

Transforming Care Delivery by Moving from Episodic to Coordinated Payment

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That's more than healthcare. That's smartcare.

Presentation Overview



I. Summa Story

II. Evolution of Physician Alignment Models

III. Population Health Initiatives

- Accountable Care Organization (“ACO”)
- Patient-Centered Medical Home (“PCMH”)

IV. Bundled Payment

- Overview of Model
- Evaluation of Models
- Business Case
- Lessons Learned

Who Is Summa?



- **Summa is...**

- An Integrated Delivery System
- Tertiary, Community and Physician-Owned Hospitals, Multi-Specialty Physician Group, Research Division, Health Plan and Foundation
- Located in a 5-County Area in Northeast Ohio
- Working to...
 - Enhance the patient and member experience
 - Create value through a collaborative focus
 - Provide high quality care at low cost
 - Serve the community as the largest employer in our service area

The Integrated Delivery System

Hospitals

Inpatient Facilities

- Tertiary/Academic Campus
- 3 Community Hospitals
- 1 Affiliate Community Hospital
- 2 JV Hospitals with Physicians

Outpatient Facilities

- Multiple ambulatory sites
- Locations in 3 Counties

Service Lines

- Cardiac, Oncology, Neurology, Ortho, Surgery, Behavioral Health, Women's, Emergency, Seniors

Key Statistics

- 2,000+ Licensed Beds
- 62,000 IP Admissions
- 45,000 Surgeries
- 660,000 OP Visits
- 229,000 ED Visits
- 5,000 Births
- Over 220 Residents

Physicians

Multiple Alignment Options

- Employment
- Joint Ventures
- EMR
- Clinical Integration
- Health Plan

Summa Physicians, Inc.

- 300 Employed Physician Multi-Specialty Group

Summa Health Network

- PHO with over 1,000 physician members
- EMR/Clinical Integration Program

Health Plan

Geographic Reach

- 17 Counties for Commercial
- 18 Counties for Medicare
- 55-hospital Commercial provider network
- 41-hospital Medicare provider network
- National Accounts in 2 States

155,000

Total Members

- Commercial Self Insured
- Commercial Fully Insured
- Group BPO/PSN
- Medicare Advantage
- Individual PPO

Foundation

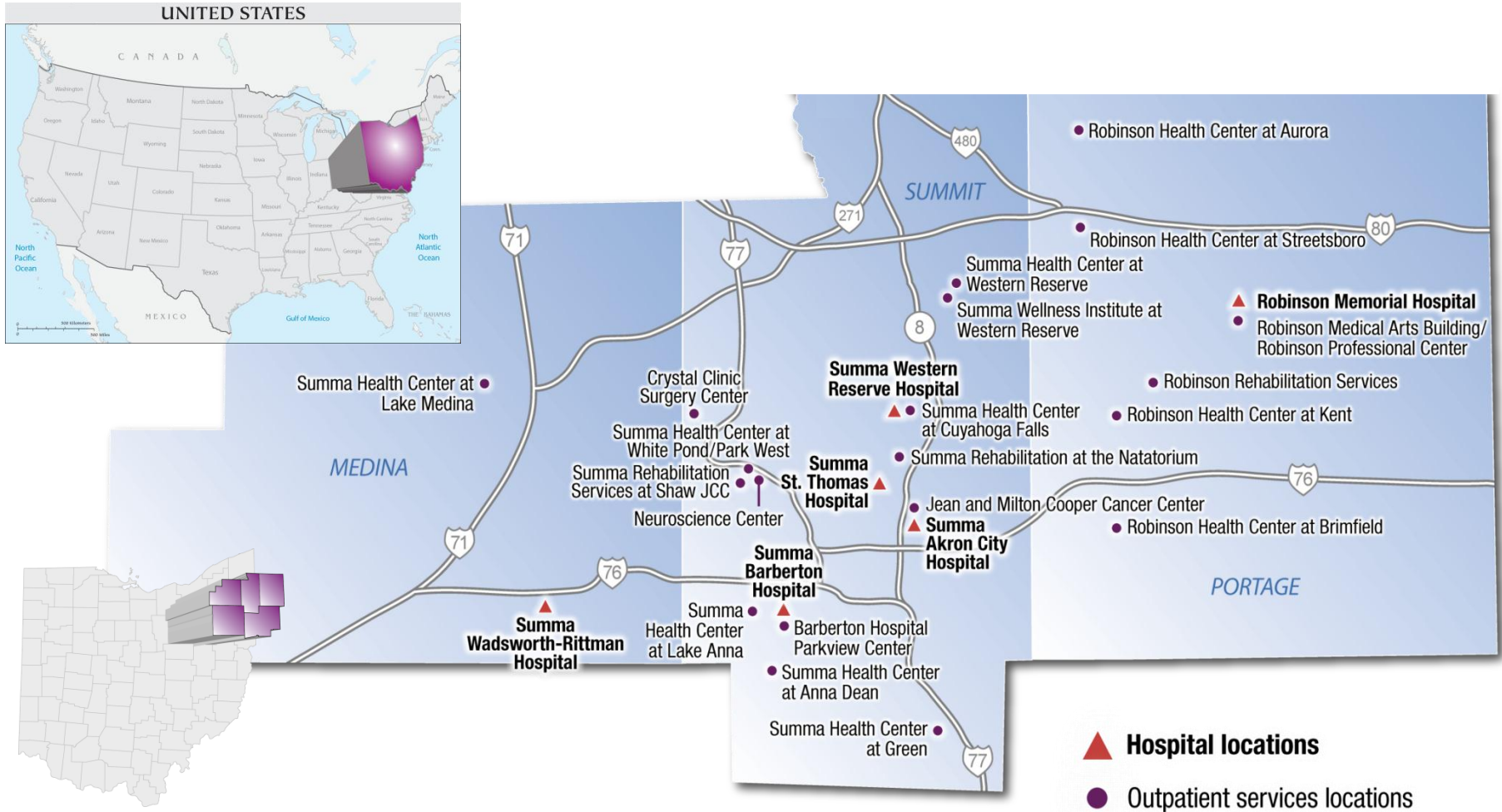
System Foundation

Focused On:

- Development
- Education
- Research
- Innovation
- Community Benefit
- Diversity
- Government Relations
- Advocacy

Net Revenues: Over \$1.6 Billion
Total Employees: Nearly 11,000

Summa Health System



Summa Akron City Hospital



St. Thomas Hospital



Summa Wadsworth-Rittman



Crystal Clinic Orthopaedic Center



Summa Barberton Hospital



Summa Western Reserve Hospital



Summa Rehab Hospital



Robinson Memorial Hospital



Summa's Delivery Network: Selected Outpatient Centers



**Crystal Clinic
Surgery Center**



**Jean & Milton
Cooper Cancer
Center**



**Summa Health
Center at Lake
Medina**



**Summa Barberton
Hospital Parkview
Center**



**Specialty Health
Center/ Heart and
Lung Center**



**Summa Health Center
at Western Reserve**

Two of the System Hospitals Are Joint Ventures with Our Physicians



■ Summa Western Reserve Hospital (“SWRH”)

- Joint venture started in June 2009 between Summa Health System and Western Reserve Hospital Partners (a local group of approximately 220 physicians)
- Commenced operations in June 2009 at the prior Hospital location (conversion of underperforming asset)

■ Crystal Clinic Orthopedic Center (“CCOC”)

- Orthopaedic Hospital Joint Venture between Summa Health System and Crystal Clinic (a local group of approximately 30 orthopedic surgeons)
- Commenced operations in May 2009 on the Summa St. Thomas Hospital (Hospital w/in a Hospital)



- **Health Insurance Company**
- **Provider Owned**
- **Four Product Lines**
- **Total Membership – 150,000 +**
- **18 County Northern Ohio Service Area**
- **Multi-State, National Accounts**
- **Annual Revenue \$400 million**
- **300+ Employees**
- **Large Credentialed Provider Network**



Physician Alignment Models



Physician Alignment Options

A Multi-Pronged Approach

- **First plank** – Develop Primary Care Network
- **Second plank** – Offer Fully-employed and Physician-Managed Employment Models
- **Third plank** – Joint Ventures
- **Fourth plank** – Clinical and Financial Integration through SHN
- **Fifth plank** – Managed Services Organization

Summa Physicians-Employed Group



Summa Physicians, Inc. (300 physicians)

Internal Medicine
(45)

Cardiology
(28)

Behavioral Health
(25)

Palliative Care
(6)

Family Medicine
(47)

Oncology
(7)

Critical Care
(11)

Gastroenterology
(4)

OB/Gyn
(21)

Surgery
(35)

Infectious Disease
(7)

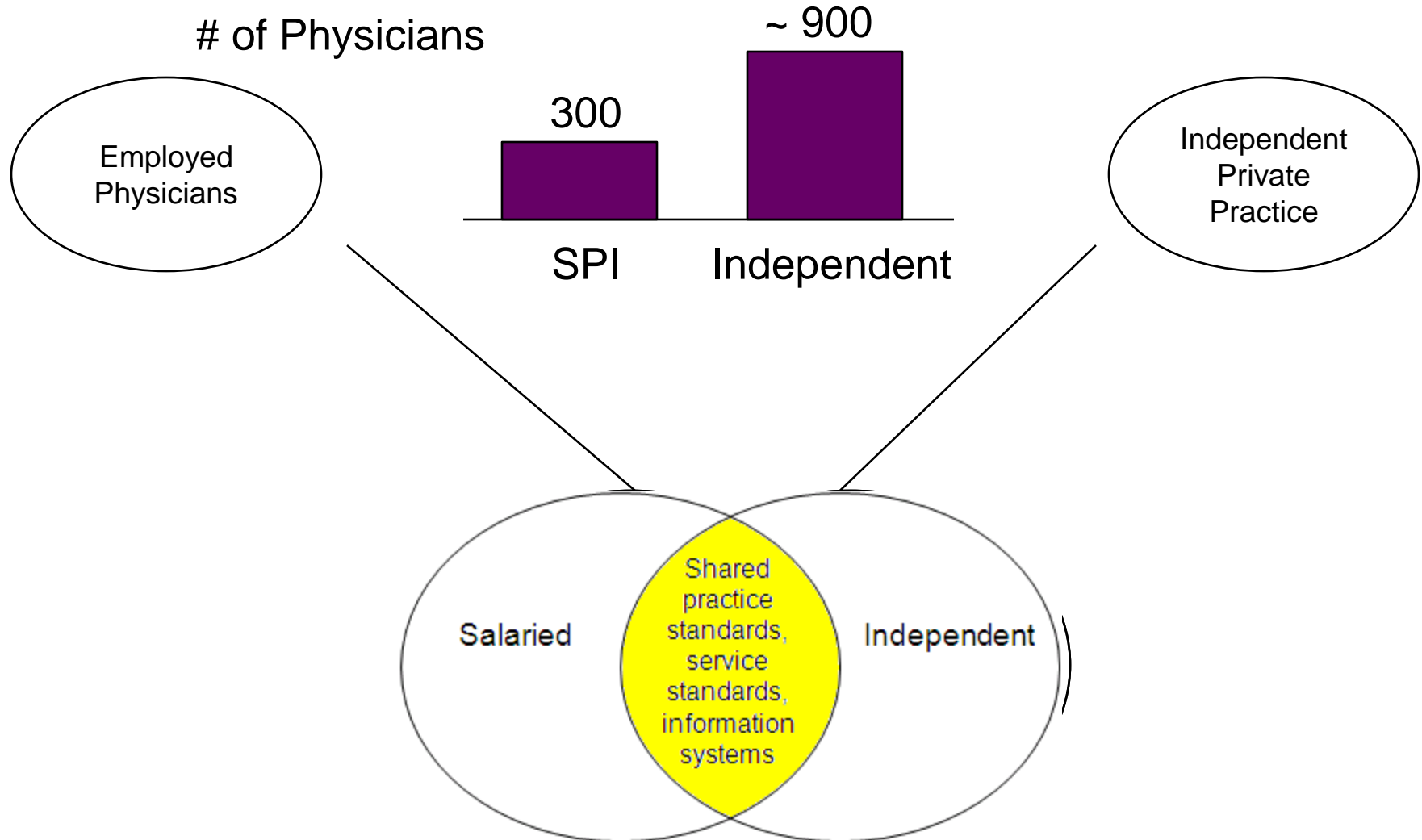
Others
(41)

