The Association of American Medical Colleges and the Brookings Institution Engelberg Center for Health Care Reform
Present:

The Pioneer Experience: Panel Session

Monday, March 26, 2012
Miami, Florida
Council of Teaching Hospitals 2012 Spring Meeting
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Background

In December 2011, the Center for Medicare and Medicaid Innovation (CMMI) announced that 32 medical care-treatment organizations would be part of the Pioneer Accountable Care Organization (ACO) Model set to begin January 1, 2012. Out of these 32 organizations, 12 are Association of American Medical College (AAMC) member institutions. The AAMC and Brookings Engelberg Center for Healthcare Reform worked together to conduct interviews and prepare a series of briefings focused on how these member institutions are implementing the new model of care, delving into how they designed their pilot programs.

The CMMI Pioneer ACO Model application process was comprehensive and highly competitive. All organizations that were selected had prior experience in managing the health of populations, and most had experience in accepting some level of financial risk for performance based on both cost and quality targets. The AAMC and the Engelberg Center for Health Care Reform at the Brookings Institution prepared these briefings to learn about AAMC member organizations’ paths to participating in the model and their up-to-date observations regarding this pioneer endeavor.

Pioneer ACO Model Distinguishing Characteristics

- The Pioneer ACO Model allows for a prospective attribution methodology based on outpatient primary care (evaluation/management) visits to PCPs and select specialists.
  - Pioneer participants will receive three years worth of historical claims data on attributed patients, plus monthly enrollment and unaudited claims data going forward.
- Eventually, the Pioneer ACO will involve downside risk as well as upside risk.
  - “The initiative will test the effectiveness of several innovative payment models and how they can help experienced organizations to provide better care for beneficiaries, work in coordination with private payers, and reduce Medicare cost growth.”
- Beneficiaries retain the ability for patients to seek care from any Medicare provider they wish.

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The AAMC authored these briefings in collaboration with the Brookings Institution.

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Sources

This briefing is based on an interview with Brian Rice, Vice President of Network/ACO Integration at Allina Hospitals and Clinics (Allina). Additional information was included from Allina’s CMMI Pioneer ACO application, and the CMMI website.

Institution Facts

The Organization

Allina is the largest not-for-profit, integrated health care organization in its region, serving the Twin Cities and western Wisconsin (WI) communities. Allina was formed in 1994 as a result of mergers and acquisitions of clinics and practices in rural and urban areas of the Twin Cities throughout the 1990s. It owns and operates 11 hospitals, more than 90 clinics, specialty care centers, and specialty medical services that provide a full range of integrated primary, secondary and tertiary medical services, hospice care, home care, oxygen and home medical equipment, pharmacies, and emergency medical transportation services.

Allina employs over 1200 physicians, including over 800 primary care physicians and nearly 300 advanced practice providers. These practitioners provide care in about 60 geographically distributed clinics in more than 40 communities throughout Minnesota (MN) and western WI.

Allina’s leaders recognized the emerging trend toward payment for value and performance early on, launching a new strategic plan (Allina 2.0) in 2009. The plan’s aim was to provide the highest quality of care and experience at the lowest appropriate cost to the community, while working with both the 1200 employed physicians and with the affiliated independent providers. Allina wanted to test and learn from programs similar to an ACO and to begin aligning the incentives of all participants accordingly.

Market Share

Allina maintains the leading hospital market share in the Twin Cities area that is comprised of 11 counties, with just over 30% inpatient discharges through Q3 2011.

Pathway to Becoming a Pioneer ACO

Allina leveraged its existing infrastructure and community partnerships to develop an advanced internal capacity to manage population health, quality and cost effectiveness. Allina’s participation in the Northwest Alliance Demonstration project further prepared it to participate in the Pioneer ACO.

Existing Partnerships

The Physician Leadership Policy Forum

A partnership of chief clinical leaders at Allina, who work on strategic issues such as decreasing unwarranted variation in care and the community standards for ethical policies with pharmaceutical and medical device vendors.
Senior Care Transitions

A partnership between Allina and long-term care facilities in the metropolitan area to assure seamless care services.

AgeWell Services

A partnership between Allina and a social service network to fulfill senior life style needs, care needs, maintain a help desk for care and a social support navigation for Allina’s patients.

Lifetime Fitness

A partnership to facilitate health and fitness of Allina’s employees through functional health assessments, health coaching, and physical fitness.

CVS MinuteClinics

A formal partnership between Allina and CVS Pharmacy, offering convenient alternative sites for preventive services, disease management and urgent care to better serve the needs of Allina’s patients and avoid unnecessary use of emergency room services.

Regional Commercial Health Plans

Allina also collaborates with regional commercial health plans, such as Blue Cross/Blue Shield, Medica and Health Partners, formally reviewing performance and setting goals to support the development of care pilots, infrastructure investment and other capacities needed to evaluate and improve quality of care for patients. Recent collaborative efforts are focusing on chronic illness and prevention measures.

Previous Demos/Initiatives

Northwest Alliance Demonstration Project

The Northwest Alliance is a 7-year affiliation arranged between Allina and Health Partners, a competing community care system and health plan. Its aim is to work collaboratively to deliver the “triple aim” of improved health, better care and lower costs to over 300,000 patients in the northwest suburbs of the Twin Cities.

Application to Become a Pioneer ACO Program

Allina utilized its care management strategies from prior demos and partnerships to apply to become part of the Pioneer ACO. Allina had a robust primary care system already in place, and a large number of specialty physicians working toward advancing integration with primary care providers.

Allina initially selected 200 primary care physicians (in 3 counties) for their Pioneer ACO application. CMS attributed 13,500 Fee-for-Service (FFS) beneficiaries to Allina’s providers.
Governance

Allina’s current Board of Directors (Board), which oversees all integrated operations throughout the health system, also serves as the Pioneer ACO Board. The Board is responsible for developing policies and infrastructure to promote evidence-based medicine and patient engagement, for reporting on quality and cost measures, and for coordinating care. Allina’s Board is structured to provide attentive, innovative and effective governance leadership at all levels.

Care Coordination

Clinician Engagement

Allina established the Allina Integrated Medical Network (AIMN), which is a physician-lead organization that engages Allina’s employed and independent physicians in improving performance. AIMN facilitates clinical integration and alignment to deliver market-leading quality and efficiency in patient care.

The development and growth in pay-for-performance payment models, shared-savings arrangements, patient-centered medical homes, commercial ACOs and now the Medicare Pioneer ACOs (Allina, Fairview, and Park Nicollet) has provided the opportunity to engage all of Allina’s physicians in the rapidly changing medical marketplace. Future clinician engagement goals are to further involve nurses, pharmacists, and social workers.

Patient Engagement

All patients enter Allina’s health system by choosing a PCP as their first point of contact. Patient care is delivered using a team-based approach. Through clearly defined roles, clinical and non-clinical members meet regularly to establish standing orders, assign and train care team members (physician assistants, nurse practitioners, PCPs and social workers) and coordinate care for individual patients.

Advanced Care Teams consisting of nurses, pharmacists, social workers, and college educated “care guides” are available to the primary care offices for particularly complex patients with both medical and psycho-social needs. Patient “navigators” are obtainable for certain patients, such as those requiring complex cancer care.

Patients are encouraged to develop relationships with their PCPs, and they are given access to medical records through MyChart which provides online scheduling, medical records, test results, after-visit summaries and clinical knowledge. A patient portal enables patients to complete health assessments, track outcomes, and obtain health information. There are over 200,000 active users.

