HealthPartners: Triple Aim Approach to ACO Development

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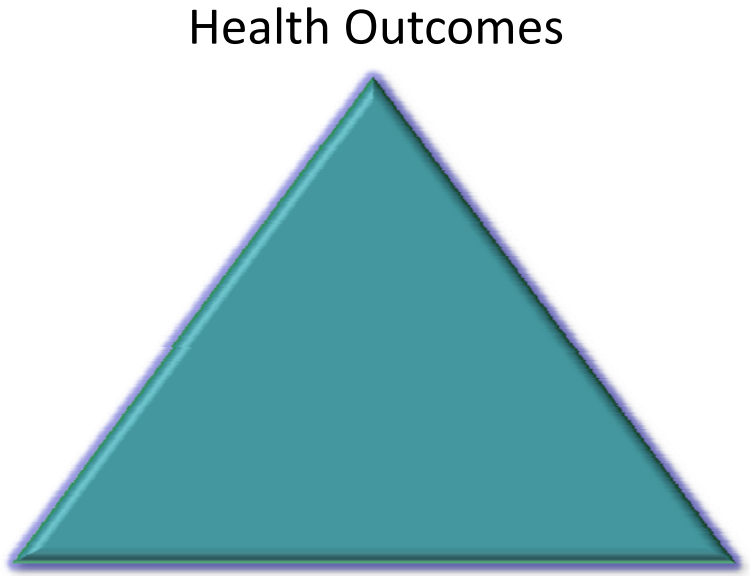
HealthPartners

- Integrated Care and Financing System
  - 10,300 employees
  - Medical Group – 400,000 patients
    - Nearly 700 physicians
      - Primary Care
      - Specialty Care
    - 35 medical and surgical specialties
    - Multi-payer
  - Hospital: 435 bed level I trauma center urban teaching hospital
  - Non-profit health plan: 1.5 million medical/dental members in Minnesota and surrounding states
  - Consumer governed
- Mission: To improve the health of our members, patients and the community.

ACO Overall Goal
The Triple Aim

To simultaneously optimize…



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Best Care

- We use the following design principles to ensure our care achieves Triple Aim results:
  1. **Reliability**: Provide the right care at the right time at the right place
  2. **Customization:** Care is customized to individual needs and values
  3. **Access:** Easy access to care, information and knowledge for patients
  4. **Coordination:** Coordinated care across sites, specialties, conditions and time

Reliability

- Reliability means that
  - Care is based on the best evidence
  - The electronic medical record supports providing evidence-based care
  - Processes are standardized and waste and rework are eliminated
  - Every member of the care team contributes to their maximum potential
- Examples
  - Strong performance across multiple health measures; better outcomes for patients
  - Focus on appropriate use across our system. Examples include
    - High levels of generic prescribing
    - Best practice for use of MRI/CT scans is built in decision support tool
    - Recommendations for how often tests (pap test, for example) and labs are needed are based on best evidence
    - Evidence-based care for acute back pain
    - Supporting patients after a hospital discharge to avoid a readmission
    - Eliminating hospital-based infections
  - Tight expense management to hold down cost per unit of service. This is critical for impacting the price component of total cost of care.

Health Results

Above average performance on 12 of 13 health measures in the 2009 **Minnesota Community Measurement** Quality Report.

Medical Group	Asthma	URI	Pharyngitis	Bronchitis	Optimal Diabetes	Optimal Vascular	Controlling High BP	Colorectal Cancer Screening	Breast Cancer Screening	Cervical Cancer Screening	Cancer Screening Combo	Chlamydia Screening	Childhood Immunization Status
HealthPartners Clinics 12 of 13		●	●	●	●	●	●	●	●	●	●	●	●
Park Nicollet Health Services 9 of 13		●	●			●	●	●	●	●	●		●
Fairview Health Services 8 of 13		●	●		●	●		●		●	●	●	
HealthEast 7 of 13		●	●		●	●	●	●					●
Children's Physician Network 3 of 6	●	●	●	N/A	N/A	N/A	N/A	N/A	N/A		N/A		

● = Medical group rate and CI fully above average. ⊗ = Data size too small to report. N/A = Measure not applicable.
Blank = Measure reported but rate was average or below average.

