UNC HEALTH ALLIANCE

How the Accountable Care Organization is Transforming Value Based Care

UNC Family Medicine Alumni Reunion

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The Healthcare Crisis by the numbers

45% of American adults fear

48 million people can't afford

44 states now spend more

$420 Million per hour

1.44x $$

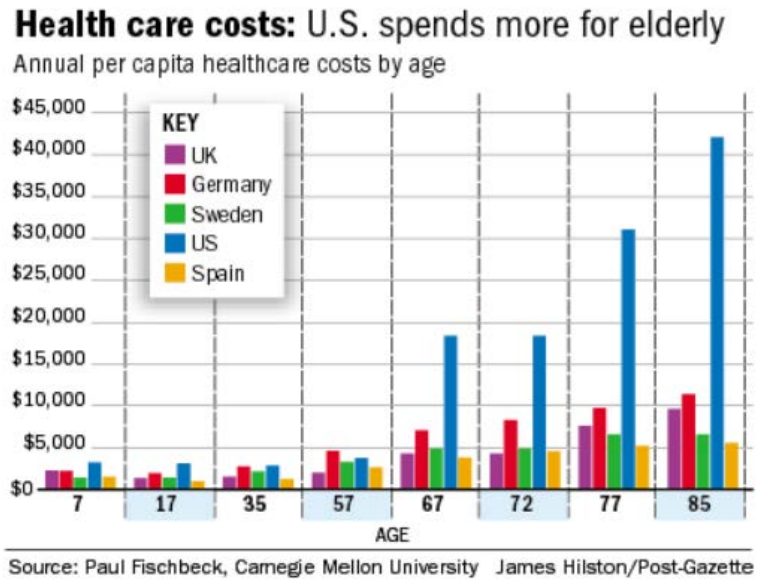
$810 Billion spent this year

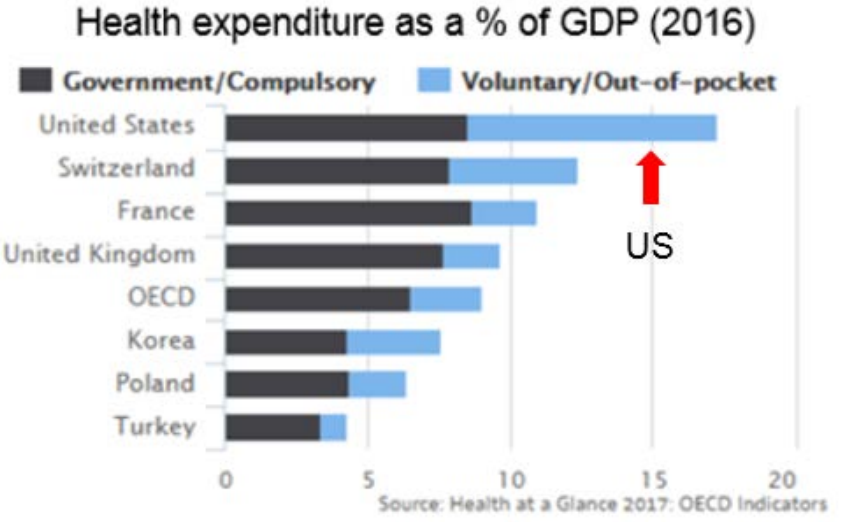
17.8%

$12 Trillion

US Health Care Costs are increasing: International Comparison

The US far outpaces the international community in Healthcare costs





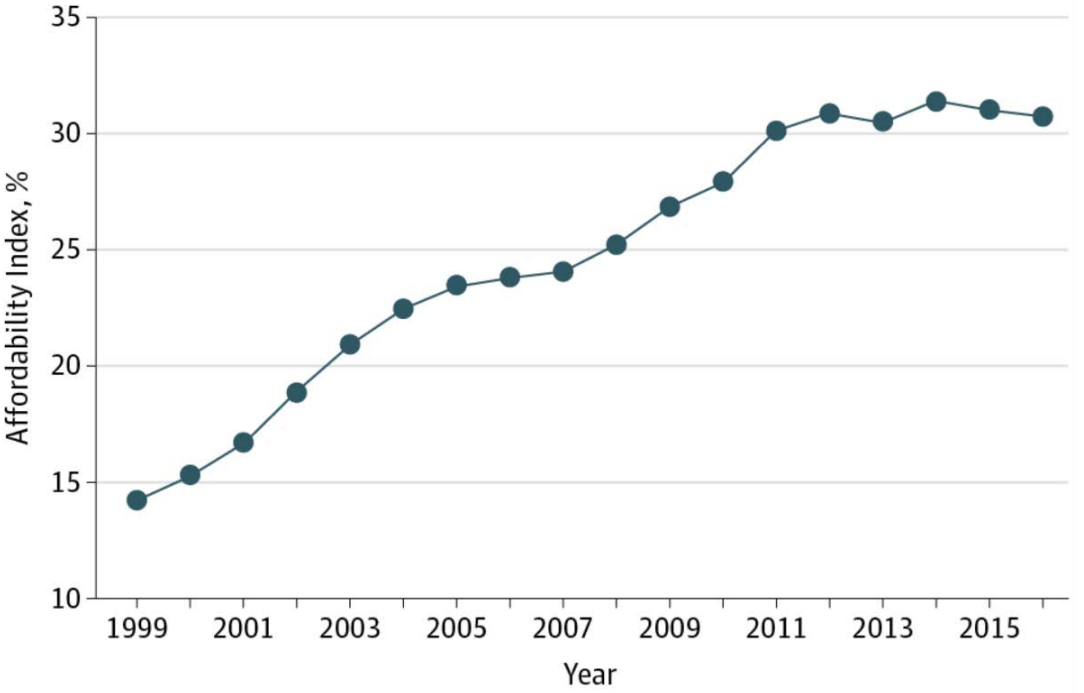
Affordability of Healthcare

The Country's "Most Urgent Health Problem"

57% of individuals report that they worry "a great deal" about "the availability and affordability of healthcare."

Affordability Index

Ratio of the mean cost of an employer-sponsored family health insurance policy to median household income.

