Valence Health

Turning Today's PHO into Tomorrow's ACO

MAY 18, 2011

BETTER CARE IS ELEMENTAL.

Today's Speakers

Carole B. Black, M.D. is a specialist in clinical program optimization to support efficient, effective care delivery. She oversees clinical development for Valence Health's innovative Clinical Integration product and TPA services. Dr. Black has extensive experience in all aspects of hospital, practice and plan/payer Medical Management including Utilization Management, Case and Disease Management, Quality and Patient Safety, and Pharmacy Management, and recently facilitated a comprehensive Medical Cost Trend analysis and implementation project at a Midwest Integrated Delivery System. Prior to joining Valence Health, she served in a variety of senior, medical executive roles, including Medical Director, with Harvard Pilgrim Health Care and Fallon Clinic.

Dr. Black is a graduate of MIT and Harvard Medical School and is a board certified internist. She can be reached at 312-277-6383 or cblack@valencehealth.com

Elizabeth Simpkin is Senior Vice President of Consulting Services for Valence Health. Ms. Simpkin consults widely with hospitals and other providers organizations on strategy, financial risk models and performance improvement. She has assisted numerous provider organizations with clinical integration and ACO program development and implementation, and negotiating quality-based pay-for-performance contracts. Before joining Valence Health, Liz was President and founder of The Lowell Group Healthcare Consulting. Her 20 years of healthcare experience include managed care contracting, strategic planning, business development, and business operations from provider, employer and payer perspectives.

Liz has a Master's degree in Healthcare Economics from Arizona State University's W.P. Carey School of Business. She is a nationally recognized speaker and author on health care issues. She and her dog Jack, a certified therapy dog, work with special needs kids in Chicago. She can be reached at 312-277-6340 or esimpkin@valencehealth.com

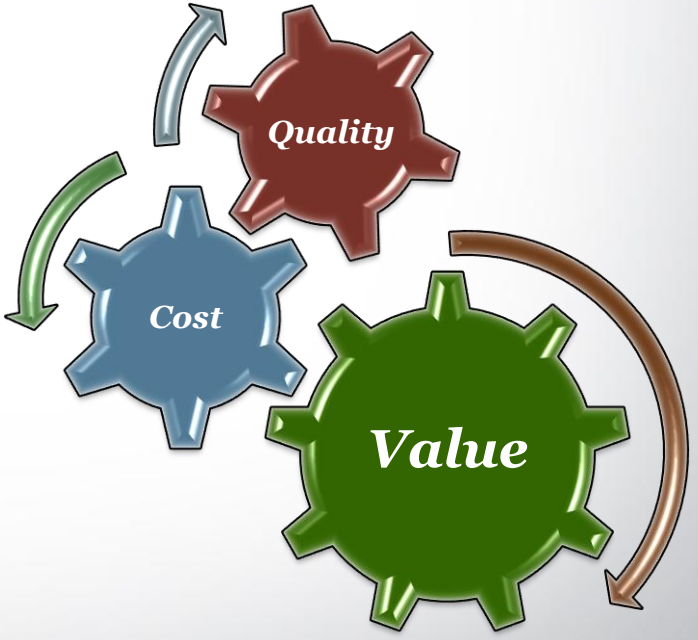
Today's Topics

- **ACOs – what we now know**
- **Bridging the Gap - building on what you already have**
  - Information Technology
  - Population Care Management
  - Physician Engagement
  - New Governance Model
- **Questions and Discussion**

Reform's Overarching Goals

To deliver and pay for HEALTHCARE VALUE:

- *Better Care for Individuals*
- *Better Health for Populations*
- *Bend the Trend*



Medicare ACOs

- **32 Pioneer ACOs announced December 2011**
- **First 27 ACOs in the Shared Savings Program announced April 2012**
- **More than 150 applications already received for July 1**
- **Over 1.1 million beneficiaries covered through various CMS shared savings care models**

Medicaid reform also includes ACOs

- State budgets are stretch, costs are out of control
- 17 million newly eligible in 2014

Expand Managed Care

- ✓*Mandated enrollment*
- ✓*Service area expansion*
- ✓*New populations*

Delivery System Models

- ✓*ACOs*
- ✓*Medical Home*
- ✓*Specific populations*

- ✓*Restricting eligibility*
- ✓*Eliminating additional benefits*
- ✓*Cutting reimbursements*

