Medicare Shared Savings ACOs: One Organization’s Lessons Learned

Gregory A. Spencer MD FACP
Chief Medical Officer
Crystal Run Healthcare LLP
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
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
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
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.
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
Crystal Run Healthcare ACO Organization

Crystal Run Healthcare Partnership

- Management Committee
- Committee Structure
- Hal Teitelbaum MD CEO
- Executive Team
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
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
Important ACO Competencies

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

- Medical Home - a foundational element
- Care managers where the patients are
- Home visits and monitoring
Required Infrastructure: Technology

- Embed best practices in EHR
- Dashboards
- Care gaps
- Claims data
- Cost data where it’s available
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
The Medical Neighborhood

- Geographical grouping of providers
- Leverage the whole team
- Embedded care managers
- Not limited to primary care
- Monthly meetings
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
   - Process Issues
   - i.e., phone calls, acute calls and connectivity to CM, access, etc.

II. TeleHealth Data

III. Polypharmacy Pilot Launching

IV. Case Study Review

V. Quality Indicator Report

VI. Education

   8 – 10 minutes

VII. Site Outcomes

   November & December

VIII. Take Aways
   - Nursing and Front Desk Staff
   - “To Do’s”
## Cardiac Care Measure - Practice Summary

<table>
<thead>
<tr>
<th>Practice</th>
<th>Report date</th>
<th>Total Patients</th>
<th>Annual Lipids Testing</th>
<th>Aspirin %</th>
<th>Smoking %</th>
<th>LDL ≥ 130</th>
<th>BPS ≥ 145/95</th>
<th>LDL &lt; 100</th>
<th>BPS &lt; 140/90</th>
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<tbody>
<tr>
<td>Practice:</td>
<td>12/1/2012</td>
<td>3043</td>
<td>84.1%</td>
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<td>99.2%</td>
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<td>99.9%</td>
<td>10.9%</td>
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<td>46.6%</td>
<td>88.8%</td>
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<tr>
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<td>59.9%</td>
<td>100.0%</td>
<td>24.2%</td>
<td>5.8%</td>
<td>30.8%</td>
<td>90.4%</td>
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<td>98.9%</td>
<td>15.2%</td>
<td>9.2%</td>
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<td>65.1%</td>
<td>99.5%</td>
<td>8.6%</td>
<td>7.1%</td>
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<tr>
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<td><strong>99.6%</strong></td>
<td><strong>17.4%</strong></td>
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<td>12.6%</td>
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<td><strong>Goal:</strong></td>
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## Cardiac Care Measure - By PCP

<table>
<thead>
<tr>
<th>Report date</th>
<th>PCP</th>
<th>Total Patients</th>
<th>Annual Lipids Testing</th>
<th>Aspirin %</th>
<th>Smoking %</th>
<th>LDL ≥ 130</th>
<th>BPS ≥ 145/95</th>
<th>LDL &lt; 100</th>
<th>BPS &lt; 140/90</th>
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<td>139</td>
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<td>13.7%</td>
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<tr>
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<td>48.3%</td>
<td>100.0%</td>
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<tr>
<td>12/1/2012</td>
<td>Lee MD, Sophia</td>
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<td>48.5%</td>
<td>99.4%</td>
<td>11.1%</td>
<td>11.7%</td>
<td>53.8%</td>
<td>83.6%</td>
</tr>
<tr>
<td>12/1/2012</td>
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<td>99</td>
<td>87.9%</td>
<td>54.5%</td>
<td>100.0%</td>
<td>13.1%</td>
<td>9.1%</td>
<td>58.6%</td>
<td>83.8%</td>
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<tr>
<td>12/1/2012</td>
<td>Meneses MD, Robert</td>
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<td>47.5%</td>
<td>98.1%</td>
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<tr>
<td>12/1/2012</td>
<td>Mitra MD, Tithi</td>
<td>1</td>
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<td>0.0%</td>
<td>100.0%</td>
<td>0.0%</td>
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<tr>
<td>12/1/2012</td>
<td>Shahid MD, Atter</td>
<td>1</td>
<td>0.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
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<tr>
<td>12/1/2012</td>
<td>Shiblee MD, Towhid</td>
<td>10</td>
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<td>50.0%</td>
<td>100.0%</td>
<td>0.0%</td>
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<td>53.4%</td>
<td>100.0%</td>
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<td>8.7%</td>
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<td>97.7%</td>
<td>8.0%</td>
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<td>84.1%</td>
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<tr>
<td>12/1/2012</td>
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<td>100.0%</td>
<td>11.7%</td>
<td>13.5%</td>
<td>39.6%</td>
<td>77.5%</td>
</tr>
</tbody>
</table>
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
Leadership Team

