PC-MH, ACO, UA/NextGen

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UNIVERSAL AMERICAN
TOWN HALL MEETING
SEPTEMBER 8, 2011
HOUSTON, TEXAS

Goals of Town Hall Meeting

- **Patient Centered Medical Home** – How this affects the Provider in both their practice setting and personal settings?
- **ACO's** – How being a member can increase revenues and other benefits?
- **How Universal American and NextGen** can help us achieve better results in the future?

Healthcare Leadership Council Membership Meeting

Strategic Area 3: Integrate Care for Populations

- Help Accountable Care Organizations Thrive
- Help Dual Eligible Beneficiaries Get Better Care
- Strengthen Medicare Advantage
- Increase Utilization of Medical and Health Homes

--Don Berwick, Administrator, CMS, January 19, 2011

SETMA Achievements

- July 2010-2013 NCQA PC-MH Tier Three
- July 2010-2018 Joslin Diabetes Center Affiliate
- August 2010-2013 NCQA Diabetes Recognition
- August 2010-2011 AAAHC Medical Home
- August 2010-2011 AAAHC Ambulatory Care
- August 2011-2014 AAAHC Medical Home
- August 2011-2014 AAAHC Ambulatory Care

Diabetes Care Improvements

From 2000 to 2011

- HgbA1C standard deviation improvement from
  1.98 to 1.33
- HgbA1C mean (average) improvement from
  7.48% to 6.65%
- Elimination of Ethnic Disparities of Care in Diabetes