Allina has established a robust Patient Advisory Committee (PAC) infrastructure, made up of 6 PACs, which engage over 75 patients and that reports to the Board. A PAC feeds ‘the voice of the patient’ to the Quality Committee and to Allina’s Clinical Service Lines. For example, a PAC
guides MyChart and patient portal enhancements. The PACs include an Allina-wide PAC, Breast Program PAC, Pregnancy Care PAC and a Depression PAC.

**Information Technology**

Allina has invested heavily in developing and deploying a robust clinical information system throughout its hospitals, clinics and offices. Allina’s system, designed by Epic, collects a wealth of clinical data that allows for rapid identification of costly patients with complex needs. A linked Data Warehouse offers predictive modeling, which will enable clinicians to proactively manage patients.

Allina uses the Excellian EHR (Epic product). Excellian provides one record for each patient, who has access to individual information through MyChart. Allina offers an extensive EHR training program to clinical staff. Allina has hosted site visits for more than a decade and has developed internal expertise on harnessing clinical data that is sufficient to demonstrate sustained quality improvement.

Excellian enables Allina to exchange information with external organizations to enhance care. Also, Allina participates in a peer information exchange with other MN EPIC customers and is able to exchange Continuity of Care Documents with other integrated networks or ACO partners.

**Key Observations Reported**

- **Timely data and useful performance measures**
  - CMS targeted March 2012 for supplying Pioneer ACOs with patient claims data; however, Allina leveraged its already available EHR data to identify its initial priority areas. The plan is to eventually integrate the CMS data with the existing EHR data to further analyze clinical opportunities for improvement and to understand the key cost drivers.
  - Allina is interested in the admission and treatment patterns for patients seeking care outside of Allina--there is an anticipated “snow bird” contingent of many MN and western WI residents who head South for the winter.

- **Balancing the Transition**
  - Allina is facing the challenge of utilizing both the FFS and the ACO value-based reimbursement models. While attempting to leverage strategies of both models that harmonize the program, difficulty presents itself in aligning incentives for providers in light of the long history of volume-based FFS reimbursement is challenging. A ‘tipping-point’ is on the horizon.

- **Gaining patient support**
  - Patient engagement is improving, but there are still gaps in patients’ understanding. Some patients are not completely clear about: what it means to participate in an ACO model, their role in maintaining compliance with care plans, and accessing new support services.

- **Learning what works and providing timely feedback for policy changes/enforcements with CMS**
  - “CMS has been a collaborative partner, active listener and engaged to support the success of all Pioneer ACO participants.”
  - “Recognize that all parties are learning as the Pioneer model unfolds and thus need to support constructive feedback and dialogue to enhance the program.”
○ “The shared learning infrastructure being implemented should prove a valuable resource for Pioneers and CMS to advance progress in a timely manner.”
○ “Predictive modeling tools will prove valuable in identifying at risk patients for focused engagement with the necessary resources, such as care management.”
Dartmouth-Hitchcock ACO
Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic

Sources

This briefing is based on an interview with Barbara Walters, DO, MBA, Senior Medical Director for Dartmouth-Hitchcock’s Southern New Hampshire Community Group Practices, and Lynn Guillette, FHFMA, CPA, Director of Contracting at Dartmouth-Hitchcock. Additional information was included from the CMMI website.

Institution Facts

The Organization

The Dartmouth-Hitchcock ACO (DH) is an integrated health care delivery system comprising Mary Hitchcock Memorial Hospital (MHMH) and Dartmouth-Hitchcock Clinic (DHC). DH developed an ACO model with a distributed network of primary care providers at its core, of which a minority practices at the Dartmouth-Hitchcock Medical Center (DHMC). DH employs 1100 physicians, 600 at the MHMH and 400-500 in primary care physician practices throughout the state. The extensive clinical network, combined with historical roots in the Mayo Clinic traditions of physician leadership and representative governance, has allowed DH to develop a population-based, patient-centered clinical focus.

Market Share

Dartmouth-Hitchcock’s primary care network represents about 35 percent of primary care providers in the state of New Hampshire. In addition, 40 percent of DHMC patients are Vermont residents.

Pathway to becoming a Pioneer ACO

DH previously participated in both the CMS Physician Group Practice Demonstration Project (PGP) and the Transition Demonstration Project. Partaking in the Pioneer ACO will continue DH's commitment to population health management, utilizing an already established Primary Care Medical Home Practice Model throughout its organization. Concurrently, DH is working to develop supportive data and clinical information systems in collaboration with other healthcare organizations to create more value for the population it serves.

Previous Demos/Initiatives

PGP Demonstration Project

The PGP demonstration project was the first pay-for-performance initiative for physicians under the Medicare program. It created incentives for physician groups to coordinate the overall care delivered to Medicare patients, rewarded them for improving the quality and cost efficiency of health care services, and developed a framework to collaborate with providers to the advantage
of Medicare beneficiaries. DH was one of 10 groups selected on a competitive basis to participate in the PGP demonstration project.

In the course of its participation, DH developed a culture of accountable care, focusing on improving quality of care while reducing costs through implementation of evidence-based care initiatives. DH was one of four groups to earn a $13.8 million pay-for-performance incentive for physicians under Medicare. This experience prepared DH well for the Pioneer ACO Model.

**Application to Become a Pioneer ACO Program**

DH is the parent corporation of MHMH and DHC and, therefore, the signatory Pioneer ACO applicant. DH leveraged its patient-centered infrastructure emerging for the past 8 years to build-up its internal capacity to manage population health, quality and cost effectiveness that is required to successfully participate in the Pioneer ACO Model. DH’s patient centered infrastructure includes the development of best practice guidelines, a network of level III NCQA PCHMs, EMR systems, a data warehouse and patient registries, transforming the role of nurses into health coaches and care coordinators, anchor specialists, and establishment of programs to improve care coordination and care transitions.

**Governance**

The existing governance structure of DH was sufficient to meet the Pioneer ACO Model requirements; two existing DH trustees were designated as a consumer advocate representatives as well as a Medicare beneficiary who received care within the DH system.

**Care Coordination**

**Clinician Engagement**

DH started to organize itself to take care of populations instead of just individual patients 8 years ago, setting various precedents early on in their CMS participation programs that included making clinical decisions that engaged physicians. Having laid this groundwork for clinical engagement, DH found that the Pioneer ACO was an easy sell to physicians for whom it would make it only easier to do what they already wanted to do.

At DH, primary care physicians and high-volume specialists --such as orthopedics, cardiologists, oncologists, and hospitalists--drive the Pioneer ACO. Other key specialists need to be increasingly engaged, but as is, this model works exceedingly well for PCP’s and the high-volume specialists.

**Patient Engagement**

As part of the ACO model, only DH patients were included. This is to ensure that all patients can be engaged in DH’s patient-centered medical homes and that they participate in shared decision making at all important points of their care. DH is seeking to make further strides in coordinated care efforts to engage patients.

All Pioneer providers were required to notify Medicare beneficiaries of DH’s participation in the
Pioneer ACO. These Medicare beneficiaries were given an opportunity to ‘opt out’ of data information sharing.

Key Observations Reported

- **Timely data and useful performance measures**
  - The more complete patient data will give Dartmouth a much more comprehensive picture on outside providers from which their attributed patients are seeking care. This knowledge will allow DH to adjust its business strategy and to selectively reach out and collaborate with institutions with which it shares patients.

