Your Declaration of Independence: Creating an Infrastructure For Population Health
CORE CONCEPTS

• Administrative & Medical Demands of Population Health

• Strategies for Successful Participation in Physician-led ACOs

• Integration Pitfalls, Pearls, and how to “Survive” in an Independence Model

• Experiences from MD Value Care, a physician led ACO in Central Virginia
AGENDA

- Market Forces & the Changing Landscape
- Collaboration: The Need for “System-ness”
- Shared Governance
- Administrative Integration
- Physician Engagement
- Care Coordination
- Reporting
- Results & Opportunities
This year, US health care expenditures projected to be more than $3 trillion

Analysts estimate 1/3 to be “waste,” driving the shift to value-based care (VBC)

By 2020, over 50% of total healthcare payments will be paid through VBC programs

Medicare enrollment alone will rise from approximately 53 million people in 2014 to approximately 63 million in 2020

Enrollment in Medicare Advantage, Medicaid Managed Care, dual eligible programs and Health Insurance Exchanges expected to double by 2020

Expansion of government led VBC models are aligning healthcare payment and delivery, incentivizing providers to deliver high-quality care in a cost-effective manner
Protocols and electronic medical records have the most impact. New clinical tools and practices are being adopted quickly, and this trend is expected to continue.

<table>
<thead>
<tr>
<th>Tool/Program</th>
<th>Percentage of Physicians</th>
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<tbody>
<tr>
<td>Other</td>
<td>52</td>
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<tr>
<td>Wellness programs</td>
<td>62</td>
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<tr>
<td>Care coordinators</td>
<td>59</td>
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<tr>
<td>Adherence initiatives</td>
<td>75</td>
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<td>Physician extenders</td>
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<td>Electronic protocol access</td>
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<td>Electronic medical records</td>
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<tr>
<td>Standard treatment protocols</td>
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<tr>
<td>Telemedicine</td>
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<td>Transparency initiatives</td>
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<tr>
<td>Remote patient monitoring</td>
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<td>Predictive analytics</td>
<td>75</td>
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<tr>
<td>Comparative effectiveness data</td>
<td>97</td>
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Note: Left-hand chart includes percentage of times each was ranked as one of the top three most impactful, with equal weight given to each of the top three rankings.

Source: Bain Front Line of Healthcare Survey, January 2015
Innovative pricing models in use

- **Per outcome**: Price escalates in steps over time, based on individual patient outcome
- **Indications-based**: Price of treatment based on effectiveness for a given indication
- **Per member per month**: Insurance provider pays a flat fee per patient per month; pharmaceutical companies provide drugs to patients who present with the disease
- **Trial-based or sample**: First month free or discounted price for the first month

Note: Responses from nonsurgical physicians (primary care physicians, endocrinologists/diabetologists, medical oncologists and non-interventional cardiologists) Source: Bain Front Line of Healthcare Survey, January 2015
Desire & Incentive to maintain independence remains strong.

COLLABORATION
Case Study: Who is MD VALUE CARE

- 450+ Physicians
  - 54 Primary Care Physicians
  - 400 Specialists
- 20 Practice Administrators
- 2,700 Total Employees
- 137 Facilities in 14 distinct markets across Central Virginia
- Long history of cooperation
- “Fight the System”!
Board Structure
- 75% PCP
- MSSP requires community participation
- PAR agreements in place
- Capitalization structure

Committees
- Quality (8 docs)
- Admin & IT (20 administrators)
- Managing (7 lead administrators)
- Specialist Mobilization (20 administrators/docs)

Physician Leaders
- Strong communicators
- Practice champions
- Inclusive, comprehensive

Values

Purpose
**SHARED VALUES**

- Shared commitment and passion to be “the best”...in quality, cost and patient satisfaction
- Early focus on getting a foundation in place to measure outcomes and value
- Belief that contracting opportunities will be realized as value is demonstrated
- Envision a nimble network of quality physicians working collaboratively to improve outcomes
- Recognize that performance improvement must occur within each practice, as well as, across practices
- Independence is a strong and shared value, and partnerships with others will be developed where interests are aligned