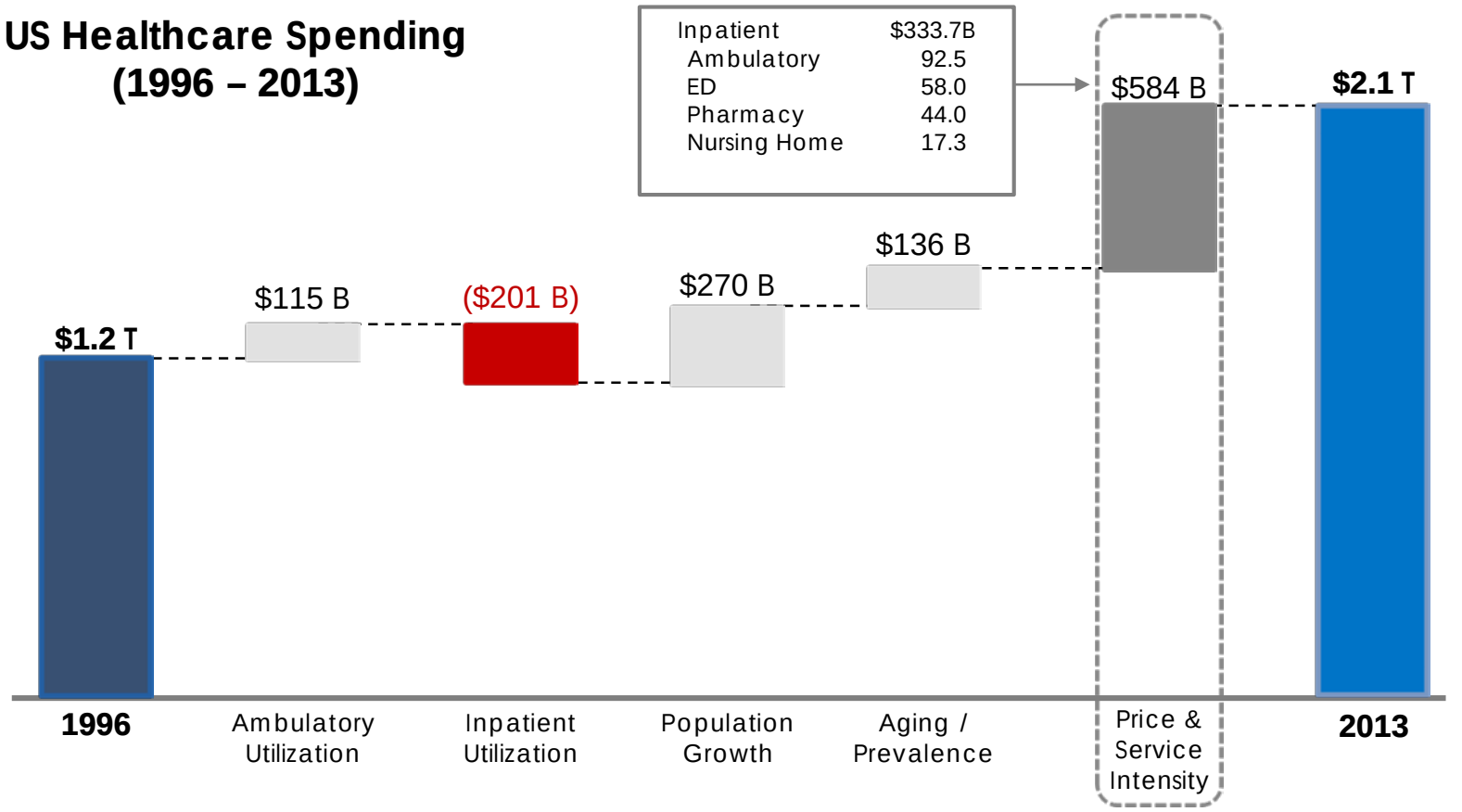


More than a quarter of patients have postponed care due to cost

Affordability = Access = Improved Outcomes

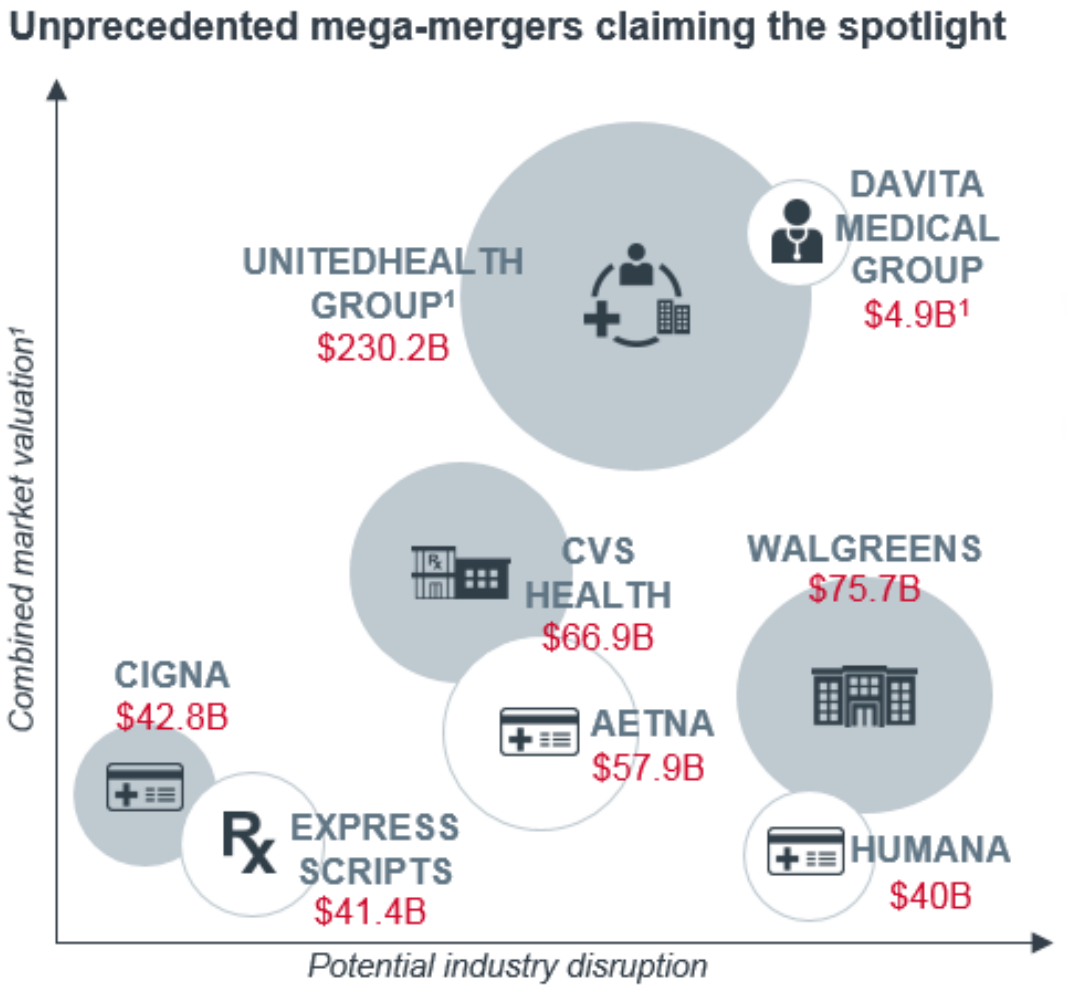
JAMA. 2017;318(19):1863-1864. doi:10.1001/jama.2017.15686

Why is Total Cost of Care increasing so much?



Source: Innosight Analysis; JAMA Factors Associated With Increases in US Health Care Spending, 1996-2013

The Healthcare Landscape is Responding Rapidly



Credit: The Advisory Board

Healthcare Technology

dispatch HEALTH

iorahealth

CITYBLOCK

omada

C3 HEALTHCARERx Care. Collaboration. Compliance.

oscar

The New York Times

"Hearing **Amazon's** Footsteps, the Health Care Industry Shudders"

Forbes

"Be Afraid: Health Care Feels the **Amazon** Effect"

Emergence of ACO's and CIN's

Clinically Integrated Network: a collection of healthcare providers, such as physicians, hospitals, and post-acute care treatment providers (e.g SNF's), that come together to improve patient care and reduce overall healthcare cost.

