Population Health in Your Own Backyard: The DVACO at Age 3

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1/11/17
Some things are black and white

Accountable Care Act?

ACA = AFFORDABLE CARE ACT
We’re not going away!
The view is better leading than following
Risk comes in many forms
Overutilization and waste reduction – reframe as safety and patient centeredness
Winners and Losers
DVACO Value Story

- Transition of Care - 53 year old woman
- Admitted w/Asthma Exacerbation for 2 days. Non-DVACO hospital, PCP unaware, follow up appointment with pulmonologist made for weeks later

- Care coordination interventions:
  - Scheduled PCP appointment within 7 days
  - Multiple dangerous issues with medication self-management addressed (inhalers, prednisone, lasix)
  - Screened positive for depression
  - Identified red flag bowel sx and no colon ca screen
  - Noncompliance with CPAP resolved (financial barrier)

- Patient now reaches out to her “health advocate”
Figure 4. APM Framework

**Category 1**
- Fee for Service – No Link to Quality & Value
- Traditional FFS
- DRGs Not Linked To Quality

**Category 2**
- Fee for Service – Link to Quality & Value
- Foundational Payments for Infrastructure & Operations
  - Bonuses for quality reporting
  - DRGs with research for quality performance
  - FFS with reward for quality reporting

**Category 3**
- APMs Built on Fee-for-Service Architecture
- APMS with Upside Gainsharing
  - Blended payment with shared savings
  - Oncology COGs with shared savings only

**Category 4**
- Population-Based Payment
- Comprehensive Population-Based Payment
  - Full or partial population-based payment (e.g., an ACO, PCMH, or COC)

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**For Public Release**

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Proprietary and Confidential 2016
How an ACO works

1. The ACO is defined as group of providers (must include primary care physicians) agreeing to collaborate.

2. A population is identified
   - May be by attribution/selection of our primary care physicians
   - May be by who purchases an insurance product which drives selection of our ACO (network) as preferential for care

3. Annual cost of care and quality targets are identified
   - May be based on trend vs. self, or trend vs. market
   - May be based on insurance premium received
   - Annual cost = unit price x volume (for all services)

4. Providers get paid some fee for service plus added $ for financial and quality targets met.

5. Success is determined by a better care model
One of the largest ACO’s in the country, and among most successful in the Medicare Shared Savings Program (MSSP) in 2014 (first year)

Joint venture of Jefferson and Main Line Health

2016 ~650 PCPhysicians, 117K MSSP lives (>3x growth from 2014) – half are independent practices. Also around 90K lives in commercial contracts with Aetna, United, Humana (all upside shared savings)

$4.6 Million distributed to participating practices to date

Employee benefits favor DVACO providers

Primary care centric; preferred specialist strategy based upon skills supporting better outcomes, better care experience, smarter spending.
Numbers of Total Covered Lives

Last Updated Nov. 30, 2016

2016 Total
Source:
MSSP Attribution File - SEP 2016
United Enrollment File - OCT 2016
Humana Attribution File - OCT 2016
Aetna Enrollment File - OCT, 2016

2016 Total

- Commercial
- MSSP
“Getting to average” on Medicare at DVACO – reflects Philadelphia

- $180 Million savings opportunity

- E+M services (mainly specialist): $37.8 M
- Skilled Nursing Facility (42%>average): $34.9 M
- Part B Drugs: $31.4 M
- Procedures: $23.2 M
- Home Health: $17.1 M
- Acute inpatient hospital (6%>average): $15 M
Practice Trending, Level of Engagement (PCMH)

Last Updated Sept. 27, 2016

- PCMH Recognized
- Working Towards PCMH Recognition
- Total Number of Practices (PCMH Eligible)
Population Health IT

- DVACO lives in a complex rapidly evolving IT ecosystem
- Not the quick fix for interoperability mess
- Underlying systems/workflows must be configured to support fee for value (from fee for service)
- Take “speed to value” approach
- Small data (boring) >> big data (cool)
- Analytics (risk stratification, risk adjusted cost, care gaps) and care coordination workflow
- Patient Engagement is not an App
Care Coordination: How we Get our Work

Stratification
- Claims Data
- Support Clinical Strategies
- Usually based on historical data

Transitions of Care (TOC)
- From Event Notifications
- Acute and Post Acute Care Settings
- More “Real Time”
- Key to 2016 Goals!!!

