

# Levers of Successful ACOs

**Health Care Transformation Task Force**

December 5, 2017

# Speakers



**Danielle Lloyd, MPH**

Vice President of Policy and Advocacy  
Premier, Inc.

*Danielle Lloyd leads Premier's policy analysis and development. Lloyd also plays a leading role in Premier's large-scale provider collaborators. Lloyd received her bachelor's degree from the University of Pennsylvania and MPH from the University of California, Berkley.*



**Marci Sindell, MBA**

Chief Strategy Officer, Senior Vice  
President of External Affairs  
Atrius Health

*At Atrius Health since 2006, Sindell leads strategy development and execution, public policy, government relations, and marketing and public relations for Atrius Health. Sindell received a B.S. Materials from Rensselaer Polytechnic Institute and her Master's degree in Business MBA from Stanford University Graduate School of Business.*



**Richard Lopez, MD**

Chief Medical Officer of VNA Care and  
Senior Vice President of Population Health  
Atrius Health

*Dr. Richard Lopez, a primary care physician at Atrius Health since 1982, serves as SVP, Atrius Health, and CMO, VNA Care. Dr. Lopez's focus includes population health, analytics, care/medical management, clinical aspects of payer/hospital contracting, and clinical programmatic integration of Atrius Health and VNA Care. Dr. Lopez received his B.A. and M.D. from Boston University.*

# Agenda

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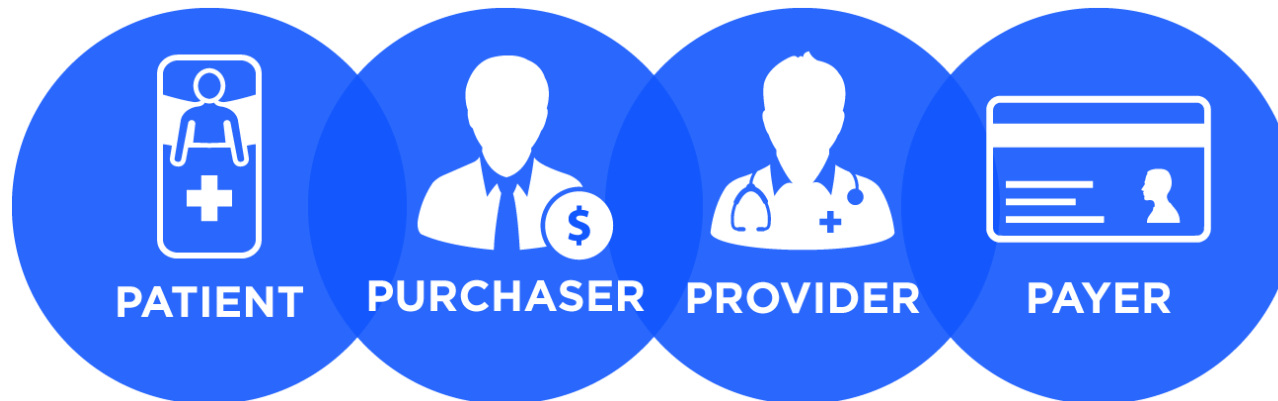
- Introduction to the Health Care Transformation Task Force
- Levers of Successful ACOs report: Project Introduction and Findings
- ACO Case Study: Atrius Health
- Q&A
- New Resource

# Who we are: Our mission to achieve results in value-based care



The **Health Care Transformation Task Force** is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change, both for ourselves and our country.

**We aspire to have 75% of our respective businesses operating under value-based payment arrangements by 2020.**



# Our Members: Patients, Payers, Providers and Purchasers committed to better value



# Agenda

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## Levers of Successful ACOs: Introduction