Accountable Care Organizations (ACOs): groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their. Concept outlined in 2009 ACA, advanced through Medicare payment models

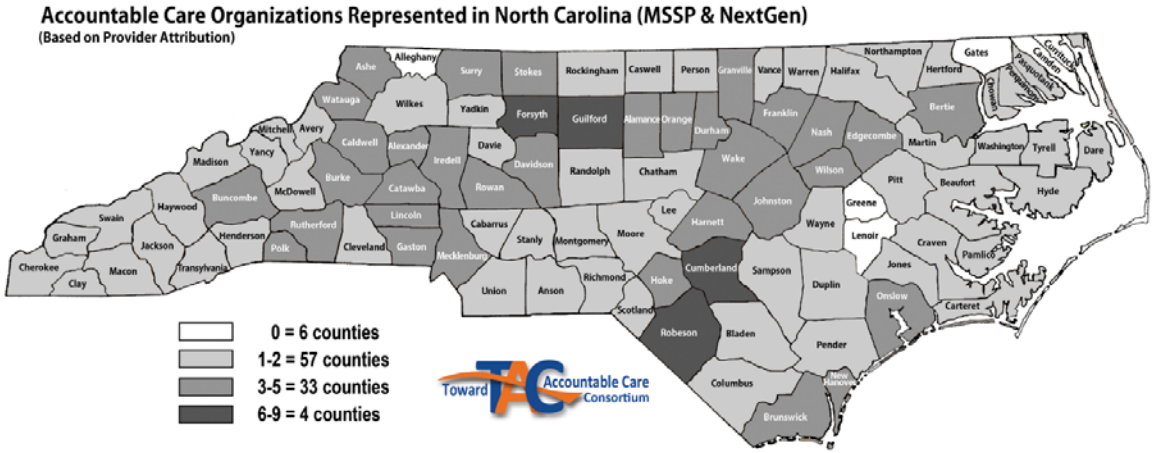
Committee on the Cost of Medical Care released a landmark study recommending the "*integrated practice of medicine rather than autonomous individual sets of practices*."

- 1932

Growth of ACO's and CIN's Nationally and in North Carolina

> 1200 ACO's nationally covering > 33 million Americans

NC is home to 30 Medicare ACO's (Next Gen and MSSP)



Health Affairs 2/2019
North Carolina: The New Frontier For Health Care Transformation

the most rapid and broad-based shift to population-based care and payment models in the country

Key Components of an ACO

Care Model

- Integrate Clinically
- Address key drivers of health
- Population Management

Alternative Payment Models

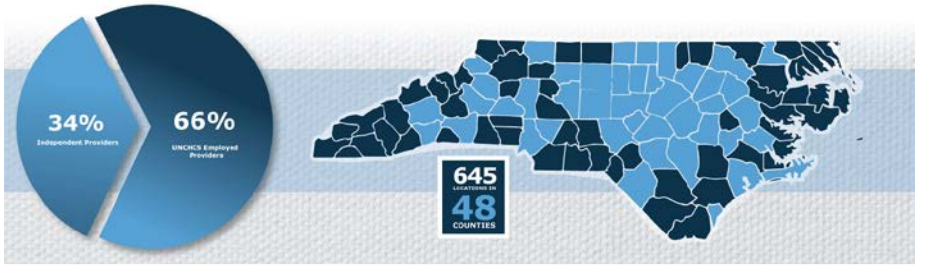
- Patient attribution
- Financial Benchmark for the population
- Quality Benchmarks
- Shared Savings and Risk Arrangement

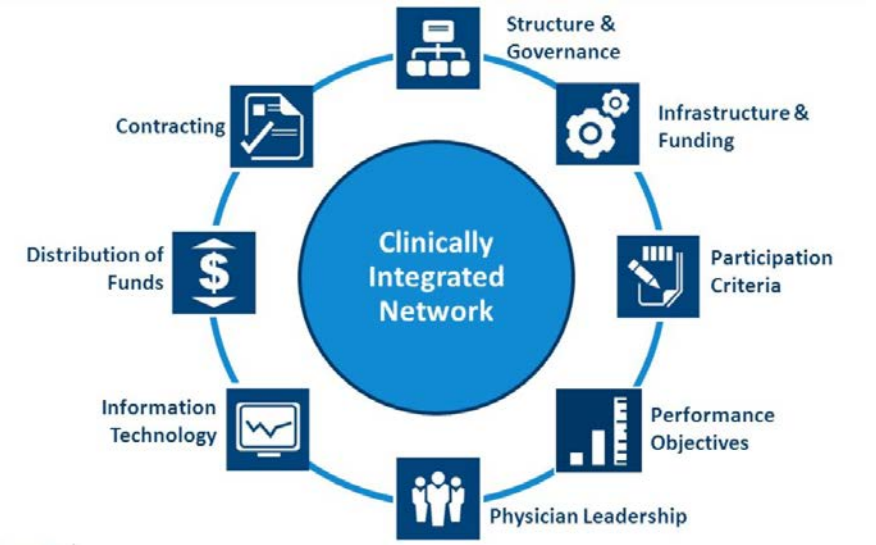
Network Management

- High Value network
- Provider engagement

Data and Analytics

Example of a ACO/CIN: UNC Health Alliance





A Clinically Integrated Network (CIN) built on an Integrated Delivery System platform including a nationally recognized Academic Medical Center and leader in primary care and large community hospital and community based provider networks:

- 11 hospitals, 13 SNF's, 8 Home Health agencies
- 5000 providers: 2/3 employed and 1/3 independent
  2/3 Specialists and 1/3 Primary Care Providers
- Geographic spread throughout rural, suburban and urban areas
- 220K lives covered under APM's 2019

What does good look like?

