# Medicare Shared Savings ACOs: One Organization's Lessons Learned

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Crystal Run Healthcare LLP

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# Learning Objectives

- Identify organizational strengths and weaknesses in preparing for the ACO model
- Assemble a leadership team to help patients and providers make the transition to a value-based system
- Develop the clinical and technology infrastructure to achieve ACO goals

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# Learning Objectives con't

- Recognize how to redesign workflow and leverage HIT to create "medical neighborhoods" supporting the ACO mission
- Describe the lessons Crystal Run has learned during its first year of ACO operation

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# About Crystal Run Healthcare

- Physician owned, founded 1996
- 300  providers, 15 locations
- ASC, Urgent Care, Diagnostic Imaging, Sleep Center, High Complexity Lab
- Early adopter EHR 1999
- Joint Commission 2006
- NCQA-designated Level III PCMH 2009


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# Accountable Care Organizations (ACOs)

- "groups of providers of services and suppliers meeting criteria specified by the Secretary [of Health and Human Services who] work together to manage and coordinate care for Medicare fee-for-service beneficiaries."
- "[who] meet quality performance standards established by the Secretary are eligible to receive payments for shared savings" [4].

ACOs are responsible for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the program.

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# About Crystal Run Healthcare ACO

- April 2012: MSSP participant
  - Single entity ACO
- Pioneer ACO finalist
- NCQA ACO accredited
- MSSP
  - 9762 attributed beneficiaries
  - 82% primary care services within ACO

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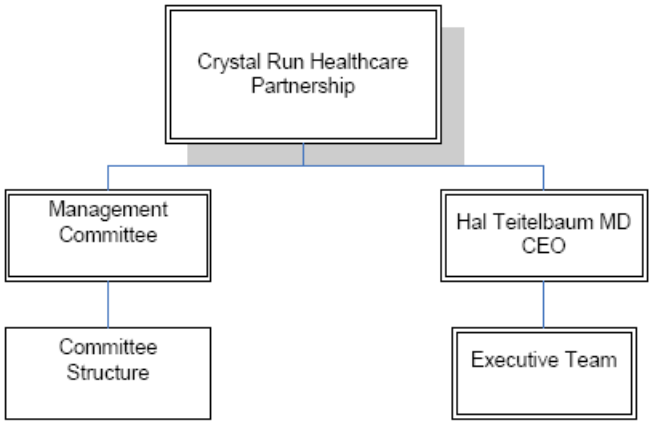
# Crystal Run Healthcare ACO Organization

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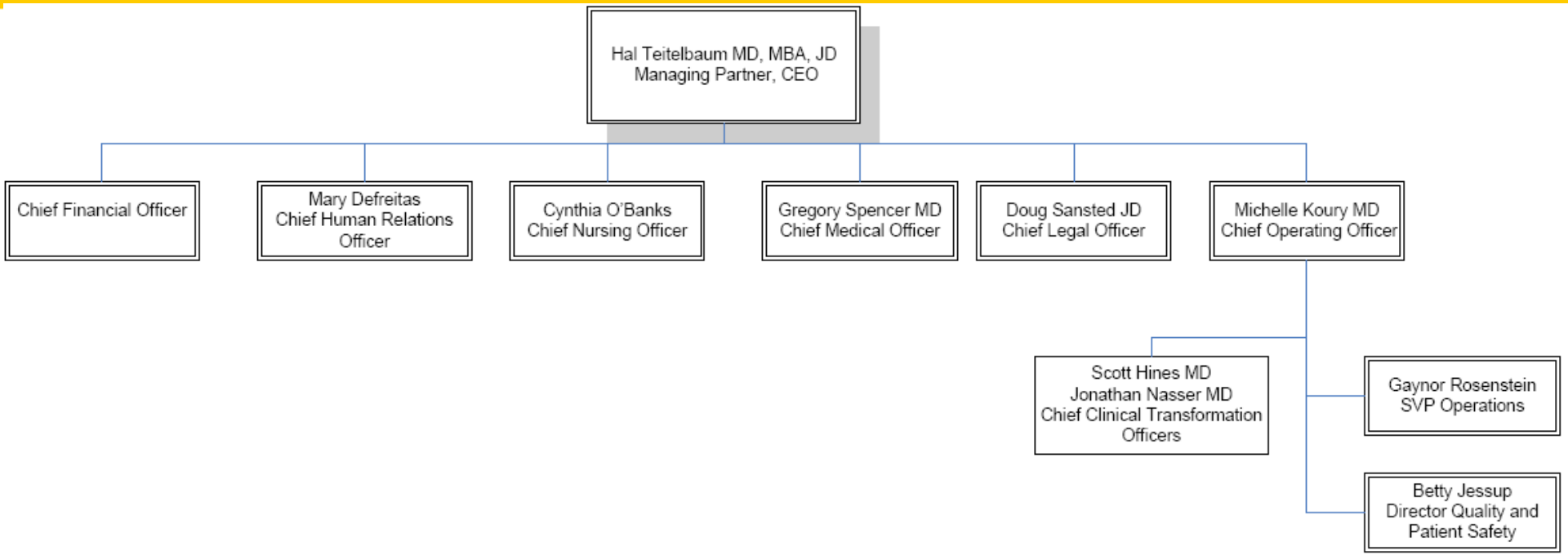


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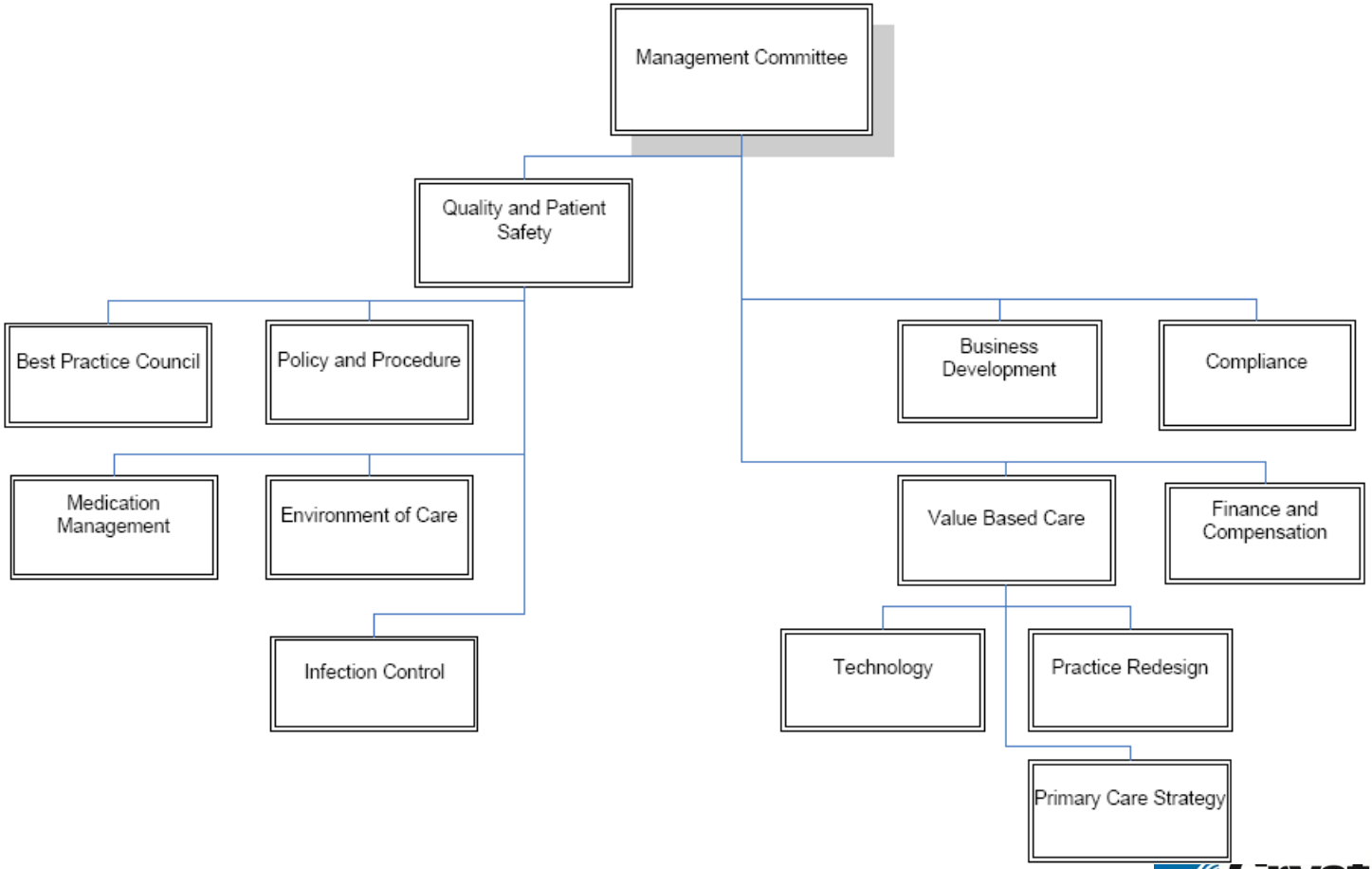


