BUILDING A THRIVING COMMUNITY

THE CASE OF LIVE WELL SAN DIEGO

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WHAT THE HEALTH IS GOING ON IN SAN DIEGO?
GAME CHANGERS IN HEALTH CARE

- **Laws & Policies**: PPACA, State Realignments
- **Demographics**: Aging, Diversity/Latinization
- **Epidemiology**: Chronic Diseases, Health Inequity
- **Technology**: Information Technology, Biotech
- **Consumer Value**: \( = \) Price + Outcome + Experience
- **Globalization**: New emerging markets
- **Cost**: Health GDP and National Deficit
TRADITIONAL BUDGET BALANCING APPROACH

- Cut people from care
- Cut provider rates
- Cut services

Meanwhile...
THE FOURTH PATH

Change how care is delivered to improve health and wellness:

- Optimize existing healthcare, public health and social service resources to innovate new service delivery, reduce waste and improve outcomes
- Create local accountability by all, not some
  - Health (and Safety) In-All-Policies
  - Promote individual responsibility
- Achieve fiscal sustainability thru new payment reforms
- Connect the Unconnected thru modernized IT
- Advance evidence-based policy making and planning
WELLNESS TRIPLE AIM

Improved Health and Social Well Being for the Population

Better Services for Individuals

Lower Cost per Capita
Building Better Health
Living Safely
Thriving
Building Better Health

- Building a better *service delivery system*
- Supporting positive *healthy choices*
- Pursuing *policy and environmental* changes
- Improving the *culture* from within
Population Health Leadership

![Diagram of a Patient-Centered Health Home]

- **Primary Care Team**: PCM / RN / LVN / MA
  - **Ambulatory Intensive Care Unit**: - Case Manager - Care Navigator
  - **Health Services**
    - Behavioral Health
    - Health Coach
    - Pharmacist
    - Physical Therapy
    - Dietician

- Community Health/Social Services

- Neighborhood

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*Image courtesy of [source link]*
Inpatient/Outpatient Care
Public Health
Military/Veteran Services
Behavioral Health
Social Services
Individual
ECO MARKET DYNAMICS

THE LEVEL OF COMPETITION

THE LEVEL OF COOPERATION

- **White Space** (No Network)
- **“Rumble in the Jungle”**
- **“Co-opetition”** (San Diego County)
- **“Love-Fest”**
Meet Donald

His wish is simple, NOT to sleep in any more hospital beds!

What’s at stake?

One Person

Many Facets
Treating the Cause, Not the Illness!

“Transitions Care Coach first, nurse second.”

“Personalized Technology”

“Healthy Bottom Line”

12.6% 17.0% 24.3%
2.3% 5.7% 8.0%

Within 30 Days Within 60 Days Within 90 Days
SMH Readmission Rate for 2009

“Transitions Care Coach first, nurse second.”
Patients/caregivers provided social support services, by referral or direct provision, to reduce the risk of avoidable readmission.
CARE TRANSITIONS INTERVENTION

- Evidence-based program to reduce hospital readmissions
- Patient- and caregiver-centered
- Supported by a Transition Coach
- Patients with complex care needs receive specific tools - electronic or paper
- Patients learn self-management skills
IT Boomers!

Providing alternative pathways for general information and access to services
Live Well
Roadmap
Live Well, San Diego is capitalizing on the inherent linkages between the public, private, and non-profit sectors and using them to promote wellness at the client and neighborhood levels.
Innovation Works!

