

ACO Accelerated Development Learning Session

Baltimore, MD
November 17–18, 2011

Case Study 1: Building an ACO on the Foundation of an IPA



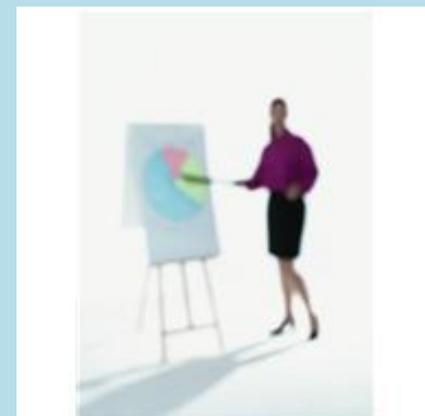
November 17, 2011
9:00–9:30 a.m.

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Monarch HealthCare

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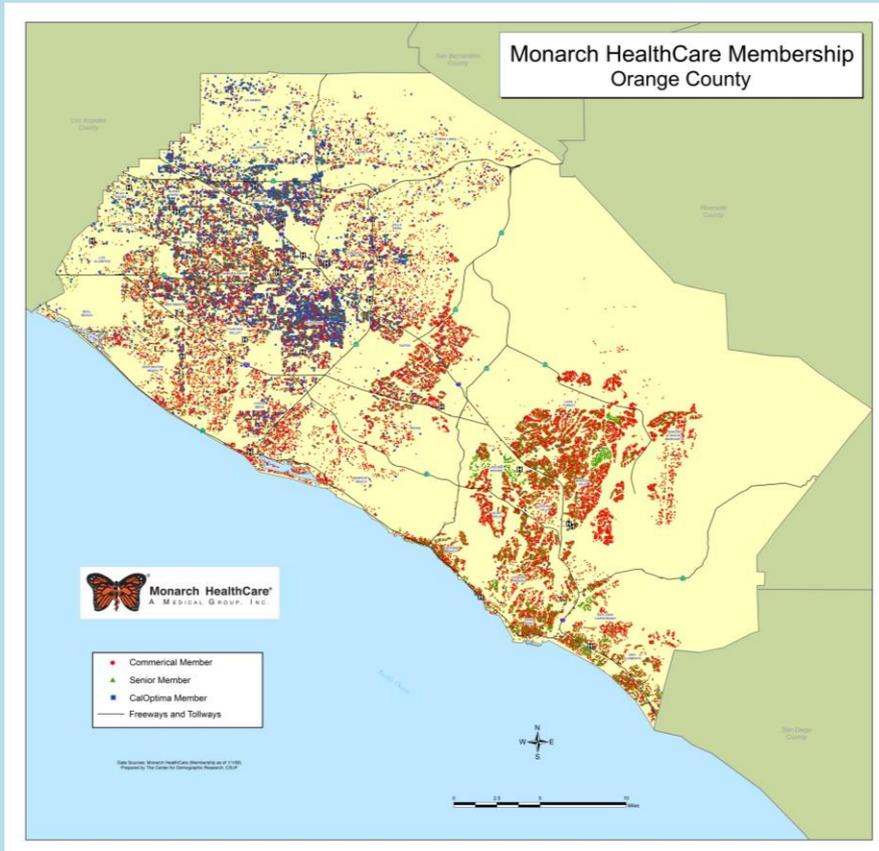
Presentation Agenda

- Monarch HealthCare—“Facts and Figures”
- The Brookings-Dartmouth ACO pilot
- The “Why” of an ACO
- Organizational structure
- Care management and the cost of care
- Financial risk bearing and financial management
- Health information technology (HIT) and the role of data analytics
- Key concepts in leading ACO development
- Learning from experience



Monarch HealthCare—Facts and Figures

“Helping Physician Partners Advance Medical Excellence in the Communities We Serve”