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# About our Region

- Small group practices
- Predominantly Fee for Service
- Multiple Payers
- Improved local quality of care, less outmigration to NYC
- Dartmouth atlas designation as high expenditure

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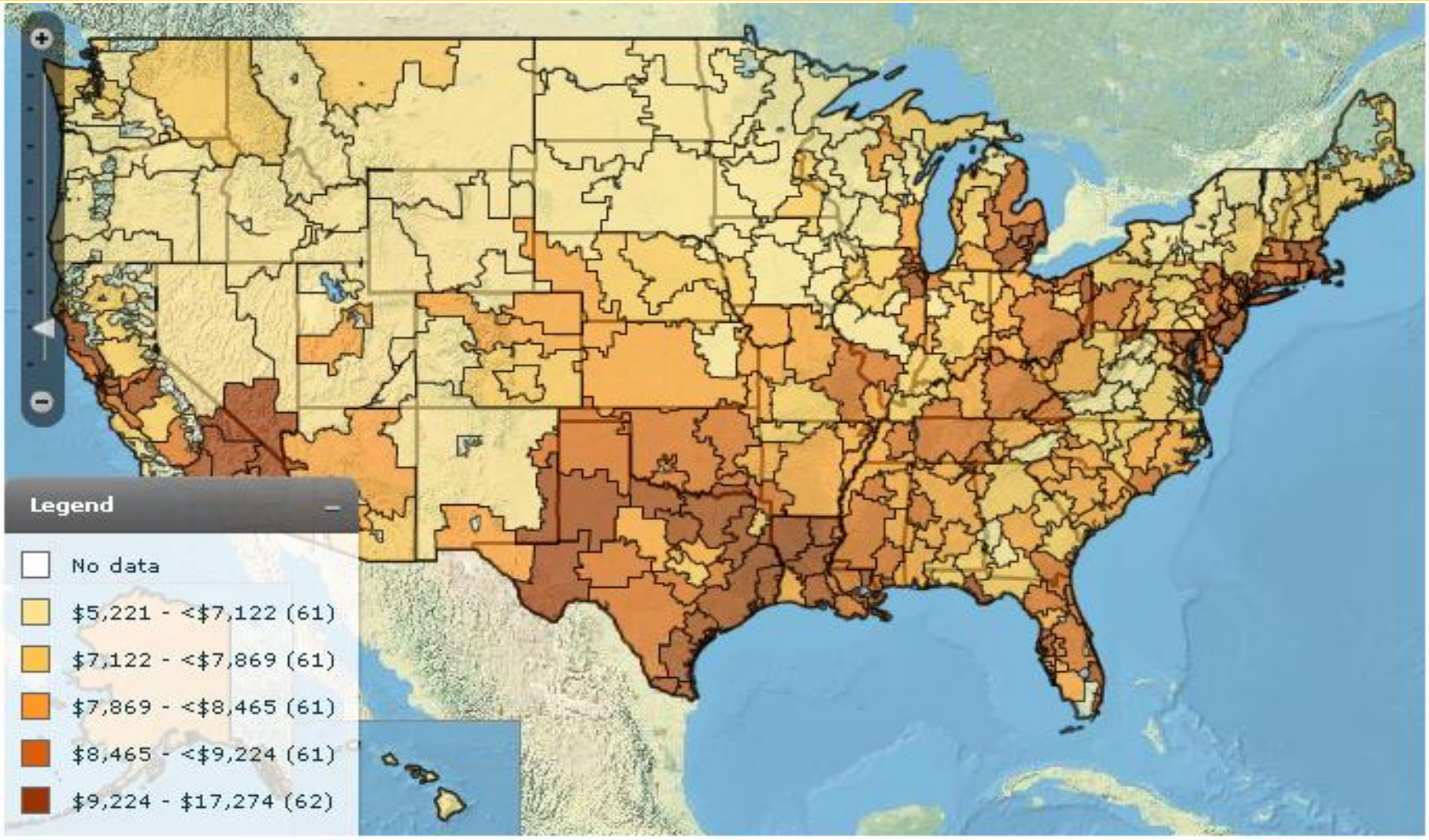
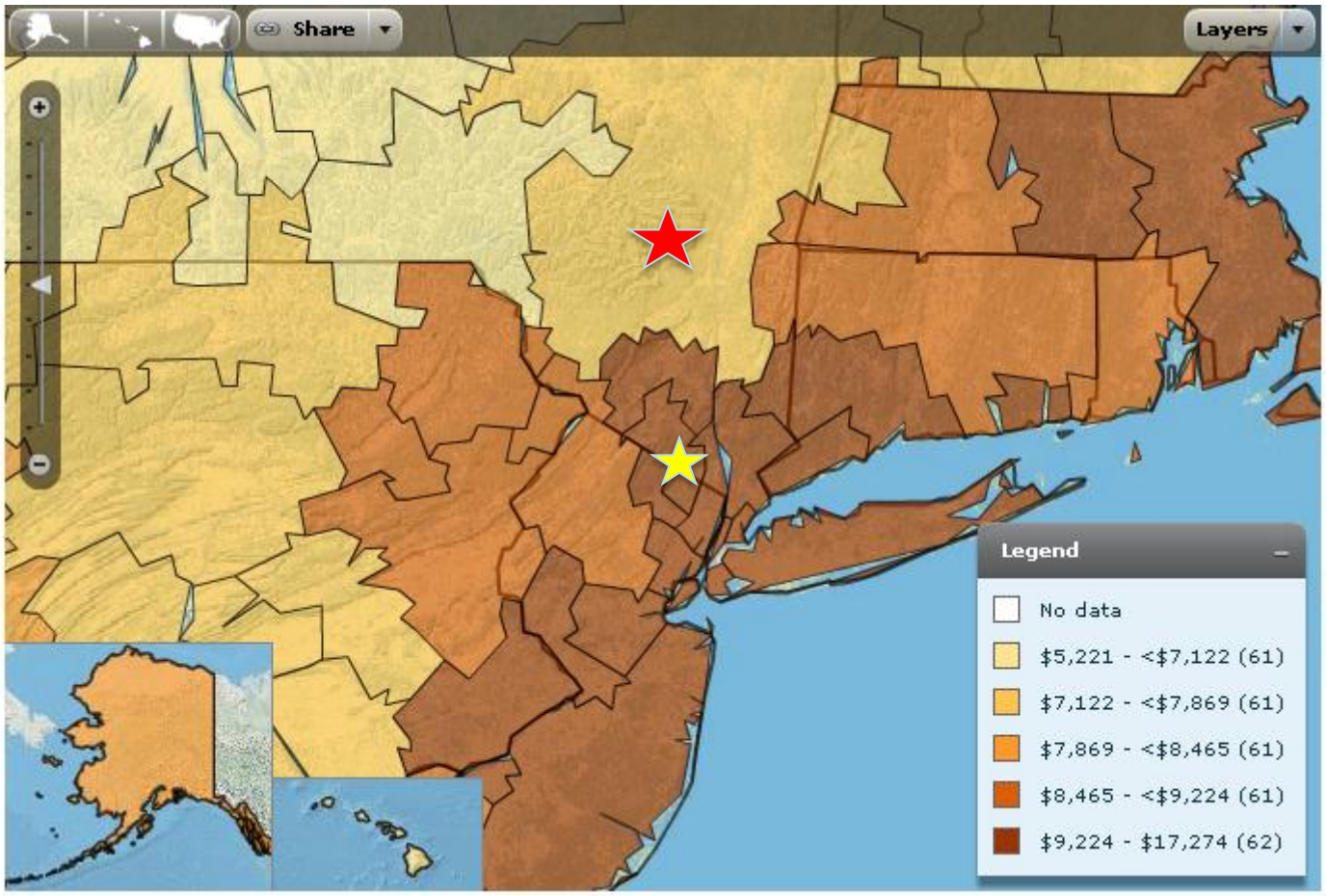
# Dartmouth Atlas



