Outline

• Describe organizational context of population health

• Discuss person-centered care and population health

• Lessons from ACOs

• Implications for future
Shared Savings Models

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>Medicare Shared Savings Program (MSSP)</th>
<th>Pioneer ACO Model</th>
<th>CMMI Bundled Payment Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>Promotes accountability for Medicare beneficiaries; improves the coordination of FFS services; encourages investment in infrastructure; and rewards higher value care.</td>
<td>Promotes accountability for beneficiaries; improves the coordination of care; encourages investment in infrastructure; and rewards higher value care.</td>
<td>Encourages providers to work together for better management of patient population.</td>
</tr>
<tr>
<td>Model Concept</td>
<td>Focused primarily on shared savings; targeted at easing organizations into the ACO concept/model.</td>
<td>Higher levels of shared savings opportunities, but accompanying risk levels.</td>
<td>Targeted at a single payment for services related to a clinical condition or specified episode only, rather than for all care for a patient during a specified time period.</td>
</tr>
<tr>
<td>Base Payment Structure</td>
<td>Maximum sharing up to 50% based on the maximum quality score with a performance payment limit of 10%.</td>
<td>Year 1 - 60% shared savings and shared losses subject to a maximum of 10% of total projected Medicare Part A and B expenditures for the ACO patients. Year 2 - 70% shared savings and shared losses subject to a maximum of 15% of total projected Medicare Part A and B expenditures for ACO patients.</td>
<td>Four potential models driven primarily on care setting and service type.</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>Two tracks hospitals may join: Track 1 - Shared savings only track for the duration of the first agreement period. Track 2 - Allows more advanced organizations to take on performance-based risk for a higher reward.</td>
<td>The first two years of the Pioneer Model are a shared savings payment arrangement and the third year is focused on transitioning to a more intense population health methodology, depending on the success of years 1 &amp; 2.</td>
<td>Not a shared savings program. Providers keep savings, but must bear risk for excess costs.</td>
</tr>
<tr>
<td>Risk</td>
<td>Track 1 does not require providers to bear risk for excess costs. Higher levels of risk and shared savings in first two years than MSSP.</td>
<td></td>
<td>Providers must bear risk for excess cost per episode of care.</td>
</tr>
<tr>
<td>Organizational Targets</td>
<td>Unlimited. Up to 30 with focus on advanced, integrated organizations.</td>
<td>Open – applicants are encouraged to implement cross-provider care improvements.</td>
<td></td>
</tr>
</tbody>
</table>

About Ascension Health

Facilities and Staff

<table>
<thead>
<tr>
<th>Sites of Care</th>
<th>1,935</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Acute Care Hospitals</td>
<td>103</td>
</tr>
<tr>
<td>Long-term Acute Care Hospitals</td>
<td>3</td>
</tr>
<tr>
<td>Rehabilitation Hospitals</td>
<td>3</td>
</tr>
<tr>
<td>Psychiatric Hospitals</td>
<td>4</td>
</tr>
<tr>
<td>Joint Ventured Hospitals</td>
<td>18</td>
</tr>
<tr>
<td>Available Hospital Beds</td>
<td>20,841</td>
</tr>
<tr>
<td>Associates</td>
<td>150,000</td>
</tr>
</tbody>
</table>

Care of Persons Living in Poverty and Community Benefit Programs: $1.5 Billion

FY13 Financial Information (in millions)

| Total Assets | $26,003 |
| Operating Revenue | $16,987 |
| Operating Income | $451 |
### Major Sites of Care

