ACO Healthcare Delivery Systems
Metrics and Money
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Board Chair Methodist Patient Centered ACO
Methodist Health System
Dallas, Texas

Learning Objectives:
Understand Population Management and its role in today’s and tomorrow’s health care delivery systems

Understand evolving metrics around quality, patient experience, utilization, and cost efficiency

Understand financing options for supporting operations of population management

Understand the primary care physicians’ roles in accountable care systems
First-Curve to Second-Curve Markets

How will health care delivery systems successfully navigate the shift from first-curve to second-curve economics?

Value-Based Second Curve
- Payment rewards population values: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives, encouraged coordination

Volume-Based First Curve
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

Highlights of our ACO

Medicare Shared Savings Program
- 15,000 attributed Medicare beneficiaries
- Top Quartile Performance on 33 Quality metrics including CAHPS patient experience survey-7000 data points
- Primary Care visits based attribution model
- 234 total participating physicians
- Incentivized performance improvement across the continuum generated $12.7 million year 1
- 1 of 52/220 nationally to qualify for shared savings

Physician Engagement
- NCQA PCMH level 3 recognition and BTE recognition of most primary care practices
- Extended hours, open access, population health management

Employee Health Plan Medical Home Program
- Targeted 1000 employees/ Participation by 500 over 3.5 years
- 817 pounds lost
- 39% achieved BMI < 30
- 90% controlled blood sugar
- 75% report exercising >4 days per week
- 20% reduction in medical claims expense compared to matched controls
Population Health Definitions

Population health has been defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group”. It is an approach to health that aims to improve the health of an entire human population.

The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Managing the health of a population is fundamentally DIFFERENT than how health care is delivered today.
What is a PCMH?

PCMH recognition benefits

- Capital Health Plan, Tallahassee, FL
  - 40% fewer inpatient stays
  - 37% fewer ER visits
  - 18% lower health care claims costs
- Geisinger Health System, Danville, PA
  - 25% fewer hospital admissions
  - 50% fewer hospital readmissions
  - 7% lower cumulative total spending
- Group Health of Washington, Seattle, WA
  - 15% fewer inpatient stays
  - 15% fewer hospital readmissions
  - Estimated costs savings of $15 million (2009-10)
  - 18 - 65% improvements in medication management
Savings data from BTE evaluations

The study in MA focused on practices that were engaged in transformation and receiving incentives for all BTE programs.

Average yearly per patient savings with recognized physicians was $245 using price-neutralized episodes.

The studies from BTE and Ingenix on DCL showed savings of $370 per diabetic patient per year.

The studies from Medstat on DCL showed savings of $400 per diabetic patient per year.

The Towers Perrin actuarial analyses showed savings of $550 per cardiac patient per year when BP control was demonstrated.

The Towers Perrin actuarial analysis showed savings of $125 per back pain patient per year when the imaging and peridural metrics are met.

Physician Engagement

Require participating physicians to provide quality performance data.

Distribution of shared savings $ keyed to:

– Attendance quality performance learning collaboratives
– Completion of performance improvement projects utilizing data to improve outcomes

Nurse navigators facilitate communication between providers

Pilot recalls/“population health management”
Population Health Outcomes

- 69% patient compliance
- 61% medication adherence
- 61% hospital admissions
- 58% hospital readmissions
- 55% ER visits
- Less absenteeism
- Better work focus

Metrics - Clinical Quality Performance

<table>
<thead>
<tr>
<th>Measure</th>
<th>A1C DE</th>
<th>A1C ACO</th>
<th>A1C Percentile</th>
<th>Mean Performance Rate</th>
<th>Median Performance Rate</th>
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<tbody>
<tr>
<td>Diabetic Ketoacidosis</td>
<td>462</td>
<td>154</td>
<td>16.1%</td>
<td>2.2</td>
<td>22.5%</td>
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<tr>
<td>Low Glucose Episodes (&lt;70 mg/dL)</td>
<td>462</td>
<td>281</td>
<td>55.1%</td>
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<td>52.5%</td>
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<td>High Blood Pressure (SBP &gt; 140/90)</td>
<td>462</td>
<td>270</td>
<td>74.2%</td>
<td>2.0</td>
<td>60.0%</td>
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<tr>
<td>Uncontrolled Use (A1C &gt; 9)</td>
<td>462</td>
<td>354</td>
<td>76.1%</td>
<td>2.0</td>
<td>73.7%</td>
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<tr>
<td>Any A1C DE</td>
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<td>117</td>
<td>75.1%</td>
<td>2.0</td>
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CY 2012 reporting
metrics-patient experience

