Nuts and Bolts
Accountable Care Organizations:
A New Care Delivery Model for New Expectations

Presented to The American College of Cardiology
October 27, 2012

Franciscan Alliance Overview

- Franciscan Alliance operates 14 hospitals in 4 regions
- Franciscan Physician Network has 780 Physicians across the state
- Franciscan Alliance ACO was chosen as one of 32 Pioneer ACOs and only Pioneer ACO in Indiana
- Franciscan Alliance ACO has successfully submitted two additional applications to begin participation in the MSSP ACO program

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Healthcare Reform

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) was signed into law. One of the main tenants of this bill was to create innovation in care delivery to:

- ***Decrease* significant variations** in the quality and cost of healthcare across the Nation
- ***Initiate* payment mechanisms** driven by quality and health outcomes rather than by volume and intensity (fee-for-service)
- **Eliminate "fragmented healthcare**" in the current delivery system and build a solid integrated delivery system

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Accountable Care Organization

An Accountable Care Organization, or ACO, is an entity that agrees to be accountable for the quality, cost, and overall care of a defined population

Who can become an ACO?

The Patient Protection and Affordable Care Act (PPACA specifies the following may become an ACO:

1) Physicians and other professionals in group practices
2) Physicians and other professionals in networks of practices
3) Partnerships or joint venture arrangements between hospitals and physicians/professionals
4) Hospitals employing physicians/professionals
5) Other forms that the Secretary of Health and Human Services may determine appropriate.

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ACO Requirements

- ✓Composed of sufficient numbers of providers and provider-affiliated entities to accept care for a minimum number of patients
- ✓Engage in true, patient-centered, coordinated care delivery for a defined group of individuals
- ✓Have a solid data infrastructure and sufficient IT "connectedness" to provide the necessary information for provider evaluation and care assessment, coordination, and management
- ✓Include support resources such as discharge planners, care managers and other non-physician staff assisting in the coordination of care for a defined population
- ✓Have formal governance and decision-making structures and involve the use of evidence-based medicine, quality management, and performance oversight
- ✓Have a formal legal structure to receive third party reimbursement and distribute those funds to participating providers based on services rendered and their relative performance on quality and other metrics

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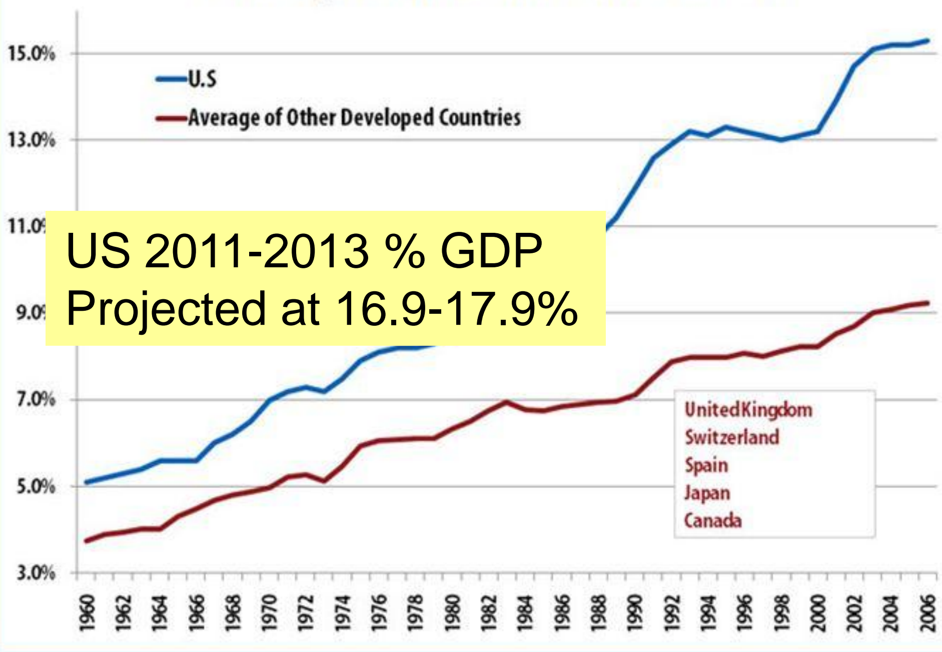
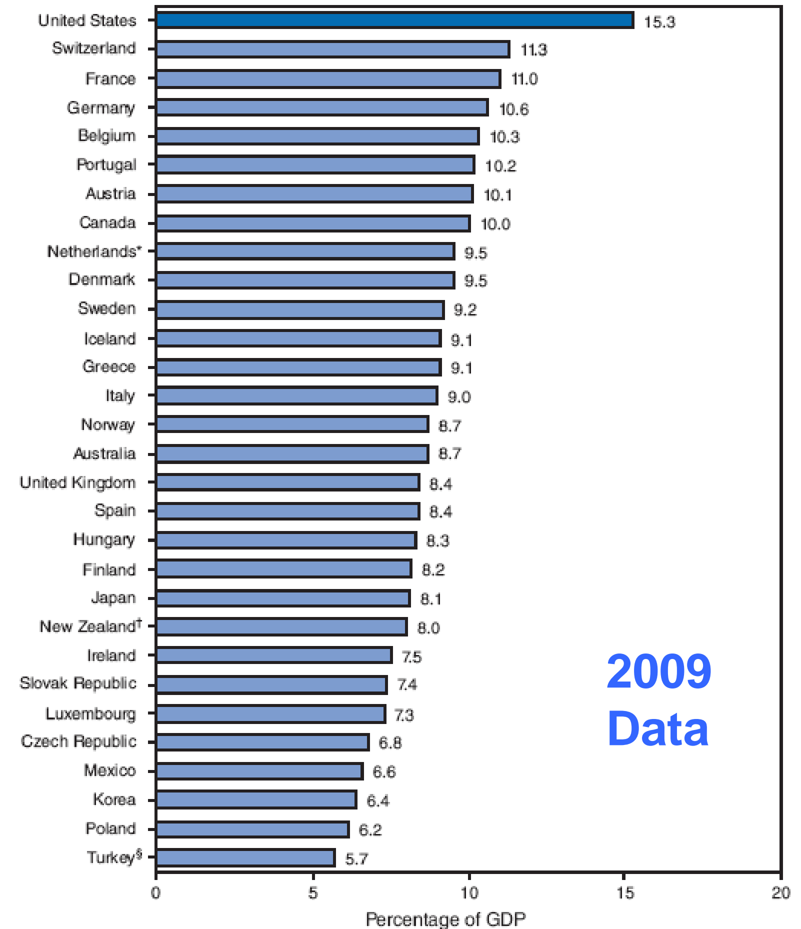
Why the Need?