# Crystal Run Healthcare ACO Regional Data




**Albany**
**$7,459**

**Ridgewood**
**$9,784**

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# NCQA Core Competencies

- Infrastructure to coordinate care, improve quality and patient experience
- Sufficient numbers and types of providers
- Access to PCMH
- Collects, integrates and uses data for care management and reporting
- Assure timely sharing of information
- Strives to improve by measuring and reporting

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# Important ACO Competencies

- Leadership
- Provider alignment, culture
- IT infrastructure
- Data management and analytics
- Payment management and contracting
- Patient engagement
- Eliminate waste wherever present

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# Lessons Learned

- It's not (just) about saving money!
  - It's about improving quality and eliminating waste.
- Talk about value based care over, and over, and over…to everyone

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# Required infrastructure: philosophical

- Do the organization and patients know what an ACO is?
- Do physicians, staff and leadership believe a new paradigm is required and is the best way (or least a better way) to go?
- Buy in: best practices
- Leveraging the entire organization, size as an advantage

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# Required infrastructure: clinical

- Medical Home- a foundational element
- Care managers where the patients are
- Home visits and monitoring

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# Required Infrastructure: Technology

- Embed best practices in EHR
- Dashboards
- Care gaps
- Claims data
- Cost data where it's available

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# The Medical Home

- This is the mechanism used to help manage patients and populations
- Educate patients and staff
- Involve the entire care team
- Embedded care manager
- Monthly meetings

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# The Medical Neighborhood

- Geographical grouping of providers
- Leverage the whole team
- Embedded care managers
- Not limited to primary care
- Monthly meetings

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# MEDICAL HOME MEETING AGENDA
## 155 IM 3rd Floor

**Date:** December 4, 2012

**Call to Order:**

**Prior to the Meeting – Identify Theme for the Meeting – Department Director & RM; DD and RM meet week prior to site meeting to prepare.**

| | | |
|---|---|---|
| I. | Workflow Team Roundtable Discussion<br>❖ Process Issues<br>❖ i.e., phone calls, acute calls and connectivity to CM, access, etc. | **Dr. Tolis** |
| II. | TeleHealth Data | **Dr. Hines** |
| III. | Polypharmacy Pilot Launching | **A. Leitenberger** |
| IV. | Case Study Review | **Dr. Tolis/Deb Azierski** |
| V. | Quality Indicator Report | **Defer** |
| VI. | Education | **8 – 10 minutes** |
| VII. | Site Outcomes<br>November & December | **B. Jessup** |
| VIII. | Take Aways<br>❖ Nursing and Front Desk Staff<br>❖ "To Do's" | |

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## Cardiac Care Measure - Practice Summary

| | Report date | Total Patients | Annual Lipids Testing | Aspirin % | Smoking % | LDL ≥ 130 | BPS ≥145/95 | LDL<100 | BPS<140/90 |
|---|---|---|---|---|---|---|---|---|---|
| Practice: | 12/1/2012 | 3043 | 84.1% | 55.5% | 99.2% | 11.3% | 9.8% | 54.7% | 81.2% |
| CRHC 155 2nd Fl FP | 12/1/2012 | 547 | 79.8% | 52.2% | 99.9% | 10.9% | 4.1% | 46.6% | 88.8% |
| CRHC - Monroe | 12/1/2012 | 136 | 86.1% | 59.9% | 100.% | 24.2% | 5.8% | 30.8% | 90.4% |
| CRHC - Goshen | 12/1/2012 | 271 | 76.9% | 45.2% | 98.9% | 15.2% | 9.2% | 47.7% | 78.8% |
| CRHC 300 | 12/1/2012 | 148 | 92.4% | 65.1% | 99.5% | 8.6% | 7.1% | 65.1% | 83.9% |
| **CRHC 155 3rd Fl Int Med** | **12/1/2012** | **1090** | **75.2%** | **51.1%** | **99.6%** | **17.4%** | **8.3%** | **42.7%** | **73.%** |
| CRHC - RH | 12/1/2012 | 851 | 89.8% | 56.8% | 98.6% | 12.6% | 11.2% | 58.3% | 74.8% |
| Goal: | 12/1/2012 | | 88.5% | MU | MU | MU | MU | 56.7% | MU |

