Trailblazers in accountable care

Leading the value transformation journey
With the health care market moving from a volume-based to a value-based model, provider organizations are covering a lot of new ground. Clinics and hospitals are becoming more accustomed to taking on a higher level of patient medical risk, and more accountable care organizations and other value-based arrangements are forming.

For example, the Centers for Medicare and Medicaid Services (CMS) reported in January 2013 that 106 organizations had joined the Medicare Shared Savings Program (MSSP), making the number of CMS-recognized Accountable Care Organizations (ACOs) 250 nationwide since the passage of the Affordable Care Act. Those 250 organizations cover more than 4 million Medicare beneficiaries, providing them with more coordinated and, ostensibly, higher quality care. More important, physicians and hospitals are working more closely to give patients health services they need.

This paper will discuss the experiences of leaders of transforming organizations who are experiencing firsthand the maturation of the market. The organizations include Monarch HealthCare of Irvine, Calif.; Cornerstone Health Care of High Point, N.C.; Mayo Clinic of Rochester, Minn.; WestMed Medical Group of Westchester, N.Y.; and Hartford HealthCare System of Hartford, Conn. Leaders from these organizations will share how they are responding to changes in local marketplaces, how they’re transforming their own business models, what progress they’ve seen in clinical integration and population health management, and how organizations like theirs will respond to changes in financial incentives over the next few years.

The Value Transformation Journey
The experiences of these and other organizations blazing the trail from volume to value have created a map of sorts that can guide the actions of other organizations working to follow the same course. There are five key waypoints on the value-based transformation journey:

- **Market Assessment** – Start by asking how the current market landscape influences the move to a value-based model. Organizations must understand how funds flow across their local marketplace, the landscape of payers and products in those markets, and how that local market influences both payers and products. Demographic and reform trends will impact payers and the patient population, and that means it’s critical to develop future state models highlighting market movement.
• **Strategic Structure** – Based on the market assessment, as well as internal analysis, the next waypoint is determining the appropriate structure and governance model for the organization. This takes evaluation and definition of the partnership and business structures. Will the organization be an ACO, a clinically integrated network (CIN), a physician/hospital organization (PHO) or something else? There must be definitions of vision, governance, guiding principles and operating models, followed by identification of the network structure for physicians and incentive models to ensure alignment.

• **Population-Based Planning** – The third waypoint on the journey is determining whether value transformation pays off for each population-based opportunity. Success will come by digging into your data to find opportunities to improve populations and partner with the payers that reach populations. Organizations also need to define future population value-based care models, evaluate current population health capabilities across the organization, and perform population-based gap analyses and resource requirements.

• **Financial and Capacity Planning** – The next waypoint addresses financial viability. Does the financial model offer the returns required to support investment and ensure financial goals? Good financial and capacity planning means defining inpatient and outpatient optimization opportunities based on operational benchmarks while also outlining risk model strategies and scenarios. Again, it is important to understand how the market and population impact utilization and capacity, which helps in the definition of financial forecasts around resource requirements, capital and costs.

• **Value-Transformation Roadmap** – Once organizations have considered the local market, determined an appropriate structure, and analyzed patient populations and financial viability, they need to plot a course that will take them from planning to practice. Top of mind for any value-based organization is costs that impact care. They must define population-based and care model paths and identify opportunities to direct care to lower cost settings. Part of this is also sequencing movement into value-based models for payers and populations, while also developing a coordinated value-transformation roadmap across capabilities.

Each of these steps is discussed in the following sections. But before embarking on a value-based transformation journey, remember that the foundation of the entire structure relies on alignment and consensus-building among all parties. Ongoing communication and regular involvement from vested constituents will mean a more streamlined, smooth trip.
Responding to Changes in the Local Marketplace

All health care is local. And while the concept of accountable care is applicable nationwide, the ways in which organizations approach it will be vastly different. “My experience creating a successful ACO in San Francisco is vastly different from my experience building one in Sacramento, though they are only 90 miles apart,” said Cynthia Kilroy, senior vice president of provider strategy at Optum. “The local dynamics are unique to their areas, and one model does not fit all.”

