

Managing the Health of Populations: Value-based Care at AMITA Health

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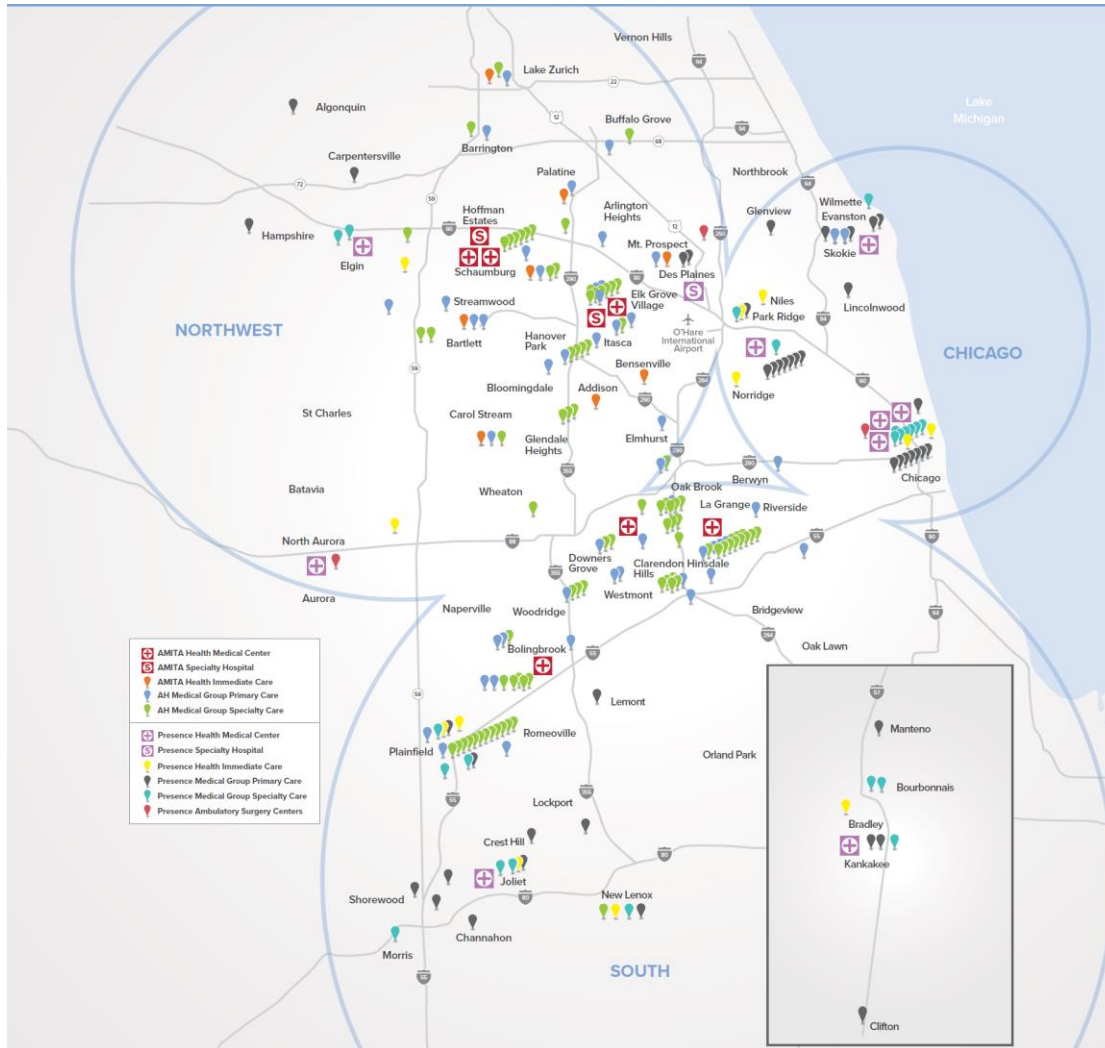
In sickness and in health™

Learning Objectives

1. Describe the structure the Medicare Shared Saving Program (the Medicare “MSSP” ACO program)
2. Explain the process by which the AMITA Health ACO approached improving cost efficiency in the MSSP Program
3. Relate the association between Medicare Annual Wellness visits and clinical quality observed in the AMITA Health ACO
4. Measure the effectiveness of a care management intervention to care for high risk Medicare beneficiaries

