An Emerging Rural ACO: Chautauqua Region’s Transitioning Medical Neighborhood/Accountable Care Community

Stewards of Change

June 11, 2013
Chautauqua County, New York

- Population: 130,000+
  - Northern tip of Appalachia
  - Over 7% Hispanic, border the Seneca Nation
  - Geographic and low income HPSA’s
- Clinical Services:
  - 3 Hospital Organizations-4-hospitals, no CAH’s
  - (all community-336 beds)
  - Approx 100+ physicians
  - Tertiary Care in Erie, PA; Cleveland, OH; Rochester, NY; and Buffalo, NY
    -- One FQHC opened 1/13
- 27,000 Medicare Beneficiaries
  - 7,000 targeted in MSSP ACO
  - 40% Medicare Advantage
- Provider Sustainability = Pay for Performance and Other QI incentive
  - Lowest wage index in the nation
  - Erosion of HMO/Managed Care Market
  - Clinical Integration strategy since 2008 anticipating payment reform
  - Accountable Care Act-focus on PCMH and CTI to start
Portrait of Chautauqua’s Provider Community
Synergy of Multiple Enterprises has made the ACO possible

9 FTE’s and a part-time medical director
Key Partners

• County and Local Agencies (e.g. Office for the Aging, LHU, etc.)
• NYSDOH Office of Rural Health
• State Hospital Association
• P² Collaborative of WNY-AF4Q
• HEALTHeLINK (RHIO)-Beacon
• HRSA Office of Rural Health Policy
• Health Foundation of W&CNY
• HIT Consultants
• HIT Vendor
• Medicare Advantage Payer Partner
• Elected Officials-State and Federal
AMP Profile

- MSSP participation only
- 7000 beneficiaries
- 8 Independent PCP’s-35 physicians
- 3 Independent Hospital Organizations-4 facilities
- 2 Independent SNF Organizations – 3 facilities
- No specialties
- Track 1-upside gain share only
- 3.4% savings target
- No advance payment
- CI infrastructure development was well underway
Differing Approaches

Conventional Wisdom

Chautauqua Health Connects
Our Plan
Build Patient Centered Medical Homes and Revitalize the Medical Neighborhood To Support Them
Focus: Medicare Beneficiaries Move to be more proactive
Our Blue Print for Medical Neighborhood Revitalization

The Chronic Care Model

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Improved Outcomes

Developed by The MacColl Institute
© ACP-ASIM Journals and Books
Our Clinical Integration Strategy
“Chautauqua Health Connects”

1. Patient Centered Medical Home
2. Health Information Exchange
3. Hospital/SNF Care Transitions
4. Patient Engagement
Chautauqua Health Connects
Strategy: Health Information Exchange

The Chautauqua Model: Maintaining Seniors with Long Term Health Needs

MEDICAL NEEDS
- Hospital
- Specialists
- Medical Tests
- Allied Health: Rehab, PT, OT, ST
- Skilled Nursing Facility
- Certified Home Health Agency
- RX
- Medical Day Care
- Durable Medical Equipment Suppliers

TRANSPORTATION

LIVING WELL NEEDS
- Housing: CHRIC & COI
- Wellness Programs: Falls Prevention, CDSMP
- Gov. Programs & Waiver Services: OFA, DOH, DSS, MH, VSA
- Community Agencies: Aspire, TRC, COI, BA, ADC
- Faith Based Initiatives
- Support Groups
- Food: MOW, Dining Out, Pantries

PATIENT CENTERED MEDICAL HOME

Chautauqua Health Connects
INFORMATION EXCHANGE
(Provider Link )
(Guided Care )

CHAUTAUQUA COMMUNITY RESOURCE CENTER
NY Connects
- Information & Referral/Assistance
- Options Counseling
- Assessment
- Eligibility Determination
- Transitional Coaching

Credit: Chautauqua Regional Associated Medical Partners, LLC.
Chautauqua Health Connects
Strategy: HIE - Building Community Connections