www.mnhealthscores.org

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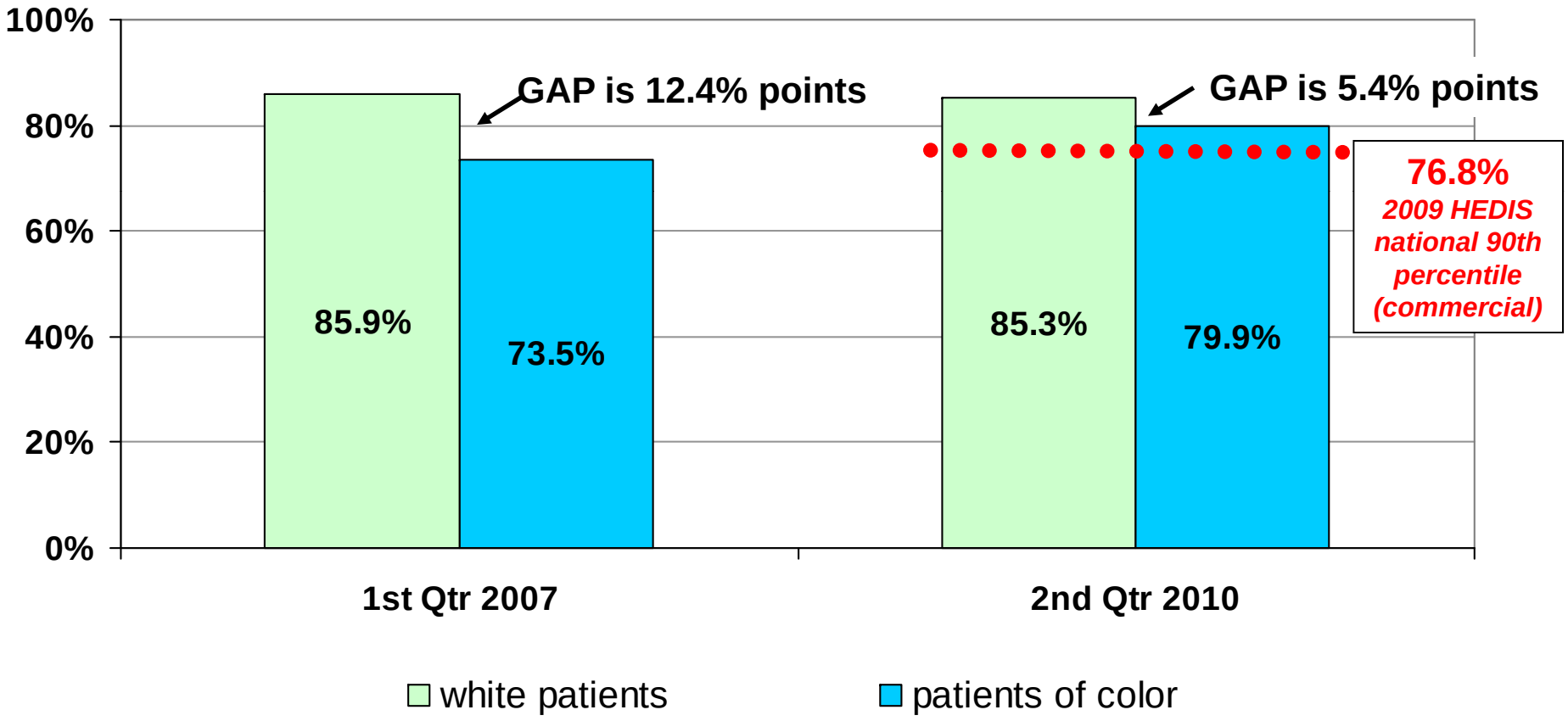
Customization

- Reliability is the first step; we then customize care to individual preferences and values
- Examples:
  - Reducing disparities
    - Offering same-day mammography
    - Colon cancer screening: alternatives to colonoscopy (FOBT)
  - Provide information and support to patients to make decisions about care options (examples include early stage breast and prostate cancer care)
  - Care for patients at the end-of-life consistent with patient preferences/values, “Honoring Choices”

HPMG – Mammography Screening Disparity by Race

Mammography Screening: *% of women age 50-75 who have been screened by Mammography in the 18 months prior to and including their most recent primary care visit.*