Successful Alternative Payment Models align the right mix of incentives, motivation, and feasibility

- combine incentives with two other key behavioral drivers: professional motivation and feasible targets.
- restore the link between economics and the professional motivation to deliver patient-centered, high-quality care
- show a feasible path for providers to deliver higher-value care.

ACO Strategies for Transitioning to Value Based Care

Strategies

1. **Increase cost awareness among physicians**
2. **Engage patients in improving their own health**
3. **Increase coordinated management of highly complex patients and high cost patients to improve their outcomes**
4. **Reduce avoidable hospitalizations**
5. **Control cost and improve quality in SNF's**
6. **Address Behavioral Health needs and social determinants of health**
7. **Utilize technology to increase information sharing among providers**

Office of the Inspector General US DHHS

'ACO's Strategies for Transitioning to Value-Based Care: Lessons from the Medicare Shared Savings Program' July, 2019

ACO's – Do They Work?

Affordability:

- CMS ACO's saved $1.5B in 2017 - 2018
- Next Generation ACO Model alone saved CMS $100M in 2016
- Cigna CAC $424M in savings between 2008-2016
- BCBS North Carolina reduces premiums for ACA by 25% over 2 years

Quality:

- MSSP quality = 91% on average 2012-2016
- High risk patients may fare better

Experience:

- Limited data however these models have introduced new patient centered services
- Very limited data on providers' experience

OneCareVermont -- an all payor experiment

Can ACO's Catalyze Transformation to Value?

Introduce and Scale Population Management strategies

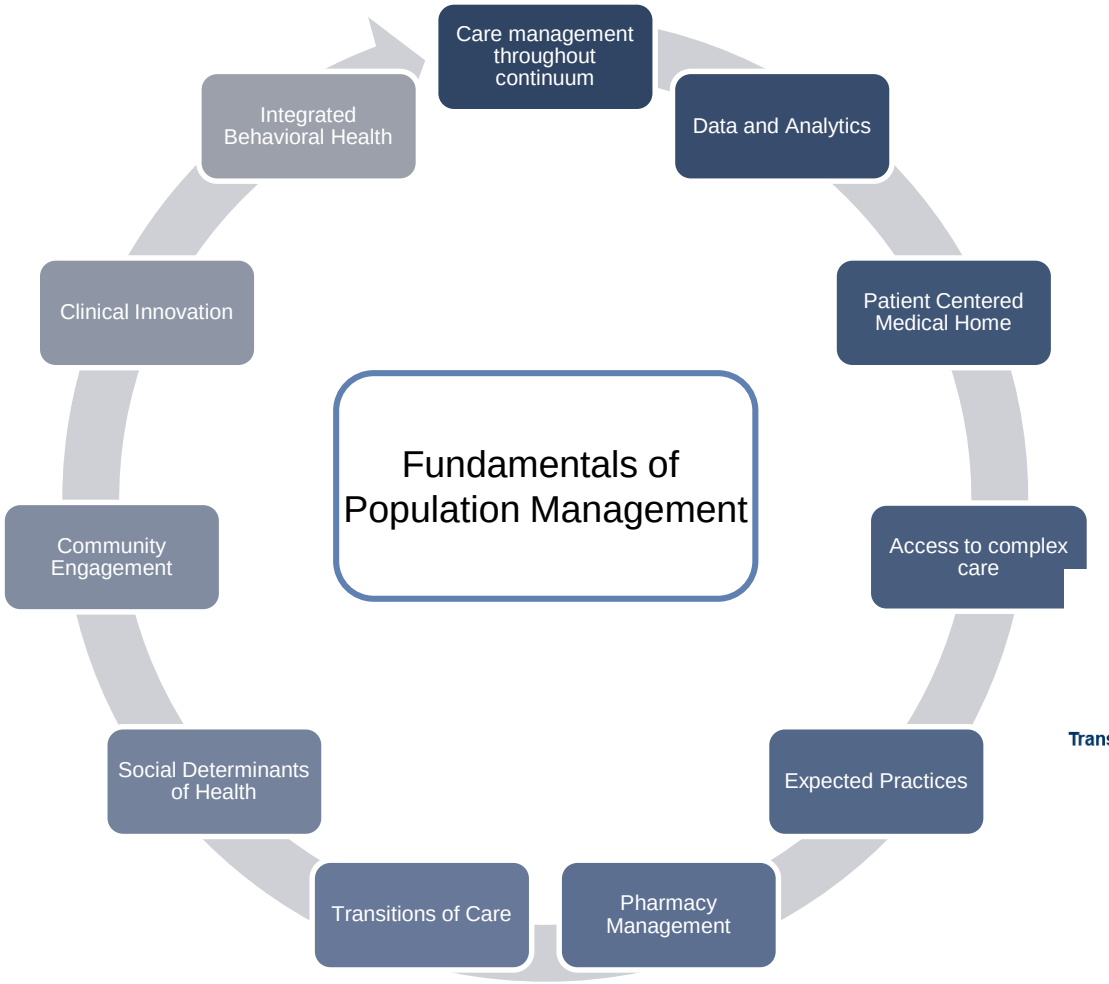
Integrate Data and Analytics to drive improvement

Integrate and coordinate care across care providers and care settings: Right care, right time, right place

New Math: Change the economics of healthcare, revenue becomes cost.