Using innovative approaches such as mobile libraries that take services to residents in their own neighborhoods
Live Well Perspective Matures

Past

- Transactional
- Volume-Based
- Competitive Advantage
- Silos & Categorical
- Connecting the Unconnected
- Sick Care/Social Welfare

Present → Future

- Transformative
- Value-Based
- Co-opetition
- Integrated System
- InterOptimability
- Wellness
QUIET OPTIMISM

- Policy makers, providers, customers and advocates are committed
- Relationships are expanding and being built on trust
- Shifting from collaboration/integration to generation
- **Realistic approach** with implementation – marathon, not a sprint
- Data sharing & Technology have become **effective enablers**
- Winnable battles on chronic health and safety conditions are showing improvements with **meaningful results**
- *Public is beginning to believe and engage*
Live Well San Diego!
ACCOUNTABLE CARE COMMUNITY

Donna Skoda MS, RD, LD
Assistant Health Commissioner
Summit County Public Health

January 30, 2014
ACCOUNTABLE CARE COMMUNITY (ACC)

- **Vision**
  - To improve the health of the community.

- **Mission**
  - To design, develop, implement, and serve as a national framework for improving the overall health of an entire community through a collaborative, integrated, multi-institutional approach that emphasizes shared responsibility for the health of the community.

- **Metrics**
  - The ACC results in job creation, a spin-out business entity, and improved health via higher quality, cost effectiveness and cost saving, and an improved patient experience in health promotion and disease prevention, access to care and services, and health care delivery.
ACCOUNTABLE CARE COMMUNITY MODEL

- Development of integrated medical and public health models to deliver clinical care in tandem with health promotion and disease prevention
- Utilization of interprofessional teams including medicine, pharmacy, public health, nursing, social work, mental health and nutrition to align care management and improve access
- Collaboration among health systems and public health, to enhance communication and planning efforts
ACCOUNTABLE CARE COMMUNITY MODEL, CONT.

- Development of a robust health information technology infrastructure
- Implementation of an integrated and fully mineable surveillance and data warehouse
- Development of a dissemination infrastructure to share best practices
- Design and execution of a robust ACC implementation platform, specific tactics and impact measurement tool
- Policy analysis and advocacy to facilitate ACC success and sustainability
PARTNERS, ACCOUNTABLE CARE COMMUNITY

Communities Transforming
To make healthy living easier

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Summit County Public Health

Community Legal Aid

County of Summit
The High Point of Ohio
Russell M. Pry, Executive

CDC

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Akron Children's Hospital

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Summa Health System

Northeast Ohio Medical University

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AKRON GENERAL MEDICAL CENTER

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Healthier by Design
Accountable Care Community

An Austen BioInnovation Institute in Akron Initiative
Collaborative partnerships leverage multi-sector resources to improve community health.

**Benefits of partnership:**

- Addresses broad range of issues with greater breadth and depth
- Coordinates services and prevents redundant efforts
- Increases public support
- Allows individual organizations to influence community on a larger scale
- Includes diverse perspectives
- Strengthens connections between existing resources
- Provides shared frame of inquiry for community health concerns
ACC STRATEGIC IMPACT DIRECTIONS & PROCESS IMPLEMENTATION

- **TOBACCO-FREE LIVING**
  Prevent/reduce tobacco use and protect people from exposure to tobacco smoke

- **ACTIVE LIVING AND HEALTHY EATING**
  Prevent/reduce obesity, increase physical activity and improve nutrition

- **HIGH-IMPACT QUALITY CLINICAL AND OTHER PREVENTIVE SERVICES**
  Prevent/control high blood pressure and cholesterol

- **SOCIAL AND EMOTIONAL WELLNESS**
  Increase health/wellness, including social/emotional wellness

- **HEALTHY AND SAFE PHYSICAL ENVIRONMENTS**
  Improve the community environment to support health
COALITION BUILDING & COLLECTIVE IMPACT

- Coalitions typically focus on a component of health and wellness
- Changes in population health requires connections and shared accountability leading to collective impact
  - Common agenda
  - Shared measurement
  - Mutually reinforcing activities
  - Continuous communication
  - Backbone organization
ACC COMPONENTS

- Integrated, collaborative, medical and public health models
- Inter-professional teams
- Robust health information technology infrastructure
- Community health surveillance and data warehouse
- Dissemination infrastructure to share best practices
- ACC impact measurement
- Policy analysis and advocacy
WHY CHANGE HOW WE PROVIDE CARE?