- **Gaining patient support**
  - DH leadership indicated that Pioneer ACO participants have formed an action committee to address patient engagement (‘opting out’) and will be working with CMS to facilitate more effective patient engagement tools and mechanisms.

- **Learning what works and providing timely feedback for policy changes/enforcements to CMS**
  - DH is looking to invest in varying types of administrative and clinical infrastructures to further improve their care delivery. Notably, DH’s investment goals have changed from the initial development seven years ago, evolving from the focus on developing care coordination and data analytics to the current interest in providing more innovative types of care to its Medicare beneficiaries. Such innovative type of care includes a mobile palliative care expert team and deploying more health care providers “in the field” to provide care in a beneficiary’s home or other community setting.
Fairview Health Services

Source:

This briefing is based on interviews with Mark Werner, MD, Chief Clinical Integration Officer, and Paula Phillippe, Senior Vice President of Integrated Network and Payer Solutions, Chief Human Resources Officer, at Fairview Health System, as well as Amy Harris, Director of Communications at Minnesota Hospital Association. Additional information was included from the CMMI website and the Fairview news release titled, *Fairview named one of 32 Pioneer ACOs by CMS* (Dec. 19, 2011).

Institution Facts

The Organization

Fairview Health Services is a not-for-profit health care system based in Minneapolis that provides care in partnership with the University of Minnesota. Fairview operates 40-plus primary care clinics, a wide range of specialty service clinics, as well as home care and senior services. Fairview owns 7 hospitals, including the University of Minnesota Medical Center, Fairview.

Fairview’s large integrated medical practice includes more than 700 Fairview-employed physicians (Fairview Medical Group) and more than 700 affiliated academic physicians within University of Minnesota Physicians (Faculty Practice). Fairview also works closely with Fairview Physician Associates, a network of 630 closely aligned independent physicians. The development of the ACO and the application for the Pioneer Program stems from work done over the last several years and in particular, the last 24 months.

Pathway to Becoming a Pioneer ACO Program

Application to Become an ACO

The foundation for the development of the ACO began after an internal evaluation of capacity to engage in care transformations that would promote accountability, quality, and coordination. Mini “care innovation pilots” at local-owned clinics with employed physicians were able to see real gains in care quality and cost reduction. In tandem with these pilots, Fairview began discussions with community payers about how to enhance other care efforts in a formal contract negotiation.

The outcome was *mutual* investment in care model innovation and a new contracting methodology that included shared savings for participating providers. The organization was encouraged to build out population management capabilities and other infrastructure around performance analytics and care coordination. The contracts supported work that Fairview was doing with pilot providers and affiliated physicians, in addition to laying the groundwork for both expansion of the model and participation in the Pioneer program.

The contracts developed incorporated providers from both the employed and affiliated networks as well as some of the faculty practice. According to Fairview leadership, the Pioneer was simply an extension of the work already started with numerous contracts already in place. The leadership at Fairview felt
that participation in the Pioneer would offer benefits not achievable simply with their regional payers including:

- An opportunity to partner with and learn from peer organizations across the country engaging in similar work;
- Develop both a dialogue and partnership with CMS around strategies to achieve the triple aim – better care, better health and lower costs;
- Opportunity to bring more FFS patients under accountable, value-based payment models.

**Governance**

Fairview Health Services sponsors the Pioneer ACO and that board has delegated most of the ACO-related governance and decision-making to the Physician Network Board. Those board entities were embedded within the leadership structure prior to the Pioneer. The one caveat was the addition of a patient advocate board member as required by the program guidelines.

Fairview did create an ACO Implementation Steering Committee. 10 individuals comprise this group and represent key streams within the organization including legal, data integration, quality, clinical integration, communication, etc. They continuously examine and analyze all of the commitments on behalf of the Pioneer and make sure they are embedded into the larger work stream and organizational processes of the system.

**Care Coordination**

**Clinician Engagement**

Fairview already had enormous success through mini-pilots and 18 shared savings contracts. Both employed and affiliated physicians had already experienced progress with patient-centered health homes, data analytics and quality reporting, performance metrics, and new care models.

The Faculty Practice associated with the University of Minnesota School of Medicine was more challenging. Some had already signed up with the shared-savings network (mostly primary care physicians), and a few specialists were engaged (cardiology, nephrology, pulmonology) in putting together integrated packages of care across the continuum. Most, however, struggled to rationalize the role of traditional academic faculty medicine with innovative care delivery models and as a result, were the least engaged and least informed about the ACO model.

Fairview engaged in what they call an “Opportunist Approach”. That is, Fairview sought out innovative and ambitious faculty who had demonstrated a more natural affinity toward the kind of work involved in an ACO and were embedding that into academic career planning. They painted a broad stroke at the University level and identified those raising their hands. For example, Fairview has a nephrologist partnering with a primary care physician examining kidney disease from prevention all the way to renal therapy, working to develop care plans between the different specialists and provider settings involved in treatment. They also identified a mid-career cardiologist who developed an academic-based CHF clinic and worked to develop
connectivity with the primary care physician community defining who treats what level of CHF patient.

**Patient Engagement**

Aside from checking the boxes for Pioneer requirements on patient engagement, Fairview knew it was a key component, so there are some things Fairview developed and continue to refine in a care model reflective of that.

First, Fairview launched a community wide effort called, “Honoring Choices”. This program brought together pastors, churches, public television, and other health care systems in the area to start a dialogue about patients’ choices, specifically end-of-life care, which has been such a cost and quality of life burden on certain patient populations.

They are also working with a new software-based patient engagement tool called, “PAM” (Patient Engagement Measure). The tool is a simple 12 element questionnaire that patients are given at the start of a visit to measures engagement with their healthcare: beliefs about their own control, skill and knowledge to manage their health etc. Providers use that to determine where a patient might need to think about care plans differently. The tool helps patients understand their health and more importantly, helps providers know where to target resources in teaching self management techniques that improve patient satisfaction and overall health.

Fairview is also using Zipnosis to help patients self-triage and “virtual visits” to help patients understand their care better. Embracing social media tools help connect patient populations in the community.

Overall, as the ACO concept began to take hold and Fairview moved forward with the Pioneer application, the overall mentality of the organization continued to shift in a progressive way. They have transitioned to an approach where they can track all programs and measure performance, especially in clinical initiatives. According to Fairview, it is important to manage all these programs purposefully and continuously adapt and change.

**Key Observations Reported**

- **Transition costs**
  - The Pioneer model posed new sets of challenges for Fairview leadership, especially the concept of accepting downside risk. Fairview prepared themselves to accept downside risk in two primary ways: from a financial standpoint and from a cultural/competency standpoint. From a financial standpoint, the physician hospital organization has been formed since mid 1990, so there was a governance structure with active committees in place that had previously engaged with these topics. The FPA had some reserves to use on the balance sheet to cover downside risk.
  - From a culture/competency standpoint, Fairview’s thought was that they could take on downside risk only if they believed they could perform in the upside. Given past demonstration pilots and demonstrated ability to generate savings within populations of patients, they were confident in their ability to do so, yet they had to convince providers
again and again they could continue to deliver. They continued to look at what pieces they had in place and continuously improved: care coordination, high risk patient management, quality management, and foster confidence in the provider community around these competencies. They also had past high level data from initial pilots that indicated they were making progress in the right direction over the years.

