MAKING SENSE OF ACCOUNTABLE CARE ORGANIZATIONS

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DISCLOSURE

I HAVE NO CONFLICTS OF INTEREST TO REPORT
HOW WE GET PAID IS CHANGING

• Quality outcomes
• Utilization outcomes
• Access
• Patient satisfaction

All providers and participating institutions are taking on risk

Specialists that “under-perform” will impact the financial viability of the entire organization
Health Reform Transition

This is where we are going

FFS Peak

Reduced ER Visits
Reduce Re-admissions
Reduce Admissions
Reduced Specialty Visits
Reduced Procedures/1000

Population Mgmt Peak

Optimal

Actual

Revenue Control

Capitated Risk

Gainshare Contracting
Care Coordination/ Pt. Engagement
PCMH/PCP Engagement
EMR/Central Data Repository

“Loss Valley”
OUTLINE

• ACOs: Shared Savings Programs and Next Generation ACOs
• Overview of how ACOs operate
• Real-life experience in an ACO
• Role for academic endocrinologist in an ACO
MEDICARE SHARED SAVINGS PROGRAM

- **New way to deliver health care**
  - Improve quality
  - Improve coordination among providers
  - Reduce unnecessary cost

- Shared savings payments are linked to quality performance based on a sliding scale that rewards attainment

- Three tracks

- High performing ACOs receive a higher sharing rate
NEXT GENERATION ACOS

- Higher levels of risk and reward vs MSSP
- Patient Access
- Patient Engagement
- Care Management
- Tele-health
HOW DO ACOS OPERATE?

- Track quality performance across participants
- Track utilization performance across participants
- Utilize software tools to facilitate communication from provider to provider and provider to patient
  - EHR
  - HIE
  - PhyTel/Verisk
- Streamline access
WHAT REPRESENTS QUALITY?

- PRE-SPECIFIED ACO QUALITY MEASURES
- REPORTING
  - DISCRETE FIELDS
  - MEANINGFUL REPORTS
- ACO-WIDE STRATEGY TO ADDRESS GAPS
Accountable Care Organization 2016 Program Quality Measure Narrative Specifications

Prepared for
(The Pioneer ACO Model)
Division of Accountable Care Organization Populations
Seamless Care Models Group
Center for Medicare and Medicaid Innovation

(The Medicare Shared Savings Program)
Division of Shared Savings Program
Performance-Based Payment Policy Group
Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
DM ACO QUALITY MEASURES

DM QUALITY MEASURES FOR 2016

• A1C POOR CONTROL + RETINA SCREEN (NEW COMPOSITE MEASURE!)
• (LIPID/STATIN)
• (NEPHROPATHY)
HOW IS UTILIZATION MEASURED?

- Based on CMS claims data
- Admission and readmission rates
- ED use
- Home Health/SNF
- Imaging
- Ambulatory services

CODING CAN GREATLY IMPACT MEASUREMENTS
WHAT DOES ACCESS MEAN?

ACCESS IS INTEGRAL TO THE ACO CONCEPT OF A PATIENT-CENTERED MEDICAL HOME AND PATIENT SATISFACTION

PROVIDERS ARE EXPECTED TO HAVE

• PROMPT NEW PATIENT APPOINTMENTS
• SAME-DAY VISITS
• AFTER-HOUR ACCESS (TO YOU, RN OR OTHER MIDLEVEL)
• ELECTRONIC ACCESS TO YOU/YOUR TEAM
• WORKFLOW TO ADDRESS COMMON MEDICAL ISSUES AND AVOID ER VISITS
EXAMPLE OF ACO AT WORK
ACO EXPERIENCE: SOUTHWESTERN HEALTH RESOURCES

- The ACO infrastructure was formed in 2013
- Our MSSP contract was effective 2014
- In 2015, 6th largest MSSP ACO in the country
- Revenue in 2015—$14 million
- Next generation ACO model began Jan 1, 2017
Currently ~600 PCPs

