2017 ACO Summit
How ACO Partnerships Are Improving Patient Care and Accelerating Performance

October 4-5, 2017
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Leveraging ACO Solutions: Big Ideas From the Summit

More than 50 Accountable Care Organizations (ACOs) gathered in Colorado for the 2017 ACO Summit, an annual event convened by UnitedHealthcare to inspire organizations on the journey to value-based health care. Participants exchanged ideas for applying technology and data-driven reporting, better integrating medical and behavioral care, and using their passion to fuel a patient-centered health care system.

This summary highlights experiences and best practices shared by a number of ACO presenters at the summit.

Emerging Themes
During a handful of full-group overview sessions, key themes emerged among attending ACOs:

• **Getting results.** ACO partners report striking progress toward the Triple Aim – better care, better health and lower costs. Working together, ACOs and UnitedHealthcare are implementing projects that address nuances of physical, behavioral and social determinants of health in member populations. (See “High-Performing ACOs” on p. 3.)

• **Building more deeply integrated relationships.** As ACOs gain momentum, they are strengthening relationships, not just with payers, but with other providers throughout the communities they serve. ACOs create an atmosphere where everyone who touches a person’s health – primary care providers, specialists, hospitals, rehab and nursing facilities, therapists and pharmacists – must better coordinate and share information with each other. The result is the creation of genuine communities of health that reach across the entire continuum of care.

• **At the forefront of innovation.** As one attendee commented after a breakout session, “This is groundbreaking stuff.” ACO representatives shared “stealable” strategies, and UnitedHealthcare presented its latest thinking on how to assist care providers with data and information.

Who was there?
The 150 attendees represented:
• 50+ ACOs
• 24 states
• 800,000 UnitedHealthcare members
• $3 billion in medical spend
Leveraging ACO Solutions (continued)

Innovation at Work
On top of introducing a host of new initiatives, participants explored progress that has been made on ideas that emerged from the 2016 Summit. Below are four examples of how UnitedHealthcare acted on feedback to improve and expand its support for ACO partners.

1. **Helping ACOs improve referral management**
Pilot projects are now underway in 32 ACOs comparing quality and efficiency data among specialty care providers who receive referrals from primary physicians. More robust data will enable UnitedHealthcare and its ACO partners to focus on areas of greatest opportunity for improved referral management.

2. **Providing more flexibility and consistency in data integration**
Last year, UnitedHealthcare could evaluate gaps in care only for Medicare ACOs. Today, UnitedHealthcare provides gaps-in-care data for all three lines of business – Medicare, Medicaid and commercial plans. Coming soon: an exciting new way to visualize complete member care records.

3. **Giving ACOs more actionable data**
An app-based ACO savings planner – similar to a retirement planning tool – allows users to run scenarios that identify potential shared savings opportunities based on specific efforts, programs and best practices. It’s available in five markets and will continue to roll out to additional markets.

4. **Promoting continuous learning**
As a way to promote continuous learning and share best practices, UnitedHealthcare has kicked off a series of ACO Summit webinars, featuring topics like “What Are Plan Sponsors Looking for From ACOs?” Look for future invites from the “UHC ACO Summit” mailbox.
High-Performing ACOs: Continuous Improvement and Keys to Success

Palo Alto Medical Foundation (PAMF), part of Sutter Health in northern California, takes a multidisciplinary approach to population health management. The ACO's data-driven method includes managing transitions in care to control costs and improve quality; ramping up behavioral health screening; and expanding pharmacists' role in medication management.

Transition of Care

Transition of care has long been an important marker for quality. Improving access to all levels of care, from primary care through follow-up after being discharged from the hospital, can decrease unnecessary hospital admissions and readmissions, which in turn reduce bed days (and cost). When care providers offer strong follow-up as part of a transition of care strategy, fewer patients return to the hospital.