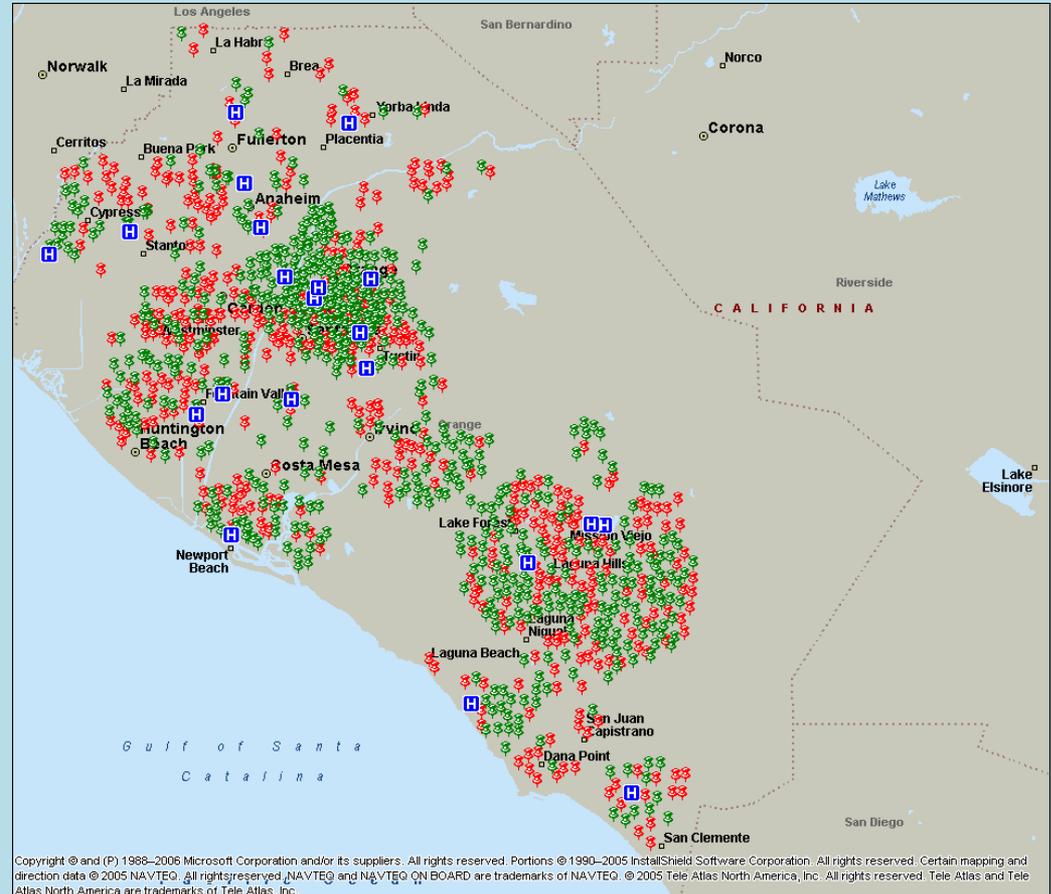


- Formed in 1994 as an Independent Practice Association (IPA)
- Aggregation of three predecessor IPAs
- Later had contiguous geographic expansion
- The only physician delivery system that spans Orange County (excluding Kaiser)
- Relationships with all major health plans