• **Looking Forward: Accountable care at Fairview**
  o The most critical success factor for Fairview is their core commitment to the work at hand. They believe that the work around accountable care and coordination is the right work: creating better patient experience, creating better care models, and improving patient health. Early on, Fairview was careful not to label their work an ACO. Rather, it was a vision on how to move health care. A consistency of purpose is necessary because the work can get messy, uncomfortable, and challenging. Fairview needed to foster first the belief in a greater vision which was helpful in staying the course.
  o Fairview now feels a palpable new direction in what is expected from themselves and, by extension, for all AMCs. They are moving away from pure hard science and quaternary care and applying innovative thought leadership to high impact, community-level patient care.
  o Fairview does not dismiss that AMCs are in a difficult position: AMCs train their competition; they operate in service areas with margins that are being increasingly squeezed, with only a few high-intensity services responsible for 80-90 percent of financial margin. There is simply not enough margin in these high-cost niche procedures moving forward to support the scale that AMCs have now and will continue to evolve within the new environment laid out in health reform.
  o Carving out a niche and standing on the sidelines of reform will likely prove a risky proposition for AMCs. According to Fairview, it is imperative for AMCs to start exploring now how they can integrate missions to lead, inform and support population-based, community-based care and embrace health care reform. Fairview sees this as their future.
Mount Auburn Cambridge Independent Practice Association (MACIPA)

Sources

This briefing is based on an interview with Ginger Lyons de Neufville, Executive Director of the Mount Auburn Cambridge Independent Practice Association (MACIPA). Additional information was included from MACIPA’s CMMI Pioneer ACO application and the CMMI website.

Institution Facts

The Organization

This Pioneer ACO is a partnership between MACIPA and Mount Auburn Hospital (MAH). MACIPA is the signatory on the application and all patients are managed through MACIPA. Therefore, this partnership ACO is referred to as MACIPA Pioneer ACO.

MACIPA is a for-profit, independent practice association established and incorporated in 1985; comprised of over 513 physician members (ranging from solo practitioners to groups of 25 physicians) who admit to MAH and/or Cambridge Health Alliance. These physicians include 94 PCPs, 17 CP/Specialists and 402 Specialists. MAH is a not-for-profit Harvard teaching hospital based in Cambridge, Massachusetts. It combines community hospital and teaching hospital services, with 203 licensed beds and over 19,000 inpatient and observation discharges per year.

Market Share

MAH has a 16 percent market share of Cambridge, Mass., and its surrounding area: Arlington, Watertown, Belmont, Somerville, Lexington, Waltham, and Medford. [Population: 637,000 (~10% state population); Over 65: ~ 13.8 % (state average: 13.4%)].

Pathway to Becoming a Pioneer ACO

MACIPA (MAH & MACIPA in collaboration) prides itself on twenty-six years of contracting with health insurance providers. MACIPA holds full risk capitation (88 percent shared savings and loss) commercial health plan contracts with 40,000 covered lives in BCBS of Massachusetts, Tufts Health Plan (HMOs), Tufts Medicare Preferred (a Medicare Advantage plan: 3,800 seniors enrolled) and Harvard Pilgrim Healthcare. MACIPA is responsible for the complete cost of commercial patients’ care, including inpatient, outpatient, physician, pharmacy, home health, and skilled nursing; however, PCPs participating in Tufts Medicare Preferred bear the financial risk for that contract.
Previous Demos/Initiatives

**Alternative Quality Contract**

MACIPA began its contracting experience in late 1980s when it entered into contract with the Tufts Health Plan in late 1980s. By the mid-1990s, MACIPA negotiated “capitation” contracts with the other two major health plans in the region. In 2009, MACIPA became the first physician organization in Massachusetts to sign an innovative “Alternative Quality Contract” with BCBS of Mass, which includes: 1) declining annual increases in global payment, and 2) performance initiative incentives for meeting inpatient and ambulatory quality outcome goals. MACIPA (plus other participating groups) achieved about twice the rate of improvement on a broad set of ambulatory care measures compared to providers who do not participate in the contract.

**Community Based Care Transition Program**

MACIPA also participated in the Community Based Care Transition Program, under Section 3602 of the ACA, with Dovetail Health. This program focused on post discharge teaching, coordination of care and IT implementation. The goal was for hospitals to improve transition care for high risk Medicare patients. For example, MAH hired case managers to: follow up with patients upon discharge; set up appointments post discharge and home visits; order home care services; and facilitate admissions to skilled nursing facilities (SNFs). Additionally, MAH contracted with NPs to round on patients and manage care at SNFs and rehabilitation centers. In fact, MAH’s readmission rate is 12-14 percent, compared to the 20 percent national average.

In general, MACIPA already has clinical staff in place to manage patients across the spectrum of care from acute hospital admissions, skilled nursing facilities and rehabilitation facilities to home based treatment. They have added 23 more staff to assist with chronic care management of the pioneer population. Also, there is a clinical pharmacist and a pharmacy management system. MACIPA has 191 physicians and another 724 non-clinical users on its EHR that is fully supported by MACIPA’s health care IT staff.

**Application to Become a Pioneer ACO Program**

MACIPA & MAH submitted a joint application to take part in the Pioneer ACO program. MACIPA included in their list of providers all of MACIPA’s PCPs and some specialists based on which CMMI determined the patient population.

**Governance**

MACIPA has a very involved Board of Directors (10 PCPs and 9 specialists) that meets often and approved the move to become a Pioneer ACO. The finance committee has also given its stamp of approval. As part of the Pioneer ACO, MICAPA needed to expand its services and hire more staff, 26 in total: a social work department to conduct a needs assessment, including a director of social sork and two additional social workers, plus more case managers, health coaches and navigators.
Since becoming a Pioneer ACO, MACIPA holds quarterly membership meetings, and conducts informational presentations on how the process of dealing with Medicare patients is different from commercial clients.

**Reconciliation**

The goal of participating in the Pioneer ACO is to increase services provided under the rules of Medicare, especially that Medicare patients can go anywhere they like to get health care. MACIPA will be working together to increase return business while expanding their market. MACIPA and MAH have arrangements made previously to share risk from their joint commercial contracts, so similar concepts will apply in sharing the gains and losses in this contract. Four meetings have already taken place between MACIPA’s physicians and MAH’s staff, COOs and the VP of Contracting to discuss reconciliation matters.

**Care Coordination**

The Pioneer ACO program is similar in its care coordination goals and addressing patients’ needs to the Community Based Care Transition Program demo. Also, MACIPA’s existing commercial payment models are based on accountability for overall quality and cost of care.

**Clinician Engagement**

While the ACO Pioneer program will provide more resources to MACIPA’s PCPs, their practice will remain basically the same: patient centered and evolving to more coordination and efficiency. Overall, physicians are pleased to be part of the ACO.

With regard to patient data, MACIPA sent out requests for information internally, through hardcopy, to most of their PCPs and some specialists asking them to identify any patients who may have died and any who may be high risk. MACIPA’s manual process was timely especially in light of CMS announcing that it will not meet the beginning of March deadline to give Pioneer ACO’s prospective data on their attributed patients. MACIPA encouraged its physicians to reach out to patients to start disease management proactively.

**Residents & Students’ Engagement**

Residents are not the first target of Pioneer ACO activities at MACIPA, but MACIPA views it as important that residents and students “gain appreciation for how medicine is practiced and how it is changing.” Also, 5 practices are in the process of becoming medical homes and residents who are working there are engaged in this conversion.

