



Chautauqua Region's Rural ACO: A Transitioning Medical Neighborhood

Chautauqua Region Associated Medical Partners, LLC

Chautauqua Integrated Delivery System, LLC

Chautauqua County Health Network

May 21, 2013

Chautauqua County, New York

- Population: 130,000+
 - Northern tip of Appalachia
 - Over 7% Hispanic, border the Seneca Nation
 - Geographic and low income HPSA's
- Clinical Services:
 - 3 NFP Hospital Organizations-4-hospitals, no CAI
 - (all community-336 beds)
 - Approx 100+ physicians
 - Tertiary Care in Erie, PA; Cleveland, OH; Rochester, NY; and Buffalo, NY
 - One FQHC opened 1/13
 - Two primary care and two dental clinics (Article 28)
- 27,000 Medicare Beneficiaries
 - 40% Medicare Advantage
- Provider Sustainability = Pay for Performance and Other QI incentive
 - Lowest wage index in the nation
 - Erosion of HMO/Managed Care Market
 - Clinical Integration strategy since 2008 anticipating payment reform
 - Accountable Care Act-focus on PCMH and Care Management





Synergy of Multiple Enterprises has made the ACO possible



Founded 1995



Founded 1997

Our Community of Doctors



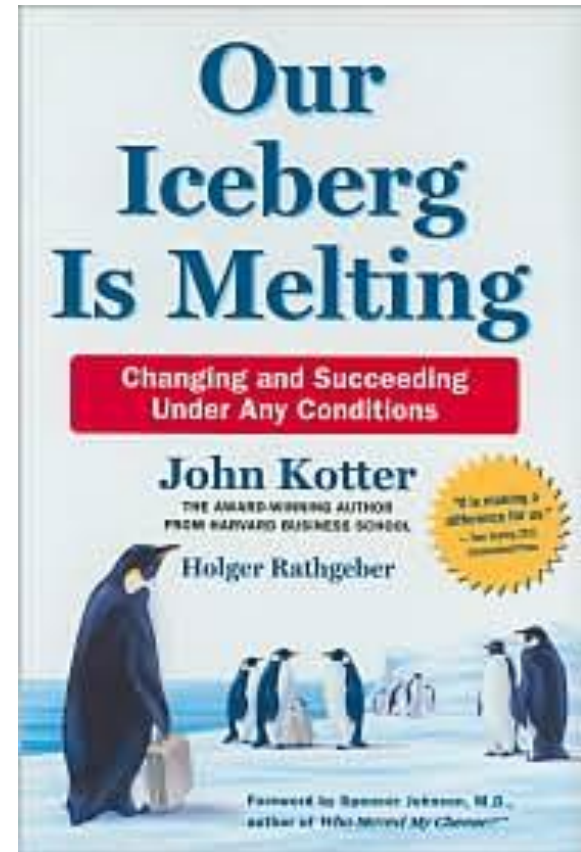
Founded 2012

By 2007

Things had been
heating up for

Chautauqua
Integrated Delivery System
IPA, LLC

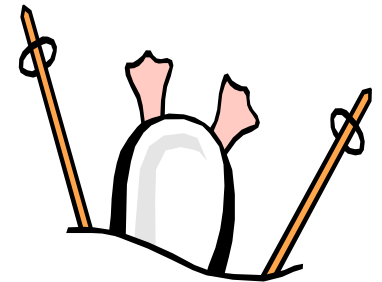
Our Community of Doctors



Integrated Delivery System (IPA) Background

- 2 hospitals and 120 physicians-PCP and specialists in MA contracts
- IDS/Medicare Advantage partnership for over 15 years; 2200 lives
- The neighborhood was going down in 2007
 - Poor financial performance in last few years
 - No delegated medical management
 - Case management confusion
 - Frustrated by lack of timely data
 - Provider base eroding
 - Fish or cut bait

Business was headed in the wrong direction.