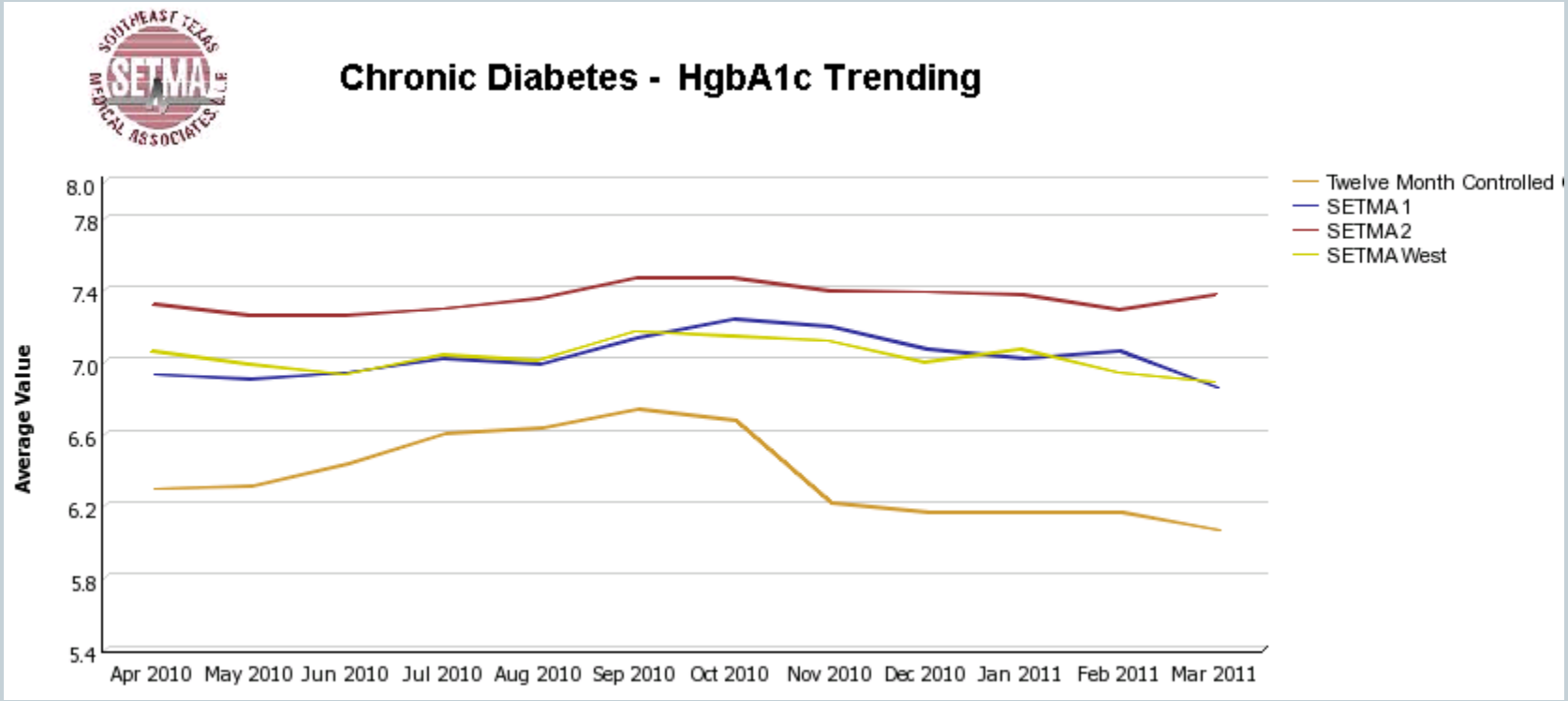
Diabetes Care Initiatives and Results

- 2000 - Design and Deployment of EHR-based Diabetes Disease Management Tool
  - HgbA1C improvement 0.3%
- 2004 - Design and Deployment of American Diabetes Association certified Diabetes Self Management Education (DSME) Program
  - HgbA1C improvement 0.3%
- 2006 - Recruitment of Endocrinologist
  - HgbA1C improvement 0.25%