**BUSINESS PURPOSE**

- To undertake business activities and undertake services to improve the quality and cost of the delivery of health care;
- To ascertain the feasibility of development of a physician directed accountable care organization (“ACO”);
- To develop and maintain such ACO;
- Engaged in such other activities as are related or incidental to the foregoing purposes or as otherwise approved by the Required Member Voting Group; and
- Engage in any other activities permitted by applicable law.
ADMINISTRATIVE INTEGRATION

READINESS ASSESSMENT
AJAC Publication details the MD Value Care process
Forms the basis for a well-structured project plan

MANAGEMENT INFRASTRUCTURE
Buy vs Build
Nimble, lightweight
Big question: who is determining incentives and distributions? How?

CAPACITY?
For extra...
...Patients
...Work in: Quality metrics Care delivery Coordination Reporting

WORKFLOW REDESIGN
Identifying patients in need of care, not just those who arrive, which has the potential to reduce your throughput
DATA SOURCES
- Claims
- Clinical measures
- CAHPS
- Fully integrated data warehouse

DATA USE
- Quality monitoring
- Reporting
- Analytics tools & staff
- Encounter activity

HIT IMPLICATIONS
- Disparate EMRs
- Health Information Exchange?
- Patient engagement & devices

CHOOSING PARTNERS
- PCP-Specialist relationships
- Hospital
- Behavioral Health
- SNF/Rehab/HH

ADMINISTRATIVE INTEGRATION
WHY IS PHYSICIAN ENGAGEMENT SO DIFFICULT?

• Because doctors...
  • Work by a doctrine
  • Beaten up and disrespected
  • Overworked
  • Still don’t understand the principles of managed care
  • Unclear on the opportunity
• And because physician engagement is always under resourced
TRAITS

- Passionate about patient care quality
- Short on resources
- Expensive EMRs functioning in default mode without an offset
- Unprepared for quarterbacking the value equation
- Quality metric management is burdensome
- What’s in it for my patient…and for me?

REQUIREMENTS

- Need iterative, face-to-face, credible help
  - Concepts
  - Data structuring
  - Role definition
  - Success management
- “How am I doing?”
- Role of the specialist
- Value of Care Management
**TRAITS**

- Better understand the principles of managed care
- Greater resources
- Greater leverage on cost and some quality measures
- Seeking a role
- See the future coming
- “What’s in it for me?”

**REQUIREMENTS**

- Iterative engagement on focused roles
  - Quality, cost and better PCP integration
- Comparative & competitive data
  - How can I do better?
- Loyalty in a changing marketplace
- Value of care management
- Leverage their talented administration, extenders
<table>
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<th>WHY</th>
<th>WHERE</th>
<th>HOW</th>
<th>WHEN</th>
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<tbody>
<tr>
<td>Fragmentation  Compressed PCP Disconnected specialist  Widening cracks  Impact of the recession  Preventable = opportunity  End of life preparation  Where to find help  Aligned to program needs</td>
<td>Embedded  Telephonic  Automated campaigns  Between sites of care  Face to face  Vended vs. home grown  Health plan</td>
<td>Integrated platform: the evolving nirvana RN, LPN, LCSW, RD Community services catalog  Physician informed and integrated  High risk patient and care gap closure  Integrated behavioral health  Encounter alerts</td>
<td>Now! It takes time to:  Stand up infrastructure  Acquire &amp; systematize data tools  Work on workflow kinks  Comfort physicians  Inculcate patients  Become a smooth running machine  Be ready to go when the contract happens</td>
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CARE COORDINATION PROGRAM DESIGN

- Physician Integration
- Evidence Based Algorithms
- Predictive Modeling
- Health IT
- Co-morbid Risk
- Functional Status
- Gaps in Care
- Behavioral Health
- Transitional Care
- End of Life
- Care Coordination
ADVANCED ILLNESS PROGRAM CAPABILITIES

All Programs are Delivered in Partnership with Local Physicians

- **CareBridge™**
  - Coleman model PDCM
  - Integrated with local market resources and physicians