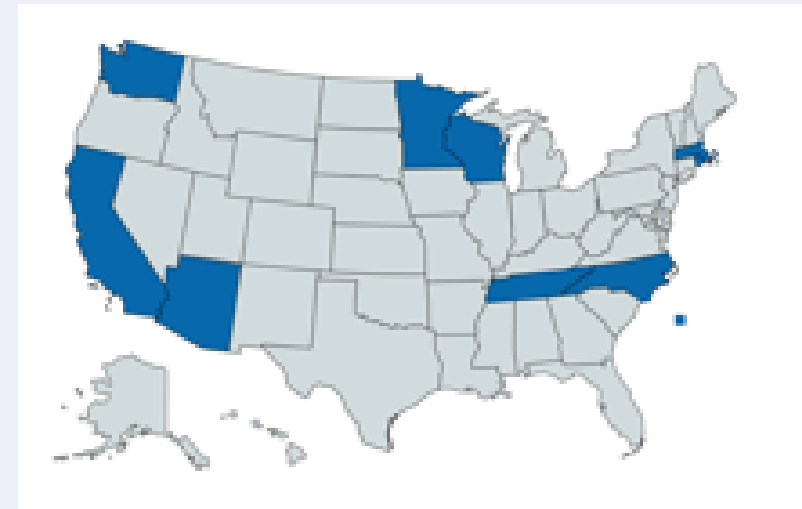
- Research product of the HCTTF Accountable Care Work Group
- Findings represent the experiences of select high-performing ACOs, including HCTTF and non-HCTTF members
- Defining “success”:
  - Shared savings rate  $\geq 2\%$
  - Quality score  $\geq 90\%$
  - Below-average baseline
  - $\geq 5,000$  ACO-covered lives
  - More than one year under an accountable care contract • At least one commercial ACO contract (in addition to a Medicare ACO contract)
  - Diverse geographic representation (preferred)



# Levers of Successful ACOs: Introduction

- Based on qualitative interviews with 11 ACOs that met the selected “highly successful” criteria

ACO Name	Headquarters
Allina Health	MN
AnewCare Collaborative, LLC	TN
Atrius Health	MA
Arizona Connected Care, LLC	AZ
Aurora ACO	WI
Banner Health	AZ
CaroMont ACO	NC
Coastal Medical, Inc.	RI
ProHealth Solutions, LLC	WI
Providence Health & Services	WA
MemorialCare	CA







# Levers of Successful ACOs: Report Findings

## Part 1: Identifying the Levers of ACO Success

- Introductory report providing background, detailed methodology, and ACO selection criteria.

## Part 2: Achieving a High-Value Culture

- Describes pre-ACO commitment from leadership and ongoing efforts to instill an organizational culture conducive to value

## Part 3: Proactive Population Health Management

- Operationalizing patient risk stratification and care management and patient engagement functions

## Part 4: Structure for Continuous Improvement

- Explains strategies for sustaining performance improvement through training, feedback, and incentives

Report available: <http://hcttf.org/accountable-care/>

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# Atrius Health



**A national leader in delivering a system of high-quality, connected care.**

**Patients:** 740,000 adult and pediatric patients in Eastern Massachusetts

**Medical Staff:** 900 physicians (MD, DO, DPM, PhD, PsyD) representing more than 50 specialties across 30 clinical practice locations

**Multi-Specialty Medical Groups:** Dedham Medical Associates, Granite Medical Group, Harvard Vanguard Medical Associates, PMG Physician Associates

**VNA Care:** Home health, palliative care and hospice

**Quality:** Consistently in the 90<sup>th</sup> percentile

**Revenue:** \$1.9 B

- Typically assume risk for all costs of care
- About 75% of gross revenue and 50% of patients in value-based contracts, including Medicare, Medicaid, commercial

# A Legacy of Managing Care

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**Multi-Specialty practice:** Enables close relationships and curbside/e-consults among primary care and specialists.

- Behavioral health program integrated with primary care
- Clinical pharmacists that do academic detailing, chronic disease management, and consult with patients
- Central laboratory, with lab, imaging and pharmacy typically on-site
- 24/7 telephone access to advanced practice clinicians

**Full-risk, Global Payment:** Most in-depth experience and expertise with third party commercial and government contracts.

- Among first to adopt BCBS-MA Alternative Quality Contract (AQC) in 2009
- One of 32 organizations selected for prestigious Medicare Pioneer Accountable Care model. Highest 2013-2015 quality scores among Massachusetts Pioneer ACOs and at top nationally in 2016
- One of 45 Next Generation Medicare ACO's in 2017
- Incited to move care out of hospital to lower cost settings and coordinate care

**Epic/Analytics:** 20 years of experience optimizing Epic.

- Advanced use with sophisticated data warehousing and analytics capability.
- Highest Stage 7 recognition from Health Information and Management Systems Society (HIMSS).
- Predictive analytics used to support clinical decision-making.
- Decision support within EMR to drive quality and cost performance

# A Legacy of Managing Care

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**Model of Care:** Physicians work in teams with Advanced Practice Clinicians (NPs, PAs), nurses, medical assistants, population health managers, clinical pharmacists, social workers, case managers and care facilitators. Extended teams with an NP home program and clinicians deployed in skilled nursing facilities.

