Clinical Integrated Network and Population Health

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Teachers of Quality Academy
Learning Session 6: Population Health
November 3-4, 2014
Objectives

• Describe the clinically integrated network in the context of accountable care organizations.

• Define population health from the perspective of a health care organization.

• Describe the populations for which clinically integrated networks are created.

• Describe the effect of clinically integrated networks on the health of the population-at-large.

• Describe the role of the physician in population health from the perspective of a private health care organization.
Clinical integration (CI)

A healthcare network managing care across the continuum by using proven protocols to improve patient care, decrease cost, and demonstrate value

• maintaining a healthier overall population that maximizes patient satisfaction while minimizing resource consumption.
Is Your Care a Good Value?
An Introduction to the Choosing Wisely and High Value Care Initiatives

Suzanne Kraemer, MD, FACP
February 28th, 2014
NC Chapter American College of Physicians
The Value Equation

Value = \frac{Outcomes}{Cost}
The Case for High Value Care

- Estimated $700 Billion of “Healthcare waste” annually
- $250-325B in “Unwarranted use”
- $75-100B in “Provider inefficiency and errors”
- $25-50B in “Lack of care coordination”
We have been ordering more services...

- Two areas of greatest expenditures and most rapid growth: imaging and tests
ACP Took a Stand

- Helping physicians to provide the best possible care to their patients.
- Simultaneously reducing unnecessary costs to the healthcare system.
Choosing Wisely

Chest X-rays before surgery

When you need them—and when you don’t

If you’re scheduled for surgery, a pre-operative chest X-ray can sometimes help make it safer by identifying medical problems that might make it a good idea to delay or even cancel the procedure. But if you don’t have signs or symptoms of heart or lung disease, you should think twice about having the X-ray. Here’s why.

The test usually isn’t helpful for low-risk people without symptoms.

Many people automatically receive a chest X-ray to “clear” them before surgery, and some hospitals even require the test for almost all patients who are admitted. But serious abnormalities found through chest X-rays are uncommon in low-risk people, so most of the time all that’s needed is a careful medical history and physical examination. A chest X-ray doesn’t add much useful information for people without risk factors for heart or lung problems and rarely changes their treatment or helps the anesthesiologist and surgeon manage their care. In fact, in those people the test can produce false alarms that require follow-up tests that usually aren’t necessary and can add needless risk and expense.

It can pose risks.

A chest X-ray exposes you to a small amount of radiation. While the risk from any single exposure is uncertain, the harmful effects of radiation might be cumulative, so it’s best to avoid exposure whenever you can. Also, most abnormal test results from the X-ray must be followed up with additional tests to rule out a serious prob-
We Are Giving Ourselves Cancer?

RITA F. REDBERG and
REBECCA SMITH-BINDMAN

JAN. 30, 2014

http://www.nytimes.com/2014/01/31/opinion/we-are-giving-ourselves-cancer.html?_
Goal:

Decrease the use of low value health care services!
Definitions

- **Patient Protection and Affordable Care Act** (PPACA or ACA) – Healthcare reform law passed in 2010

- **Medicare Shared Savings Program** (MSSP) – program that started in 2012 that allows ACOs to contract with CMS with the goal of improving quality and efficiency. ACOs that contract with CMS are deemed as CINs

- **Population Health Management** – managing the care for a defined set of individuals with the goal of improving the quality, efficiency and patient satisfaction for the overall group
Definitions

Alphabet Soup

- **Accountable Care Organization (ACO)** - groups of providers who are willing and able to take responsibility for improving the health status, efficiency and experience of care for a defined population.

- **Clinically Integrated Network (CIN)** – Providers in a joint venture that meet the Federal Trade Commission (FTC) definition of an active and ongoing program that evaluates and modifies practice patterns by the venture’s participants and creates a high degree of interdependence and cooperation among the venture participants to control costs and ensure quality.

- **Clinical integration** - integration of clinical information and healthcare delivery services across the continuum of care to improve the value of the care provided. This may include preventive, acute care, post-acute, rehabilitation, home health services, and palliative care.
The Population Health Enterprise Model: Creating an Organized System of Care

A group of providers willing and capable of accepting accountability for the total cost and quality of care for a defined population.
Accountable Care Organizations (ACOs) or Accountable Care Delivery Systems, while still evolving, are expected to connect groups of providers who are willing and able to take responsibility for improving the health status, efficiency and experience of care for a defined population.
Balancing Accountable Care Delivery Activities

Positive Margin Impact

1. Reduction in high input costs
   - Supplies
   - Pharmacy
2. Performance improvements
   - Readmissions
   - LOS improvements
   - Site of service distribution across the care continuum
3. Growth
   - Increase market share

