Population Health: The Risks & Rewards

BY HOWARD LARKIN

For Heartland Regional Medical Center in St. Joseph, Mo., the future of risk-based reimbursement is now. All told, nearly half of the 352-bed community hospital’s patient revenue already carries some degree of performance-based risk. That’s three times the average of 14 percent reported by 1,300-plus hospitals responding to a 2013 AHA survey; it’s even well-ahead of the 27 percent those hospitals expect in two years [Fig. 1, Page 31.]

Consisting of the hospital and a network of 173 employed physicians and advanced practice nurses in clinics about 45 minutes north of Kansas City in northwest Missouri, Heartland derives about one-quarter of its revenue from a Medicare accountable care organization contract with both upside rewards and downside penalties for quality and cost outcomes. Another 7 to 8 percent come through commercial gain-sharing arrangements with only upside rewards so far.

Heartland is also at full risk for its employee health plan costs, and considers itself at full risk for self-pay and uninsured patients — many of whom are served through the Heartland Clinic, one of the oldest free health clinics west of the Mississippi and an integral part of the system’s mission. “Managing self-pay as well as our own employed population is critically important,” says Linda Bahrke, R.N., who administers Heartland’s community health improvement program as well as the system’s ACO.

Risk-based revenues will soon far exceed half at North Shore-LIJ Health System in New York City, predicts Howard Gold, executive vice president for managed care and business development at the system. While 95 percent of his system’s 2013 revenue was straight fee-for-service, “in five to seven years, only 20 to 25 percent will be fee-for-service; the rest will be some form of value-based contract — shared savings, shared risk, full risk, narrow network, bundled pay or pay for performance. Dramatic change is going to occur in 2014, 2015 and 2016.”

Yet, rather than shy away from ostensibly more revenue risk, both North Shore-LIJ and Heartland are actively pursuing performance-based contracts with private and commercial payers. That’s because they are both redesigning their delivery systems for population health management.

Making the transition

Heartland and North Shore-LIJ are moving away from providing — and billing for — discrete fee-for-service care transactions. Instead, they are refocusing system resources on managing patients’ health in all settings. Under performance contracts, they are rewarded for meeting evidence-based population care goals, such as testing and controlling hemoglobin A1C levels in all diabetic patients.

Population health contracts also reward providers for reducing the need for inpatient admissions and other costly interventions, and for reducing overall costs, Bahrke points out. But shifting operations to achieve these goals is financially incompatible with the fee-for-service model, which only pays if patients use traditional services. “It’s kind of like you can’t be partially pregnant. Once you get started on population health, it is to your advantage to move over to it as quickly as possible.”

ABOUT THE SERIES: This series chronicles how individual hospitals in different circumstances are preparing for population health management and value-based risk contracting. The first article outlines core capabilities. The second will look more closely at the organizational and legal structures health plans are adopting, including accountable care organizations. The third will examine risk contracting and the fourth will profile several system successes.
Heartland executives anticipate the shift will be complete in three to five years, depending in part on how quickly commercial payers embrace the concept. The change will profoundly affect the system’s structure, including both physical and human resources, Bahrke says. Heartland’s Medicare ACO is part of a strategic plan that executives expect will sharply reduce inpatient and long-term care beds, and greatly increase home support services.

Heartland’s plan already is reshaping the role of physicians from providers of office services to supervisors of nurse practitioners and care managers who oversee patients’ care plans at home, in the office and in the hospital and rehab. Bahrke anticipates that acute care nurses gradually will take on more responsibility for managing patients before and after they leave the hospital, a transition already under way through greater emphasis on discharge planning and linking hospital and community-based medical and social services. Transitioning provider payment from a fee-for-service model based on billable face-to-face physician encounters to one that pays based on how well Heartland meets defined process and outcome goals for populations with specific risks is essential for making this delivery model work, Bahrke says.

Likewise, North Shore-LIJ executives recognize that adopting population health methods undercuts existing fee-for-service revenues. Many systems identify this as a key hurdle, and worry that they may not have the financial capacity to clear it — and whether their physicians will go along.

The transition to population health management is not easy, even for systems with a long history of risk contracting. Henry Ford Health System, which has operated the 670,000-member Health Alliance Plan for 50 years, anticipates a need to make changes. “Having been clinically integrated for 30 or 40 years, we’ve in some ways locked into an integrated model that may not be perfectly designed for the future,” says Bruce K. Muma, M.D., chief medical officer of the 1,200-member Henry Ford Physician Network in the Detroit area.

For example, the system’s providers operate largely independently from its insurance operations and may have to collaborate more actively. “Population management on the provider side can be much more effective,” Muma says. “There is a lot more opportunity to eliminate waste and orchestrate care when the patient is in our possession. What the health plan can do through benefit designs and telephone prompting is not as effective.” Henry Ford also is struggling with integrating care managers into its outpatient operations, in part because different insurers have different population management goals, he adds.

Nonetheless, the population health management approach shows great promise in health systems all across the country. For example, Heartland has held its employee health plan costs increases to about 1 percent a year since it began taking a population management approach seven years ago and, as it finishes
its first year with a 12,000-member Medicare ACO, total costs are down at least 5 percent, Bahrke says.

Similarly, Metro Health, headquartered in Wyoming, Mich., comprising a 208-bed osteopathic teaching hospital and 204 employed and independent physicians affiliated through a physician-hospital organization, cut its employee health costs by 5 and 10 percent, respectively, in the first year of a narrow-panel network using a population health approach, says Michael Faas, president and CEO. The system also has organized its primary care networks as patient-centered medical homes and has implemented disease management and care outreach programs for its sickest and highest-risk patients.

Lehigh Valley Health Network, comprising three hospitals and 1,100 employed and affiliated physicians headquartered in Allentown, Pa., also has set up extensive home support services for patients with such advanced and complex illnesses as cancer, organ failure and dementia. Using nurse managers, palliative care specialists and social support personnel, these services have reduced hospitalization and overall costs by 40 to 45 percent in these high-risk target populations, says Sue Lawrence, Lehigh’s senior vice president for the care continuum.

As of mid-November, 541 patients were being served at home by the Lehigh advanced and complex illness program. This may not seem like many, but they represent a disproportionate share of health care expenditures for the system and the community. Keeping them out of the hospital actually may cost the system in terms of revenue foregone because, so far, Lehigh has just a few shared-savings contracts with upside rewards only. But Lehigh executives anticipate that as much as 25 percent of revenue could be risk-based in two to five years, much of it from bundled payments for very ill patients, so the investment is worthwhile. "We are developing the infrastructure to manage bundled payments at such time as it comes to fruition," Lawrence says.

Indeed, one thing these diverse organizations share is a commitment to developing the capacity to deliver population health-management services. Whether the system is a single hospital or a diversified network, or the payment mechanism is an ACO contract, bundled payments or full-risk capitation, the same core capabilities are required. What these capabilities are and how these systems are putting them in place are detailed below.

**The critical role of IT**

Effective population health management requires that providers keep tabs on the health status and utilization of thousands of patients, and respond immediately when they need or request service. Moreover, it requires the ability to predict risk within a patient population so it can be managed with appropriate preventive and early interventions. All this takes substantial IT capability, says Eric J. Biber, M.D., chief medical officer of University Hospitals Case Medical Center in Cleveland. "IT is a key enabler. You can do a fair bit without it but, to get all the way, you have to have it."

Information essential for population health management comes from a variety of sources. These may include inpatient and outpatient medical records, hospital and physician billing records, insurance records and government sources such as Medicare, Medicaid, community health clinics, public health agencies and even school records. Obtaining each presents its own challenges. Raw data from these sources also must be integrated and transformed into usable information using some kind of analytics, and pushed back out in the form of decision support and predictive risk modeling.

Despite several years of efforts to create interoperable health records across platforms, fully integrating inpatient and outpatient records remains a challenge. Structured data, such as patient vital signs, complaint and condition lists, and medication lists, are formatted differently in systems from different vendors, making it difficult to share.

Many systems try to solve the problem by adopting a single vendor for both hospital and outpatient, as Metro Health has. All of the hospital’s employed physicians and the hospital use an Epic record system, as do many independent physicians, says Frank Belsito, D.O., Metro Health’s chief medical officer. This enables all payer and patient registries to be updated with incoming clinical data in real time.

However, federal law does not allow the hospital to give independent physicians its record system, so some use other systems, notes Heartland’s Bahrke. Heartland physicians can access some data from these systems through a regional health information exchange, including X-ray and other images, as well as progress and discharge notes, and complaint and medi-
What is Population Health?

One widely accepted academic definition of population health is: “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.” It was formulated a decade ago by David Kindig, M.D., of the University of Wisconsin-Madison School of Medicine, and Greg Stoddart of McMaster University, Hamilton, Ontario.

Managing population health involves improving health outcomes of the group as a whole by identifying, monitoring and addressing the health need of individuals within the group.

What this means in practice depends on how “group” and “outcome” are defined. Is the group or population all the individuals living in a geographic area? Or those served by or enrolled with a specific provider? Or is it all those with a specific medical condition? Or those with particular demographic characteristics, such as age or gender? Or those covered by a type of insurance or a specific insurance contract? Are outcomes clinically defined? Do they include things like functional status, well-being or specific health behaviors like diet and exercise or smoking cessation? Do they include nonmedical health determinants like economic or housing status?

These distinctions are important both philosophically and practically. Philosophically, by embracing a mission of caring for uninsured and indigent patients, a system also adopts a broad definition of the population whose health it intends to manage. From a practical view, identifying, monitoring and serving the needs of this population require developing outreach and social-service capabilities and interventions well beyond those traditionally associated with a medical care provider. These include things like arranging transportation, and pharmacy and nutrition support for many patients or at-risk community members.