**Patient-Centered Medical Homes:** Highest possible national certification as “Level 3 Patient-Centered Medical Homes” from National Committee for Quality Assurance (NCQA 2011), for coordinated care with focus on keeping patients healthy.

**Hospital Collaboration:** Extensive network of preferred hospitals with electronic health record (EHR) interoperability and ADT notification feeds.

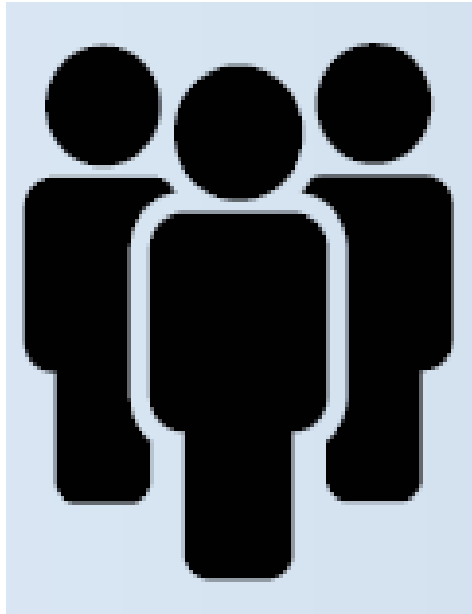
**VNA Care:** Moving care into the home to avoid ED, hospital, and post-acute facility utilization.



# Perspectives on the Levers of Successful ACOs



# Achieving a High-Value Culture



Lever of Success	Key Strategies
<b>Pre-ACO activities</b>	<ul style="list-style-type: none"><li>• Cultural commitment at the board level to delivering high-quality, efficient care</li><li>• Manage risk and quality performance for commercial and public contracts, including Medicare Advantage, Medicaid managed care, and large purchasers</li></ul>
<b>Involvement by senior decision-makers in ACO operations</b>	<ul style="list-style-type: none"><li>• Align governance bodies for multiple ACO contracts</li><li>• Engage clinical/administrative dyad structures at the governance level</li><li>• Involve patients in practice redesign</li></ul>
<b>Physician and community practice engagement</b>	<ul style="list-style-type: none"><li>• Co-create project plans with front-line staff</li><li>• Devise sub-groups for the purposes of education and performance measurement</li><li>• Utilize physician advocates to convey ACO policies and requirements</li><li>• Establish a parsimonious set of actionable performance measures</li></ul>
<b>Expanded clinical partnerships</b>	<ul style="list-style-type: none"><li>• Identify and engage high-performing post-acute and long-term care providers, including skilled nursing, home-health and hospice providers</li><li>• Embed nurse care managers within in-patient hospitals, emergency departments and skilled nursing to support transitions of care</li><li>• Integrate behavioral health with primary care to manage exacerbating co-morbidities</li></ul>

## Achieving a High-Value Culture

<b>Pre-ACO Activities</b>	<ul style="list-style-type: none"> <li>• Organizational major initiative driven by executive leadership</li> <li>• Driver diagram established teams</li> <li>• Work built on Medicare Advantage and Commercial risk</li> <li>• All Medicare patients treated alike</li> </ul>
<b>Involvement by Senior Decision-makers</b>	<ul style="list-style-type: none"> <li>• Atrius Health Board served as Pioneer Board</li> <li>• Small central team created with experienced Director, Accountable Care and including Epic analysts, data analysts, project managers</li> </ul>
<b>Physician engagement</b>	<ul style="list-style-type: none"> <li>• Champions from practices</li> <li>• Monthly ACO Day</li> <li>• Many educational sessions on geriatric care management topics</li> <li>• Work groups on specific areas of focus (skilled nursing facilities, VNA, advanced care planning, etc) with both clinical leaders and front line clinicians</li> </ul>
<b>Partnerships</b>	<ul style="list-style-type: none"> <li>• Established preferred hospital partners</li> <li>• Built preferred SNF network</li> <li>• Utilized VNA Care subsidiary</li> </ul>





