evidence the organization has the financial strength to invest in required infrastructure and still sustain the enterprise during the business model transformation.*
Payor Relations / Market	*Evidence the local payer market and MCOs are motivated, willing and capable of partnering with the health system to achieve the transformation.*
Local Healthcare Market	*Evidence the local market is requiring change and that business and regulatory circumstances are aligning to allow the organization to pursue transformation*

For more information

For more information contact
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And mention the “ACO Readiness Presentation”

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