- Committed leadership with buy-in at the top
- Involve all levels in VBC
- Committee structures
- Chief Clinical Transformation Officers
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
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
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”
Care Manage Highest Risk Patients

- CARETEAM
- Home monitoring if necessary
- Embedded care management
  - In the medical home
  - In the hospital
CARETEAM process map

Indication Home Visit → Care Man./Transitions Coordinator → Home Visit

Stable: PCP f/u 3-4 days
Unstable: Intervention
Stable At risk: PCP f/u + 2nd home visit
CARETEAM Visit Outcome (n=106)

- April: 1 actionable out of 4
- May: 10 actionable out of 10
- June: 10 actionable out of 15
- July: 15 actionable out of 35

Total actionable: 32%

Crystal Run Healthcare
CARETEAM Actionable Visits (n=34)
30 day Readmission Rate 2011
Age > 65
30 day Readmission Rate 2012

Month

Jan  Feb  Mar  Apr  May  Jun  Jul  Aug

CARETEAM

0%  5%  10%  15%  20%  25%  30%
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
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.
Strategies for Provider Engagement

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

- Decide on a best practice standard
- Analyze utilization
- Compare utilization between physicians
- Analyze the variation
- Educate
- Wait
- Repeat
Cost for Diabetes Diagnosis per Provider

- Radiology per patient
- Lab per patient
- Provider charges
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%
## Variation Reduction Pilot Projects

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Department</th>
<th>Total % Change in Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>Cardiology</td>
<td>1%</td>
</tr>
<tr>
<td>Thyroid Nodule</td>
<td>Endocrinology</td>
<td>-14%</td>
</tr>
<tr>
<td>Otitis Externa</td>
<td>ENT</td>
<td>-7%</td>
</tr>
<tr>
<td>GERD</td>
<td>GI</td>
<td>0%</td>
</tr>
<tr>
<td>Cholelithiasis</td>
<td>General Surgery</td>
<td>-9%</td>
</tr>
<tr>
<td>COPD</td>
<td>Hospitalists</td>
<td>-3%</td>
</tr>
<tr>
<td>HTN</td>
<td>FP/IM</td>
<td>4%</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>FP/IM</td>
<td>-6%</td>
</tr>
<tr>
<td>HA/Migraine</td>
<td>Neurology</td>
<td>-3%</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Oncology</td>
<td>15%</td>
</tr>
<tr>
<td>Lateral Epicondylitis</td>
<td>Orthopedics</td>
<td>2%</td>
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<tr>
<td>Asthma</td>
<td>Pediatrics</td>
<td>-1%</td>
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<tr>
<td>Asthma</td>
<td>Pulmonology</td>
<td>-3%</td>
</tr>
<tr>
<td>Renal Mass</td>
<td>Urology</td>
<td>-10%</td>
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</table>
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
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

**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.
Table 2-5
Medicare Shared Savings Program

Distribution of Assigned Beneficiaries by Service Area Counties
A1043, Benchmark Year 2011

<table>
<thead>
<tr>
<th>County Name</th>
<th>State Name</th>
<th>County Number</th>
<th>Beneficiaries</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>9,796</td>
<td>100.0</td>
</tr>
<tr>
<td>Orange</td>
<td>New York</td>
<td>33540</td>
<td>5,830</td>
<td>59.5</td>
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<tr>
<td>Pike</td>
<td>Pennsylvania</td>
<td>39630</td>
<td>123</td>
<td>1.3</td>
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<tr>
<td>Rockland</td>
<td>New York</td>
<td>33620</td>
<td>244</td>
<td>2.5</td>
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<tr>
<td>Sullivan</td>
<td>New York</td>
<td>33710</td>
<td>2,734</td>
<td>27.9</td>
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<tr>
<td>Ulster</td>
<td>New York</td>
<td>33740</td>
<td>302</td>
<td>3.1</td>
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<tr>
<td>Outside Service Area</td>
<td></td>
<td></td>
<td>563</td>
<td>5.7</td>
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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.
### 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