# Proactive Population Health Management



## Lever of Success

## Key Strategies

Lever of Success	Key Strategies
<b>System for identifying high-risk patients</b>	<ul style="list-style-type: none"> <li>• Establish and utilize standard risk models based on claims and clinical data</li> <li>• Regularly test and refine the risk model for maximum risk predictability</li> <li>• Integrate real-time data sources where possible (e.g., ADT feeds)</li> <li>• Make the risk score actionable for clinicians and case managers using decision support tools</li> </ul>
<b>General care management functions</b>	<ul style="list-style-type: none"> <li>• Redefine the care management role and recruit/retrain staff to meet the new objectives of accountable care</li> <li>• Use a combination of centralized and embedded services to make most efficient use of face-to-face patient time, and regularly evaluate the right balance of services</li> <li>• Embed care managers in the emergency department, skilled nursing facility, and on inpatient rounds and care team huddles to support patient education and transitions of care</li> </ul>
<b>Specific disease management programs</b>	<ul style="list-style-type: none"> <li>• Identify priority conditions for the ACO population</li> <li>• Develop disease registries to track and refer patients to disease management programs</li> <li>• Engage clinicians to develop standardized clinical care protocols and close care gaps</li> <li>• Educate patients about effective self-management for chronic conditions</li> <li>• Initiate huddles among care management staff that have overlapping responsibility for the same patients</li> </ul>

## Proactive Population Health Management

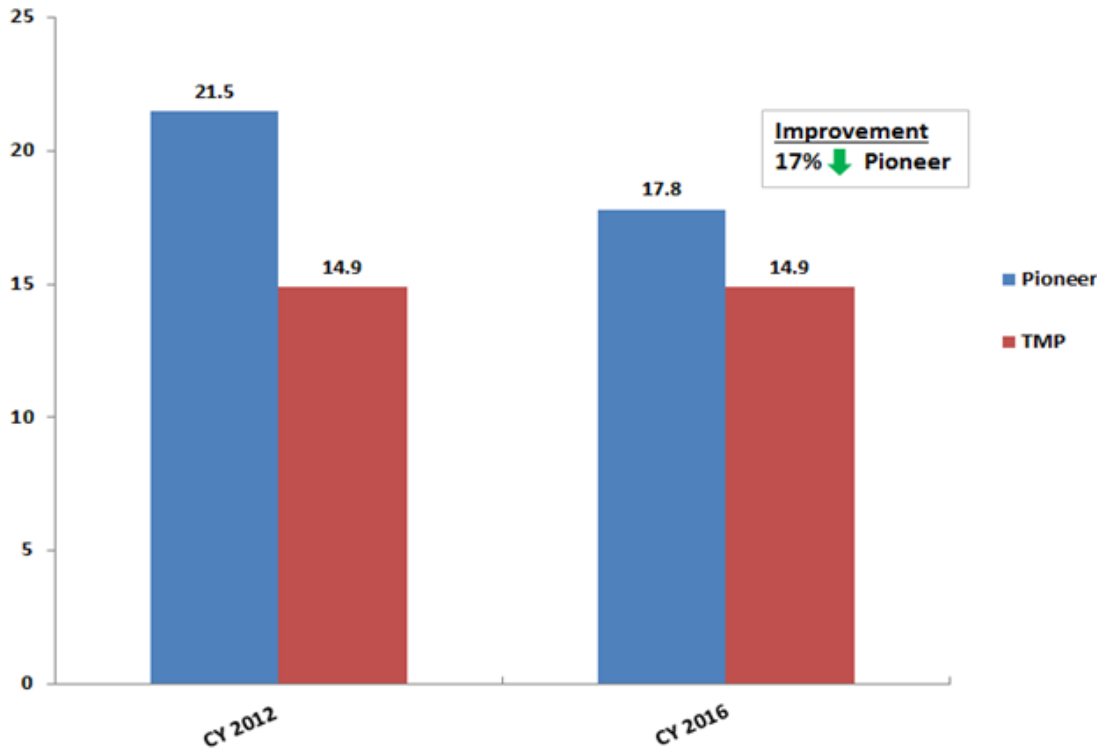
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- **Pioneer work was built on Tufts Medicare Preferred best practices**
  - SNF network, management basis of ACO SNF work.
  - Case management experience informed ACO CM.
  - TMP and ACO data provide on-going benchmarking.
- **Common Epic resources and tools**
  - High Risk Reports, Geriatric Checklist in Epic for all 65+.
  - Unified, improved Care Management assessment tools for all patients. Including in-house risk predictor, fall risk, depression screen, early id of CKD
  - Post-Discharge, Care Transition and post-ED workflows.
- **ACO supports TMP continued improvement**
  - ACO was foundation for expanding delegation to smaller practices
  - Clinical improvements supported 5 Star increases in revenue and enrollment opportunities