## Cardiac Care Measure - By PCP

| Report date | PCP | Total Patients | Annual Lipids Testing | Aspirin % | Smoking % | LDL ≥ 130 | BPS ≥145/95 | LDL<100 | BPS<140/90 |
|---|---|---|---|---|---|---|---|---|---|
| 12/1/2012 | Gonzalez Klayman MD, Noemi | 139 | 61.2% | 48.2% | 100.% | 6.5% | 13.7% | 40.3% | 74.8% |
| 12/1/2012 | Guindi MD, Nabil | 29 | 79.3% | 48.3% | 100.% | 17.2% | 10.3% | 51.7% | 65.5% |
| 12/1/2012 | Lee MD, Sophia | 171 | 87.1% | 48.5% | 99.4% | 11.1% | 11.7% | 53.8% | 83.6% |
| 12/1/2012 | Mathew MD, Liby | 99 | 87.9% | 54.5% | 100.% | 13.1% | 9.1% | 58.6% | 83.8% |
| 12/1/2012 | Menezes MD, Robert | 162 | 87.% | 47.5% | 98.1% | 16.7% | 7.4% | 48.1% | 82.7% |
| 12/1/2012 | Mitra MD, Tithi | 1 | 100.% | 0.% | 100.% | 100.% | 0.% | 0.% | 0.% |
| 12/1/2012 | Shahid MD, Atter | 1 | 0.% | 100.% | 100.% | 0.% | 0.% | 0.% | 100.% |
| 12/1/2012 | Shiblee MD, Towhid | 10 | 80.% | 50.% | 100.% | 0.% | 10.% | 50.% | 70.% |
| 12/1/2012 | Spencer MD, Gregory | 103 | 90.3% | 53.4% | 100.% | 6.8% | 8.7% | 68.% | 80.6% |
| 12/1/2012 | Tolis MD, Arthur | 264 | 86.4% | 53.8% | 97.7% | 8.% | 6.8% | 59.5% | 84.1% |
| 12/1/2012 | Yeddu MD, Mrilini | 111 | 68.5% | 57.7% | 100.% | 11.7% | 13.5% | 39.6% | 77.5% |

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# Lessons Learned

- Give people data early and often, even if it's not perfect.
- Work the lists
  - Care gaps
  - Before, during and after the visit
  - Reach out to those who don't have appointments

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# Leadership Team

- Committed leadership with buy- in at the top
- Involve all levels in VBC
- Committee structures
- Chief Clinical Transformation Officers

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# Clinical Transformation Officers

- Two well-respected partner physicians
- Dedicated time blocked, supported
- Broad interactions and authority
- At most high-level meetings
- Work with many committees

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# Clinical Transformation Officers

- VBC education
- Mentoring program
- Best practice council
- Variation reduction
- CARETEAM
- PCP90x, FLOG
- Physician matrix
- Physician experience task force
- Patient portal contest
- Executive team retreat
- Partner retreat
- Medicare patient advisory panel

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# Lessons learned

- There need to be people with time dedicated to VBC.
- These individuals do best with broad, coordinated power
- Should be respected clinical leaders with “street cred”

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# Care Manage Highest Risk Patients

- CARETEAM
- Home monitoring if necessary
- Embedded care managment
  - In the medical home
  - In the hospital

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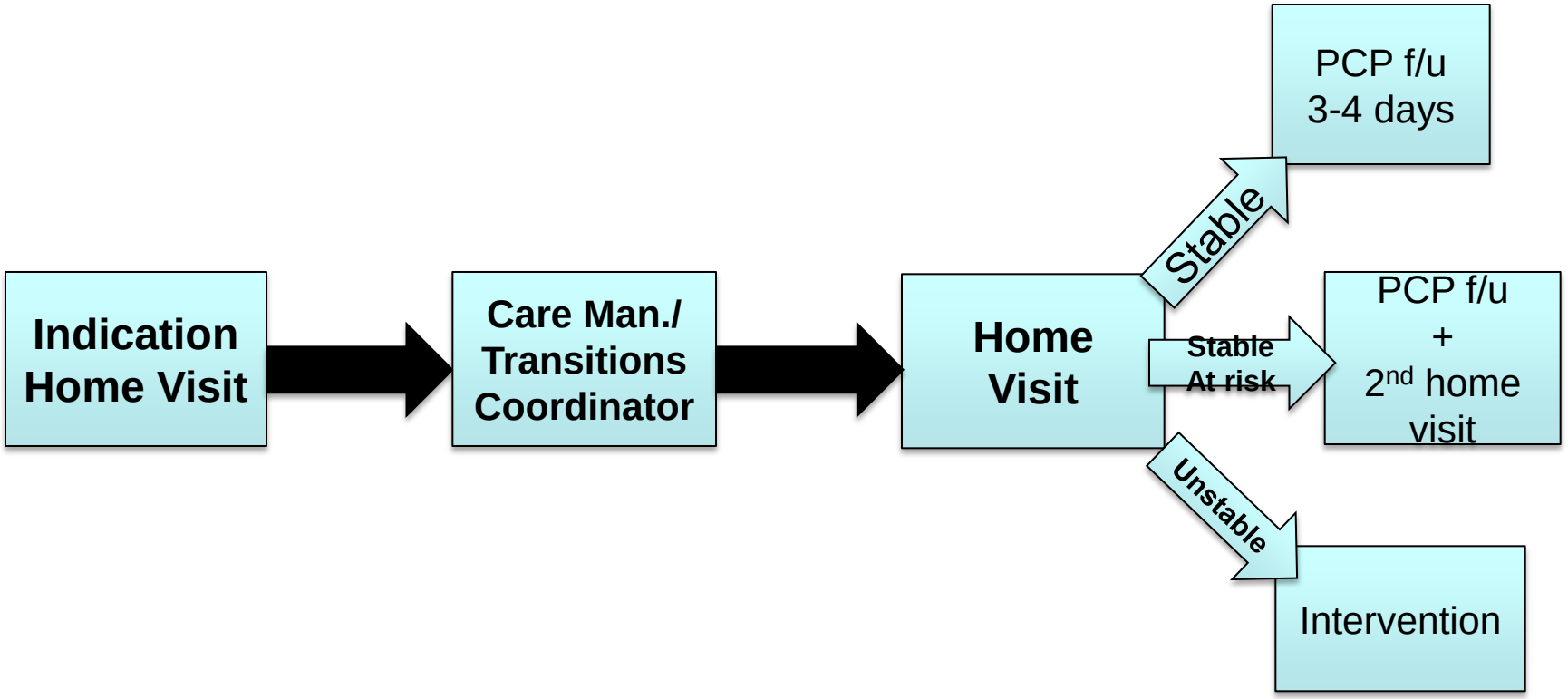
# CARETEAM process map

