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# Value-based Health Care Models

## TASC 90 Webinar

May 2015

# Definitions

- Accountable Care Organization (ACO)
- Coordinated Care Organization (CCO)
- Patient Centered Medical Home (PCMH)
- Population Health

# Accountable Care Organizations

Accountable Care Organizations:

- A mechanism to monetize value by increasing quality and reducing cost
- A group of health care providers that takes responsibility for the cost and quality of care for a group of patients or individuals

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# ACOs

- When an ACO succeeds both in delivering seamless, high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare Program
- Various Models:
  - Medicare Shared Savings Program
  - Advance Payment ACO Model
  - Pioneer ACO Model
  - Next Generation ACO Model

# ACOs

- Rapid growth
  - August 2012: 154
  - January 2015: 747
- Both hospital and physician led
- Medicare and private insurance models
- A growing number based in rural

# Coordinated Care Organization (CCO)

- Develop case management and coordination building blocks
- Develop strategies for population health management and shared responsibility for health
- Implement plan for risk-based population contracts
- Implement an integrated payment and delivery system

# Patient Centered Medical Home (PCMH)

The medical home encompasses five functions and attributes:

- Comprehensive care
- Patient-centered
- Coordinated care
- Accessible services
- Quality and safety

Source: Agency for Healthcare Research & Quality, http://www.pcmh.ahrq.gov/page/defining-pcmh

# Population Health

Serves as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three stages:

- Distribution of specific health statuses and outcomes within a population
- Factors that cause the present outcomes distribution
- Interventions that modify the factors to improve health outcomes

# Clarifying Population Health

"Population Health" used interchangeably for:

- Targeted population: Improving health and reducing costs for *specific groups of patients*, often grouped by insurance type and focused on chronic disease
- Total Community Health: Health outcomes of an *entire group* of individuals, often geographically defined, including the distribution/disparities of outcomes within the group

*It's Both/And Situational*

# Panel Discussion

Pat Schou
Illinois Critical Access Hospital Network (ICAHN)

Tim Putnam
Margaret Mary Health & National Rural ACO

Charlie Alfero
Hidalgo Medical Services – Southwest Center for Health Innovation

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# Illinois Critical Access Hospital Network

- **ICAHN** is a not-for-profit 501(c)3 corporation established in 2003 for the purposes of **sharing resources, education, promoting efficiency** and **best practice** and improving health care services for member critical access hospitals and their **rural communities**. ICAHN, with 53 member hospitals, is an independent network governed by a nine-member board of directors.
- Located in rural Princeton, IL / 20 employees and consultants
- Members = 34 Independent ; 19 Systems
- Incubator for new ideas and services
- Illinois – Chicago and then downstate Illinois…rural dominated

*"Working Together"*

ICAHN
Illinois Critical Access Hospital Network

# Illinois Rural Community Care Organization


**Mission** – to improve the health of rural communities served

**Vision** – IRCOO is a collaborative of committed rural hospitals, clinics, physician and other providers who recognize certain healthcare and social services are best delivered and supported at the local level and that innovation and sharing of resources and as well as talent will guide providers to build clinically integrated systems of care placing special effort to ensure that the patient is the center of all services