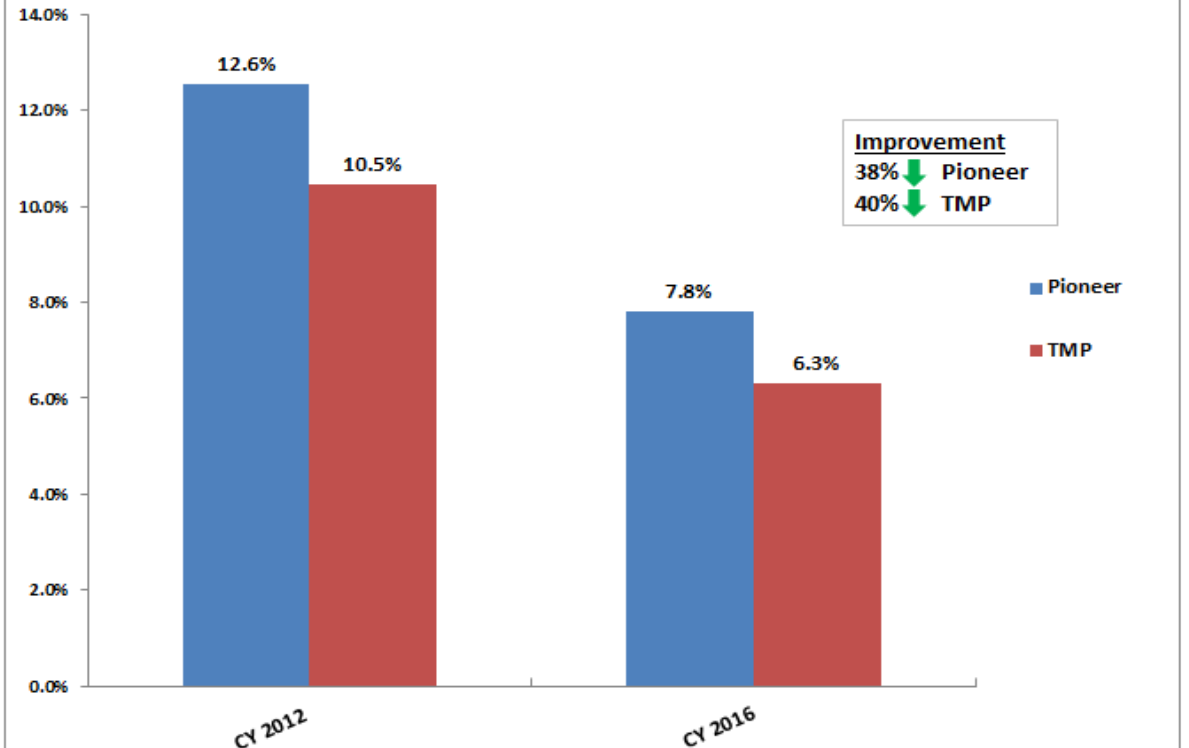
## Proactive Population Health Management

Staffing preferred Skilled Nursing Facilities in a preferred network and creating performance standards for clinicians and facilities led to decrease in average length of stay and readmits for both Pioneer and Medicare Advantage