Consider the major southern California counties—Orange, Los Angeles and San Diego. The penetration of health maintenance organizations (HMOs) is deep, so most physicians in these markets have experience with managed care and incentive-based performance models. As a result, southern California is further along the learning curve toward accountable care, said Colin LeClair, executive director for Monarch HealthCare ACO.²

“A good managed care physician can deliver high-quality, cost-effective care to one patient at a time. But to manage the health of the entire patient population on an ongoing basis, today even a great physician must also be a good manager and leverage his/her staff,” LeClair said. “Allowing clinicians to practice at the top of their license is a cliché, but it has never been more true than in the ACO world where your mid-level providers, medical assistants and office staff must be trained and empowered to keep your patients healthy and engaged.”

The old axiom “think globally, act locally” definitely applies to health care’s value transformation. National regulations inevitably affect local delivery. Current initiatives of concern for providers include Medicaid expansion, health insurance exchanges and dual eligibles. Medicaid expansion may drive more volume for the historically low-reimbursing program stretching provider resources. The effects the health insurance exchanges will have on local markets are less certain. Depending on the market, they may provide access to a more profitable patient population. The Medicare/Medicaid dual eligibles demonstration projects happening around the country are of great interest to California-based Monarch. LeClair sees California’s senior-focused ACOs losing up to 20% of their enrollees to Medicare Advantage special needs plans, when they are compelled to enroll because of their dual Medicare/Medicaid eligibility. ACOs may see a big hit to their own health and stability.

Focusing on the local market means more than just adjusting to what the marketplace throws at you; it’s also paying attention to what the local market needs and who they are. Leadership needs to pay attention to these demands to ensure responses hit the mark for the community.

In New York, WestMed caters to many different cultural and religious populations with differing needs. According to Simeon Schwartz, founding president and CEO of WestMed, it’s all about paying attention to community, culture and customs.³

“Physician leadership needs to understand who it is really taking care of and what they need,” Schwartz said. “It all begins with listening, and leadership—myself included—tends to talk too much. We must listen to what the community wants.”
Business Model Changes

Organizations are straddling the line between volume and value. Movement from one payment model to the other takes strong leaders with a vision and tenacity to execute on solid, well-planned strategies, wherever they are on their value transformation journey. There is a certain necessity in being methodical and adapting as business trends change.

One beneficiary of strong leadership is Cornerstone Health Care in North Carolina, where 100 percent of its contracts include a fee-for-value gain sharing element. Grace Terrell, MD, Cornerstone’s CEO, said the multispecialty clinic has moved far forward in implementing care transformation that is showing tremendous results. The organization has worked hard to build infrastructure for high-risk populations, setting up a heart failure clinic, redesigning its oncology clinic and developing a concierge practice for Medicaid and Medicare dual eligibles. “The results on our Medicare Shared Savings alone shows that we are performing far better than our market and far better than the average national ACO,” Terrell said.

Such changes can result in big returns if the proper infrastructure is in place. It requires looking at an entire system and determining what pieces are needed and pushing for those in a singular motion, said Ted Schwab, partner with Oliver Wyman Group, a health and life sciences consulting firm.

“If you take a step back and look at the natural horizon, you have to create the infrastructure or you can’t do any of this,” said Schwab, whose group has helped Cornerstone make changes to its business model.

Another success story is Monarch HealthCare, which has converted a portion of its independent practice physicians’ Medicare business to an accountable care structure. The change happened, in part, due to a refocus on patient and physician engagement. Having made its name in the HMO world, where patients are directed to appropriate providers and care settings, creating an ACO with fee-for-service Medicare patients took a significant adjustment.

