Becoming Accountable

William Bithoney, MD, FAAP, Founder and CEO
Bithoney and Associates, ACO Consulting Group

Bob Edmonson, MPH, FACHE,
Chief Strategy Officer Carroll Health System

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Accountable Care represents a revolutionary shift in the healthcare business model

From:	To:
Treating individuals when they get sick	Keeping groups of people healthy
Emphasizing volumes	Emphasizing outcomes
Maximizing the use resources/assets	Applying appropriate levels of care at the right place
Offering care at centralized facilities	Offering care at sites convenient to patients
Treating all patients the same	Customizing care for each patient
Avoiding the sickest chronic patients	Creating venues to provide special chronic care services
Being responsible for those who seek our services (Market Share)	Being responsible for the needs of all our people (Community)

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Transforming the Patient Experience: Healthcare Today

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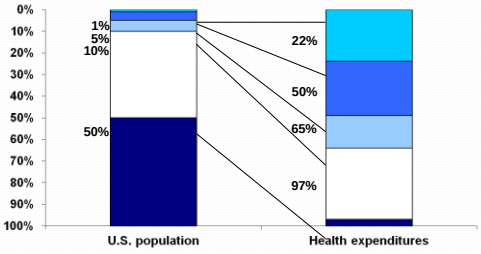
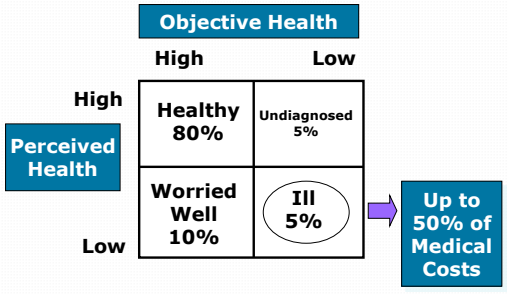
Health Care Costs Concentrated in Sick Few: Sickest 5% Account for 50% of Expenses

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 2009



Source: Agency for Healthcare Research and Quality analysis of 2009 Medical Expenditure Panel Survey.

Population Health Management Concept



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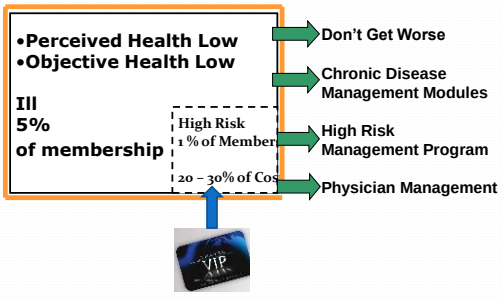
Focusing on the Frequent Flyers: The Ill 5%



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Transforming the Patient Experience: A Model for the Future

Physicians and hospitals assume responsibility for managing health of entire population

Community members screened for health risk factors

Low-Risk Community Members

- Wellness and screening
- Healthy lifestyles
- Track health status
- Convenient access to multiple sites
- Patient portals

High-Risk Community Members

- Disease management
- Teams of physicians, physician extenders, care coordinators, and patient coaches develop care plans
- Weight loss, smoking cessation, medication management
- Post-discharge transition management

Objective: Keep people healthy and appropriately manage utilization

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What the population health manager is looking for--

- All hands on deck with frequent flyers
- Coordinated information systems
- Obsessive focus on the continuum of care
- Drive care to the lowest level
- Reduce readmissions
- Provide wellness at every healthcare "touchpoint"

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Coordinated systems of care can manage complex patients across the continuum

Information Technology

HIS/RIS/PACS

- Electronic Medical Record
- Health Information Exchange
- Patient Portals
- Tracking and Reporting

Patient Centered Medical Home

- Primary Care Physicians
- Specialists
- NP/PA's
- Patient Coaches
- Pharmacists
- Mental Health Providers

Chronic Disease Management

- Care planning
- Transitions Management
- 24/7 Call Center
- Medication Reconciliation
- Referral Management
- Telehealth
- Routine checks
- Education
- Healthy behaviors

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Volume versus Value: Balancing Two Worlds

Solution: Fee-For-Service + Shared Savings Incentives

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Key Components of a Population Health Management Delivery System

Community	Health System	Post Acute
Disease Management	Access	Transition Management
Behavioral Health	Patient Navigation	Long-Term Care/Rehab
Pharmacy	Case Management	Home Health

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Community Services

Disease Management

- Risk stratification
- Chronic population identification
- DM program enrollment
- Care planning
- Prevention and wellness
- Disease protocols
- Preferred physician visits

Behavioral Health

- Government and community agencies
- Drug-seeking guidelines
- ED case management
- Substance abuse assistance
- Socio-economic factors