AMITA HEALTH®

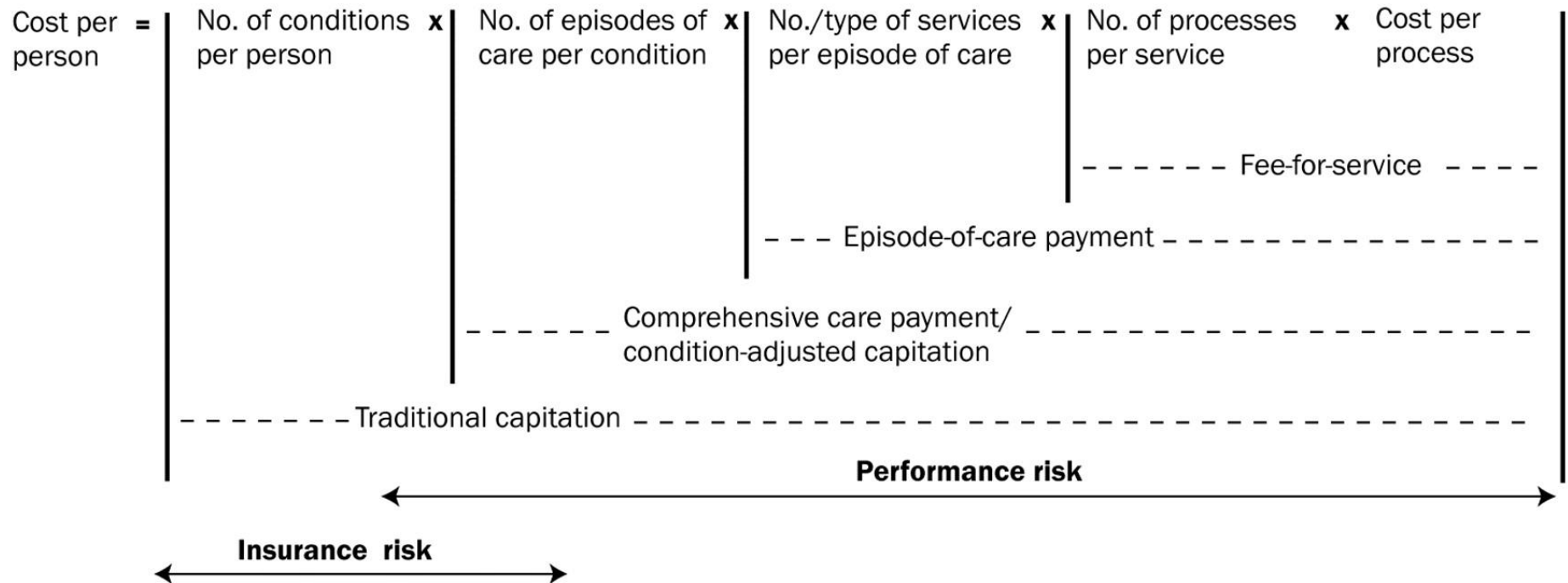
In sickness and in health™



AMITA Health is a \$4 Billion healthcare system including 16 acute care hospitals as well as an acute rehabilitation hospital, a long term acute care hospital, a Women and Children's hospital and a behavioral health hospital.

AMITA Health includes two Medicare Shared Savings ACOs, over 4000 physicians participating in clinical integration, and over 400,000 attributed patients.

Changing Payment Models: Redistribution of Insurance and Performance Risk



Alternative Payment Model Framework



CATEGORY 1

FFS with no link to quality and value

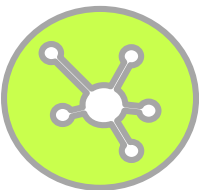
- Traditional Medicare



CATEGORY 2

FFS linked to quality and value

- Foundational Payments to improve care (AHC Model)
- Rewards/Penalties for Reporting/Performance (MACRA, HRRP, Hospital VBP, HAC Penalties)