PAMF’s three-part approach to managing transitions of care centers on:

• **Timely identification**: A daily report lists every admitted ACO member and the admitting hospital. (PAMF does not own hospitals.)

• **Stratification of opportunity**: A limited number of PAMF-employed nurse case managers call higher-risk patients after discharge, based on a risk algorithm. (See another approach in “High-Risk Patient Management Innovations,” p.9.)

• **Appropriate care team**: Most patients receive post-discharge calls from specially trained, medical assistant-level health coaches. Coaches screen (based on Coleman’s four pillars) for red flags that could lead to readmission. If patients have one or more red flags, a nurse can help with tasks like medication reconciliation, obtaining hospital paperwork or arranging primary care physician or specialist visits.

Does it work? PAMF’s bed days – an early indicator of appropriate care – have remained around the Milliman’s commercial “well-managed” benchmark for the past 30 months. The program successfully reduced unnecessary admissions, identified interventions for top ED users and stabilized the readmission rate.

![Graph showing 30-day readmission rate based on follow-up screening, August 2016-June 2017]

**Screened by health coach only**: 3.3%
**Screened positive and follow up with nurse case managers**: 6.9%
**Screened positive; do NOT follow up with nurse case managers**: 9.0%

**Monthly average**: 4.8%
High-Performing ACOs (continued)

Behavioral Health Screening

Responding to self-funded employers who were concerned about employees’ behavioral health needs, PAMF put new measures in place to identify and treat commercial members at risk:

1. Screened members who were identified and accepted outreach using the PHQ (Patient Health Questionnaire) and short GAD (Generalized Anxiety Disorder) scales.
2. Sent “red flag” members to a social worker for more specific PHQ-9 and GAD-7 screenings.
3. Coordinated therapy for those in need.
4. Provided no-charge counseling by PAMF social workers for members who chose not to seek therapy within the network or in the community.

Members whose initial screening indicated a mental health concern showed improvement from May 2016 to July 2017. Average PHQ-9 scores dropped from 13.7 (moderate depression) to 8.9 (mild depression), and GAD-7 scores decreased from 10.8 (moderate anxiety) to 6.2 (mild anxiety).

Pharmacist-Led Medication Management

To maintain the health of patients with complex medication regimens, PAMF pharmacists designed a plan to more proactively manage medications. The goal was for diabetic patients with A1C hemoglobin levels above 9 to achieve better glycemic control.

A collaborative practice agreement gave pharmacists full scope to change dosages and discontinue medications. After six months, patients connected to an ACO pharmacist decreased their A1C from an average of 9.64 to an average of 8.59 – a drop of 1.05. (A healthy A1C level for someone with diabetes ranges from about 7 to 8, according to the American Diabetes Association.) Non-followed patients had a much smaller decrease of 0.32 (not statistically significant).

Key Takeaways

1. **Engage the right expertise at the right time:** PAMF manages most transitions of care with health coaches but escalates to RN case managers as needed.
2. **Look holistically at patient needs:** Putting all the pieces together is key to addressing the whole health picture – and keeping patients healthier and employers happier.
3. **Listen to patients – literally:** PAMF tapped into advice from patients to develop language introducing new approaches to care. The refined language resulted in greater engagement by members and physicians.

“Great financial results can’t be the primary motivation. You’ll engage providers when an initiative is about quality of care and the patient experience.”

– Rick Leary, MD
Palo Alto Medical Foundation
When deciding which specialists or health care facilities to refer patients to, primary care providers typically rely on existing historical relationships and previous experience. That’s not because primary care providers lack interest in exploring alternatives or focusing on cost, utilization and quality when making referrals. Instead, it’s because the information on data-based cost variation often is not readily available.

Recognizing that clinical databases house a plethora of cost and utilization information, Arizona Connected Care (AzCC) began mining that data to identify comparative specialist data, and then focused their referrals to those specialists whose overall treatment patterns aligned with the evidence – or were willing to change their behavior to adapt to their data-driven protocols. As a result, AzCC is able to direct its patients to the highest-performing specialists and facilities that pay attention to quality, cost and utilization – the hallmarks of value-based care.