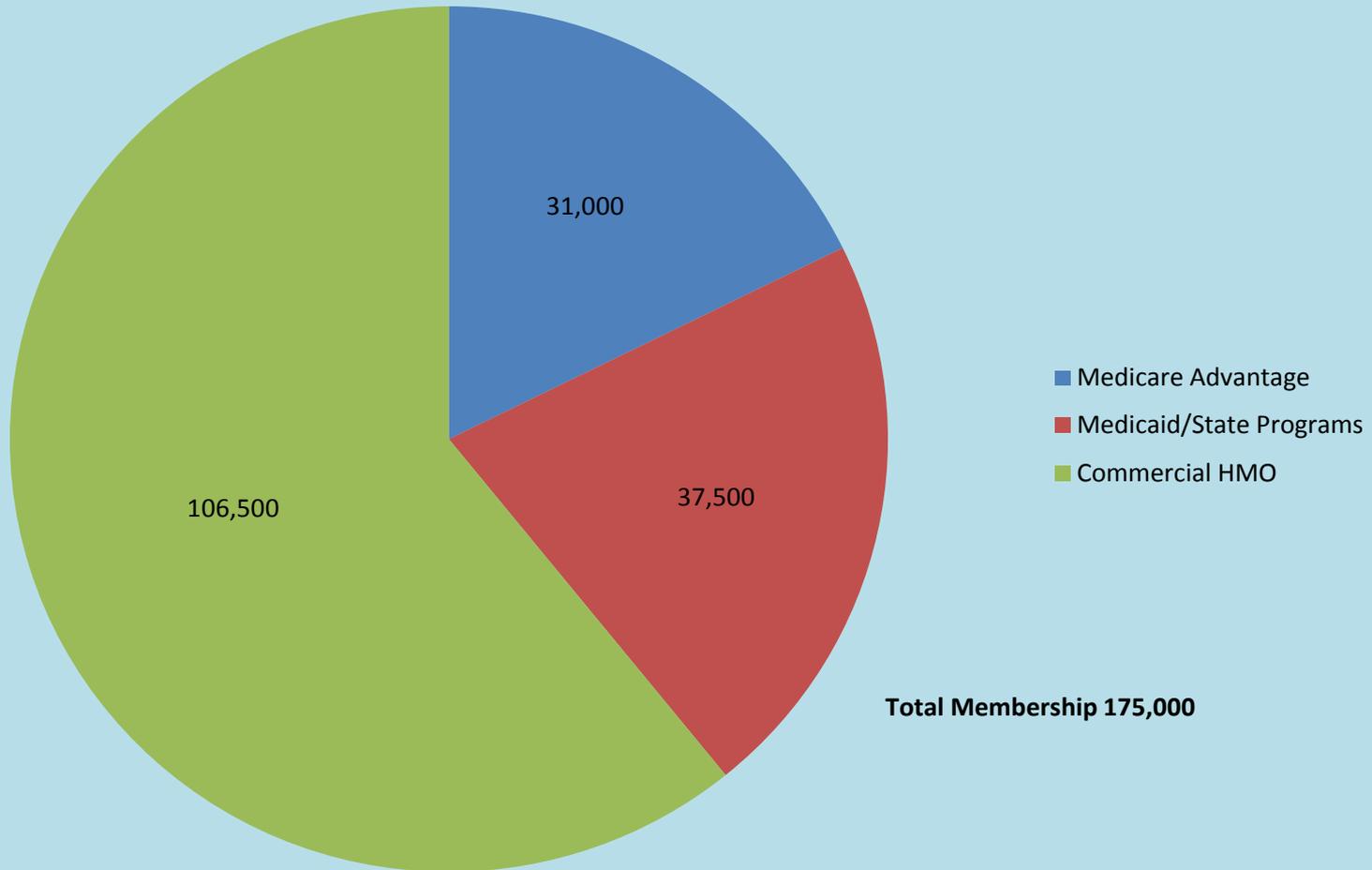
Monarch HealthCare—Fact and Figures

- 750 primary care providers (PCPs) and 1,600 specialists
- 18 hospital contracts, countywide

	Hospitals
	PCPs – 750
	Specialists – 1,600



Monarch HealthCare—Fact and Figures



The Brookings-Dartmouth ACO Pilot

- In 2010, selected by the Brookings-Dartmouth Institute
- One of five ACO pilot sites in the nation
- Five-year pilot, began January 1, 2011
 - Patients received a new ID card and welcome letter explaining benefits of ACO and program details
 - Preventive care reminders
 - Patient Profile launched
 - Physician-driven care coordination
- Focus on identifying performance measures for the commercial population and implementing improvements impacting quality and cost