Integrated Delivery System (IPA) Background (Cont'd)

- Informational interviews with sustainable IPA's = CI
- IDS began working on Clinical Integration in 2009
 - RFP for consulting services to strategically plan for CI
 - Lots of education and QI energy in Western NY
 - Working to stabilize Primary Care
 - Board and provider education
 - Studying feasibility for building data infrastructure
 - Stepping up QI best practice efforts
 - Exploring different Care Management opportunities
 - Planning to form new corporate entity if deciding to continue



CI Build Up Efforts Began Early

- Committee Structures had /or were being built - IT and CI/Medical Management
- Integrated registry for analytics and reporting was being built
- HRSA Registry grant project – DM and CVD measures and activities aligned with MSSP
- Medicare Advantage Performance measures were aligned with MSSP
- PCMH assistance underway for first wave of practices
- Meaningful Use assistance for PCP's-REC
- CG-CAHPS Survey by payers in the region
- Care Transition Initiative –hospital to home transition service was launching in June 2012
- Hospitals participating in HEC initiative with state hospital association
- Care Management (CM) Program identified; first wave of nurse just trained
- Depression screening and management built into CM pilot
- Fall screening tool identified



Chautauqua Region Associated Medical Partners (AMP)

- Attended CMS “ACO boot camp” in Nov. 2011
- Formed 1/25/2012- LLC-a subset of the IDS (IPA)
- Joint venture with hospitals and physicians
- Non-exclusive-can choose which contract(s) to par
- Board was formed in March 2012
- Operating Agreement, Participation Agreements, and Compliance Plan were developed, approved, and executed in time for March submission for July cohort
- IDS agreed to loan the start-up capital; no advance payment

Portrait of Chautauqua's Provider Community





AMP Profile

Independent Provider Network

- MSSP participation only
- 7000 beneficiaries
- 8 Independent PCP's-35 physicians
- 3 Independent Hospital Organizations-4 facilities
- 2 Independent SNF Organizations – 3 facilities
- No specialties
- Track 1-upside gain share only
- 3.4% savings target
- No advance payment
- CI infrastructure development was well underway



Projects We are Working on Together

- Increasing data sharing between participants
- Reducing readmissions
- Building Care Management
- Consumer Engagement
- Managing referrals/narrowing referral patterns



