PREMIER

ADVOCACY **RE: HEALTHCARE 2017**

A NEW PERSPECTIVE ON HEALTHCARE

VALUE-BASED CARE SUCCESSES IN ACTION

SUCCESS STORIES | DECEMBER 2016

Value-based Care Successes

Change starts from the inside out. Which is why members of the Premier alliance have been working to measurably improve quality, reduce costs and take accountability for populations of patients. While still in its early stages, this work is succeeding. Measurable improvements in healthcare quality are evident.

Read about our members and how they are making great strides in improving quality while safely reducing costs as part of new payment and delivery system models.

01

ORGANIZATION: AnewCare Collborative, the ACO organized by the Mountain States Health Alliance
STATES SERVED: Tennessee, Virginia, Kentucky and North Carolina

AnewCare Collaborative was organized in 2011, and accepted into the Medicare Shared Savings Program (MSSP) the following year. AnewCare utilizes robust data analytics to analyze claims, identify trends in utilization and isolate opportunities to improve care. Based on the data, AnewCare deployed clinical staff into primary care practices to actively coordinate and manage beneficiary care, closing gaps to help improve the ACO's quality score from 69% in year one, to 87.5% in year two, and to 93% in year three.

Additional best practices AnewCare has put into place over the course of their agreement period include: creating standardized evidenced-based care models across the care continuum; implementing home visits for patients after a hospitalization; and developing a robust care management and coordination program. Since AnewCare began their work in the program in 2012, they have saved the Medicare program $17.5 million.

02

ORGANIZATION: Aurora Health Care
STATES SERVED: Wisconsin

In August of 2016 Aurora's Lakeshore Medical Clinic ACO stands as a high performer in the MSSP for achieving quality and cost reduction measures. Aurora's ACO, which serves 7,500 Medicare beneficiaries, received a quality score of 95.31% and saved the Medicare program $2.6 million in the last year. Aurora's high performance is a result of their focus on population health management and use of their integrated delivery system to manage patient care transitions. Specifically, Aurora coached physicians on opportunities for improvement by reviewing their Medicare results on an ongoing basis, and engaged beneficiaries using home health nurses and coaches to establish close relationships, closely monitor progress and improve patient outcomes. Because of that sustained effort, Aurora has been able to reduce costs by $200 per beneficiary in 2015 and their patients continue to receive the right care at the right time.

03

ORGANIZATION: Baptist Health South Florida
STATES SERVED: Florida

Baptist Health's Tele-ICU program (installed in 161 rooms across 6 hospitals) serves more than 12,000 patient stays annually. In the last eight years, this 24/7 surveillance center, staffed by expert critical care physicians, nurses and pharmacists, as reduced mortality in the intensive care unit by 28%, reduced length of stay by 24% and reduced costs by a total of $92 million. The Tele-ICU leadership team has also been instrumental in the implementation of several system-wide best practices, including low-tidal volume ventilation, glycemic control and targeted temperature management.

04

ORGANIZATION: Baycare Health Partners
STATES SERVED: Massachusetts

Baycare Health Partners' ACO is Pioneer Valley Accountable Care (PVAC), a participant in the MSSP from 2013-2015, and now, as one of 18 ACOs participating as a Next Generation ACO (NGACO). Approximately 35,000 Medicare beneficiaries are attributed to PVAC. Potentially avoidable hospitalizations have been identified by experts as leading to poor health outcomes and costly care. Using data, PVAC determined that approximately 45% of all emergency department visits for were preventable. To reduce these unnecessary admissions, PVAC created the Acute Care Alternative Program. The program relies on embedding a board-certified internist within the emergency department to work with nurse case managers and patients, diverting those with non-emergent conditions to other, more appropriate settings, such as primary care or skilled nursing facilities. In its first year, this program has avoided 92 unnecessary admissions, saving >$400,000 while simultaneously improving patient satisfaction. This accomplishment has allowed for continuation of the program with goal of collaborating with other local hospitals caring for large numbers of NGACO beneficiaries.

05

Organization: CaroMont Health
States Served: North Carolina

CaroMont Health is a regional health system based in Gastonia, NC (outside of Charlotte, NC). The system entered the MSSP program beginning in PY 2014 and have seen great success in saving Medicare dollars over the first two years of the program. In 2014 CaroMont was able to reduce medical spend by 5.6%. In 2015, they reduced it even further to 9.5% compared to benchmark. In real dollars, these improvements amount to more than $14 million in savings to the Medicare program for just 9,000 assigned beneficiaries. CaroMont achieved these results by closely managing the assigned population, leading to a 19% reduction in inpatient stays for patients with COPD, heart failure and pneumonia.