Direct Referrals
- Mostly from doctors/practices
- May come from community agencies or hospital discharge planners
- Arrive by phone, fax, email
- DVACO referral form
- Anyone may take a referral!
## MSSP Quality Performance Results

**Reporting Year: 2015**

*Last Updated July, 2016*

<table>
<thead>
<tr>
<th>Domain</th>
<th>Projected Points*</th>
<th>Δ</th>
<th>Points Earned</th>
<th>QI Points&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Points Earned w/ QI Points&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Possible Points</th>
<th>Domain Score</th>
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<tbody>
<tr>
<td>Patient/Caregiver Experience</td>
<td>15.55</td>
<td>-0.45</td>
<td>15.10</td>
<td>0.48</td>
<td>15.58</td>
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<td>Care Coordination/Patient Safety</td>
<td>19.30</td>
<td>+0.45</td>
<td>19.75</td>
<td>3.56</td>
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<td>Preventive Health</td>
<td>13.00</td>
<td>+0.90</td>
<td>13.90</td>
<td>1.36</td>
<td>15.26</td>
<td>16</td>
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<td>At-Risk Population</td>
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<tr>
<td>Total</td>
<td>58.80</td>
<td>+0.90&lt;sup&gt;**&lt;/sup&gt;</td>
<td>59.70</td>
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<td>ACO Overall Quality Score</td>
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<td>96.00%</td>
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*Projections are based on preliminary GPRO results, claims data and practice reports. It is possible to earn up to 4.00 additional points per domain if significant quality improvement is demonstrated (can NOT exceed total possible points).

**Weights across all four domains in 2015 were assigned equally (25% each). Weights assigned to each domain may change in future MSSP performance years.

1 ACOs in the second and third year of their agreement period can earn a maximum of 4 quality improvement rewards per domain.

2 ACOs cannot earn more than the maximum possible points in each domain.
ER Visits/1000 Person-Years

Last Updated Nov.30, 2016

Source: MSSP P.A2024.ACO AEXPXU
Agg. Utilization Report
ED CONVERSION RATE
DVACO VS AVERAGE ALL MSSP ACO’S

Last Updated Nov.30, 2016

Source: MSSP P.A2024.ACO AEXPU
Agg. Utilization Report
Hospital Discharges/1000 Person-Years

Last Updated Nov. 30, 2016

Source: MSSP P.A2024.ACO AEXPU
Agg. Utilization Report

![Graph showing hospital discharges per 1000 person-years from 2011 to 2016, with two lines representing DVACO and the average of all MSSP ACOs. The graph indicates a decrease in discharges over time.](image-url)
SNF - Expenditures Per Assigned Beneficiary
DVACO VS Average of All MSSP ACO’s

Last Updated Dec. 19, 2016

Source: MSSP P.A2024.ACO AEXPU Agg. Utilization Report
SNF – Discharges Per Thousand
DVACO VS Average of All MSSP ACO’s

Last Updated Nov.30, 2016

Source: MSSP P.A2024.ACO AEXPU
Agg. Utilization Report
30-Day All Cause Readmission rate

Last Updated Nov. 30, 2016

Source: MSSP P.A2024.ACO AEXPU Agg. Utilization Report

Proprietary and Confidential 2016
Congestive Heart Failure
Discharge Rates Per 1,000 Beneficiaries

Last Updated Nov.30, 2016

Source: MSSP P.A2024.ACO AEXPU
Agg. Utilization Report
WHACK-A-JACKPOT!

MATCH 3 VALUES

WIN UP TO x10,000 YOUR STAKE

BUT, 3 STRIKES
AND YOU'RE OUT!

MALLETS THE HOE OR CLICK 'REVEAL ALL' TO PLAY
Part B Drugs - Expenditures Per Assigned Beneficiary

Last Updated Dec. 19, 2016

Source: MSSP P.A2024.ACO AEXPU Agg. Utilization Report

- DVACO
- Avg All MSSP ACOs

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<thead>
<tr>
<th>2011 ACO @2016</th>
<th>2012 ACO @2016</th>
<th>2013 ACO @2016 / 2015 ACO @2015</th>
<th>2016Q1 ACO @2016</th>
<th>2016Q2 ACO @2016</th>
<th>2016Q3 ACO @2016</th>
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Coming our way in 2017
For more information:

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