Everyone is working in their own silos...
ACCOUNTABLE CARE AS THE INTEGRATOR
Everyone is working in their own silos...

THE COMMUNITY ISN’T ANY DIFFERENT..
ACCOUNTABLE CARE AS THE COMMUNITY INTEGRATOR

Residents in the Community
Diabetes: a specific clinical issue of significant impact

Diabetes has a significant impact on health, economics, and quality of life.

Currently, $174 billion spent annually in the United States for care of individuals with diabetes.

10% of the Ohio population are diagnosed with diabetes.

By 2050, the percentage estimate is 33%.

8% of Akron population are diagnosed with diabetes.

Diabetes has a significant impact on health, economics, and quality of life.
ACC SUCCESS: PERSONALIZED EDUCATIONAL AND EXPERIENTIAL MODULES FOR DIABETES MANAGEMENT

- Patients with diabetes at 3 independent health systems, varying insurance status (38% private, 31% public, 31% none)

- Multi-disciplinary team with multi-focal modules (medical care, nutrition, physical activity, social and emotional well-being, and self-management)

- Results included
  - Cost $25/person/contact hour (comparison to other Diabetes Prevention Projects $37.50/person/contact hour)
  - Better management leading to decrease in A1C and LDL cholesterol levels
  - More than half of participants lost weight (more than 115 pounds), decreased BMI (almost 23 points), and reduced waist size (more than 25 inches)
  - No amputations and a decline in emergency department visits because of diabetes
  - Increase in self-reported exercise and flexibility
ACCESS TO CARE - DIABETES

Figure 1: Mean Cost per Client per Month by Length of Enrollment Among ATC Clients with Diabetes, 2010
### ACCESS TO CARE - DIABETES

<table>
<thead>
<tr>
<th>Years of Enrollment</th>
<th>Number of Clients</th>
<th>Mean Cost per Client per Month</th>
<th>Estimated Savings per Month</th>
<th>Estimated Savings per Month</th>
<th>Estimated Savings per Year</th>
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<tbody>
<tr>
<td>Less than 1 Year</td>
<td>152</td>
<td>$113.30</td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>1 Year</td>
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<td>$100.66</td>
<td>$12.64</td>
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<tr>
<td>2 Years</td>
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<td>$84.68</td>
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<td>$2,762.69</td>
<td>$33,152.28</td>
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<tr>
<td>Total</td>
<td>414</td>
<td>$98.94</td>
<td>---</td>
<td>$5,943.25</td>
<td>$71,319.00</td>
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</tbody>
</table>
ACC SUCCESS: RETURN ON INVESTMENT

- Examination of ROI program connecting more than 2000 adults with the ACC

- Results included
  - The average cost per month of care for individuals with diabetes reduced by more than 10% per month
  - After one year of involvement, consistent reduction in costs are in excess of 25%
KEY METRICS OF SUCCESS

- Improvement in patient experience; The patient feels comfortable in his or her knowledge of how to access and leverage applicable programs in the community
- There is a subsequent reduction in healthcare costs and improved value
- The burden of disease is decreased
- There is an improvement in the quality of life
ACC METRICS FOR SUCCESS

- Community participation
- Local, regional, and national burden of disease (Impact Equations)
- Institute of Medicine Specific Aims for 21st century healthcare
- Primary, secondary, and tertiary prevention indicators
- Community intervention measures
- Care coordination metrics
- Determinants of health
- Health information technology utilization and information sharing
- Clinical improvement
- Patient safety
- Patient self-management
- Patient-centered medical home measures
REFERENCES


Ohio Behavioral Risk Factor Surveillance System. Chronic Disease and Behavioral Epidemiology Section, Ohio Department of Health, 2010.


Ohio Family Health Survey. Health Profile of Summit County, February 2010.


THANK YOU!

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Accountable Care Communities 101

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Premier healthcare alliance

January 30, 2014
Premier is the largest healthcare alliance in the U.S.