At the same time, defining subpopulations according to specific conditions, diseases or health risks is essential to implementing targeted, evidence-based treatment protocols. And economically, defining populations as enrolled or allocated provider panels or by insurance class is also essential — particularly when financial incentives or outcome measures differ among contracts. Identifying, monitoring and serving patients by specific needs require information systems that track both clinical and utilization data in real time, and integrated delivery systems capable of responding immediately with appropriate interventions. These also go beyond traditional acute care to include prevention, telemedicine and home care to keep patients out of the emergency department and hospital beds when possible.

In many ways, the approach, with its emphasis on keeping close tabs on patients’ conditions, recalls earlier delivery models. “It’s what a lot of us called general practice 30 years ago,” says Frank Belsito, D.O., chief medical officer at Metro Health, Wyoming, Mich., which is organized around patient-centered medical homes. “We focus on accessibility and availability of the primary care physician. That’s what primary care is all about — being the provider of choice for the majority of what people need around health care. It is about re-embracing the values of the days of family practice.”

Population health management also recalls managed care, Belsito says. “Conceptually, you are responsible for a segment of the population; for high quality, low cost and patient satisfaction.”

But today’s population health management transcends managed care in important ways, says Eric J. Bieber, M.D., CMO at University Hospitals Case Medical Center, comprising 10 hospitals and 1,500 employed physicians serving Cleveland and northeast Ohio. For one thing, it really can be held accountable for quality based on meaningful and measurable performance metrics. “In the early 1990s, there was less focus on quality, in part because we didn’t have good quality metrics and we didn’t have the ability to benchmark,” Bieber says. “We didn’t have the IT infrastructure and we didn’t have real-time data needed to manage care processes.”

Even more important, accountable population management puts the patient at the center and builds out based on patient needs, rather than forcing the patient to conform to a rigid network, adds Bieber, who is also chair of the UH Coordinated Care Organization, the system’s umbrella ACO. “Accountable care is about care across the complete continuum and that is a different focal point. We had some of the pieces in place and the ACO brought them together. This is a work in progress, but we have the infrastructure and analytics to drive quality and value.”

— HOWARD LARKIN

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Bieber:

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In the way, you have to...
About the Surveys

In 2011, the Health Research & Educational Trust and the Commonwealth Fund sponsored a survey of hospital efforts toward developing capabilities. It found that most hospitals were developing key care coordination capabilities. The 2013 survey by the American Hospital Association and Health Forum largely duplicated the 2011 survey to track the evolution of new systems of care, care coordination functions and various payment and insurance models for delivering population-based health services.

Figure 1
Shift from fee-for-service to value-based payment expected

<table>
<thead>
<tr>
<th>Percentage of net patient revenue at risk by select payment methods</th>
<th>Now</th>
<th>2 years from now</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-service + shared savings</td>
<td>8%</td>
<td>13%</td>
<td>+5%</td>
</tr>
<tr>
<td>Bundled payments</td>
<td>1%</td>
<td>6%</td>
<td>+5%</td>
</tr>
<tr>
<td>Partial and global capitation</td>
<td>5%</td>
<td>8%</td>
<td>+3%</td>
</tr>
<tr>
<td>Total</td>
<td>14%</td>
<td>27%</td>
<td>+13%</td>
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</tbody>
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Bundled payments

Currently in bundled payment arrangement ............................................11%
Negotiating for private bundled payment in next 12 months ................7%
Considering applying for bundled payment arrangement in next 12 months .............................................9%
Not considering bundled payment in next 12 months .......................73%

Source: AHA Survey of Care Systems & Payment, preliminary results November 2013

Figure 2
Hospital participation in regional health information exchanges

Participating, actively exchanging data at least one HIE/RHIE ............41%
Have electronic framework, not participating at this time .................34%
Don’t have electronic framework, plan to participate in next year ......14%
Don’t have electronic framework, not participating at this time ........11%

Source: AHA Survey of Care Systems & Payment, preliminary results November 2013

Figure 3
Care coordination grows, but few have critical capabilities

<table>
<thead>
<tr>
<th>Care coordination grows, but few have critical capabilities</th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assigned nurse manager to patients at high risk</td>
<td>26%</td>
<td>34%</td>
</tr>
<tr>
<td>Assigned nurse manager for outpatient care</td>
<td>15%</td>
<td>22%</td>
</tr>
<tr>
<td>Disease management</td>
<td>22%</td>
<td>27%</td>
</tr>
<tr>
<td>Prospective management of patients at high risk for poor outcome</td>
<td>23%</td>
<td>27%</td>
</tr>
<tr>
<td>Chronic care programs</td>
<td>21%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Source: AHA Survey of Care Systems & Payment, preliminary results November 2013

Figure 4
Use of predictive analytics rising, but still low

Use of predictive analytics tools
<table>
<thead>
<tr>
<th>Use of predictive analytics tools for population health management</th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>12%</td>
<td>18%</td>
<td></td>
</tr>
</tbody>
</table>

Sources: 2011 AHA Care Coordination Survey (N=1,680),
2013 AHA Survey of Care Systems & Payment, preliminary results November 2013. (N=1,323)

Figure 5
Detecting readmissions problematic

Yes, detect most readmissions ..........................................................15%
Yes, detect virtually all readmissions ................................................6%
Yes, detect readmissions to our hospital only ....................................28%
Source: AHA Survey of Care Systems & Payment, preliminary results November 2013

Figure 6
Systems reporting patient-centered medical homes

Yes .............................................70%
No ..................................................30%

Source: AHA Survey of Care Systems & Payment, preliminary results November 2013

Figure 7
Half of hospitals have or plan a legal structure to receive and distribute payments

Yes .....................................................8%
No, but plan to establish in the next year ...........................................50%
No ..................................................42%

Source: AHA Survey of Care Systems & Payment, preliminary results November 2013
All or any part of this network may be owned by one system, or networks may be assembled by contract as needed to cover specific geographic areas or population needs. “Sometimes you may need to offer more accessible care or a broader breadth of care than your own network can provide,” Anderson says.

Without an integrated network, controlling utilization, predicting costs and meeting quality standards are difficult. Even so, slightly less than one-third of hospitals reported having a clinically integrated network in place in 2013.

Building an integrated network requires physician leadership to design and implement team-based care models that make full use of available care resources. Heartland began developing its model about three years ago. It involved educating physicians on concepts including patient-centered medical homes and care coordination. Physician champions began implementing the model, which makes extensive use of advanced practice nurses to deliver routine care in the office and check on patients at home. The goal is to move to two or three nurse practitioners for each primary care physician. Some physicians resisted at first, but clinical and financial results are good, and support is growing, she says.

Physician committees with primary care and specialty care representatives were established to develop care protocols for targeted high-risk patients in cardiology and oncology. Next up are joint replacements in orthopedics.

Hospitalists also were brought in. About 75 percent of emergency services and inpatient admissions, and 80 percent of Medicare risk services now are provided by Heartland-employed physicians. “If you can get collaboration among the emergency department, the hospital and specialists, you have come quite a way toward achieving your goal,” Bahrke says.

Working with physicians to understand and practice within a team-based model is essential, says Ira Nash, M.D., medical director of the 2,500-member North Shore-LIJ physician group, noting that “changing incentives does not automatically create the capability to deliver coordinated care.” Before new protocols or insurance programs roll out, the group educates physicians on the concepts, supporting evidence, incentives and, most important, the physicians’ role. “The new world is new for doctors as well,” he says. “You can’t explain it too many times.”

Nash emphasizes the need to engage physicians financially, too. Payment must be structured so that physicians share in any bonuses. Otherwise, it may look as though the system is benefiting at physicians’ expense — not good for collaboration.

Several North Shore-LIJ primary care practices have adopted the patient-centered medical home model. Nationally, about 30 percent of systems reported doing so [Fig. 6].

All of Fairview’s 43 primary care practices are certified as medical homes, Anderson says. He credits the team-based approach the model adopts with helping to shift the system’s culture toward care coordination and risk-sharing.

However, refocusing services on giving patients a seamless and positive experience is more important than adhering to the medical home model per se. Some aspects of the model, such as care management and coordination, cross practice boundaries and are handled at the system level at UH Case.

Developing effective integration protocols also requires great skill in process development and improvement. To develop those skills in physician leaders, nearly two-thirds of hospitals reported that they formally trained clinical leaders in continuous quality improvement in 2013. Lean, Six Sigma and Baldrige were the programs most frequently used.

Practical steps to coordinating care
Making the best use of clinically integrated services requires ongoing care coordination. Half or more of system health care expenditures typically go to care for the 5 to 10 percent of the sickest patients. Reducing unnecessary hospitalizations and urgent care in complex populations provides the greatest economic returns, and this is typically accomplished through intensive case management, disease management and coordination of home and outpatient care.

While more hospitals have been developing these capabilities since 2011, overall less than one-third reported assigning nurse managers to high-risk patients or to outpatient services, providing disease management, prospective patient management or chronic care programs [Fig. 3].

One reason may be that in many cases care management and coordination protocols are fragmented, Muma says. At Henry Ford, case management is built into inpatient operations, where the system long has been at risk for costs. But on the outpatient side, physicians aren’t paid for it so it is mostly provided by health plans — and their various approaches are often inconsistent. The Michigan Blues have 24 case managers operating in Henry Ford clinics, the United Auto Workers health plan has four, and other payers pay for services, but all have different approaches, greatly complicating care delivery. The system is trying to coordinate inpatient and outpatient case...
management and to come up with a consistent way to pay for it. "Some plans pay fee-for-service and some pay $1 or $2 per member per month. The model is still developing," Muma says.

Care managers and visiting nurses are one way systems can go beyond the medical model to address social health determinants, including patient education, poverty and other barriers, Belsito says.

Case managers are also invaluable for detecting and addressing issues such as transportation or patients who can't afford co-payments for medications.

Lehigh recently added social work to its case-management mix. Case managers coordinate extensively with community and volunteer groups to provide rides to clinics, groceries or whatever patients need to stay healthy, Lawrence says.