Commercial Insurers embracing ACOs too

- **"Leapfrogging" beyond CMS ACO model**

1. Medical Home programs
2. Shared Savings Models – with upside only, or with shared losses too
3. Risk and partial risk agreements
4. "ACO" contracts for fee-for-service members

Supreme Court review – question mark but not a final answer for ACOs

- **Considering constitutionality of PPACA**
  - validity of the individual mandate
  - Medicaid expansion
- **Oral arguments March 26-28, 2012**
- **Expect written opinion before end of June**

The Way Forward …

Bridging the Gap

Need

- What you need for ACO

Have

- What you likely have today

Do

- What to do to bridge the gap

Step "0" = Organized Provider Group

Organized Entity: PHO or IPA	• Leadership and Governance structure
	  • BOD, Officers, CI Committee
	  • Physician Leaders/Champions
	• Policies and Procedures

Population Management	• Secure participation/BAAs • Guidelines and Metrics • Build knowledge, Begin to share data and tools
Negotiate and Administer Contracts	• Structure participation requirements • Develop rewards & distribute incentives • Build infrastructure

Need

- **Sophisticated IT and reporting**

Have

- Diverse Practice Management systems
- 20-40% on different EHRs
- Hospital rolling out EHR and CPOE

Do

- Use the data that is available
- Enhance with targeted clinical data
- Incentivize doctors to use tools

Using Information to Improve Clinical Quality and Outcomes

Performance reports

- Compliance with clinical guidelines & metrics
- Comparison to peers and benchmarks
- Identification of areas for improvement

Care Coordination tools

- Disease registries
- Point of care tools
- Alerts & reminders
- Patient outreach, education and engagement

Performance Improvement tactics

- Data identifies quality, patient safety or efficiency opportunity
- Transparency, info sharing, teams
- Root cause analysis & P-D-C-A
- Physician engagement, with aligned incentives

Approaches to Getting Data

- **From Payors**
- **From Practice Management Systems**
  - Supplement with Hospital and Vendor data feeds
- **From Paper Medical Records – Manual Registries**
- **Participate in Health Information Exchange**
- **Common Electronic Health Record**

- **Use the data you can get most readily - often practice management system**
- **Deliver value – tools that actually help today**
  - "Registry and action lists" to identify and outreach

Measure Results[Vision® by Valence]

WGH PHO

Main Page

Dr. A. Smith

Compliance Rates by Measure

Print to PDF | Print to Excel | Search: Submit Clear

Measure	Current Measurement Period (December 1, 2010 - November 30, 2011) Compliant	Eligible	% Compliant	Prior Measurement Period (December 1, 2009 - November 30, 2010) Previous Compliant	Previous Eligible	Previous % Compliant	% Change
Breast Cancer Screening	218	435	50.1%	336	618	54.4%	(4.3%)
Cervical Cancer Screen 18 - 64	103	484	21.3%				21.3%
Colorectal Cancer Screening	61	1,182	5.2%	29	1,239	2.3%	2.8%
Diabetes Management	107	184	58.0%	93	156	59.4%	(1.3%)
Diabetes Screening	1,358	1,481	91.7%	1,340	1,581	84.8%	6.9%
Heart Failure Management	15	16	91.7%	12	21	55.6%	36.1%
Hypertension Management	706	955	73.9%	654	862	75.9%	(1.9%)
Lipid Screening Ages 20 - 80	1,854	2,342	79.2%				
Osteoporosis Women Routine	198	447	44.3%				
Pneumonia Vaccine-Older Adult	173	779	22.2%				

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For compliance measures with more than one sub-measure, partial credit is given to the patient for services met. As a
nearest whole number, and therefore may not reflect the number of compliant individuals.

Dr. A. Smith

Comparison

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Measure	Your Patients	All Quality Alliance Patients	Comparison
Annual Review Age 65 & Older	72.3%	57.3%	↑
Asthma Management	24.1%	27.6%	↓
Back Pain Lower Acute	100.0%	71.9%	↑
Breast Cancer Screening	50.1%	50.3%	↓
Cervical Cancer Screen 18 - 64	21.3%	60.3%	↓
Colorectal Cancer Screening	5.2%	23.1%	↓
Diabetes Management	58.0%	47.3%	↑
Diabetes Screening	91.7%	66.2%	↑
Heart Failure Management	91.7%	40.4%	↑
Hypertension Management	73.9%	50.4%	↑
Lipid Screening Ages 20 - 80	79.2%	40.2%	↑

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PHO

Diabetes Management[Vision© by Valence]