**Patient Engagement**

Patients are engaged at this time in terms of ‘opting out’ from data sharing within the ACO. All PCPs and staff received training to respond to patient inquires about the ACO letter.
Information Technology

MAH uses a Meditech IS platform for patient registration, demographics, clinical data, patient care, finance and ancillaries and is fully implemented on Computerized Patient Order Entry (CPOE). Last summer, MAH installed Acuity Health EMR for case managers to document and is working to implement it with eClinicalWorks. All of the hospital’s systems are “Meaningful Use” certified.

MACIPA is working with its current system (eClinicalWorks EMR) “to implement, train and maintain.” Within eClinicalWorks, there are interfaces for labs, radiology, discharge, etc. MACIPA is also part of the EX4 community health record exchange.

Verisk Analytics has been hired to conduct analysis about the sickest, frailest patients to ensure that those who need care the most get it. The goal is to be able to conduct a timely collection of data for purposes of normalization, analysis and redistribution of actionable information gathered from patients (personal health records), clinicians (EHRs & case management) and payers (administrative database).

Key Observations Reported

- **Timely data and useful performance measures**
  - “Attempting to share data in a way that has never been seen before has resulted in initial delays with receiving the data.”
  - 3 years worth of data on attributed patients who had not opted out was an appealing characteristic of the Pioneer ACO, allowing ACOs to better plan how to adapt care processes to patients’ needs.
  - As an interim measure, MACIPA began to mine its internal data for the information, but the picture of total care costs is incomplete without data on care received outside of MACIPA.

- **Data intersection between institutions**
  - Like for other Pioneer ACOs, data intersection has proven to be a challenge because there is no system in place that enables an ACO to receive information when one of their attributed Medicare patients receives care at a different ACO, or a non-ACO provider. This information has been available for MACIPA when dealing with its commercial patients.
  - Also, creating a special designation for the ACO Pioneer patients in the EHR system has proved to be a challenge.

- **Transition costs (expanding the EHR infrastructure)**
  - There had been hope that CMMI would provide infrastructure support in form of grants to expand the EHR system. Because no grants were offered, one of the biggest challenges is to re-appropriate funds for the EHR expansion.

- **Gaining patient support**
  - Once the ACO letters drafted by CMS were sent out, 500 total MACIPA patients were counted as ‘opting out’ by contacting MACIPA directly: 350 sent in ‘opt out’ forms and 150 letters had been ‘returned to sender’, which CMS considered as ‘opted out’ also. There may also be additional ‘opt-outs’ who have contacted Medicare directly. That number has not yet been provided to us.
MACIPA plans to provide more education to patients on the Pioneer ACO program, finding that most of the ‘opt outs’ were based on a lack of understanding by patients. PCPs also received lists of those patients who ‘opted out’ to see if providing them with more information will change their minds.

- **Learning what works and providing timely feedback for policy changes/enforcements to CMS**
  - “Establishing the Pioneer ACO feels like a start-up, despite that MACIPA is piggy-backing off of what we have been doing for decades.”
  - “Realizing each task undertaken takes more time and more steps than anticipated: for example, it must be considered who has to know, who has been imparted, etc. Another words, ‘the stone in the lake ripples wide.’”
  - “There is no intermediary to deal with Medicare, instead we need to adjust to dealing with Medicare directly: maintaining logs, biweekly phone calls, short-notice meetings, etc.”
Partners HealthCare
Massachusetts General Hospital

Sources

This briefing is based on an interview with Tim Ferris, MD, MPH, Medical Director of Mass General Physicians Organization (MGPO) at Massachusetts General Hospital (MGH), and Associate Professor at Harvard Medical School. Additional information was included from the CMMI website.

Institution Facts

The Organization

Partners HealthCare (Partners) is an integrated health system founded by Brigham and Women’s Hospital and MGH. In addition to 2 academic medical centers, the Partners Pioneer ACO includes community and specialty hospitals, a physician network, home health and long-term care services, and other health-related entities. Partners’ primary service area includes greater Boston and eastern Massachusetts, which has a population of approximately 4.9 million. Partners’ mission is dedicated to patient care, research, teaching, and service to the community, locally and globally.

Partners is a leading biomedical research organization and a principal teaching affiliate of Harvard Medical School. Partners HealthCare is a non-profit organization.

Market share

MGH holds 10.7 percent of the market share, while its hospital system (Partners) holds 28 percent share of the Boston and surrounding service area.

Pathway to Becoming a Pioneer ACO

Previous Demos/Initiatives

Care Management Program

In 2006, Massachusetts General Hospital (MGH) began the Care Management for High Cost Beneficiaries Demonstration, 1 of 6 projects nationwide. During the 3-year demonstration, MGH developed new strategies to improve the delivery of health care to its most vulnerable high risk patients, those with multiple health conditions and chronic disease. In 2009 CMS renewed the demonstration; MGH expanded the initiative to Brigham and Women’s and North Shore Medical Center. Only 3 of the 6 participants demonstrated savings and MGH was the only one that demonstrated significant savings net of fees.
Application to Become a Pioneer ACO Program

In its application and for the purpose of beneficiary attribution, Partners included all employed primary care physicians—mostly internists—and approximately 50 non-employed affiliate PCPs. Most of the affiliate PCPs were already working with Partners on commercial populations of patients and so amendments to exiting agreements were all that was needed. Partners took on the risks while the PCPs had the benefit of the resulting infrastructure investment.

Governance

To participate in the Pioneer ACO Program, the process started with appointing the VP for Population Health Management. In this role, the VP is now in the midst of advocating for budget appropriations to carry out the Pioneer program—Partners is in the very beginning stages of the ACO Pioneer Program and had no comments about further developments.

Care coordination

Clinician Engagement

MGH’s goal is to have quality metrics to measure in real time what is happening in practice and to change clinician incentives throughout the process. In fact, MGH has been moving in this direction since it committed one year ago to convert to medical health homes. Regarding the mandated measures already in place (past 10 years), they are far removed from being true indicators of real-time medical practice, so Partners utilizes numerous internal measures that their physicians created through internal initiatives in years past.

MGH hopes that in the future physicians will define and measure quality, the public will decide if they agree, and payers will take part only as auditors. The prediction is that in three years providers will be holding themselves to measures that are more relevant than the current portfolio of claims-based measures.

Residents & Students’ Engagement

Residents and medical students at MGH are excited to be involved in the conversations regarding the Pioneer ACO program. They want to be part of the solution—there are lists of residents wanting to participate in quality of care projects.

Patient Engagement

ACO letters drafted by CMS were sent out to 47,000 Medicare beneficiaries. Of that number, a few percent opted out of having their data shared. Perhaps 50% of those ‘opting out’ did not really understand what was being asked and the other half ‘opting out’ included attorneys, victims of prior identity theft and those with sensitive mental health histories.
Key Observations Reported

- **Overlapping demos**
  - Partners have been involved in the Chronic Disease Demo, as mentioned, but because Partners cannot “double dip” (i.e. receive funds from the government from two different programs to do the same work), it is now negotiating to close down the Chronic Disease Demo.

- **Timely data and useful performance measures**
  - CMS has been delayed with the delivery of prospective patient information to the Pioneer ACOs.