Our Mission: to improve the health of communities

- Uniting more than 2,800 hospitals – 40% of all U.S. hospitals – and nearly 93,000 alternate sites of care
- $40+ Billion in group purchasing volume, $5 Billion in savings in 2012
- Database representing 1 in every 4 discharges
- 2.5 Million clinical real-time transactions each day
- Named six times as Ethisphere most ethical company
- Malcom Baldrige Quality Award Winner
Enabling members ACO success

Connecting People: National ACO Collaboratives

Connecting Data: Population Health Analytics

Connecting Knowledge: Operational Deployment

ACO Implementation & Readiness

80+ members collaborating on best practices
120+ market assessments

Population Health data management

Analytics supporting clinical integration and risk-based relationships

Resources to build capabilities

Cohorts, best practices portal, guidebooks, tools, vendor contracts
Today’s discussion

▶ What is an ACO?
  • ACO Model

▶ What do ACOs look like?
  • Incentives
    » Shared Savings
  • Medicare
    » Basics
  • Medicaid
    » Colorado

▶ ACO’s future
  • Growth
  • Results
  • Challenges
What is an Accountable Care Organization?

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together to provide coordinated high quality care to their patients.

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves.

ACOs were designed with a three-part objective:

1. **Better Care** – in a safe environment, equitable to all who seek it and available when needed
2. **Improved Health** – accomplished through prevention and chronic care management
3. **Lower Per Capita Costs** – intended to reduce the trend of cost increases associated with the Medicare FFS population
The Accountable Care Organization Model

A group of providers willing and capable of accepting accountability for the total cost and quality of care for a defined population.

Core Components:
- People Centered Foundation
- Health Home
- High-Value Network
- Population Health Data Management
- ACO Leadership
- Payor Partnerships
What does an ACO look like?

**High Value Network** delivers provider networks that will optimize care delivery within and across the continuum and ensure that care is coordinated.

**Medical Home (PCMH)** redesigns primary care to create a new PCP model that provides people-centric care as well as care guidance to the practice population, and **Health Home** provides population care management.

**People Centered Foundation** will ensure that the first principle for accountable care design and ongoing operations is to enable all people within the AC community to meet their needs and desires for good health.

**Leadership** addresses the strategic leadership and operational infrastructure necessary to support a successful network that is organized around Triple Aim goals.

**Population Health Data Management** facilitates the flow and analysis of clinical, financial, and patient-related data and information across all components of accountable care delivery system.

**Payer Partnerships** - focused on the framework necessary for the network to develop and maintain mutually advantageous relationships with AC payer partners (plans and employers).
Basic Shared Savings Model

ACO Launched

Projected Spending

Threshold

Shared Savings

Actual Spending

Expending

Year
-3  -2  -1  0  1  2  3

Shared Savings Program

- One-sided (shared savings only) risk model
- Caps savings at 10% of benchmark
- Threshold of 2%-3.9% depending on size of population
- Once MSR met, share up to 50% of first dollar savings depending on quality scores

- Two-sided risk (shared savings and losses)
- Up to 60% shared savings
- First dollar savings/loss after 2% MSR surpassed
- Caps savings at 15% of benchmark
- Caps losses at 5% in year 1, 7.5% in year 2, and 10% in year 3
Medicare ACO Basics

- Patients are assigned to the ACO based upon their pattern of utilization
  - (No election or lock-in)
- Minimum 3 year agreement
- Required to have structure to receive and distribute payments for shared savings
- Enough Primary Care Physicians (PCPs) and other providers to care for assigned patients (minimum 5,000)
- Program effective January 1, 2013
- Participation voluntary for providers
- PCPs can only participate in one ACO
- Providers paid fee-for-service payments by CMS
- Shared savings payments distribution made by ACO
Medicaid: Payment Reform

ACOs: 17
Bundled Payment: 1

As of 1/20/14
A closer look at a provider-led model: Colorado

Accountable Care Collaborative (ACC) model

- Regional Care Collaborative Organizations (RCCOs)
- Statewide Data Analytics Contractor (SDAC)
- Primary Care Medical Providers (PCMPs)
Per member per month distribution of payments