Current Measurement Period: **December 1, 2010 - November 30, 2011**

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▸ Back to All Measures ▸ Main Page ▸ Measure Definition

Measure Snapshot | Reporting Notes

Reference: American Diabetes Association; National Quality Forum

Conditions: Diabetes

Relevant Care Elements/Visits: Attention to Nephropathy, Diabetes Management Visit, HgbA1C, LDL, Retinal Screening

Excluded Conditions: Gestational diabetes, Nonspecified disorder of pancreas, exclusion from diabetes, Polycystic ovarian syndrome (PCOS), Steroid induced diabetes

Minimum Age: 18

Maximum Age: 75

Submeasure Profile

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Submeasure	Your Patients	All IPA Patients
Eye Exam	47.2%	48.0%
HbA1C : % With Current Test	51.7%	63.0%
% HbA1C Poor Control : > 9.0*	28.9%	9.0%
% HbA1C Control : < 8.0*	53.0%	58.0%
% HbA1C Control : < 7.0*	10.0%	8.0%
Lipid : % W		82.0%
% LDL Control : < 100*	51.2%	62.0%
Office Visit	84.3%	84.1%
Overall Compliance	52.7%	63.0%

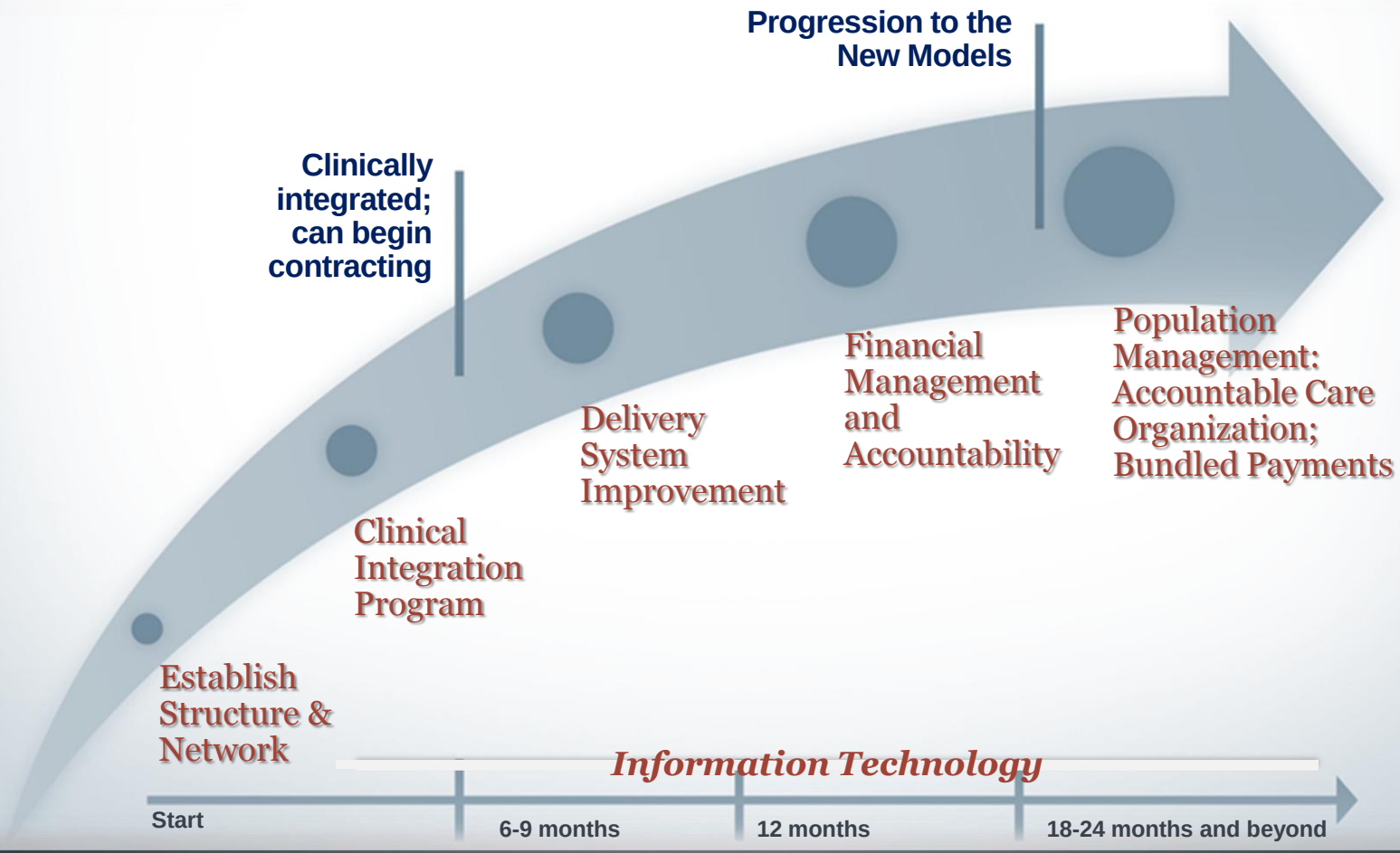
Based on the subset of 83 patients with an HbA1C result available.