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Sites</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Acute Care</td>
<td>103</td>
<td>18,712</td>
</tr>
<tr>
<td>Rehabilitation Hospitals</td>
<td>3</td>
<td>173</td>
</tr>
<tr>
<td>Psychiatric Hospitals</td>
<td>4</td>
<td>324</td>
</tr>
<tr>
<td>Long Term Acute Care Hospitals</td>
<td>3</td>
<td>144</td>
</tr>
<tr>
<td>Joint Ventured Hospitals (&lt;50% ownership)</td>
<td>18</td>
<td>1,488</td>
</tr>
<tr>
<td>Ambulatory Surgery Centers</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>Occupational Health Programs</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>On-Site Employer Clinics</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Free-standing Imaging Sites</td>
<td>148</td>
<td></td>
</tr>
<tr>
<td>Retail Lab Collection Sites</td>
<td>265</td>
<td></td>
</tr>
<tr>
<td>Primary Care Clinics</td>
<td>371</td>
<td></td>
</tr>
<tr>
<td>Retail Pharmacy Sites</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Sleep Centers</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Virtual Care Programs</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Community Health Centers</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Long Term Care/Skilled Nursing</td>
<td>34</td>
<td>3,745</td>
</tr>
<tr>
<td>Independent and Assisted Living</td>
<td>9</td>
<td>1,823</td>
</tr>
<tr>
<td>Other Living (HUD, other)</td>
<td>4</td>
<td>377</td>
</tr>
<tr>
<td>PACE Programs/Enrollees</td>
<td>3</td>
<td>726</td>
</tr>
<tr>
<td>Mobile Clinical Services</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Wellness Centers</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Community and Social Programs</td>
<td>162</td>
<td></td>
</tr>
<tr>
<td>Dispensary of Hope Sites</td>
<td>82</td>
<td></td>
</tr>
<tr>
<td>Other Miscellaneous Services</td>
<td>123</td>
<td></td>
</tr>
</tbody>
</table>

### Ascension Health Footprint

Ascension Health is the largest Catholic and private nonprofit health system in the United States, operating in 23 states and the District of Columbia.
Ascension Integrated Strategic Priorities

Aspiration: Vital Catholic health ministry called to improve health and healthcare through sustainable, values-inspired innovation.

Strategic priorities:

1. Create sustainable **person-centric delivery system** to serve individuals throughout their lifetime

   1A. Transform our local health ministry operations
   1B. Assemble standardized physician practice management services offering as foundation for enhanced physician relationships
   1C. Build the physician/caregiver-driven, person-centric & community-based care delivery model of the future

2. Build best in class services businesses that enable our delivery system and strengthen Catholic healthcare by serving other organizations

3. Continue to innovate, incubate and acquire new solutions, services and capabilities to strengthen our health ministry in a rapidly changing environment

4. Ensure the **healthiest, most inspired Associates** as we realize our **Model Community** ambition

5. Develop **strong, diversified financial platform** to support and sustain our combined ministry

In Other Words …

- Opportunities for income improvement from inpatient volume growth or commercial rate increases are limited
- Population health capabilities need to be developed
- Cost structures must fundamentally change
- Access to care for the poor will continue to challenge the delivery system
- The basic relationships and care model between hospitals, doctors, and patients will change dramatically
- Leadership in palliative care and end of life care is part of Catholic identity
Population Health

Financial Risk Management Capabilities

Network Development and Management

Person-Centered Care

Analytics

Physician/Caregiver Development and Engagement

Ascension Health Value-based Healthcare Delivery Efforts

- Genesys PACE, Genesys HealthWorks, and Genesys PHO Pioneer ACO
- Quality Health Solutions Commercial ACO
- Alexian Brothers MSSP ACO
- Community Care Health Plan
- Via Christi PACE
- HealthChoice PPO VIVA Health Plan
- Partners in Care MSSP ACO
- Catholic Medical Partners MSSP ACO
- Maryland Physicians Care MCO Medicaid HMO
- Capital Clinical Integrated Care Network (CMMI Innovation Grant)
- St. Vincent’s HealthCare 3 CMMI Bundles
- Ascension SmartHealth

Mercy Care Medicaid HMO
Accountable Care Consortium Commercial ACO
Seton Health Plan, Seton Health Alliance, and Pioneer ACO
MissionPoint Health Partners MSSP ACO, 13 CMMI Bundles, Commercial ACO
St. Thomas Medical Group MSSP ACO

(a) Jacksonville, FL; Tulsa, OK; Pensacola, FL; and Wichita, KS submitted MSSP applications for January 2014 start
(b) Seton Pioneer ACO transitioning to MSSP beginning January 2014
(c) Map current through June 2013
How the Pioneer ACO Model Needs to Change Lessons From Its Best-Performing ACO