Lehigh case managers also are experimenting with new models for less ill patients, including extended intake interviews and periodic calls to make sure patients are following up on any needed chronic or preventive care. In its first year of applying the program in its employed population, 70 percent of enrollees improved or held steady on key long-term health indicators including body mass index and hemoglobin A1C.

Disease management is also a fruitful approach. At Metro Health, care packages have been developed for the 5 percent of sickest patients, and care navigators are assigned to help patients with congestive heart failure access needed services on an ongoing basis.

At Lehigh, high-risk patients are identified by means of algorithms’ examining patient data aggregated in disease registries, and case managers intervene when abnormal test results pop up. Root-cause analysis helps to develop new programs to keep patients healthy. The system’s program for advanced and complex disease also checks up on oncology patients after chemotherapy for dehydration and connects them with outpatient infusion if they are at risk, a practice that has cut hospital admission considerably.

"What we do in the hospital is really crisis work," says Donna Stevens, director of palliative care. "Cancer patients are going to continue on chemo and follow up and need long-range support over the journey of advanced illness." Lehigh’s palliative care team doesn’t just concentrate on end-of-life care, but actively follows patients with cancer, dementia and other long-term illness, she notes.

Overall, about 28 percent of hospital systems report using disease management widely.

**Infrastructure to handle payments**

As with any complex enterprise, an infrastructure is required to administer the finances of a risk-bearing care plan. It must be legally and functionally structured to contract with health plans and for services, establish payment terms and performance criteria, and track performance by provider and distribute payments accordingly. It must also be able to set rates based on expected utilization, and monitor ongoing costs. Overall, 42 percent of hospitals have established a legal structure to do so.
BY HOWARD LARKIN

ACO or No?

Hospitals must weigh the benefits and the perils before deciding if — and what kind of — an accountable care organization is right for them

In the hothouse of health care innovation that is Minnesota’s Twin Cities, executives and physicians at North Memorial Health Care arrived at a crossroad a couple of years back.

A fiercely independent lot consisting of two of the last unaffiliated hospitals in the region and several independent, mostly smaller, physician groups, they had succeeded for years in the northwest metro area in the shadow of some of the largest integrated systems in the country. But the expense of developing advanced data and management infrastructure to meet the growing demand for higher quality and cost accountability threatened to swamp their resources.

“Allina, Fairview and Park Nicollet all have pursued the Pioneer ACO model, so there is a movement afoot in the broader Twin Cities market to pursue this level of clinical integration,” says Craig Matticks, M.D., president of the North Collaborative Care network, headquartered in Robbinsdale, Minn. “Among payers, there is an appetite for collaboration with physician networks that may not have existed in previous attempts to control costs.”

Since the physicians and hospitals mostly shared geography and
patients, there was a strong basis for collaboration, Matticks says. So a task force of primary care and specialty physicians representing the entire care continuum convened to explore creating a network.

In mid-2012, the nonprofit North Collaborative Care network was incorporated. It comprises 353-bed North Memorial Medical Center and 130-bed Maple Grove Hospital, as well as 13 hospital-run primary care clinics, specialty clinics and dozens of independent physician clinics. Taking care to accommodate the diverse cultures of its members, the network set about developing the care paths, care management across the continuum, and electronic health record and information technology integration required to manage population health.

Despite early physician wariness, the move to consolidate operations didn’t stop there. “To their credit, our board quickly saw the advantage of deepening clinical integration and decided to pursue ACO status with the Medicare shared savings program in 2014,” Matticks says. “To move from forming a network and sharing data to getting into bed together as an ACO speaks volumes about how far we have come in 2 1/2 years. At first, they were explicitly saying they did not want to be an ACO.”

Ready or not, risk is coming
But an ACO is not always the best solution. For example, Metro Health, a 208-bed osteopathic teaching hospital with 204 employed and independent physicians affiliated through a physician-hospital organization in Wyoming, Mich., has developed sophisticated disease registries and care management systems that allow it to monitor performance and contract for performance bonuses.

However, Metro Health’s population is spread out across western Michigan and its payer mix is fragmented, making accepting full risk difficult, says Frank Belsito, D.O., chief medical officer. “To really
enter into those contracts, you need a large population paid by one payer. There is a critical mass you need to reach and we are not quite there.”

Similarly, Lehigh Valley Health Network, comprising three hospitals and 1,100 employed and affiliated physicians, headquartered in Allentown, Pa., has shared savings contracts with several private payers, but has not pursued an ACO or bundled payments with Medicare. “We decided not to do it, but we are evaluating a commercial bundled-payment approach,” says Sue Lawerence, senior vice president for the care continuum.

Metro and Lehigh’s decisions put them well within the mainstream. In 2013, just 15 percent of hospitals had established or were part of an ACO, with another 7 percent actively working on it, according to the American Hospital Association’s Survey of Care Systems and Payment (Figure 1).

Still, executives at Lehigh and Metro Health — as well as every other hospital executive interviewed for this series — acknowledge that risk contracting based on quality and cost is coming. Whether it is shared savings and loss, bundled payments or some form of capitation, they are developing management structures, clinical integration strategies and risk management capabilities to get ready.

“We are not yet in an ACO, but everything we are doing supports it. When and if we are part of an ACO, we will have processes in place to do very well,” Belsito says. But the capability is more important than the designation, he adds. “ACO is alphabet; it’s what you do inside that counts.”

**Big is good — but not essential**

Hospitals and health networks are wise to think twice before undertaking an ACO strategy because it usually requires a large initial investment in management, IT, network development, care protocols, quality reporting and financial reserves, says Robert James Cimasi, CEO at Health Capital Consultants in St. Louis. He considers these sophisticated systems essential. “You can’t get Buck Rogers without spending the bucks.”

Current rules governing the Medicare Shared Savings Program strongly favor larger organizations in several ways, Cimasi notes. He estimates up-front costs of about $5.3 million to launch an ACO serving 5,000 Medicare beneficiaries, or about $1,040 per enrollee, rising to $12 million to serve 80,000 beneficiaries, or about $150 each. Large organizations, particularly those with managed care experience, also are more likely to have in place some essential infrastructure, such as experienced contract managers, advanced EHRs and sophisticated quality management, potentially further reducing out-of-pocket startup costs.

A shorter payback period is always better from a capital return perspective, Cimasi says. He notes that an ACO with a payback period exceeding three years may not be financially justifiable since it would run past the current Medicare contract limit, and renewal terms are unknown.

The advantage larger ACOs have from lower per-beneficiary initial costs is compounded in the one-sided, gain-sharing only Medicare model, which requires the smallest ACOs to achieve 3.9 percent savings before receiving bonuses, falling on a sliding scale to 2.0 percent for the largest players.

Using Cimasi’s cost and best-case cash flow assumptions, an ACO would need about 25,000 beneficiaries to reach a one-year payback of its initial cost under the two-sided shared savings and shared losses model, or about 50,000 beneficiaries under the one-sided shared savings-only model. ACOs serving 5,000 members are not financially viable under either model using these assumptions, and plans as large as 55,000 beneficiaries have a payback period pushing 12 years.

“Unless getting a reasonable return is feasible, there may be better places to invest scarce capital,” Cimasi says. He recommends developing a comprehensive business plan that examines a range of structural factors affecting potential performance before proceeding [see Executive Corner, Page 31].

However, finance alone should not drive the ACO decision, Cimasi says. Other positive externalities also should be considered. These may include strategic concerns, such as repositioning the system away from a provider of hospital beds to a convener of health resources across the continuum in anticipation of future payer demands for greater efficiency. It also might include mission-related concerns, such as quantifying the organization’s role in improving community health.

“There could be a move to redefine community benefit in terms of positive externalities,” Cimasi says. “The whole idea of an ACO has really
positive benefits for the community, and that should not be overlooked as a reason to start one if it is not going to crush you [financially].”

Given the economies of scale, degree of management sophistication required, control over more resources across the care continuum, and efficiencies of delivering care in a densely populated area, the profile of hospitals participating in ACOs is not surprising. According to the 2013 AHA survey, ACO hospitals are three times more likely to be urban, and more than twice as likely to be teaching institutions and system-affiliated than non-ACO hospitals. Participation rates are almost directly related to size, ranging from 7 percent of those with up to 99 beds to 29 percent of those with 400-plus beds (Figure 2).

Still, smaller ACOs can be very successful. For example, the Heartland Regional Medical Center ACO serving 12,000 Medicare beneficiaries in northwest Missouri was one of only two two-sided MSSP ACOs launched in 2012 to generate shared savings in its first year, earning an interim payment of $2.86 million.

However, the system developed its accountable care approach over a long period and applies it over a much broader population, notes Mark Laney, M.D., president and CEO of Heartland Health and Mosaic Life Care. ‘For more than 10 years, we successfully applied the accountable care model to our own employees — long before becoming an ACO under the CMS shared savings program.’ Heartland also uses the approach to get the most out of its free clinics and charity care operations, which remain substantial in part because Missouri declined Medicaid expansion under the Affordable Care Act.

Overall, 54 of 114 MSSP ACOs that were started in 2012 generated shared savings totaling $128 million, CMS announced in January. Similarly, a November 2013 independent review of Medicare Pioneer ACOs by L&H Policy Research, Washington, D.C., found that eight of 32 achieved significant cost savings totaling $115 million, with 23 close to local market costs and one with significantly higher costs totaling $8.5 million for the first year. That works out to a savings of $20 per beneficiary per month for the entire program, with the eight plans achieving significant savings ranging from $33 to $104 per beneficiary.

The review also found that successful Pioneer ACOs varied in geographic location, size, market conditions and organizational structure. This suggests that many types of ACOs, including integrated systems, group practices and hospital-physician networks, are viable, and can succeed even in markets with low initial Medicare costs.

**Making it work**

The old health care saw, “when you’ve seen one integrated system, you’ve seen one integrated system,” also applies to ACOs, Cimasi notes. Their diversity reflects both the flexibility of CMS ACO regulations, which to some extent were designed to accommodate differing markets and delivery systems across the country, and commercial programs, which vary even more. “An ACO is in the eye of the beholder and the federal version is much different from the commercial.”