Total Records: 9 / Page 1 of 1

= Your patients are above the overall IPA for this measure.
= Your patients are below the overal IPA for this measure.
*Only reflects patients for which lab values are available.

= Your patients are above the overall for this measure.
= Your patients are below the overall for this measure.

A Clinical Integration Program is the Foundation for Accountable Care



Need

- **Delivery System Improvements**
- **Population Management & Care Coordination**

Have

- Referrals, some UM and lagged payer reports
- Able to identify patients with a condition
- Payer Medical Management programs – remote

Do

- Aggregate data, identify high risk, high cost patients
- Address care continuum : understand/close care gaps
- Implement “Medical Home” components

Population Management

- **Comprehensive patient data, viewed across service providers**
- **Clinical guidelines available to all providers**
- **Compliance reporting showing variations in care at the provider and network level**
- **Physician performance against peers and benchmarks – data transparency**
- **Clinical decision support and Point of care tools**
- **Secure mechanism for provider communication**
- **Governance vehicles to support/require physician engagement**

Welcome Dr. A. Smith Vision© by Valence

WGH PHO

POPULATION MANAGEMENT Tools

Vision© Usage Guide

Click to View CONDITION REGISTRY - From here you can access and conduct outreach to patients in your condition registry. Patients can be identified through either predefined specialty reports or through a custom report builder.

Click to View PATIENT PROFILER - Use this link to directly access the integrated profile for a patient, including required care elements, identified conditions and important clinical reporting.

CLINICAL INTEGRATION Reports

Click to View Guideline Results - From here you can view your retrospective guideline compliance results and compare performance by guideline across your organization. Reporting includes current vs. prior period compliance comparisons and detailed patient listings.

Click to View WGH PHO **Report Card** - Follow this link to a report showing WGH PHO results for all measured guidelines.

QUESTIONS/FEEDBACK

Have a Question? - This link provides contact information for any questions you may have regarding this reporting or the clinical integration program.

Submit Feedback/Problem - This link accesses a form allowing general problem and/or feedback submission.
(Note: Use the 'Have a Question?' link if you need more immediate assistance.)

Patient Profiler – Point of Care Tool

PATIENT SUMMARY

First Name	CHRISTOPHER
Last Name	MIDDLETON
Patient ID	353208699
Date of Birth	12/05/1928
Phone	(312) 452-1778
Address	11641 LEOPARD ST - APT 5B
	Chicago, IL 60628

MOST RECENT ENCOUNTER

Last Visit Date	01/15/2009
Provider	Dr. William Jones - 1234567890
Specialty	Internal Medicine
Primary Dx	487: Influenza

View All Services | View Labs | View Rx

View Diagnostic Testing

GUIDELINE STATUS

Condition/ Guideline	Status
Diabetes	
Hypertension	
Screening for Dyslipidemia	

Compliant | Non-Compliant

View Claims Detail
Print Report

HOSPITAL ADMISSIONS

(Reflects Claims Through February 2009)

Admit Date	Discharge Date	Primary Dx	Description	Facility
08/25/2006	09/03/2006	564.1	IRRITABLE BOWEL SYNDROME	Hospital C
08/01/2006	08/05/2006	846.0	LUMBOSACRAL (JOINT) (LIGAMENT)	Hospital C
07/23/2006	07/27/2006	959.01	OTHER AND UNSPECIFIED INJURY T	Hospital C
04/10/2006	04/13/2006	560.9	UNSPECIFIED INTESTINAL OBSTRUC	Hospital C
04/04/2006	04/08/2006	820.21	FRACTURE OF INTERTROCHANTERIC	Hospital C

EMERGENCY DEPARTMENT UTILIZATION

(Reflects Claims Through February 2009)

