REDWOOD COMMUNITY CARE ORGANIZATION

ACO on a Shoestring
What Have We Learned?

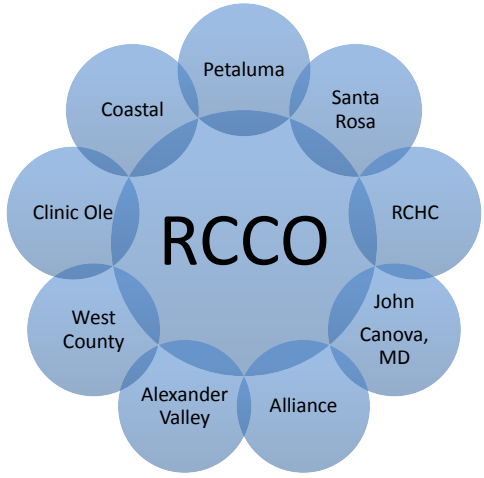


REDWOOD HEALTH COMMUNITY COALITION

Serving Sonoma, Napa, Marin & Yolo Counties

RCCO Background

- Medicare Shared Savings Program (MSSP) ACO 2014-2016
- Health center-based primary care ACO
- MOAs with local hospitals and multi-specialty groups



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RCCO

The Head….

- Preparing for value-based care models and reimbursement
- Position RCHC health centers as a regional provider group
- Population health across health centers
- Potential to reinvest savings towards service
- Better care for patients!

The Heart….

So What Have We Learned So Far?

1) Population Health Across a Shared Population
2) Total Cost of Care
3) Data Analytics
4) Working with Community Partners
5) Improving Quality & Achieving Shared Savings
6) Value-Based Care in the Safety Net

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Lesson #1: Population Health Across a Shared Population

- Sharing a patient population across independent health centers requires:
  - Major mindshift
  - Organizational alignment and consensus across ACO and at each health center
  - Population health management across health centers
  - Resources/Expertise vary greatly across health centers and impact ability to implement population health management
  - Standard data management methods & shared analytics

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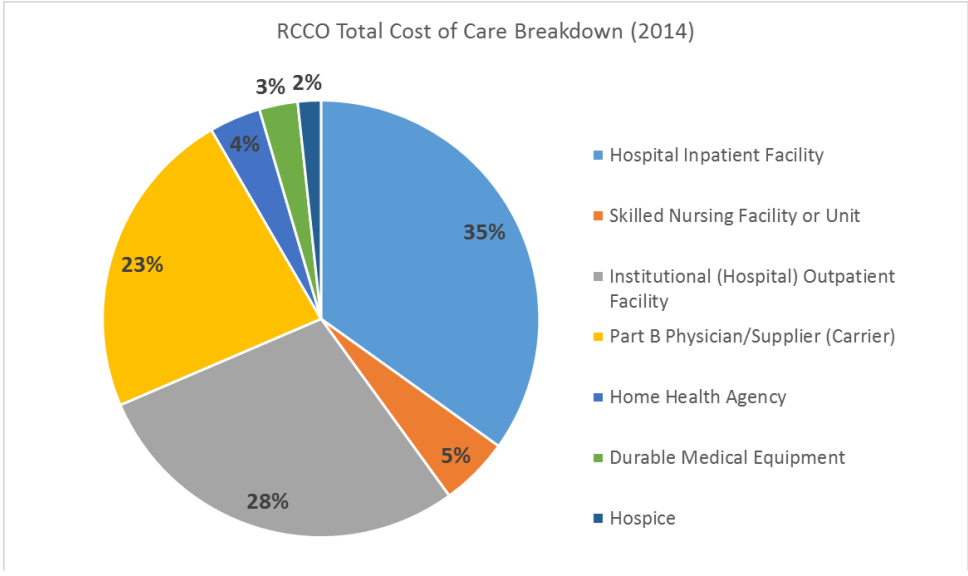
#2: Total Cost of Care



Lesson #2: Total Cost of Care

- Fundamental shift in perspective
- ACO responsible for patient costs across continuum of care
- ACO responsible for patients costs whether you see patient or someone else does
- Drives strategy
  - Reduce hospitalizations and re-admissions
  - Collaboration across partners
- Claims access and analytics essential

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Claims Access and Analytics Necessary to Population Health Management

- Total Cost of Care
- Predictive Modeling
  - Using combination of claims data and clinical review
  - Complex care management
- New level of provider engagement and interventions across continuum of care
- Combination of claims and EHR clinical data very powerful

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Better Care. Smarter Spending. Healthier People.