Geriatrics
(11)

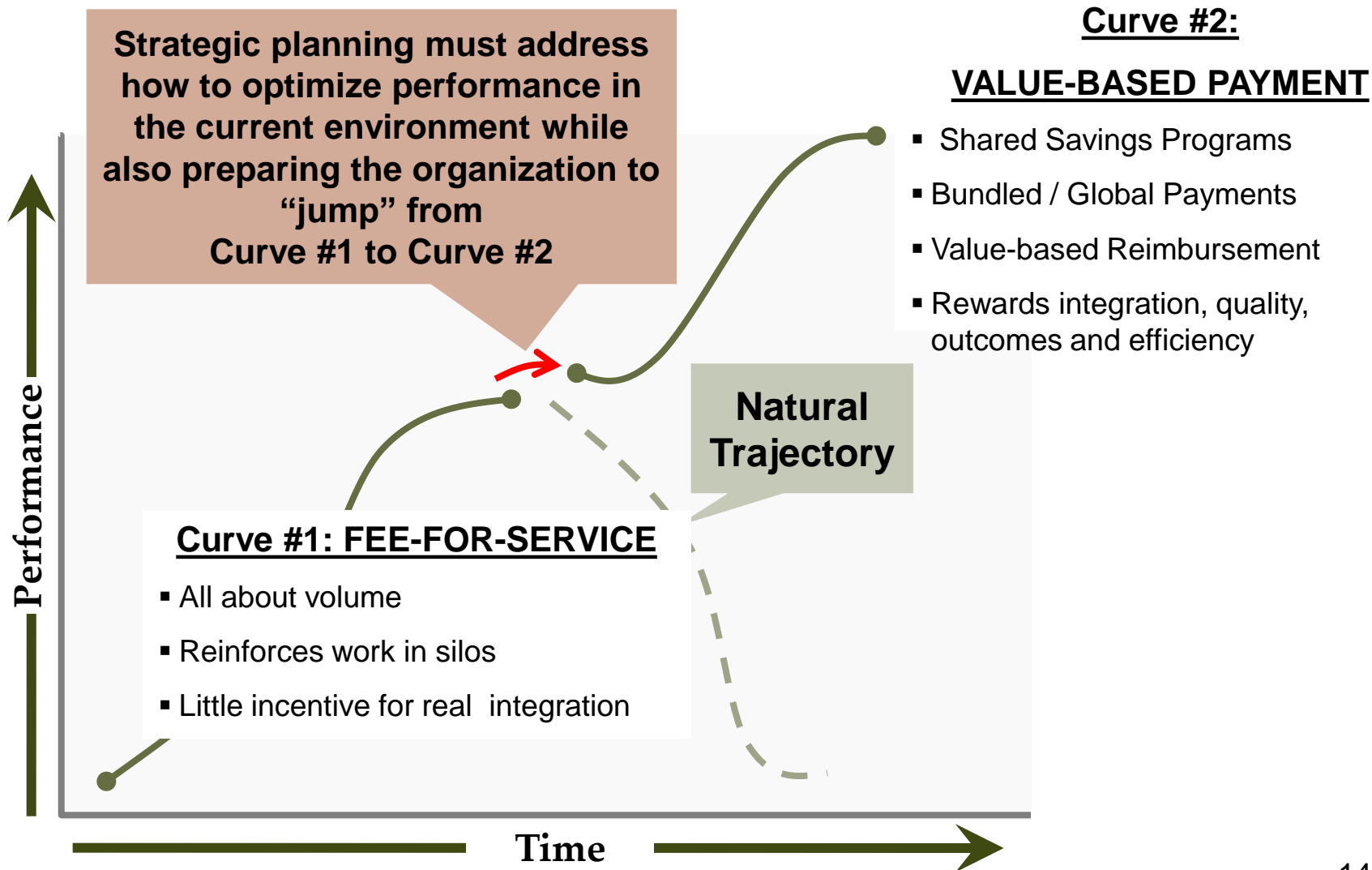
Ortho/Sports
(8)

Endocrinology
(4)

Development of The Common Ground



Our Challenge: *Jumping to "Curve 2"*

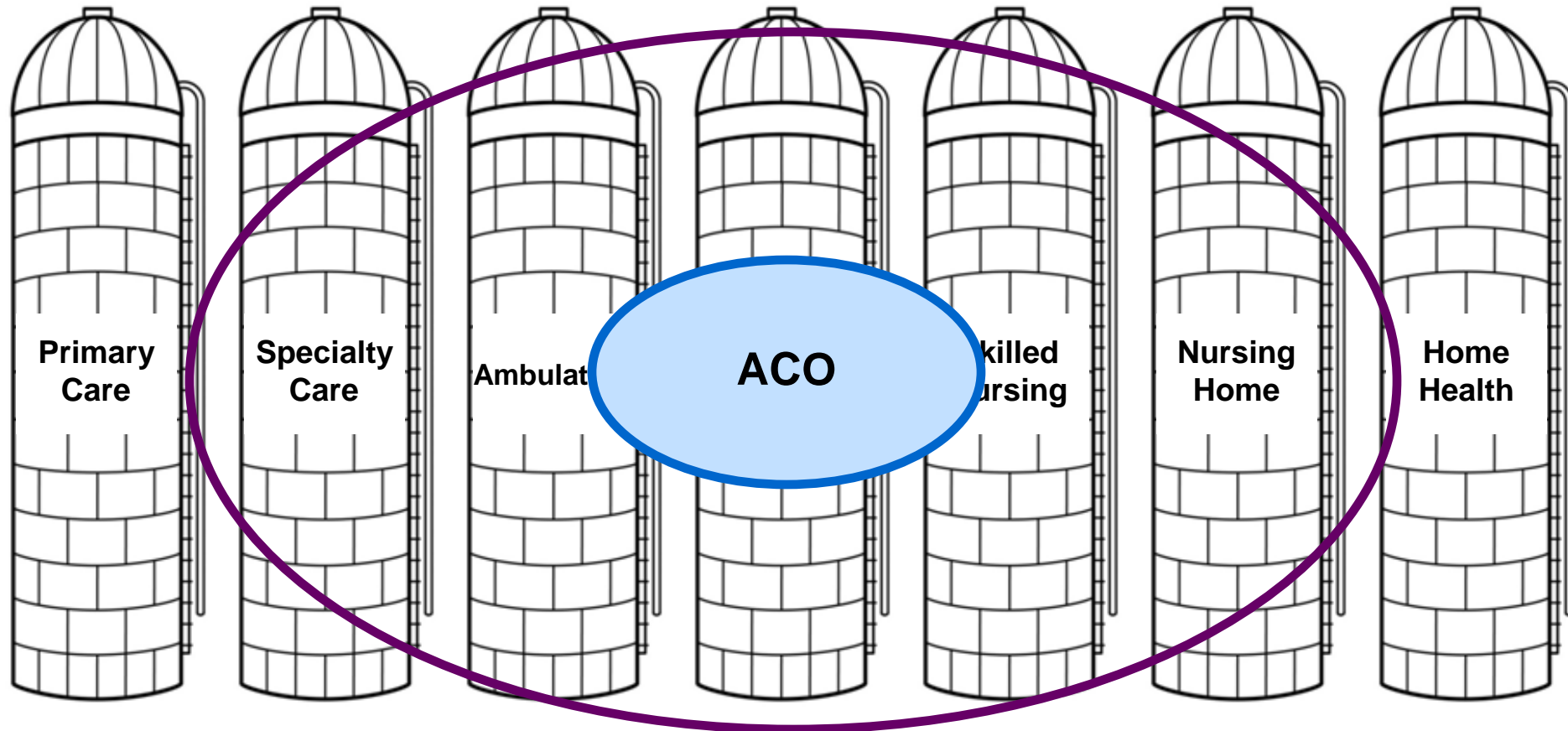


Combining Parts into an ACO



Why Change How We Provide Care?

Everyone is working in their own silos..., which impedes coordinated care



The Change Process: 2010



ACO Steering Committee
Physician and Executive Strategic Thought Leaders Guiding the Process

*Co-Chaired by
CEO and
System VP of
Quality*

**IT
Work Group**
System IT
SummaCare IT
SHN/EMR
CPOE
Data Warehouse

**Delivery
Network
Work Group**
PHO
Physician Leaders
JV Partners

**Care Model
Work Group**
Service Lines
Physician Leaders
Primary Care
Nursing
Care Management

**Finance
Work Group**
Entity CFOs
Hospitals
SummaCare

*Physician and
Administrative
Co-Chairs*

*Included
Community-
Based
Physicians*

System-Wide Educational Forum
Large-group vehicle for communication and reporting to key constituencies across the System, including:
Board Leaders, Entity Presidents and Senior Leaders, Physician Leaders from Entities and the Community, Joint Venture Leadership, All Work Group Members

*Educational
sessions
occurred at
Summa
and with
participating
physician
groups*

What is the Summa ACO?

Vision Statement: “Summa ACO” is a Clinician-Led Organization that Partners with Communities to Compassionately Care for and serve in an Accountable, Value and Evidence-based manner

Organizational Facts

- **Start Date** – Began operations January 1, 2011
- **Initial Pilot Population** – Approximately 12,000 SummaCare Medicare Advantage members that currently see a participating primary care physician
- **Legal Entity** – Non-profit taxable structure allows for physician majority on the Board
- **Board Composition** – 4 community primary care physicians, 1 medical specialist, 1 surgical specialist, 3 Summa representatives

How Summa Views Accountable Care

- **The concept of Accountable Care creates a Burning Platform for Hospitals, Physicians and other Providers along the Care Continuum to work Collaboratively to deliver High-Quality, Coordinated and Cost-effective Care**
- **Paradigm Shift from Fee-for-Service Medicine to comply with Dr. Berwick's Triple Aim-Better Care, Better Population Health and Lower Costs**

How Summa Views Accountable Care (cont.)