One of AzCC’s first endeavors using data to identify a high-performing specialty network for referrals started with one of the most common and costly diagnoses for Medicare patients: age-related non-diabetic macular degeneration. A National Institutes of Health study showed no clinical differences between two different medications used to treat macular degeneration given to 1,100 patients. One drug cost $50. The other exceeded $1,500. Switching to the more affordable medication could have saved AzCC $2.3 million over three years, with no difference in patients’ clinical outcome.

Similar research showed significant cost variations – up to threefold – for identical surgical procedures for lumbar fusions and up to sixfold for cataract surgery. (See another approach to using data in “Driving Accountability for Quality and Efficiency” on p. 15.)
Referral Management (continued)

The Power of Persuasion

AzCC’s key challenge was to convince existing and prospective specialty care providers to pause, review the data and change how they treat patients to reflect these best practices. Yet when it invited community specialty providers to learn more, only a handful responded.

Clearly, a different approach was in order. When approaching specialty providers directly didn’t work, AzCC opted to engage primary care providers. To capture the eyes – and the prescribing pads and referral pens – of primary care providers, AzCC developed these tools:

• **Cost and utilization dashboard:** AzCC has begun to transparently report cost and utilization variations. By using a system modeled after CMS quality scoring methodology, AzCC made it easy for its network and potential partners to see how they compared.

• **Narrow network utilization dashboard:** AzCC helped care providers redirect referrals to specialists who have demonstrated that they reduce costs and utilization, which also incented moderate performers to improve.

These efforts are gradually building AzCC’s referral network into a high-performing system. As the pool of qualified specialty providers increased, the organization found that it needed a way to simplify locating these high-performing specialists. A new algorithm that identifies top tiered specialists based on their performance and patients’ unique needs is being integrated into AzCC.

“This effort has resulted in some difficult conversations with our specialty providers but, ultimately, our goal is to help educate them to embrace value-based care,” said Dr. Jeff Selwyn, AzCC’s chief medical officer. “More payers and purchasers are demanding it.”

Key Takeaways

1. **Leverage the power of data:** By mining data, ACOs can identify treatment cost and effectiveness and use that data to guide referrals to those most committed to evidence-based treatment practices. Doing so drives the ACO’s referral network to top performance.

2. **Expect discomfort from care providers:** Change takes time. It’s vital to educate and engage practices on why this is important – especially established physicians.

3. **Provide convincing tools:** To move the needle, ACOs must make it easy for primary care physicians and referral clerks to know which providers they should be referring to and why.
With one in five consumers willing to switch from their current doctor to one who offers video visits, it’s no wonder telehealth has become a priority for a growing number of physician practices.

UnitedHealthcare is working with a handful of high-performing ACOs to make this appealing option a reality, by offering telehealth visits that allow members of UnitedHealthcare commercial plans to visit by video with their personal doctor.

ACOs can do this in part because UnitedHealthcare is expanding its payment practices for telehealth visits. Based on CMS requirements, UnitedHealthcare reimbursement for telehealth historically has been confined to patients located at a CMS-defined Originating Site, such as a hospital or skilled nursing facility. Now, UnitedHealthcare will pay providers for telehealth visits with commercial members who are at their home or workplace. And they will pay for those visits at the same rate as for a bricks-and-mortar office visit.

“It’s not about seeing any doctor,” says UnitedHealthcare’s Anthony Nguyen, MD, senior vice president, Population Health. “It’s about seeing your own doctor. This initiative is a natural extension of our existing ACO partnerships and our shared efforts toward achieving the Triple Aim.”

As of October 2017, five ACOs across the nation offer these kinds of telehealth visits to commercial members in partnership with UnitedHealthcare. Another 60 ACOs are in the planning stages. Among the early adopters are Centura Health, through its Colorado Health Neighborhoods network, and Weill Cornell with its hospital partner, NewYork Presbyterian (NYP).