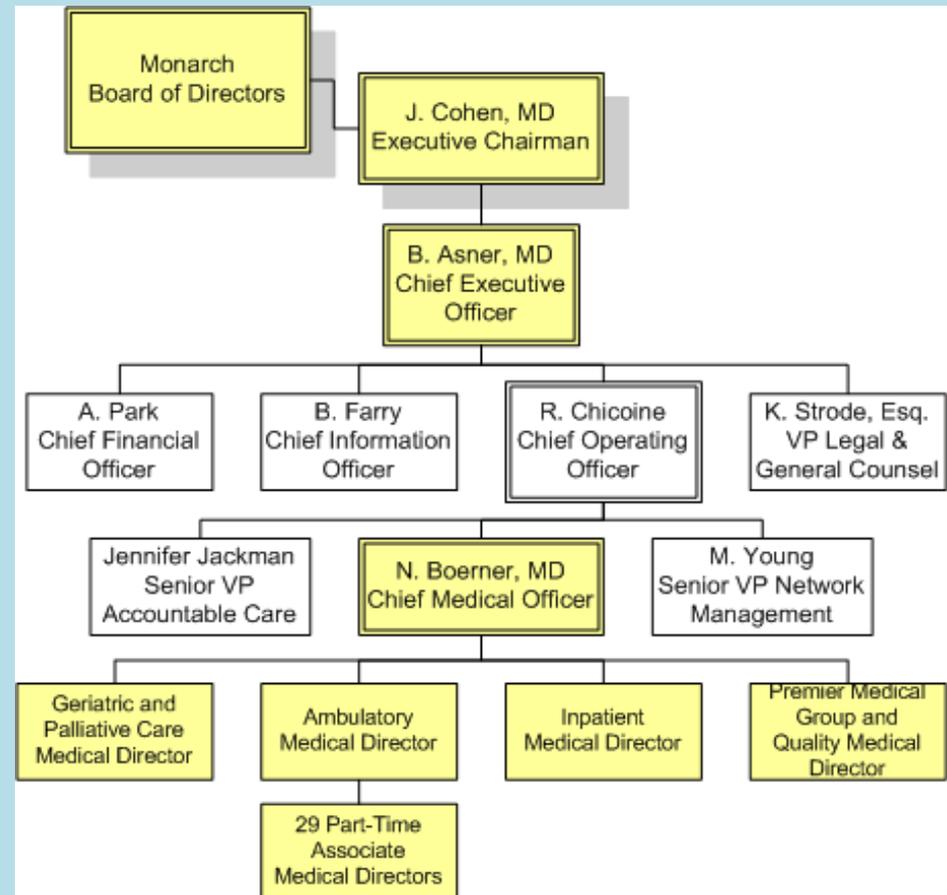


The “Why” of an ACO

- Three-part aim: better population health, better healthcare delivery, reduce costs
- An ideal opportunity to utilize Monarch’s core competencies
- A value proposition for physicians
 - Preserves the independent practice of medicine in association with a high-quality “branded” delivery system
 - Assistance through care management support, reports, and tools
 - Cultural commitment to “do the right thing”
- A value proposition for Monarch
 - Growth potential in a new market
 - Monarch’s mission will include more providers and patients
 - Enhances provider engagement and success through aligned incentives