**Values** – quality, respect, service, collaboration, excellence and partnership

**Rural Providers –** open to all

# How does the MSSP/ACO work?

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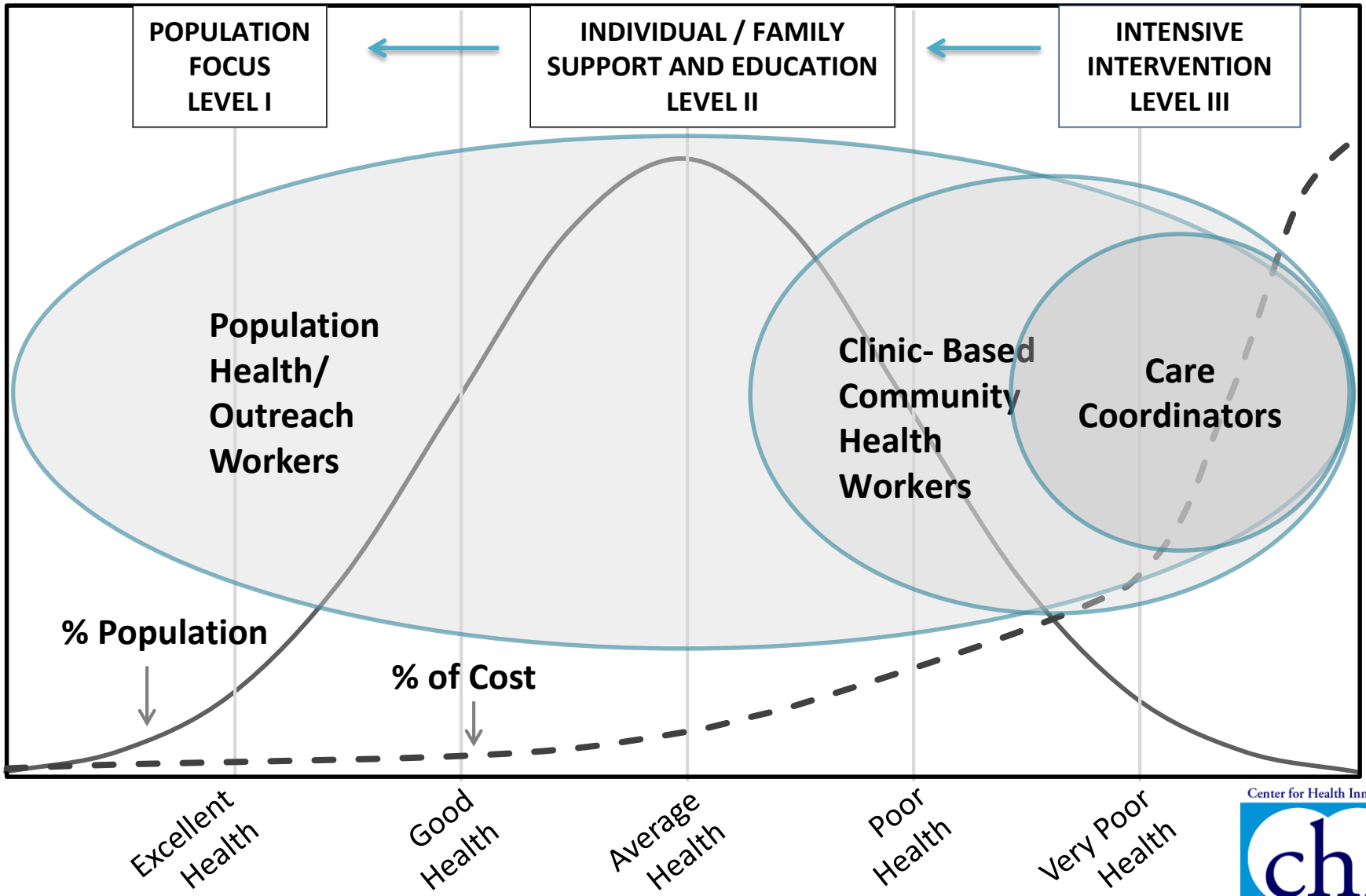
# Non-Clinical Value-based Services – Population Payments




Center for Health Innovation
chi
A Division of Hidalgo Medical Services

# Panel Discussion

With regards to value-based models of care:

- What are the main reasons rural health care providers are moving in this direction?

# Transition to Value Based Payment

- Strong motivation from legislators (ACA and SGR) bureaus (CMS, CMMI) as well as insurance companies and employers.
- The improvement of the health of the community is why most rural healthcare facilities were founded and what our communities expect from us.

# Panel Discussion

With regards to value-based models of care:

- What are the main reasons rural health care providers are moving in this direction?
- What have been the biggest obstacles standing in the way of adoption?

# Building the Service

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Education and Training – Patient Centered Medical Home Model serves as foundation

****Physician Panel – Evidenced Based Care based on rural standards/proven care

Care Coordination Processes – patient care…RE-DESIGN INTERNALLY CARE DELIVERY

- Increasing primary care base and satisfaction
- Quality and efficiency
- Population Health – improvements in care delivery by providers
- Healthier populations
- Secondary Relationships – begin pilot with tertiary care (i.e. Carle)

Care Transition- relationship with community providers and secondary care

Making a difference – Access to quality services

# What are our Challenges?

Unsure of ability to meet performance measures – quality reporting/data collection

Lack of experience as an ACO and care coordination

Team building of a new organization – multiple interests and skills

Disparate electronic medical records (15 +)

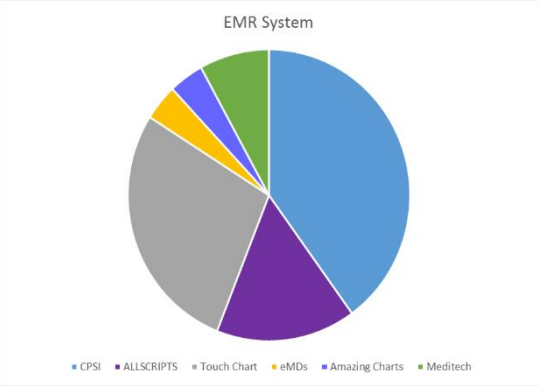
Variability in care – practices and clinics

Geography of participants

Build as you go – CASH

- Assessment
- ICAHN Support/Management Contract

Data Analytics…where do we begin



# Panel Discussion

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- What have been the biggest obstacles standing in the way of adoption?
- What are some of the strategies and tools being used in the transition?