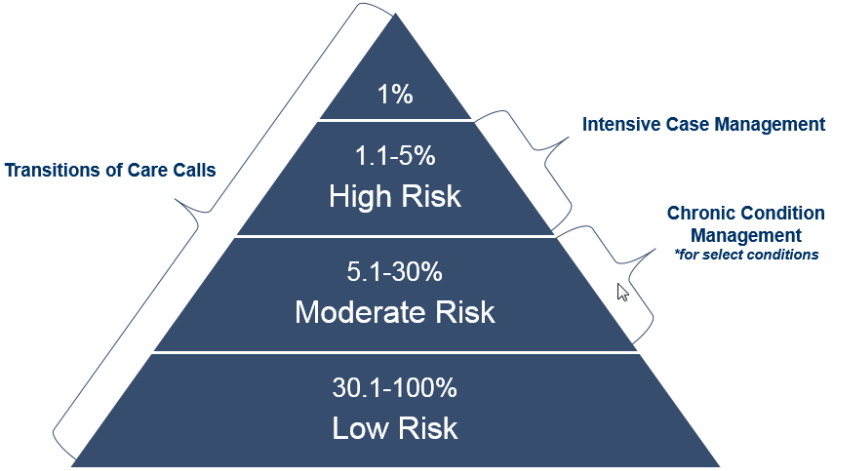
Identify and address real drivers of Health
Primary Care at the Center

Introduce and Scale Population Management strategies



Population Health Services

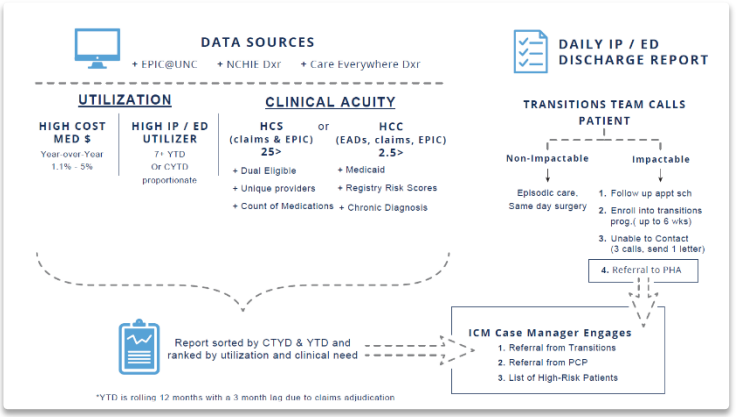
- Risk Stratification
- Population Segmentation
- Clinical Services