### Reduction in SNF Average Length of Stay



### Reduction in SNF Readmit Rate

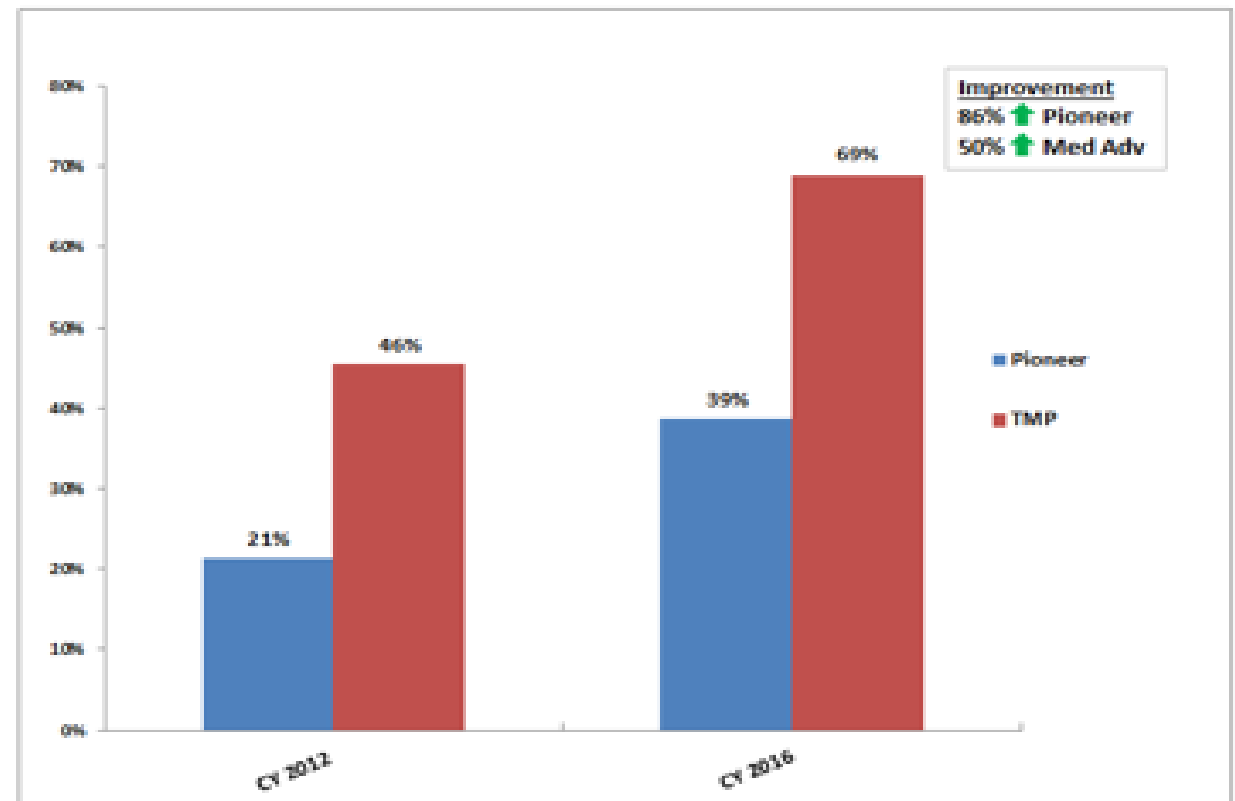


## Proactive Population Health Management

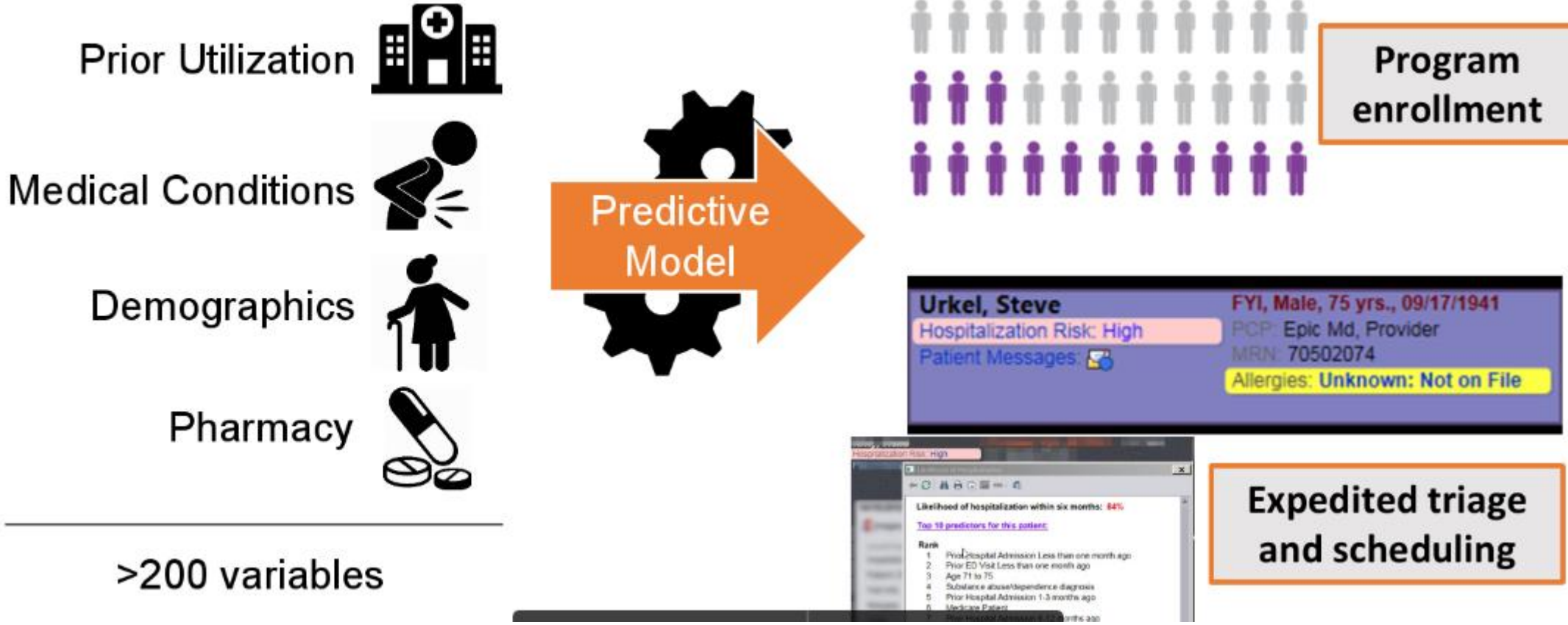
### Post-Hospital Coordination: One Care Team