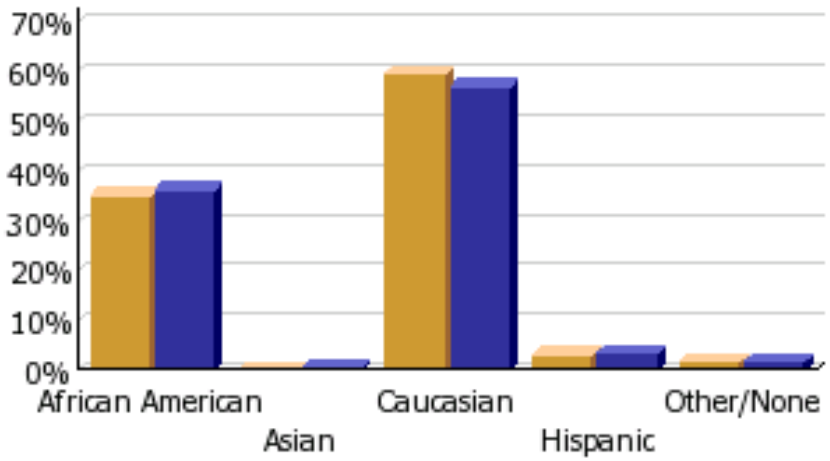
2011 NCQA Diabetes Metrics

Location Name	Provider	Encounters	A1c >9.0 <= 15%	A1c < 8.0 >= 60%	A1c < 7.0 >= 40%	BP > 140/90 <= 35%	BP < 130/80 >= 25%	Eye Exam >= 60%	Smoking Cessation >= 80%	LDL >= 130 <= 37 %	LDL < 100 >= 36%	Nephropathy >= 80%	Foot Exam >= 80%	Total Points
SETMA 1	Aziz	534	9.7%	78.5%	59.0%	20.6%	52.4%	58.4%	95.0%	13.5%	68.5%	77.3%	74.5%	80
	Duncan	363	9.1%	84.8%	69.7%	11.6%	65.6%	58.7%	92.1%	14.0%	68.9%	86.0%	82.6%	90
	Henderson	432	11.6%	80.1%	66.7%	12.3%	63.4%	62.3%	95.9%	12.5%	65.3%	83.8%	95.4%	100
	Murphy	723	5.3%	88.4%	70.0%	14.8%	55.7%	48.3%	79.1%	13.6%	72.2%	86.6%	84.9%	80
	Palang	129	1.6%	39.5%	30.2%	17.1%	57.4%	17.8%	85.7%	4.7%	34.9%	21.7%	24.0%	57
	Thomas	148	9.5%	69.6%	45.3%	19.6%	56.1%	79.7%	100.0%	12.8%	60.8%	77.7%	83.1%	95
SETMA 2	Ahmed	1,461	18.4%	54.9%	35.9%	7.9%	62.3%	65.0%	74.2%	11.4%	63.5%	65.9%	99.5%	60
	Anthony	529	11.0%	78.6%	63.1%	12.1%	70.9%	63.7%	83.1%	9.5%	69.8%	91.7%	96.2%	100
	Anwar	716	8.9%	81.1%	66.2%	4.5%	80.7%	65.2%	96.6%	12.3%	62.8%	91.9%	75.6%	95
	Cricchio, A	522	15.1%	52.7%	34.9%	7.9%	74.3%	64.2%	82.2%	9.8%	69.2%	75.1%	99.2%	70
	Cricchio, M	445	8.8%	79.1%	64.5%	12.4%	61.1%	60.7%	64.9%	12.1%	63.1%	89.4%	84.5%	90
	Holly	134	6.0%	85.8%	73.1%	4.5%	81.3%	78.4%	82.6%	12.7%	69.4%	97.0%	94.0%	100
	Leifeste	532	7.0%	81.0%	69.9%	12.6%	67.5%	70.7%	58.1%	9.8%	66.4%	88.7%	81.6%	90
	Wheeler	353	7.9%	85.0%	75.1%	21.5%	58.6%	60.9%	80.0%	13.0%	62.0%	89.8%	87.3%	100
SETMA West	Curry	222	10.4%	79.3%	59.0%	14.9%	60.8%	71.6%	82.5%	12.6%	65.8%	89.6%	93.7%	100
	Delparine	393	9.2%	74.3%	56.7%	24.9%	49.1%	53.2%	96.5%	12.7%	59.5%	67.4%	88.0%	85
	Halbert	583	13.2%	75.5%	61.6%	20.6%	55.7%	42.5%	98.6%	16.1%	58.8%	57.8%	84.7%	85
	Horn	405	4.7%	80.2%	64.9%	1.2%	68.4%	46.4%	90.8%	16.3%	52.6%	79.0%	95.1%	85
	Qureshi	212	18.9%	66.5%	55.2%	7.1%	73.1%	51.9%	98.3%	17.9%	59.9%	67.0%	97.6%	73
	Satterwhite	218	16.5%	62.8%	47.2%	18.3%	61.9%	54.1%	93.5%	21.6%	48.2%	75.2%	88.1%	73
	Vardiman	311	10.0%	74.6%	62.1%	20.9%	46.9%	62.7%	98.1%	12.2%	64.3%	66.6%	84.6%	95

Diabetes Audit - Trending



Diabetes Audit – Ethnicity



	African American	Ethnicity Asian	Caucasian	Hispanic	Other/None
Controlled	35.3%	0.3%	59.6%	3.2%	1.6%
Selected	36.4%	0.9%	57.2%	3.6%	2.0%

Trust and Hope

Nevertheless, in the midst of health information technology innovation, we must never forget that the **foundations of healthcare change are "trust" and "hope."**

Without these, science is helpless!

Domains of Healthcare Transformation

1. **The Substance** -- Evidenced-based medicine and comprehensive health promotion
2. **The Method** -- Electronic Patient Management
3. **The Organization** -- Patient-centered Medical Home
4. **The Funding** -- Capitation with payment for quality outcomes

The SETMA Model of Care

The SETMA Model of Care is comprised of five critical steps:

1. Tracking
2. Auditing
3. Analyzing
4. Public Reporting
5. Quality Improvement

How Does Medical Home Help You?

It will change your:

- Processes
- Outcomes
- Cost
- Quality
- Future

CMS Commissioned RTI International

The following is a review of SETMA's quality, coordination and cost compared to benchmarks and 312 medical homes. (From a study done by RTI International for CMS)

For the full report go to:
http://www.jameslhollymd.com/Medical-Home-Study-conducted-by-RTI-International.cfm

CMS Commissioned RTI International

Measure	SETMA (# patients 3682)	Benchmark (# patients 24,210	All study NCQA Medical Homes (# patients 146,410) (# practices 312)
Quality of Care			
LDL-C	93%	86%	85%
HbA1c	97%	86%	90%
Influenza Vaccination	57%	39%	50%

SETMA's Influenza Audit

(Patient refused shot was included in denominator)
(Patient allergic to shot excluded)

	7/1/2009 to 6/30/2010		7/1/2010 to 6/30/2011	
Clinic	CMS Study	All Medicare	CMS Study	All Medicare
SETMA 1	54.3 %	61.3	57.5	57.5
SETMA 2	57.4	73.7	71.1	83.0
SETMA West	53.0	62.2	60.2	68.9

Table 2. Overview of Trends in Measures for Your Practice: July 2007 to June 2010.