Monarch took great pains to persuade patients that taking part in value-based care does not take away benefits, nor is the health system simply trying to sell them something. “It took great effort to convince and persuade patients that what we have to offer is of value,” said Bart Asner, MD, Monarch’s chief executive officer. “Our message is if we can help you and keep you well, you may not end up in the hospital.”

Monarch has a team of nurses and social workers that engage patients by phone and other workers who visit patients in their homes. Once a patient’s needs are identified, Monarch builds engagement directly with the person and through his or her primary care physician.

“We may say [to a patient], ‘I know you have diabetes, which you are trying to get under control. I have a diabetic educator or nurse who would love to talk with you and try to help,’” Asner said. “If that message comes from the doctor or the doctor’s office, or is at least endorsed by the doctor, we are way ahead of the game.”
Organizations just getting started with value-based services need to focus on areas that make the most sense for a particular facility or practice. Hartford HealthCare is structuring models to live in a fee-for-service world while determining what clinical transformations should be done first. Hartford’s leaders asked which hospitals demonstrate the most target-rich potential for quick progress, said James Cardon, executive vice president and chief clinical integration officer for Hartford HealthCare.

“There are certain hospitals that are going to benefit more from focusing on a specific challenge, for example, length-of-stay issues,” Cardon said. “We focus on the opportunities that are most pressing for specific facilities, execute a plan to create a best practice and then roll that best practice out across the system.”

Cornerstone, an organization much further along in its journey than Hartford, followed the same route. “We prioritized where we felt the most opportunity for improvement in the system was, and with the resources we had,” Terrell said.

Resources are at a premium in every organization, so sometimes it becomes necessary to partner with outside organizations to accomplish high-priority parts of your transformations. But Cardon said that outsourcing any service related to the care model should be a temporary strategy for provider organizations. “There are just certain things a provider needs to offer, and I don’t know how you would do that when more hands are involved and [care] is not controlled by one entity,” he said.

Ultimately, successful business model changes must come from the top down. Challenges arise when leaders do not understand the scope of the investment and scientific knowledge required to properly institute change, Schwab said.

“It takes a strong man or woman to stand up in front of an organization and say we are going in a different direction,” Schwab said. “We are just at the stage of early adopters when it comes to care model change, and I don’t mean there hasn’t been some terrific work, but we’re just beginning to see that instituted. Everybody knows it will be a rocky road getting from point A to point B, and it takes a specific type of leader to effect change.”

**Clinical Integration and Population Health Management**

On the journey from volume to value, ACOs must adopt coordinated, organization-wide efforts that utilize capabilities driven by market movement and population health management.

A key to this approach is managing costs and improving quality by building integration between the organization and its providing physicians and hospitals. Monarch’s organization mostly works with affiliated rather than employed physicians. As such, LeClair said his organization’s integration effort focuses on incentives. And though profits were part of the equation, Monarch worked to ensure doctors kept their attention on quality care as the path to incentives and created a communication channel where information sharing between physicians and administrative leadership was consistent and strong.

“We are just at the stage of early adopters when it comes to care model change, and I don’t mean there hasn’t been some terrific work, but we’re just beginning to see that instituted.”

—Ted Schwab, Oliver Wyman
“We’re getting very tangible, actionable feedback from our Physician Advisory Committee,” LeClair said. “Most of our participating physicians care for 50-100 Medicare fee-for-service lives in our ACO but have multi-hundred patient practices. Physicians are overburdened with quality improvement programs and medical cost savings initiatives from a variety of payers. It’s sometimes hard to get their attention. So we offer incentives to make our programs attractive. Our physicians have been helpful in guiding those decisions and structuring incentives appropriately to ensure we keep their attention and get the desired results.”

Mayo Clinic, another organization making great strides from volume to value, bears full risk for its self-insured employees and dependents. The organization developed its care coordination program through its primary care physicians based in its flagship academic medical center. The challenge Mayo is undertaking is translating the care coordination concepts that work in an academic setting to more regional and local settings, said Kari Bunkers, MD, a family medicine physician in Mayo’s Owatonna, Minn., facility and medical director for Mayo’s office of population health management.