- **Transition costs—establishing the EHR infrastructure**
  - **Funding the infrastructure**
    - Because there was no grant to fund the initial infrastructure, the VP of Population Health Management has to solicit money from the CEO’s of the member entities (through a new tax) to fund the Pioneer ACO. Due to the uncomplimentary timing of the application award and Partners’ FY period, the ACO project and associated infrastructure were not in the current fiscal year budget.
    - Phase 1 of the Pioneer ACO program is meeting the IS requirements (commercial and Medicare populations), reaching quality targets (same as commercial but dramatically increased in population numbers), and hiring or designating a workforce to manage the process.

- **Intersection between the multiple Boston area ACOs**
  - MGH indicated four points of data intersection:
    - Notification management
      - MGH and the other 4 Pioneers in the greater Boston area are considering putting in place proactive mechanisms to coordinate care between ACOs, but is challenged by the asymmetry of services provided by MGH and the other institutions when arranging to care for each other’s patients interchangeably.
    - ED notification
    - Discharge notification
    - Sharing of best practices between colleagues

- **Learning what works and providing timely feedback for policy changes/enforcements to CMS**
  - Governance—are we organized to execute correctly?
  - Defining our priority tasks.
  - Use the Pioneer framework to enhance services and to reduce “leakage” to outside ACO’s/institutions.
    - Simultaneously two goals
    - Manage risk (to create savings)
    - Sustain business volume
Montefiore Medical Center

Sources

The information included in this briefing came from an interview with Lynn Richmond, NP Director of Clinical Affairs, Office of the Medical Director at Montefiore Medical Center at the Albert Einstein College of Medicine in Bronx, NY., and a summary on Montefiore’s ACO Pioneer Model written by Lynn Richmond, as well as the CMS website.

Institution Facts

Montefiore Medical Center, the University Hospital for Albert Einstein College of Medicine of Yeshiva University, was founded in 1884 to care for patients with chronic diseases. Today, Montefiore is an academic medical center and an integrated delivery system serving residents of lower Westchester and the Bronx, N.Y., one of the most economically disadvantaged regions in the United States. Montefiore has 1,491 beds across four acute-care hospitals, including the Children’s Hospital at Montefiore and an extensive network of ambulatory care practices in the Bronx, including more than 50 primary care sites, 50 specialty care sites, the nation’s largest school health program with 19 clinics, 9 mental health sites and 5 dental care sites. Last year, Montefiore had 93,000 discharges and provided over 3.4 million ambulatory visits including 500,000 home health visits.
Pathway to becoming a Pioneer ACO

Previous Demos/Initiatives

Montefiore began its experience in care management in 1995, recognizing the need for innovation in the health care delivery system to better serve Medicaid, Medicare and commercially-insured patients. Montefiore founded the Montefiore Independent Physician Association (IPA), a network of 3,100 providers that offers services across the continuum of care. The Montefiore IPA subsequently contracted with health plans to assume full financial risk in capitated contracts for the medical and behavioral health of a large population in the Bronx. The Montefiore IPA contracted with the Care Management Organization (CMO), a subsidiary of Montefiore, to provide the infrastructure, expertise and experience needed to deliver accountable care. Montefiore’s IPA includes employed and voluntary physicians, as well as other providers.

Currently, the IPA and CMO manage nearly $800 million in capitation payment. The CMO employs 400 staff to provide back-office functions, medical and social service care coordination, chronic disease management, health education and state-of-the-art telemedicine services to enrolled patients.

By reducing fragmentation in the delivery system through well-coordinated and managed care, Montefiore has been able to reduce health care costs while improving outcomes. Between 2009 and 2010, Montefiore reduced the total medical cost in its largest Medicaid risk contract by 0.6% and held the trend for Medicare to 3.7%. Concurrently, Montefiore improved health outcomes for complex patients with multiple chronic diseases, such as Type II diabetes and congestive heart failure.

The CMO has a risk stratification process to identify high-cost, high-risk individuals who might benefit from one or more of a range of programs:

- Calls from nurses or social workers that cater to those with special needs – calls are sensitive to the need for expanded hours for those who work 2 jobs/night shift, etc.
- Care management advice that can be provided face-to-face, via phone, or teleconference
- Provider-based care management programs
  - Working with patients to increase engagement and understand their role in care
  - Evidence-Based Guidelines: Low Back Pain (LBP), Hypertension (HTN), Diabetes, and more
- Home-based primary care program: reduces emergency room admissions, improves quality of care
Application to Become a Pioneer ACO Program

In 2011, Montefiore founded the Montefiore ACO and entered into a relationship with the Centers for Medicare and Medicaid Services (CMS) to become the only ACO in New York State.

Key features of the Montefiore ACO include:

- 1,750 employed physicians in Montefiore’s integrated delivery system.
- 600 community-based, affiliated physicians
- 750 allied health professionals
- 60 contracted providers of ancillary care services, such as 11 skilled nursing facilities, 2 ambulatory surgery centers, 4 home care agencies etc.
- CMO care management and coordination services
- 23,000 Medicare FFS beneficiaries prospectively attributed for January 2012

Governance

The Montefiore IPA is separate from the Montefiore ACO in order to ensure independent governance and contain the risk.

The ACO Board includes Montefiore executives and physicians and consumer advocate and patient representation.

The ACO has contracted with the Montefiore IPA to provide care and with the CMO, for care management services.

Care coordination

Clinician Engagement

The CMO and IPA provide Montefiore with a significant experiential advantage managing the health of large numbers of patients with integration of clinical care and finances. Timely use of data, performance metrics and accountability of all providers is increasingly part of the organizational culture.

Residents & Students’ Engagement

As the University Hospital for Albert Einstein College of Medicine, Montefiore has the second-largest residency program in the United States and one of the largest training programs for primary care physicians. Transitioning from fee-for-service to population-based reimbursement requires a transformation of the delivery system. Montefiore care management programs reduce avoidable admissions and readmissions, promote the integration of primary, specialty and preventive care, coordinate care, and increase the role of patients in their own health. As a result, Montefiore is well underway as a learning laboratory training its 1,200 residents, the next generation of physicians, in patient-centered accountable care.
Patient Engagement

Top three things Montefiore wants to enhance:
1. Preventing ambulatory care-sensitive avoidable admissions and readmissions
2. Delivering the right care at the right level of service and location
3. Improve palliative care model
   a. Expand Palliative Care throughout the system
   b. Focus on what patients want/need: some services provided not necessarily what patients and their families would have chosen
   c. Strengthen ties with nationally known Montefiore-Einstein Center for Bioethics

Information Technology

Montefiore providers use Centricity Enterprise (CE-inpatient) and Centricity-EMR (C-EMR-outpatient). CE has been in use since 1997. As of January 2012, all ambulatory primary and specialty care providers use these tools capable of sharing/exchanging problem lists, orders, medications, clinical notes, care plans, imaging and other data. CE also has extensive decision support functionality that includes Montefiore-specific rules for patient safety and clinical quality measures. C-EMR-outpatient enables decision support through functionalities such as knowledge sources, template-driven encounter forms, patient banners, system alerts, protocols and drug interaction checking. Patient access for secure messaging is available as well.

The Montefiore ACO, in collaboration with the Regional Extension Center, will assist the estimated 350 affiliated, community-based physicians who do not currently have EHRs to secure systems and encourage them to join the Bronx RHIO to exchange clinical data important to the care of patients.