- ✓ Next day start of care
- ✓ Common assessments
- ✓ Expanded home telemonitoring
- ✓ Capacity for one-time assessments, stat visits
- ✓ Tight coordination of home care and in office services during an episode

% HHA referrals to preferred VNA



# Proactive Population Health Management



**Built strong Predictive Analytics Capability, including validation and implementation**

## Proactive Population Health Management

**Providing right data to clinicians and their team is essential to driving outcomes and engagement:**

- “Purple people”
- Monthly quality reports by individual physician
- Quarterly cost and patient experience data by individual physician
- Rosters: diabetes, hypertension, COPD etc. with population health managers to do outreach
- 2-way web portals with preferred hospitals used 130k times/month
- ADT feeds of daily hospital census



# Structure for Continuous Improvement



Lever of Success	Key Strategies
<b>Operational infrastructure for performance measurement</b>	<ul style="list-style-type: none"><li>• Dedicate data/actuarial analysis and performance improvement resources to ACO efforts</li><li>• Streamline performance metrics across ACO contracts to maximize impact of interventions</li><li>• Integrate analytics, performance improvement, and clinical staff to design, pilot, and evaluate new workflows</li></ul>
<b>Tying performance to compensation and network contracts</b>	<ul style="list-style-type: none"><li>• Incorporate key quality and utilization metrics into compensation plans for employed physicians</li><li>• Establish separate funding pools to incentivize primary care process changes</li><li>• Develop network criteria for affiliated post-acute care providers and specialist referrals</li></ul>
<b>Participation in shared learning opportunities</b>	<ul style="list-style-type: none"><li>• Establish voluntary learning collaboratives with regional or model peers for best practice sharing and addressing common challenges</li><li>• Participate in national consortiums for easy access to content expertise</li><li>• Seek consulting resources and publications for data analysis and implementation guides.</li></ul>

## Structure for Continuous Improvement



- Analysts who work in EPIC and Claims Database to pull data
- Project managers to facilitate clinical initiatives
- Epic Analysts to configure decision support
- Consult to service lines, providing information, data, targets, and project management
- Implementation occurs within the service lines but performance measurement/tracking occurs within Performance Excellence



## Structure for Continuous Improvement

Almost all Atrius Health physicians are employed; a physician compensation committee recommends comp formula for each specialty; PCP's have 10% of compensation based on quality/patient experience.



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# Questions?

Use the question box on the Zoom screen

To access our materials and the recording of this webinar, please visit:

<http://hcttf.org/resources-tools-archive/2017/11/8/levers-of-successful-acos>

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# New Resource

Available in Partnership with NEJM Catalyst



## ECONOMIC INVESTMENT AND THE JOURNEY TO HEALTH CARE VALUE

Full reports available on <https://catalyst.nejm.org/navigating-payment-reform/>  
Additional reports available our website: <http://hcttf.org/tools-and-resources/>

### Providers

Examines the broader economic impact of provider investments in value, such as IT/data analytics infrastructure and expanded workforces.

### Payers

Identifies how payers are streamlining their efforts and positioning their businesses on value-based arrangements that have shown success in reducing costs and improving outcomes.

### Purchasers

Explores how employers continue to pursue innovative channels such as centers of excellence, high-performance networks, and bundled payments, among others, to tamp down costs and improve employee health.