# How to Communicate the Transition

- Community Leaders and Trustees
- Medical Staff
- Hospital Staff
- Community at Large

# Resources for Transition

- Medicare Data
- Experiences with:
  - National Rural ACO
  - Suburban Health Organization
  - Regional Healthcare Providers

# Key is Primary Care

## What do rural providers do best?

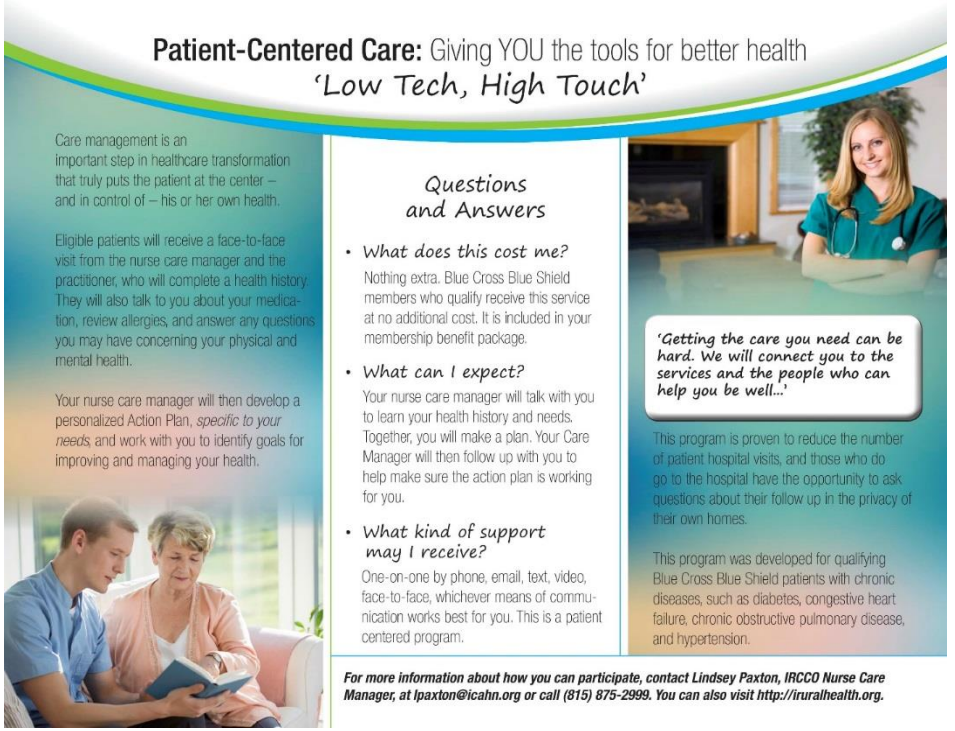
- Physician and Hospital Partnership

# How will IRCCO be Special?

Want will set your organization and providers apart?

Will your service make a difference for patients and their families?

Will your service have better outcomes?



# Managing Care Variability – CMO

*(Targeted Interventions)*

| Types of Patients | IRCCO Impact | Practitioner Impact | Hospital Impact |
|---|---|---|---|
| Healthy People 50% | Education, quality reporting, wellness activities | Provide necessary treatment, screening, quality, patient satisfaction | Wellness and screening activities |
| Early onset of chronic disease | Incentives to practitioners and patients; care navigation; health promotion programs | Recognition of early problem intervention; follow up and referral to specialist; best practices | Diagnostic tests; patient education and targeted community education; care coordination |
| Full Onset of Chronic Disease | Policies and procedures; best practices; active case risk management and report quality measures | Follow up with specialists and acute care intervention | Treatment and care; transitional care management; full active care coordination; medical neighborhood |
| Complex Care Episodes | Decide best center of excellence; quality and monitor costs | Immediate referral; evaluation of services; acute episodes or end of life management | Partner with centers of excellence; transitional care management; coordinate local services with Centers; medical neighborhood |

# Panel Discussion

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- What are the main reasons rural health care providers are moving in this direction?
- What have been the biggest obstacles standing in the way of adoption?
- What are some of the strategies and tools being used in the transition?
- What are some potential positive outcomes of adoption? Potential risks?

# Different Conversations

- Patient Categories
  - High Utilizers
  - Rising Risk
  - Healthy – Preventative Care
- Parish Nursing
- Transportation
- Loose Rugs and Poor Lighting

# Surviving the Transition

- Financial Transition Risk
- Staff Resources
- Patient Expectations

# Panel Discussion

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- What have been the biggest obstacles standing in the way of adoption?
- What are some of the strategies and tools being used in the transition?
- What are some potential positive outcomes of adoption? Potential risks?
- What are a few of the key lessons you've learned in your work?

# Lessons Learned

- Moving from Illness to Health
  - People still think of us as treating the sick & injured
- Engaging the Community in the Transition
- Yes, it was included in Obamacare
- Unpredictability of CMS and Insurers

# Key Points – *Moving from Volume to Value*

- Believe care is local…CAH is the hub
  - Build out then to regional care/specialist
  - Medical neighborhood…sharing services and full set of primary services
- Work redesign…grassroots for sustainability
  - Hospital transformation
  - Patient centered medical home/a foundation
  - Rural based care
- Data driven yet high touch and low tech
- Treatment model to health maintenance model
- Care coordination is a process and the glue

# Change is a Journey

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"Better to be part of the journey than not at all."

# Questions?

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- Tim Putnam
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