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Access

Access means easy availability of care (including lower cost), as well as information and support needed for living healthy lives

- Improved appointment availability (30% same day access in primary care)
- Enhanced communication with after visit summaries and care plans
- Online services (see next slide)
- Phone care
  - 24 hour nurse care for numerous conditions using best practice standards approved by physicians
  - Phone visits/Evisits with provider
- Worksite and clinics staffed by nurse practitioners/health coaches for on-site care and health improvement
- Information and support for healthy lifestyles
  - Testing use of the health assessment at the clinic with initial health coaching by care team
  - Links to phone-based and online programs
- Access to health information across systems through MN Health Information Exchange and Epic's Care Everywhere

Online Services

- >30% of Patients enrolled
- Lab results automatically shared online with patients; most within 4 hours
  - Over 10 million results-to-date
  - Test results linked to patient friendly explanations
- Access to medication list and immunization records
- Refill prescriptions and mail order pharmacy
- Online appointment scheduling
- Online bill pay
- Secure email with doctor, nurse
- Recently introduced Virtuwell, new online diagnosis and treatment service for 30 common medical conditions

Coordination

- Care is coordinated across sites, specialties, conditions and time
  - Patient tracking and registry functions
    - Care team uses information in the electronic record to track care needs
  - Care management
    - RN on the care team plays key role
    - Coordinate with centralized case/disease management
      - Rare/chronic diseases
      - Complex case management
  - Patient self management and support
    - Care teams work with patients to develop plans and help patients link to other resources
  - Transitions
    - Electronic record supports seamless flow of patient information between primary, specialty, ED, and urgent care
    - Care coordinators focus on patients post hospital discharge
- Received highest level NCQA Medical Home recognition across all clinics
- Awaiting MDH recognition for all clinics and our care system as a whole

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2010
Accountable Care Organization / Medical Home
Measurement Framework

Health Outcomes

Staying Healthy
- Breast Cancer Screening[1]
- Cervical cancer Screening[1]
- Colorectal Cancer Screening[1]
- Cancer Screening Combined[1]
- Chlamydia Screening in Women[1]
- Childhood Immunizations[1]
- *Health Assessment Completion %*[2]
- *Change in Modifiable Health Potential Score*[2]
- Optimal Lifestyle[2]
- Preventive Services Up to Date[2]

Getting Better
- Avoidance of Antibiotic Treatment of Adult Bronchitis[1]
- Treatment for Children with URI[1]
- Testing Children for Pharyngitis[1]

Living with Illness
- Controlling High Blood Pressure[1]
- Optimal Diabetes Care[1]
- Optimal Vascular Care[1]
- Use of Appropriate Medications for People with Asthma[1]
- *CHF - LV Assessment; ACE/ARB Use*[2]
- *Depression - PHQ9 Use, Remission Rate*[2]
- Medication Possession Rates[2]
- Optimal Depression Care[2]

Consumer Experience

Satisfaction
- Access[3]
- Communication[3]
- Coordination[3]
- Quality of Care[3]
- Decision Making[3]

Safety & Avoidable Events
- *Unplanned readmissions to the hospital (# of Occurrances)*[2]
- *Preventable/unnecessary ER visits (# of Occurrances)*[2]
- *Adverse drug events associated with high-risk medications (# of Occurrances)*[2]
- Expanations about prescription medications[3]
- Explanations about medication side effects[3]

Coordination of Care
- *% of Patients seeing 8 or more physicians*[2]

End-of-Life Care
- *Advanced Directives*[2]
- *Hospice Referral Timing*[2]
- *ICU in the last 14 days of life*[2]

Affordability

Total cost of care
- Total Cost Index (TCI)[2]
  - TCI for Diabetes, Heart Failure, Other Chronic Conditions[2]
- Resource Use Index (RUI)[2]
  - RUI for Diabetes, Heart Failure, Other Chronic Conditions[2]

Appropriate use of hospital resources
- Length of Stay: All, Diabetes, CHF, Other Chronic Conditions[2]
- Admit Rate: All, Diabetes, CHF, Other Chronic Conditions[2]

Safety & Avoidable Events
- *Unplanned readmissions to the hospital (value)*[2]
- *Preventable/unnecessary ER visits (value)*[2]
- *Adverse drug events associated with high-risk medications (value)*[2]