- RCCO: 65%
- PCMP: 20%
- Contractor: 15%

Colorado data from COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING
ACO development accelerating nationwide

- Estimated over 600 public and private ACOs in nearly every state
- Medicare specific ACOs:
  - First ACOs (10 organizations) part of the PGP demonstration project beginning in 2006
  - 32 CMMI “Pioneer” participants, program began 1/1/2012; 9 dropped out with 7 converting to MSSP 1/1/2013
  - Medicare Shared Savings Program
    - 4/1/2012: 27 ACOs added
    - 7/1/2012: 89 ACOs added
    - 1/1/2013: 106 ACOs added
    - 1/1/2014: 123 ACOs added

Source: Leavitt Partners Center for Accountable Care Intelligence, January 2013
The Pioneer ACO Model is designed for providers that want to accept more risk in order to reap more reward. These groups are effectively “cutting edge” providers—mature ACOs that are already coordinating care.

**Pioneer ACO year one results**

- Costs for the more than 669,000 beneficiaries cared for by Pioneer ACOs grew by only 0.3 percent in 2012, compared to 0.8 percent the for a similar patient population.

- 13 of the 32 ACOs achieved savings that it shared with CMS.

- Generated gross savings of $87.6 million in 2012, with $33 million going to the Medicare Trust Funds. Only two Pioneer ACOs incurred shared losses which totaled $4.0 million.

- All participating organizations also earned incentive payments for successfully reporting quality measures for the first year.

- 25 of 32 Pioneer ACOs achieved lower readmission rates than the benchmark rates.
Some Pioneers have left the program

Of 32 first year Pioneer participants -

- Twenty-three Pioneer participants will remain in the program for year two.
- Seven first year Pioneer participants are dropping out and moving to the Medicare Shared Savings Program (MSSP) – a program with more easily achievable goals and no risk of losing money if benchmarks are not met.
- Two Pioneer participants dropped out and will not transition to MSSP.
Ongoing financial pressures:
- In 2014, PPACA will introduce 30M+ newly insured to U.S. healthcare system
- Payment reductions driven by federal deficit and the economy
- Reduced inpatient hospital admissions

Increasing focus on value and quality:
- Ongoing transition toward value-based payment models
- Increased regulatory complexity leading to greater transparency
- Accountable care organization expansions

Collaboration and consolidation on the rise:
- Blending of delivery systems, health insurance plans, and technology firms
- Consolidation of hospitals, health systems, and the continuum of care
- Shifting of Medicaid plan management to private sector managed care plans

Significant investments in IT to continue:
- Growing administrative burden is compelling modernization of processes and data, and automation of regulatory and service level compliance
- Information technology will drive data integration and care redesign
Managing in two payment worlds

Dominant payer resistance

Medicare/Medicaid beneficiary engagement

Behavioral health integration

Specialty physician engagement

EMR integration

Speed of Clinical transformation

Transitions of care

Aligning the employed physician compensation
Transitions are Difficult

- Pay for volume
- Fragmented care
- FFS
- Treating sickness
- Adversarial payors
- Little HIT
- Duplication & waste

- Pay for value
- Coordinated care
- Global payment
- Fostering wellness
- Payer partners
- Fully wired systems
- Right care, right setting, right time

Laggards → Late Majority → Early Majority → Early Adopters → Innovators
Managing populations requires fundamental change in health delivery.

The focus of primary transformation should be aligning clinical with payment.

Physician leadership and engagement is pivotal in the shift to accountable care.

Care models and coordination are critical building blocks to success under value-based reimbursement models.

Executive leadership with Governance support is vital to success.

Comprehensive, coordinated primary care services and integrated IT systems are key ingredients for success.

Market pressures can create opportunities for novel partnerships that serve both parties well.

The pace of execution will be limited by payer readiness to participate in innovative, value-based reimbursement models.
Questions?

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