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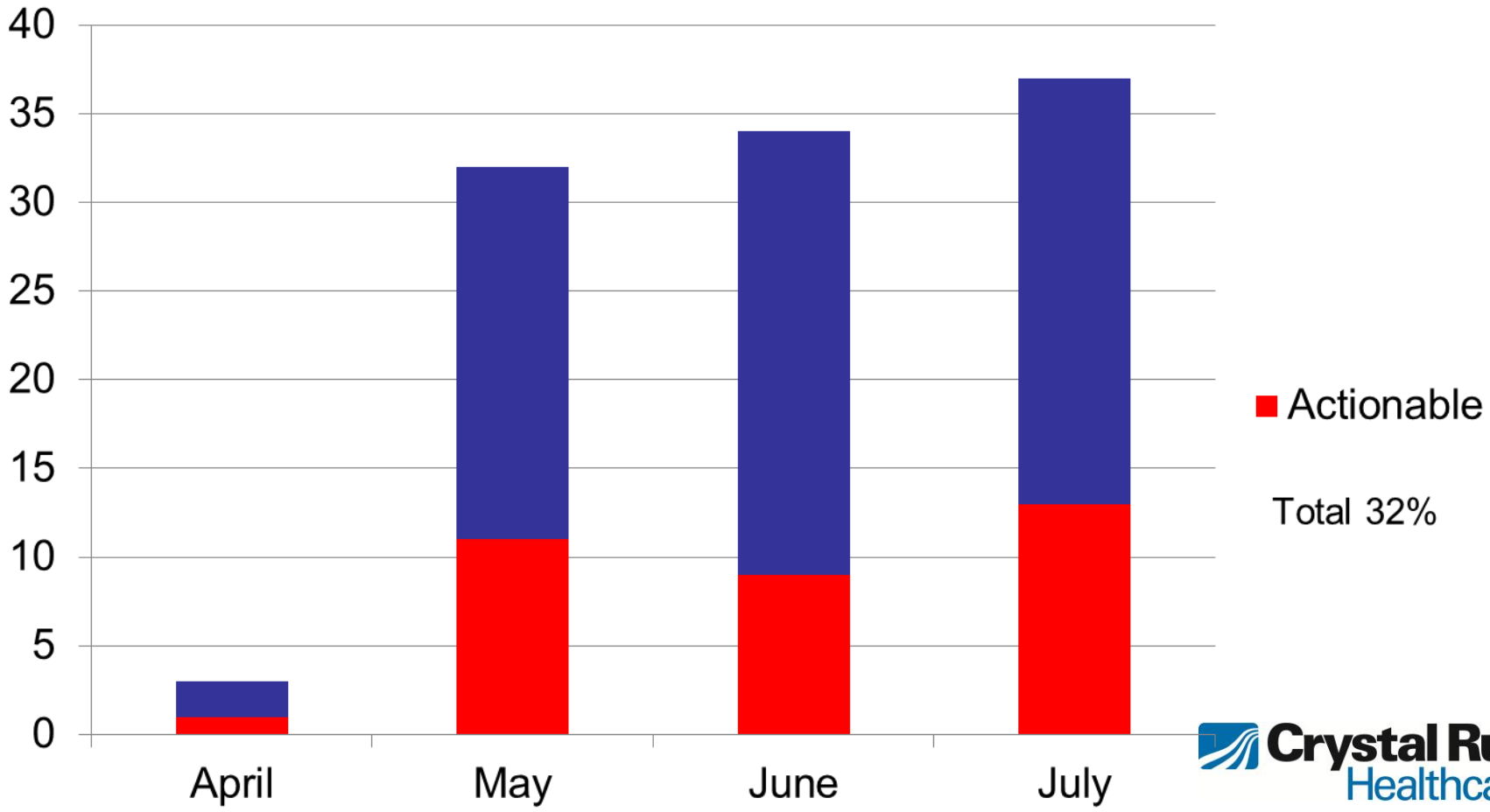
# CARETEAM Visit Outcome (n=106)

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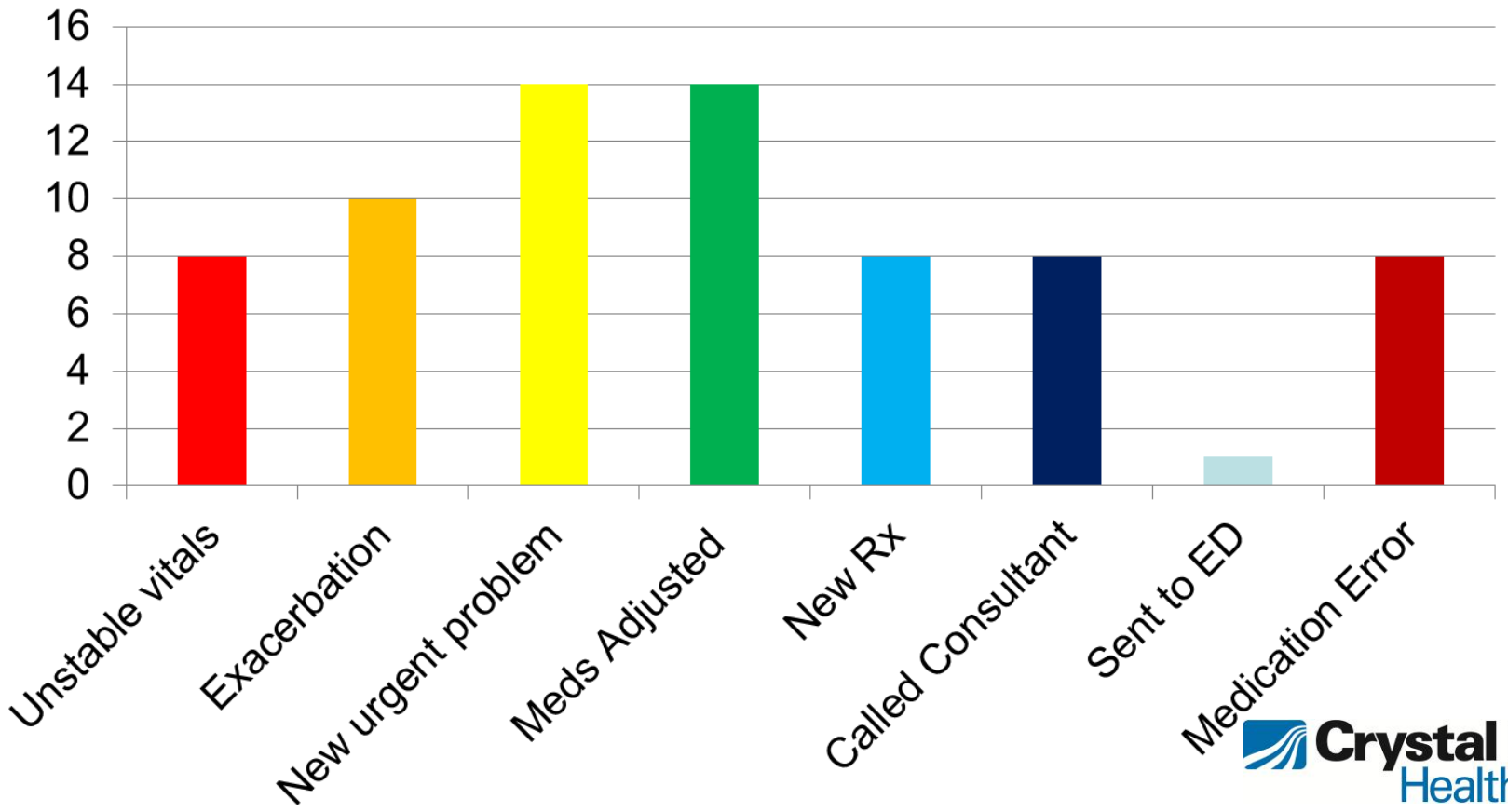
# CARETEAM Actionable Visits (n=34)