Pharmacy Services
- Generic utilization rate[2]

National Prioritiies Partnership - Measures

Safety & Avoidable Events
- *Healthcare associated infections*[2]
- *Serious adverse events*[2]

Wasteful and Inappropriate Care
- *Inappropriate Medication Use %*[2]
- *Unnecessary diagnostice procedures*[2]
- *Unnecessary lab tests*[2]
- *Unwarranted maternity care interventions*[2]
- *Unwarranted therapeutic procedures*[2]

Sources:

1. Minnesota Community Measurement
2. HealthPartners Measurement
3. HealthPartners Consumer Choice Survey

Gray Italics: denotes future population health measures

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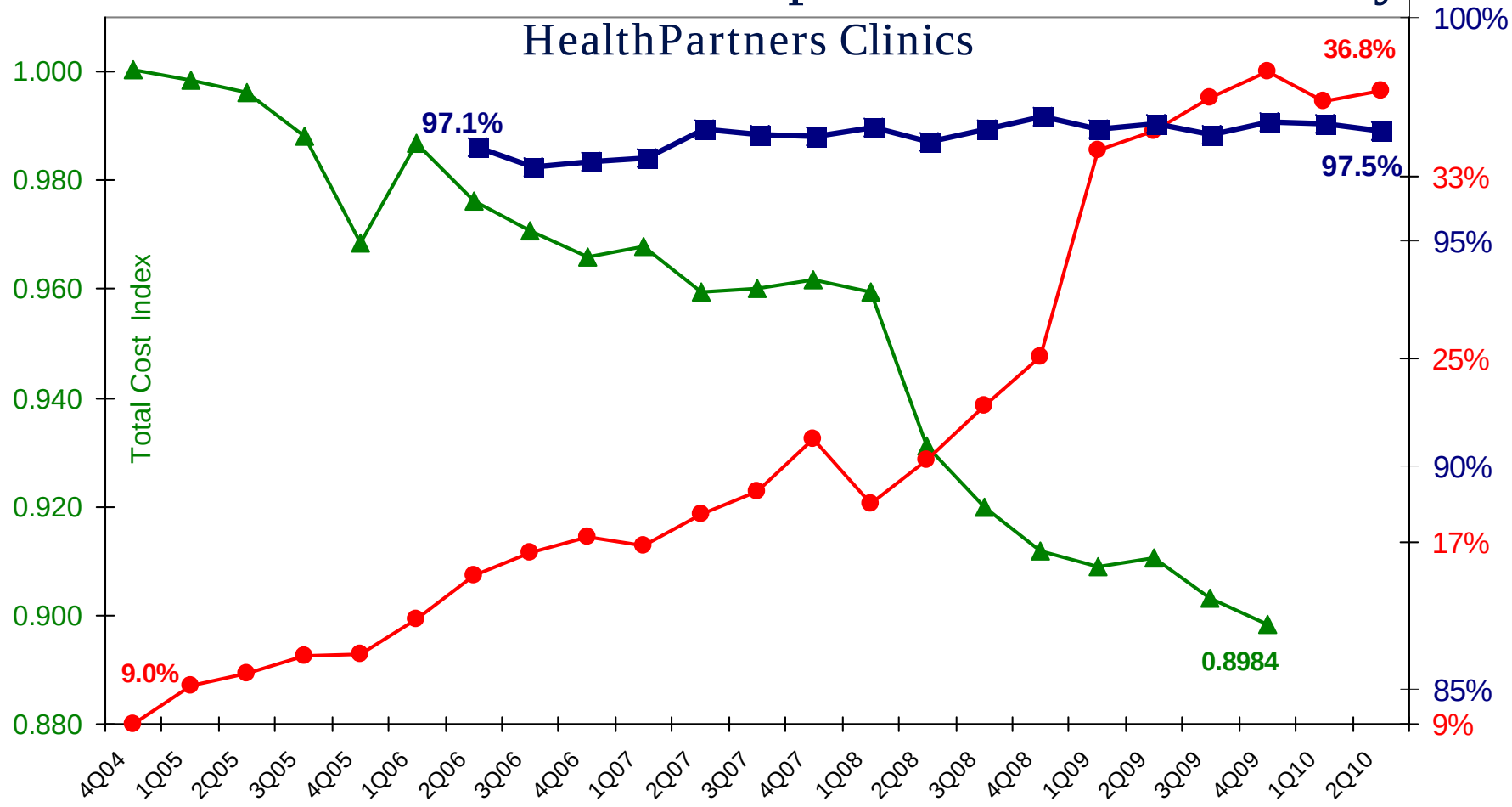
TRIPLE AIM: Health-Experience-Affordability