At the summit, Michael Wolk, MD, senior health policy advisor for Weill Cornell, presented results from his group’s total of 7,200 telehealth visits last year. While he noted that the process can be slow, expensive and challenging, the experience has delivered highly effective practices, including:

- **Nation’s first ED-based telehealth express service**: The bulk of Weill Cornell and NYP’s telehealth visits have been low-acuity ED patients. These patients can opt for a telehealth consultation – available in about 40 minutes rather than waiting hours for ED care. The outcomes are reassuring: Just 1.1 percent of patients had unplanned return visits to the ED.
- **Remote consultation**: NYP partners can review a digital scan from a rural doctor or hospitalist who may not have on-site specialists available, greatly enhancing peer-to-peer consultation capabilities and improving outcomes. Having expert consultation and interpretation has avoided at least two unnecessary surgeries.
- **Building behavioral health availability**: Behavioral health is a clear need – but for too many Weill Cornell patients, a behavioral health appointment came with a wait of up to 120 days. Tapping into a tele-mental health network made 4,000 behavioral health providers available to get patients the care they need, right away.
A Closer Look

Putting Telehealth Into Practice (continued)

Centura is starting small, with a few practices, for low-level acuity visits. Member appointments will begin this winter. Still, the opportunity to add services hasn’t been without its challenges. For those preparing a telehealth launch, Sam Lippolis, telehealth director, Centura Health, offered a few tips from the field:

• **Look beyond promised perfection:** Beware any telehealth technology vendor who tells you that everything will work perfectly. No technology is perfect. What’s important is how the vendor will work with you to resolve issues.

• **Promote a patient test run:** Patients don’t always test the video technology in advance, which means appointments are sometimes canceled. That’s a dissatisfier for both members and providers. Make sure you emphasize that point with members as much as possible, and look to your vendor partner for assistance.

• **Ensure care providers retain control of virtual visits:** Centura has been very deliberate in involving clinicians, recognizing that providers should be the deciders on which members can use telehealth and what conditions they’re comfortable treating through telehealth. In any kind of telemedicine, the comfort level of providers is imperative. If they’re not comfortable, it won’t work.

“Our providers are most interested in and excited about doing the PHQ-9 depression screening virtually,” said Lippolis. And with good reason: Anywhere from 30-50 percent of patients take mood stabilizers, and for those individuals, periodic screening is important. “Doctors believe providing the virtual option will make it easier for their patients while ensuring more get the follow-up care they need.”

The upshot: Better care is the reason care providers are willing to take the risk, Lippolis said. “Anything that is outside the normal workflow will take longer, at least in the beginning. Our doctors don’t actually think telehealth will save them time. It’s more about making it more convenient for patients to seek out the care and advice they need to stay healthier.”

“The decision to see patients virtually can feel like a risk for providers. Providers feel more comfortable about taking this on if they know that payers are behind it and are paying for it. It puts providers at ease, especially when everything you read says providers don’t get paid for virtual health.”

– Sam Lippolis, Centura Health
High-Risk Patient Management Innovations

To reduce costs and improve quality of life for members, ProHEALTH℠ Care, a leading New York-based primary, specialty and urgent care provider, partnered with UnitedHealthcare beginning in 2015 to develop creative solutions for improving care delivery. Using claims data as a guide, the team developed several pilot programs that are seeing real results.

**Tailored Care for Kids and Seniors**

ProHEALTH identified its largest patient groups and developed ways to improve care for these populations – at lower cost. It focused on children and seniors with two programs:

- **“Call First” campaign:** With kids experiencing frequent illness and injuries, parents routinely visit emergency departments. ED utilization and costs are a notable issue for ProHEALTH, with a member population that’s close to 50 percent pediatric. ProHEALTH launched a “Call First” campaign to give parents 24/7 telephone access to pediatricians, who can advise on the best action to take before a member heads to the ED. Because the service has successfully offered convenience and cut costs, ProHEALTH is expanding it to include primary care providers for adult members.