Montefiore has invested heavily in technology infrastructure for over 10 years and is upgrading its capabilities to include an enterprise data warehouse (EDW) with comprehensive clinical and financial data that incorporates multiple data sources and a business intelligence layer. Currently, Montefiore utilizes an analytical tool, Clinical Looking Glass (CLG), developed by internal clinical IT specialists. CLG analysis is accessible to practicing physicians with minimal training provided on-site and enables organizational as well as localized QI efforts.
Key Observations Reported

- **Timely data and useful performance measures**
  - Timely availability of CMS data will enhance the ability to focus care on the relatively small percentage of patients who both account for the greatest health care costs and present the greatest opportunity for improved outcome.
  - Improved data will also facilitate the coordination of care with physicians and other providers who are not employed by Montefiore, but are aligning closely in the ACO effort.

- **Looking Towards Future**
  - With responsibility for the care of over 200,000 lives, Montefiore is approaching fifty percent performance based payment (capitation or shared savings) equaling $1.3 billion.
  - Montefiore has recently been designated as a Health Home, a program launched by the New York State Department of Health (NYS DOH) to implement care coordination for Medicaid beneficiaries with multiple chronic physical and behavioral conditions. Subject to discussions with NYS DOH and CMS officials, Montefiore will seek to develop an initiative that fully aligns all stakeholders in the improvement of quality, access and efficiency across the continuum for those duel-eligible for Medicare and Medicaid.
  - The Pioneer ACO, coupled with Montefiore’s current and prospective outcomes-based payer relationships, represent a tipping point in aligning incentives to accelerate the rate of health care reform. Montefiore’s interest and willingness to enter into a Pioneer ACO relationship with CMS demonstrates a commitment to the common goals of reducing fragmented care, promoting effective engagement with patients, protecting the Medicare Trust Fund and finding new ways to deliver care that optimizes experience and outcomes.
University of Michigan Health System
(UM)

Sources

This briefing is based on information on the CMMI website and 2 presentations: “Accountable Care: Lessons Learned and Preparation for the Future” by David A. Spahlinger, MD, Senior Associate Dean for Clinical Affairs, Executive Director, Faculty Group Practice and “Lessons From The Physician Group Practice Medicare Demonstration – Building an Accountable Care Organization: Challenges and Successes in an Academic Healthcare System,” by Caroline S. Blaum, MD, Professor, Geriatric Medicine (Internal Medicine), Dave Spahlinger, MD, Steve Bernstein, MD, MPH, Research Scientist, Department of Health Management and Policy, Jean Malouin, MD, MPH, Associate Chair for Clinical Programs Regional Medical Director - Ambulatory Services, Medical School Administration, and Jack Billi, MD, Associate Dean for Clinical Affairs, Medical School, Associate Vice President for Medical Affairs, University of Michigan. Additional information was included from the PR Newswire news release: “University of Michigan, IHA to Participate as Medicare Pioneer Accountable Care Organization,” (Dec. 19, 2011).

Institution Facts

The Organization

The University of Michigan Health System (UM) is a leading health care organization. UM’s Faculty Group Practice, part of the UM Medical School, includes all of the nearly 1,600 UM faculty physicians who care for patients at the 63 UM hospitals and 40 UM health centers. UM completes 45,000 inpatient hospital stays and 1.8 million outpatient visits and surgeries annually. UM is participating in the Pioneer Accountable Care Organization (ACO) model in partnership with IHA Health Services Corporation (IHA), an Ann Arbor, Michigan-based multi-specialty group practice.

Pathway to Becoming a Pioneer ACO

Previous Demos/Initiatives

With the Pioneer ACO, UMHS plans to build on the success it achieved participating in the Physician Group Demonstration (PGP).

PGP

UM hopes the Pioneer ACO Model will continue to build on its work in the Medicare Physician Group Practice Demonstration. In that 5-year project, U-M’s Faculty Group Practice saved Medicare more than $22 million by efficiently caring for Medicare patients. Of the 10 groups that participated, U-M was one of only two that earned shared savings during all 5 years of the demonstration. And in the last year of the project, U-M scored a 98 percent grade on quality

In participating in the PGP demonstration, UHMS sought to accomplish the following and made progress in many of these areas:
• Develop provider-based care coordination and quality interventions;
• Develop skills for population management for cost and quality;
• Leverage key strengths – experience with managed care and collaboration with payers and large employers;
• Prepare for value-based purchasing in Medicare and other payers;
• Collaborate across specialties;
• Improve hospitals throughout;
• Benefit from collaboration with 9 leading physician groups and CMS;
• Achieve possible financial returns from CMS “shared savings” model.

PGP Transitions Demonstration

UM’s Faculty Group Practice also participated in this supplement to PGP from Jan. 2011 until Jan. 1, 2012, when the Pioneer ACO program began. Under the PGP Transitions demonstration, UM set out to achieve shared-savings through lower Medicare costs relative to a national benchmark.

Application to Becoming a Pioneer ACO Program

UM applied to participate in the Pioneer ACO Model in partnership with IHA.

Care Coordination

As a result of its involvement in the PGP demo, UM developed a comprehensive strategy to achieve its financial goals in a future ACO environment. This strategy focused on UM’s capacity to decrease preventable admissions, manage chronic conditions, and coordinate care of complex and costly patients. To develop competencies and skills in these areas, UM deployed the following initiatives:

• Transitional care interventions
• Care coordination interventions for patients with chronic diseases and psychosocial problems
• Population-based management of complex patient groups in the FFS environment:
  o Frail elderly;
  o Chronic diseases;
  o Dual eligible / disabled / mental illness;
  o ESRD / transplant / palliative care.

As part of its participation in the PGP demonstration, UM developed clinical practice guidelines and disease registries for diabetes mellitus, childhood obesity, and other chronic diseases. Leveraging these clinical guidelines and disease registries, UM developed an ambulatory care-quality management program that produces quality care reports at the clinic and faculty level. The quality management program allows for exceptions (patients that are assigned but not seen by the provider) and can produce “just-in-time” reports that are patient-specific and can target specific quality gaps.
Clinician Engagement

UM’s success in the PGP demonstration was partly due to the Faculty Group Practice assuming management of clinics, outpatient diagnostic services, and surgery. A medical director was assigned to each ambulatory care unit that was assessed according to a balanced scorecard with criteria for access, quality, profit, and loss. Additionally, all departments were moved to benchmark RVU payments.

Under the management of the Faculty Group Practice, a network of medical home certified primary care clinics were developed that offer:

- Advanced access;
- Care management capabilities;
- Monitoring performance (quality and efficiency);
- Allocated resources to clinics based on chronic condition and panel size ($4 per member per month for each condition);
- Moving call back program to clinics;
- Connecting discharge planning to clinic care manager.

Information Technology

UM has just embarked on a multi-year journey to completely transform the way its physicians, nurses, other care providers and administrators use information technology in every UM hospital, clinic and office. UMHS recently signed a contract with Epic Systems Corporation for the first stage of a multi-year effort that will involve hundreds of UMHS computing and clinical staff. UM doctors and patients who refer patients to UM will also gain access to the system.

Key Observations Reporter

- Moving Forward and Maintaining Accountable Care
  - The UMHS strategy is to build upon the expertise and infrastructure the organization developed for the PGP demo and other prior demos to participate successfully in the Pioneer ACO. According to Dr. Caroline Blaum, “We believe this [Pioneer] model will help us build upon our experience in the other demonstration projects and allow us to continue to improve the quality and efficiency of care we provide our patients and their families.”
Wayne State University Physician Group
(WSUPG)

Sources

This briefing is based on an interview with Robert Frank, MD, Chief Medical Officer/Chief Executive Officer of Wayne State University Physician Group (WSUPG), Vice Dean of Clinical Affairs, and Associate Professor of Surgery at Wayne State University School of Medicine. Additional information was included from the Detroit Medical Center (Vanguard) CMMI Pioneer ACO application and the CMMI website.