“Our challenge is with integrating the concepts and models developed in a resource-rich academic environment into our already lean regional and community practices that have a long history of providing primary care in a fee-for-service model,” Bunkers said.

Mayo has developed a population health management framework with focused programs to transform its regional and community practices to the fully value-based “Mayo Model of Community Care.” Toolkits developed by program leaders give local sites structure with which to phase in the transformative changes in their practice model.

Hartford HealthCare is also putting physicians at the forefront of its value-based efforts. The integrated system started a doctor-led integrated care program that has the objective of seamless transitions from one care setting to another.

“At first, the focus was on aligning the physicians, who tend to be fairly independent,” said Hartford’s Dr. Cardon. “But it became clear that if you don’t build a culture from the ground up, if you don’t have the physicians engaged in the process and instead try to impose it, it is not going to work.”

Cardon said Hartford worked to have representatives from all areas of the system, including physicians, on the steering committee. The organization started at a granular level and made an effort to move the entire group along the same education and information pathway at the same time. Nearly a year later, engagement is fast growing, and all parties are seeing the value behind the transformation.

Cornerstone’s integration effort is focusing in part on its various service lines. Doctors and mid-level providers are coming to consensus on how they, as a group, can most effectively work together. “It has been absolutely wonderful,” said Terrell. “We are having conversations [with physicians] we’ve never had before. One of our most productive interns has turned into one of our poly-chronic specialists. He cares for our sickest patients in a team-care setting and sees half the number of patients he used to. He came to me the other day and said, ‘This is what I dreamed medicine would be. This is the way I have wanted to practice my whole life.’”

“At first, the focus was on aligning the physicians, who tend to be fairly independent,” said Harford’s Dr. Cardon. “But it became clear that if you don’t build this from the ground up, if you don’t have the physicians engaged in the process and try to impose it, it is not going to work.”

—James Cardon, MD, Hartford HealthCare

Doctors and mid-level providers are coming to consensus on how they, as a group, can most effectively work together.
Financial Transformation

Ultimately, there is a financial side and a clinical side to the ACO equation, and both need to be in balance. An essential piece in the volume-to-value transformation is how organizations financially adjust to new market realities. Schwab, of Oliver Wyman, sees ACOs and other value-based organizations becoming more externally focused long term in their contracting, partnering and how they invest in populations that matter.

“This transformation from volume to value is about carrots, not about sticks,” Schwab said. “ACO leaders have looked for those partnerships that are going to bring them value-based contracts, and they’ve looked for external infrastructure.”

The short-term strategy, he said, is to focus on the low-hanging fruit—the three-to-five percent of the population that drives 60 percent of costs. Smart organizations will also pay attention to long-term strategies, which include focusing on internal aspects of improvement: stimulating utilization of generic prescriptions, reducing waste in care, and reducing technology variation.

The elephant in the room, especially for hospitals and integrated systems, is what to do as the changes start taking effect and inpatient utilization begins to decrease. Hartford HealthCare is in the early stages of determining what facilities and departments within its system will be most impacted as utilization drops. It is currently doing what many other systems are doing: getting leaner by removing costs.

“There is a seriousness of purpose around understanding what is going to happen. It is unclear whether all hospitals or only some grow within the system and which ones shrink. Do they all lose volume?” Cardon said. “I think there is no question that there’s a sense that volumes are going to drop. What we need to do is figure out the essential care provided by the hospitals and become more cost efficient than anybody else.”

Mayo Clinic is more mature than most in its ability to evaluate impacts to utilization and finances. It has done research on population trends and care trends within its primary care service area over the next five years, which should give Mayo leaders a sense of what service lines to scale back and which ones to ramp up, Bunkers said.

Medicare’s Pioneer ACOs are a heterogeneous group, but as one that is emerging as a top performer, Monarch views its careful launch into fee-for-value as a key tactic.