Visit Date	Primary Dx	Description	Facility
05/17/2008	496	CHRONIC AIRWAY OBSTRUCTION NOT	Facility C
01/17/2006	276.51	DEHYDRATION	Facility C
01/13/2006	599.0	URINARY TRACT INFECTION SITE N	Facility C
12/23/2005	535.50	UNSPECIFIED GASTRITIS AND GAST	Facility C

MOST FREQUENT DIAGNOSES

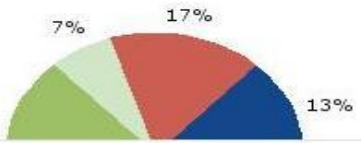
Primary Dx	Description
250	DIABETES MELLITUS
496	CHRONIC AIRWAY OBSTRUCTION NOT
530	DISEASES OF ESOPHAGUS
599	OTHER DISORDERS OF URETHRA AND

PERCENT OF SERVICES

By Provider Type

PERCENT OF SERVICES

By Distinct Specialty



Detailed Patient Summaries

Patient Summary | All Services | Diagnosis & Provider Profile | Diagnostic Testing | Inpatient & ER Service | Labs | Rx | Reports

Contact Info

First Name	BETTY
Last Name	MIDDLETON
Date of Birth	12/28/1952
Phone	6785550000
Address	1234 LANIER ST
	SUWANEE, GA 30740

Patient was recently contacted. Click to view recent outreach.

Patient Clinical Snapshot

Age	59
Height	5'4"
Weight	155 lbs.
BMI	26
Blood Pressure	145/90

Click to review recent patient history.

Selected Patient : BETTY MIDDLETON

Recent Contact History

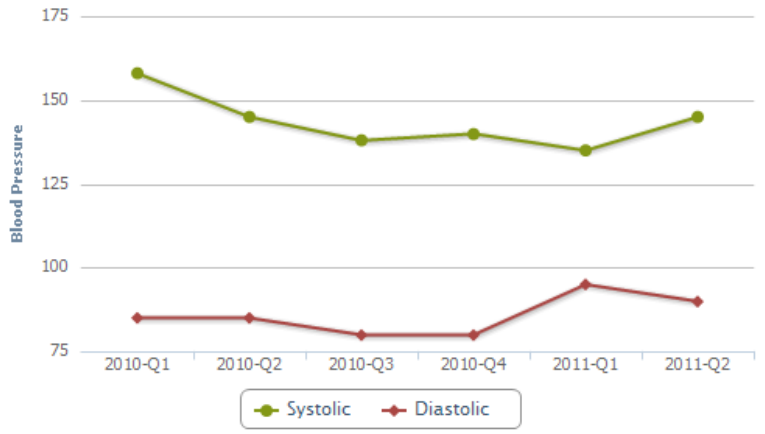
Print to PDF | Export to Excel

Contact Date	Message Desc	
08/21/2011	Due Service Reminder	, MD (Napolitano Associa
07/25/2011	Upcoming Service Reminder	Franklin Leiner, MD (The
06/22/2011	Please Contact Us	Alfred Fulkerson, MD (Co
05/19/2011	Due Service Reminder	William Miller, MD (South
04/19/2011	Due Service Reminder	Ilija Mason, OD (The Doc

Total Records: 5 / Page 1 of 1

*Contacts for last 6-months shown. Reflects contacts initiated through Vision© c

Patient History: Blood Pressure



Automated Registry for Patient Tracking

Registry Report

Selected Report: Diabetes Management

Report Date: 02/16/2012

Recall dates for each care element are calculated based on the last service date for that care element in the available data. In the event that no service dates are available for a care element (for example, a patient never had a lipid profile), this will be flagged as "overdue" and a due date coinciding with the **Report Date** will be assigned by default. For further details regarding patient episodes, refer to the Patient Profiler to directly access the integrated profile for a specific patient, including required care elements, identified conditions and important clinical reporting.