One thing they all share, however, is a commitment to reorient health care from delivering procedures to delivering value. Value is defined as delivering evidence-based care, including coordinating care across the continuum, as well as clinical, financial and patient satisfaction outcomes for both individuals and populations.

This puts providers at risk, but it is a risk they can conceivably control, Cimasi says. And unlike HMOs, which often created incentives to undertreat by transferring financial risk indiscriminately through capitation, ACOs reward providers for improving both quality and efficiency.

Defining value in terms of concrete clinical, financial and satisfaction outcomes also puts providers in the driver’s seat, says Howard Gold, executive vice president for managed care and business development at 16-hospital North Shore-LIJ Health System in New York. “The insurers add no value unless they work with a provider who adds the value of a positive experience for their members. They have to pick sides and work with some of the more innovative providers.”

The converse is true for providers; they must find payers who will support their transformation to accountable care, Gold says. Savvy payer partners are critical both to develop arrangements that truly align rewards with value, and to manage the inevitable financial hit from reducing inpatient care and procedure volume. “The problem is most insurance companies
have not made the leap that the future is working closely with providers who want to work with them. A few really get it, but others are just clueless.’

Because the strategic, financial and operational implications are profound, system-level leadership is essential to build an accountable care infrastructure. At University Hospitals Case Medical Center, an integrated academic system comprising 10 hospitals and 1,500 employed physicians headquartered in Cleveland, the journey began in 2010 with a commitment of $100 million, says Eric J. Bieber, M.D., chief medical officer and chair of UH Coordinated Care Organization, the system’s umbrella ACO.

“It wasn’t ACOs in isolation. At the same time, we were looking at driving value through new models of care and leveraging IT,” Bieber says. “Reading the tea leaves, we knew value would be the driver and we needed to make things as efficient as we could.”

That the system included everything from the very urban Case Medical Center to suburban hospitals to two critical access hospitals made the challenge all the more intriguing — and potentially valuable as a model, Bieber says. “How do we leverage what we do to serve a heterogeneous social demographic over a complex geography? If we can do this, it may be portable.”

Lots of prep time and folks at the table
As with many systems, UH Case’s project began with its self-insured plan for 24,000 employees and their families. But knowing the model must be scalable and flexible, significant time was devoted to governance and architecture, Bieber says. In addition to physicians, system finance, contracting, legal and operations managers were tapped. “The advance work was done with lots of folks at the table. That has paid significant dividends as it has become more complex.”

To accommodate the different needs of different populations, UH Case developed a flexible approach, resulting in formation of three ACOs — one for pediatrics, one for commercial patients and one for Medicare. Each is governed by a physician advisory council and relevant advisers, such as county public health officials, school board and Head Start representatives, and Medicaid managed care officials for the pediatric plan.

The three ACOs developed their own care management protocols using information sources and IT solutions tailored to their respective populations. The three report up through the umbrella ACO, which helps to ensure consistency of approach and accountability at the system level. But the structure is not frozen. “ACOs are a vehicle today to get where we are going, but we have to be able to adapt,” Bieber says, adding that building a culture of continuous improvement with a structure that allows nimble response is essential for long-term success.

The need to overhaul clinical practice, physician engagement and leadership is especially important — so much so that CMS requires extensive physician representation on ACO boards. Matticks believes that putting physicians in charge of developing the North Memorial network helped to overcome initial resistance to the ACO concept. Indeed, the more the doctors examined the facts, the more compelling the case became.

“In general in the United States, we have too many fixed assets, we are overbedded and we have an overabundance of specialists, and this is also true in the Twin Cities,” Matticks says. “Because our foundational work was done by physicians, not the health system, I think we laid the groundwork for the difficult conversation we will need to have to get different outcomes from what we are currently getting.” Doing so will be essential to survive in a market dominated by accountable systems, he adds.

Making the numbers work
Although it is also a physician-driven network, the market situation is reversed for Metro Health, Belsito says. “If we had 200,000 members in a capitated plan, we could really manage [an ACO]. But when membership is all over the place under different payers and payment structure, it’s hard to make the numbers work.”

Instead, Metro Health focuses on programs needed to manage in the current payment structure, Belsito said. This includes an all-patient, all-payer registry that facilitates care...
coordination and preventive care for all patients served by the system. The system’s growing IT capabilities also support quality incentive contracting through the PHO.

Metro Health also has shifted from a hospital-based care strategy to one centered on 14 community clinics located one to 30 miles from the hospital, says Michael Faas, president and CEO. With patient satisfaction rising and regional payers getting behind the concept, he sees an integrated ACO-type arrangement in the future.

With a 208-bed hospital, Metro Health lacks the resources to go it alone. But rather than a threat, Faas sees that as an opportunity to build a best-of-breed system with partners including enlightened payers and the top long-term care, home care and physician services in the area. “We can begin to think of other combinations of physicians and other care with the goal of doing the best for the families and patients we take care of,” Faas says. With accountable care, “you are getting incentivized through payment for what always should have been the goal of health care. It just highlights something we have always worked toward.”

And as many systems — including those already formally operating ACOs — continue transforming operations toward a comprehensive ACO model, the model itself may be a transition to even more comprehensively integrated approaches, Cimasi says. “Managed outcomes, mutually beneficial partnerships with doctors, evidence-based care, transparency and proof of value to patients — these are all things we are trying to move toward as a society. Whether ACOs are the vehicle to get there, well, the jury is still out. We may be heading toward a national risk pool and ACOs may be the bridge that shapes the care continuum that lets us get there.” — Howard Larkin is a contributing writer to H&HN.

AHA recommendations for ACOs

The American Hospital Association in April sent a letter to Patrick Conway, acting director of the CMS Innovation Center, recommending changes to the Pioneer ACO Model and the Medicare Shared Savings Program. “While our members are committed to the concept of accountable care — many are pursuing public and private models — we continue to have significant concerns about the design of the current Pioneer ACO and Medicare Shared Savings Program,” the letter stated. Below is a very brief synopsis of the AHA’s recommendations. To read the letter in full, go to www.aha.org.

Encourage participation in the Pioneer ACO program

CMS should allow for multiple “paths” toward more accountable care. Providers are in different places in their ability to coordinate care and manage risk; they need options along a spectrum so they can move away from fee-for-service toward managing the health of a population.

Encourage participation in the MSSP

The timeliness and accuracy of claims data from CMS has been a major challenge.

• CMS’ overall risk versus reward equation continues to tilt too much toward risk and too little toward reward.

• The No. 1 way to increase participation in ACO programs is to modify the shared savings determination to ensure that more ACOs are able to receive a bonus — and a larger bonus — so that they can continue to invest in the program. Suggestions include:

Identify which patients are in the ACO earlier

Currently, providers do not know which patients are assigned to the ACO program until year-end, after CMS assigns them based on a retrospective analysis. Providers cannot effectively identify high-risk individuals, develop specific outreach programs and proactively work with patients and their families to establish care plans unless they can pinpoint their assigned population up front.

• CMS should implement a voluntary sign-up process in which Medicare beneficiaries can choose their care from an ACO.

• CMS should create some financial incentive on the part of the beneficiary to stay “in network” so that their care can be coordinated.

Revise quality measures and thresholds

ACOs that do not meet quality performance standards in Year 2 and beyond will not be eligible for shared savings, regardless of whether they reduced expenditures below their benchmarks.

• CMS should determine and set quality benchmarks prior to the beginning of the performance year so that ACOs will know what thresholds they will be required to meet.

• CMS should align the ACO quality metrics with those reported for other programs, such as HEDIS, the Medicare Star Program.

• An ACO’s quality score should be used to award additional shared savings, rather than as a means to reduced the shared savings amount. CMS should reward those ACO providers that exceed certain threshold levels. The more potential there is to earn a shared savings bonus, the more attractive the program will become to prospective participants.
Population-based accountable care exposes hospitals to many new operational and financial challenges. Ignoring them may be the biggest risk of all.

BY HOWARD LARKIN
If you haven’t already met someone like Mike Pykosz, chief executive officer of Chicago-based Oak Street Health, chances are you will soon.

After graduating from Harvard Law and a stint at the Boston Consulting Group, Pykosz returned to his native Chicago last year as a health care entrepreneur. Backed by a group of investors “excited about the model,” he opened four primary care clinics exclusively serving Medicare and Medicare-Medicaid dual-eligible patients mostly from underserved, low-income communities — with plans for more.

The clinic model Oak Street’s well-informed backers find so attractive meets social service as well as medical needs. Patients are served by a team including a geriatric-trained primary care physician, a nurse and a medical assistant, with support from care coordinators. Panels are limited to 500 patients, or 750 with the addition of a physician’s assistant or nurse practitioner — about one-quarter the typical primary care size. This allows half-hour visits as well as quick and comprehensive follow-ups to ensure that chronically ill patients comply with care plans and are seen within 48 hours of a hospital visit. And, Oak Street’s physicians earn more than average for their specialties.

Oak Street also provides transportation for patients to clinics and other services, and each clinic hosts a community gathering place where patients can come for frequent special programs or just to pass the time. Clinics include on-site dental and pharmacy services, which patient surveys found are common care gaps — all without charging deductibles or co-payments.

How is this possible? Shared savings.

In its first nine months, Oak Street significantly reduced hospital admissions and emergency department use, cutting costs for its population by more than 10 percent below projections. This nets bonuses that more than cover the extra services. “The biggest levers to improve performance are primary care and social services,” Pykosz says. “If you do both, you can save a lot.”

Traditional fee for service simply wouldn’t produce enough income to pay for it all. For that matter, a low-risk patient population with less total savings potential also might not support the model, Pykosz says. “We looked at the risks and opportunities for reducing costs and improving health in this population and built a doctor’s office around it.”