- **Accountable Care continues the following transitions:**
 - Move away from the current fee-for-service payment system to a new model that incentivizes primary care, wellness and population health
 - Providers become clinically and fiscally accountable for the populations they serve (consistent with our Joint Ventures)
 - Patients become actively engaged to take responsibility for their health
 - Hospitals and physicians build upon their relationships with each other and partner in a deeper way with patients, populations and payers
 - Improve the health of our communities while, at the same time, reduce costs by anticipating health needs and proactively managing chronic care

Future Goals Drive Change

- **Future Goals include:**
 - Enhance Physician Engagement and System Integration
 - Expand Market Penetration (selectively and strategically) and Increase our Patient Population
 - Replace Episodic Care with Coordinated Care
 - Improve Population Health through ACO and Medical Homes
 - Seek to move from independent silos to group culture by evolving to full connectivity on common IT platform

ACO Membership Strategy

- **Inclusive, not exclusive**
 - View the ACO as a community collaboration
 - Engage both employed and independent providers
 - Expand to all segments along the care continuum
 - Inclusive of all physicians that want to participate as long as they meet ACO quality and utilization standards as defined in Conditions of Participation in Membership Agreement

- **Initial partners include about 200 PCPs, more than 200 specialists and 6 hospitals**
 - 4 large independent primary care groups
 - 2 employed multi-specialty groups
 - All Summa hospitals
 - SummaCare as the payer partner

ACO Conditions of Participation

- **Sample provisions:**
 - Have capacity to exchange clinical and demographic information through secure transaction sets
 - Provide patient data to develop care plans consistent with patient choice
 - Adhere to ACO protocols to promote improvement in patient outcomes and patient satisfaction
 - Make Referrals to other ACO providers when medically necessary and consistent with patient choice
 - Protect privacy of patient PHI as required under HIPAA

Care Model Development



- **Care Model Concept**
 - Review High-cost and High-utilization Clinical Conditions
 - Start with Transitions of Care as a way to approach all Care Models- Better Hand-Off of Patients

- **Initial Care Model – Heart Failure**
 - Identified as a Leading Cost and Utilization Driver for the Pilot Population
 - Will serve as an example for how to develop additional Care Models
 - Create Evidenced-based Protocols which are followed by all Providers
 - Target preventable readmissions through better follow-up and monitoring of the patient

Transformation of Care Clinical Practice Guidelines

■ 7 Clinical Practice Guidelines

- Adopted from best practice clinical pathways currently in use by SummaCare
- Endorsed by Clinical Value Committee
 - Hypertension
 - Asthma
 - Diabetes
 - Chronic Obstructive Pulmonary Disease
 - Congestive Heart Failure
 - Cardiovascular Disease
 - Chronic Kidney Disease

■ Next Steps – Electronic Integration

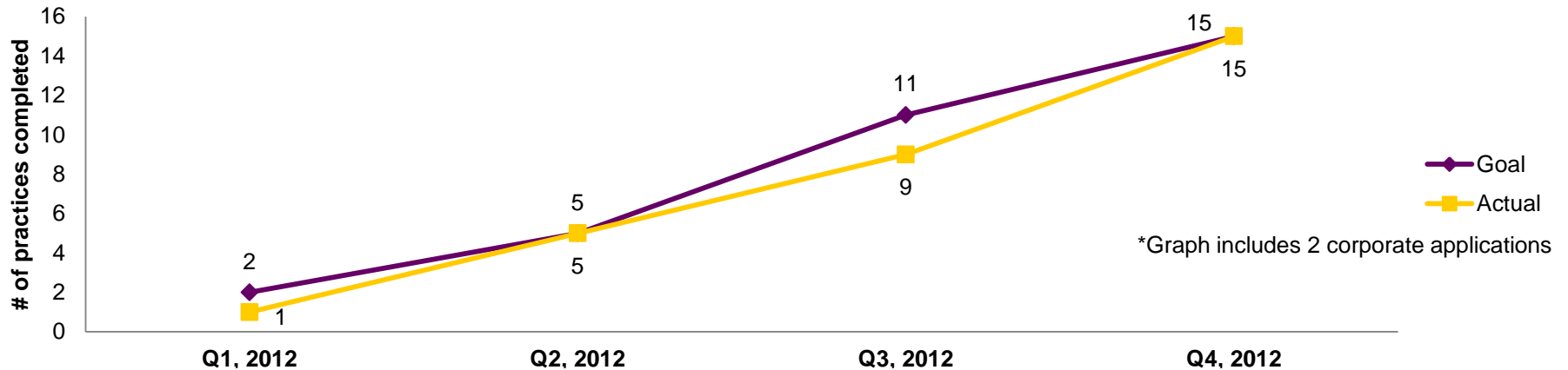
- Process measures to be proposed to CVC in February
- Clinical Informatics Council to lead decision making on location within EMR

- Teamwork is essential in the PCMH
- **Pre-Visit Team Planning (a.k.a. huddles):**
 - Increase Team Unity
 - Minimize potential clinic bottlenecks
 - Increase communication
- Implemented daily huddles in Phase 1 PCMH practices in 2012
- Introduce “Huddle” workflow not only PCP offices, but also specialists in ACO in 2013
- Developed “**Tasks for Staff, Decisions for Physicians**” approach to workflows
- Worked with offices to identify chronic disease management, with the goal of standardizing workflows



PCMH NCQA Recognition

NCQA Application Progress, 2012



-4 practices received Level 3 (Highest) NCQA Recognition

- First Patient-Centered Medical Homes in **Summit, Medina, and Stark counties**

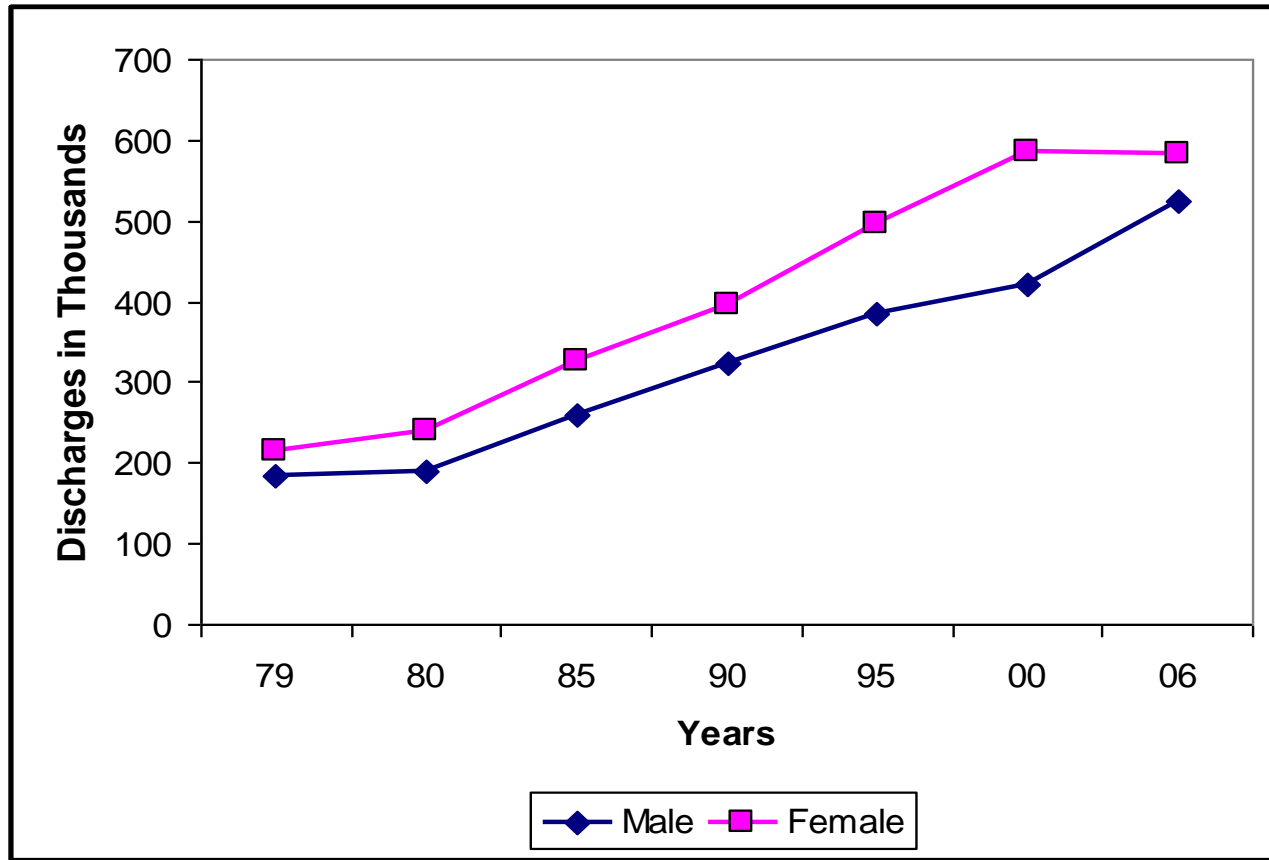
-9 additional practices have submitted their NCQA Level 3 application

- Remaining results are expected 1 Qtr 2013

-10 practices are planned to complete by 1 Qtr 2013

Disease-Specific Care Models: CHF as a Use Case

Hospital discharges for heart failure (US: 1979-2006)



Source: NHDS/NCHS and NHLBI

Heart Failure Care Model: Current Elements

- Focus on **Transitions** from Hospital to Home
- Focus on **Patient-Centered Medical Home Management**
- Focus on **Patients' Ability to Self-Manage**



New Heart Failure Transitional Processes (Hospital to Home)

- Improved notification of PCP at the point of admission and discharge from hospital, with transfer of pertinent clinical information and establishment of a follow-up visit
- Expansion of Transitional Care Nurse Case Management Program across all System Hospitals
- Clinical Guidelines for Post-Discharge Care with utilization of Electronic Health Record where possible

HF Medical Home Management

- **Development of visit-based ambulatory guidelines incorporated into the Electronic Health Record**
- **Enhanced Management of patients with highest risk factors**
- **Ongoing support with integrated care plan via assignment of case managers to primary care offices**
- **Proactive identification of patients for home monitoring, other supportive services**

- **Restructure patient education materials to allow for an individualized, staged approach to patient activation**
- **Shift in delivery of materials from an “education” perspective to a “coaching” mode with the objective of patient *engagement***
- **Develop and incorporate materials focused on enhancing patients’ self management and emphasize the patient’s role within the health care team**