- **Continuous care for snowbirds:** After data showed that 2,000 retired patients spend the winter in Florida, ProHEALTH forged a relationship with MedExpress®, an urgent care provider in the Sunshine State. Now, when ProHEALTH members seek care in their winter home, their PCPs can stay in the loop – thus providing continuous care and better outcomes, no matter the season. Most important, ProHEALTH patients and their care providers can address issues before they escalate.

**Providing Advanced Care at Home**

According to the CMS, the sickest 5 percent of beneficiaries are the most expensive to treat. These members typically are old, frail or disabled, with multiple conditions or inadequate access to care. They also visit EDs and are admitted to hospitals more often.

ProHEALTH set out to develop a home-based advanced illness and palliative care program for high-risk members and their caregivers. It offers:

- 24/7 access to care.
- Team-based care management led by physicians and delivered at home.
- Care coordination (e.g., home health aides, food, transportation).
- Telehealth consultations that connect patients, families and care teams to collectively discuss issues and needs.
High-Risk Patient Management (continued)

The results help persuade busy care providers to get on board. Most primary care providers, after all, are not trained in palliative care – instead, they turn that phase over to experts in end-of-life care. Thanks to palliative care education, ProHEALTH’s providers know it isn’t necessary to wait until hospice is needed to get palliative help for patients and their caregivers. Instead, by identifying the highest-risk members, doctors and payers can help people receive the care they want, how they want it – improving quality and satisfaction while keeping a check on costs.

“Today’s health care system fails people with chronic conditions. Patients and their families suffer as a result.” – Dana Lustbader, MD, ProHEALTH Care

Key Takeaways

1. **Don’t wait until patients are in trouble:** Proactively mine claims data to identify high-risk patients. Look for markers of frailty or functional decline (e.g., two admits in the last six months, comorbidity, in-home oxygen use, the ordering of a hospital bed).

2. **Better care and lower costs can go hand in hand:** It’s crucial to offer 24/7 access to care and caregiver support. ProHEALTH has found that patients with solid palliative care at home spend three times as long in hospice care. That’s a good thing, because hospice care is a setting typically preferred by patients and is more affordable than hospitalization – saving $12,000 per patient.

3. **Ask tough questions:** Ask PCPs this key question, “Would you be surprised if this patient died in a year?” If not, the member may be a good candidate for palliative care, with a plan to transition to hospice care if circumstances change and end of life becomes more imminent.

Since implementing advanced home care, patient and caregiver satisfaction have risen dramatically at ProHEALTH. Other results:

- **$12K**
  Reduction in health care costs per patient during the final three months of life.

- **34%**
  Reduction in hospital admissions in the final month of life.

- **35%**
  Increase in hospice enrollment.

- **240%**
  Extension of the median hospice length of stay.

- **87%**
  Patients died at home vs. in a hospital, as they preferred to do.
Across New Mexico, Presbyterian Medical Services (PMS) provides primary medical, dental, behavioral health, home, and hospice care, as well as early childhood education and senior programs. PMS has 50 federally qualified health centers, including a Farmington health center that offers traditional Native American healing techniques.

In this complex setting, integrated care means collaborating to identify patient needs and creating the best individual care plans.

“Today’s health care consumers want fast, user-friendly, easy-to-use and expedient health care – and that includes our underserved populations,” said Vice President of Clinical Affairs David Gonzales, MD. “Integrated health services help us achieve that.”

Getting a full picture of patients’ needs up-front is the surest way to embark on a coordinated care pathway. To that end, PMS assesses patients one-on-one with a care coordinator. Medicaid members at highest risk – most often, those with a comorbidity, which may be behavioral – may have an in-home comprehensive needs assessment to provide a full picture of the social setting.