Diabetes Management (Reference : American Diabetes Association; National Quality Forum)

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Patient Name	DOB		Status	Min Recall Date	Diabetes Management Visit		HgbA1C	
					Status	Recall Date	Status	Rec
A, Patient	08/29/1960		Overdue	08/18/2011	Overdue	08/18/2011		03/
A, Patient	10/03/1954		Overdue	02/14/2011	Overdue	02/14/2011	Overdue	02/
A, Patient	01/01/1956		Overdue	03/09/2011	Overdue	02/17/2012	Overdue	03/
A, Patient	08/20/1964		Overdue	06/10/2011	Overdue	06/10/2011	Overdue	06/
A, Patient	01/20/1941		Overdue	05/05/2010	Overdue	05/05/2010	Overdue	05/
B, Patient	08/07/1937		Overdue	05/21/2010	Overdue	05/21/2010	Overdue	02/
B, Patient	05/21/1951		Overdue	05/04/2011	Overdue	05/04/2011		06/
B, Patient	11/10/1966		Overdue	08/05/2011	Overdue	10/18/2011	Overdue	08/
B, Patient	11/05/1948		Overdue	09/06/2011	Overdue	09/06/2011	Overdue	02/
B, Patient	07/15/1939		Overdue	01/17/2012	Overdue	01/17/2012	Overdue	01/

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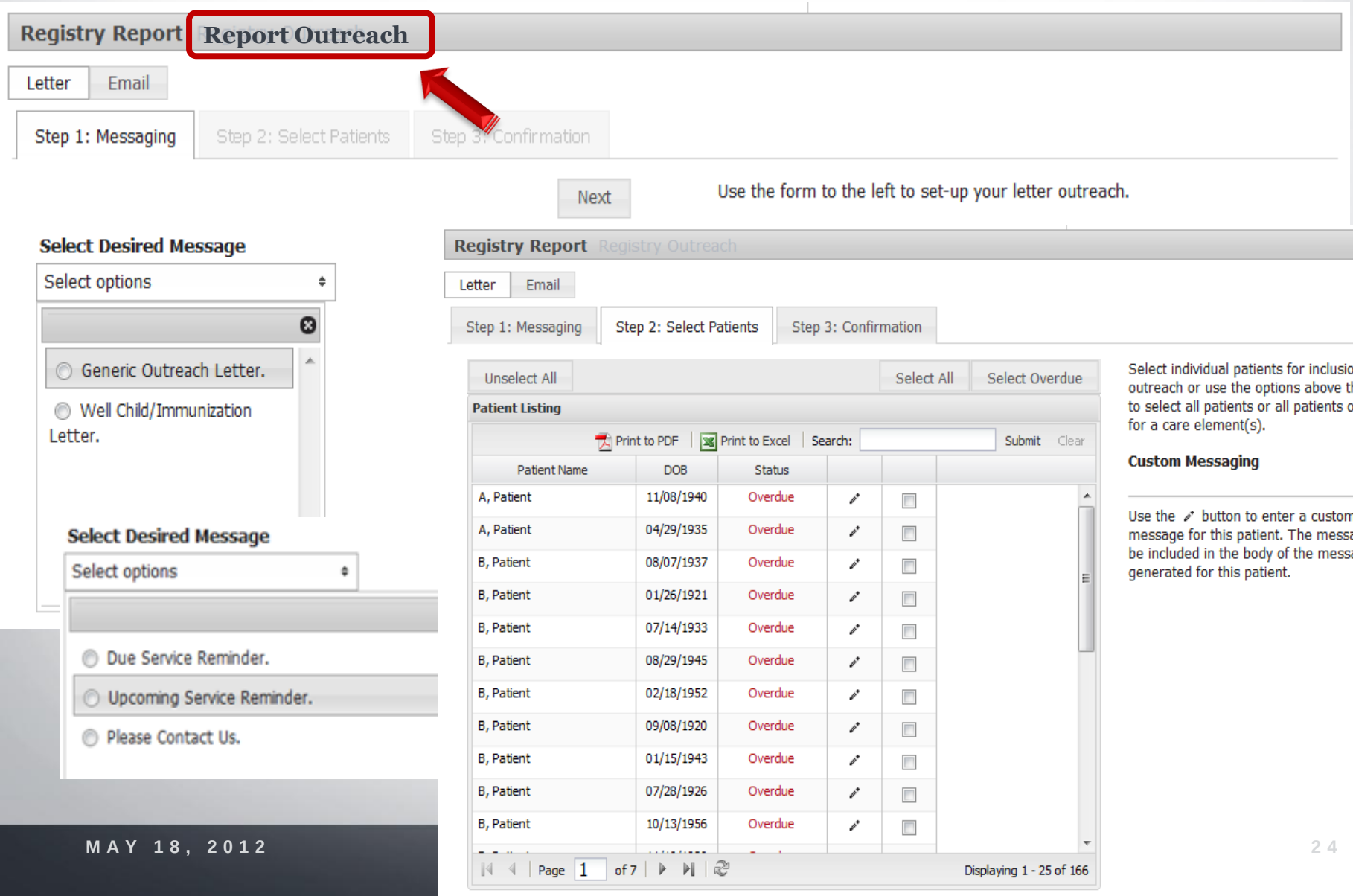
… and Outreach



WHAT programs will be needed for Population Management?