Financial Model



ACO Surplus Payment Criteria: PCP

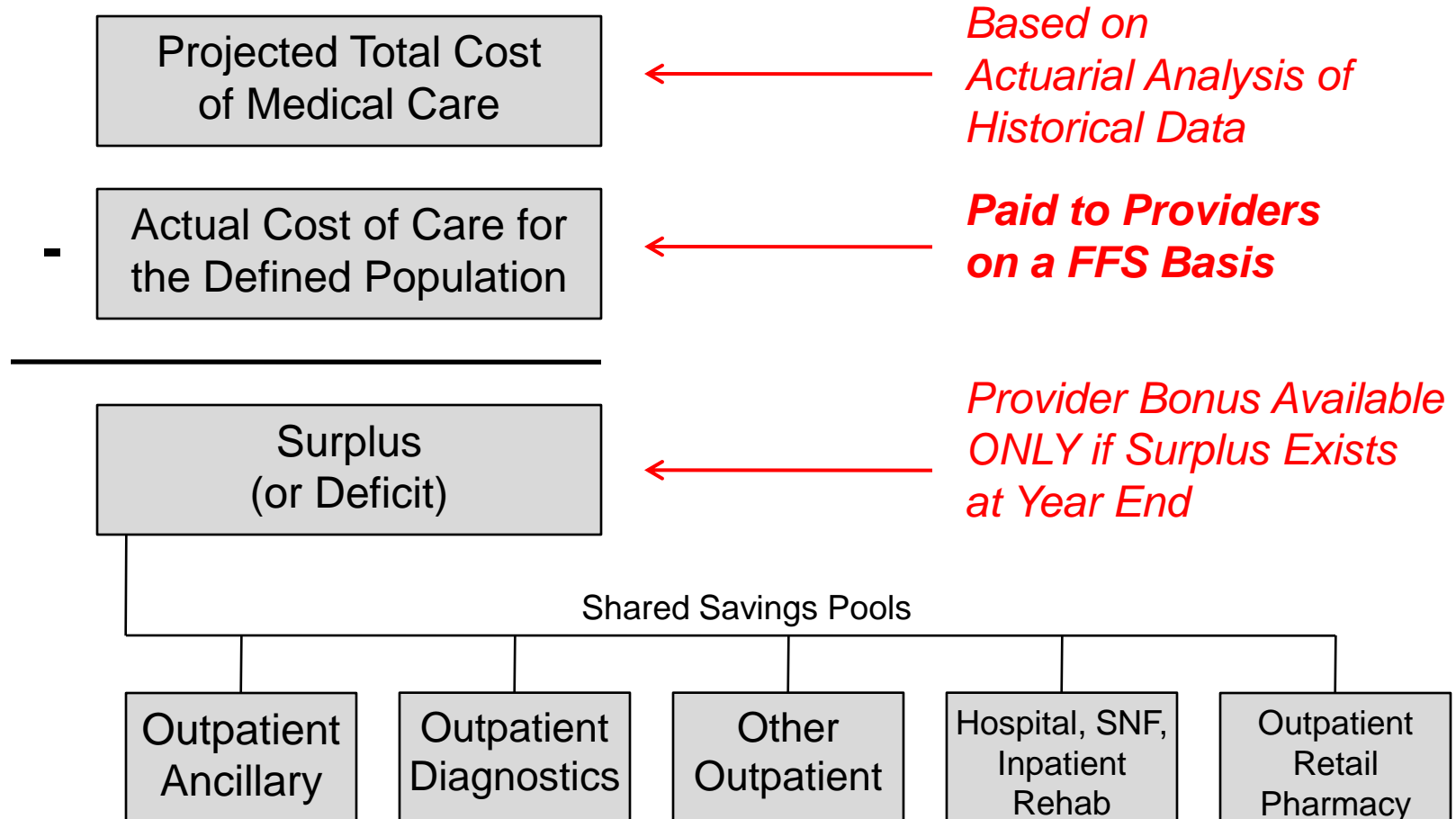


Incentive	Performance Measure	Benchmarks
50% PCP	Number of Enrollees	10 Enrollees per PCP
12.5% PCP	Patient Outcomes evidenced by HEDIS measures (e.g. Diabetes A1c control >9), Blood Pressure Control >140/90, Diabetes Cholesterol Control (LDL <100)	Improve on existing % by 10% or exceed 75% of HEDIS regional threshold
12.5%	Advance Care Model development by integration of Care Model templates into practice and timely completion of Health Risk Assessments (“HRA”)	Complete 50% of HRAs by end of year
12.5%	Attend 1 education session on patient care process improvement	Documented Attendance
12.5%	CG CAHPS Survey (e.g. getting appts, Dr. communication, helpful office staff, Dr. rating, f/u test results)	Exceed benchmark in 3 of 5 categories

ACO Surplus Payment Criteria: Specialist

Incentive	Performance Measure	Benchmarks
50% Specialist	Number of Enrollees	5 Enrollees per Specialist
12.5% Specialist	Patient Outcomes evidenced by Timely Consultation to PCP, and Standard Consult Report	20% of consultation reports received by PCP within 7 days
12.5% Specialist	Advance Care Model development by integration of Care Model templates into EMR	Introduction of charting templates into EMR
12.5% Specialist	Attend 1 education session on patient care process improvement	Documented Attendance
12.5%	CG CAHPS Survey (e.g. getting appts, Dr. communication, helpful office staff, Dr. rating, f/u test results)	Exceed benchmark in 3 of 5 categories

Financial Model

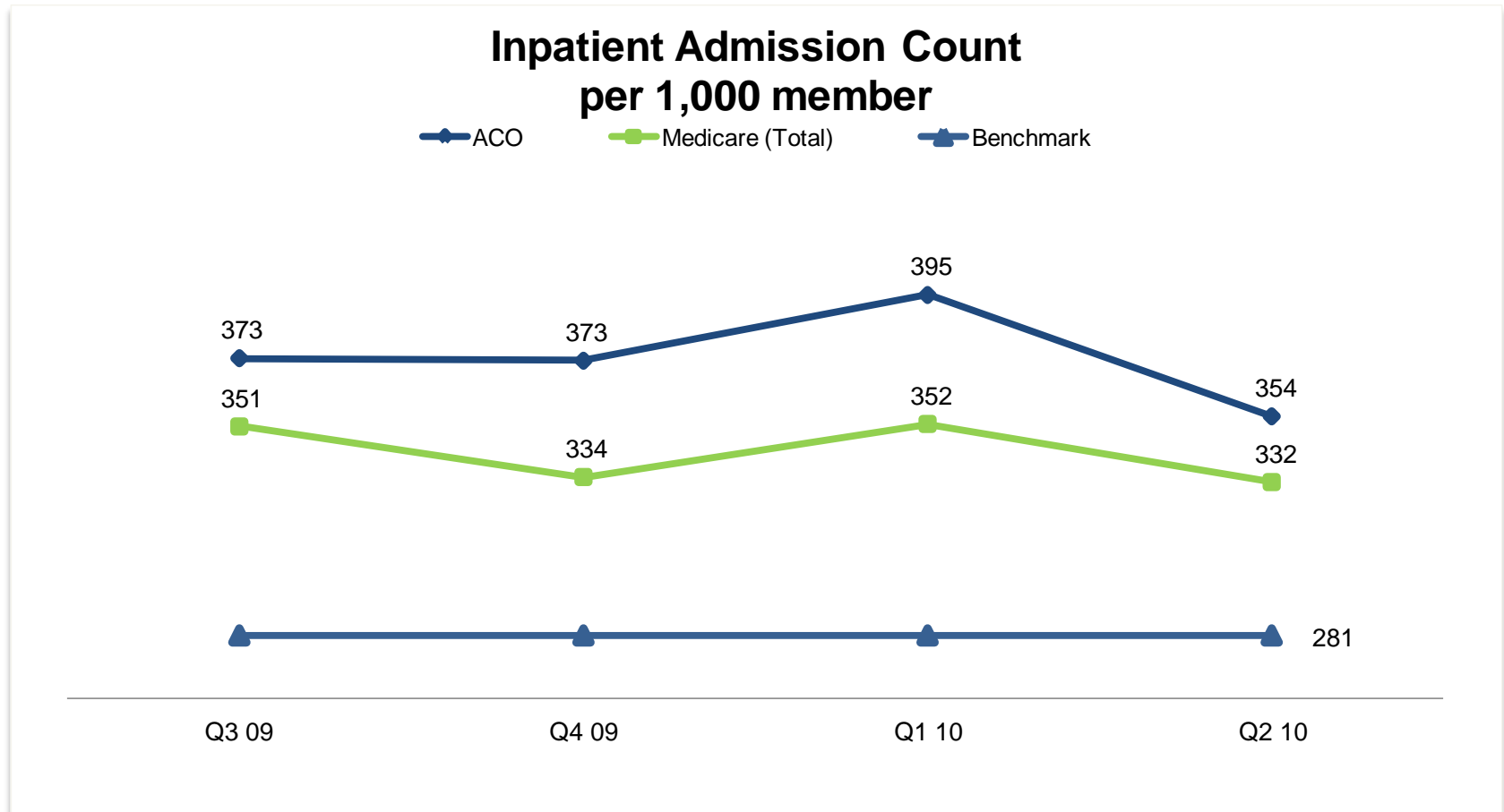


Different Provider Types Participate in Pools Based on an Estimated Ability to Impact Associated Costs

Evolution of ACO



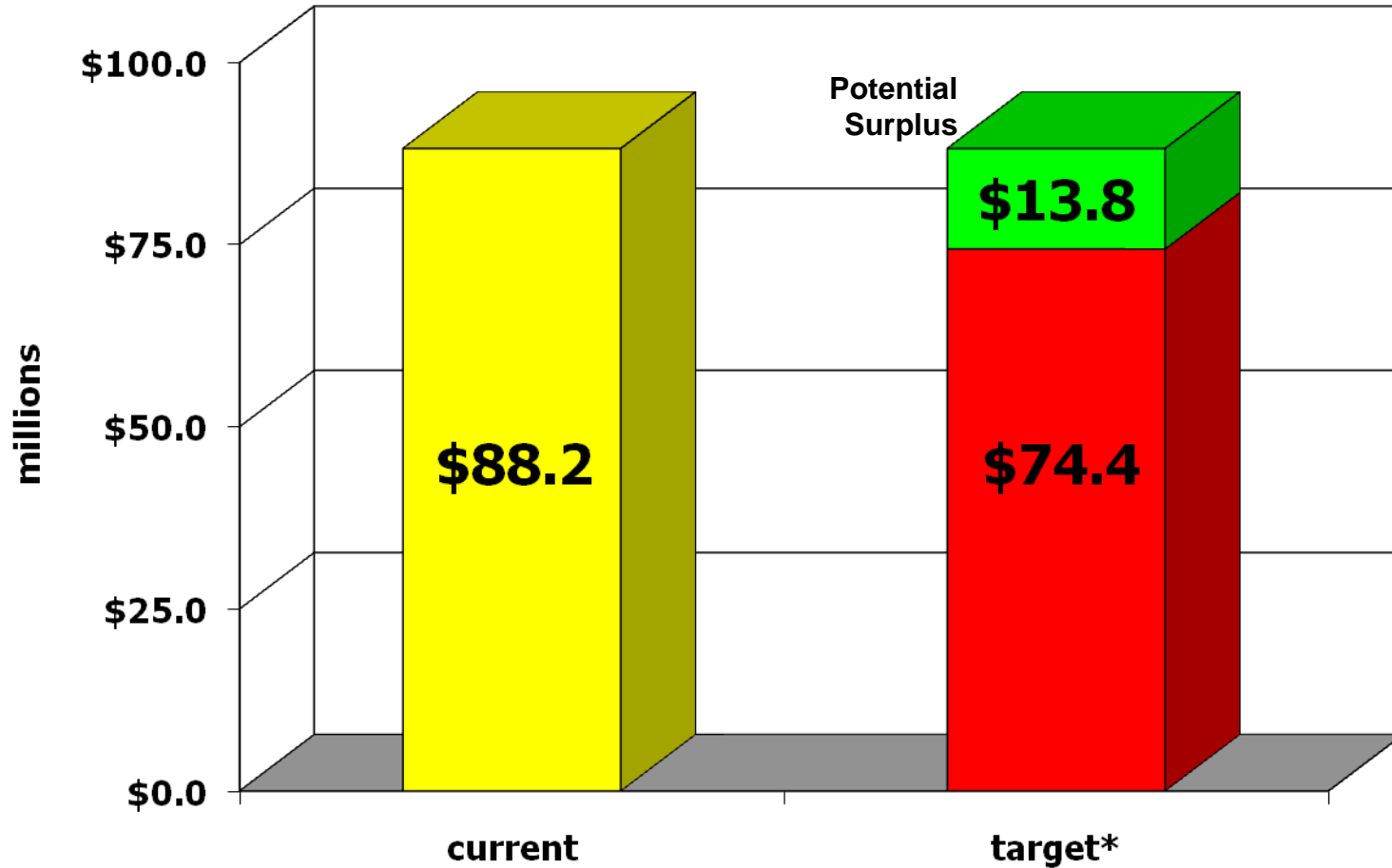
Opportunity: *Total Admits*



Note: Benchmark is based on Moderately Managed Midwest Utilization Targets – Milliman

Medical Expenditures

Total Medical Spend for ACO Pilot Population (8,500 members)