To Do Triple Aim…

Better Care. Smarter Spending. Healthier People.

To Do Triple Aim…
You Need the Claim

Lesson #3: Data analytics

- Data warehouse for all ACO participant info from CMS & EHR
- Enormous amount of data, need staff expertise to understand where to focus
- Significant resource investment required to turn data into actionable info
- Understanding & really using data takes months/years
- As an “early adopter” RCCO has worked to co-develop a data analytics platform

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Lesson #3: Data Analytics

- "… a single, integrated mature solution that meets all PHM (population health management) IT needs does not exist in today's market."

  -Hunt et al. "Guide for Developing and Information Technology Road Map for Population Heath Management" *Population Health Management,* Nov. 3, 2015

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Lesson #4: Working with Community Partners

- Existing relationships with community partners strengthened and new relationships developed
  - St. Joseph Health
  - Sutter Santa Rosa Regional Hospital
  - Aurora Behavioral Health Care
- Collaborative systems approach to understanding shared population and coordination of their care
  - Real-time utilization data, including Admit, Discharge, Transfer (ADT) feeds
  - HIE, including Continuity of Care Documents (CCD)
  - Care transitions
  - Relationships

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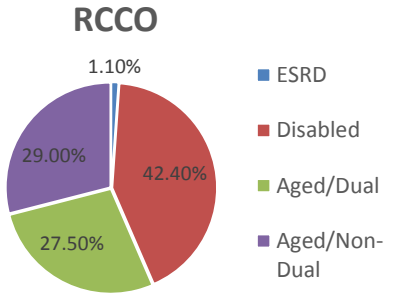
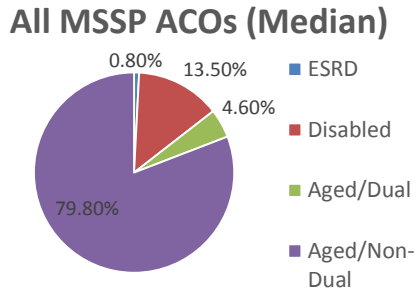
Lesson #5: Improving Quality & Achieving Shared Savings

- RCCO has been successfully improving performance on quality metrics from 2014-2015
- Achieving savings has not been easy
  - Financial benchmark
    - Already providing low-cost care to a complex population
    - Population characteristics
    - Impact of risk adjustment
- Managing Expectations
  - Developing the culture and population health management structure to significantly reduce expenditures takes time!

Lesson #6: Value-Based Care in the Safety Net

- An FQHC-based Medicare ACO is different from the average Medicare ACO





Lesson #6: Value-Based Care in the Safety Net

- Population risk stratification and risk adjustment are essential to value-based care models and payment
- Current CMS risk adjustment model does not adequately adjust for behavioral health diagnoses and social determinants of health that disproportionately impact health center patient population
- Health centers don't document and code in a manner that fully characterizes the complexity of patients within the current CMS risk adjustment model (CMS-Hierarchical Condition Category -HCC)
- The combination of these 2 factors leads to a lower risk score for health center patients in value-based models and decreased ability to achieve shared savings

Lesson #6: Value-Based Care in the Safety Net

- Health centers need to advocate and inform the design of value-based models and payment to assure that they can work effectively and be successful in the safety net

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"If you're not at the table, you're on the menu."

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Questions?

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If you want to go fast, go alone,
If you want to go far, go together.
-African Proverb

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