Our Plan

Build Patient Centered Medical Homes
and

Revitalize the Medical Neighborhood
To Support Them

Focus: Medicare Beneficiaries



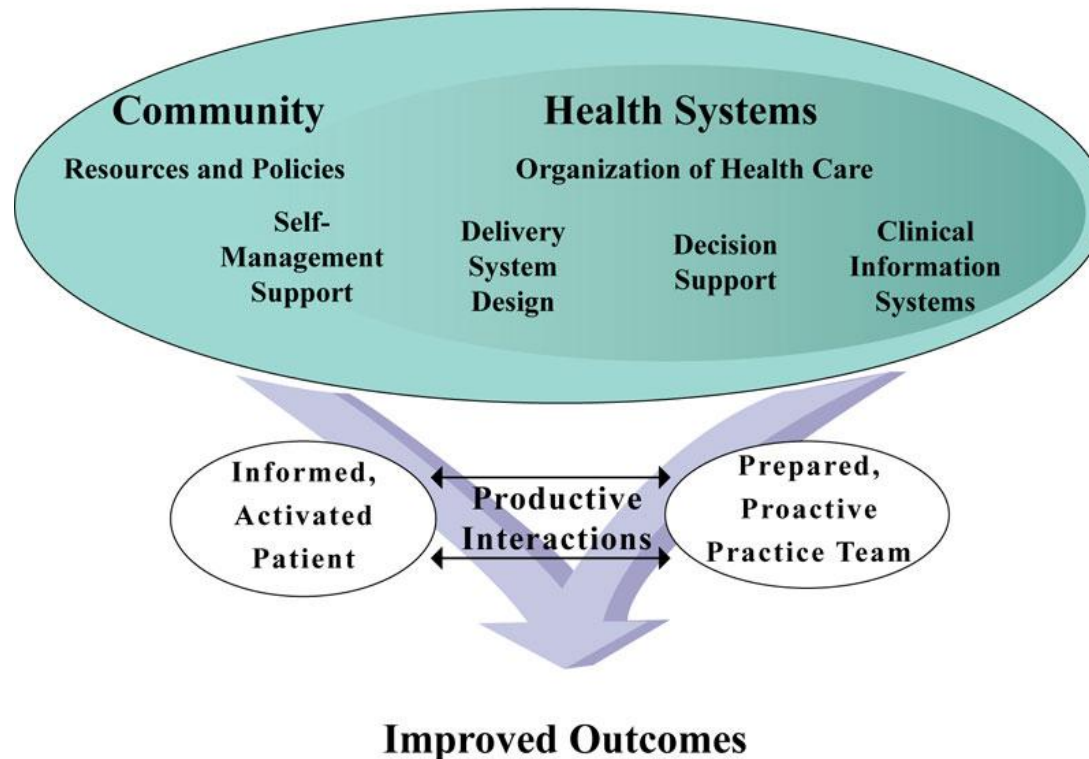
Our CI Strategy

“Chautauqua Health Connects”

1. Patient Centered Medical Home
2. Health Information Exchange
3. Hospital/SNF Care Transitions
4. Patient Engagement

The Blue Print for Medical Neighborhood Revitalization

The Chronic Care Model

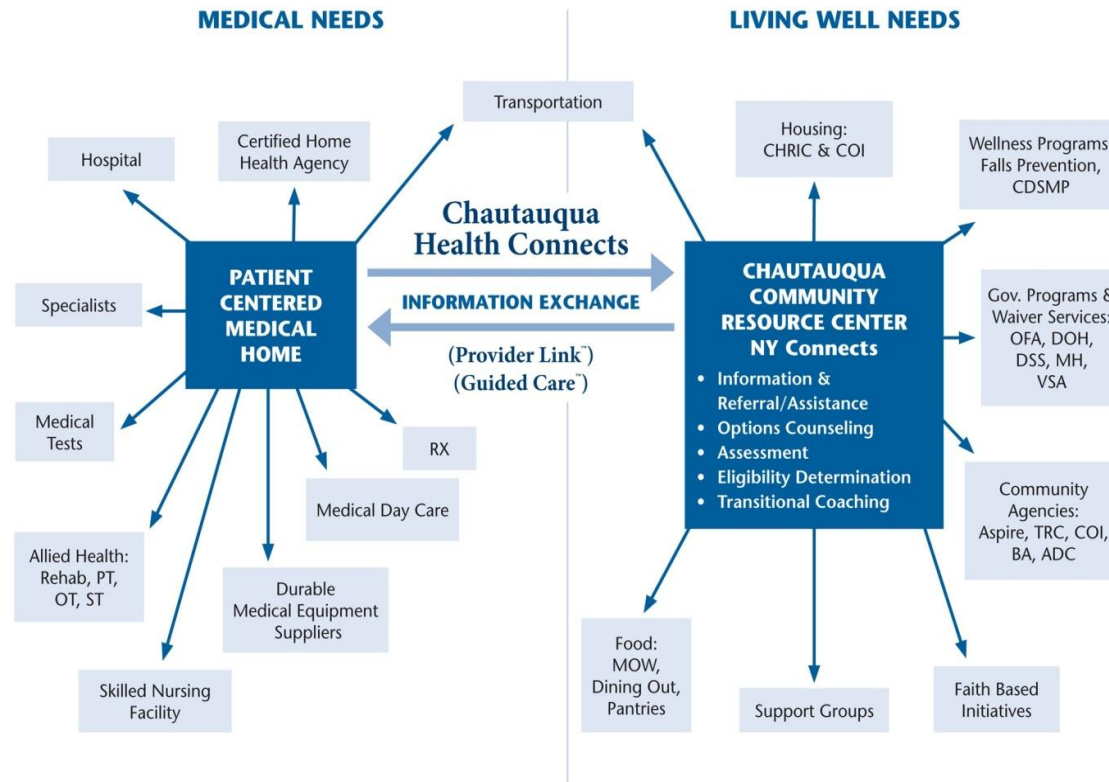


Chautauqua Health Connects

Medical Neighborhood Revitalization

Health Information Exchange

The Chautauqua Model: Maintaining Seniors with Long Term Health Needs





Examples of Challenges

- Working Capital for data and care management infrastructure
- Managing expectations of cost savings
- HIT and data aggregation demands
- MSSP shifts
- Staffing skills and resources
- Network-Participating Providers