*Target based on Moderately Managed Midwest Utilization Targets – Milliman

Summa ACO Lessons Learned

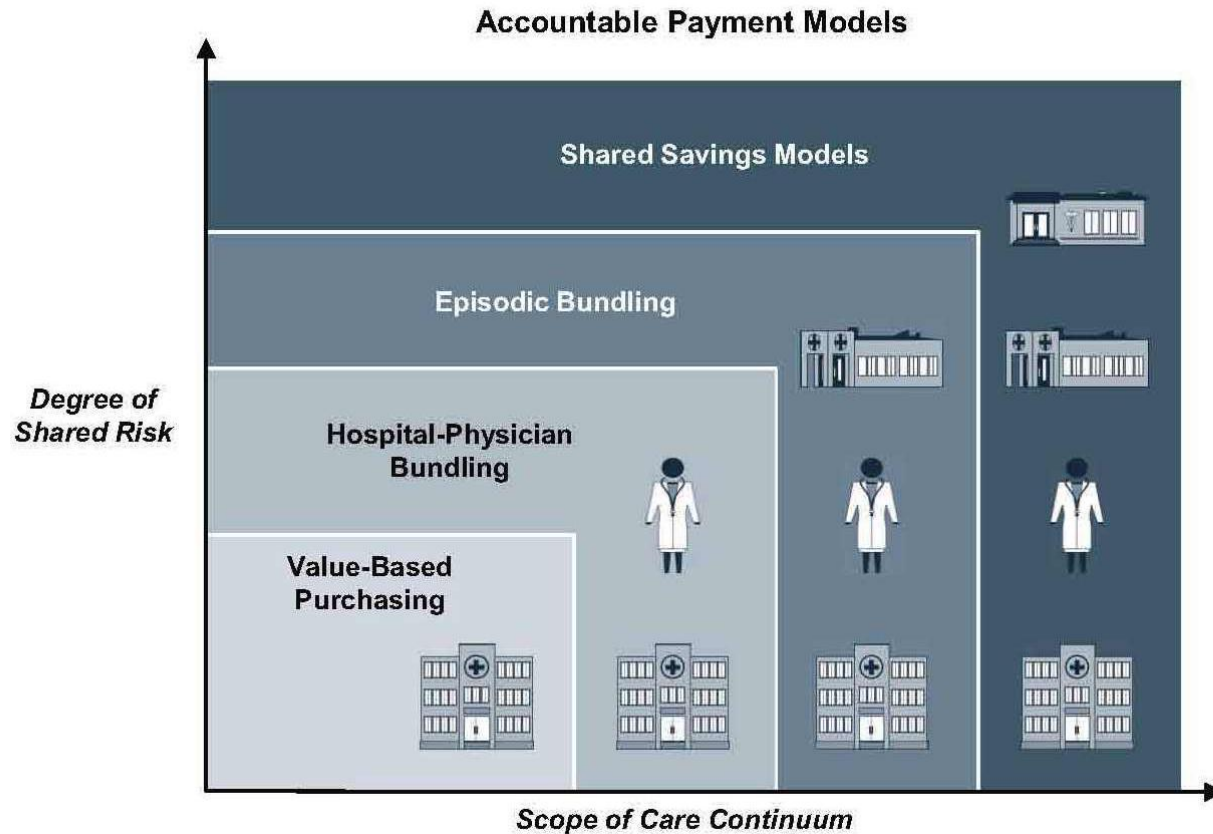
- **To truly achieve Care Delivery redesign, ACO needs to be Physician-Led**
- **Need to navigate carefully the balance between PCPs/Specialists and their respective contributions to the ACO**
- **Design achievable Conditions of Participation and enforce these requirements in order to ensure behavior modification**
- **To ensure compliance with metrics, need to create dashboards or other measures to keep Physicians informed of progress**

Evolving Population Health Models



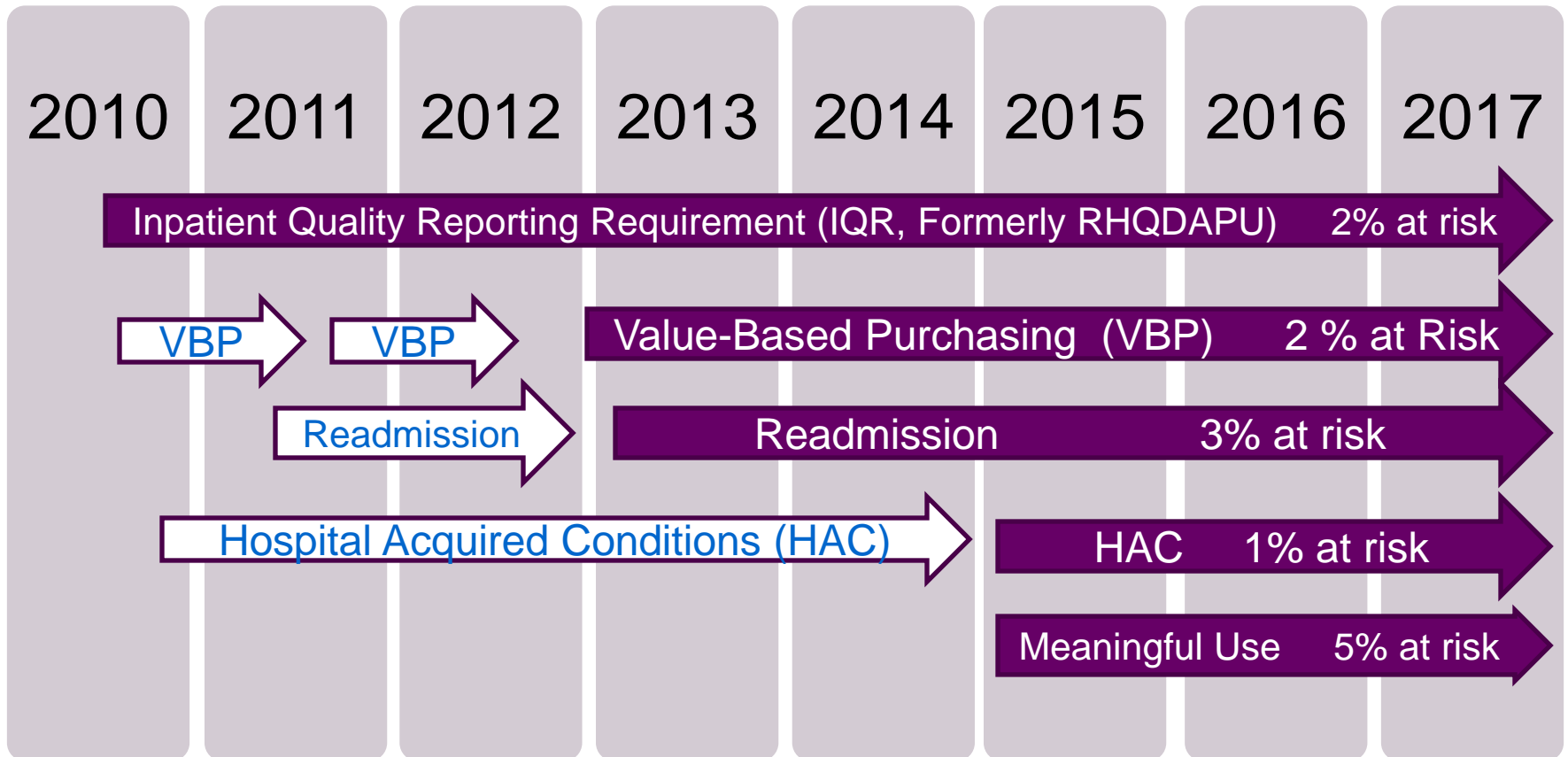
Preparing for Shifting Incentives

Accountable Care Necessitating an Expanded Network



Slide courtesy of the Advisory Board Company

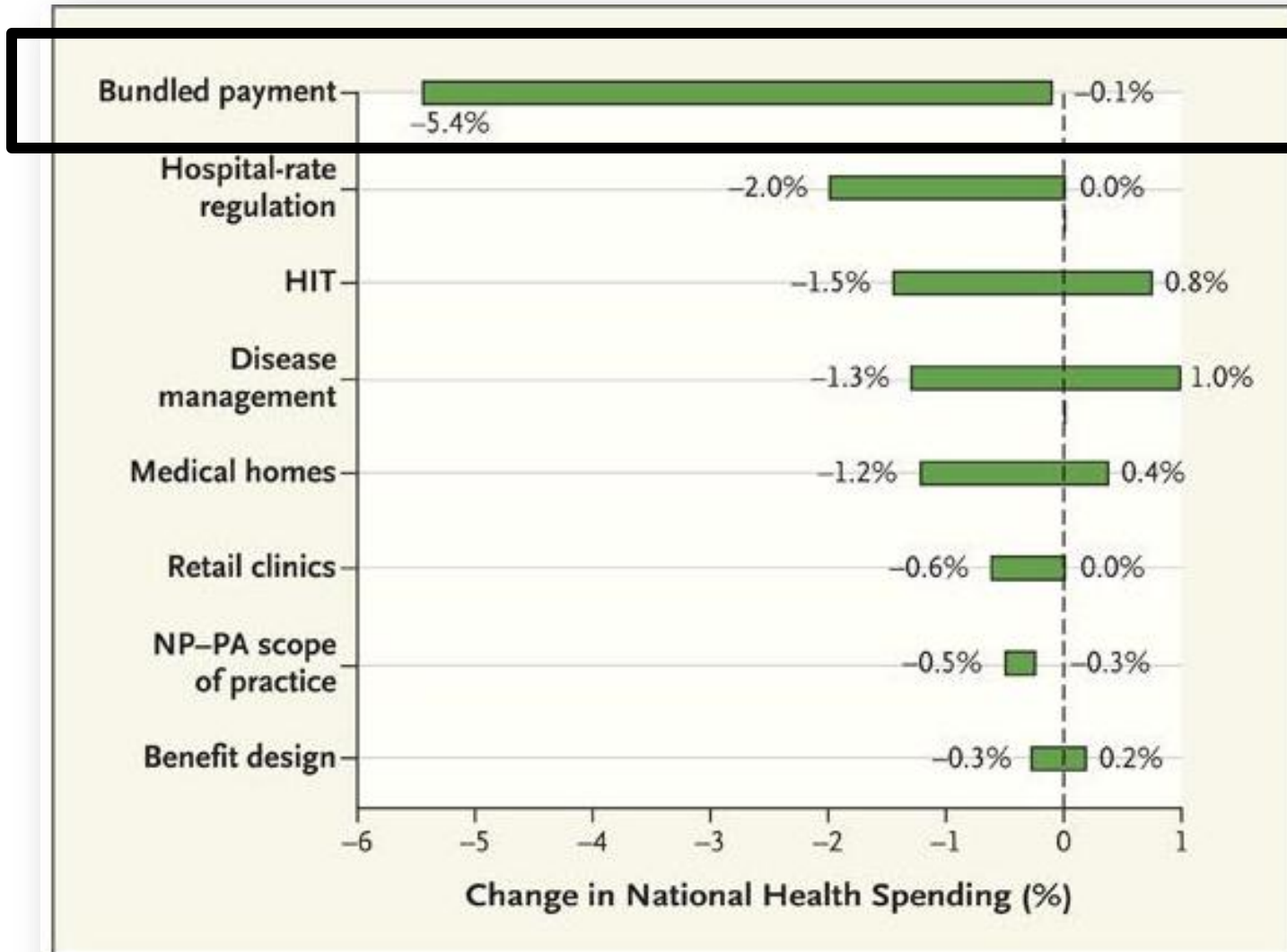
Payment At Risk



Charles S. Lauer, Hospital Executive Summit – January 28, 2012

13% of payment at risk will private insurers may follow suit!

