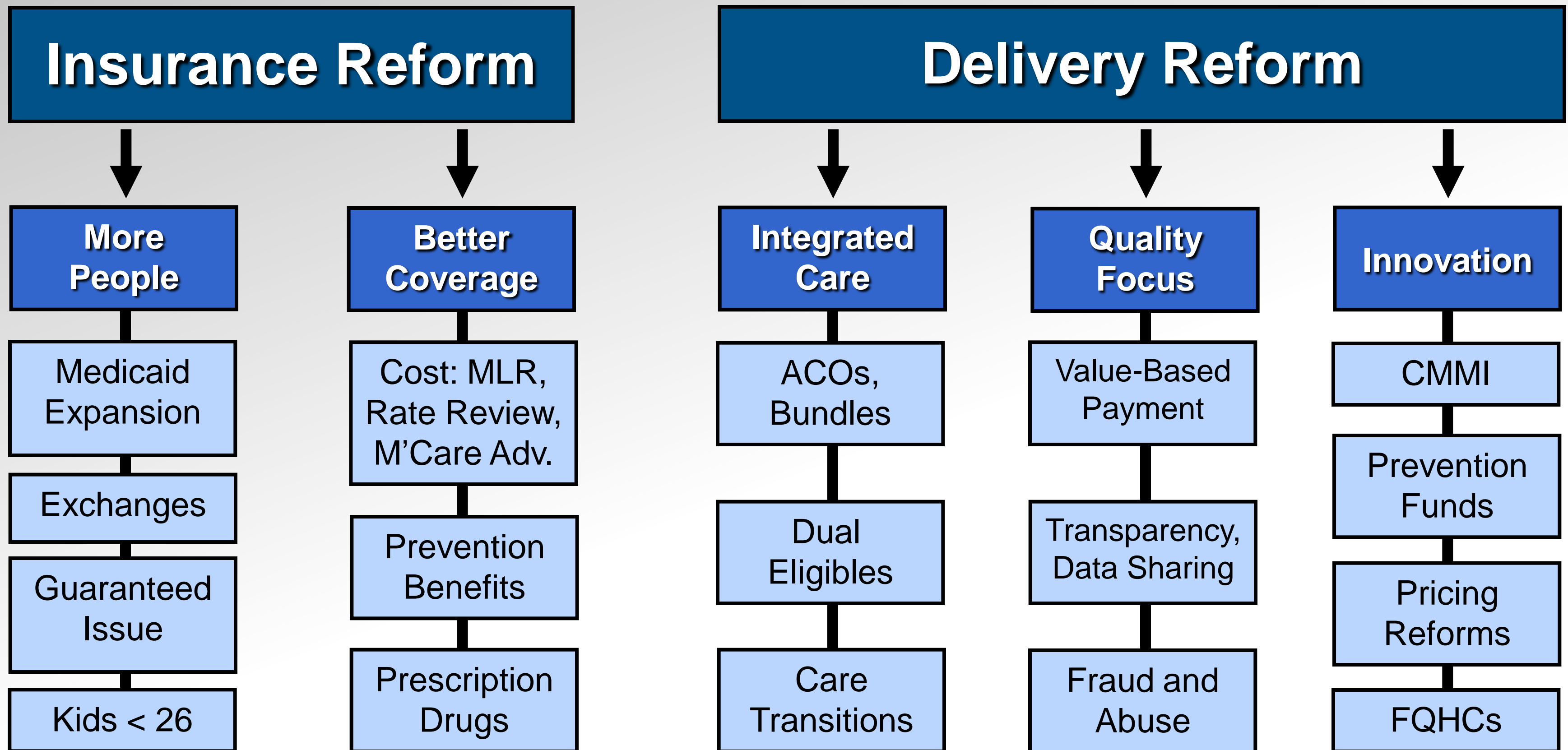
# UW Health Delivery System Innovation

## ACOs and Bundled Payments: Moving Toward Population Health

UW Health

# The Structure of Health Care Reform
## Affordable Care Act

Health care reform offers tools and incentives to achieve our vision




Don Berwick, *GPIN*, Boston, MA, Oct. 17, 2012

# The Challenge: Systems in Transition

**Current World**
**FEE-FOR-SERVICE**

- All about volume
- Reinforces work in silos
- Little incentive for real integration

