Maine Quality Counts and the Maine Health Management Coalition present...

QC Brown Bag Forum
Accountable Care Organization (ACO) Series

EMHS ACO (Beacon Health LLC) & MaineHealth ACO

February 26, 2013 (12N - 1PM)

** Don’t forget to dial in to hear the audio! **
Dial: 866.740.1260, Access Code: 6223374
Who We Are

Maine Quality Counts (QC) is a regional health improvement collaborative that brings together people who give care, get care and pay for care to improve health care quality throughout Maine.
QC is transforming health and health care in Maine by leading, collaborating and aligning improvement efforts.

- Maine Patient Centered Medical Home Pilot
- Community Care Teams
- Aligning Forces for Quality (AF4Q)
- Behavioral Health Integration
- Quality Counts for Kids / First STEPS Initiative
www.mainequalitycounts.org
QC Learning Community Webinars

• Monthly webinars:
  – Provider Lunch & Learn: 1st Tues/mo – 12N
  – HIT Roundtable: 2nd Thurs/mo – 12N
  – QC 2013 Triple Aim Series: 3rd Thurs/mo – 12N
  – QC Brown Bag Forum: 4th Tues/mo – 12N

• Next ACO Series Webinar:
  – Tues, March 26 at 12N
    • Central Maine ACO and Maine Community ACO
ACO Resources:
www.mainequalitycounts.org
QC 2013
Aligning Maine’s Forces to Become the First State to Reach the *Triple Aim*
*population health • cost reduction • care experience*

**Wednesday, April 3, 2013 8am-4pm**
Augusta Civic Center, Augusta, Maine

A Maine Quality Counts conference held in partnership with Maine Public Health Association—Maine Primary Care Association

**Keynote Speakers:**

Dr. Donald Berwick
Rosemary Gibson

Register online at
www.mainequalitycounts.org
Important Webinar Notes

• To minimize background noise, all lines will be muted
  • To unmute your line, press *7
  • To mute your line, press *6

• To ask questions or share comments, use one of two ways:
  1. Raise Your Hand button (press *7 to unmute your line)
  2. Type in chat box on the lower left-hand side of the screen

• Please state your name and organization before asking your question or sharing your comment
Iyad Sabbagh, MD, joined the EMMC Husson Internal Medicine team back in 2002. He has been involved with IT and quality and process improvement projects. He has also worked with the medical staff office at Eastern Maine Medical Center. At EMHS he has helped launch the outpatient care management program and was involved in the accountable care initiatives. He currently is the Medical Director for the Accountable care activities at EMHS.

Jeffrey Aalberg, MD, MS, is Chief Medical Officer for the Maine Medical Center Physician-Hospital Association, Senior Medical Director for Prevention and Ambulatory Care at MaineHealth, and Associate Clinical Professor at the Tufts University School of Medicine. After years in private practice, Dr. Aalberg joined the Faculty of the Maine Medical Center Family Medicine Residency Program. He served as Medical Director and Associate Chief of Family Medicine until he entered his current role for the MMC PHO.

Andrea Dodge Patstone is Vice President for Strategic Initiatives at MaineHealth. She is responsible for strategic development of MaineHealth’s Accountable Care Organization and for implementing changes across the system that will enable MaineHealth to respond to – and thrive under – new models for healthcare finance and governance. Andy’s career has spanned the government, corporate and non-profit sectors. Most recently she served as Chief Operating Officer for human services in the state of Massachusetts.
What is an ACO?