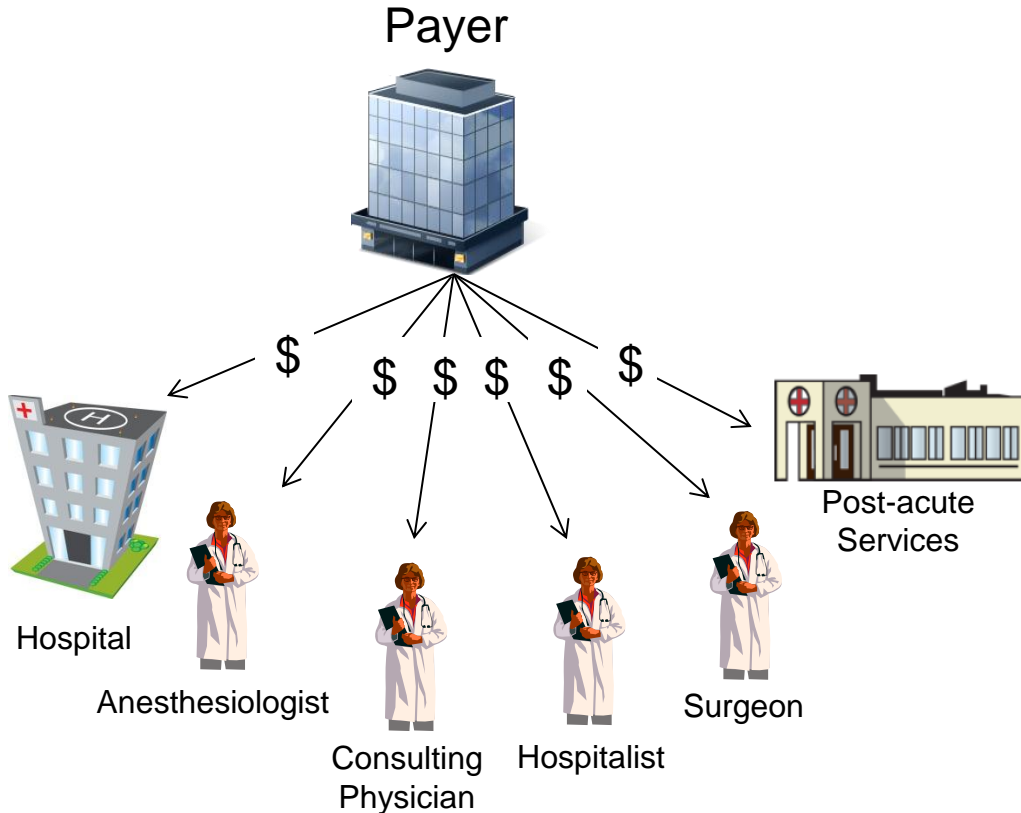
Greatest Opportunity to Bend the Cost Curve



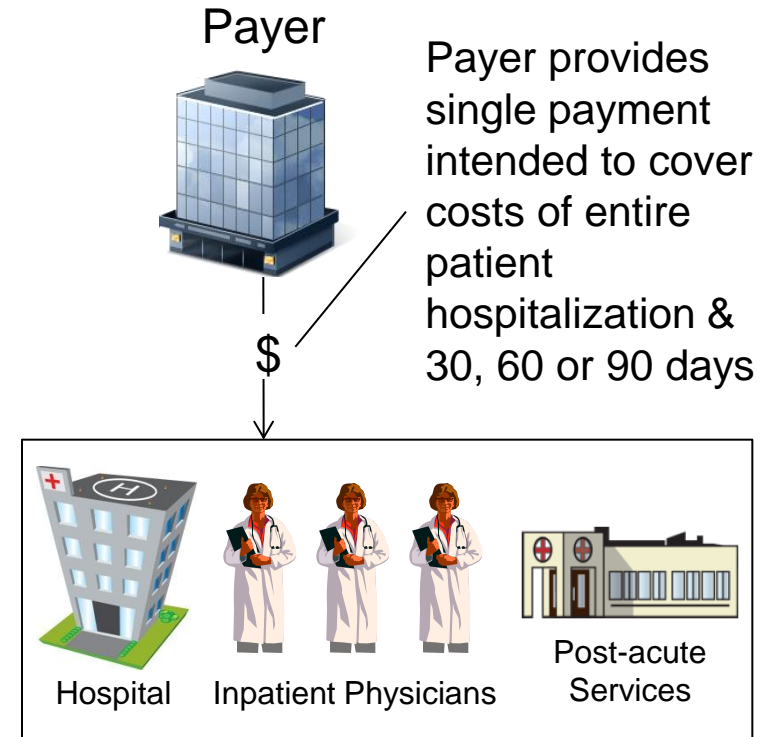
Bundled Payment – A Simple Illustration

Inpatient and Post-Acute Episodes of Care

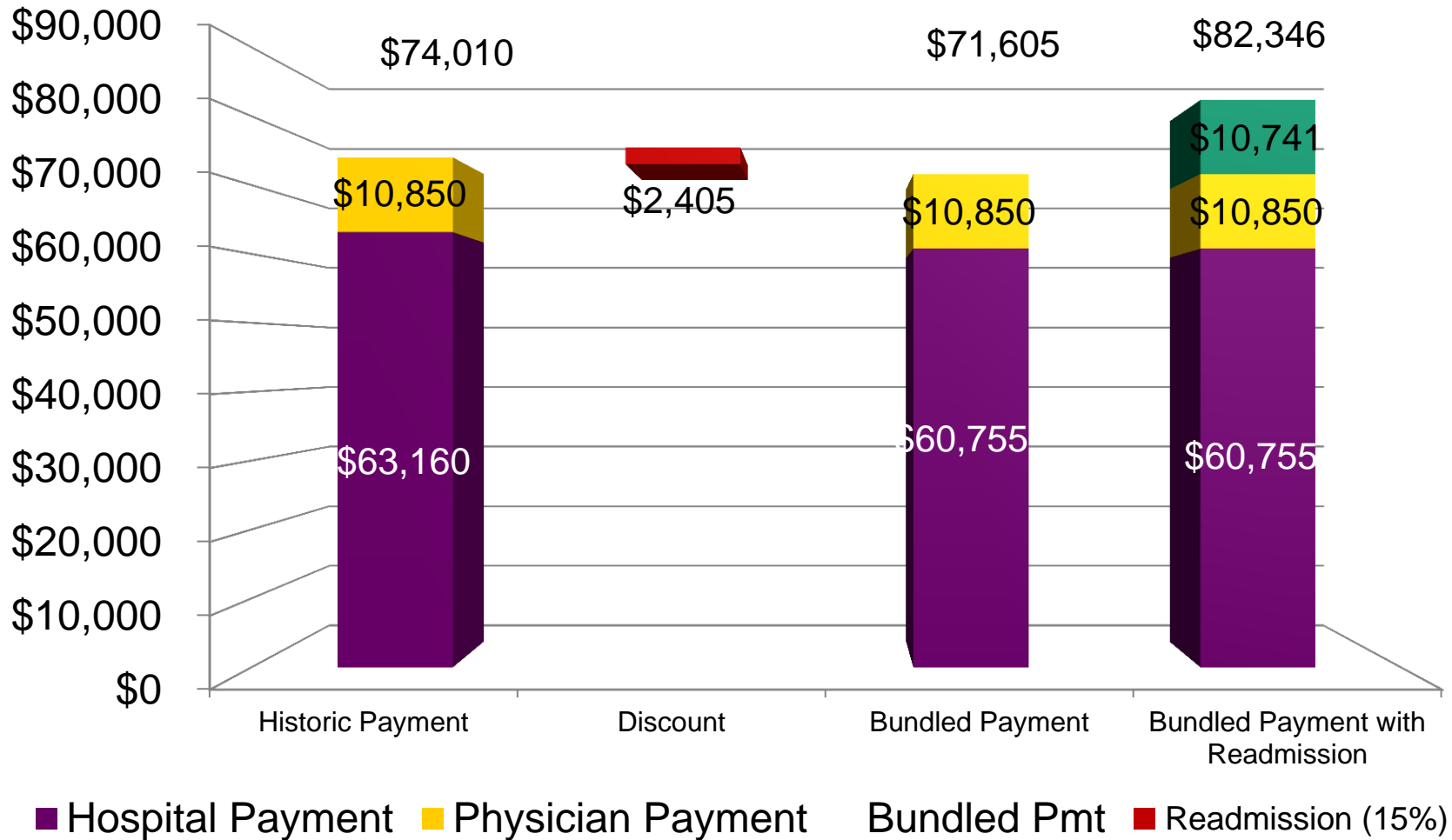
Fee-for-Service



Bundled Payment



Bundled Payment – A Simple Illustration



Payment amounts are for demonstration purposes and do not reflect actual payments.
 MS-DRG = Medical severity diagnosis-related group.

Evaluation Process - Bundled Payment



CMMI Program-4 Models

- **Section 115A of SSA authorized CMS to test innovative payment and service delivery models to potentially reduce program expenditures while improving quality of care**
- **Model 1**
 - Retrospective Acute Care-Hospital Only
- **Model 2**
 - Retrospective Acute Care Hospital Stay Plus Post-Acute Care
- **Model 3**
 - Retrospective Post-Acute Care Only
- **Model 4**
 - Acute Care Hospital Stay Only

Bundled Payment – CMMI Approach



Payment of Bundle	Acute Care Hospital Stay Only	Acute Care Hospital Stay plus Post-acute Care	Post-acute Care Only	Chronic Care
“Retrospective” (Traditional FFS payment with reconciliation against a predetermined target price after the episode is complete)	Model #1	Model #2	Model #3	Model #7
“Prospective” (Single prospective payment for an episode in lieu of traditional FFS payment)	Model #4	Model #5	Model #6	Model #8