The Healthcare Bubble



US 2011-2013 % GDP Projected at 16.9-17.9%



2009 Data

OMB states by 2020 Healthcare Cost Approaching 20%GDP!!!

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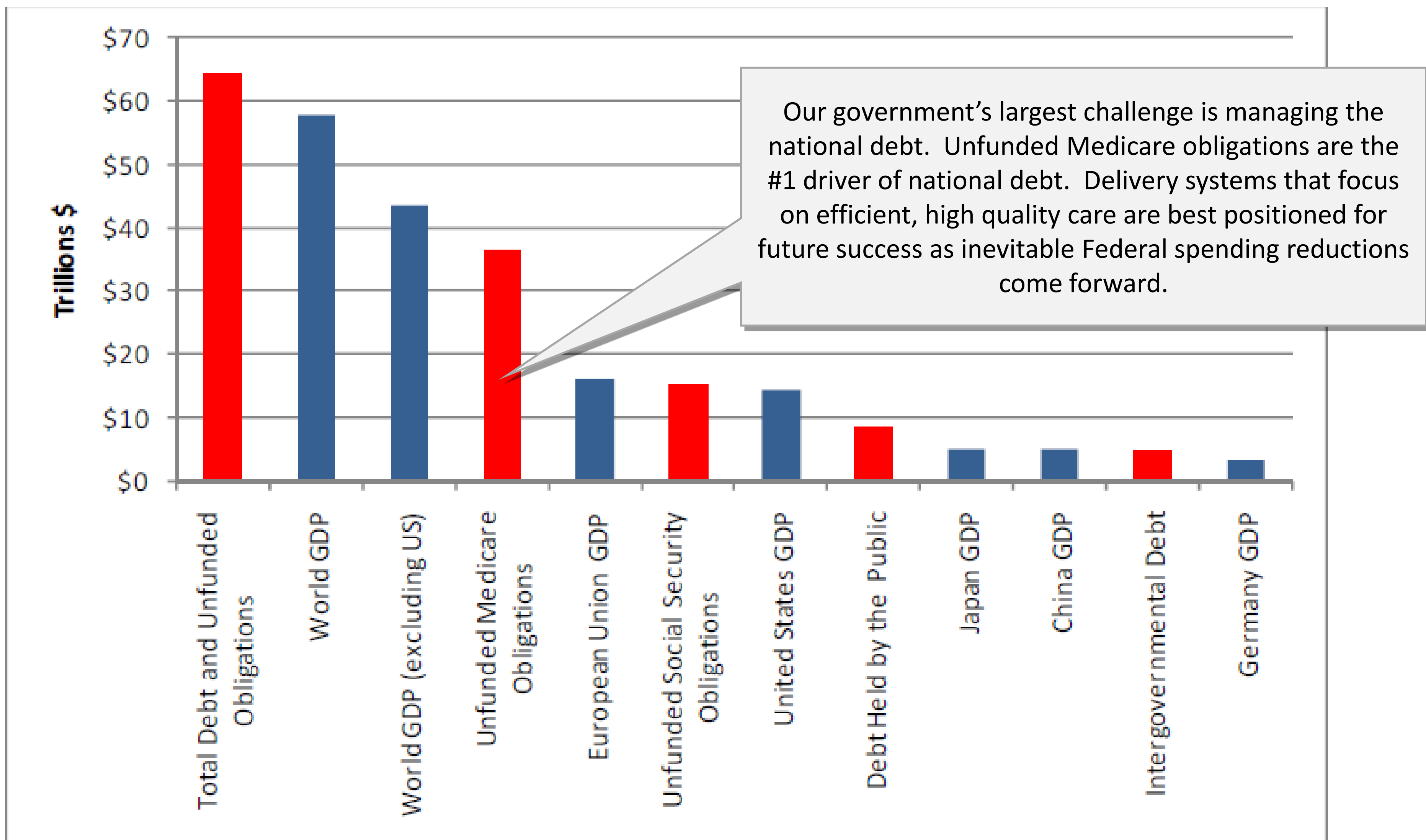
Large HealthCare Spending Reductions Appear Inevitable



