ACOs: What you need to know need to be successful

Our values guide everything we do.

Integrity
We do the right thing for the right reason.

Excellence
We strive to deliver the highest quality and value possible through simple, easy and relevant solutions.

Inspiration
We inspire each other to explore ideas that can make the world a better place.

Caring
We listen to and respect our customers and each other as we act with insight, understanding and compassion.
Our diverse suite of tools and services enable the ACO model and make Aetna a partner of choice.
Our Beliefs about Risk Transition

- Moving toward risk requires 3 primary steps
  - Data has to be a strategic imperative
  - Performance and Risk have to be assessed and benchmarks set along with disease management applications:
    - 34% of patients have a chronic disease and it costs us 67% of the dollars.
  - Provider and Patient Engagement is difficult and critical to success
- Technology tools and process change are used to drive
  - Population Management/Disease Management
  - Improved Utilization Management
    - Risk Stratification
    - Care planning and execution
  - Improved Care Coordination
  - Patient Engagement to improve health and to educate are equally important
- Three levels of interaction
  - Retrospective – Claims based
  - Near-Real Time – Claims plus EBM
  - Real-Time – HIE enabled

Local Clinically Integrated Network – Standard Model

- Market leading health systems in a Tiered Narrow Network
- Patient engagement tools for navigation, wellness and personal health
- Narrow network of employed and affiliated PCPs and Specialists – Starts as PCMH model
- Employers and CMS buy based on value
- Data Management tools that identify the highest risk patients, track performance based metrics and enable detailed reporting to the physician level.
- Population Management, including Disease and Care Management
- Performance Based Payment Structure – $ provided by a shared savings pool and the CIN determines distribution of their share.
**Clinically Integrated Network – Data Flow**

1. **Collect Data**
2. **Normalize Data**
3. **Plan Care**
   - Plans of care are generated using evidence-based guidelines. Alerts are only used in rare cases when necessary as early warning.
4. **Coordinate Care**
   - Virtual care teams are created & coordinated.
5. **Engage Patient**
   - Patients are engaged, receiving clinical summaries & health action reminders.
6. **Manage Populations**
   - Patient populations are monitored & measured.
7. **Results, reports, and outcomes are collected & aggregated.**

**Health Information Exchange – creates a communication network of real time data.**

**Health ontology is applied.**

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**Data Infrastructure Requirements**

- EMRs can now connect to all other EMRs in a communications network – no rip and replace.
- Maintain unique EMR structure – communicating with other Health System and Physician EMR’s through a translation process.
- Rapidly deploy clinical interoperability in incremental steps – implementation expertise through templates.
- Standards-based approach (HL7, CCHIT, HITSP, etc.) - leave no integration technique or care setting behind.
- Flexibly configured architecture adapts to environment – true distributed and service-oriented architecture for most mission critical services.
- Ensure reliability, availability and scalability – fault tolerance, high availability, and disaster recovery designed into solution.
- Deliver highly secure information collaboration across all stakeholders – compliant compliant compliant.

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**ACO**
Unified Data Management – Solution: Health System Analytics

Data Sources
- Patient Demographics
- EMR Clinical Data
- Lab Order and Results
- EBM Guidelines
- Benchmarks
- Provider Information
- Surveys/HRA
- Contracts/Benefits
- Provider Billing
- Revenues
- Patient Registries
- Medical Claims
- Pharmacy Claims
- Authors/Referrals
- External Data
- Populations/Markets

HDMS Provided Functionality
- Fully Integrated Data with Standard and ad hoc reporting functionality

Analytics/Outputs
- Quality Metrics
- Episode of Care
- Predictive Modeling
- Gaps in Care
- Prospective Risk
- Severity Adjustment
- Population Profiling
- Provider Profiling
- Patient/Registries Improvement
- Opportunities System Level ROI
- CRM & Marketing
- Strategic Planning
- Workflow Info Delivery
- Patient Registries Delivery
- Outcomes Measurement

Value Delivered
- Support & Improve alignment of goals & incentives between the entities within the System
- Deliver the right information at the right time to the right place to maximize care efficacy, service, decisions

Executive Dashboard (.pdf)

Metropolis ACO

Report generated: January 2011

Overall Expenses

Inpatient Facility Utilization

Outpatient Facility Utilization

Enrollment

Professional Detail

Quality Measures - Condition Specifics & Other Measures

Accountable Care Solutions from Aetna
Population Management Requirements

- Ability to manage chronic conditions beyond episodes of care
- Ability to track and monitor patients any time they receive care in the high performance network
- Co-morbidity Management
- Educational tools and resources
- Combining Health and Wellness
- Coaching and counseling

How Well Do You Know Your Population?
The Patient Registry dashboard offers a population level view of risk stratification across conditions, with drill downs to the patient level.

How Can I Proactively Improve the Quality Measurement Performance across my Panel?
Quality Measures Dashboard

The Quality Measures dashboard incorporates data from all available sources and tracks compliance against the most important measures.