**Future World**
**VALUE-BASED PAYMENT**

- Shared Savings Programs
- Bundled / Global Payments
- Value-based reimbursement
- Rewards integration, quality, outcomes and efficiency

# A Framework for Change

**Health care reform bring tools and incentives to achieve our vision**

**Keep getting better at what we're good at**
- Caring for acute health needs
- Translating research to practice
- Training new professionals

**Current strengths position us well**
- Regional referral center
- Advanced treatments/clinical trials
- Stay on top in current system while we transition to new

**Rapidly add new capabilities**
- Care coordination
- Teamwork
- Preventive care

**Build on current initiatives**
- Primary care redesign
- Health Link optimization
- Transitions of care
- UWHIN/process improvement
- New facilities – right care in right setting
- Panel management
- Disease registries

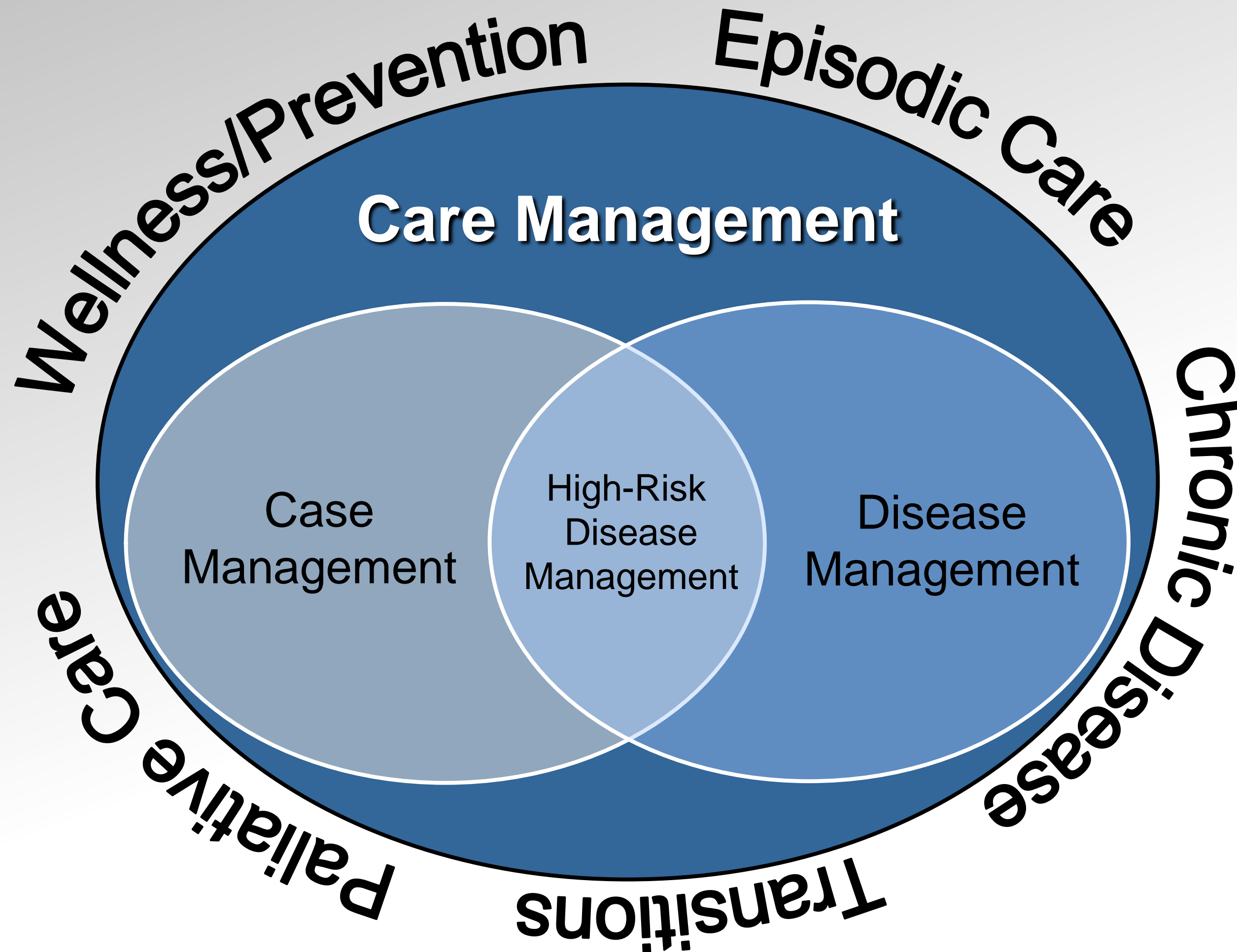
**Use all the tools of reform**
- Accountable care organizations
- Bundled care
- Patient-centered medical home