Measures	Your Practice Time Period 1: July 2007 – June 2008 (N benes=390)	Your Practice Time Period 2: July 2008- June 2009 (N benes=421)	Your Practice Time Period 3: July 2009- June 2010 (N benes=446)	Your Practice % Change (July 2007- June 2010)	Average % Change across all study NCQA Medical Homes (N benes=146,410 N practices=312)
Quality Of Care Measures (% of beneficiaries)					
LDL-C Screening	97 %	90 %	93 %	-4.1 %	3.5 %
HbA1c Testing	98 %	95 %	97 %	-1.0 %	1.5 %
Influenza Vaccination	32 %	34 %	51 %	59.4 %	20.2 %
Potentially Avoidable Hospitalizations / ER Visits based on Ambulatory Care Sensitive Conditions (ACSCs)					
Potentially Avoidable Hospitalizations (rate per 100 beneficiaries)	7.4	9.5	6.7	-9.5 %	-2.2 %
Potentially Avoidable ER Visits (rate per 100 beneficiaries)	13.6	17.6	11.9	-12.5 %	-5.2 %
Average Annual Payments ($ per beneficiary)					
Average Total Medicare FFS Payments	$6,430	$7,464	$8,703	35.4 %	12.0 %

CMS Commissioned RTI International

Comment from RTI staff about benchmarks:

"The benchmarks are from a predictive model that uses the comparison group performance and models the relationship between the outcomes and practice characteristics such as average health status of beneficiaries assigned to the practice, size of practice, type of practice, etc. To the extent that your two clinics have different characteristics you will have different benchmarks."

CMS Commissioned RTI International

RTI staff comment about the problem with influenza-immunization rates taken from CMS charges:

"I have always had reservations about reporting influenza vaccination from Medicare claims data. And, your data shows why I am hesitant. We simply do not capture in our rates vaccinations provided to Medicare FFS beneficiaries that are not subsequently billed to Medicare. You clearly have a more robust system for capturing the actual rate of receipt among your patients."

CMS Commissioned RTI International

Measure	SETMA (# patients 3682)	Benchmark (# patients 24,210)	All study NCQA Medical Homes (# patients 146,410) (# practices 312)
Coordination and Continuity of Care			
Hospitalization rate	24.5% per 100	47.4%	16.9%
30-Day readmission	17.5%	40.4%	13.2%

CMS Commissioned RTI International

Measure	SETMA (# patients 3682)	Benchmark (# patients 24,210	All study NCQA Medical Homes # patients 146,410 (# practices 312)
Annual Payments			
Total Medicare Payments	$8,134	$12,919	$5,715
Potential Avoidable Payments			
Avoidable Inpatient	$962	$2,259	$710

How Does Medical Home Help You?

It prepares you for the future by helping you recapture the best of the past

- The foundation of health care has always been trust and hope.
- Today, patients often have more trust in technology than in their healthcare provider.
- PC-MH helps you engage the patient as a part of their healthcare team and thus helps them take charge of their own care with the trust and hope that "making a change will make a difference."

How Does Medical Home Help You?

It helps you prepare the patient to accept responsibility for their own care.

- If the patient's healthcare team is envisioned as a "relay team," the patient's plan of care and the treatment plan is the "baton."
- Often, it is forgotten that the team member who carries the "baton" for the majority of the time is the patient and/or the family member who is the principal caregiver.
- If the 'baton' is not effectively transferred to the patient or caregiver, the patient's care will suffer.


Firmly in the provider's hand,
the baton – the care and treatment plan –
must be confidently and securely grasped by the patient,
if change is to make a difference,
8,760 hours a year.

The Baton – What Does it Mean?