- The Accountable Care Organization works to coordinate better care and collaborate with payers by aligning provider incentives to improve quality and health outcomes as well as to achieve cost savings.
Pioneer ACO: Program Highlights

• Annual expenditures for 9,000 beneficiaries: ~ $90 million
• Increase accountability for costs
  – YEAR 1
    • 50% share of savings (varies with quality score) up to a cap of 5% of total part A and part B expenditures ($4.5 million)
    • Must achieve a Minimum Savings Rate of approximately 2.5%
  – YEAR 2
    • 70% share of savings or losses (varies with quality score) up to a cap of 15% of total part A and part B expenditures (~$14 million)
    • 1% Minimum Savings Rate
  – YEAR 3
    • Migrate to capitation models, and
    • Have > 50% of revenue from risk share contracts
Beacon Health, LLC
Participants
2012 & 2013
Beacon Health, LLC
2012

Participants;
• Eastern Maine Medical Center
• Inland Hospital
• The Aroostook Medical Center
• Three Rivers (Waterville).
Covered Lives;
- ~9,400
- Average spend per member = $10,220
Beacon Health, LLC - 2013

Participants:

- Blue Hill Memorial Hospital, EMHS
- Charles Dean Hospital, EMHS
- Eastern Maine Medical Center, EMHS
- Inland Hospital, EMHS
- Mount Desert Island Hospital **
- Penobscot Community Health Center
- Sebasticook Valley Hospital, EMHS
- Sebasticook Family Doctors **
- St. Joseph’s Hospital
- The Aroostook Medical Center, EMHS
- Three Rivers (Waterville)

** indicates strategic partner/associate
Beacon Health, LLC - 2013

Covered Medicare Lives;
• ~14,000

Employees;
• Effective 1/1/13 – Geisinger Health plan is the TPA for EMHS
• ~ 10,000 lives
IT structure and challenges

- Blue Hill Memorial Hospital, EMHS (Cerner, Centricity, Meridios)
- Charles Dean Hospital, EMHS
- Eastern Maine Medical Center, EMHS
- Inland Hospital, EMHS
- Mount Desert Island Hospital ** (eClinicalWorks; CPSI)
- Penobscot Community Health Center (Centricity)
- Sebasticook Valley Hospital, EMHS
- Sebasticook Family Doctors ** (NextGen)
- St. Joseph’s Hospital (Centricity CPS; MedSeries4; T-System for E.D.)
- The Aroostook Medical Center, EMHS
- Three Rivers (Waterville) (Centricity)
# HealthInfoNet Connections

## Beacon Health Facilities/Practices Connected to HealthInfoNet

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Basic Framework

Strategic Analytics

Core System: Data Warehouse(s), Data Marts, Data Mining

Principal Participants: Analysts

Tools: Custom Reports and Data Display Tools

Operational Analytics

Core Systems: Data Warehouse(s), Data Marts, Risk Models

Principal Participants: Senior Management, Clinical Leadership, Analysts

Tools: Standard Reports, Data Marts, Custom Reports, Dashboards

Panel Management

Core Systems: Electronic Health Record

Principal Participants: Regional Director CM, CMO, Dir. Operations

Tools: EHR Contact Reports, Panel Quality Scores, Panel Expenditures, Panel Readmissions

Direct Care Management

Core System: Electronic Health Record

Principal Participants: Beneficiary + Care Manager

Tools: Care Record, Risk Scores, Quality Status, EHR History
IT Challenges:

- Multiple, different EHRs across provider organizations.
- Variability in connections to HIN.
- Data Use limitations and security requirements.
- Lag time in receiving key data.
- Developmental status of tools for analytics.
Clinical Strategies
Clinical Structure and challenges

Beacon Health, LLC Organizational Structure
Population Health Management
- Medical Directors
  - Members
    - INLAND
    - CA Dean
    - EMMC
    - TAMC
    - SVH
    - BHMH
    - PCHC
    - SJH
  - Strategic Partners
    - SFD
    - MDI
    - THREE RIVERS
- Regional Manager
  - North
  - Central
  - South
- Medical Neighborhood System Team
  - EMMC
  - CA DEAN
  - PCHC
  - ST. JOSEPH HEALTHCARE
  - MDI
  - INLAND
  - SVH
  - BHMH
  - SFD
  - THREE RIVERS
- Practice Director/Medical Director
- CMO/VP
- CCC
- Pharmacy
- VP

*Strategic Contractors
Population Health Management

- Population Health committee with three subcommittees; Performance Improvement, Pharmacy, and Care Coordination Committees.
- Purpose is to provide clinical leadership, facilitate collaboration, define reporting strategies, and plan medical management for Beacon Health LLC.
- Each Beacon Health LLC member organization will designate a Medical Director and a Lead Care Manager to serve on the committee. Each facility will have one vote.
Population Health committee cont.