Current

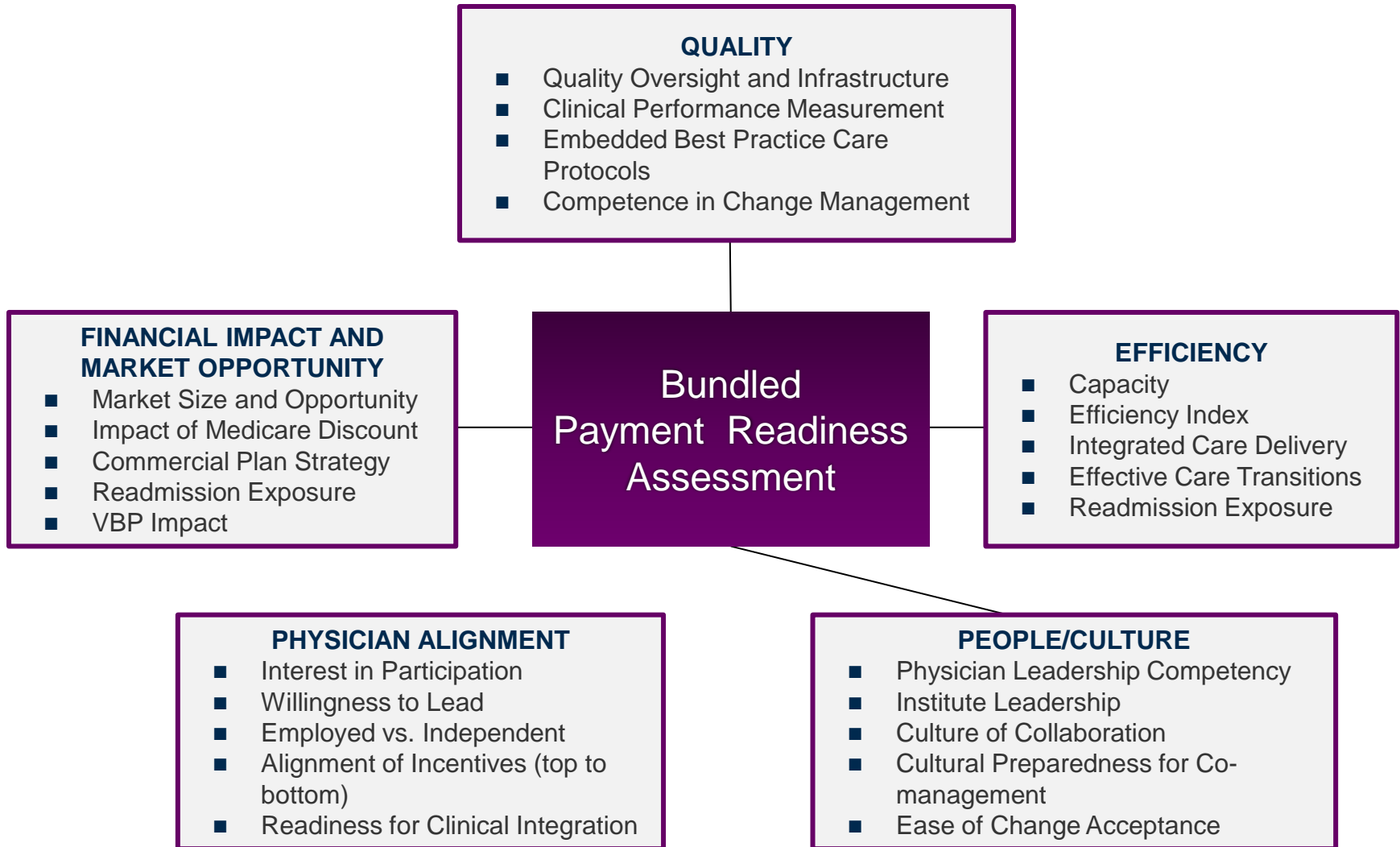
Future (projected announcement 1/2013)

Model Differences – Models 2 -4



Eligible Awardees	Model 2	Model 3	Model 4
Physician group practices	✓	✓	✓
Acute care hospitals paid under the IPPS	✓	✓	✓
Health Systems	✓	✓	✓
Long-term care hospitals		✓	
Inpatient rehabilitation facilities		✓	
Skilled nursing facilities		✓	
Home health agency		✓	
Physician-hospital organizations	✓	✓	✓
Post acute providers	✓		
Conveners of participating healthcare providers	✓	✓	✓
Types of Services Included in Bundle	Model 2	Model 3	Model 4
Inpatient hospital services	✓		✓
Physician services	✓		✓
Related post-acute care services	✓		
Post-acute care services		✓	
Related readmissions	✓	✓	✓
Other services defined in the bundle	✓	✓	

Slide courtesy the Camden Group



Key Questions

- **Does the Organization have the cultural commitment to develop new model of care?**
- **Which model and what DRGs should be included?
Episode Definition?**
- **What will be the financial impact to the Organization from discount on Cardiac Services to Medicare?**
- **How does the Organization currently perform on clinical performance benchmarks?**
- **Does the Organization have willing partners in its Providers to reduce costs and improve efficiency of care delivery?**

Key Questions (cont.)






- **Do we need to partner with our Cardiologists through a Clinical Co-Management Agreement?**
- **Will our Providers agree to standardization without substantial Gainshare or other incentives?**
- **What are the risks of not adopting Bundled Payment model? Likelihood of CMS moving to implement model for both acute and post-acute care?**
- **Will the Organization have the growth necessary to make participation in the Bundled Payment program successful?**

Readiness Assessment

Summary of Findings

SACH

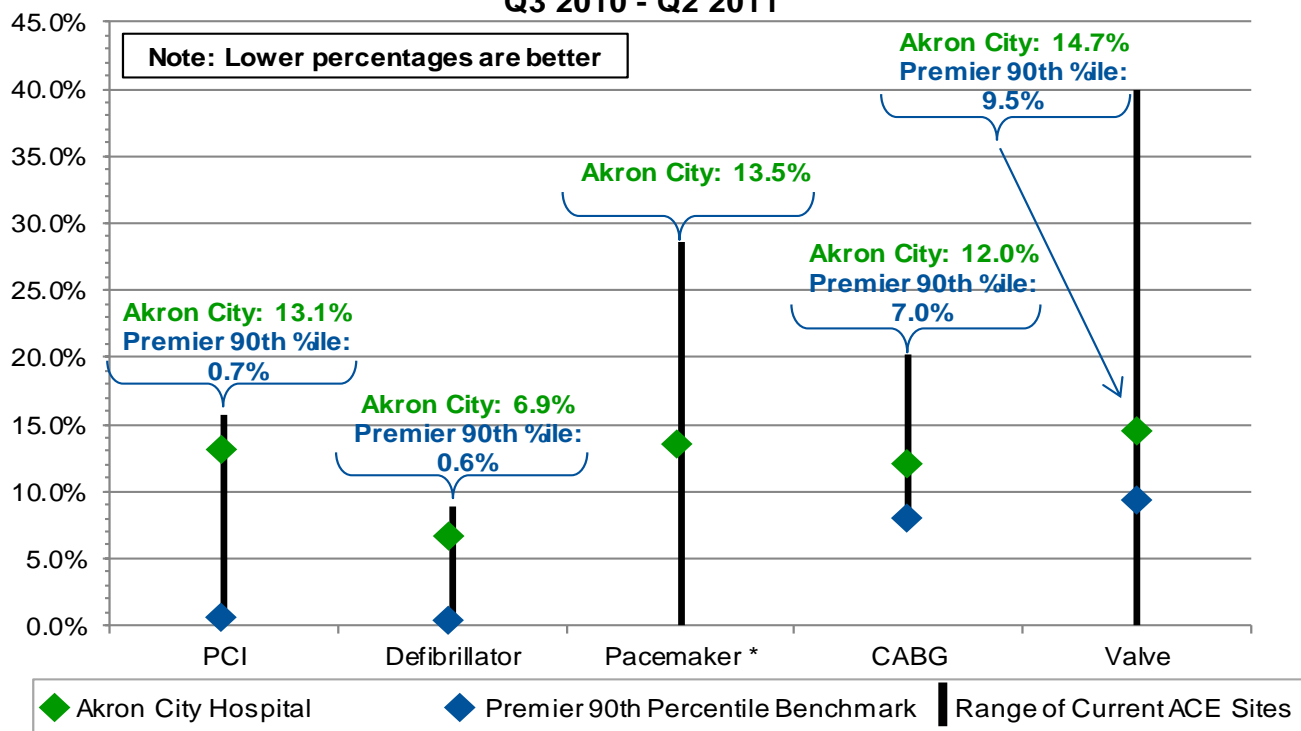
Assessment of Readiness for Cardiac Bundled Payments - Summary of Findings

Criteria	Rating	Rationale
Quality		Quality outcomes consistent with existing ACE sites with some room for improvement; however, processes can be inconsistent and result in underperformance.
Efficiency		Adequate capacity to accommodate incremental volume of Medicare fee-for-service beneficiaries. Medical directors demonstrate knowledge of current performance on aggregate efficiency measures and have done significant work in the area of implantable devices; however, there is a history of resistance to standardization.
People and Culture		Leadership is supportive and encouraged by the potential of bundled payment; lack of clarity and inconsistent knowledge sharing across SCI stifles development of a culture of accountability and sustained best-practices.
Physician Alignment		Siloed SCI organizational structure contributes to physician perception that they do not have an ability to effectively influence care delivery; some physicians are anxious about level of standardization required to succeed in bundled payment.
Financial Impact/ Market Opportunity		SCI has adequate volume and market share to ensure economies of scale and generate additional volume, and there is opportunity for positive operational and financial results under bundled payment.

Readiness Assessment - Quality

Summa Akron City Hospital Quality Performance Compared to Current Demonstration Sites

**Akron City Performance on Cardiac ACE Measure 17 (30-Day Readmission Rate) in Comparison to Five ACE Demonstration Sites and Premier 90th Percentile Benchmarks
Q3 2010 - Q2 2011**



[https://sharepoint.thecamden.com/Clients/Summa/Bundled_Payment_Assessment/\[ACE_Cardiac_Comparisons.xlsx\]Graphs](https://sharepoint.thecamden.com/Clients/Summa/Bundled_Payment_Assessment/[ACE_Cardiac_Comparisons.xlsx]Graphs)