In all public areas and in every examination room, SETMA's "Baton" poster is displayed. It illustrates:

- That the healthcare-team relationship, which exists between patient and healthcare provider, is key to the success of the outcome of quality healthcare.
- That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is created, transmitted and sustained.

The Baton – What Does it Mean?

- That the means of transfer of the "baton," which has been developed by the healthcare team is a coordinated effort between the provider and the patient.
- That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but without its transfer to the patient, the provider's knowledge is useless to the patient.
- That the imperative for the plan – the "baton" – is that it be transferred from the provider to the patient, if change in the life of the patient is going to make a difference in the patient's health.

The Baton – What Does it Mean?

- That this transfer requires that the patient "grasps" the "baton," i.e., that the patient accepts, receives , understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.

- That the patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the baton," longer and better than any other member of the healthcare team.

How Does Medical Home Help You?

You are the healthcare generation which is bridging the health science revolution with the health delivery transformation. **Medical Home is the substance, structure and support of that bridge.**

Future generations of healthcare providers will not experience the quality chasm which has motivated the Medical Home movement and will not see a "bridge," only a continuum of care.

How Does Medical Home Help You?

It allows you to envision a future of your own creation in healthcare.

One patient who came to the clinic He was angry depressed. He left the clinic with The SETMA Foundation buying all of his medications, giving him a gas card to get to our ADA certified DSME program, the fees waived for the classes, help in applying for disability, and an appointment to an experimental program for preserving the eyesight of patients with diabetes. He returned in six weeks with something we could not prescribe. He had hope and joy. By the way, his diabetes was to goal for the first time in years.

This is PCMH and it is humanitarianism.

They may be the same thing.

Medical Home: What Should I Do?

- **Get started!**

  In my life, I have started many things which I never finished, but I have never finished anything I didn't start. No matter how daunting the task, the key to success is to start.

- **Compete with yourself, not others!**

  "I do not try to dance better than anyone else. I only try to dance better than myself "– Mikhail Baryshnikov.

  It doesn't matter what someone else is or is not doing; set your goal and pursue it with a passion. Measure your success by your own advancement and not by whether someone else is ahead or behind you.

Medical Home: What Should I Do?

- **Don't give up!**

  The key to success is the willingness to fail successfully. Every story of success is filled with times of failure but is also characterized by the relentlessness of starting over again and again and again until you master the task.. When we started our IT project, we told people about what we are doing. We call that our "Cortez Project". Like Cortez, we scuttled our ships so there was no going back. We had to succeed.

Medical Home: What Should I Do?

- **Have fun! Celebrate! Enjoy what you are doing and celebrate where you are.**

  In May of 1999, my co-founding partner of SETMA lamented about our EMR work; he said, "We are not even crawling yet." I said, "You are right but let me ask you a question. 'When your son turned over in bed, d id you shout and say to your wife, "this retard, dimwitted brat can't even crawl, all he can do is turn over in bed?" Or, did you shout to your wife, "He turned over in bed?" Did you celebrate his turning over in bed?" He smiled and I added, "I am going to celebrate that we have begun. If in a year, we aren't doing more, I will join your lamentation, but today I celebrate!"

Accountable Care Organizations

"…(An ACO) is a local health care organization that is accountable for 100 percent of the expenditures and care of a defined population of patients. Depending on the sponsoring organization, an ACO may include primary care physicians, specialists and, typically, hospitals, that work together to provide evidence-based care in a coordinated model. “

Accountable Care Organizations

To be successful an ACO must be built:

- upon multiple Medical Homes
- an existing infrastructure
- without a hospital as a partner
- as a bridge to Medicare Advantage
- with patient engagement and agreement

With the realization that without the above five elements, ACOs cannot succeed.

Accountable Care Organizations

Some ACO functions are like those of traditional insurance. The differences are that Medicare still pays the bills rather than the ACO and Medicare is liable for paying all of costs whether they exceed a budget or an expected expenditure, or not.

In Medicare Advantage programs, Medicare transfers its risk to the HMO which allows Medicare to budget its cost for each ,ember. No matter what the actual cost of care is, Medicare will never pay the HMO more than the contracted per member payment.