Payer < -- > < -- > Practice

Care Management

- UM/CM/DM
- Levels of care
- Social Service
- Benefit administration
- Wellness/HRA

Care Delivery

- Patient visits/calls/referrals
- Orders/Tests/Rx
- Access, follow-up & outreach
- Practice supports; Incentives

Advanced Care Coordination

- PCMH, & Neighborhood
- Amb Sens Cond's; Continuum-based Care
- Transitions/Hand-offs; "Team"
- Practice Pattern Changes
- Clinical Tools: Order set/Guidelines
- Patient Engagement: "Stickiness"
- Performance Improvement, CQI

Population Management Program Development

Modify tactics as program matures →	**Immediate**	**Next**	**… and Then**
Program Focus	**UM/CM/Referrals:** Basic "blocking and tackling"	**DM/Populations:** High cost High frequency High risk	**Enhanced capabilities:** PCMH Care Continuum/Transitions Practice Pattern Changes Focused PI
Network/Incentive Focus	Participation -> Process	Process -> Outcomes	Outcomes -> VALUE
Patient Focus	Educate	Engage	Empower

Medical Home characteristics

- **Resources at IPA/PHO deployed to offices**
- **Patient tracking, follow-up and outreach**
- **Focus on care transitions and care gaps**
- **Target conditions +/or populations**
- **Start small, and grow**
- **Look for a payer or employer partner to fund start-up**
- **Improve "stickiness"**
  - Help patients feel attached to a physician practice
  - Keep them within the network
  - Better chance of engaging them in their care

Need

- **Engaged Physicians**
- **Transformed practice paradigm**

Have

- Loosely affiliated independents
- Little leadership depth/no successors
- Care for “visitors”

Do

- Physician leadership
- Population focus with Meaningful clinical initiatives
- Incentive program

Finding & Grooming Physician Leaders

Search results for **Medical Director**

No results returned for Medical Director.

- **Respected clinically**
- **Leader among "equals"**
- **Transmit vision - inspire**
- **Confident, creative**
- **Actively listens & integrates ideas**
- **Honest, fair, balanced, tact**

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- **Born with … Learned**
- **Training, coaching**
- **Peers, mentors**
- **Content knowledge, skills**
- **Succession planning**
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Transitioning the Care Delivery System

- **Transform the Care Delivery Paradigm**
  - Culture
  - Integration & Practice Evolution
  - Access
- **Develop a robust Care Coordination Program**
  - Focusing on Key Populations

Physician Culture and Practice Changes

- **Anticipatory, pro-active programs**
  - All patients, not only those I see
  - Prospectively assess health care needs and plan care
- **More is not always better**
  - What is truly EBM and Best Practice *vs*. lore?
  - Track and follow care: tests, consults, transitions
- **Collaborative care team … and quality culture**
  - Shared responsibility, stop the line safety mentality
  - No more *"fell through a crack … lost to follow-up"*
- **Engaged patients and families:**
  - Nothing about me without me

Integration … who and how?