It remains to be seen whether Oak Street Health continues to clear its financial hurdles as it rapidly scales up. But as Pykosz sees it, there’s plenty of opportunity to improve on the cost and performance of the current system. “As long as we are the best, we will be OK. And our performance is very much above average now.”

Leads or get out of the way

That entrepreneurs are betting on comprehensive primary care for high-risk Medicare patients demonstrates the disruptive potential of population health-based risk-contracting. The potentially huge rewards created by shared savings, bundled payments and capitation are sure to entice competition for the traditional physician-hospital delivery model.

And since the rewards mostly come from funds previously budgeted for hospital services, it’s critical for health systems to recapture a share, even if it won’t make them whole. “The truth about health care is that no matter what happens, we are going to spend less money on it,” says Bruce Muma, M.D., chief medical officer of the 1,200 member Henry Ford Physician Network, part of the five-hospital Henry Ford Health System based in Detroit. Doing more with less is not optional, he adds.

So the question for hospitals is not whether to participate. It is how, when, where, with which partners and for which target populations they can do so — without going under.

Many systems are developing capabilities to address new risks presented by population-based accountable care. These include reorganizing, integrating and streamlining clinical services; aggregating and tracking risk pools; and building patient outreach and counseling services. Many find that these capabilities help them fulfill their community service mission, including better serving uninsured and underinsured patients.

“Our hospitals are in many different places in terms of where they are on the spectrum of taking risk and how they are engaging in population health,” says Ashley Thompson, director of policy at the American Hospital Association. “As part of the Triple Aim, we are committed to improving population health.”

Bulking up carefully

For Juan Serrano, senior vice president of payer strategy and operations for Englewood, Colo.-based Catholic Health Initiatives, the issues around population health management are complex, but the solution, at least generally, is clear. “All the answers lead in the direction of being the best we can be in serving the needs of our community and serving our fair share of the community,” he says.

That means aggressively developing population-based services, even if it means temporarily taking a loss, Serrano says. For example,
FRAMING THE ISSUE:

• Population-based accountable care arrangements reward innovators who can cut costs and improve outcomes.

• The rewards mostly flow from revenues previously budgeted for hospital services — often funding services that directly reduce inpatient volume.

• Optimizing operational effectiveness and efficiency, and better integrating hospital and other services are prerequisites to delivering value-based care.

• Population health management also exposes hospitals to new risks, including defining and tracking populations and patient compliance.

• Successfully negotiating the transition to value-based care requires careful assessment and management of local market conditions and population risks.

CHI, which operates 93 hospitals in 18 states, accepts risk for more than 200,000 lives through Medicare shared savings programs — despite rules that make it hard to keep patients within its network, or even know all the patients for which it is responsible.

The AHA anticipates changes in federal shared savings programs that will clarify attribution and simplify quality reporting, Thomson says. However, it’s not clear if these and any changes to the formula for sharing savings will be enough to keep most hospitals in once the upside-only option expires.

Regardless, Serrano believes participating provides valuable experience that will pay off as CHI expands its Medicare Advantage plans, which currently enroll 17,000. It’s simpler to predict and manage risks in Advantage plans because enrollees join voluntarily and accept incentives to stay in-network.

CHI also will expand its commercial plans, which now include 70,000 members, some at full risk and others in self-funded programs. In addition, about 12–15 percent of CHI’s commercial contracts include some kind of value-based purchasing component, but that’s rising fast, Serrano adds.

“It is anyone’s guess how much of our revenue will be at risk five years from now, but it will be more than it is today,” Serrano says. “To be paid for value, we have to be adept at creating and maintaining value — that is a requirement. We don’t believe we have the choice but to invest in population health programs.”

Indeed, CHI is restructuring itself around the task. At the system level, it has added technical resources that include actuarial analysis, underwriting and health plan management on the insurance side, and clinical network development and care coordination on the provider side, with IT support for it all. The system also provides financial backing, including a $1 billion investment in health plans serving the Little Rock, Ark., and Louisville, Ky., markets. The goal is three-pronged: own and operate health plans partner with payer health plans, and provide managed health services directly to employers, Serrano says.

That’s not to say CHI enters risk-bearing arrangements blindly. To the contrary; the system launched this strategic initiative by systematically assessing its capabilities and opportunities in each market.

Insurance products and services for both commercial and Medicare patients were examined along with the cost of care relative to national and regional norms. From this, the financial potential for specific risk products was projected, as well as the potential for improving care quality and access. "In some markets the total cost represents an opportunity we can work toward reducing outright," Serrano says, "but more important is rationalizing health care consumption, which makes it more affordable in the community."

Markets also were assessed in terms of readiness for risk-contracting. Those already served by HMOs, PPOs and Medicare Advantage plans, or by narrow provider networks, are good candidates for value-based contracting, Serrano says. Building capacity quickly makes sense under these conditions.

OAK STREET DISRUPTOR:

In its first nine months, Oak Street Health significantly reduced hospital admissions and emergency department use, cutting costs for its population by more than 10 percent below projections, says CEO Mike Pykosz.

Does your organization have a state approved health insurance license to provide health insurance services to defined populations such as employers, Medicaid or Medicare?

Source: AHA Survey of Care Systems and Payment, May 2014 Data Release

No

73%

Yes

27%
A
other challenge for organizations taking population-based risks is conflicting patient incentives, notably high-deductible health plans. Out-of-pocket costs not only increase self-pay balances and bad debt, they also discourage patients from seeking the regular care that is the cornerstone of population health management, says Kris Kurtz, controller at Metro Health, a 208-bed osteopathic teaching hospital with 204 employed and independent physicians affiliated through a physician-hospital organization in Wyoming, Mich.

National data suggest the problem is growing, says Ann Garnier, chief operating officer for CarePayment, an Oswego, Ore.-based finance firm that partners with providers to fund patient out-of-pocket charges. As of 2012, 41 percent of U.S. residents reported carrying or having trouble paying medical debt, up from 31 percent in 2005, according to surveys by the Commonwealth Fund. Over the same period, those reporting deductibles of $1,000 or more rose to 25 percent from 10 percent. That contributed to a 12 percent rise in uncompensated care reported by hospitals to $46 billion in 2012, according to the latest available data from the American Hospital Association.

Even modest deductibles and co-payments financially strain patients, particularly when they recur, as with chronic conditions. According to a 2014 study of medical debt by the Kaiser Family Foundation, the average 2013 single-coverage deductible of $1,135 was nearly double the average liquid assets of households earning up to 100–250 percent of the poverty level. Add typical co-payments and coinsurance, and the total for a major medical case exceeds the $2,740 average cash on hand for households up to 400 percent of poverty. Over two years, it even comes close to depleting the $12,000 in average liquid assets of households above 400 percent of poverty.

Given that family deductibles for Bronze plans on insurance exchanges, which are chosen by about 20 percent of buyers, average more than $10,000, and for Silver plans, chosen by about 60 percent, average more than $6,000, providers anywhere likely will see patient balances explode, Garnier says. Many already have.

At Metro Health, uncollected patient balances rose from about $500,000 monthly in late 2013 to $800,000 in the first quarter this year, driven mostly by higher deductibles and co-payments, Kurtz says. “Self-insured balances did not change; the upward trend is on the underinsured side.”

More insidious, out-of-pocket costs create disincentives to seek regular preventive and maintenance care. While cost sharing is supposed to prompt more prudent health care buying, it instead drives many patients to avoid treatment altogether until their conditions are too serious to ignore. In a recent Gallup poll, nearly one-third said they put off care because of cost last year.

That undercuts providers’ ability to reduce costs by providing continuing care. “If you have most people choosing high-deductible plans, it creates risk for an ACO, which is tied to patient outcomes,” Garnier says. Metro Health has taken several steps to manage high deductibles, including beefing up its charity care and outreach programs, such as free screening for vascular disease. The system also publishes average prices paid for services on its website and offers zero percent financing through CarePayment, Kurtz says. He credits the program, which is co-branded with the system and integrated into its patient intake processes, with keeping total bad debt stable despite rising patient account balances. Typically, such a plan can double self-pay collections over internal collection efforts, Garnier says.

Kurtz also thinks it gives Metro Health a competitive edge as out-of-pocket costs loom larger in patients’ decision-making. “People in this community like to pay their bills, and this gives them an opportunity to do it in an affordable way.”

Patient financial counseling also may help hospitals to reduce self-pay risks. “Consumers need to make fundamental changes in spending habits to budget in health care,” says Garnier. “They haven’t been used to being asked for money up front. It’s a sea change and it will take a few years to adjust to the new world, but it has to become more retail.”

Counseling should extend to choosing plans that make care more accessible, Garnier adds. “Patients need to know the difference among a Bronze, Silver and Gold plan. They need to know they are getting good providers, good quality and how much it will cost, and how to pay for it. We need to support patients as consumers.”

Prevalence of high-deductible plans also may create opportunities for systems to offer

KURTZ: Out-of-pocket costs not only increase self-pay balances and bad debt, but they also discourage patients from seeking the regular care that is the cornerstone of population health management.
BAURKE: Heartland Regional Medical Center in St. Joseph, Mo., operates a free clinic that serves a large uninsured population in the area. Its care managers steer low-acuity patients who seek care at the ED to other venues, and helps them to connect with primary care and clinic providers.

But where employers have little experience or interest in risk contracts, a slower approach may be better. Willingness of commercial insurers to partner in shared risk products also influences how quickly and with which products CHI moves forward.

CHI also examined its own readiness. The system is building clinically integrated networks in each of its markets and adding technology, informatics and care coordination capabilities, as well as developing provider reimbursement and legal structures that support risk sharing. Physicians from key specialties are brought in to help identify specific population health needs and structure programs to meet them. This helps to improve care efficiency and shift caregiver culture toward managing populations, Serrano says.