Accountable Care Organizations

Traditional insurance defines its risk by contract. Medicare Advantage defines its risk by its "bid," which is a contractual relationship with CMS which defines benefits in addition to the regular Medicare benefits. In both cases, insurance companies and Medicare Advantage plans have no Protection from "down-side" risk, i.e., the potential for the care of a patient or client costing more than what the insurance company is paid.

Accountable Care Organizations

The highest probability of success may occur in integrated delivery networks that already have an electronic infrastructure which can be adapted to the functions needed for ACO accountability and accounting and have strong relationships with IPAs. The principle reason for the higher potential of success is the HMO/IPA partnership already has a model for the sharing of revenue. This will be one of the biggest hurdles for other ACOs.

Accountable Care Organizations

When the participants in an ACO do not have an existing integrated financial relationship, it will be very difficult to hold the group together once the division of profits begins to take place. Our health care system has placed high value on facility and procedure services and has placed little to no value on comprehensive and coordinated care. There is nothing structurally within the ACO model to date which addresses that dichotomy in anything but a *Laissez faire* manner. The division of the financial benefits of the ACO may be its Achilles heel.

Accountable Care Organizations

Patients who understand the benefits of restricted-access healthcare (managed care) have already elected to join Medicare Advantage programs. For agreeing to see only certain healthcare providers, the patient receives Increased benefits and reduced cost. This methodology has increased access to healthcare for many. Others have rejected that model of care.

To involuntarily enroll those who have previously rejected a "managed care" model creates an ethical dilemma.

Accountable Care Organizations

The ACO can avoid this pitfall by transparently notifying those whose care is to be managed in an ACO.

And, the ACO must enroll only those who give prior consent to do so. As with patient-centered medical home, engaging the patient as a partner in preserving American healthcare with improved quality by cost savings is the best solution to this potential hazard. .

Accountable Care Organizations

The involuntary enrollment of patients into ACOs creates a potential legal hazard in the event of an adverse outcome, particularly if the patient wanted to go to one provider and was sent to another. That would probably not be the cause of the negative outcome but the ACO will bear the burden of proving that. The potential hazard is avoided by full disclosure and informed consent.

Accountable Care Organizations

As noted above, most patients have more confidence in technology than a personal relationship with physicians, which means that the principle way to decrease the cost of care is to ration care. But, the most effective way to change the cost curve is to restore patient's trust in their doctor so that their counsel is sought before a test is ordered.

This is the reason why, any ACO which has the least potential for success must be built upon healthcare providers who are not only have the designation but who are also actually functioning in a patient-centered medical home.

Accountable Care Organizations

In a compassionate, comprehensive, coordinated and collaborative relationship, it possible to recreate the trust bond which supersedes technology in the healthcare-decision-making equation. In that relationship, wise decisions can be made about watchful waiting, appropriate end-of-life care and a balance between life expectance with and without expensive but unhelpful care. Increasingly, we have to wonder if technological advances are actually resulting in a decreased rather than an increased quality of life.

Accountable Care Organizations

At present the ACO design is based on an annual reconciliation of cost with the potential for sharing the savings realized.

It is highly improbable that that is a sustainable model. It is more likely that the reconciliation will be multi-year with either a gong-forward withhold for past losses or a with hold of earned savings in anticipation of possible adverse results in the future.

Accountable Care Organizations

IBNR stands for "incurred but not received" and refers to services which have been provided but for which the bill has not yet been presented. Financial planning for a successful ACO must take into account fluctuations in results.

Careful cash management with adequate capitalization initially can help the ACO weather revenue shortfalls and benefit from positive results in the good times. The first step is to anticipate multi-year reconciliation and to build a business model on that expectation.

Accountable Care Organizations

Inherent in this entire discussion is the fact that the ACO is a public-policy initiative which has no inherent value to the patient but only to the ACO and to CMS.

In reality, in the ACO, there is no structural benefit for the patient. This can be resolved by the policies of the ACO which concentrates on comprehensive, preventative health with wellness metrics and with coordination of care. In this way, the patient returns to the focus whether or not the ACO "makes money."

Universal American & NextGen

This is a first of its kind collaboration

- HCC & RxHCC
- Patient-Centered Medical Home
- Disease Management

NextGen is taking SETMA's database And incorporating it into the NextGen data base. Let me show you!!