ACO Partnerships – A Case Study

Bob Edmondson, MPH
Vice President, Innovation
West Penn Allegheny Health System
Pittsburgh, PA

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1. The Strategic Imperative for Accountable Care
2. Population Health Management
3. The Micro-ACO Model
4. Case Study Results
The Problem: Healthcare expenditures engulf too much of the economy with no end in sight

Accountable Care represents a revolutionary shift in the healthcare business model

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

Questions:
1. Why do this?
2. Haven't we been here before?
3. Why not wait for repeal of reform?

Answer: Cost/quality pressures are driving the convergence of forces and shifting the foundation of healthcare.
Patients: Demanding Value

- Communication
- Convenience
- Information
- Comparative data (Consumer Reports)
- Clarity
- On-line access
- Instant reporting/follow-up
- Health promotion guidance and support

All at a lower cost!!

The Purchaser: Private Pay and Federal Reforms

Transition from fee-for-service to bundled and risk-based payments

Reduced payments to hospitals for excessive readmissions and hospital-acquired conditions

Emphasis on quality, efficiency and patient-centeredness

Shared savings between payers and providers

Use of evidence-based medicine and coordinated care

Accountable Care Organizations and Patient-Centered Medical Homes

Technology: Transformative applications increase value and effectively manage care

- Electronic Health Records
- Patient Portals
- Interfaces
- Use of PDA’s and handheld devices
- Real-time imaging
Key Question:

How do we create value when we have to do more with less?

Value Innovation for Accountable Care

Blue Ocean Strategy:
The Simultaneous Pursuit of Differentiation and Low Cost

- Eliminate and/or reduce the factors an industry competes on = cost savings
- Raise poorly offered elements and/or create elements the industry has never offered = raise/create value

The Four Actions Framework Builds the Foundation for Accountable Care

<table>
<thead>
<tr>
<th>Eliminate</th>
<th>Raise</th>
<th>Reduce</th>
<th>Create</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary and redundant testing</td>
<td>Chronic disease management</td>
<td>Fragmented approach to care</td>
<td>Integrated networks</td>
</tr>
<tr>
<td>Avoidable hospital readmissions</td>
<td>Patient engagement in their care</td>
<td>Overall hospital admissions</td>
<td>Patient care teams</td>
</tr>
<tr>
<td>Use of paper documentation</td>
<td>Home monitoring and follow-up</td>
<td>One-on-one and face-to-face provider visits</td>
<td>Patient registries</td>
</tr>
<tr>
<td>Hospital-acquired infections</td>
<td>Health promotion</td>
<td>Poor health maintenance</td>
<td>Patient portals</td>
</tr>
<tr>
<td></td>
<td>Screenings</td>
<td>Use of phone and fax</td>
<td>Virtual visits</td>
</tr>
</tbody>
</table>

Driving Costs Down

Driving value up and creating new demand

Population Health Management

Healthcare Delivery Today
- Individual experiences health need or event
- Accesses health system and receives unit of service
- Payment for unit of service
- Patient discharged with limited information and follow-up

Healthcare Delivery Tomorrow
- Population assigned to an ACO/PCMH
- ACO/PCMH customizes health plan to fit individual needs
- Payments by PMPM, bundles, P4P, FFS and Shared Savings
- Patient actively participates in health promotion and care

Principles of Population Health Management
- Manage patient population through risk stratification
- Keep healthy people healthy
- Keep sick people from getting sicker
- Aggressively manage high risk population
- Use evidence and threat-based resourcing
- Maintain 90-95% panel participation and keep 75-85% at low-risk
- Partners: health plan, pharmaceutical company, consumers/patients, community resources
Risk Stratification

Objective Health

<table>
<thead>
<tr>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>Undiagnosed</td>
</tr>
<tr>
<td>80%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Perceived Health

<table>
<thead>
<tr>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worried</td>
<td>Well</td>
</tr>
<tr>
<td>10%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Up to 50% of Medical Costs

Core Tenets of Population Health Management

1. Individuals can maintain low-risk health status even as they age
2. A Patient-Centered Medical Home can help patients obtain and maintain low-risk health status
3. The major economic benefit is paying attention to those with low risk, keeping them there and aggressively managing those with high-risk
4. As patient population health is maintained panels can expand the number of patients (doing more with less)

Payment Reform Target

Readmissions

Almost twenty percent of Medicare patients are readmitted within 30 days...

...resulting in $15B in cost to the program...