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<tr>
<th>Measure</th>
<th>A1195</th>
<th>All ACOs</th>
<th>2/2</th>
<th>Not Available</th>
<th>2/2</th>
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<tr>
<td>Overall Patient Experience Summary Survey</td>
<td>81.95</td>
<td>81.89</td>
<td>79.45</td>
<td>81.06</td>
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<tr>
<td>Time Spent Waiting for Care, Appointment, and Information (ACSN)</td>
<td>91.09</td>
<td>92.80</td>
<td>92.05</td>
<td>94.30</td>
<td>92.81</td>
<td>92.05</td>
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<tr>
<td>How Well Your Doctor Communicates (ACSN)</td>
<td>91.53</td>
<td>91.81</td>
<td>90.80</td>
<td>91.57</td>
<td>91.81</td>
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<td>Access to Specialists (ACSN)</td>
<td>83.44</td>
<td>83.11</td>
<td>83.12</td>
<td>87.34</td>
<td>83.07</td>
<td>83.12</td>
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<tr>
<td>Health Promotion and Education (ACSN)</td>
<td>56.66</td>
<td>56.61</td>
<td>56.75</td>
<td>60.71</td>
<td>56.45</td>
<td>56.75</td>
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<tr>
<td>Speed of Decision Making (ACSN)</td>
<td>76.75</td>
<td>75.99</td>
<td>76.71</td>
<td>76.71</td>
<td>75.99</td>
<td>76.71</td>
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<td>Health Status Functional Status (ACSN)</td>
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<td>73.25</td>
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Patient Experience Summary Survey Measures from the CARPN Source

CY 2012 reporting

metrics-utilization

Admit per IE vs Available Admission Rate

Shaping the Future of Health Care
Population Health Management: Nurse Navigation

Looking At The Numbers...Effort...Cost

Inpatient/ER census
Crimson risk scores
Physician referrals
Case management referrals
Individual assessments

More than 50% of the cost

High Risk Group >400

Active Patient Panel 13,400

The rest of the cost

Level 6 - 1% to 3%

Level 5 - 5% to 7%

Level 3 and 4 - 40% to 50%

Levels 1 and 2 - The Rest
Nurse Navigation

- Risk stratification of entire population
- Nurse navigation based upon medical complexity
- Personalized navigation
  - Work collaboratively and maintains active communication with physicians, nursing, and other members of care team to execute against care plan
  - Ensures that the plan of care and services provided are high quality and cost effective
  - After hours/complications action plan
  - Attend physician visits, communicate between visits
  - Phone and in person following during transitions of locations
  - Medication reconciliation during transitions
  - Advanced directive
  - Social services

April-May 2013 Cohort
Total Members 14
Dec 12 – May 13
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<thead>
<tr>
<th>Overall PMPM</th>
<th>$10,000</th>
<th>$8,000</th>
<th>$6,000</th>
<th>$4,000</th>
<th>$2,000</th>
<th>$0</th>
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<tbody>
<tr>
<td>Admissions Per 1K</td>
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<td>2,634</td>
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<td>ED Visits per 1K</td>
<td>7,000</td>
<td>6,000</td>
<td>5,000</td>
<td>4,000</td>
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<tr>
<td>Avoidable Admissions</td>
<td>21%</td>
<td>14%</td>
<td>14%</td>
<td>28%</td>
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<td></td>
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<tr>
<td>Readmission</td>
<td>17%</td>
<td>9%</td>
<td>26%</td>
<td>29%</td>
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July 2013 Cohort
Total Members 52
March 13 – July 13
<table>
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<tr>
<th>Overall PMPM</th>
<th>$10,000</th>
<th>$8,000</th>
<th>$6,000</th>
<th>$4,000</th>
<th>$2,000</th>
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<td>Admissions Per 1K</td>
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<td>2,564</td>
<td>1,450</td>
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<tr>
<td>ED Visits per 1K</td>
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<td>6,000</td>
<td>5,000</td>
<td>4,000</td>
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</tr>
<tr>
<td>Avoidable Admissions</td>
<td>17%</td>
<td>9%</td>
<td>26%</td>
<td>29%</td>
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<tr>
<td>Readmission</td>
<td>17%</td>
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<td>26%</td>
<td>29%</td>
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</tbody>
</table>
Capitalize on Quality Experience

2007: IPA data collection and education
PCP then specialists

2011: Employed physician incentive program for performance
Physician directed metrics and incentives

2014: NCQA PCMH level 3 recognition
Pay for performance diabetes recognition
Improve Quality Performance

Wellness Advantage

Basic Wellness

Employer Wellness Solutions
Feedback

• “...refer anyone to me that is having doubts about doing it.”

• “I am so proud of this program and the success that I have experienced. The weight loss felt great and I have never, never ever lost weight while also not smoking. I also feel very confident of not smoking due to a stop smoking program and Chantix. I have been off Chantix for several weeks and still no desire to smoke. Thanks so very much for this program. I am so proud to be Methodist.”

• “The attention and priority the hospital has shown for this program and us has been amazing and definitely makes me feel proud to be a Methodist employee.”

Partners who have engaged
LiveBright
Financing Population Health

Many options

Superior Clinical, Experience and Financial Outcomes

Funding:
PMPM
Block grant
embedded care managers
“faith” investment

Population Health

Upside gain share only
Fixed fee/trend guarantee
2 sided risk model
Medicare Shared Savings

- Attributed patient base from where they received predominance of Primary Care Services
- Report on CMS 33 metrics performance/outcomes
- Yearly reconciliation relative to a weighted benchmark