Total Cost Index

(compared to statewide average)

< 1 is better than network average

% patients with Optimal Diabetes Control*

** controlled blood sugar (per ICSI guideline A1C changed from < 7 to < 8 in 1st quarter 2009), BP & cholesterol, AND daily aspirin use, AND non-tobacco user*

% patients "Would Recommend" HealthPartners Clinics

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Health Plan Supports for ACOs

- Have a population health discipline
- Have advanced analytic capabilities, using data from multiple sources and perspectives including claims, surveys, and medical records with benchmarks
- Are experienced at evaluating and managing risk
- Are experienced at working with diverse provider networks

Policy Supports for ACOs

- Enable the health care community to innovate – Minnesota leads the nation in these efforts for good reason
- Avoid being prescriptive in ACO design and payment in statute – the marketplace is moving too quickly to lock predictions about the future in statute
- Help eliminate regulatory obstacles when the community brings them forward
- Support Minnesota Community Measurement as the common measurement source and place for public reporting (Health, Experience & Affordability)

Patient Involvement

- Patient Council
- Focus Groups
- Participation in Design Sessions
- Patient comments on satisfaction surveys = 1,000 per month
- Patient complaints/kudos – multiple points of entry
- Community Councils
- EBAN Experience: reducing disparities through incorporating community involvement in our clinics

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Appendices

Accountable Care Organizations: A National Perspective

Brian Rank, MD
Medical Director, HPMG

Accountable Care Organizations (ACOs) and the Affordable Care Act (ACA)

- A Medicare shared savings program established for qualifying ACOs as of January 2012 – regulations to be promulgated yet in 2010.
- Fosters pilot programs to extend the ACO model to private payers and Medicaid.

Centers for Medicare & Medicaid Services (CMS):

- Have a formal legal structure to receive and distribute shared savings.
- Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum).
- Agree to participate in the program for not less than a three-year period.
- Have sufficient information regarding participating ACO health care professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared saving

Centers for Medicare & Medicaid Services (CMS):

- Have a leadership and management structure that includes clinical and administrative systems.
- Have defined processes to:
  - promote evidenced-based medicine,
  - report the necessary data to evaluate quality and cost measures – this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing, and Electronic Health Records, and
  - coordinate care.
- Demonstrate it meets patient-centeredness criteria, as determined by the Secretary.

NCQA ACO DRAFT STANDARDS - OCTOBER 2010

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NCQA - Goals of the ACO Evaluation Program

- Identify entities that are capable of taking accountability
- Promote evidence-based practices that will improve their chances for success
- Provide a blueprint and a pathway to full ACO capability with clear stages

NCQA Draft – What is an ACO?

- Accountable Care Organizations (ACOs) are provider-based organizations that take responsibility for meeting the health care needs of a defined population with the goal of simultaneously improving health, improving patient experience and reducing per capita costs.
- How providers organize themselves as accountable entities is expected to vary based on existing practice structures in a region, population needs or local environmental factors. Within the ACO structure itself (i.e. subject to the direct authority of the ACO's governance) ACOs are likely to vary widely with respect to the components of care delivery directly included.

NCQA's ACO Guiding Principles
(core aims of accountable organizations)

- **ACOs have a strong foundation of primary care.** A core of primary care providers with medical home capabilities provides the foundation for the ACO to deliver comprehensive, coordinated, patient-centered care.
- **ACOs report reliable measures to support quality improvement and eliminate waste and inefficiencies to reduce cost.**
- **ACOs are committed to improving quality, improving patient experience and reducing per capita costs**
- **ACOs work cooperatively towards these goals with stakeholders in a community or region.**
- **ACOs create and support a sustainable workforce.**

NCQA Draft Criteria Summary

Category	Summary of Criteria (Standard/Element)
1. Program Structure Operations (PO)	• The organization clearly defines its organizational and leadership structure. (PO1) • The organization has the capability to manage its resources effectively. (PO 2) • The ACO arranges for pertinent health care services and determines payment arrangements and contracting. (PO3)
2. Access and Availability (AA)	• The organization ensures that it has sufficient numbers and types of practitioners who provide primary and specialty care (AA1)
3. Primary Care (PC)	• Primary care practices within the ACO provide patient-centered care.