- **Engage™**
  - Complex case management
  - High risk
  - Clinical algorithms + predictive modeling

- **Pathways™**
  - Intensive co-morbid condition protocol-based interventions: Face to face

- **Beacon™**
  - Supporting end of life care
INTEGRATED CARE: HEART FAILURE

FOCUSED CARE FOR THOSE WITH THE GREATEST NEED

MDVC Care Compact
Defined Roles and Responsibilities
- HF medications
- Hospitalization
- Transitions of care
- Co-morbidity management
- Care coordination
- Gaps in care closure
- MDT meetings
- Home visits

Mutual Standards of Care
- Communications
- Office visit referral access
- Shared information
- EMR access for care managers
- Education
- NCQA specialty measures

Shared Value Proposition
ACO REPORTING SHOULD...

- Reflect the needs of the recipient
- Mirror the success factors of the organization/program
- Reiterate previously shared messages
- Inspire action
- Serve as an adjunct to the communication plan
GOVERNANCE
- Utilization & cost
- Quality performance
- Care mgmt. performance
- vs Benchmarks
- Medical expense mgmt.

PHYSICIANS
- Patient level reports, care management activity
- Comparative physician level performance - clinical metrics
- Report card

PRACTICE
- High level ACO performance against goals
- What drives success
- Comparative practice and physician level performance

REQUIREMENTS
- Data sources (CMS, Payers, EMR, CMIS, HIE, quality and cost dashboards)
- Analytics tools and staff
- Must include identified opportunities and solutions

REPORTING TARGETS
REPORTING TARGETS

Dr Smith’s Report Card (by Percentile)

- Quality
- Drug
- ER
- Readmission
- Hospital
- Cost
RESULTS & OPPORTUNITIES

2014 Reconciled National Performance Results

Source: Florida Association of ACOs (FLAACOs) (2015)
IN YEAR 1 MDVC...

- Achieved 100% quality reporting performance score
- Performed well on quality reporting, cost & utilization compared to the average MSSP ACO
- Did not achieve 2.8% reduction below expenditures benchmark
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- Achieved 100% quality reporting performance score
- Performed well on quality reporting, cost & utilization compared to the average MSSP ACO
- Did not achieve 2.8% reduction below expenditures benchmark
IN YEAR 2 MDVC...

- Just completed 2015 chart abstraction and GPRO submission
- In aggregate, MDVC practices demonstrated significant improvement along core quality measures
- Cost & utilization trends are moving in the right direction
MDVC

ACCOMPLISHMENTS

PROGRAMS & PLATFORMS
• Implemented 10 new evidence-based high risk care management programs
• Established a technology framework by leveraging five new IT platforms

NETWORK MANAGEMENT
• Developed an evaluation framework, partnership requirements and agreements for recruitment
• Created a proprietary algorithm for identifying potential high value post-acute care partners

COST & QUALITY
• Improved all abstracted ACO 33 measures, 8 significantly
• Reduced ER visits, acute hospitalizations, readmissions and complex radiology events
• Reduced the relative cost trend

INSIGHT & ENGAGEMENT
• Matured the organizational culture
• Coordinated physician and practice educational events, established recurring patient engagement
MDVC

IN DEVELOPMENT

RECENT LAUNCH OF HOME HEALTH NETWORK

SKILLED NURSING
• Facility network
• SNFist

POST-STROKE CARE COORDINATION PILOT

REFERRAL HUB

MOBILE DEVICES INTEGRATED WITH CM
**DESIRED ACCOMPLISHMENTS**

- Pride in our results and outcomes
- Recognition as being a true leader in population health and clinical outcomes
- Higher patient and physician satisfaction
- Solid infrastructure in place for sharing clinical data, population health, outcomes, and patient satisfaction
- Value-based contracts with aligned incentives
- Viable and sustainable business enterprise

**THE GOAL: IHI TRIPLE AIM**

- Improving the health of populations; and
- Reducing the per capita cost of health care; and
- Improving the patient experience of care (including quality and satisfaction).
QUESTIONS?

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inHEALTH
innovative | integrated | inclusive

MD Value Care
your trusted health partner