Quality Measurement Reports – Risk Profile

Active CareTeam – QM Clinical Risk Profile Report

As of <mmm yyyy>

Patients for <Primary Care Provider ID> compared to <Account Level (client, provider org, county, practice)>

Report run on yyyy-mm-dd hh:mm am/pm Page x of y
How Can I Effectively Decrease Readmission Rates for the Patients I Manage?

Integrated Discharge Assessments

The Care Manager can address open actions after reviewing the hospital discharge plan and assign action accordingly to coordinate ambulatory and transitional care to help prevent readmission.
How Can I Proactively Manage My Care and Stay connected with My CareTeam?

Patient Engagement Tools – Personal Health Record

- Ability to Chat with a Health Coach*
- Using common record
- Assignments from Health Coach
- Digital coaching sessions for conditions and lifestyle behaviors
Patient Engagement Solution

The challenge to changing patient behavior is getting relevant, concise and actionable content in the hands of the patient at the moment they are contemplating care, and facilitating provider/patient communication. Our solution will positively impact:

- Non-urgent ER visits
- 30-day Readmissions
- Out of Network Care

Leverage our industry-leading platform and distribution capabilities to uniquely engage patients and influence their care choices through the following solutions:

Care Coordination Tools

- Prescription Refill
  - The user can select to refill their prescription electronically either from their saved medication or from the list of catalogued medications.

- Appointments by Proxy
  - Through a revamped customer portal, providers can create referrals. They find the correct doctor by providing the date range, specialty and appointment reason, location, and network.
  - After identifying the correct doctor, the patient information and notes may be input. If integrated, may be imported from an EMR.

- Clinical Inbox
  - Users have a secure inbox with to allow them to send and receiving secure messages to and from providers.
  - Test results, discharge instructions and provider email messaging are just a few of the options with this feature.

- PHR Info Selection & Transmission
  - Users can view their PHR from within personalized portion of our platform. Users can select the PHR information they would like to send and securely transmit it to a provider.
  - After selecting a provider with secure messaging enabled, the user’s PHR information is sent directly to the provider.
Aetna’s ACO Experience

Collaborations offer value beyond a contractual relationship

ACOs aim to improve quality, enhance patient experience and reduce cost for ACO members.

**Joint Operating Council**
- Integrated Aetna claim data and ACO clinical data provides a comprehensive patient view allowing a variety of in-depth, stratified analyses to help identify at-risk ACO patients early.
- Aetna and ACOs work together as one team, meeting on a regular basis to review the analyses, identify trends, and develop improvement plans.

**Doctor-Driven Outreach**
- ACOs drive outreach to at-risk patients to engage them in targeted Care Delivery programs.
- Doctor-driven outreach tends to increase patient engagement so employees can be healthier.

**Aligned Incentives**
- Provider incentives are based on value, not volume of services.
- We measure value with specific quality and efficiency metrics designed to help ACO patients receive the right care at the right place at the right time.
Impressive results from Accountable Care: Results from Banner Health Network ACO

- Aetna and Banner Health Network have collaborated to deploy an insurance plan, technology and care management capabilities across multiple populations.
- The goal is to achieve medical cost savings, quality improvement and an enhanced patient experience.
- Early results for 2012 are showing year-over-year improvements as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial premium reduction</td>
<td>8–10%</td>
</tr>
<tr>
<td>Medical cost savings</td>
<td>3.9%–4.5%</td>
</tr>
<tr>
<td>PCP visits increase</td>
<td>0.5%–1.2%</td>
</tr>
<tr>
<td>Hospital admissions reduction</td>
<td>0.9%–1.6%</td>
</tr>
<tr>
<td>Hospital readmissions reduction</td>
<td>2.0%–5.0%</td>
</tr>
<tr>
<td>Lab utilization reduction</td>
<td>3.5%–4.5%</td>
</tr>
<tr>
<td>Radiology utilization reduction</td>
<td>5.3%–6.0%</td>
</tr>
</tbody>
</table>

*Medical results above are generated by the Pioneer Medicare population. Commercial population results are not yet available.

Accountable care benefits all stakeholders

**Lower cost, higher quality, enhanced member experience**

**Employers**
- Cost savings
- Sustainable solution
- Improved quality
- Enhanced wellness and care management
- National network
- Improved employee productivity

**Consultants/Brokers**
- Innovative client cost savings solution
- Increased growth through opportunity to differentiate
- Quality indicator reports, for self-insured cases

**Members**
- Enhanced member experience
- Lower out-of-pocket costs
- Quality-based, coordinated care
- Broad network access
- Tools to support a healthy lifestyle

**Aetna and ACOs**

**Care Providers**
- Reimbursement incentives aligned with efficient, quality care based on measures and patient satisfaction
- Technology enhancement supporting care coordination
Thank you

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