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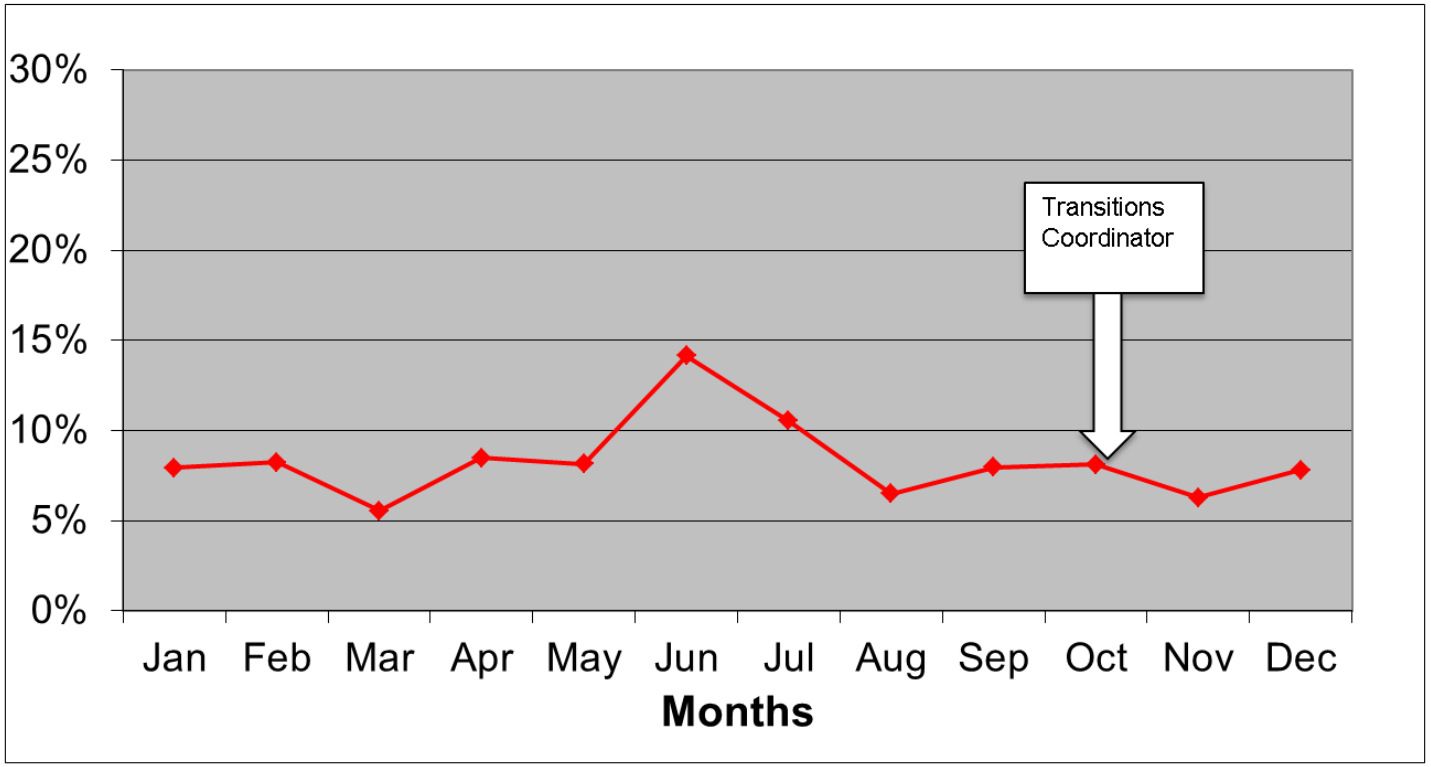
# 30 day Readmission Rate 2011
# Age > 65

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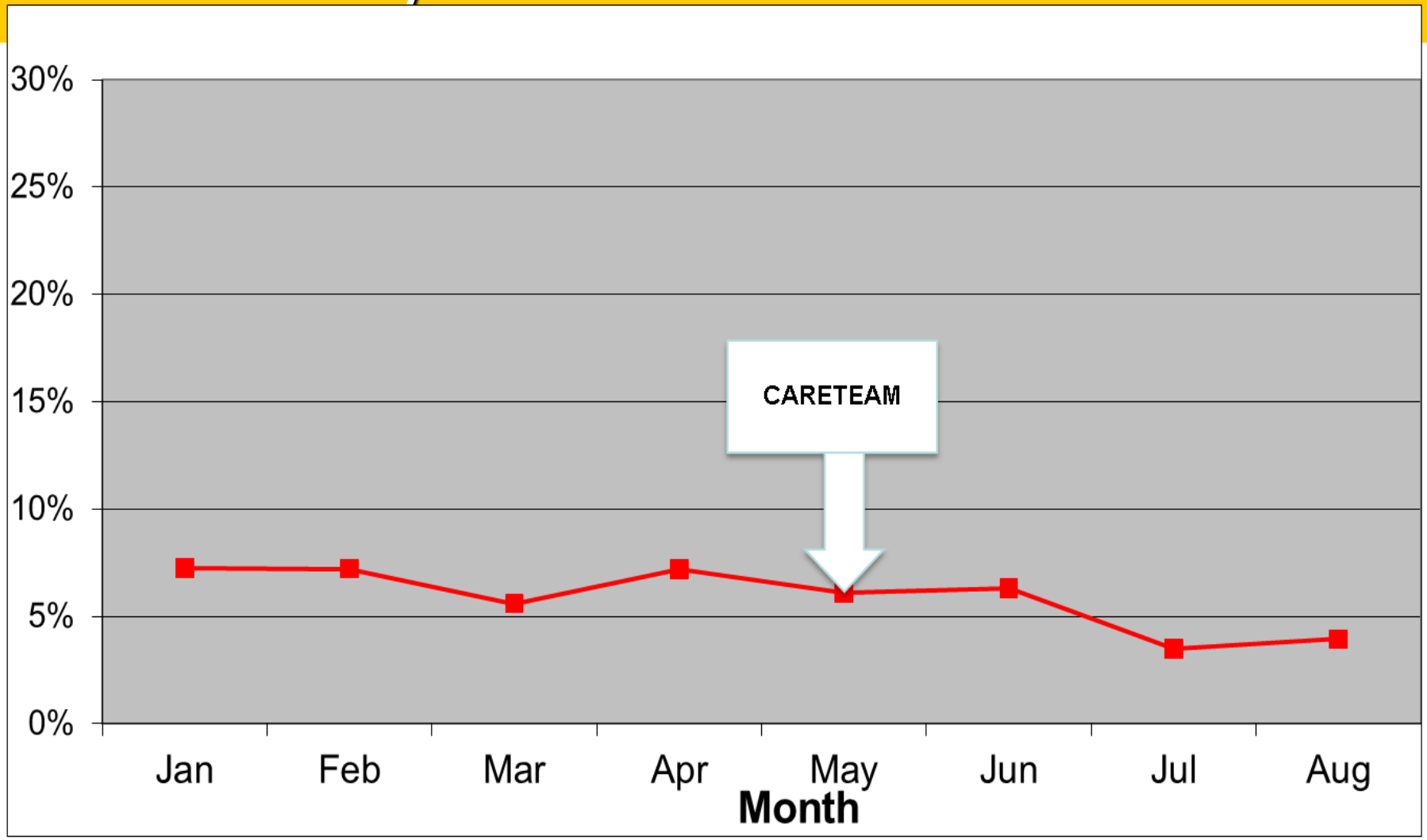
# 30 day Readmission Rate 2012



# Identify High Risk Patients

- No claims data?
  - CHF, COPD, poor diabetes control
  - Know high utilizers
  - Patients thought to be high risk
- Claims data available
  - Actuarial models
  - Utilization

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# Lessons Learned

- Develop enterprise best practices and involve providers in development
- Variation reduction projects are very useful
- Outside experts will be saying the same thing you do, but are helpful.