Source: www.treasurydirect.com and CIA World Factbook

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Why the need?
Utilization Driven By Few

Top 1% -----20.2% of total plan costs
Top 5% ----- 47.5% of total plan costs
Top 10% ---- 63.6% of total plan costs
Top 15% ---- 73.4% " " " "
Top 20% ---- 80.2% " " " "
Top 50% ---- 96.9% " " " "
Bottom 50% -- 3.1% of total plan costs

Data from Kaiser Family Foundation

Why the need?
Utilization –Another Look

Medicare spent 1% ----- Those with NO chronic medical conditions

Medicare 3% spent ----- 1 chronic condition

Medicare 6% spent ----- 2 chronic conditions

Medicare 10% spent -----3 chronic conditions

Medicare 9% spent ------ 4 chronic conditions

Medicare 79% spent -----5 chronic conditions

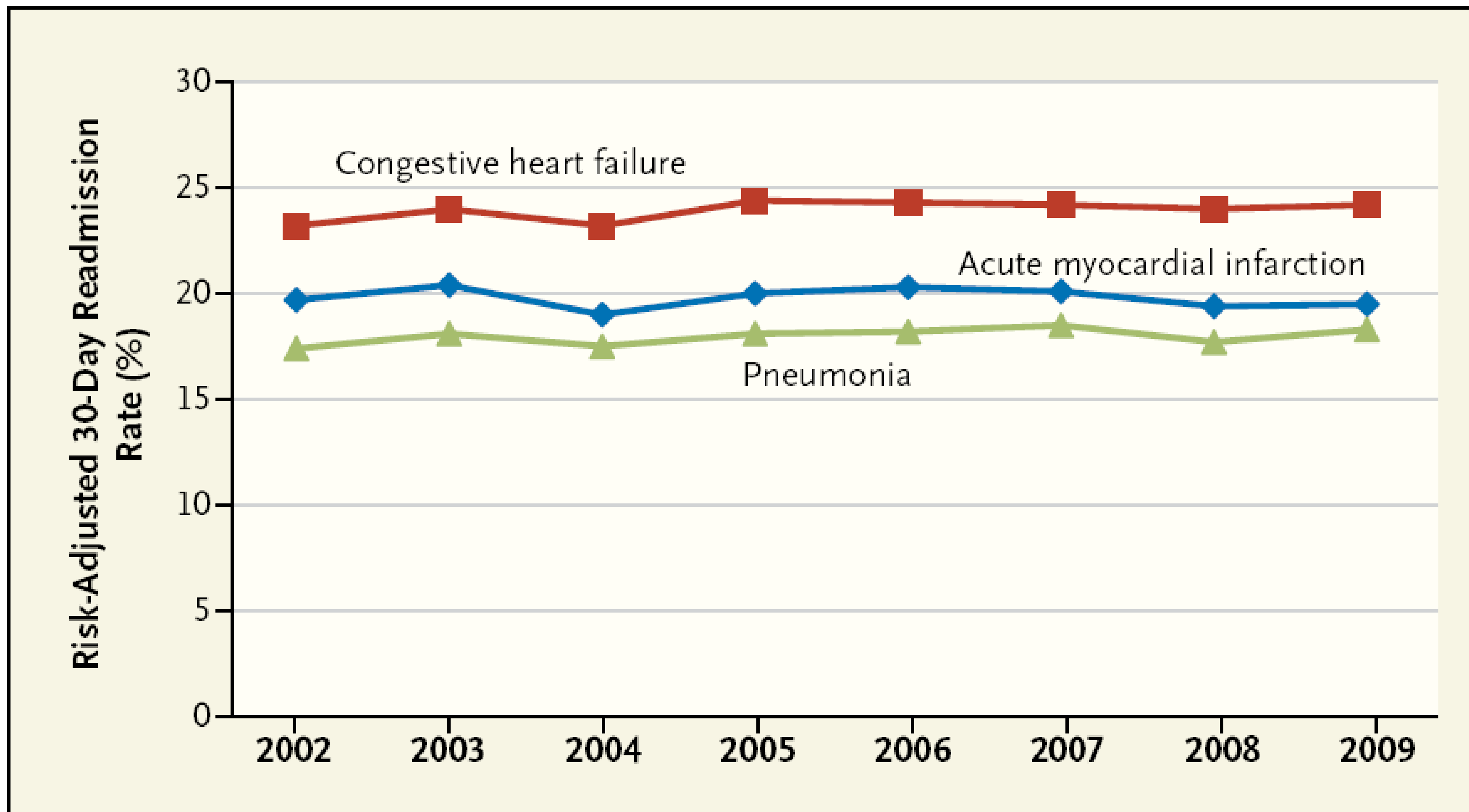
Anderson, G. ---- Chronic Care: Making the case for ongoing care ---RWJ @ RWJF.org

Why The Need? Broken Down Increases

Health care spending is out of control for those paying the bills – from 2007 to 2011

37.6 % increase in payment for IP services
48 % increase in spend for OP services
24 % increase in MD payments
37 % pharmacy cost increase

Milliman Medical Index



National Trends in 30-Day Readmission Rates, 2002–2009.

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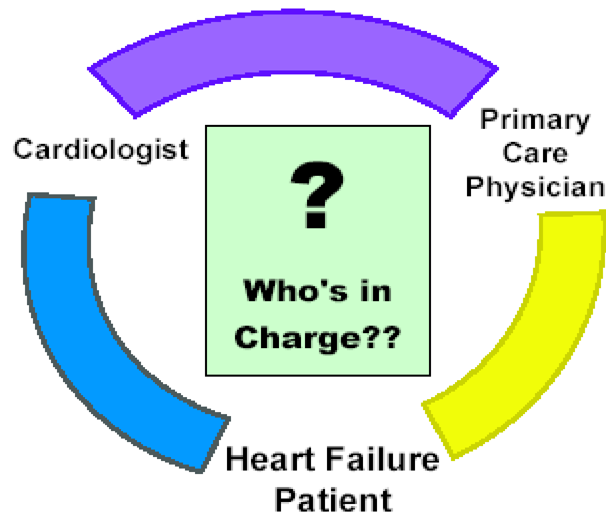
Conceptual Model for HF GAP Clinical Advocate Current Process of Care