Savings Game

One sided Model

Example: MET = \$70M

- MSR= 3.4% to share = \$2.38 M
- Sharing cap = 10% of ACO's Benchmark \$7M
- Target savings range = \$2.4-\$7 M
- Up to 50% return to network = \$1.2M-\$3.5M
- Operating costs: \$1.2 M

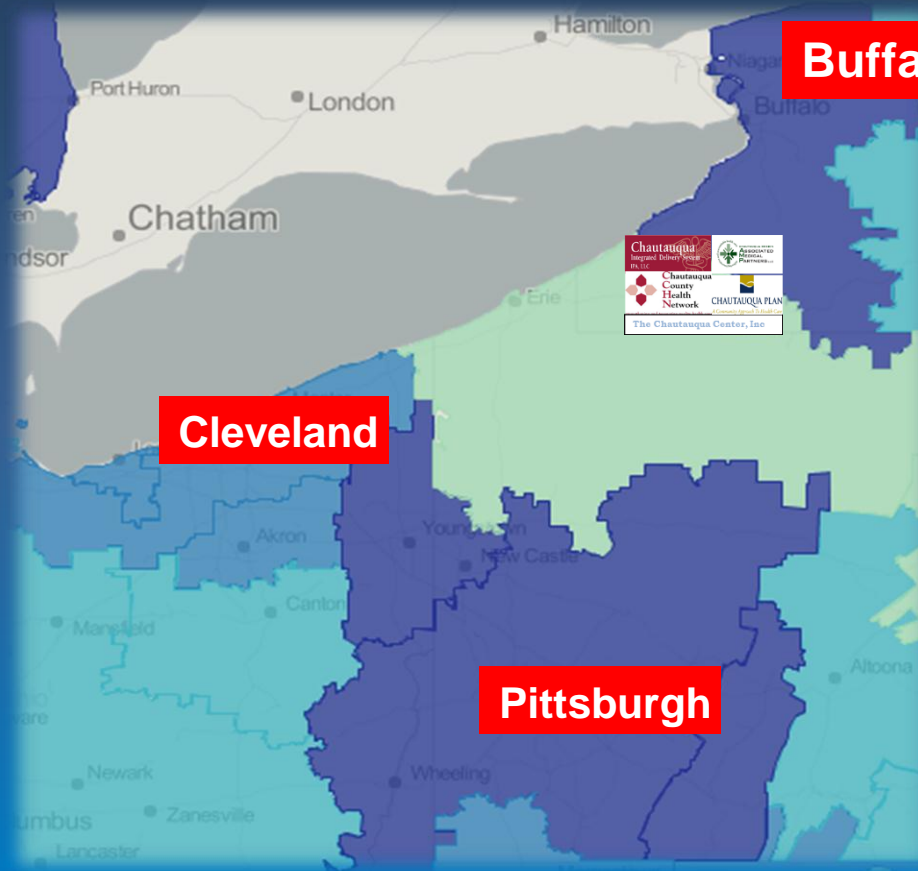
How to pace the savings?

Where will it come from? Where will it go?

How much goes into Risk Reserve and to Re-invest?