Integrate Data and Analytics to drive improvement

Multifactorial approach to identifying high risk patients

Risk Stratification and Prediction Algorithm



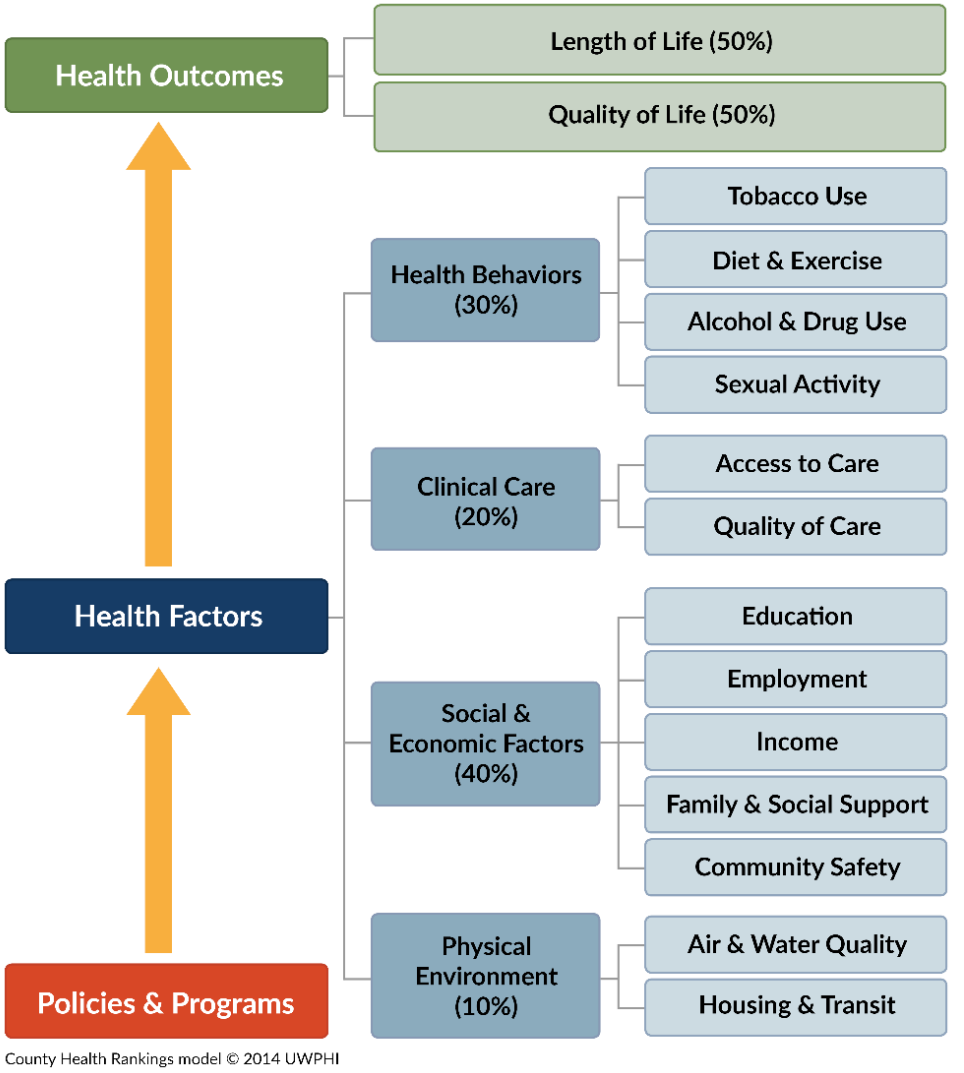
Patient Cohorting: JHG

- Home based technology
- NCCare360: SDOH screening and engagement with community resources
- Claritas American Community Service (ACS) census data (NSS7)
- Propensity to Pay scoring (ACA)

Leveraging multiple data sources to identify patients needing additional support

Looking Beyond Clinic Walls to Understand Health Influences

Excellent clinical care alone is not enough to help patients achieve their optimal health



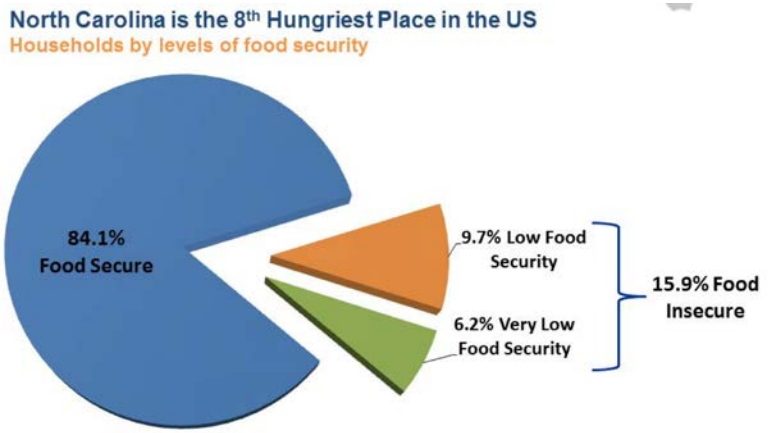
Coordinating Care Across Care Settings

NEMT Transportation

CIRCULATION

1) Patients identified with transportation as their key barrier to care
   - Case management ID
   - No-Show predictive data
   - Specific conditions: ESRD
2) Care Coordinators manage transportation through Circulation
   - Uber, Lyft, Taxi