• Practice redesign:
  – Redefine roles of each member and redeploy so each team member is working to the top of their license.
  – PMCH/HH practice participation (or implementation of core elements).
  – IT optimization.
  – Lean methodology.

• Providers awareness and education:
  – Introduce and educate providers about utilization metrics.
  – Incorporate utilization metrics into quality dashboard.
  – Choose Wisely.
Population Health

Community Care Model

Clarifications:

Transition Coordination – One area that historically increases errors is when patients are transitioned from one level of care to another. The transition coordination on the model herein may be accomplished by PCP based care coordinators, home health nurses, community care teams or a new pilot being designed in Bucksport known as SASH (Support And Services at Home).

Medical Neighborhoods – Building off the patient centered medical home model, a new term being used in the accountable care arena is Medical Neighborhoods. When the various elements on the community care model graph are effectively integrated with patient centered medical homes in a high performing, high value model, it can be referred to as a medical neighborhood.
Performance Improvement Subcommittee

- Purpose to review clinical performance and provide advice on implementing, changing or modifying clinical operational processes and action plans to meet and exceed the performance goals set by the Medical Management Group.
- Data to be reported by system, organization, practice, and individual provider
- Each member will designate provider and key non-provider involved in PI to serve on the committee
# Standard Measurement and Dashboard

## All Measures

### Key Measurements

1. **All EMHS April 2012**
2. **All EMHS May 2012**
3. **All EMHS June 2012**
4. **All EMHS July 2012**
5. **All EMHS August 2012**
6. **All EMHS September 2012**
7. **All EMHS October 2012**

### Table Data

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**Note:** Additional detailed tables and metrics are available for in-depth analysis.
Pharmacy Subcommitte

• Purpose to enhance efforts to coordinate and improve pharmacy care
• Goal is to promote best practices and protocols, promote the role of pharmacists in the primary care team, enhance medication reconciliation, promote use of generic medications, and lower costs
Care Management Subcommittee

- Care Coordination:
  - Complex Case Management:
    - Use Care Coordinators to facilitate treatment of acute and chronically ill patients based on utilization and risks.
  - Disease Management:
    - Use Disease Managers to manage patients with one or two chronic diseases.
  - Transition Care Coordination
  - CCT
Clinical Challenges

- Multiple, different EHRs across provider organizations which makes data collection a challenge.
- Variability in connections to HIN.
- Different stages of implementation of PCMH concepts.
- Different levels and processes for care coordination.
- Different levels of providers buy in.
- Aligning clinical priorities of the ACO with organizations priorities (clinically and financially).
Early Results
“I am more positive than I’ve ever been. Diabetes is hard to understand and my nurse is teaching me how sugars affect my life.”

Gerry’s uncontrolled diabetes was taking a toll on his life. Six months ago his A1C was 12.3 it is now 8.5 and he’s lost 74 pounds.

Improved health has him doing all the things he loves hunting, trapping, tanning hides, and taking folks on moose safaris.
Early Achievements

• Positive patients feedback.
• Improvement in 19 out of 23 clinical measures.
• Embedding CM in PCP practices.
• Adding new partners.
EMHS Accountable Care Organization
PY1, Quarter 2 YTD
Actual Change in Trend

Observed - Capped

EMHS

Together We’re Stronger
Questions
MaineHealth
Accountable Care Strategy

Andrea Patstone
Vice President, Strategic Initiatives

Jeff Aalberg, MD
Chief Medical Officer, MMCPHO

Quality Counts Brown Bag Forum
February 26 2013
What is MaineHealth?