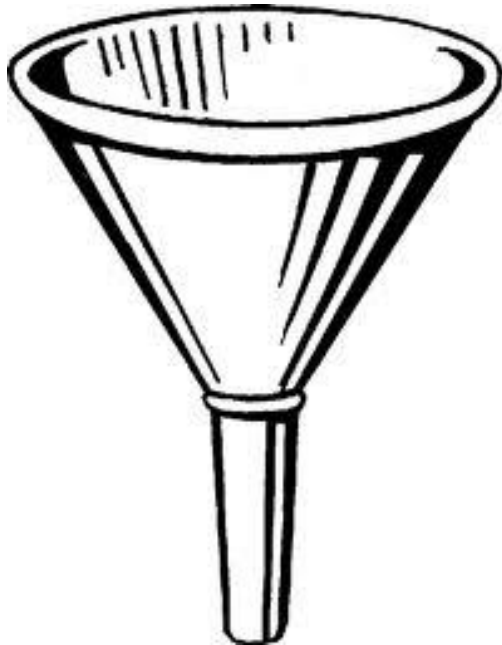
Chautauqua & Direct Affiliates

4 Referral Centers in 3 States, 1 HIE & too Many EHRs

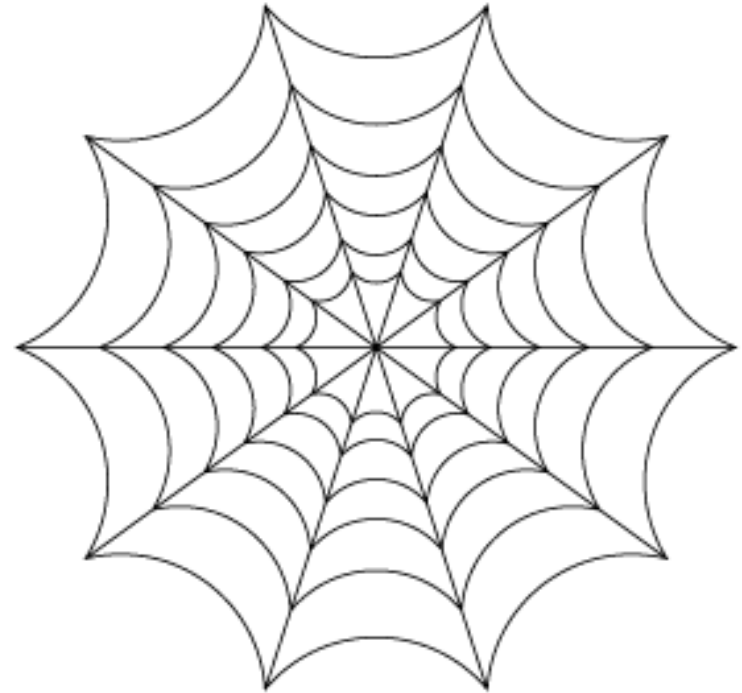


Differing Approaches to Integration

Conventional Wisdom



Chautauqua Health Connects



What's Been Easy (Relatively)

- Size of Network, Relationships, tacit agreement to move forward
- MSSP design was familiar; CI part of our on-going strategy
- Meaningful Use for PCP's-early adopters
- PCMH for some
- NCQA Diabetes Recognition Program
- Clinical Integration Committee

What's Been Difficult



What's Been Difficult

- Managing/pacing so much change at one time
- Concerns from Hospital Members
- Slow implementation/uptake of initiatives
- Logistics
 - Software is not ready anywhere
 - Maintaining census in ACO
 - Focusing on Patient Engagement
 - PQRS/GPRO changes/submission
 - Discrepant formularies, etc.

Who moved my
cheese?