Consumer preferences also are examined. “We conduct sensitivity analysis to find out how aggressively we can transform our culture from a patient perspective without undermining the economic stability of the system,” Serrano says. For example, moving to restrictive networks before patients accept them can undermine loyalty.

The program already has delivered some notable successes. In Des Moines, a shared savings partnership with the Blues improved compliance with national standards for blood pressure, diabetes and cholesterol control, from about 50 to 85 percent by adopting a medical home model, says Stephen Moore, M.D., CHI’s CMO. Health plans acquired in Washington state and Arkansas have expanded operations into Kentucky, Nebraska, Ohio and Tennessee. Products include commercial plans, third-party administration services and Medicare Advantage and supplemental plans. Services offered directly to employers include wellness education, preventive screenings, personal health coaching, disease-management support and on-site health services.

“We have to trust that putting the value proposition in the marketplace will result in a favorable economic response from employees and consumers,” Serrano says.

Pinpointing different populations
Identifying and tracking patient populations are crucial for managing risk. It’s also a challenge, both technically and economically.

Consider Fairview Health Services, which includes seven hospitals and about 3,350 physicians in Minneapolis and surrounding areas. Located in one of the most active managed care markets in the nation, Fairview launched its population health program five years ago. It participates in the Pioneer ACO program, has risk-sharing contracts with all local commercial payers and has developed network products to appeal to targeted consumer segments.

Extensive as the offerings are, they still mostly focus on about 5 percent of the population — those with high-cost conditions, including chronic obstructive pulmonary disease and congestive heart failure. The potential savings from aggressively managing these patients justifies the expense of frequent checkups, monitoring equipment, calls from care managers and even home care visits, says Dan Anderson, chief operating officer and president of community hospitals.

Another 20 percent or so are at elevated risk for future problems, but identifying and engaging them is less immediately rewarding. “Our next challenge in preparing for alternative models of capitation or global payment is extending them to a less-complex population,” Anderson says. “The impact on total costs is less for an individual, but the size of the population in less critical categories is quite large.” Better automated tracking of care received inside and outside the network as well as expanded care networks are needed to effectively manage these patients.

This is where many global risk arrangements fall down, particularly taking risk for the total cost of care for a large population — with potentially catastrophic consequences for providers, says Lynn Carroll, senior vice president of provider economics for PaySpan, which automates and coordinates payments among providers, patients, payers, health plans and financial institutions across a wide variety of reimbursement models.

Risks in relatively small populations with known high-cost conditions treatable through well-defined protocols can be controlled because they are identifiable and the value of specific interventions is clear, Carroll explains. But as the population expands and unknown conditions multiply, that value relationship breaks down. “We are a long way from universally being able to assess fee-for-value across every concatenation of patient need and service provided.”

Real-time tracking of patient encounters is the only way to keep up, but that’s not easy, Carroll points out. “There are
plenty of horror stories of providers that take risk and then six or nine months later they get a reconciliation report and they owe a couple of hundred thousand dollars, and it’s too late to do anything about it,” he says. Needless to say, this dampens enthusiasm for risk-contracting.

Since tracking claims and costs historically has been a payer rather than provider function, it may make sense to partner with a payer for those services, Carroll says. Better yet, contract fee for service with bonuses for recommended preventive care. “It’s not about ACOs, shared savings or fee for service, it is about achieving the most value for what you are paying. As long as there is a quality component that is measurable and makes sense, we are going in the right direction,” Carroll says.

Indeed, risk-contracting can deliver value only if providers understand — and are able to meaningfully address — exactly the risks they’re taking, he adds.

**Rationalizing operations**

As value-based purchasing squeezes hospital revenues, optimizing operational efficiency and effectiveness will be essential not just to maintain margins. With hospitals viewed as cost centers, they’ll need to show evidence that a certain level of spending is necessary to maintain quality — and deliver value — to keep payer rates reasonable.

“If you reduce fees without understanding the cost structure, you make cuts based on what you’re paying rather than what is needed to do the job,” says Henry Ford’s Muma. “It becomes a downward spiral, a race to the bottom.”

Understanding costs mostly comes down to good old-fashioned cost accounting — something hospitals historically

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### how is care coordination being used?

<table>
<thead>
<tr>
<th>TYPE OF CARE COORDINATION</th>
<th>NOT AT ALL OR MINIMAL USE</th>
<th>MODERATE USE</th>
<th>WIDELY OR HOSPITALWIDE USE</th>
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<tbody>
<tr>
<td>Chronic care management processes or programs to manage patients with high-volume, high-cost chronic diseases</td>
<td>39%</td>
<td>33%</td>
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<tr>
<td>Use of predictive analytic tools to identify individual patients at high risk for poor outcomes or extraordinary resource use</td>
<td>57%</td>
<td>24%</td>
<td>19%</td>
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<td>Prospective management of patients at high risk for poor outcomes or extraordinary resource use by experienced case managers</td>
<td>44%</td>
<td>27%</td>
<td>28%</td>
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<tr>
<td>Assignment of case managers to patients at risk for hospital admission or readmission for outpatient follow-up</td>
<td>43%</td>
<td>21%</td>
<td>36%</td>
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<td>Post-hospital discharge continuity-of-care program with scaled intensiveness based upon a severity or risk profile for adult medical-surgical patients defined diagnostic categories or severity profiles</td>
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<td>24%</td>
<td>22%</td>
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<td>Nurse case managers whose primary job is to improve the quality of outpatient care for patients with chronic diseases (e.g., asthma, CHF, depression, diabetes)</td>
<td>56%</td>
<td>20%</td>
<td>23%</td>
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<tr>
<td>Disease management programs for one or more chronic care conditions (e.g., asthma, diabetes, COPD)</td>
<td>44%</td>
<td>28%</td>
<td>28%</td>
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Source: AHA Survey of Care Systems and Payment, May 2014 Data Release
have’t done well. “It involves getting out a stopwatch and figuring out how many nurse hours, how many pharmacy hours, how many tech hours it takes to do a hip replacement — figuring out what is needed and what is not,” Muma says. “It involves figuring out actual supply costs and joint prosthesis costs. That is where the learning needs to be, and it needs to be more broadly applied across all hospital services.” Henry Ford is participating with 24 other organizations in a bundled joint replacement initiative through the Institute for Healthcare Improvement aimed in part at developing such standards.

And just as hospital responsibility for care now extends beyond the hospital walls, so must operational analysis, says Andrew Ziskind, M.D., managing director, clinical solutions, at Huron Consulting Group. Employing physicians gives systems much greater ability to coordinate care across a much broader continuum. But it’s also new territory for systems that previously focused on inpatient care. Many need help connecting care processes so readmissions are reduced and care is delivered in the lowest-cost appropriate setting. In what has become a health mantra, the goal is providing the right care to the right patient in the right setting at the right time.

This often requires rethinking the delivery system. “We focus heavily on optimizing assets,” Ziskind says. “Do you have redundant services? Too many beds? The right mix of primary care and specialty physicians? The right clinical programs? With efficient operations and infrastructure you are well-positioned from a delivery and cost structure perspective to build the core competencies to successfully manage population health and the risk that goes with it.”

But truly managing population health goes further, says Rob Schreiner, M.D., also a Huron managing director. “It’s one thing to construct coordinated care that consumes fewer dollars than uncoordinated care. It’s even better to have some kind of upstream intervention that avoids acute episodes altogether.”

This is done by analyzing records to identify patients at risk for specific illnesses and intervening early. For example, out of 100,000 patients, a handful might be obese adults with a history of diverticulitis not requiring surgery, putting them at significant risk of severe diverticulitis. Reaching out to these patients with diet and lifestyle support could head off a repeat episode requiring colostomy, Schreiner says. “That can be replicated for heart attack, asthma, obstructive lung disease and a multitude of conditions if you have the right analytics, reporting and outreach.”

Still, systems must avoid financially crippling themselves as they transition to population health. “The tipping point comes when you move beyond your initial self-insured or small-risk contract, Ziskind says. “When it gets to the point where you truly shift the way care is delivered, we often see

<table>
<thead>
<tr>
<th>Does the hospital have the ability to detect readmissions, even when the patient is readmitted to a different hospital?</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>7%</td>
<td>15%</td>
<td>51%</td>
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</table>

Does your hospital systematically track the source of the readmission (e.g., readmitted from home, rehab facility, etc.)

<table>
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<th>Yes</th>
<th>No</th>
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<td>81%</td>
<td>19%</td>
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safe transitions

Describe your hospital’s processes for facilitating safe transitions. Is the process standard?

Identifying patients who transition between settings of care

Sharing clinical information between settings of care

Providing patient discharge summaries to primary care providers

Providing patient discharge summaries to other providers (e.g., rehabilitation hospitals)

Tracking the status of transitions, including the timing of information exchange

Source: AHA Survey of Care Systems and Payment, May 2014 Data Release
dramatic decreases in inpatient volume."

Managing mission risk

While population health discussions mostly focus on making it pay for insured patients, many systems also find it useful for managing another risk — caring for underserved, uninsured and underinsured community members.

“As we plan to take more risk in the Medicare and commercial markets, we want to tap that expertise to give our most vulnerable populations care that mirrors what is available to populations that can afford better coverage and access,” CHI’s Moor says. He estimates system cost for charity care and self-pay shortfalls run $500 million to $600 million annually.

In a study of high-utilizing uninsured patients in Louisville, CHI found that most were impoverished, with multiple chronic illnesses requiring active management; many were homeless or itinerant; and most had a comorbid psychiatric diagnosis. The patients were identified primarily from the system’s own medical records and about 500 accounted for nearly a quarter of the system’s uncompensated care in the region.

CHI developed a program that included regular primary care focusing on managing chronic conditions. Other services included transportation to clinics and providing telephones for those who didn’t have them. All were offered services, and about 80 percent enrolled, Moore says.

At nine months, the enrolled group saw a 30 percent reduction in emergency department use and a 50 percent reduction in inpatient use. More important, both physical and mental health status improved markedly, Moore reports. If expanded systemwide, the program could cut uncompensated care 10–15 percent while providing better service. A similar approach might reduce Medicaid losses, he adds.