“What we need to do is figure out the essential care provided by the hospitals and become more cost efficient than anybody else.”

—James Cardon, MD, Hartford HealthCare

“We took a very conservative approach and screened our physicians thoroughly for a few specific traits,” LeClair said. “We looked to our exclusive physicians first: the ones who work only with us, where we already have a strong relationship. We also look for strong performance in quality and utilization in other lines of business. For example, those with high Medicare Advantage Star Quality scores, low emergency room utilization and low 30 day all-cause readmission rates probably make great candidates for the ACO.”

The message here, LeClair continued, is to be highly selective in who you choose to be a part of your ACO. “Make sure they are already fluent in your medical management and quality protocols. That way, you don’t have to spend one-and-a-half years bringing them up that curve.”
Getting to the End of the Journey

The ultimate goal is to develop a value-based system that focuses on local market needs and how engagement at all levels can be attained. Getting there is another matter, which is why the development of a comprehensive, strategic value-transformation roadmap is crucial for success.

The way hasn’t been easy for the trailblazers. There will be individuals who fight the changes, and in Terrell’s opinion, there will always be the “theoretical evil” people on all levels who are in it for the money.

“The [existing fee-for-service system] has created all sorts of disincentives and misalignment because there is a lot of ‘me’ and less of ‘we,’” she said. “I think most people are good people. But there is evil in this world, and for some people, that’s who they are. We have to design a system that allows everyone to do the right thing for our patients. If we create a well-designed system, then even the evil people do it!”

For Monarch’s LeClair, success lies in being conservative and focusing on physician and patient engagement. “The truth is, we are still learning. ACO guidelines continue to evolve. We don’t completely understand how Medicare fee-for-service patients make health care choices. And we don’t yet know how best to help them choose high-quality, low-cost care. So for now, maintaining a narrow, engaged network of physicians seems to be the prudent approach,” he said. “If we can continue to move patient care from the acute environment into the ambulatory environment, then we’ll be able to reinvest the savings in our infrastructure, grow our network and improve care for a larger patient population.”

“The path to accountable care is continuous improvement. Don’t try to solve all of your ACO patients’ problems at once,” he said. “Direct physicians’ attention to the highest risk patients and to the weightiest quality measures. Allow them to bite this off in small pieces and then build on that.”

---

2Colin LeClair (Monarch HealthCare ACO executive director), interview by Cynthia Kilroy, April 26, 2013. All information attributed to Mr. LeClair is from the aforementioned interview.
3Simeon Schwartz, MD (WestMed founder and CEO), interview by Cynthia Kilroy, April 25, 2013. All information attributed to Dr. Schwartz is from the aforementioned interview.
4Grace Terrell, MD (Cornerstone Health Care president and CEO), interview by Cynthia Kilroy, April 16, 2013. All information attributed to Dr. Terrell is from the aforementioned interview.
5Ted Schwab (partner in Oliver Wyman’s health and life sciences practice), interview by Cynthia Kilroy, April 18, 2013. All information attributed to Mr. Schwab is from the aforementioned interview.
6Bart Asner, MD (Monarch HealthCare CEO), interview by Cynthia Kilroy, April 18, 2013. All information attributed to Dr. Asner is from the aforementioned interview.
7James Cardon, MD (Hartford Healthcare executive vice president and chief clinical integration officer), interview by Cynthia Kilroy, April 24, 2013. All information attributed to Dr. Cardon is from the aforementioned interview.
8Kari Bunkers, MD (Mayo Clinic Health System chief medical information officer), interview by Cynthia Kilroy, April 25, 2013. All information attributed to Dr. Bunkers is from the aforementioned interview.
About Optum

Optum is an information and technology-enabled health services company serving the broad health care marketplace, including care providers, health plans, life sciences companies and consumers and employs more than 30,000 people worldwide. For more information about Optum and its products and services, please visit [www.optum.com](http://www.optum.com).