06

ORGANIZATION: Delaware Valley Accountable Care Organization
STATES SERVED: Delaware

The Delaware Valley Accountable Care Organization (DVACO) is a MSSP ACO and the region's largest Medicare ACO with more than 670 primary care physicians and over 107,000 Medicare fee-for-service beneficiaries. In 2014, DVACO skilled nursing facility (SNF) care was contributing disproportionately to a higher total cost of care for the beneficiaries attributed to the ACO, as compared to the national average. Contributing factors included fragmentation of care regionally and limited information flow, particularly back to primary care physicians, and a historically prevalent volume-based fee for service model. Care model transformation initiatives were undertaken, including implementation of the patient centered medical home model; improving primary care access and care coordination particularly around transitions of care; implementation of complex care coordination programs for the highest risk patients; implementing technology solutions for real-time notifications of emergency visits and hospitalizations; and establishing a network of higher performing post-acute providers (including SNFs). In less than two years, DVACO SNF care utilization and length of stay decreased significantly. In the most recent quarter of 2016 data, total per capita spend on SNF care has gone down by 16% compared to 2011-2013.

07

ORGANIZATION: Johns Hopkins Medicine
STATES SERVED: Maryland and DC

Johns Hopkins Medicine Alliance for Patients (JMAP) is a MSSP ACO. In all, some 2,900 providers care for 38,000 fee-for service Medicare beneficiaries. Through JMAP, intensive care coordination, quality improvement efforts, urgent specialty access and population-based pharmacy review have made a significant difference in the lives of thousands of individuals. In collaboration with Johns Hopkins HealthCare, one way that JMAP is working to improve care quality and value is by having care coordinators work with JMAP's most medically complex patients, helping them stay healthy and out of the emergency department or hospital. This includes assisting an elderly patient with getting set up with Meals on Wheels, helping a patient obtain a nighttime breathing machine or facilitating a patient's move into a rehabilitation center after a hospital stay. These efforts, coupled with the active collaboration of dozens of workers throughout the enterprise, are allowing Johns Hopkins Medicine to prepare for the future. JMAP achieved a 96.2 percent quality score and reduce rates of hospital admissions and emergency department visits by 2 percent from 2014 to 2015.

08

ORGANIZATION: Memorial Healthcare System
STATES SERVED: Florida

Memorial Healthcare System (MHS) targeted a system-wide reduction of 30-day readmission rates in order to improve quality, increase satisfaction and better manage unnecessary costs. To accomplish their goal, MHS created multidisciplinary work groups to standardize care for patients with congestive heart failure, COPD and sepsis. MHS partnered with a complex care management program to identify high-risk patients and assist them with the transition from the hospital back to home and their primary care providers. In addition, the team utilized a data-driven approach to monitor the progress of these efforts and to modify the programs as indicated by the data. As a result, MHS patients experienced a marked reduction in 30-day readmissions. At Memorial Regional Hospital, the system's flagship facility, heart failure readmission fell by 25%, heart attack by 13.7% and pneumonia by 14.2% from 2014. At Memorial Hospital West, the system's second largest facility, there was a 16% reduction in heart failure readmissions, 15.5% in heart attack and 16.1% in pneumonia during the same timeframe. Based on its performance, Memorial Hospital West was the only hospital in South Florida to pay a "zero" penalty in the Medicare Hospital Readmission Reduction Program.

09

ORGANIZATION: Mercy Health
STATES SERVED: Ohio, Kentucky

With more than 34,000 employees in eight regions, Mercy is one of the largest healthcare systems in the country. Mercy serves 130,000 patients through its ACOs, the majority of which are cared for through its MSSP ACO. In 2012, Mercy implemented a population health IT platform to integrate population health decision support into its electronic health record (EHR) workflow. In doing so, it created risk scores for overall utilization, mortality and potential risk of an ED visit to identify patient populations in need of enhanced care coordination. In drilling down to focus on at-risk patients, by 2015 Mercy's MSSP ACO achieved an overall quality score of 97.1%, its utilization rates were relatively flat and it nearly achieved shared savings with Medicare.

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ORGANIZATION: South Broward Community Health Services
STATES SERVED: Florida

South Broward Community Health Services (SBCHS) provides high-quality, cost-effective, patient-centered care for the uninsured and those covered by Medicaid or private insurance. Part of the Memorial Healthcare System, SBCHS has earned the highest ranking from the National Committee for Quality Assurance (NCQA) for a delivery model that places the patient at the center of care. Since earning this designation in 2013, SBCHS has saved $3,385,625 on specialist fees and has decreased total hospital admissions for patients under their care from 1,903 in FY 2014 to 1,312 in FY2016. These reductions have led to total cost savings of $8.3 million. SBCHS's patient-centered model is delivered through a team concept that assigns health coaches to coordinate the care of each patient. This includes everything from preventative screening and lab work to imaging and pharmaceutical, which enables doctors to establish deeper connections with patients and focus exclusively on medical care.