CATEGORY 3

APMs built on FFS architecture

- Predominant bundled payment, shared savings arrangements



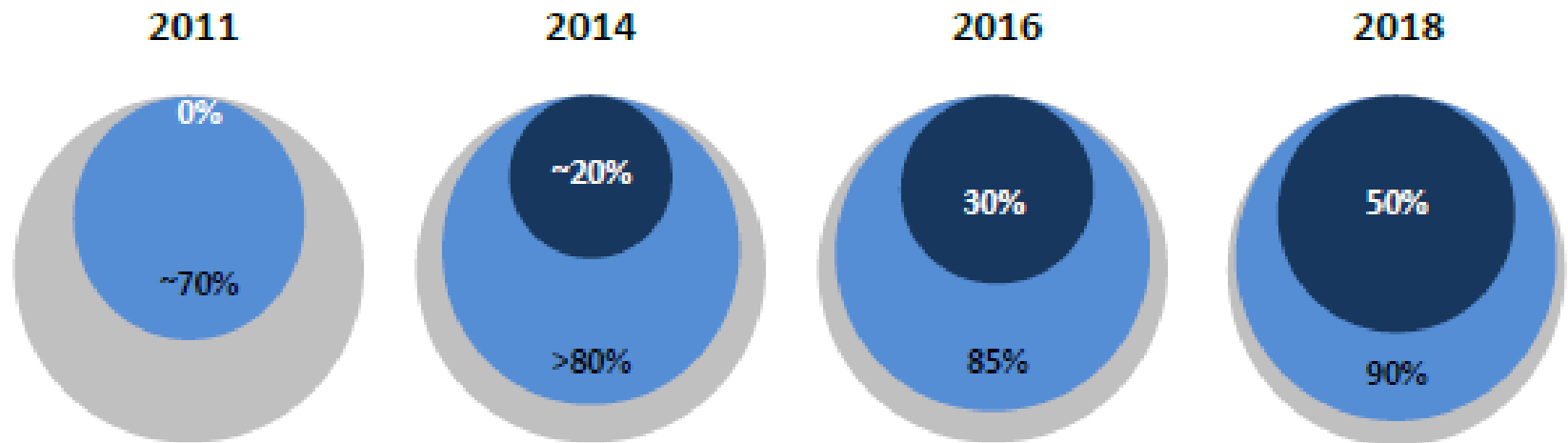
CATEGORY 4

Population-based payment

- Where things get really crazy

CMS APM Implementation Goals

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)



Centers for Medicare & Medicaid Services. Fact Sheets: Better Care. Smarter Spending. Healthier People: Paying Providers for Value Not Volume. (Press Release) January 1, 2015

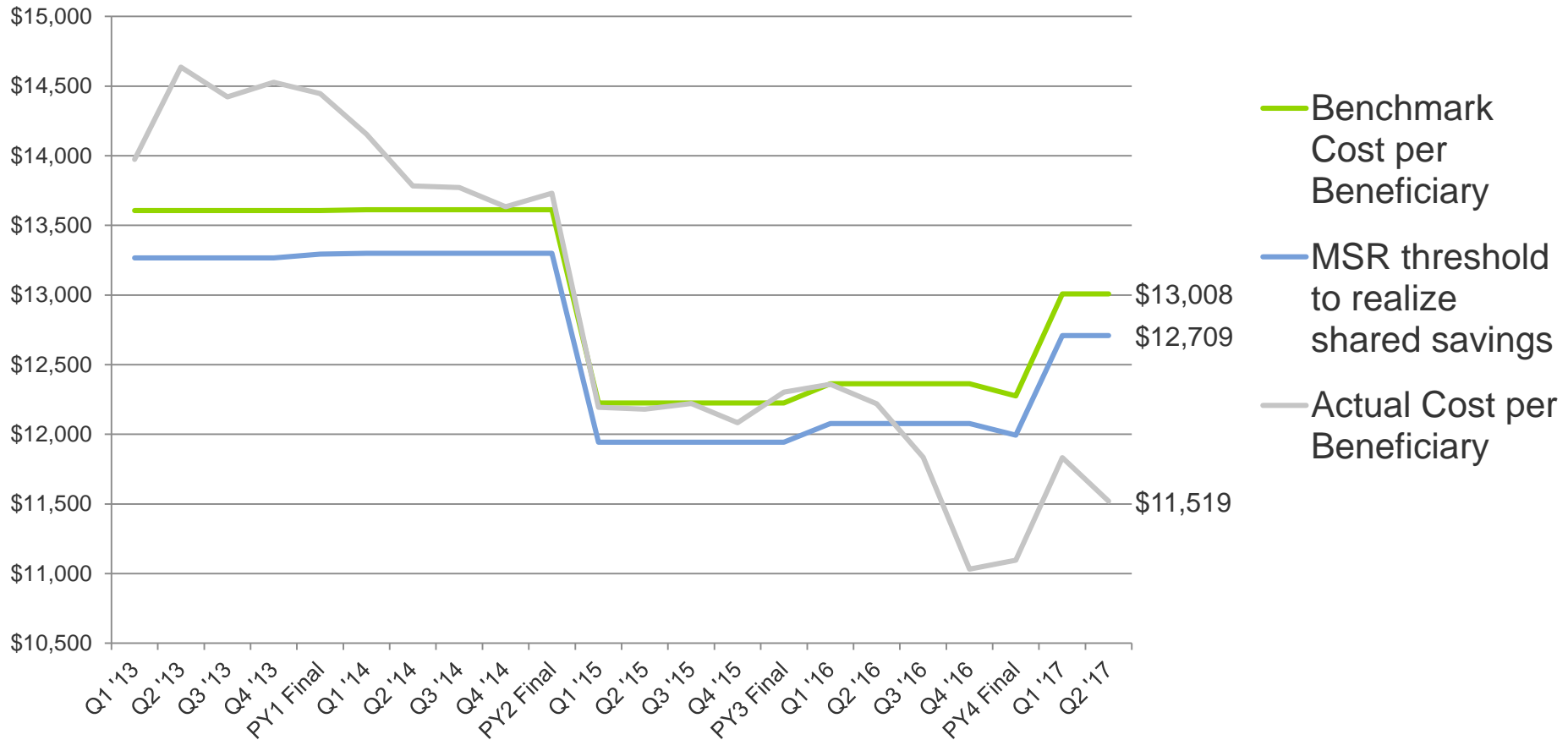
AMITA ACO: Formation, Culture and Background