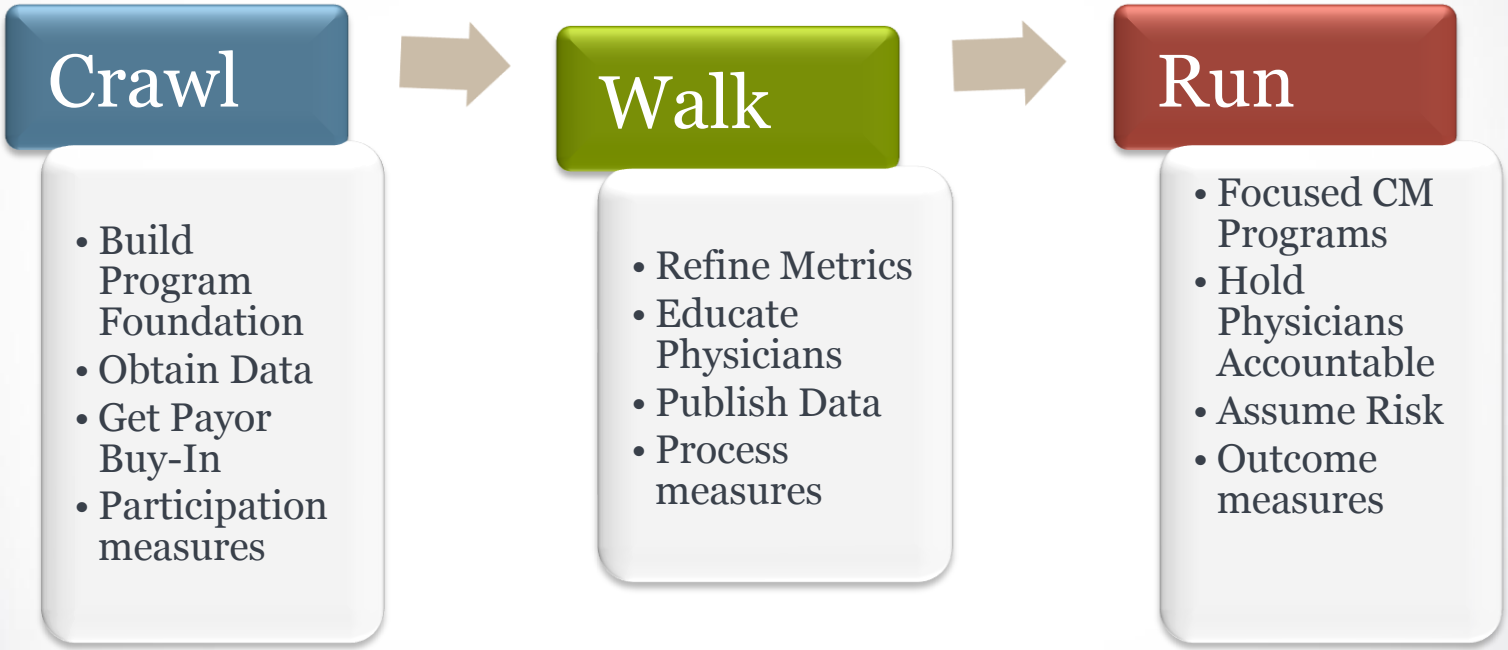
- **For success, integration across groups and types of clinicians; sites of care; and care delivery processes is absolutely essential**

- **And this will require:**
  - Active collaboration among constituents
  - Reliable use of EBM and Best Practices
  - Shared clinical knowledge and approaches to care
  - Measurement with relentless pursuit of improvement
  - Effective communication -- rigorous hand-offs; outreach
  - Practice redesign: teams, staffing mix, processes
  - Performance Improvement & Implementation execution: culture, expertise and infrastructure to drive results
  - Focus on *Patient centeredness … Access and accessibility*

Engaged Physicians: Getting a Doctor to Change

- **Be concrete about what's needed, why and how**
  - **Why should I change?**
  - **What exactly should I do?**
  - **Prove that change will work in a way that matters**
    - *For my patients … For my practice … For me*

Incentivizing Change



Align Incentives → Program Assumptions:

- **Modify compensation to reward desired outcomes**
- **Compensation must be altered for a significant portion of a practice for physician to "take notice"**
- **Incentives should mimic what you are trying to accomplish at each phase**

Incentivize use of IT tools and Teamwork

- **Get doctors used to looking at reports**
- **Give them actionable tools that help today's practice**
- **Pay them to use CPOE, review and update data**
- **Pay them to attend training & participate in PI projects**
- **Enhance with targeted clinical data**
  - Sampling basis

Need

- **New Governance Model**

Have

- Hospital dominated board
- Aging leaders/no successors
- No patient or community representation

Do

- Create an imperative
- New vision, not just “tweaking”

Now is the time

- **Use the ACO program to drive change**
  - Amend bylaws – or radically change your legal structure
  - Rethink who you want to be
- **Bring in "new blood"**
  - Use committees as training for Board positions
  - Training for younger doctors
  - Mandatory committee participation - "jury duty" model
- **Meaningful community and patient input**

Foster transparency and openness

Steps to Accountable Care

Integration

- Create an ***Integrated*** organization
- Culture and capabilities to organize for and deliver coordinated care

Delivery System Improvement

- Implement programs to support efficient, effective care delivery
- Leadership and governance to value and deliver results

Accountability

- Expertise and financial/management processes
- Monitor results; manage risk & reward

WHAT ARE YOUR NEXT STEPS?

QUESTIONS ?

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