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# Strategies for Provider Engagement

- Quarterly Meetings
- Small Group Meetings
- The Page
- Recognizing Expertise of Physicians
- Recognizing Top Performers
- Transparency
- Incentivizing Change

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# Best Practice Guidelines

- Best Practice Guidelines
  - Assemble representatives from involved specialties
  - Review current literature
  - Develop best practice guidelines
  - Reviewed and accepted by Best Practice Council
  - Post on our intranet

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# Clinical Practice Guidelines

- Asthma
- Asthma, Pediatric
- Cancer
- Epicondylitis, Lateral
- Diabetes
- Gestational Diabetes
- Pre-Diabetes
- Hyperlipidiema
- Hypertension
- Lung Nodules
- Osteoporsis
- Postmenopausal Bleeding
- Thyroid Nodule
- Vitamin D deficiency

## Practice Guidelines for the treatment of Outpatient Diabetes, 2011

- History and Exam
- Laboratory and Diagnostic Testing
- Treatment Guidelines
- Consultations

*Disclaimer: This Best Practice Guideline is presented as a model only by way of illustration and all medical care at Crystal Run Healthcare LLP is appropriately tailored to each individual patient, including without limitation, such patient's history and medical condition.*

*Updated January, 2012*

# Variation Reduction- Definition

- A cost control measure which seeks to standardize care according to clinical guidelines and eliminate waste amongst those not adhering to national or local practice standards.

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# Variation Reduction

- Decide on a best practice standard
- Analyze utilization
- Compare utilization between physicians
- Analyze the variation
- Educate
- Wait
- Repeat

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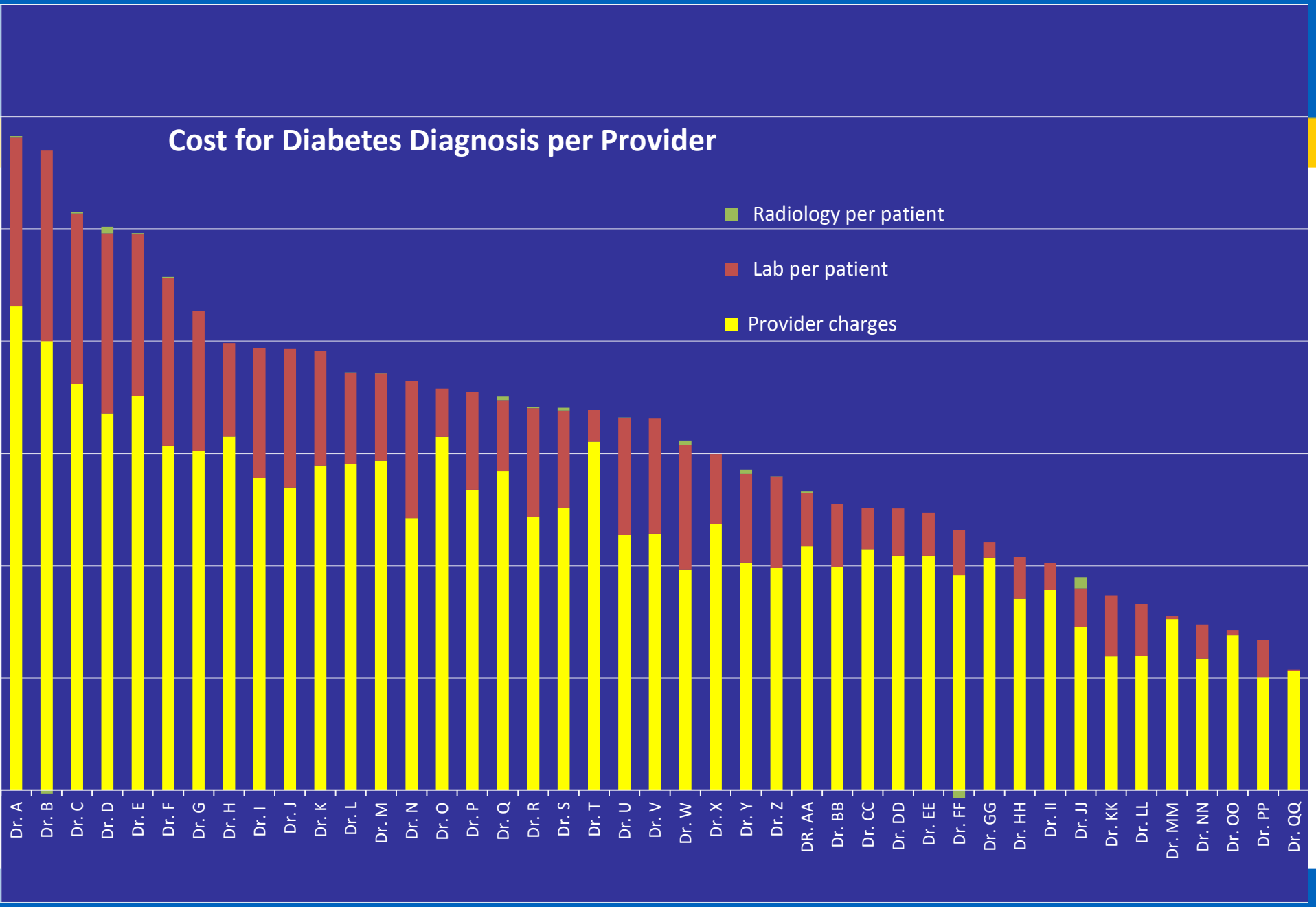
Cost for Diabetes Diagnosis per Provider
Radiology per patient
Lab per patient
Provider charges
Dr. A
Dr. B
Dr. C
Dr. D
Dr. E
Dr. F
Dr. G
Dr. H
Dr. I
Dr. J
Dr. K
Dr. L
Dr. M
Dr. N
Dr. O
Dr. P
Dr. Q
Dr. R
Dr. S
Dr. T
Dr. U
Dr. V
Dr. W
Dr. X
Dr. Y
Dr. Z
DR. AA
Dr. BB
Dr. CC
Dr. DD
Dr. EE
Dr. FF
Dr. GG
Dr. HH
Dr. II
Dr. JJ
Dr. KK
Dr. LL
Dr. MM
Dr. NN
Dr. OO
Dr. PP
Dr. QQ

# Diabetes Variation Reduction Pilot

- Compare Q3-Q4 2010 v. Q3-Q4 2011
  - Provider cost for DM reduction: 7%
  - Lab cost reduction: 15%
  - Radiology cost reduction: 53%
  - Total cost for DM reduction: 9%