- AMITA Health ACO is a hospital-aligned MSSP ACO established through AMITA Health
- The AMITA Health ACO was one of the first system-wide clinical entities when AMITA was created in 2015 and has been an important vehicle for clinical integration
- As we integrate with Presence Health, we expect that alignment of legacy systems' ACO's will again be a vehicle for system integration

AMITA Health MSSP ACO

- Track 1 (2013-2017), Track 1+ (2018)
- Number of practitioners: 320
- Number of assigned beneficiaries: 31,320
- Major Program Elements
 - Attribution
 - Financial and Quality Evaluation
 - Shared Savings/Losses Distribution

Medicare Shared Savings Program Design



2017 ACO Quality

Measure	2017 Performance	2017 Percentile/Quality Points	*2016	**2015
Fall Risk	92.26%	90th/2	84.78%	76.45%
Med Rec	21.05%	P4R/2	NA	NA
Diabetes	46.12%	60th/1.55	37.10%	29.41%
HTN	75.18%	70th/1.70	72.98%	70.45%
IVD	93.75%	90th/2	90.14%	83.72%
MH-PHQ9	8.57%	P4R/2	0.00%	0.00%
BMI Screen	67.61%	60th/1.55	78.09%	73.62%
Colorectal	63.48%	60th/1.55	57.09%	56.61%
Depression	80.28%	80th/1.85	73.05%	74.73%
Flu	82.56%	80th/1.85	72.59%	66.09%
Mammo	76.21%	70th/1.70	68.30%	60.90%
Pneumo	85.23%	80th/1.85	74.30%	65.77%
Statin Use	86.90%	P4R/2	83.93%	NA
Tobacco	80.14%	80th/1.85	95.09%	91.72%

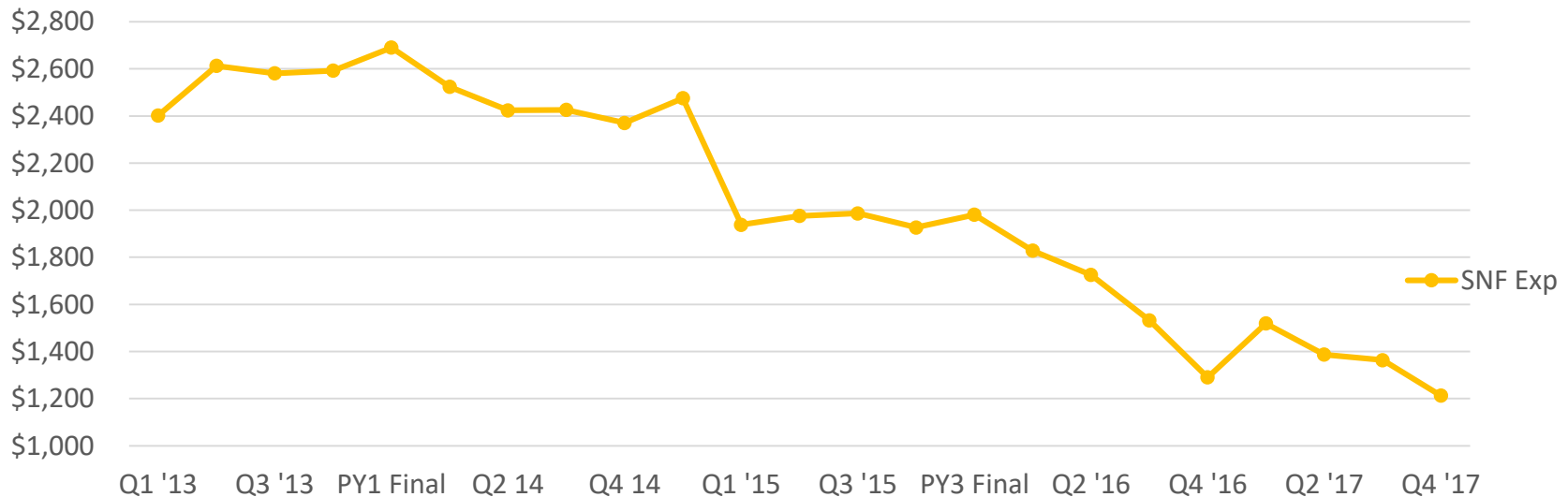
Key strategies used to improve quality and address costs