Addressing food insecurity across communities



- Coordinate funding sources
- Coordinate community resources

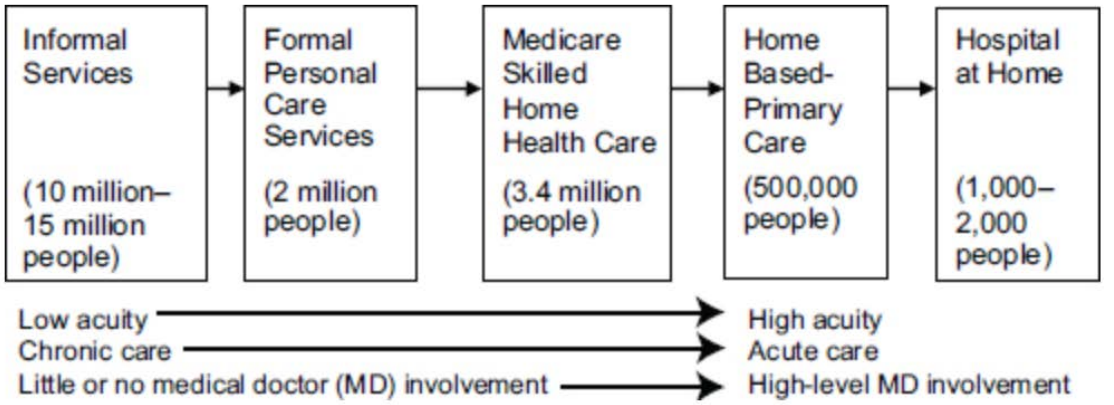
Coordinating Care Across Care Settings

Collaborative Management of Post-Acute Services

Skilled Nursing Facility preferred network

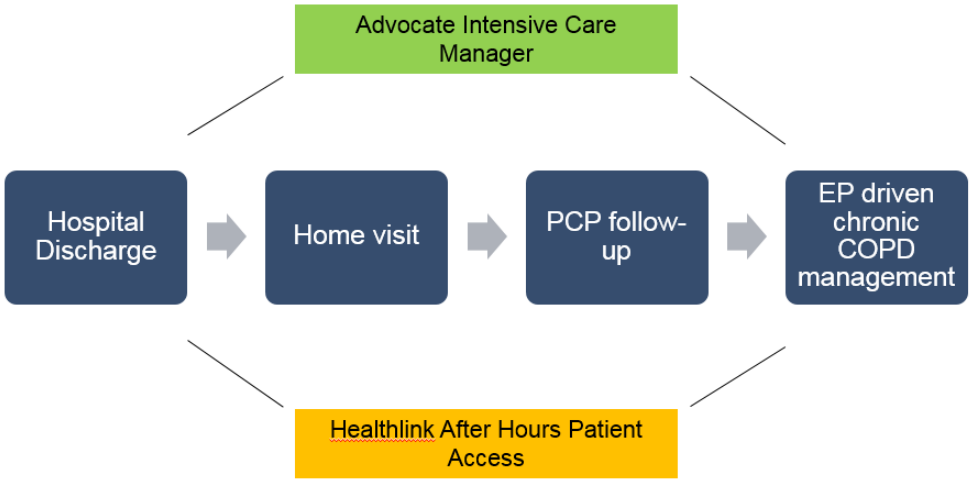
- Transition Planning
- Care Pathways
- Care management and Care Coordination
- Collaborative Quality Improvement

Home Care Spectrum



Coordinating Care Across Care Settings

Regional Care Redesign for COPD

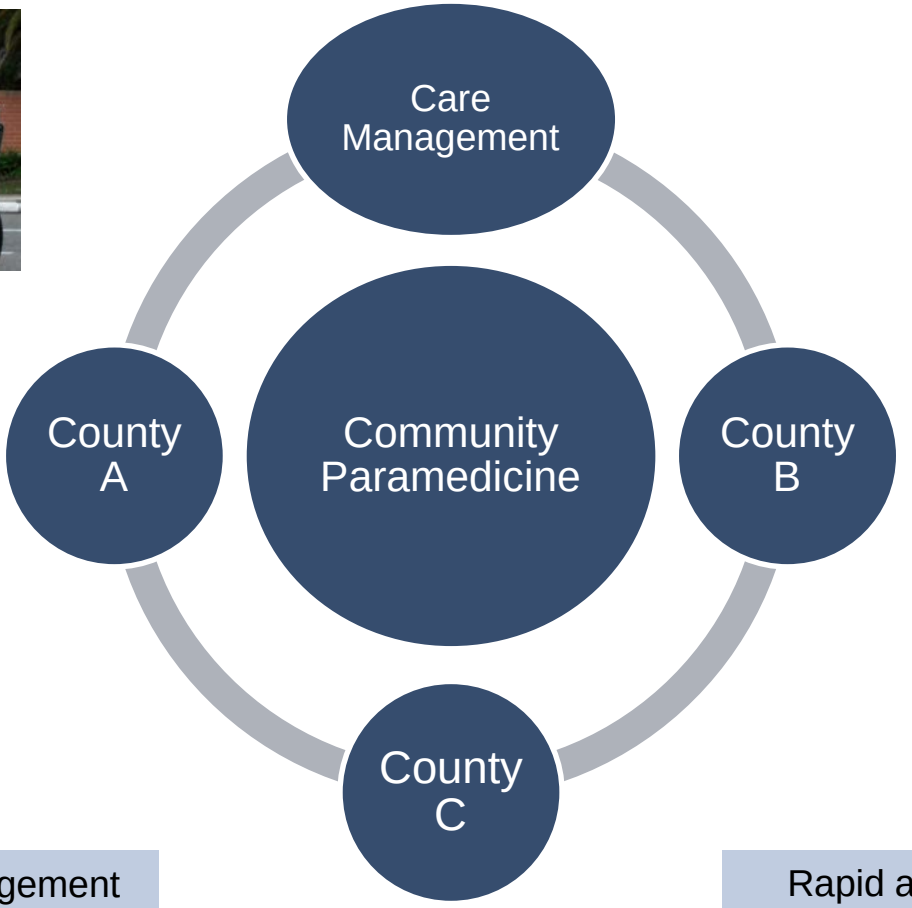


Key components of redesigned care in a rural region:

- Identify COPD as key driver of ED utilization
- Align incentives across the care continuum
- Convene Geographic Service Area Counsel
- Standardize management of COPD – Expected Practices
- EMR redesign to support standardized work

Coordinating Care Across Care Settings

Integrating with Established Community Partners



Standardized management of Chronic Disease

In home management of mild disease

Rapid access to PCP or Specialty care

Virtual access to clinical care team (pharmacist, LCSW)

New Math – Changing the Economics of Healthcare

Alternative Payment Model (APM) Framework

- Move payment away from Fee For Service
- Generate accountability for quality and total cost of care
- Support population payment models: Capitation
- Align Incentives - Historic revenue becomes cost