Institution Facts

The Organization

The Detroit Medical Center (DMC) has been a subsidiary of the Vanguard Health System since December 2010, when it transformed its eight-hospital-system into a for-profit entity. The DMC PHO is the physician organization of independent doctors practicing in Southeast Michigan that includes faculty physicians from Wayne State University Medical School, community physicians in private practice and employed physicians of the DMC.

WSUPG has 750 members mostly made up of specialists, who are all appointed faculty at the Wayne State Medical School. The ten faculty physicians who are participating in the Pioneer ACO with DMC (Vanguard) are cardiologists and geriatricians.

This Pioneer ACO arrangement is said to be particularly interesting to the CMS because of its real-world application to providers who are working with different physician groups that have different priorities while collaborating at a safety net hospital/clinics. The success of the Pioneer ACO in Michigan--where the average cost of care ($17,000) is above the average national cost ($8,000)--is particularly telling of the program’s potential for bending the cost curve nationwide.
Pathway to Becoming a Pioneer ACO

Previous Demos/Initiatives

Friends and Family Program

The DMC Friends and Family Program put a mature care coordination program in place that was designed to align DMC patients with primary care providers and to navigate their care.

Beacon Grant

DMC was a recipient of the Beacon grant, a project focused on improving the care of diabetics through culturally appropriate, care-navigator directed coordination of treatment across venues and hospital systems.

STARR Program

DMC has been a pilot member of the “State Action on Avoidable Re-hospitalizations” (STARR) program. Through this program, DMC participated in on-going bi-weekly IHI webinar sessions focused on learning principles of transition in care by utilizing small cycles of change.

The participating WSUPG physicians were chosen for the Pioneer ACO based on their experience with collaborative medicine. They have been practicing at medical homes, provided care plans for communities in poor neighborhoods and were part of the safety net hospital health care team for many years.

Application to Become a Pioneer ACO Program

Vanguard invited WSUPG to participate in its Pioneer ACO application as a conglomerate with DMC and the DMC PHO physicians. WSUPG agreed and submitted 15-20 TIN’s of physicians who could participate, 10 were chosen. Those 10 physicians contributed 1,200 lives out of the 13,000 lives in total attributed to this Pioneer ACO. The DMC PHO provides medical management for this Pioneer ACO—monitoring the quality and utilization numbers for the private, employed, and WSUPG doctors. Vanguard is the signatory Pioneer ACO applicant.

Governance

The Wayne State University Medical School Dean sits on the Pioneer ACO’s Board of Directors.

Reconciliation

In its invitation for WSUPG to join in the DMC Pioneer ACO application, Vanguard offered the participating physicians the option of indemnification for any assumed risk. Conversely, those physicians would not share in any savings. Participating physicians have other options, too, which allow them to participate in upside or upside and downside risk.
Care Coordination

For WSUPG members, being part of the Pioneer ACO is “business as usual.” Aside from the opportunity for increased income, the chosen geriatricians and cardiologists already have been serving the community as safety net providers and have been collaborating to coordinate care.

This Pioneer ACO is in the process of hiring care coordinators, finalizing two RNs to conduct follow up calls, as well as hiring medical directors and ramping up back office action to facilitate the necessary processes of creating the ACO.

Clinician Engagement

DMC offers an online library of videos (60) to advance health literacy of the public, patients and their families (YouTube, Facebook, and Twitter). The videos offer a list of DMC physicians who perform the procedures with appointment e-request functions, and links to related topics.

DMC’s People’s Medical College is a free educational series that explores the science behind medical and surgical diagnoses to help patients achieve health literacy. Face-to-face presentations by DMC physicians cover the latest advancements and treatments offered today on variety of different health topics.

In January 2012, 3 WSUPG Medical Directors were placed at each Wayne State University practice to be an ACO champion. Their goal is to inform peer physicians about the ACO and help further implement the collaborative practice.

Residents & Students’ Engagement

WSUPG conceded that so far residents and students have not been involved in the process as much as they could be and should be; however, the WSUPG leadership is considering to invite residents to become part of the Board, giving them opportunity to voice their ideas.

Patient Engagement

DMC is developing a high-impact PHR that engages patients as partners in care. The PHR will provide direct access to patients’ electronic health information and will provide tools to help patients manage their own care. DMC plans to use electronic methods to assure population management by DMC care navigators utilizing the DocSite disease registry.

DMC has recruited an “interpreventationalist” cardiologist to launch DMC’s engagement and wellness program. Also DMC re-established its Patient Education Council in 2008 to develop and implement a process to assess the educational needs of DMC’s population.

At this time, patient engagement is measured by the ‘opt out’ percentage. For the ten WSUPG physicians’, less than 10% of their attributed patients ‘opted out’. Many of the patients who came into the physicians’ offices to ask and clarify about the ACO did not ‘opt out’.
**Information Technology**

The DMC PHO has been a leader in encouraging physicians to adopt their modular EMR (“Meaningful Use” certified) consisting of All Scripts E-prescribing and DocSite, a disease registry.

When Vanguard invited WSUPG to participate in the Pioneer ACO, it guaranteed that all participants would be able to use DocSite EHR by December 2012. DocSite is a very basic modular EMR that allows physicians or care managers to view the important details of patients’ chronic diseases and provides for critical information sharing. Further, the Evidence-Based Clinical Practice Guidelines (reviewed and implemented by the DMC PHO) have been designed to meld together with the capabilities of the modular EMR, enabling appropriate reporting and monitoring activities to take place. This will also enable care plans to be more personalized.

TheraDoc leverages DMC’s EMR to yield real-time critical patient information needed to intervene quickly, prescribe appropriately and improve care, particularly with regard to infection control and antimicrobial stewardship practices. DMC’s EMR alerts clinicians as to 5 key questions: 1) which patient they need to look at; 2) what they need to examine; 3) what they need to do; 4) why they need to do it; and 5) what they need to document. Surveillance is conducted 100 percent through TheraDoc and interventions are noted and documented in TheraDoc as well.

DMC is working with pharmacy directors at Vanguard to improve clinical documentation with TheraDoc, to enable it to report the number of different interventions that were made that positively impact patient care through monitoring of adherence to evidence-based practice, improved outcomes, cost avoidance, and decreased use of broad spectrum agents.

DMC is a Health Information Management Systems Society Stage VI hospital system. It implemented closed loop medication administration across its eight-hospital system in conjunction with the launch of computerized physician order entry (CPOE).

Meanwhile, WSUPG physicians are on NexGen EMR. To participate in this Pioneer ACO, WSUPG is creating a link to the data warehouse of the Pioneer ACO.

**Key Observations Reported**

- **Timely data and useful performance measures**
  - CMS has set a new target date of claims data release for March 2012. WSUPG Pioneer ACO physicians will continue putting their systems in place.

- **Data intersection**
  - Once patients leave downtown Detroit, the Pioneer ACO providers are unaware of services such a patient may receive—there is no system in place to share this information from other ACO’s and non-ACO’s.

- **Finding an appropriate ACO for a specialty physician group**
  - WSUPG is looking for an ACO, which will be appropriate for this large group of specialists to join and allow it to function in bundled payments.