Negative Margin Impact

1. Reimbursement
   - Reduction in reimbursement trends
2. Utilization
   - Reduction in readmissions
   - Reduction in ED, radiology, and other utilization
   - IP to OP volume trends
3. Investment costs
   - Administrative
   - Clinical Care
   - Systems / IT infrastructure

Shared savings payments

Source: Adapted from Baptist Health System presentation
The Role of the ACO/CIN

- ACOs will promote the delivery of seamless, coordinated care that promotes better care, better health, and lower growth in expenditures by:
  - Putting the beneficiary and family at the center
  - Remembering patients over time and place
  - Attending carefully to care transitions
  - Managing resources carefully and respectfully
  - Managing the beneficiary’s care proactively
  - Evaluating data to improve care and patient outcomes
  - Using innovations focused on the three-part aim
  - Investing in care teams and their workforce
Shared Savings Program: ACO Structure

Typical ACO/CIN Structure:

ACO/CIN
- Legal Entity

TIN’s
- ACO Participants – Ex: Acute Care Hospital, Group Practice, Individual Practice, FQHC, CAH, LTCH, etc.

Provider
- ACO providers/suppliers that bill through ACO participants (e.g. physicians, NP, PA, CNS, pharmacists, etc.)
Shared Savings Program: Statutory Requirements

- By statute, ACOs must meet the following eligibility criteria:
  - Agree to participate in the program for at least a 3-year period
  - Have a sufficient number of PCPs for assignment of at least 5,000 beneficiaries
  - Have a formal legal structure to receive and distribute payments
  - Have a mechanism for shared governance and a leadership and management structure that includes clinical and administrative systems
  - Shall provide information regarding the ACO professionals as the Secretary determines necessary
  - Define processes to:
    - Promote evidence-based medicine
    - Promote patient engagement
    - Report quality and costs measures
    - Coordinate care
  - Demonstrate it meets patient-centeredness criteria
The Roadmap from Volume to Value

Don't Leave Money On The Table!
Why Now... (The Journey to Population Health Management)

**Changing reimbursement models:**
- Reimbursement cuts
- Value-based reimbursement
- Pay for performance contracts
- Tiered networks / payments
- Bundled payments / gainsharing
- ACOs/shared savings
- PCMH/care management premiums
- Global or total cost of care payment

1. Preparatory
   - Manage costs to reimbursement
   - Maximize performance
   - Engage physicians
   - Develop network
   - Capitalize on payment incentives
   - Balance the service portfolio/ growth strategies

2. Transformational
   - Manage episodes longitudinally
   - Address complex cases
   - Initiate care coordination
   - Employ data analytics
   - Utilize physician alignment models

3. Implementation
   - Establish insurance risk capability
   - Measure and monitor population health efforts
   - Narrow the network
   - Grow covered lives

4. Expansion

**Necessary capabilities in each of the stages:**

- Care redesign should not outpace reimbursement changes
### Shared Savings Distribution Model

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>ACO Type:</strong></td>
<td>Medicare</td>
</tr>
<tr>
<td><strong>Distribution Metrics:</strong></td>
<td>Quality, Patient Satisfaction, Utilization</td>
</tr>
<tr>
<td>**Hospital</td>
<td>Physician Split:**</td>
</tr>
<tr>
<td>**Specialist</td>
<td>PCP Split:**</td>
</tr>
<tr>
<td><strong>Provider Measure Split:</strong></td>
<td>40% Quality Performance Measures / 40% Patient Satisfaction / 20% Utilization</td>
</tr>
<tr>
<td><strong>Physician or Group Payment:</strong></td>
<td>Provider Group Payments</td>
</tr>
</tbody>
</table>
# MSSP Quality Measures (33)

## EXHIBIT 1

### Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure titles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/caregiver experience</td>
<td>Getting timely care, appointments, and information; how well doctors communicate; patients’ ratings of doctors; access to specialists; health promotion and education; shared decision-making; health and functional status.</td>
</tr>
<tr>
<td>Care coordination/patient safety</td>
<td>Risk-standardized, all-condition readmission; ambulatory care-sensitive conditions admission; chronic obstructive pulmonary disease, congestive heart failure; percentage of primary care physicians qualifying for electronic health records incentive program payment; medication reconciliation after inpatient facility discharge; screening for fall risk.</td>
</tr>
<tr>
<td>Preventive health</td>
<td>Influenza immunization; pneumococcal vaccination; adult weight screening and follow-up; tobacco use assessment and cessation; depression screening; colorectal cancer screening; mammography screening; proportion of adults having blood pressure measured within past 2 years.</td>
</tr>
<tr>
<td>At-risk populations</td>
<td></td>
</tr>
<tr>
<td>- Diabetes</td>
<td>Hemoglobin (Hb) A1c control (&lt; 8%); low-density lipoprotein (LDL) cholesterol &lt; 100; blood pressure &lt; 140/90; no tobacco use; use of aspirin; diabetes mellitus: HbA1c poor control (&gt; 9%).</td>
</tr>
<tr>
<td>- Hypertension</td>
<td>Blood pressure control.</td>
</tr>
<tr>
<td>- Ischemic vascular disease</td>
<td>Complete lipid profile and LDL cholesterol control &lt; 100 mg/dl; use of aspirin or other antithrombotic.</td>
</tr>
<tr>
<td>- Heart failure</td>
<td>Beta-blocker therapy for left ventricular systolic dysfunction.</td>
</tr>
<tr>
<td>- Coronary artery disease (CAD)</td>
<td>Drug therapy for lowering LDL cholesterol; angiotensin-converting enzyme inhibitor or angiotensin receptor blocker therapy for patients with CAD and diabetes and/or left ventricular systolic dysfunction.</td>
</tr>
</tbody>
</table>