PMS uses two types of care coordinators embedded in its clinics – community health workers and care coordinators (CCs) – to provide in-person assessment. Where a clinic doesn’t have a complete team embedded, care providers use instant messaging and shared EMRs to stay in touch with each other. (For a contrasting experience on embedded CCs, see Member Engagement, p. 13.) Two consulting pharmacists are available via videoconference to address questions or medication management issues from care providers or patients.

A Personalized Approach for Better Results

Once patients engage with a clinic, PMS emphasizes patient-centered team care and trackable measures to help care providers stay up-to-date on their patient panel.

Primary and behavioral health providers use collaborative care plans, including a pre-visit planning report tied to the appointment scheduling program. These tools help care teams identify gaps in care, whether medical, dental or behavioral.

Care providers specifically target objectives such as depression and cholesterol screening. To keep care meaningful to patients, practices track personal and clinical goals. If a person isn’t improving as anticipated, practices reach out and modify treatments.
Behavioral Health Integration (continued)

True integrated care lines up with the Triple Aim. PMS results include:

- **3 percent no-show rate** for UnitedHealthcare Medicaid members – a remarkable feat in a time when the average practice may have a no-show rate of around 12 percent, with some experiencing up to a 50 percent rate. Providers may entice members with a promise of a hot cup of coffee when the member comes to meet the new provider. PMS teams have “taken an oath” to get members into a clinic within seven days. In addition to the Medicaid transportation benefit, PMS is looking into ride-sharing to expand transportation.

- **4 percent reduction in avoidable ED visits.** CCs proactively contact patients and let them know care providers are available. Care teams also evaluate causes for ED visits holistically. If a community sees many unnecessary ED visits in the evening, an evening clinic may be needed.

- **14 percent decrease in inpatient admissions,** thanks to aggressive risk stratification. Care coordinators watch a smaller number of high-risk patients so they can manage them effectively. CCs verify that patients have what they need, from their daily medications or a hospital bed to relieve pressure from bedsores, to knowing how to use a peak-flow meter.

**“Why do we do this? Because when you have an integrated health program, it boils down to one thing, and that’s the patient experience.”**

– David A. Gonzales, MD
Presbyterian Medical Services

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**Key Takeaways**

1. **Patient-centered care requires focus:** A daily huddle allows teams to identify needs and schedule prompt follow-up.

2. **Get real answers to real-life questions:** True integrated care requires asking about living conditions, nutrition, mental and behavioral health, medications and social relationships. For the most truthful answers, allow people to answer the questionnaire privately, in the clinic, with answers flowing directly into the EMR.

3. **The power of a warm handoff:** PMS care providers personally introduce patients to other providers of all disciplines. Where in-person introductions aren’t possible, PMS uses a telehealth handoff.

4. **Shared practice space is vital:** The Farmington, NM, clinic includes 36 exam rooms, 10 dental suites and five behavioral health rooms, plus a common space where all providers can interact. In this “bullpen,” providers share information, review patient cases together and hold morning huddles at long, shared tables.
Arguably, it’s never easy to make the initial transition to an ACO. Provider practices may be wary it will require additional red tape and paperwork, while patients may worry that a change could disrupt their connection with a beloved doctor or nurse practitioner. Florida-based Orlando Health has seen success by leveraging the strengths of an ACO – centralized data, powerful mid-level provider support and coding expertise – to engage patients and care providers alike and create a better experience for everyone.

**Engagement Using Centralized Coordination**

Orlando Health’s key to healthy outcomes and creating a stronger bond among doctors, the ACO and patients includes:

- Defining the member population and finding ways to serve them and physicians.
- Stratifying the population to determine who needs the most care.
- Identifying gaps in care.
- Measuring outcomes to hit targets and improve care.

In contrast to Presbyterian Medical Services (see p. 11), Orlando Health found that care coordinators (CCs) embedded in its clinics weren’t effective. In the hospital setting, CCs too often were called to replace nurses who were out and, soon, nurses were no longer operating at the top of their licensure – a key to a productive ACO.