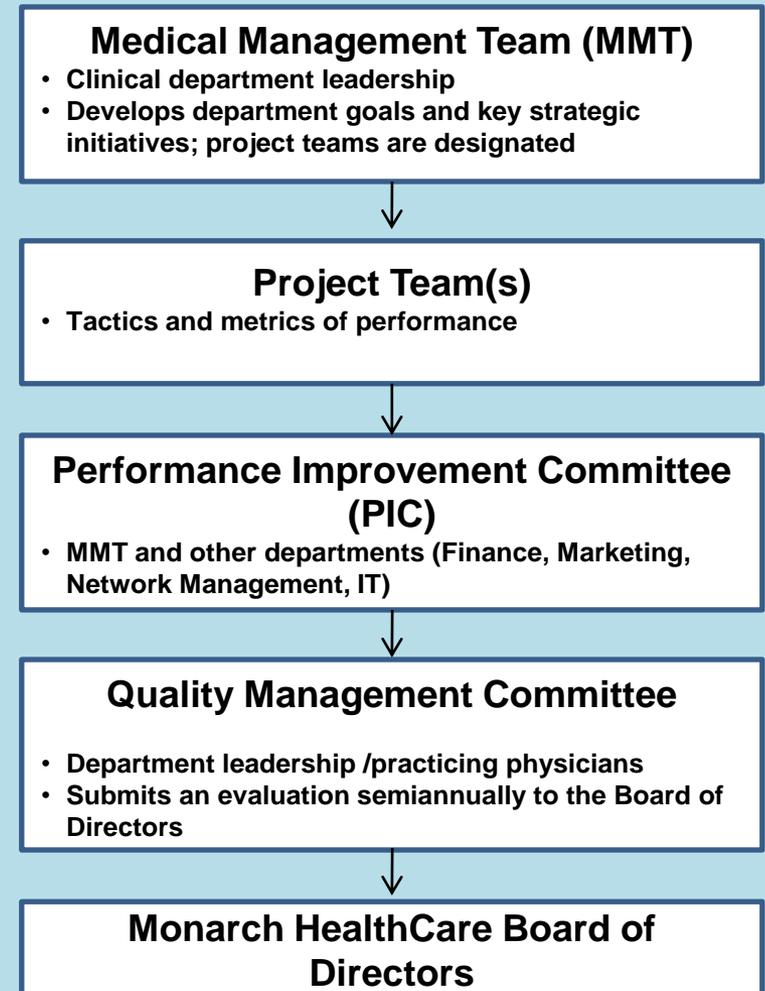
Organizational Structure: Monarch

- Strong physician leadership
 - Emphasis on physician leadership development
- Annual strategic planning
- Aligned departmental goals
- Electronic network connectivity and electronic health records (EHR) deployment
- Performance is measured against quality and efficiency benchmarks