NCQA Draft Criteria Summary

Category	Summary of Criteria (Standard/Element)
4. Care Management (CM)	• The organization collects and integrates data from various sources, including, but not limited to electronic sources for clinical and administrative purposes. (CM1) • The organization conducts an initial assessment of new patient's health. (CM1). • The organization uses appropriate data to identify population health needs and implements programs as necessary. (CM3) • The organization provides resources for, or supports, the use of patient care registries, electronic prescribing and patient self-management. (CM4)

NCQA Draft Criteria Summary

Category	Summary of Criteria (Standard/Element)
5. Care Coordination and Transitions (CT)	• The organization can facilitate timely information exchange between primary care, specialty care and hospitals for care coordination and transitions. (CT 1)
6. Patient Rights and Responsibilities (RR)	• The organization has a policy that states its commitment to treating patients in a manner that respects their rights, its expectations of patients' responsibilities, and privacy. A method is provided to handle complaints and to maintain privacy of sensitive information. (RR1)
7. Performance Reporting (PR)	• The organization measures and reports clinical quality of care, patient experience and cost. (PR 1) • At least annually, the organization measures and analyzes the areas of performance and takes action to improve effectiveness in key areas. (PR2)

NCQA Proposes 4 levels of Scoring For ACOs

- Level 1 – meet the core qualifying criteria which include standards for infrastructure (e.g. legal entity, leadership team, available primary care and specialty providers, etc.) and processes that promote good patient care and quality improvement (e.g. care coordination and managing patient transitions).
- Level 2 – meet core qualifying criteria and have some advanced features which may include integration of electronic clinical systems and the ability to integrate data for reporting and quality improvement.
- Level 3 – meet core qualifying criteria, possess advanced features and can report standardized, nationally-accepted clinical quality measures, patient experience and cost measures.
- Level 4 – meet core and advanced criteria and demonstrate excellence or improvement in the metrics.

NCQA - What about performance measures?

- Ultimately, success will be measured by ACO performance
  - However, most potential ACOs do not yet have sufficiently complete data to produce a reasonable number of standardized, reliable, valid measures for comparison and benchmarking
- Until meaningful, comparative performance reports are available, ACOs should demonstrate core capabilities critical to improving quality and reducing costs
- Standardized measures representing the triple aim should be phased in over time

SOME ACO CHALLENGES

ACOs – Some Challenges

- Conflicting methods for defining ACOs, setting spending benchmarks, and tracking performance (weak cost and quality metrics)
- Lack of technical knowledge and trust among physicians, hospitals and payers
- Crucial lack of leadership, culture, knowledge, and management skills.

Modified from McClellan M. et al., A National Strategy To Put Accountable Care Into Practice. Health Affairs 20. No. 5 (2010): 982-990.

ACOs – Some Challenges

- Concern that ACOs would exacerbate the trend to provider concentration and "make it easier for providers to collude to raise costs." *

*Modified from McClellan M. et al., *A National Strategy To Put Accountable Care Into Practice.* Health Affairs 20. No. 5 (2010): 982-990.

See also, Berenson, Ginsburg, and Kemper. *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform.* Health Affairs 29, No.4 (2010).

And, State Of Massachusetts, Office of the Attorney General Martha Coakley. *Investigation of Health Care Cost Trends and Cost Drivers: Preliminary Report,* January 29, 2010.

ACOs – Some Opportunities

- Focus on requiring performance against triple aim outcomes – Patient Experience, Improved Health, Lower Costs.
- Flexibility - Specifying Structure and Process too early will be a Big, Big Mistake.
- Create incentives for Performance against triple aim outcomes with incentives.

ACOs – Some Opportunities

- Ultimately, aim to move away from FFS and Unit Payment
- Leverage the experience, skills and motivation that exists in today's providers and payers