Pharmacy

- Medication reconciliation
- Medication assistance and compliance
- Discharge meds

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Health System Services

Access

- Call centers
- Patient portals
- Primary care
- Specialty care
- Retail clinics
- Urgent care
- Emergency services
- Inpatient intake
- Post-discharge follow-up

Patient Navigation

- Coordination of services
- Patient education
- Care planning
- Follow-up and tracking
- Scheduling
- Resource assistance

Case Management

- Emergency department
- Inpatient services
- Discharge planning

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Post Acute Services

Transition Management

- Post-discharge planning
- Readmission risk identification
- Medications
- Follow-up call center
- Physician scheduling

Long-Term Care/Rehab

- Skilled nursing clinical management
- LTACH
- Rehabilitation

Home Care/ Hospice

- Home visits
- Telehealth
- Hospice and palliative care

Putting it All Together

Community

Self Care

Primary Care/ PCMH

Retail Clinics

Specialty Care

Health System

Urgent Care

Emergency Department

Hospital

Objective: Drive care to the lowest cost/most convenient setting

Post Acute

Skilled Nursing

Rehabiliation

Home Care

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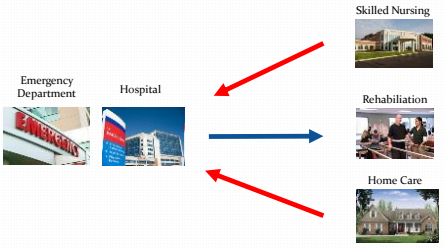
Avoidable Readmissions: The Epic Fail



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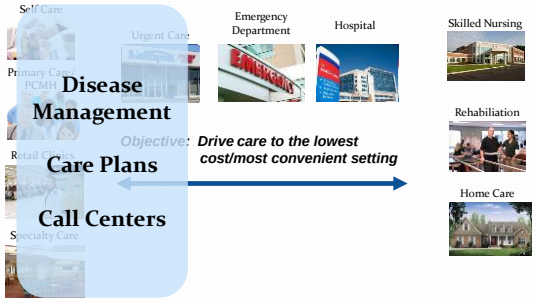
Putting it All Together

Community | **Health System** | **Post Acute**



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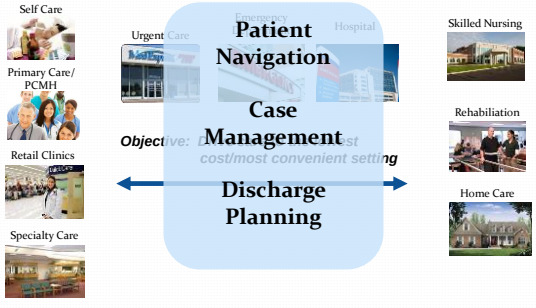

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Putting it All Together

Community

Self Care

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Objective: Drive care to the lowest cost/most convenient setting

Post Acute

Skilled Nursing

Transition Mgmt

PAC Networks

SNFist

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Integration for Accountable Care: Who, what and how?

The Emerging Healthcare Industry

- Large consolidated providers
- Focus on coordination, collaboration, communication
- More comprehensive continuum of care
- Population health management vs. volume

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Key Strategic Issues for ACO Development

- Who will take the lead?
- What are the essential components of an ACO?
- How should we aggregate the components and structure the organization?
- What components should be…
  - Incorporated into structure?
  - Purchased?
  - Partnered?
- What is the role of the Payor?

Physician-driven models are taking lead in building patient-centered care

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Case Study: Hospital-Based ACO Partnership

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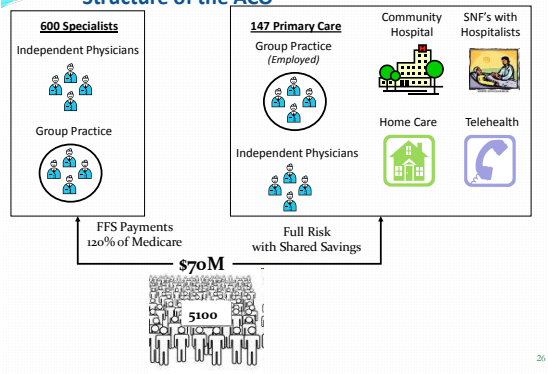
Hospital-based ACO Partnership

- 280-Bed community hospital in the northeast
- Diverse mission with multiple special programs e.g. homeless, methadone treatment program, ethnically diverse population, DSH status
- A Multispecialty group led by a geriatrician with expertise in disease management
- 13 years experience at full risk for a Medicare population
- 5100 patients enrolled in Health Plan
- Owned Psychiatric and Rehab Hospitals, Home Health, Hospice and Nursing Homes