**ACO**
Responsible for quality and total cost of care for medically homed patients insured by Medicare

**Bundled payments**
Paid based on outcomes and total cost for an episode of care – for example, a total knee replacement

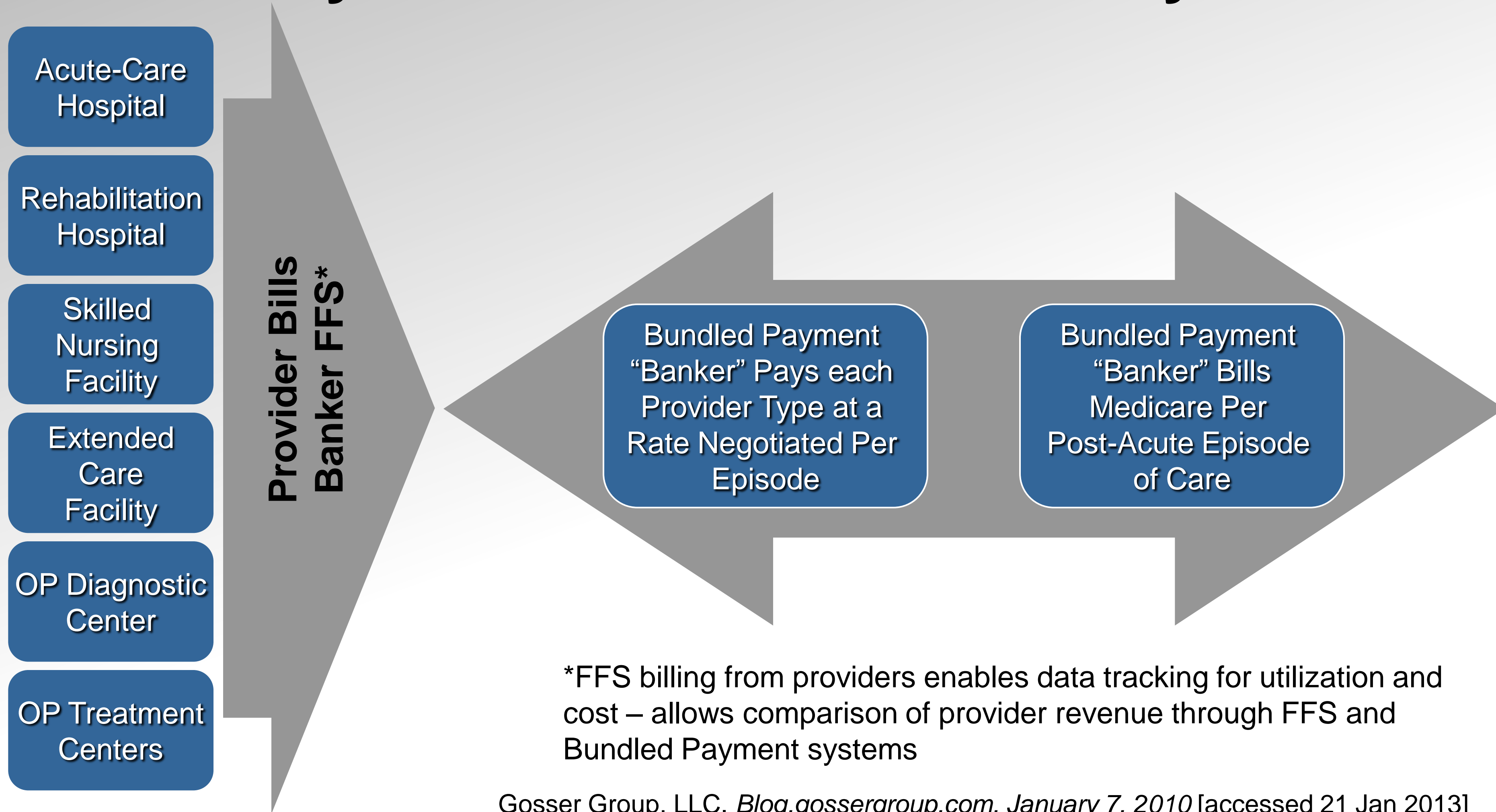
**PCMH**
Coordinate care across the continuum for all medically homed patients