Source: Akron City Hospital and The Camden Group

Notes: ACE Demonstration site data represents CY 2007 experience

Premier 90th percentile benchmarks are not available for Pacemaker data

* Indicates that data represents experience from Q4 2010 - Q3 2011

Gainsharing: Opportunity to Partner with Physicians



Opportunity – Decrease In Length of Stay

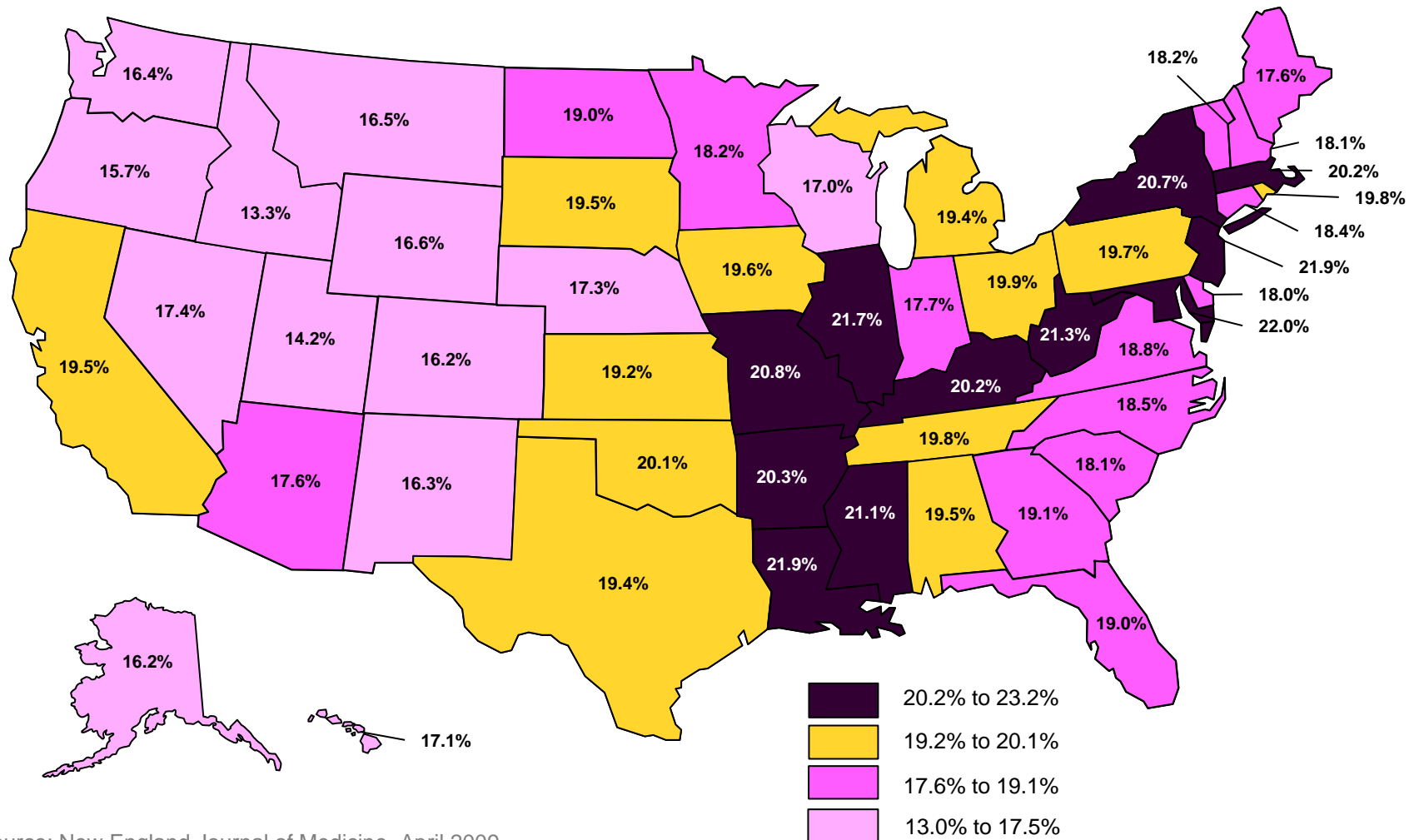
Opportunity – Decrease In Supply Cost

Opportunity – Decrease In Readmission Rate

Gain Sharing – Up To 50 of Savings

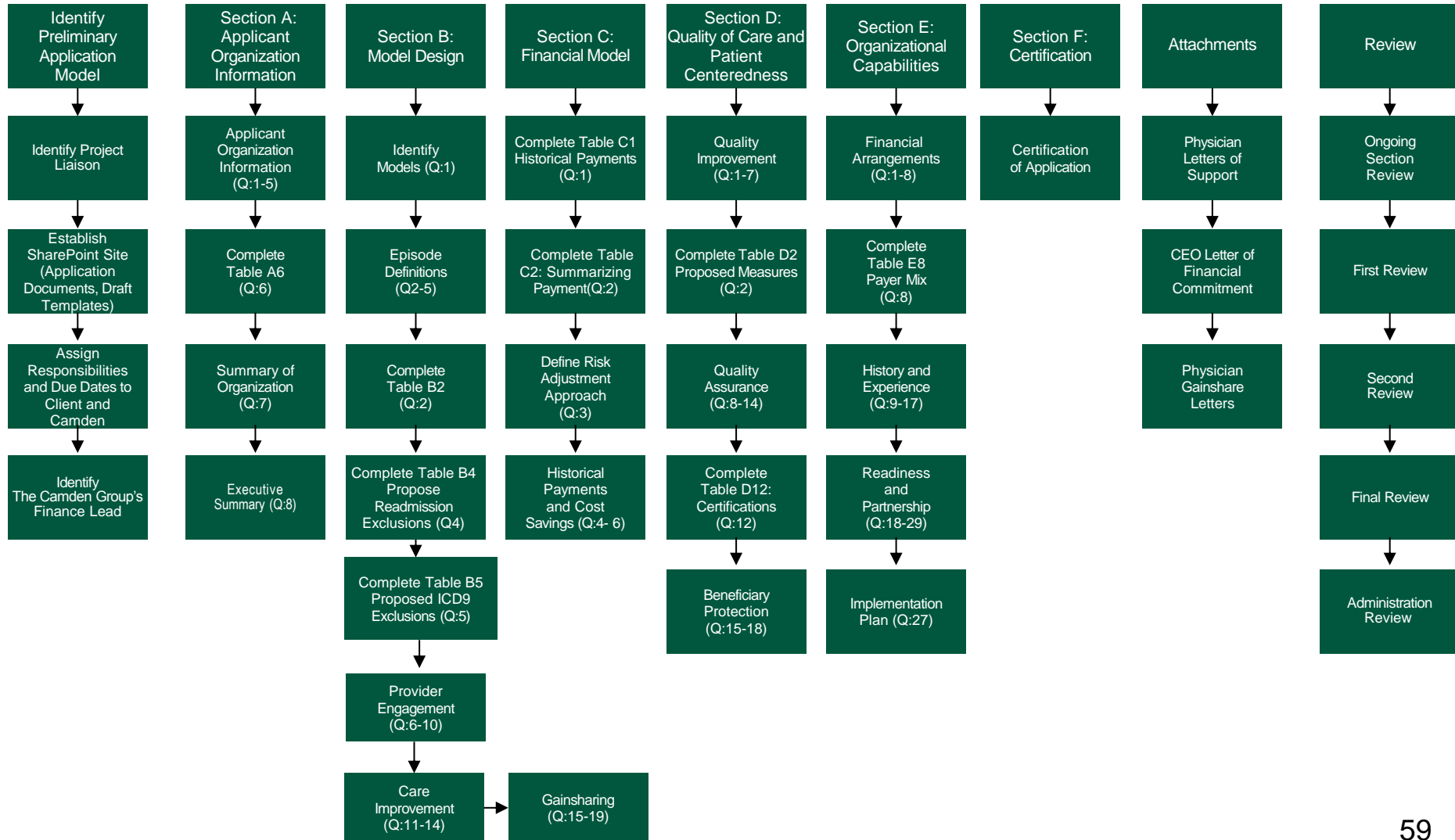
Opportunity – Reduce Readmission Rate

U.S. Hospital Readmission Prevalence



Source: New England Journal of Medicine. April 2009

CMMI Application Process



Business Case Assumptions



Business Case Summary – Summa Akron City Hospital



Updated baseline projections

	Business Case Projection Period ⁽¹⁾			Business Case
	Year 1	Year 2	Year 3	Update
Assumptions				
Number of Cases	616	628	642	1,886
Payment Discount of 3.25% Applied	(\$348,631)	(\$355,489)	(\$362,919)	(\$1,067,038)
Incremental Program Costs				
Marketing	(\$100,000)	(\$100,000)	(\$100,000)	(\$300,000)
Cost of Administering Claims ⁽²⁾	(\$15,402)	(\$15,710)	(\$16,040)	(\$47,152)
Subtotal Program Costs	(\$115,402)	(\$115,710)	(\$116,040)	(\$347,152)
Cost Saving Opportunities				
Reduction in Average Length-of-Stay	\$136,279	\$208,491	\$283,804	\$628,573
Reduction in Implant Costs	\$44,072	\$44,910	\$45,808	\$134,790
Reduction in Readmissions	\$131,182	\$133,805	\$136,615	\$401,603
Subtotal Cost Savings	\$311,532	\$387,206	\$466,227	\$1,164,966
Estimated Gainsharing Bonus ⁽³⁾	(\$155,766)	(\$193,603)	(\$233,114)	(\$582,483)
Net Financial Impact	(\$308,266)	(\$277,596)	(\$245,845)	(\$831,707)
Gainshare Bonus per Case	\$253	\$308	\$363	\$309
Maximum Gainshare Bonus (50% of Part B)	(\$897,403)	(\$915,351)	(\$934,574)	(\$2,747,328)

Business Case Assumptions-New Developments

- **CMMI changes the discount rate from 3.1 to 3.25 percent for Acute Care Episode (“ACE”) MS-DRGs**
- **CMMI also imposed new definitions of related readmissions (standard readmissions within 30 days of discharge from anchor admission) which adds risk for additional MS-DRG readmissions**
- **CMMI to provide claims data during Phase I period to include beneficiary level claims specific to participant**

Strategic Decisions

1. Ability to gain share with physicians: 50 percent over Medicare FFS rates
2. Discount to CMS with no promise of incremental volume
3. Defining the Episode of Care
 - Readmission risk
 - Elective procedures are well tested under this payment methodology
4. Physician Leadership and Engagement
 - Improve and ensure high quality
 - Reduce costs and provide healthcare value
5. Organizational Readiness
 - Use of standardized best practice care protocols
 - IT infrastructure
 - Access to cost and quality data at provider and patient level

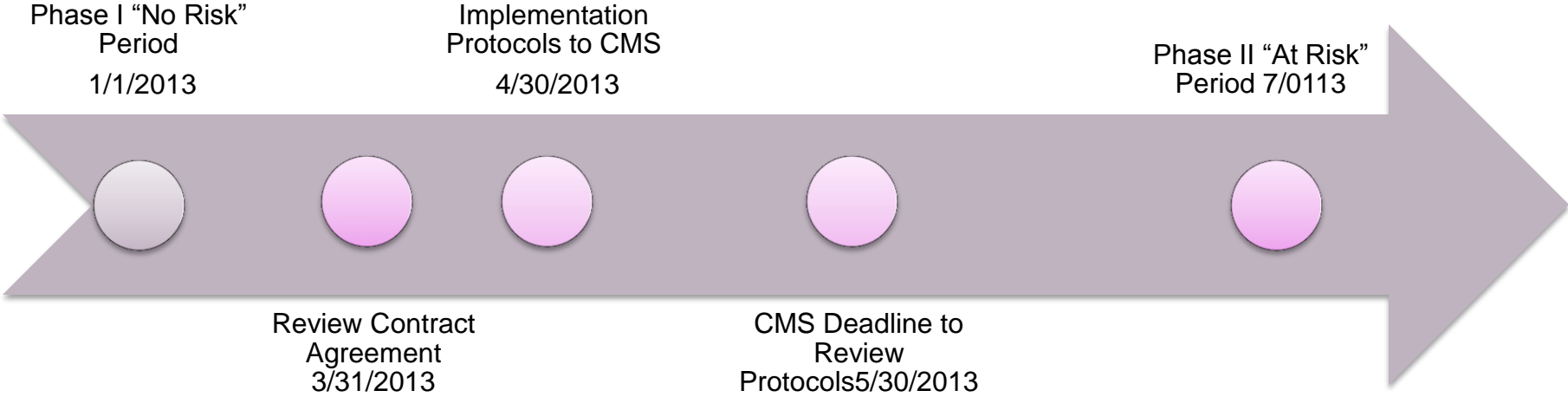
Summa Health System

Bundled Payment for Care Improvement Initiative Model 4



Quality and PI	Gainsharing	Financial and Audit Process	Communications and Marketing	Information Technology	Legal
<ul style="list-style-type: none"> Care Redesign Initiatives Quality Reporting Report Card Effectiveness Monitoring Plan Management and Staffing Roles and Responsibilities 	<ul style="list-style-type: none"> Participation Criteria Participation Agreement Metric Development Compliance Monitoring Evaluation 	<ul style="list-style-type: none"> TPA Beneficiary Identification Reporting Protocol Template List of Enrolled Practitioners Evaluation and Monitoring Plan 	<ul style="list-style-type: none"> Beneficiary Education and Notification Physician Communications Marketing to Consumers Messaging to Internal Stakeholders 	<ul style="list-style-type: none"> Shared Portal and Email Distribution List EMR Interface Reports Patient Identification and Notice of Admission 	<ul style="list-style-type: none"> Contracting Compliance Regulatory Gainshare Agreement Provider Agreement TPA Contract PSA Considerations

Time Line for Implementation



Lessons Learned



Lessons Learned

- **Bundled Payment will develop core organizational competencies in the Hospital and its Physicians through advancing Clinical Integration**
- **Establish a Model of Cardiac Bundled Payments that can be replicated in other Service Lines and with both Commercial and Governmental Payers**
- **Build a foundation to grow market share through delivering higher value care (better clinical outcomes, lower cost and higher patient satisfaction)**
- **Utilize synergies that exist among other Population Health models to allow for most effective jump from Fee-For-Service to Value-Based Payments**

Lessons Learned (cont.)

- **Focus on key drivers of readmission and build evidenced-based care pathways to prevent avoidable readmissions.**
- **Involve Process Improvement staff to drive redesign of care delivery system while building team based-approach through inclusion of providers, business, staff and care managers**
- **Develop scorecards to foster accountability through dissemination of Provider performance data**

Questions?