**Source:** Centers for Medicare and Medicaid Services, “Improving Quality of Care for Medicare Patients: Accountable Care Organizations,” Fact Sheet, October 20, 2011
Top Ten Key Steps Taken by Successful ACOs

1. Identify/communicate/engage beneficiaries
2. Select and implement data analytics platform
3. Establish a public and physician communications plan and office
4. Identify your highest risk population (2-3% of patients that are currently or are predicted to be the highest utilizers)
5. Establish a process to capture and report 33 measures (GPRO)
6. Develop a plan to grow market share by using data analytics to identify leakage and develop action plan
7. Establish robust team based patient centered medical homes (PCMH) across the participating MSSP provider network
8. Establish and implement a care management plan for high risk patients
9. Define and finalize a shared savings distribution methodology
10. Assess post-acute care processes and local market providers
4. Identify your highest risk population

- Identify your highest risk population as 2-3% of patients that are currently or are predicted to be the highest utilizers generate 40% of your cost
  - Understand patient risk and cost across physician practices
  - Access metrics from the CMS quarterly report to drill into cost and utilization by beneficiary
- **Primary care protocols**
  - Avoid unnecessary lab, radiology and referrals
  - Helps avoid unnecessary ED visits and admissions
  - Promotes preventive services

- **Gaps in care alerts**
  - Monitor for needed preventive (primary and secondary) services

- **Condition specific care programs**
  - Target patients with specific conditions such as CHF, COPD,
  - Focus high touch outreach to these patients
  - 24 hour call line with ready access to non-ED care

- **ED admission avoidance**
  - If a patient does make it to the ED, limit admissions by following appropriate admission indications
  - Careful and immediately follow-up by PCP and condition specific care program
Hip Fracture Care Variation

Significant variation in home-going rates by surgeon
Medicare ACO program

Performance year results

- **Medicare Shared Savings Program**
  - Held spending $652M below targets
  - Earned shared savings over $300M
    - One ACO in Track 2 overspent target by $10M and owed shared losses of $4M
  - Saved Medicare Trust Funds ≈$345 M
  - Improved on 30 of 33 quality measures
  - Surpassed other Medicare FFS providers' performance on 17 of the 22 GPRO Web Interface measures

- **Pioneer shared savings:**
  - $96M (saved Medicare Trust Fund ≈$41M)
  - Showed improvements in 28 of 33 quality measures and experienced average improvements of 14.8% across all quality measures

**MSSP PY1 Financial Results**

- Earned shared savings: 24%
- Generated savings but did not pass MSR: 52%
- Did not generate savings: 24%

**Pioneer PY2 Financial Results**

- Earned shared savings: 13%
- Generated shared losses: 48%
- Did not surpass MSR: 26%
- Deferred reconciliation: 13%
Outcomes for some CIN’s: MSSP

In comparison, Partners Healthcare that was founded by Brigham and Women’s Hospital and Massachusetts General Hospital saved $14.4 million (or 3%) across 52,000 beneficiaries. This amounts to about $277 per beneficiary per year.

<table>
<thead>
<tr>
<th>Savings for Beacon Health</th>
<th>Total Savings for All 32 Pioneer ACOs</th>
<th>Total Savings for Partners Healthcare</th>
</tr>
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<tbody>
<tr>
<td>$499 per beneficiary per year</td>
<td>$130 per beneficiary per year</td>
<td>$277 per beneficiary per year</td>
</tr>
<tr>
<td>5% savings</td>
<td>~1% savings</td>
<td>3% savings</td>
</tr>
</tbody>
</table>

1 $87.6MM in savings over 669,000 beneficiaries are calculated to be ~$130 per beneficiary.
2 Partners press release dated 07/16/2013, see www.partners.org/about/media-center/articles/pioneer-aco-year-1-results.aspx
Results at Geisinger Health System

PTMPY: Per Thousand Members Per Year
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