# Strategies for Medically-Homed Population



# Strategies for Regional Populations

## New Payment Model: Bundled Payments




*FFS billing from providers enables data tracking for utilization and cost – allows comparison of provider revenue through FFS and Bundled Payment systems

Gosser Group, LLC. *Blog.gossergroup.com, January 7, 2010* [accessed 21 Jan 2013]

# The Work to Be Done

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<tr><td rowspan="2"></td><td>Longitudinal Care</td><td colspan="2">Episodic Care</td></tr>
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# Work to be Done: Initial Priorities

- **Population Health**
  - PCMH– medically homed patients
    - High-risk disease management program (Heart Failure)
    - Evidence-based practice tools (Heart Failure)
  - Bundled care – regional (and local) patients
- **Measurement and Reporting**
  - 33 CMS Quality measures
  - Cost analysis – *Total Cost of Care*
  - Predictive modeling (Heart Failure)
  - Data-driven ID of high-risk and -utilization populations

# How this builds on the work already being done

- UW Health has been building out Primary Care for years
- PCR has enabled the development of the care model/PCMH
- Integrated, population-focused primary care comp plan is 1st in class
- Emphasis on PFCC Model
- Cost Management

# Discussion

- What this means to patients and providers
- Goals of Delivery System changes
- Clear actions needed to achieve goals

# What this means to patients/families

- Care will be coordinated across the spectrum, including outside UW Health
- Care experience is consistent
- Increasingly the focus is on health, not solely health care

# What this means to providers

- Adjust to thinking about populations and team-based care
- Future is about taking on risk/responsibility for patients through the continuum of care
- Increased need to deliver the highest quality care at the lowest cost possible

# Goals of Delivery System changes

1) Standard pt. experience across all sites
2) Coordinate care across the spectrum
3) Shift care to PCMH whenever possible
4) Reduce total cost of care
5) Align incentives with population health

# Clear actions needed to achieve goals

- Fully develop true PCMH model
  - Care management, starting with high-risk
- Standardization
- Total cost of care as a clear metric
- Align incentives with population health
- Unified operating calendar

# Questions/Discussion

# ACO Metrics

| Measure # | Domain | Measure Title | Method of Data Submission | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| 1 | Patient/Caregiver Experience | CAHPS: Getting Timely Care, Appointments, and Information | Survey | Report | **Perform** | **Perform** |
| 2 | Patient/Caregiver Experience | CAHPS: How Well Your Doctors Communicate | Survey | Report | **Perform** | **Perform** |
| 3 | Patient/Caregiver Experience | CAHPS: Patients' Rating of Doctor | Survey | Report | **Perform** | **Perform** |
| 4 | Patient/Caregiver Experience | CAHPS: Access to Specialists | Survey | Report | **Perform** | **Perform** |
| 5 | Patient/Caregiver Experience | CAHPS: Health Promotion and Education | Survey | Report | **Perform** | **Perform** |
| 6 | Patient/Caregiver Experience | CAHPS: Shared Decision Making | Survey | Report | **Perform** | **Perform** |
| 7 | Patient/Caregiver Experience | CAHPS: Health Status/Functional Status | Survey | Report | Report | Report |