Potential Avoidable Readmits: $12B

Unavoidable Readmits: $3B

Source: Healthcare Financial Management Association
Avoiding Readmissions

• Engage each patient in the most effective way for them
• Interventions: follow-up appointments, medication management, etc
• Interact with Primary Care Physicians to keep them informed
• Work with patient as appropriate based on their location
• After 30 days, patient placed in surveillance program
Hospital-based ACO Partnership

- 200-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

Structure of the ACO
The “Micro-ACO” Model

Key Clinical Management Activities

Primary Care
- Real-time MD availability for urgent needs
- Patient centered medical home
- Proactive health management
- Urgent care, walk-ins, retail clinics

Hospital
- Assure admission to lower cost, in-network hospital
- Dedicated hospitalist, specialty management
- Steer patients to lower levels of care
- Aggressive case management

Skilled Nursing Facility
- Assure admission to lower cost, in-network SNF, TCU, rehab
- SMHist manage nursing home care
- Patients who went home from 36,000 in 2009 to 82,000 in 2010

Home Care
- Robust in-home teaching, in-clinic management, patient engagement
- Home visits, VNA, growth from 8,000 to 20,000

Telehealth
- Phillips Telehealth for sickest patients
- In-home monitoring
- Post-admission follow-up
- Telekriti

Case Study Results
### Utilization

#### Observation Admissions - 2009

<table>
<thead>
<tr>
<th></th>
<th>Unmanaged Medicare</th>
<th>Managed Medicare</th>
<th>ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation Admissions for 1,000 members</td>
<td>25</td>
<td>72</td>
<td>128</td>
</tr>
<tr>
<td>Observation Length of Stay for 1,000 members</td>
<td>1.3</td>
<td>1.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Observation Days for 1,000 members</td>
<td>33</td>
<td>108</td>
<td>179</td>
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</tbody>
</table>

#### DRG Admissions - 2009

<table>
<thead>
<tr>
<th></th>
<th>Unmanaged Medicare</th>
<th>Managed Medicare</th>
<th>ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG Admissions for 1,000 members</td>
<td>380</td>
<td>304</td>
<td>173</td>
</tr>
<tr>
<td>DRG Length of Stay for 1,000 members</td>
<td>6.2</td>
<td>5.6</td>
<td>5.8</td>
</tr>
<tr>
<td>DRG Hospital Days for 1,000 members</td>
<td>2356</td>
<td>1709</td>
<td>1008</td>
</tr>
</tbody>
</table>

#### DRG & Observation - 2009

<table>
<thead>
<tr>
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<th>Unmanaged Medicare</th>
<th>Managed Medicare</th>
<th>ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Admissions and Observations for 2,000 members</td>
<td>405</td>
<td>376</td>
<td>301</td>
</tr>
<tr>
<td>Length of Stay range</td>
<td>5.0</td>
<td>4.8</td>
<td>3.9</td>
</tr>
<tr>
<td>Total Days Cost for 2,000 members</td>
<td>2389</td>
<td>1817</td>
<td>1187</td>
</tr>
<tr>
<td>% of Patients Readmitted within 30 days</td>
<td>20.0</td>
<td>16.4</td>
<td>9.8</td>
</tr>
</tbody>
</table>
Results

Management of Financial Risk
Admission to High Quality/Low Cost “Home Hospital”
Aligned with Shared Savings

<table>
<thead>
<tr>
<th></th>
<th>Unmanaged Medicare</th>
<th>Managed Medicare</th>
<th>HHSBA ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>% DRGs at home hospital</td>
<td>22%</td>
<td>62%</td>
<td>81%</td>
</tr>
<tr>
<td>% OBS at home hospital</td>
<td>22%</td>
<td>69%</td>
<td>95%</td>
</tr>
<tr>
<td>% OPD use at home hospital</td>
<td>22%</td>
<td>65%</td>
<td>91%</td>
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</tbody>
</table>

Net revenue to hospital with At-Risk Surplus added in when compared to Medicare is $6,951,000

Results

“Micro-ACO”
Financial Performance

<table>
<thead>
<tr>
<th>Hospital Service Fund (HSF) allocation</th>
<th>50.3% of PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSF Expenses</td>
<td>92%</td>
</tr>
<tr>
<td>HSF Surplus</td>
<td></td>
</tr>
</tbody>
</table>

| Medical Service Fund (MSF) allocation | 36.2%         |
| MSF Expenses                          | 77%           |
| MSF Surplus                           | 23%           |

Annual cost for managed population
Savings compared to unmanaged Medicare population of same size

PCP’s earned $2 in excess of MCare

Net revenue to hospital with At-Risk Surplus added in when compared to Medicare is $6,951,000

Results

Member Satisfaction Survey Results

<table>
<thead>
<tr>
<th>Question</th>
<th>Excellent</th>
<th>Very good</th>
<th>Appropriate</th>
<th>Just fair</th>
<th>Not appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall evaluation of services</td>
<td>61%</td>
<td>31%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>64%</td>
<td>22%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information about services</td>
<td>83%</td>
<td>13%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing staff</td>
<td>25%</td>
<td>33%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone/Office services</td>
<td>61%</td>
<td>19%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Customer service experience</td>
<td>50%</td>
<td>22%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital staff</td>
<td>44%</td>
<td>25%</td>
<td>&lt;1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other/other</td>
<td>66%</td>
<td>20%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5/13/2011
Growth in Residuals for Shared Savings

The key: Disease Management!!

Disease Management Outcomes:
Top 3% Users as % of Budget:

49% → 43% = $5,000,000/year savings

Questions and Discussion