Organizational Structure: Clinical Services

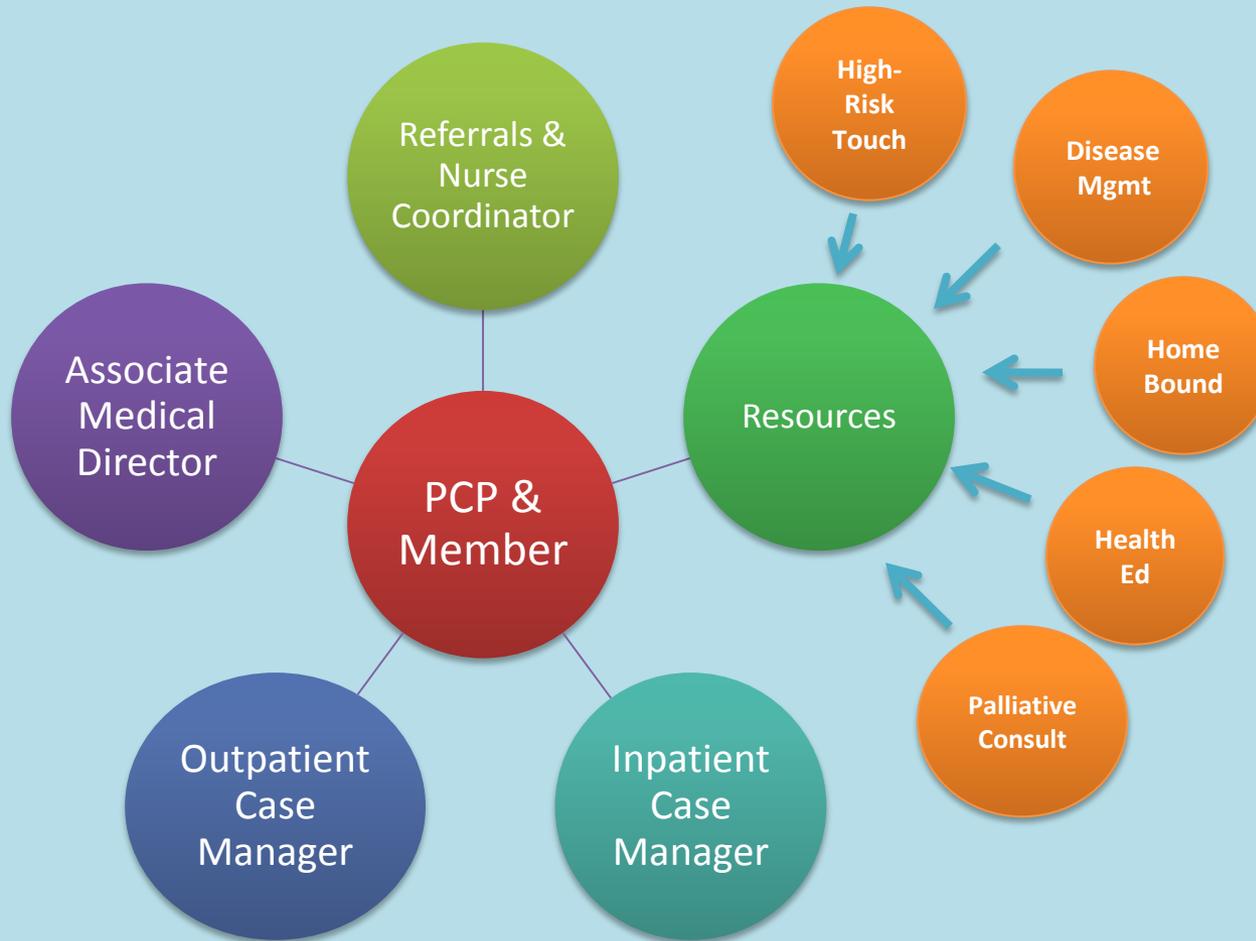
- Chief Medical Officer
- Four full-time Medical Directors
- 29 part-time specialty-specific Associate Medical Directors
- Director of Strategic Projects (RN)
- Pharmacist
- Registered Nurse Practitioners (NPs)
- RNs
- Licensed Vocational Nurses (LVNs)
- Social Workers
- Certified Diabetes Educators
- Health Educators



Organizational Structure: ACO



Care Management: Integrated Care Teams



Care Management Programs

- On-site hospital and skilled nursing facility (SNF) case managers with 24/7 availability
- Employed hospitalists and SNF physicians/NPs
- Post-discharge calls
- Complex case management
- Disease management
- Anticoagulation clinic
- SNF wound management program
- Palliative medicine program
- High-risk touch team
- Homebound program



Care Management Operations

- Referrals management based on evidence-based guidelines
- Risk stratification tool
- Patient registries that identify gaps in preventive care
- Actionable quality data: by population, practice, and patient
- 1:1 physician visits by medical director/assistant medical director
- Aligned incentives with physicians to improve quality

Managing the Cost of Care

- Avoidable emergency room visits
- Generic prescriptions
- Ambulatory surgery center use
- Bed days/readmissions
- Local/community care alternatives



Financial Risk Bearing and Financial Management

- Multidisciplinary team approach to financial and risk management
- Identification of cost drivers and measurement development
- Monthly monitoring of trends
- Claims management—Incurred But Not Reported (IBNR)
- Financial solvency is regulated by the California Department of Managed Health Care (DMHC)