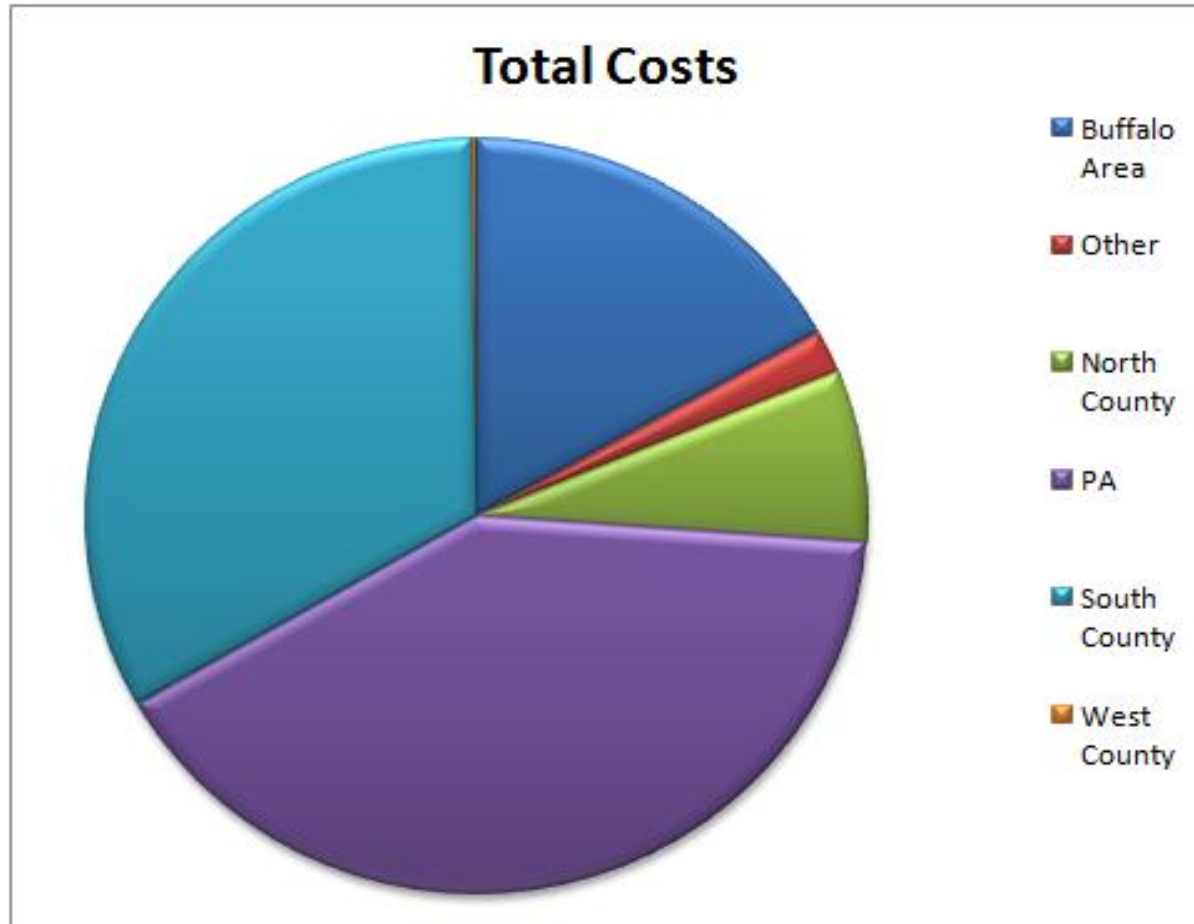
Lessons Learned

- The Learning Curve is long
- It's all about relationships
- Leverage every resource
- Data is essential but doesn't have to be expensive
- No one has this figured out
- Pilot projects are a wonderful thing
- Learning Collaboratives are invaluable
 - EHR User Group
 - Practice Managers meet monthly via WebEx
 - Care Managers meet monthly
 - CI Committee meets quarterly
- Care delivery documentation needs work
- MSSP is logical in design