Structure of the ACO



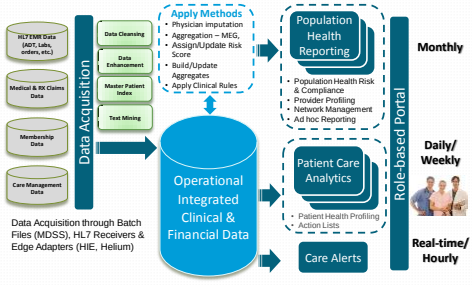
Key Clinical Management Activities

Primary Care	Hospital	Skilled Nursing Facility	Home Care	Telehealth
Real time MD availability for urgent needs	Assure admission to lower cost, in network hospitals	Steer patients to lower levels of post acute care	Robust in home training in disease self management, patient engagement	Phillips telehealth for sickest patients
Patient centered medical home	Dedicated hospitalists optimally manage care	Assure admission to lower cost, in-network SNF, TCU, rehab	Home visits: VNA growth from 65,000 in 2008 to 80,000 in 2009	In-home monitoring
Proactive health management	Steer patients to lower levels of care	SNFist manage nursing home care with PCP		Post-admission follow-up and tracking
Urgent care, walk-ins, retail clinics	Aggressive case management	Rehab management		

TECHNOLOGY: TRANSFORMATIVE APPLICATIONS INCREASE VALUE AND EFFECTIVELY MANAGED CARE

- Electronic Health Records
- Provider Profiling
- Virtual Single Medical Record
- Risk Profile DCG
- Population Health Messaging, Alerts
- Clinical Decision Support: Micromedex, Zynx, CPOE
- End of life management: palliative care, hospice

POPULATION HEALTH ANALYTICS FOR RISK–BEARING PROVIDER ORGANIZATIONS



Results

Utilization

DRG Admissions - 2009

	Unmanaged Medicare	Managed Medicare	ACO
DRG Admissions Per 1,000 members	380	304	173
DRG Length of Stay	6.2	5.6	5.8
DRG Hospital Days Per 1,000 members	2356	1709	1008

Results

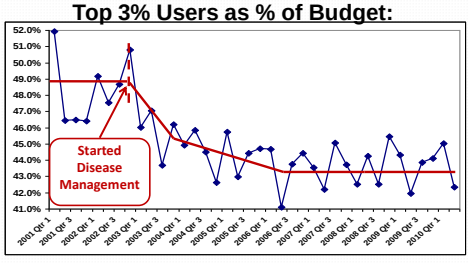
Utilization

DRG & Observation - 2009

	Unmanaged Medicare	Managed Medicare	ACO
Total Admissions and Observations Per 1,000 members	405	376	301
Length of Stay Average	5.9	4.8	3.9
Total Days Total Per 1,000 members	2389	1817	1187
% of Patients Readmitted Within 30 days	20.0	16.4	9.8

Disease Management Outcomes

Top 3% Users as % of Budget:



49% → 43% = $5,000,000 /year savings

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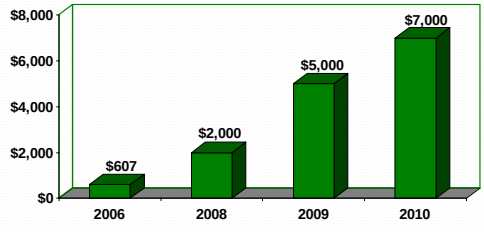
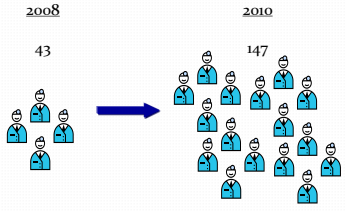
Growth in Residuals for Shared Savings

ACO Shared Savings FY 2006-2010
(in 000's)



The key: Disease Management!!

Primary Care Physician Panel Growth



How: Distribution of Shared Savings
(As much as $X00,000's)

Mercy Hospital Awards and Honors

Cleverly Associates
Top 100 Hospitals

Leapfrog Group
Top Decile for Hospital Efficiency

ACHE Innovations Award

Most Profitable
Community Hospital in
Massachusetts

The Future of Accountable Care

- Backlash against bureaucracy and complexity of CMS rules
- Many leading health systems opting out of Medicare program
- Likely revision/restructuring of rules
- Bottom line:
  - Right thing to do
  - Demand for value
  - Opportunity to create the future!

Questions and Discussion