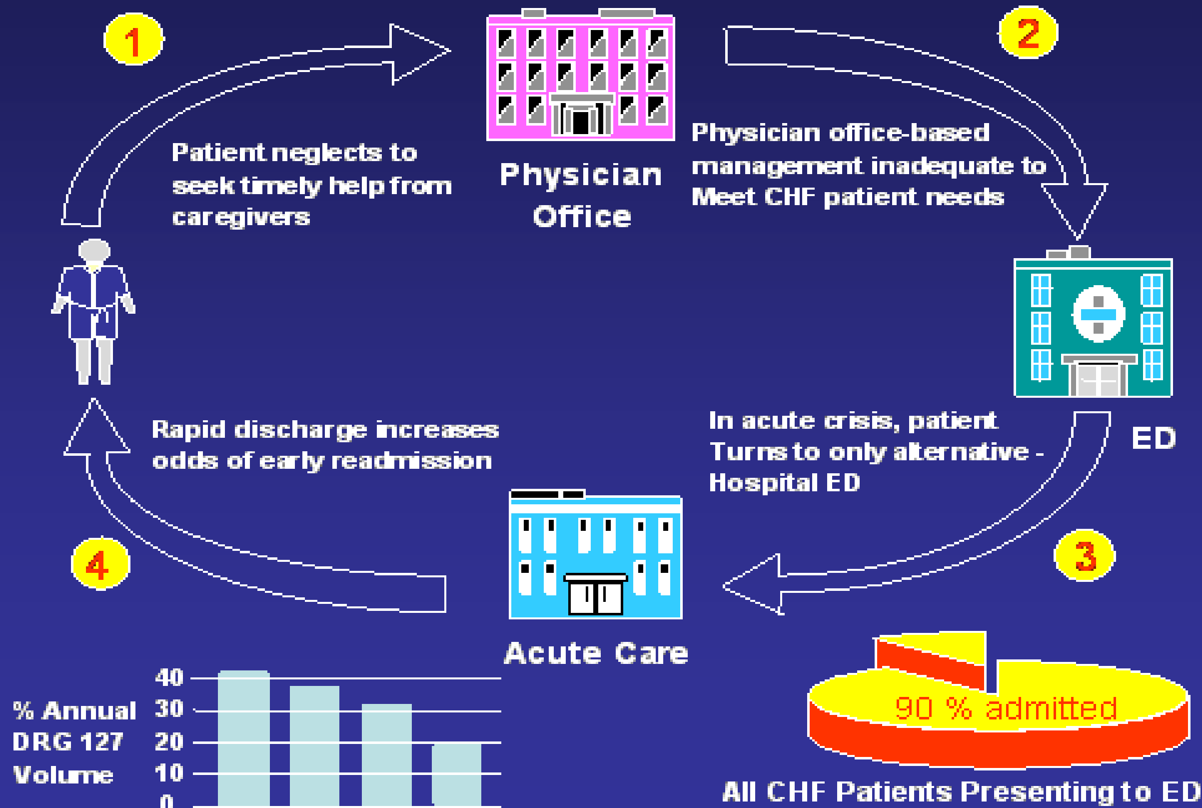
"I have an internist to take care of my regular problems, an endocrinologist to take care of my diabetes, a vascular surgeon to take care of my circulatory problems, a cardiologist to treat my heart disease, and an ophthalmologist to take care of my eye problems." The doctors do not communicate with one another; each one keeps his own records and does things his own way. The patient has to put it all together for herself and make sense of the confusion because the medical-care system is not designed to. *"You people need to get it together,"* the woman told the professionals and community leaders.

--*From Chaos to Care: The promise of Team-based Medicine*
(David Lawrence, MD 2002)

Observations from Dr. Joe Russell (General Internist from Mercy Anderson SWO (Cincinnati) Region)
(March 10, 2003)
Dear Don,
"I thought the meeting went well and I personally learned something I never had previously thought about:
the vital link between the primary care physician and the cardiologist has never been discussed or defined as to what role each needs to play.
We kind of just have accepted that there is some way in which we work together that is well understood amongst parties and it is not.
I am quite sure that all our cardiologists know full well how to treat congestive heart failure.
How much they ensure happens kind of depends on how they view themselves in the relationship between specialist, PCP, and patient.
Some serious dialogue between PCP's and Cardiologists needs to occur to assure that each CHF patient achieves a uniform standard of care before, during, and after hospital admission. I don't think the lack of consistent quality is due to a PCP caring for the patient or a Cardiologist caring for the patient but a lack of a care plan that spells out the duties of each plus communication to the patient as to how things work within this process."
thanks, Joe (Russell)