Health Information Technology and the Role of Data Analytics

- ACO Operations
 - Proprietary web-based connectivity between providers and with Monarch (PracticeConnect®)
 - Data warehouse
 - Patient registries
 - Web site: www.monarchhealthcare.com
 - ACO/provider/patient connectivity
- Goals and Performance Monitoring
 - Enterprise analytics
 - Reports



Key Concepts in Leading ACO Development

- Patient engagement
- Physician engagement and alignment
- Quality metrics and measurement
- Clinical infrastructure for high-risk patients
- Institutional relationships
- Health IT

Key Concepts

Patient Engagement

- The ACO is value added
- Patient focus groups
- Care navigator
- Patient toolkit
- Educational health information
- Patient communication



Key Concepts

Physician Engagement and Alignment

- Communication
- Physician Advisory Board
- Aligned financial incentives
- Office staff engagement
- Data sharing
- Care management support



Key Concepts

Quality Metrics and Measurement

- Use validated measures, start simple
- Understand the metric specifications
- Are the data collectible?
- Identify quality gaps: at the group, practice, and patient levels
- Physician communication
- Don't forget the office staff



Key Concepts

Clinical Infrastructure for High-Risk Patients

- Identification and Management
 - Risk stratification
 - Patient/family engagement and education
 - Hospitalists/SNF physicians
 - Complex case management
 - End-of-life care
 - Right care, right place
- Transitions of Care
 - Physician handoff
 - Medication reconciliation
 - Patient education/self-management
 - Postdischarge appointment

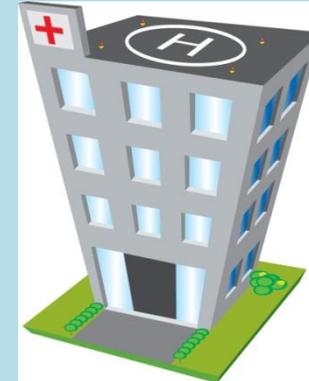


Key Concepts

Institutional Relationships/IT

Hospital and SNF Relations

- Strong relationships
- Communication



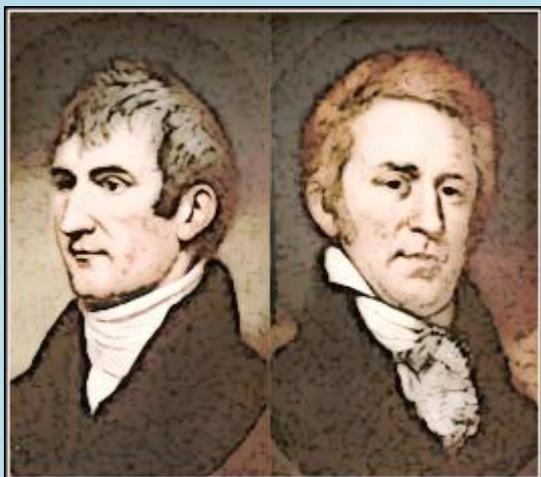
Information Technology

- Connectivity
 - Health information exchange, patient portal, electronic health record
 - Data, data, data



Venturing into Unknown Territory

- Lewis and Clark



- Columbus in America



Learning From Experience

- Patient attribution data
- The challenges of data exchange
- Rules of patient engagement
- Physician understanding and participation
- Quality metrics: identification and measurement
- Benchmarks and targets: what are the landmarks of success?
- Resource commitment



Tools and Resources

- IPA Primer
- Brookings Dartmouth Pilot Site Overview
- Integrated Healthcare Association (IHA)
 - Pay-for-Performance Overview
 - 2011 Measurement Set
- California Association of Physician Groups (CAPG)
 - Standards of Excellence FAQ
- California Office of the Patient Advocate
 - Medical group ratings
- Department of Managed Healthcare (DMHC)
 - Financial solvency requirements and ratings



Agenda in Review

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