Heartland Regional Medical Center in St. Joseph, Mo., sees a population health approach as essential to maximize the benefit of its free clinic, in operation for more than 100 years, says Linda Bahrke, R.N., who administers Heartland’s community health improvement program and the system’s ACO. The uninsured population in the area is still large, in part because Missouri declined to expand Medicaid under the Affordable Care Act.

The clinic has added care managers to help patients with chronic conditions. It also intercepts and steers low-acuity patients who seek care at the ED to other venues, and helps them to connect with primary care and clinic providers. But managing or even finding uninsured patients is challenging because many move often or are homeless. “It’s hard to get your arms around this population,” Bahrke says.

The ACA mandate that nonprofit hospitals do annual community needs assessments is helping many to identify and respond to local needs, Thompson adds. “It has been extremely valuable to members to address voids in local health services. We hear a lot about dental and mental health needs. Hospitals can fill the void themselves or contract with others in the community to fill the need. It’s amazing.” — Howard Larkin is an H&HN contributing writer.

EXECUTIVE CORNER

Risk-contracting factors to consider

Revenue vs. cost trends — Do historical and projected revenues exceed costs for a given population cohort?

Opportunity for lowering costs — Can costs be reduced while maintaining or improving quality by “rationalizing” service delivery (for example, keeping chronically ill patients out of the hospital through better integrating services)?

Are employers ready to move from fee for service to pay for performance? If so, what measures are they likely to embrace (for example, FFS plus quality bonuses, FFS plus gain-sharing, accountable care with FFS plus gain-sharing plus outcome bonuses, bundled payment for episodes of care, partial capitation, full capitation)?

Will payers support or partner in risk-contracting, or view provider-sponsored plans as threats?

How willing are patients to accept narrow networks, care coordination or preventive medicine and lifestyle coaching?

MARKET OPPORTUNITY

MARKET CONDITIONS

Do you have the contracting expertise and infrastructure to clearly distribute payments accordingly?

Do you have the financial expertise to price bundled or capitated services, or global costs for a given population?

What provider-based models are most viable and sustainable?

Do you have historical clinical and financial information sufficient to assess the risks of a given population segment?

How willing are you to accept risk if you do not have the right infrastructure?

Are you prepared to manage acute episodes of care?

How do you assess the quality of your risk-contracting models?

Does your system have the ability to coordinate services across the care spectrum?

Do you have quality improvement and quality reporting systems in place?

Are your clinical services operating at optimal efficiency?

Are your physicians on board with specific types of risk-contracting?

Do you have in place or can you buy or contract for all services required for a particular type of risk-contracting (such as control of inpatient and outpatient costs for gain-sharing, or all elements of a service line for episodes of care)?

Have you established or can you establish care management protocols among all network members?

Can you track and report clinical and financial utilization data in real time?

Do you have the financial expertise to price bundled or capitated services, or global costs for a given population?

Do you have the contracting expertise and infrastructure to clearly assign risk to network providers, track contract performance and distribute payments accordingly?

Source: Juan Serrano, senior vice president of payer strategy and operations, Catholic Health Initiatives, Englewood, Colo.
Keys to success: Support doctors, talk to patients and leverage whatever data exist. Are you ready for ACO 2.0?

BY HOWARD LARKIN

Bajner believes integrating acute and accountable care could reduce costs as much as 50 percent in high-risk groups. It also may help acute care-centered organizations make the transition to value-based population health management.

And there is much to learn from early ACO experience, Bajner says. Among the most important lessons are the need to carefully assess market opportunities and your own capabilities, build your organization and choose partners to develop the capabilities needed to achieve specific goals, and cultivate leaders — especially physician leaders — who can execute your strategy [see Executive Corner, Page 34].

Many health systems also find they've learned valuable lessons in accountable care in the first year or two. Among them are how porous their networks are — and the importance of engaging patients in a variety of ways to keep them in network. Supporting physicians and making the most of imperfect data reporting are other key learnings. Below, four systems discuss their early experience and the challenges ahead.

I called my doctor, but ...

Controlling out-of-network costs starts with what patients hear on the phone

If this is an emergency, hang up and call 9-1-1 or go to the emergency room.

Call a physician after hours, or even during lunch or busy periods, and there's a good chance you'll hear these words. They sound reasonable enough. But they can also drive out-of-network utilization and costs — bad news for systems with risk contracts.

You're basically telling patients to go somewhere else when they might need you the most, says Alan Murray, president and CEO of CareConnect, the insurance arm of North Shore-LIJ Health System, which operates 16 hospitals and nearly 400 physician practice locations throughout New York, including Long Island, Manhattan, Queens and Staten Island.

Instead, North Shore-LIJ provides its at-risk network with a central phone bank linked to physician offices, care managers, on-call triage nurses and physicians 24/7, Murray says. In addition to making appointments and handling things like routine prescription requests, the service can answer clinical questions and direct patients to network physician offices or urgent care when needed.

"We pick up the phone in less than six seconds. You speak to a person, not a machine, and 88 percent of calls are resolved by the person picking up the phone," Murray says. Providing instant access directly reduces out-of-network utilization and avoidable ED and inpatient admissions. Providing it consistently reduces future leakage even more as patients come to trust the call center, and call it first when they need help, he adds.

Effective outreach

The phone service handles calls from North Shore-LIJ’s 5,000-patient cohort in the Montefiore Medicare Pioneer ACO, 12,000 patients in its individual health plan, 50,000 patients in its self-funded employee benefit plan, and several ACO and pay-for-performance contracts with commercial insurers. It also will serve the system’s Medicare bundled payment service set to launch next year. Overall, about 7 percent of the system’s revenues came from at-risk contracts in 2014, projected to rise to 10 percent or more in 2015, says Richard Miller, senior vice president, payer relations and contracting. The individual plan offered on New York’s health insurance exchange did exceptionally well, capturing 7 percent of the market in Nassau County, and just under 3 percent each in Suffolk and Queens counties — well beyond the 1 percent goal.

The call center itself is just one aspect of a comprehensive patient engagement strategy that touches every level of the organization. Indeed, North Shore-LIJ has restructured itself around patient care management, says Joseph Schulman, executive director of North Shore-LIJ’s population health management program, if patients don’t agree to partner with you, you can’t accomplish its service-right-now mission, Murray explains.

Integrating outreach into patient care models is also critical, says Kristofer Smith, M.D., medical director of advanced illness management. North Shore-LIJ considered telephone outreach to get high-risk patients into care management, but few patients responded. Embedded care managers who can engage patients in the physician office when they seek care are much more effective. Care managers are trained to develop trusting relationships, including how body language and word choices influence perceived trust.

The 24/7 phone service is crucial to reinforce that trust, Smith says. "Patient engagement is the most important thing you have to get good at quickly. Even if you have a good clinical program, if patients don’t agree to partner with you, you can’t improve their care."

Data collection and analytics are also essential to track patients and their care, and to find those in need of aggressive care management, says Joseph Schulman, executive director

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of North Shore-LIJ Care Solutions. The lag in reporting of claims information from the Centers for Medicare & Medicaid Services remains an issue, but it still has been very enlightening, he adds.

"As a large integrated health system, you have the perception a large percentage of care is delivered within the system, but that is not necessarily the case. It was pretty eye-opening to see the use of ancillaries and skilled nursing facilities that we don’t necessarily have," Schultz says.

As the system takes on bundled payment for chronic obstructive pulmonary disease, staying on top of care use will be critical because patients will be attributed to the system as of their first diagnosis or visit.

Involving physicians
Developing care models for accountable care and bundled payment has required a lot of work with physicians, Smith says. Keeping them informed of what changes need to be made and why, and providing evidence for adopting new protocols helps to allay suspicions that quality will be sacrificed for profit. Directly involving physicians at all levels in protocol development also helps. 'If we can put on paper what physicians agree is the right thing to do, we can manage the threat of underutilization.'

Different services are needed for different care models, Smith says. Where pay for performance involves broad contact with patients across the system for things like diabetes monitoring, ACOs and full-risk plans require identification and aggressive case management of high-risk patients, and bundled payments require integration of acute and post-acute care.

Framing new care approaches in positive terms also can help. For example, for joint replacement bundles, North Shore-LIJ has adopted "patient days at home" during the postoperative period as an outcome measure. That pushes providers to think in terms of preparing the patient for re-entry into a home environment instead of looking for ways to cut inpatient rehab or nursing home discharges, Smith says.

"It is a measure everyone can get behind — doctors, nurses, administrators, patients," Smith says. "Everyone wants the patient to be at home, but to be at home comfortably and safely. That’s the goal and, if patients need inpatient rehab or a nursing home, that’s what we do."

Assessing patient risk
For the Medicare program, Heartland leaders thought they could reduce costs by 5 percent, and came very close to its estimate, Bahrke says. This was mostly accomplished by identifying high-risk patients — those with one or more chronic conditions not under control — and providing comprehensive care management. Electronic health records identified patients who were taking six or more medications and who had visited the ED twice in a month or three times in six months, or had a hospital admission. Analytics also assigned a risk score. These patients represented about 5 percent of the Medicare population. Services included regular follow-up on such care indicators as weight gain for heart failure, social assessments and support for nutrition and medication compliance, assessment of fall risks, and home visits by nurse practitioners to keep frail patients out of the hospital.

All told, including investments in extra staff and IT infrastructure, averting loss of income from inpatient admissions, and the $5 million bonus, Heartland broke even on the Medicare program, Bahrke says. "We didn’t expect to be better off financially; we expected to learn how to provide care in a better way. There is a move to value-based reimbursement and we wanted to prove we could do it."

Bahrke expects next year to be more challenging as the requirements for managing patients tighten. This will require Heartland to focus on patients in the much larger rising risk category, which includes all patients with at least one chronic condition that is well-controlled. The goal is to reduce the Medicare spend another 4 percent. Bundled payments are also in the works, with total knee and hip replacement to launch Jan. 1 and respiratory and heart failure programs on April 1.