79K Medicare patients; 200+K with Commercial
QUALITY PERFORMANCE PER GROUP

Overall Avg for 2015 Performance Measures

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<th>Percentage</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
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<th>Aug</th>
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ACO ATRISK POPULATION: DM

- CMS scales expectation of cost to size of ACO and norms for that disease

**Example**

- 50,000 DM Medicare ACO patients

- Savings of ~$40/patient below CMS est. costs = could be $2 million in savings
**QUALITY REPORT**

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**Patient Management > Patient Summary**

**NEXT VISIT / PROVIDER**: 06/11/2014 10:15 AM / PFT 2 / POB

**LANGUAGE**: English
**ETHNICITY**: Other
**CARE MANAGER**: [Personal Information Redacted]

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**Care Opportunities**

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<tr>
<th>Opportunity</th>
<th>Last Value</th>
<th>Date</th>
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<tr>
<td>LDL: Missing Test (High Risk Pop)</td>
<td>79 mg/DL</td>
<td>5/21/2012</td>
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<tr>
<td>BMI: Underweight</td>
<td>21.8</td>
<td>4/29/2014</td>
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<tr>
<td>CAD: Missing LDL Testing</td>
<td>79 mg/DL</td>
<td>5/21/2012</td>
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<tr>
<td>CAD: ACO - Missing LDL Test</td>
<td>79 mg/DL</td>
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<tr>
<td>IVD: ACO - Incomplete Lipid Profile</td>
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**Systolic/Diastolic Blood Pressure**

![Graph showing blood pressure trends over time]

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**BMI**

![Graph showing BMI trends over time]

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**Alerts & Recommendations**

- BMI: Underweight
- CAD: Missing LDL Testing
- LDL: Missing Test (High Risk Pop)
- CAD: ACO - Missing LDL Test
- IVD: ACO - Incomplete Lipid Profile
- Prev: ACO - Missing Influenza Vaccination
At A Glance - All Payor Composite

Overall Composite ACO Measures

85%

Overall Risk Adjusted Efficiency Index 83%

Overall Financial Performance

Efficiency Index by Service Type
DIABETES PILOT PROGRAM
SOUTHWESTERN HEALTH RESOURCES

- PILOTED 2016
- TARGETED 150 MEDICARE PATIENTS, ANY A1C; 18-74 YR (NO GDM)
- LOCATION: LARGE PRIMARY CARE CLINIC
- INTERVENTION:
  - INTERACTIVE BILINGUAL DM EDUCATION
  - TELE-CONSULTATION
  - TELE-RETINA SCANS
DM PILOT: PRELIMINARY DATA

- **Endpoints:** (A1C, Lipid Panel, Retina Exam, Nephropathy Screen)
- **Pre-program A1C 7.3%; post-program 5.8%**
- **Pre-program LDL 188; post-program LDL 101**
- **Pre-program missed 6 DM measures; post-program missing 1**
LESSONS LEARNED FROM DIABETES PILOT

**Pros**
- Well-received by attendees; active participation

**Cons**
- Barriers by staff (lack of engagement)
- Scheduling, low show-rate (50%)
- Fee-for-service model hindered lab draws/vaccines same-day if no PCP appointment
- The people who want to get better are the ones that come
WHAT IS YOUR ROLE AS AN ENDOCRINOLOGIST IN AN ACO?

- **Work on innovative ways to provide patient care and education in the community**
- **Work with PCPs to provide cost-effective and timely diabetes care**
- **Establish useful value-based metrics**
- **Better patient data-sharing and educational tools**
- **Quality and utilization research**
MAKING THE SHIFT FROM FEE-FOR-SERVICE MODEL TO POPULATION MANAGEMENT

- Forming a team
- Patient care protocols and care pathways
- Group patient visits
- Expanding diabetes education
- Integrating clinics with podiatry, retina camera, onsite CDE
- Tele-medicine
- Varying strategies based on varying risk
ACKNOWLEDGEMENTS

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- Claudia Grau

ONE GOAL