Vicious Cycle of Conventional Care

Conventional CHF Care

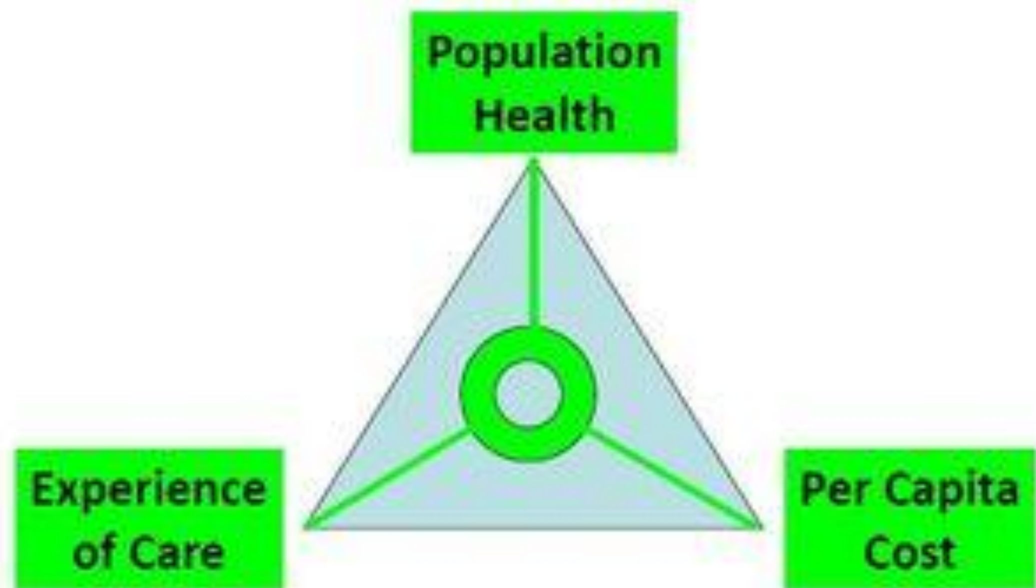


Goals

Accountable Care Organization Goals

Three-part Goal of an ACO:

1. Better population health
2. Higher-quality care
3. Lower costs of care



How does Franciscan Alliance achieve the "Triple Aim"?

We focus on better healthcare via the implementation of systematic efforts to improve quality and reduce costs across the organization and the entire care continuum:

- Improved care coordination
- Reduced waste (e.g. duplicate testing)
- Actionable, timely data
- Data Integration via EMR
- Chronic Disease Management
- Better information that engages physician, supports improvements and informs consumers
- Realign incentives both financial and professional with care goals
- Foster integration, accountability and partnerships across the full continuum of care

Franciscan Alliance Embraces Clinical integration As A Means to Address

Population Health

Experience of Care

Per Capita Cost

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Integrated System Outcomes

- 57% reduction in Medication Errors
- 50% reduction in Diabetes admissions for complications or disease sequella
- 50% reduction in cardiovascular disease related mortality
- 26% reduction in office visits (concurrent increase in e visits)
- 11% reduction in ER utilization (call centers and primary care homes)
- 8% reduction in unexpected follow-up visits

Kaiser Health System

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Finance

Payment Reform

- Current healthcare reform is centered around **PAYMENT**
- Payment mechanisms are changing; reimbursement is decreasing and increasingly being tied to quality & cost:
  1. **CMS**
     - *Medicare*: Shared-Savings ACO's; Pioneer ACO's; Bundled Payment Initiatives; Inpatient Value-Based System 2012;
     - *Medicaid*: Dual Medicare/Medicaid programming;
  2. **Commercial** ACO initiatives: Anthem; "Blues"; CIGNA; Humana; etc.
  3. **Local** examples: Quality Health First

Payment Model Evolution Would Seem To Be Forcing More Integration?

Episodic Costs | Total Costs

Prospective Payment System → Pay-for-Performance → Hospital-Physician Bundling → Episodic Bundling → Shared-Savings Model/ACO → Capitation

Provider Cost Accountability

Source: Health Care Advisory Board, "Promise or Peril? Preparing Your Health System for Success in the New Health Care Economy", 2010

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Franciscan Alliance Financing ACO Services

- Focus on Primary Sources of Quality and Cost
- Achieving high levels of evidence-based care performance using quality measures
- Reduced unnecessary hospitalizations
- Reduced hospital readmissions
- Reduced unnecessary ER use
- Aligning with our specialist (cardiologist, endocrinologist, etc.)
- Increased efficiency in laboratory, diagnostic test and drug expenditures
- Increased data management and integration

Focus

Evaluation of efficiency: The “Key D’s”

Drugs
Devices
Diagnostics
Delays in Care
By Design
Decision Maker(s)

Demand (Technology)
Demand (Services)
Deficient Care
Defensive Medicine

Atlantic Health

pej

the Physician Executive

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Franciscan Alliance Focus For The Future

- Value And Evidence Based Orientation To Care Designs
- Patient Centered Care- The Right Care, Delivered At The Right Time, In The Right Location
- Population Based Care Delivery (We Treat The Community)
- Transition Away From Hospital Centric Models Of Care Delivery
- Foster integration, accountability and partnership across the continuum of care

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Thank you

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