Extending the medical home
Heartland also is piloting an extended team-based care model in which each physician works with three nurse practitioners who provide more services to patients in the office. The system frees physicians to see the most complex cases and spend more time with each patient. The target is to cut the number of visits per day to about 15 from as high as 40 in conventional practice.

So far, the program seems to be succeeding. "We are seeing fewer ED visits and fewer urgent care visits," Bahrke says. "We have a goal of closing urgent care and having offices open longer so..."
you can go to your medical home even in the evening. We feel strongly that even though we have a robust EHR that supports services anywhere in the system, the patient should be seen as often as possible in the medical home.”

Physician engagement has been critical to the transformation, Barhke says. One way the system has involved doctors is through a dyad management structure, in which each unit is headed by both an administrator and a physician. She stresses constant communication to shift the culture from looking at cost per case to the total cost of care. Measuring and improving processes is also a key, as are real-time data to support timely caregiving.

Placing care managers in physician offices is also critical. That way they can see patients at the same time as physicians, and physicians can refer patients to extended services in real time. “Surrounding physicians with the tools and resources is one of the best ways to achieve success with culture change,” Barhke says. “Provide the tools and they will use them.”

Supporting change

For Andrew Hertz, M.D., transitioning to accountable care comes down to one thing: changing the way physicians and patients relate to each other. “You can create any kind of structure and support services, but until you change physician and patient practices, you can’t succeed.”

As vice president and medical director of the UH Rainbow Care Network, Hertz uses several strategies to engage physicians. These include a physician advisory council that develops quality metrics and new care strategies and continuing medical education presentations on the goals and methods of health care reform.

Perhaps most important, though, are skilled practice facilitators, who visit each location every week. Though not physicians, facilitators work directly with physicians and staff to redesign practice processes and educate them on national quality standards. The teams also monitor practice performance and engage staff in rapid-cycle quality improvement, giving feedback and tweaking performance on a weekly basis. “It’s not a cookie-cutter approach. Every practice is different, and this allows us to tailor our support. We tell them, ‘This is the goal. How can we work with you to get there?’” Hertz says.

This is especially important given the diversity of UH Rainbow Care’s membership, which stretches from inner-city Cleveland to small rural communities. The pediatric ACO encompasses 166 practitioners serving 70,000 Medicaid enrollees at 51 locations in eight Ohio counties.

The program has improved care greatly for some of the most common and costliest childhood conditions, including asthma and attention deficit hyperactivity disorder. The program also provides oral health services, which are a big cost-driver, Hertz says. Organized under a $12.7 million grant from the CMS Innovation Center, the network has not yet released its first-year results. But Hertz says the network qualified for Medicare Shared Savings Program payments in its first three quarters.

Targeting complex cases

Like most programs, a small group of patients with complex chronic conditions generate a disproportionate share of UH Rainbow Care’s costs. They receive a multidisciplinary assessment including primary care, specialty care, social work, dietitians and a plan with follow-up. “We try to increase the functionality of the whole family and this decreases hospital admissions and the length of stay in hospitals,” Hertz says.

The network provides 24/7 access to a multidisciplinary team via telephone and telemedicine. Some of the sickest patients are given iPad
EXECUTIVE CORNER

The next step in developing ACOs may be integrating bundled payment packages for specialty care that complement primary care networks, according to Rich Bajner and Dennis Butts Jr. of Navigant Consulting. They outline three steps for transitioning to what they call ACO 2.0:

STEP ONE | Assessment
Are local payers pushing for ACO 2.0? Are market economics (utilization, enrollment, rates) sufficient to justify the risks? Are actuarial assumptions sound and finances strong enough to bear downside risk? Which bundled payment programs are best, and in what order should they be adopted? What capital is required? What business partners are needed? Do your homework. A bad contract to assume risk is worse than no contract.

STEP TWO | Organization
How will your high-performing networks be defined, constructed and incentivized to act as a clinically integrated model? How will you select from all providers to create narrow networks? How is governance constructed to comply with laws? Pick partners carefully. It’s better to have a few of the right players than lots of questionable players.

STEP THREE | Implementation
How will utilization, outcomes and patient experience be measured and improved systematically? How is each discrete patient population managed? How is utilization coordinated and tracked? How and where are savings optimized that enhance quality? How are underperforming providers addressed? How is adverse selection handled? Where are accessible savings in the populations under contract? Execution is everything. Physician leaders who can drive ACO 2.0 and systems in place to measure and monitor savings are key.

Data challenge
Still, the network struggles with issues of slow and incomplete data from Medicaid, Hertz says. This makes it hard to find out how much patients are going out of network. But engaging patients more actively through coordinated care plans creates opportunities to keep them in network by referring them to preferred providers.

At the end of its first year, the network is both a financial and popular success, Hertz says. Patients like the access and better care, giving UH Rainbow Care satisfaction ratings in the upper 90s percentile. Physicians are polled every six months and satisfaction runs around 80 percent. “For physicians, that’s pretty good,” Hertz says. “It’s really a grassroots effort. We engage physicians at every peer level from the individual to the group to the whole ACO.”

Data is insight
Even incomplete and retrospective data help to assess and improve performance

When it comes to data collection, systems operating in Connecticut are disadvantaged, says Michael Hunt, D.O., chief medical information officer and chief medical officer at St. Vincent’s Health Partners in Bridgeport. Connecticut ranks 49th out of 50 in physician adoption of electronic health records.

Nevertheless, St. Vincent’s has built a physician-hospital organization that successfully participates in shared savings plans with Medicare and several commercial payers, Hunt says. Within three years, he hopes to take full-risk contracts through the network, which includes about 400 primary care and specialist physicians in 50 practices, along with three skilled nursing facilities, four home health agencies and 473-bed St. Vincent’s Medical Center in Bridgeport. The network is also the first to be certified as clinically integrated by the URAC, formerly known as the Utilization Review Accreditation Commission, Hunt says.

St. Vincent’s addresses the EHR issue in part by connecting with its members’ practice management software, which provides encounter data and some clinical data in near real time. The network also draws as much data from payers as it can, although this, too, is fragmented and often delayed, Hunt says. Payer data are especially important for determining how patients are attributed in shared savings plans. Attributed populations can shift as much as 20 percent in a month, he adds. Data from referral laboratories are also gathered.

In all, the operation culls data from about 2,000 sources. Hunt uses it to construct profiles of each physician and practice in terms of where they stand on shared savings clinical quality indicators, ED use and hospital admissions, and...
their referral patterns. The goal is to identify and close gaps in care continuity. In conjunction with the network’s utilization oversight committee, plans are constructed to help practices keep patients in network and out of the hospital.

These plans are presented monthly by Hunt or a system care coordinator. “We tell them at these high-visibility times that we need to communicate and not lose momentum,” he says.

After two and a half years, the results are good, Hunt says. About 75 percent of patient encounters are kept in network and avoidable admissions are down. The network is generating savings on a Medicare ACO, although its results won’t be finalized until early 2015.

St. Vincent’s is moving toward an integrated EHR, which should simplify data capture and analysis. Until then, it will take whatever data it can. “We don’t waste any data,” Hunt says.

Closing care gaps

Early on, analysis of network referral patterns revealed higher levels of out-of-network utilization after hours and on weekends. Tracing the causes, Hunt realized that many practices did not have nurse triage after hours, and used telephone scripts that told people to call 9-1-1 or go to the nearest ED. These were reworked to direct patients to in-network urgent care.

Analysis also showed that many primary care offices had stopped communicating with urgent care. The network brought physicians from practices and urgent care together one-on-one to re-establish relationships. A system of reporting urgent care encounters immediately to primary care also was implemented.

Patient engagement was part of the strategy. Patients are educated on what kind of problem warrants an ED visit. For example, patients with diabetes are instructed to call their doctors if their sugar levels are out of control, rather than go to the ED. “We are engaging to manage ambulatory care-sensitive conditions,” Hunt says.

Similarly, data on hospital and ED visits are gathered and forwarded to primary care offices for follow-up within 14 days for ED and seven days for hospital. “We have been successful in managing that,” Hunt says. “Overall compliance is around 80 percent, sometimes higher, sometimes lower.”

St. Vincent’s also negotiates with payers to get special data feeds on out-of-network ED and hospital visits, Hunt says. This helps primary care doctors to follow up with patients in accordance with value-based guidelines, and offer them referrals to in-network providers. “It requires us to be connected to a wide variety of data sources. Our care coordinators scour them and are as proactive as possible in managing against the claims.”

Redefining doctor productivity

Translating data into actionable items for physicians is critical, Hunt says. Care coordinators forward data as they come in, with instructions on what actions are needed to meet care and payer guidelines. “Physicians have struggled in the past because they have not known the rules of the game,” he says. “We tell them what condition and utilization they are accountable for.” Recognized national guidelines such as those from CMS and the Healthcare Effectiveness Data and Information Set ensure objectivity. The network also negotiates with payers to develop common quality measures among them to cut down on the number of measures used.

But as successful as the program has been, physicians still have questions. “To be honest, they are waiting for proof,” Hunt says. “They are waiting to see if they are able to get shared savings, and that the changes they make today will make a difference tomorrow.”

Care coordination requires investing in IT infrastructure and staff, which is difficult for independent physicians in any case, but even more so when they are asked to make a leap of faith that they will be paid for it.

In essence, the role of the physician is changing from caregiver to care manager, and the traditional relative value unit-based reimbursement models no longer apply, Hunt says. “We are asking physicians to use their skill sets in more sophisticated ways. As we move away from face-to-face physician encounters, we need the public and payers to recognize the value of using physician skills for care management and care coordination. These efforts need to be compensated so physicians can accept the transformation to a new care model.” — Howard Larkin is a contributing writer for H&HN.