<table>
<thead>
<tr>
<th>Metric</th>
<th>Year 2012</th>
<th>Quarter 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Day All-Cause Readmissions Per 1,000 Discharges^3</td>
<td>196</td>
<td>144</td>
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<tr>
<td>30-Day Post-Discharge Provider Visits Per 1,000 Discharges</td>
<td>843</td>
<td>815</td>
</tr>
</tbody>
</table>

#### Ambulatory Care Sensitive Conditions Discharge Rates Per 1,000 Beneficiaries:

- **Diabetes, Short-Term Complications**
  - Year 2012: 0.43
  - Quarter 2: 0.11
  - Year 2011: 0.66
  - Quarter 2: 0.16

- **Uncontrolled Diabetes**
  - Year 2012: 0.43
  - Quarter 2: 0.00
  - Year 2011: 0.41
  - Quarter 2: 0.00

- **Chronic Obstructive Pulmonary Disease or Asthma**
  - Year 2012: 9.64
  - Quarter 2: 1.84
  - Year 2011: 9.58
  - Quarter 2: 1.84

- **Congestive Heart Failure**
  - Year 2012: 13.10
  - Quarter 2: 2.49
  - Year 2011: 12.83
  - Quarter 2: 2.49

- **Bacterial Pneumonia**
  - Year 2012: 9.85
  - Quarter 2: 2.27
  - Year 2011: 9.45
  - Quarter 2: 2.24

#### Additional Utilization Rates (Per 1,000 Person Years)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Year 2012</th>
<th>Quarter 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalizations^6</td>
<td>424</td>
<td>88</td>
</tr>
<tr>
<td>Emergency Department Visits</td>
<td>679</td>
<td>142</td>
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<tr>
<td>Emergency Department Visits That Lead To Hospitalizations</td>
<td>287</td>
<td>53</td>
</tr>
<tr>
<td>Computed Tomography (CT) Events</td>
<td>742</td>
<td>181</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI) Events</td>
<td>240</td>
<td>53</td>
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<tr>
<td>Primary Care Services^7</td>
<td>3,701</td>
<td>868</td>
</tr>
<tr>
<td>With a Primary Care Physician^8</td>
<td>868</td>
<td>1,018</td>
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<tr>
<td>With a Specialist Physician^9</td>
<td>7,452</td>
<td>1,777</td>
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<tr>
<td>With a Nurse Practitioner/Physician’s Assistant/Clinical Nurse Specialist^10</td>
<td>785</td>
<td>214</td>
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<tr>
<td>With a FQHC / RHC^11</td>
<td>24</td>
<td>3</td>
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<tr>
<td>Ambulance Events</td>
<td>1,138</td>
<td>245</td>
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</table>
Suprises from Claims Data

- Leakage
- Highest cost categories
  - Re-evaluate rehab
- Excess spend on labs
  - Standardize
  - Cost
<table>
<thead>
<tr>
<th>Test</th>
<th>Cost</th>
<th>Code</th>
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<tbody>
<tr>
<td>Assay thyroid stim hormone</td>
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<tr>
<td>Comprehensive metabolic panel</td>
<td>$142,618.16</td>
<td>12744</td>
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<tr>
<td>Complete cbc w/auto diff wbc</td>
<td>$127,235.99</td>
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<tr>
<td>Lipid panel</td>
<td>$124,172.64</td>
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<td>Glycosylated hemoglobin test</td>
<td>$58,306.06</td>
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<tr>
<td>Tissue exam by pathologist</td>
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<td>Prothrombin time</td>
<td>$35,349.06</td>
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<tr>
<td>Vitamin B-12</td>
<td>$31,684.01</td>
<td>1494</td>
</tr>
<tr>
<td>PSA screening</td>
<td>$28,444.12</td>
<td>1098</td>
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<tr>
<td>Metabolic panel total ca</td>
<td>$26,212.24</td>
<td>3390</td>
</tr>
<tr>
<td>Blood folic acid serum</td>
<td>$26,093.48</td>
<td>1262</td>
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<tr>
<td>Assay of free thyroxine</td>
<td>$22,075.70</td>
<td>1737</td>
</tr>
</tbody>
</table>
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
Thank You!

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Questions?