Instead, Orlando Health created a centralized department staffed with RNs, medical assistant-level providers, quality team members and medical risk adjustment coders. This team supports:

- **Population health management registry**: Automated outreach reminds patients about preventive screenings, vaccinations and upcoming appointments.

- **Transitions of care**: After hospital discharge, patients receive a call within 48 hours. A follow-up call in two weeks usually finds commercial members back at work. Medicare members sometimes need more help. CCs can help them transition back to the PCP for follow-up.

- **Chronic care management**: With monthly outreach calls, CCs help patients focus on health goals, such as diabetes care. They provide education, counseling and access to support between office visits.

- **Lifestyle management coaching**: CCs contact patients about tobacco cessation, weight management and stress management – and work to get patients into the physician’s office to improve their health status.

**Member Engagement and Staff Incentives**

Suzanne Gruszka, RN
Vice President, Care Coordination Services Administration, Orlando Health
Too Much Paperwork: Barriers to Physician Buy-In

Physicians were initially reluctant to commit to the ACO concept because they wanted to focus on care, not coding. Payers’ different metrics complicated reimbursement and obscured the value in value-based care.

In response, Orlando Health streamlined processes so that physicians could focus on their mission of care. The organization focused outcomes measures on common metrics that stretched across payers and member populations – essentially extending population health techniques to the entire population regardless of payer.

Additionally, the ACO provided support with workflows, such as helping medical assistants and other care team members work at the top of their licensure. This tactic helped physicians be more productive while keeping member care front and center.

Finally, Orlando Health supported practices in earning recognition as a patient-centered medical home or patient-centered specialty practice. These designations require improved health outcomes that lead to greater shared savings.

Did it work? The ACO and physicians have generated shared savings of more than $59 million in just a few years. Mid-level providers soon will have their own shared-savings program. Most importantly, with shared quality metrics, everyone’s on the same team and accountable to the same results. “Money isn’t really the driver,” Gruszka said. “Instead, our shared purpose is improving the health of the population and community we serve.”

Key Takeaways

1. **Eliminate waste:** Coding teams, each assigned to a physician group, physically go to medical offices to observe and evaluate – and provide recommendations for accurate coding that can make the billing process more efficient and ensure risk factors are incorporated appropriately. Still, physicians remain the ultimate decision-makers.

2. **Drive improvement through transparency:** On a monthly or quarterly basis, use concrete, specific examples to present coding opportunities and trends to practice staff. Nothing is more persuasive than seeing your own practice’s missed opportunities for care – and revenue.

3. **Graduate patients from chronic care management:** People who enter chronic care management don’t need to stay there forever. Keep care at the right level by “graduating” those who reach personal goals from the care management program. (Orlando Health marks the moment with a personalized card signed by the care team.) Patients who simply need less monitoring can transition to lower-level care – for instance, a less-frequent check-in from a coach rather than a nurse.

4. **Reward gains:** Providing staff incentives when quality or process metrics are met for care management teams can help motivate staff.
How do you ensure your providers are truly accountable for quality and cost effectiveness? If you’re Baylor Scott & White (Quality Alliance), you keep it simple. You narrow the focus so it’s razor sharp in support of your overall strategy. Then you arm providers with all the information and data they need to make changes and adjustments. Finally, you create a process to bring low performers up to speed – or eventually guide them out of the network as a last resort.

The Quality Alliance is an accountable care organization in north and central Texas with more than 5,000 primary and specialty providers practicing within a mix of employed and independent arrangements. It revamped its accountability approach in 2016 when leaders determined they could be more effective by sharpening their focus. “We needed to focus on what can drive true change,” said Trent Hadley, manager of healthcare economics for the Quality Alliance.