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# Variation Reduction Pilot Projects

| DIAGNOSIS | DEPARTMENT | TOTAL % CHANGE IN COST |
|---|---|---|
| CHF | Cardiology | 1% |
| **Thyroid Nodule** | **Endocrinology** | **-14%** |
| **Otitis Externa** | **ENT** | **-7%** |
| GERD | GI | 0% |
| **Cholelithiasis** | **General Surgery** | **-9%** |
| **COPD** | **Hospitalists** | **-3%** |
| HTN | FP/IM | 4% |
| **Hyperlipidemia** | **FP/IM** | **-6%** |
| **HA/Migraine** | **Neurology** | **-3%** |
| Breast Cancer | Oncology | 15% |
| Lateral Epicondylitis | Orthopedics | 2% |
| **Asthma** | **Pediatrics** | **-1%** |
| **Asthma** | **Pulmonology** | **-3%** |
| **Renal Mass** | **Urology** | **-10%** |

# Lessons learned

- Go to meetings and get to know leaders in VBC
  - AMGA, HIMSS, GPIN, MGMA, regional etc.
- Align contracts now
- Software to analyze claims data
  - You can use Excel to start (but not for very long)
  - Many offerings available

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# Frequently Asked Questions Blog: FLOG

Home | The Page | Buzzwords | Clinical Guidelines | Flog

## Flog

**What is the Flog?**
The FLOG is a venue for communication where providers can post a question to a specific specialty. Once a question is posted, the specialist designated to maintain the FLOG for his/her specialty will enter a response in a timely fashion. All providers who are signed up for the service will then receive an e-mail notification that a new post has been created. Obviously, urgent issues need to be discussed by phone in the usual manner.

flog@crystalrunhealthcare.com

CRYSTALRUN\mperry
9/12/2012 2:32 PM

### secondary erythrocytosis due to cyanotic heart disease

Rather than solely using a target hematocrit, phlebotomy should be performed only in patients with intrusive symptoms of hyperviscosity, and then only with caution in the setting of iron deficiency. Some experts also recommend preoperative phlebotomy to improve hemostasis.

- The 2008 ACC/AHA guidelines recommend therapeutic phlebotomy for hemoglobin greater than 20 g/dL and hematocrit >65 percent, associated with headache, increasing fatigue, or other symptoms of hyperviscosity in the absence of dehydration or anemia.
- Repeated routine phlebotomies are **not** recommended because of the risk of iron depletion, decreased oxygen-carrying capacity, and stroke.

**Manage**

My Subcriptions

**Archive**

**September**

secondary erythrocytosis due to cyanotic heart disease

**August**

Antibiotic Prophylaxis for patient with joint replacments

Tick bite

DM2 or not DM2, that is th question

**Table 2-5**

**Medicare Shared Savings Program**

**Distribution of Assigned Beneficiaries by Service Area Counties**

**A1043, Benchmark Year 2011**

| County Name | State Name | County Number [1] | Beneficiaries | Percentage |
|---|---|---|---|---|
| Total | | | 9,796 | 100.0 |
| Orange | New York | 33540 | 5,830 | 59.5 |
| Pike | Pennsylvania | 39630 | 123 | 1.3 |
| Rockland | New York | 33620 | 244 | 2.5 |
| Sullivan | New York | 33710 | 2,734 | 27.9 |
| Ulster | New York | 33740 | 302 | 3.1 |
| Outside Service Area | | | 563 | 5.7 |

Notes:

Preliminary reports: Includes beneficiaries assigned based on claims with dates of service during the 12-month period that are processed as of 03/17/2012.

A small percentage of 2011 assigned beneficiaries were excluded from this preliminary report because they enrolled in Medicare in late 2011 and at the time this report was prepared, the Medicare enrollment data were only available through the first 9 months of 2011.

[1] County codes used by the Social Security Administration (SSA).

Service Area is defined as counties with at least 1% of assigned beneficiaries.

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**Medicare Shared Savings Program**

**Aggregate Expenditure/Utilization Trend Report**

**ACO A1043 Crystal Run Healthcare ACO, LLC**

**Year 2012, Quarter 2**

| | | | | |
|---|---|---|---|---|
| **Transition of Care/Care Coordination Utilization** | | | | |
| 30-Day All-Cause Readmissions Per 1,000 Discharges[5] | 196 | 144 | 159 | 131 |
| 30-Day Post-Discharge Provider Visits Per 1,000 Discharges | 843 | 815 | 784 | 718 |
| Ambulatory Care Sensitive Conditions Discharge Rates Per 1,000 Beneficiaries: | | | | |
| Diabetes, Short-Term Complications | 0.43 | 0.11 | 0.66 | 0.16 |
| Uncontrolled Diabetes | 0.43 | 0.00 | 0.41 | 0.00 |
| Chronic Obstructive Pulmonary Disease or Asthma | 9.64 | 1.84 | 9.58 | 1.84 |
| Congestive Heart Failure | 13.10 | 2.49 | 12.83 | 2.49 |
| Bacterial Pneumonia | 9.85 | 2.27 | 9.45 | 2.24 |
| **Additional Utilization Rates (Per 1,000 Person Years)** | | | | |
| Hospitalizations[6] | 424 | 88 | 354 | 78 |
| Emergency Department Visits | 679 | 142 | 661 | 142 |
| Emergency Department Visits That Lead To Hospitalizations | 287 | 53 | 247 | 52 |
| Computed Tomography (CT) Events | 742 | 181 | 619 | 138 |
| Magnetic Resonance Imaging (MRI) Events | 240 | 53 | 284 | 58 |
| Primary Care Services[7] | | | | |
| With a Primary Care Physician[8] | 3,701 | 868 | 4,479 | 1,018 |
| With a Specialist Physician[9] | 7,452 | 1,777 | 4,629 | 1,089 |
| With a Nurse Practitioner/Physician's Assistant/Clinical Nurse Specialist[10] | 785 | 214 | 596 | 123 |
| With a FQHC / RHC[11] | 24 | 3 | 39 | 8 |
| Ambulance Events | 1,138 | 245 | 814 | 162 |

# Suprises from Claims Data

- Leakage
- Highest cost categories
  - Re-evaluate rehab
- Excess spend on labs
  - Standardize
  - Cost

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# Cost of common lab tests

| | | |
|---|---|---|
| Assay thyroid stim hormone | $149,320.97 | 6304 |
| Comprehen metabolic panel | $142,618.16 | 12744 |
| Complete cbc w/auto diff wbc | $127,235.99 | 11612 |
| Lipid panel | $124,172.64 | 8489 |
| Glycosylated hemoglobin test | $58,306.06 | 4258 |
| Tissue exam by pathologist | $41,313.85 | 971 |
| Prothrombin time | $35,349.06 | 6378 |
| Vitamin B-12 | $31,684.01 | 1494 |
| PSA screening | $28,444.12 | 1098 |
| Metabolic panel total ca | $26,212.24 | 3390 |
| Blood folic acid serum | $26,093.48 | 1262 |
| Assay of free thyroxine | $22,075.70 | 1737 |

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# Lessons Learned

- There are long claims lags
- Try to leverage data you already have
  - Meaningful Use
  - Quality measures
- Use data from other payers
  - Generic prescribing rates
  - Readmission
  - Ambulatory sensitive admissions
  - CT, MRI, Nuclear stress testing
  - Pool data if possible

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# Thank You!

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# Questions?

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