- Post-acute utilization management
- Network refinement
- Annual wellness visit optimization

AMITA Health ACO Skilled Nursing Facility Performance

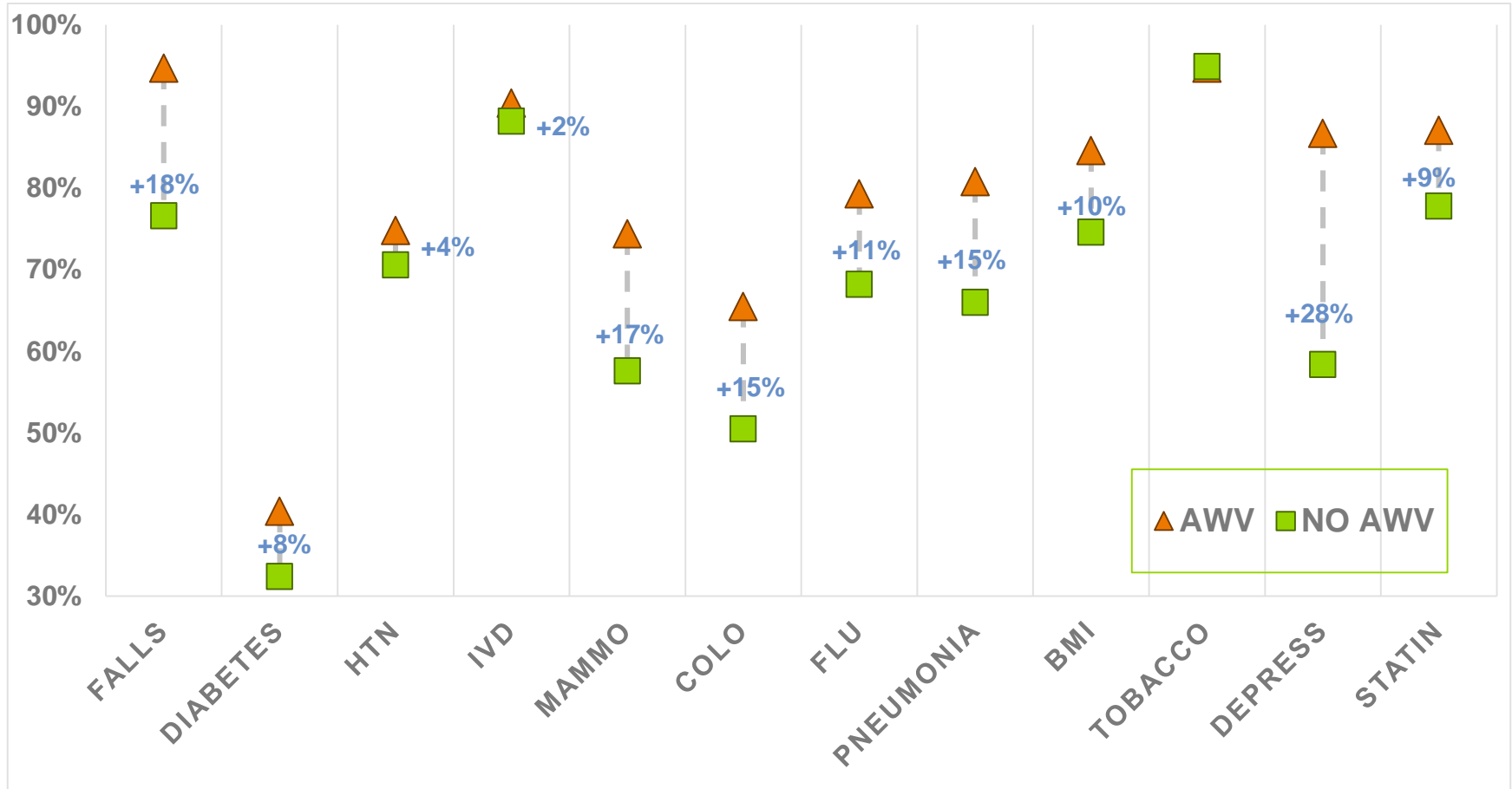
Facility ID	Admits	Avg LOS (< 21 days)	30 Day Readmits	30 Day % (< 12%)	JH Risk Score	5 star As of 2.18	Medical Director
A	196	30	29	14.1%	2.53	4	
B	195	27	25	11.7%	2.27	4	
C	151	26	23	14.6%	2.38	5	
D	113	26	16	13.3%	2.98	3	
E	81	33	10	11.2%	3.73	5	
F	81	31	12	14.1%	3.09	5	
G	193	34	28	14.1%	2.43	3	
H	161	27	21	12.4%	2.06	4	
I	156	25	15	9.4%	2.30	5	
J	154	27	24	15.3%	2.41	5	
K	76	29	10	12.5%	4.01	3	
L	61	36	3	4.5%	2.82	3	