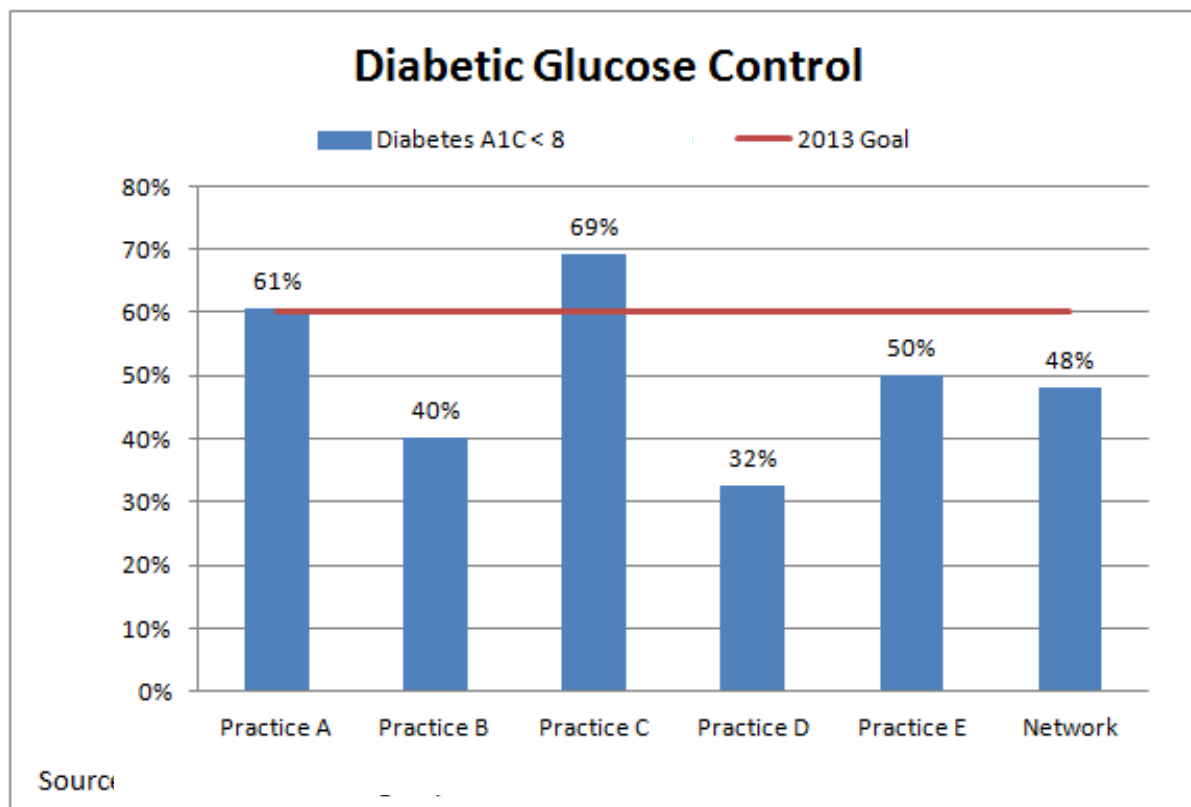
Results So Far

- Still waiting on savings report, CG-CAHPS survey results
- ACO is still a “big idea”
- Not easy or quick--takes time, if ever to achieve
- Don't expect this SSP formula to last long; expect ACO model to last
- Nothing too much different--living in parallel worlds
 - Still having to pursue two different care and financing models
 - Will be positioned for total cost of care models when/if they come
- We know where we are with an idea of where we are going and developing strategies to get there

Sample: Acute Inpatient Utilization Costs for 1 Payer



Sample Working Report – Q3 status





Impact on Community

- Too soon to say if money is saved
- ACO is a definite catalyst to improve clinical care delivery
 - Providers are starting to align
 - Patients are starting to respond
- ED visits avoided, medication reconciliation, home safety, wellness screenings, advance care planning, etc.
- Over 400 eligible discharges to CTI
 - 36% acceptance rate
 - 26% completed home visit
- Promising physician recruitment tool

Thoughts on Roles for Rural Hospitals in ACO

How is your cheese being moved?



- Accept a less dominant role
- Careful management of affiliations and out of area referrals
- Position as Data Source/ Recipient
- Focus on internal QI-HEC, reduce “never” events
- Support seamless care transitions at discharge
- Ensure that specialists and hospitalists communicate with PCP’s
- Chronic Disease Management Services is a large part of the future
- Support for PCMH- perhaps retooling for care management and/or self-management education, esp. behavioral health
- Partner with Physicians and CBO’s in new, collaborative ways, i.e. Community Services Plans (ACA) and *Million Lives Initiative*
- Be open, receptive, and responsive to innovation
- Be a good neighbor
- Other –???

Questions?

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