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ORGANIZATION: Southwestern Health Resources
STATES SERVED: Texas

Southwestern Health Resources was formed as an integrated health network in December 2015, blending the strengths of Texas Health Resources and its partner UT Southwestern to better serve North Texas residents. The joint effort has been successful at managing populations through multiple value-based contracts, including commercial payers, Medicaid, Medicare Advantage and the Medicare Shared Savings Program (MSSP). With MSSP, the 2015 financial performance yielded $30 million in savings –ranking the organization 2nd in Texas and 8th nationally. Moreover, the program's quality results score was 97%, as evaluated by CMS. Based on its strong track record, Southwestern Health Resources has been accepted to participate in the Next Gen ACO program beginning in January 2017.

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ORGANIZATION: St. Luke's University Hospital and Health Network (SLUHN)
STATES SERVED: Pennsylvania

SLUHN manages 84 clinical condition bundles as a participant in the voluntary bundled payment program. To ensure effective transitions of care and high-quality post-acute care outcomes, SLUHN studied referral patterns, length of stay, readmission rates, cost metrics and physician engagement within their coverage area to select 16 post-acute providers as partners in the program. To support their partners, SLUHN helped create standardized clinical pathways and care delivery models, transition of care process and strategies for patient and family engagement. SLUHN also met with all preferred providers to offer ongoing coaching, outcomes evaluations and data to pinpoint opportunities for improvement. Since starting the program, SLUHN has significantly cut post-acute length of stay in half, from 40 days in the baseline period to 20 days. They've also halved their 90-day readmissions from over 40% to 20%, generating more than $10 million dollars of savings to Medicare. Based on their success, SLUHN is now working to integrate community health workers within post-acute care to decrease 30-day readmission rates, increase physician- to- physician accountability for care planning and identify palliative care/hospice candidates to increase services to that population.

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ORGANIZATION: Texas Health Resources (THR)
STATES SERVED: Texas

Texas Health Aetna is a partnership between Aetna and Texas Health Resources, the first joint venture between a national insurer and a provider in the Dallas-Fort Worth Metroplex. This partnership creates a jointly owned health plan company that will focus on improving quality, affordability and the overall consumer experience. Texas Health Aetna combines Texas Health's high quality, local providers and delivery systems with Aetna's health plan experience, care management, analytical insights and health information technology. By sharing ownership and accountability equally, the new health plan will focus on the consumer experience by combining fully integrated care teams, health insurance benefits and administrative services to eliminate redundancies of care and administrative hassles. New commercial insurance products will be offered to employers and consumers in 14 counties in the Dallas-Fort Worth area starting this year. The partnership is Aetna's second joint venture with a nonprofit health system, as Aetna moves 75% of its contracts to value-based care models by 2020.

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ORGANIZATION: Triad Healthcare Network
STATES SERVED: North Carolina

Triad Healthcare Network, a Cone Health-backed ACO, reduced the cost of care for a pool of 35,000 North Carolina Medicare patients by 4.6 percent, or $21.5 million, from mid-2012 through the end of last year, while reporting quality metrics about the care the patients received. According to Triad's leaders, most cost reductions came from reducing unnecessary hospitalizations and emergency department visits. During their initial 18-month participation in the MSSP, Triad reduced hospitalizations by 2,000 patient days, by either keeping chronic conditions in check or ensuring that patients with ambulatory conditions received treatment from primary care providers.

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ORGANIZATION: White River Health System
STATES SERVED: Arkansas

White River Health System joined the voluntary bundled payment program in April 2015, and sought to achieve success by creating a perioperative surgical home (PSH). In their pilot program for total joint arthroplasty, White River focused on getting patients healthier and setting clear expectations prior to surgery. In "prehabilitating" patients, White River is now able to send 80% of patients home with home health or ancillary services, compared to 30% in 2013. In addition, their average length of stay in the hospital has fallen from 3 days to less than 2 days, and their readmission rate declined from 10% to 3%. These clinical improvements prompted orthopedic surgeons to expand the PSH process to other service lines such as hip fractures, outpatient shoulder surgery, and many others. From a financial standpoint, the first year of the program resulted in a savings of more than $650,000 – half of which went to Medicare.