SNF Cost Control Central Importance

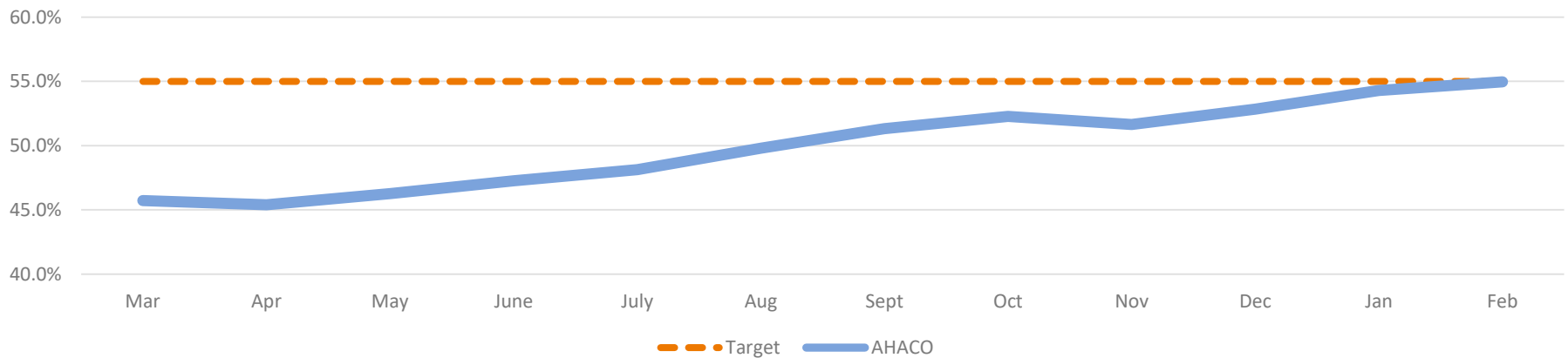


- Annual SNF cost has fallen over \$1000 per beneficiary, or approximately \$30,000,000 per year
- SNF days per beneficiary remains significantly above other ACO's (2291 vs 1799 days per 1000 person-years)

Annual wellness visit optimization



Annual Wellness Visit Performance



Org	2017										2018	
	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Target	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%
AHACO	45.7%	45.4%	46.3%	47.3%	48.1%	49.8%	51.3%	52.3%	51.6%	52.8%	54.3%	55.0%
Legacy ABMG	43.3%	43.4%	43.4%	43.6%	44.1%	44.7%	45.7%	46.2%	45.7%	47.5%	48.5%	50.1%
Legacy AHP	47.5%	47.3%	49.5%	51.7%	53.2%	56.0%	58.6%	60.2%	59.8%	61.2%	62.3%	62.7%
Legacy MCG	22.1%	13.3%	9.0%	7.9%	9.2%	12.2%	14.3%	17.3%	18.9%	23.0%	26.1%	30.0%
Independents	48.0%	48.3%	49.0%	49.6%	50.0%	51.0%	51.7%	52.4%	51.2%	50.7%	53.3%	52.6%

AMITA SYSTEM-WIDE CARE MANAGEMENT VISION STATEMENT

AMITA is committed to making the patient the center of all we do. The vision for the AMITA Care Management process will hold true to that commitment as its foundation. Given that commitment, it is the goal of the process to achieve the following:

SYSTEM

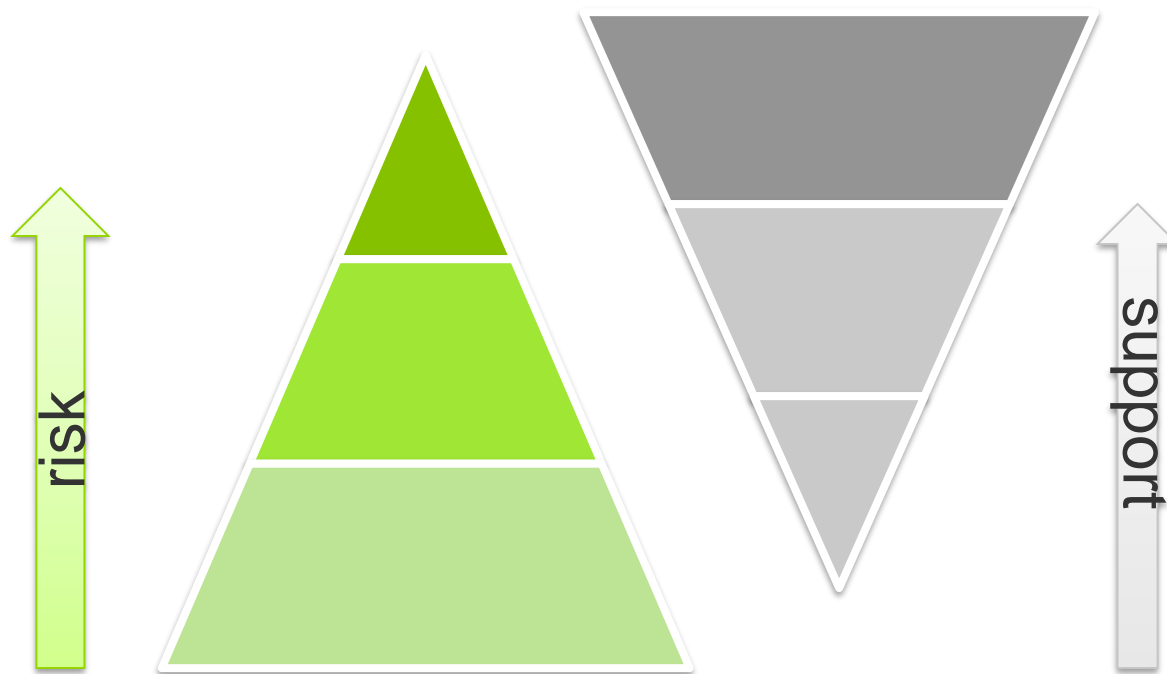
- Care management will function as a single, cross continuum entity within AMITA that will support the defined patient populations.

PATIENTS

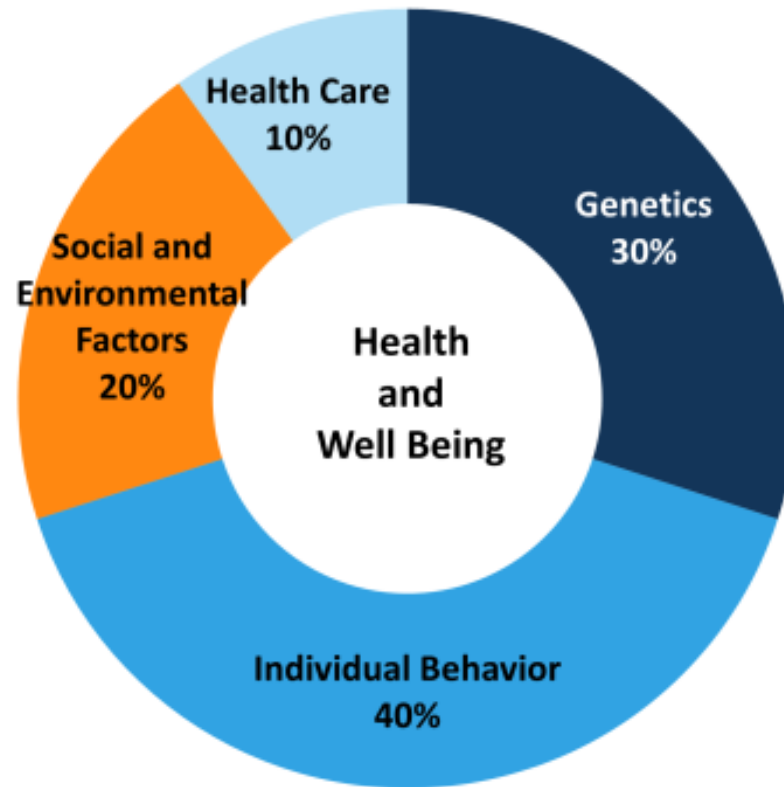
- Care management will be provided for a defined patient population. These patients will meet ‘rising risk’ and ‘high risk’ categories defined by evidence based criteria, across all AMITA entities.
- Patients within these defined risk categories will have a single care management contact within the AMITA system.
- Every patient in defined categories will have a care plan that is integrated between patient (caregiver), primary care physician, and other care providers.

The most important thing about the population health approach:

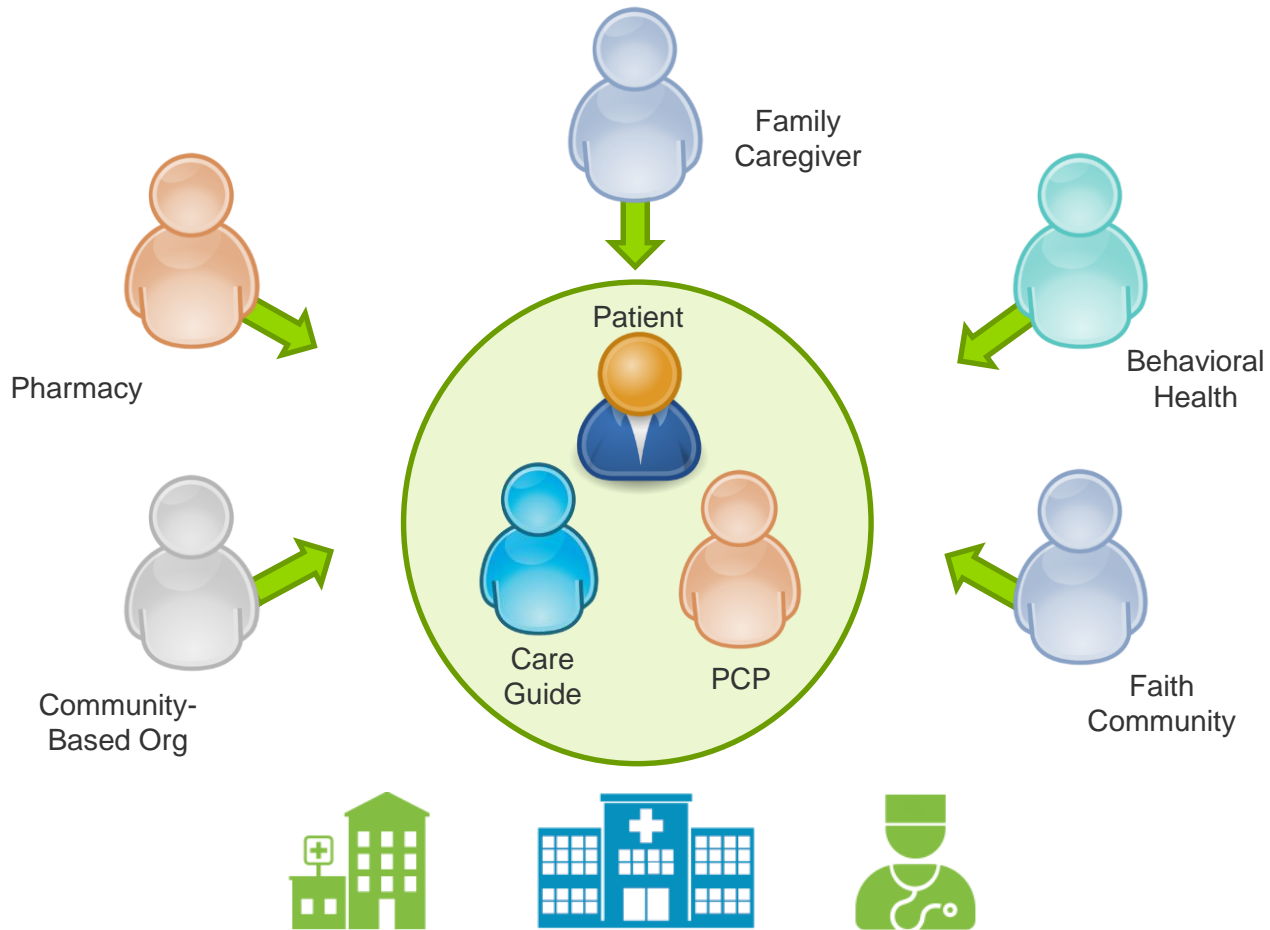
Proactive, risk-based application of relationship intensity and continuity



Non-Medical Determinants of Health



Embedded Care Management for High Risk Patients



Characteristics of AMITA Medicare ACO Patients Top 10% Risk

- Mean Age 78
- Comorbidity
 - HF 43%
 - COPD 16%
 - ESRD 8%
- PMPY \$55,680 (remaining ACO \$7,158)
- Dual Eligible 10%
- Annual Mortality 34%
- Admissions 4
- Readmission Rate 33%
- SNF stay within 15 months 46%

The Care Guide Program

- A care model in which practice-embedded care managers provide intensive coordinated care of high risk patients in partnership with PCP's and hospital care managers
- For analysis, Care Guide patients are matched at month of enrollment with non Care Guide patients from same payor (Medicare ACO), with same risk score and same 3 month hospital utilization history.

Program Outcome Measures 90 days post enrollment

	Care Guide Enrolled		Control Group	
	Raw	Per 1000	Raw	Per 1000
All Events (Inpatient, Obs, ED)*	49	325	124	411
Acute Inpatient Admission*	25	166	58	192
Observation Event*	6	38	18	59
ED Visits*	18	119	48	159
Acute Inpatient Admissions flagged as Readmission	4	27	29	96
Per Member Average - Medical Claim Costs*	\$5,300	NA	\$5,800	NA

*Counted Events or Claims that occurred between enrollment start date and 90 days post enrollment date or death date or disenrollment date or 11/01/2017 (whichever came first). Not all patients had a 90 day window.

“Pearls of wisdom”

- High quality data, analytics and transparency regarding performance at the physician and facility level are essential
- Identify providers whose practice performance supports (and undermines) program success and do not ignore poor performers
- Tailor intensity of care management to patient risk

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