| Measure # | Domain | Measure Title | Method of Data Submission | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| 8 | Care Coordination/ Patient Safety | Risk-Standardized, All Condition Readmission1 | Claims | Report | Report | **Perform** |
| 9 | Care Coordination/ Patient Safety | Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5) | Claims | Report | **Perform** | **Perform** |
| 10 | Care Coordination/ Patient Safety | Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8 ) | Claims | Report | **Perform** | **Perform** |
| 11 | Care Coordination/ Patient Safety | Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment | EHR Incentive Program Reporting | Report | **Perform** | **Perform** |
| 12 | Care Coordination/ Patient Safety | Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility | GPRO Web Interface | Report | **Perform** | **Perform** |
| 13 | Care Coordination/ Patient Safety | Falls: Screening for Fall Risk | GPRO Web Interface | Report | **Perform** | **Perform** |

| Measure # | Domain | Measure Title | Method of Data Submission | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| 14 | Preventive Health | Influenza Immunization | GPRO Web Interface | Report | **Perform** | **Perform** |
| 15 | Preventive Health | Pneumococcal Vaccination | GPRO Web Interface | Report | **Perform** | **Perform** |
| 16 | Preventive Health | Adult Weight Screening and Follow-up | GPRO Web Interface | Report | **Perform** | **Perform** |
| 17 | Preventive Health | Tobacco Use Assessment and Tobacco Cessation Intervention | GPRO Web Interface | Report | **Perform** | **Perform** |
| 18 | Preventive Health | Depression Screening | GPRO Web Interface | Report | **Perform** | **Perform** |
| 19 | Preventive Health | Colorectal Cancer Screening | GPRO Web Interface | Report | Report | **Perform** |
| 20 | Preventive Health | Mammography Screening | GPRO Web Interface | Report | Report | **Perform** |
| 21 | Preventive Health | Screening for High Blood Pressure | GPRO Web Interface | Report | Report | **Perform** |

| Measure # | Domain | Measure Title | Method of Data Submission | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| 22 | At Risk Population - Diabetes | Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (<8 percent) | GPRO Web Interface | Report | **Perform** | **Perform** |
| 23 | At Risk Population - Diabetes | Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (<100) | GPRO Web Interface | Report | **Perform** | **Perform** |
| 24 | At Risk Population - Diabetes | Diabetes Composite (All or Nothing Scoring): Blood Pressure <140/90 | GPRO Web Interface | Report | **Perform** | **Perform** |
| 25 | At Risk Population - Diabetes | Diabetes Composite (All or Nothing Scoring): Tobacco Non Use | GPRO Web Interface | Report | **Perform** | **Perform** |
| 26 | At Risk Population - Diabetes | Diabetes Composite (All or Nothing Scoring): Aspirin Use | GPRO Web Interface | Report | **Perform** | **Perform** |
| 27 | At Risk Population - Diabetes | Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent) | GPRO Web Interface | Report | **Perform** | **Perform** |
| 28 | At Risk Population - Hypertension | Hypertension (HTN): Controlling High Blood Pressure | GPRO Web Interface | Report | **Perform** | **Perform** |
| 29 | At Risk Population – IVD | Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL) | GPRO Web Interface | Report | **Perform** | **Perform** |
| 30 | At Risk Population - IVD | Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic | GPRO Web Interface | Report | **Perform** | **Perform** |
| 31 | At Risk Population - Heart Failure | Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) | GPRO Web Interface | Report | Report | **Perform** |
| 32 | At Risk Population - Coronary Artery Disease | CAD Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol | GPRO Web Interface | Report | Report | **Perform** |
| 33 | At Risk Population - Coronary Artery Disease | CAD Composite: All or Nothing Scoring: ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD | GPRO Web Interface | Report | Report | **Perform** |