The result is a “best care” approach that drives clinical quality and efficiency performance. As a first step, physician leaders culled the considerable list of performance measures from payers and employers to a list of 21 focus measures that they believed would have the greatest impact on quality and utilization.

Underpinning this is data. “It all starts with data; meaningful and actionable data,” says Hadley.

The Quality Alliance’s in-house data warehouse stores and analyzes patient and claims information for 900,000 patients from payers, employers and electronic medical records. (See another take on data in “Referral Management,” p. 5.) The data forms the baseline for goals and thresholds for each focus measure. Quality Alliance analysts take into account differences in patient population among providers. In general, 3 percent improvement per year is a reasonable goal. Leaders also establish a minimum performance threshold for each measure.

### Baylor Scott & White Quality Alliance Focus Measures

**Utilization Measures**
- Global $ network utilization
- % participating labs and imaging
- ED/1,000
- Avoidable ED/1,000 Visits (NYU)
- 12-month continuous member risk adjustment factor (RAF)
- Lab/1,000
- Imaging/1,000
- Admits/1,000
- Avoidable admits/1,000
- All cause 30-day readmissions

**Quality Measures**
- Annual Medicare wellness visits
- Well child visits age 3-6
- Adolescent well visits
- Hypertension: Blood pressure control
- Diabetes management: A1C good control
- Diabetes management: Eye exam
- Statin adherence
- Colorectal cancer screening
- Breast cancer screening
- Osteoporosis management
Driving Accountability (continued)

A comprehensive dashboard gives care providers a clear picture of where they stand. Developed in-house, the dashboard presents an easy view of each provider’s patient panel – with the ability to drill down for additional detail on each individual patient – and their progress on utilization and quality measures. Providers also can use the dashboard to see action items for improvement, as well as tip sheets with additional information on focus measures.

Utilization Measures

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<th>Measure</th>
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<th>Goal</th>
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<tbody>
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<td>19.8%</td>
<td>13.2%</td>
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<td>Admissions/1000</td>
<td>CMLC</td>
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<td>Available Admissions/1000</td>
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<td>Available ED Visits/1000</td>
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Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Your Rate</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidant WellCare Visits</td>
<td>100.5%</td>
<td>54.0%</td>
</tr>
<tr>
<td>Annual Medicare Wellness Visits</td>
<td>CMLC</td>
<td>63.0%</td>
</tr>
<tr>
<td>Annual Preventive Care (RPC)</td>
<td>CMLC</td>
<td>54.0%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>CMLC</td>
<td>79.4%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>CMLC</td>
<td>79.4%</td>
</tr>
<tr>
<td>Diabetes Eye Exam</td>
<td>CMLC</td>
<td>6.67</td>
</tr>
<tr>
<td>Hemoglobin A1c Control</td>
<td>CMLC</td>
<td>6.67</td>
</tr>
<tr>
<td>Maini Therapy CVD</td>
<td>CMLC</td>
<td>6.67</td>
</tr>
</tbody>
</table>

Strategic communications further reinforce the importance of focus measures, including a web page that offers links to helpful hints and patient brochures.

Finally, the Quality Alliance uses an established process and schedule to engage providers in improvement. The level of improvement needed dictates the level of review, which can include outreach by mail or email, or meetings with a Quality Alliance network field director or medical director. Providers who don’t make necessary improvements may be asked to leave the network.

While the Quality Alliance’s accountability approach is still fairly new, initial results are promising, though adoption has room for improvement. “The dashboard and other tools are pretty incredible,” said Watson. “Our next challenge is to really get the doctors to understand it and use it.”

Key Takeaways

① **Concentrate efforts:** From the multitude of CMS, employer and payer quality metrics, select measures that have the greatest potential to impact health outcomes and contract performance measures for your patient population.

② **Focus the provider:** Give providers data and information in an easy-to-understand-and-use format. Equipped with these tools, they can make changes in their own practice and help their patients make changes, too.

③ **Follow through:** Have a concrete plan for working with the provider to improve performance – and use it.