- Health System with 6 member and 3 affiliate acute care general hospitals
  - Member hospitals operate over 1,400 inpatient acute care beds
  - 38% of all hospital discharges in Maine
- Physician-Hospital Organization: Over 1,000 independent and employed physicians
  - >300 primary care physicians
- Home health agency, inpatient psychiatric hospital, multi-service outpatient behavioral health organization, and clinical laboratory
MaineHealth and Accountable Care: beginning with our 2012-2014 Strategic Plan …. 

First of Four Strategic Goals:  

“MaineHealth will develop and implement plans to reposition our health system as a leader in accountable care through the redesign of our care delivery and financing systems”  

In alignment with this goal MaineHealth has, among other things…. 

- Formed the MaineHealth Accountable Care Organization as the primary vehicle for accountable care contracting  
- Been selected with 89 other ACOs nationally to participate in the Medicare Shared Savings Program  
- Nearly completed negotiations with 2 private payers to bring over 20,000 commercial lives under accountable care contract models  
- Set transformation and investment benchmarks that require all primary care practices to become Patient Centered Medical Homes  
- Supported member hospitals to align individual strategic plans financial targets, and clinical delivery strategies with the demands of accountable care
MaineHealth Accountable Care Organization
Strategy: Steady Transition to Global Payments

Fee For Service, Volume Based Payment

Shared Savings – Upside Only

Shared Savings & Risk Partial Capitation Bundled Payments

Global Payments Shared Risk

Develop the clinical and operational capabilities required for success as we move along this progression
Our ACO is pursuing a four-point care improvement strategy to succeed under new payment models.

**Primary Care**
Our primary care practices will operate as Patient Centered Medical Homes, and be financed to do so

**Streamline and Consolidate Care Coordination**
MaineHealth will assess, consolidate and/or reorganize system-wide care coordination resources to ensure right focus on right patients

**Improve Information Available to Clinicians & Administrators**
1) At the point of care: successful implementation of SeHR and 2) Trends & variation in care: Northern New England Accountable Care Collaborative

**Full Transparency**
A physician-led peer review program will focus on reducing unwarranted variation in care
Patient Centered Medical Home

- Support for Maine State Pilot
- PHO>MaineHealth Initiative
  - Collaborative Model
  - Central Oversight; Regional Deployment
- Community Care Teams
- Nurse Care Managers
- Practice Improvement Advisors
- NCQA Submission Support
Care Coordination

- Medical Neighborhood
- Delineation and Integration of System Resources
- Community Based Care Transitions Program
- Guides to Care and Referrals
- Care Navigator
- Secure messaging pilot
Information Systems and Quality Reporting

- EHR Support - SeHR
  - Athenahealth support for non-MaineHealth practices
- NNEACC development and implementation
  - Care Coordination portal in development
  - Physician and administrators views are next in queue
- PCP reporting (Clinical Improvement Registry)
- Support for external quality reporting
Transparency

*reducing unwanted variations in care*

“MHACO Value Oversight Process”

- As an ACO, MHACO requires a transparent approach to engaging Participants in discussions regarding healthcare value

- These “discussions” must serve at least two purposes:
  1. Pro-active identification of opportunities and setting of goals for improvement on specific efficiency and quality measures
  2. Predictable and transparent way to respond to / correct challenges of variations as they are identified
Variation Work: A System Example:
MaineHealth Health Partners Plan

Outpatient Radiology Allowed Costs PMPM 2011
Age-Sex Adjusted

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To continue moving down the payment reform continuum, MaineHealth and its ACO partners must:

- Continue expanding ACO activities into the commercial sector
- Begin assessment and pilot implementation of new financing for primary care
- Continue to invest in IT and data analytics to drive both care coordination and value improvement programs