Pioneer ACO Savings
Only 0.3% costs increase for 669,000 beneficiaries in 2012 (compared to 0.8%)
13 out of 32 pioneer ACOs produced shared savings

Pioneer ACO Quality
All demonstrated care improvement
Several ACOs developed innovative care management models

Pioneer ACO Impact on Health Care Organization
Significantly negative impact

Achieving Lower Costs

Over 12% decline in total costs for first 15,000 members
Producing Better Outcomes

Fee For Service versus Fee For Value Urban Myths

1. Market share and hospital volume
2. Counting encounters versus counting lives
3. Physician employment versus physician alignment
4. Challenges and Stark Laws
Ascension Health Lessons

Quality and cost are independent outcomes

It takes more than ACO shared savings models to succeed in serving populations

Population Health and Person Centered Care in the Catholic Ministry

• Catholic social teaching, social justice, and population health

• Catholic social teaching, human dignity, and person centered care

• Connection between population health and person centered care

“Each human is a microcosm of the universe.”
Louise de Marillac, Thoughts on the Feast of St Fiacre
Picker Institute Definition

1. Respect for the patient’s values, preferences, and expressed needs
2. Information and education
3. Access to care
4. Emotional support to relieve fear and anxiety
5. Involvement of family and friends
6. Continuity and secure transition between health care settings
7. Physical comfort
8. Coordination of care


Translated Picker’s work into primary care

1. Superb access to care
2. Patient engagement in care
3. Clinical information systems that support high-quality care
4. Care coordination
5. Integrated, comprehensive care and smooth information transfer
6. Ongoing, routine patient feedback to a practice
7. Publicly available information on practices

*A 2020 Vision of Patient-Centered Primary Care*

Karen Davis, PhD,1 Stephen C. Schoenbaum, MD,1 Anne-Marie Audet, MD2

1The Commonwealth Fund, New York, NY, USA.
For Underserved Populations

Kellogg Foundation:

1. Welcoming environment
2. Respect for patients’ values and expressed needs
3. Patient empowerment or “activation”
4. Socio-cultural competence
5. Coordination and integration of care
6. Comfort and support
7. Access and navigation skills
8. Community outreach

Towards a global definition of patient centred care

*The patient should be the judge of patient centred care*

**Care that:**

- Explores the patient’s main reason for the visit, concerns, and need for information
- Seeks an integrated understanding of the patient’s world—that is, the whole person, emotional needs, and life issues
- Finds common ground on what the problem is and mutually agrees on management
- Enhances prevention and health promotion
- Enhances the continuing relationship between the patient and the doctor
Limitations of definitions

• The example of centers of excellence and the need for house calls

Challenges

• The example of Access:
  – Call light
  – Clinic appointment
  – Response to patient’s telephonic inquiries
  – Expectations of response (timely, yet sub-optimal responses)
  – Relative urgency of access (tissue diagnosis after abnormal mammography)
Hierarchal Framework

<table>
<thead>
<tr>
<th></th>
<th>Ambulatory Care</th>
<th>Hospital</th>
<th>Subacute and LTC</th>
<th>Home Care</th>
<th>End of Life Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfort (pain, sleep, privacy)</td>
<td></td>
<td></td>
<td>(bowel and bladder, food preferences ... )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Function (ADLs and IADLs)</td>
<td>Pain management protocols</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental (fear, depression ...)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>Third appt.</td>
<td></td>
<td></td>
<td>Call light response</td>
<td></td>
</tr>
<tr>
<td>Autonomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
<td></td>
<td>Care planning</td>
<td></td>
</tr>
<tr>
<td>Care Coordination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spirituality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care planning and design</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strategic Organization To Serve Populations

- Focus on quality
  - Organizing central leadership around safety, equity, experience, process reliability

- Role of leadership
  - Creating a passion for service and continuous improvement
  - Empowering middle management with QI science

- Focus on market segments
  - Systematic focus on horizontals: long term care, physician enterprise, home care, hospital, segment, etc.

- Focus on customer segments, service lines, and demographic segments
Example of Physician Enterprise

“High Performing Medical Group”

Network Development

Discussion

Thank you for your interest.

Ziad Haydar
ziad.haydar@ascensionhealth.org