- Improve community resource referrals starting with Office For the Aging (ARDC)
Chautauqua Health Connects
Medical Neighborhood Revitalization
Hospital Community Care Transition Initiative
Part 1: Improve Communications

- Access Admission/Discharge (ADT) information from RHIO
- Establish ADT information transfer from Pennsylvania facilities
- Currently mapping the data/work flows for each pilot group
- Identifying data elements to be built into CHC that can be extracted by each partner for specific needs
- Piloting secure messaging and referral between 4 hospitals, 12 physician offices, 2 home care, 2 SNF, and OFA-working w/ RHIO
Examples of Best Practice Public Health Collaborations

- Local Health Information Exchange
- Integrated Community Health Planning
- Patient Empowerment Program
- CTI-Community Coaching
- Smoking Cessation
- Now U Know-Cancer Awareness Education
- Stepping On
- Moving For Better Balance
- Healthy Bones
- CDSMP-including Diabetes, Pain Management
- Diabetes Prevention Program
- Farmer’s Market and Community Garden Promotion
- Built Environment initiatives
- Million Hearts
Harriet’s PCMH in Action

- Harriet is assigned to one of AMPS PCMH’s and MPI is established
- Local Hospital admission pinged in HIE
- Hospital signs Harriet up for CTI; notifies OFA
- CTI Home Visit completed by OFA and reported through HIE
- PCP pinged on ADT in HIE and tracking discharge
- Guided Care Nurse reaches out for 7 day f/u visit in office
  - Pulls her profile from the Community View in HIE before visit
  - Signs her up for GC at this visit
  - Home visit-medication reconciliation
  - Office Visit Screenings –Registry alerts for aberrant metrics and needed screenings, i.e. PAM, SF 12, falls, depression, BP, etc.
  - Care plan developed
    - Advance care plan, possible MOLST
    - Smoking Cessation if needed
- Referral to OFA for options counseling
  - Meals, HEAP, Home Safety improvements, SNAP, transportation coordination, PERS, Personal Care Aide, fitness video
- Referral to CDSMP
- Referral Follow-ups reported and monitored in HIE
- Monthly contact-24/7 access to nurse
- Trying to establish that PCMH is the point for all patient service initiation with other agencies
Chautauqua Health Connects
Strategy: Patient Engagement

The Chronic Care Model

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Improved Outcomes

Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team

Creating Healthy Places
Community Transformation Grant
Care Transitions Intervention
Chronic Disease Self-Management Program
Advance Care Planning
Consumer Engagement Associates
Accountable Care Organization
Meaningful Use
HIE
Patient Centered Medical Home
Nurse Care Managers
Practice Enhancement Associates
Developed by The MacColl Institute
What’s Been Difficult
Sample of Challenges

• Working Capital for data and care management infrastructure
• Language
• HIT and data aggregation demands
  – Software is still not ready anywhere
  – Hospital EHR implementation
  – Data sources
  – EMR’s that won’t export data
  – Alignment with RHIO
  – Data entry variability
• Staffing skills and resources
  – Organizational-culture change to build high-performing health system-hospital resistance to change
  – Man-time
  – Leadership capacity
• Legal-Data Use
  – Beneficiary Consent
  – Developing agreement with OFA
• Network-Participating Providers
  – Size and scalability
  – Composition of provider membership
  – Emerging hospital system affiliations
  – Referral networks-tertiary care/border issues
  – Network Self-confidence
  – Patient Engagement in the PCMH is an after thought
• Managing/pacing so much change at one time
• Managing expectations of cost savings-Re-investment and scorecard development
Lessons Learned

• Too many to count!
• Persistence pays
• Have a flexible strategy/plan
• Stay on message
• The ACO-Medical model would not be working on community support w/o a public health conscience
• Data is essential and doesn’t have to be expensive
• Learning curve is steep-pace is important
• One size does not fit all
• Learning Collaboratives are invaluable
• It’s all about relationships
• $$$$ drives the system
An example of Smarter Care
Bringing together health and social care for better outcomes
Smarter Care brings together lifestyle, social and clinical choices

- **Lifestyle**
  choices have direct impact on an individual’s mental and physical wellness.

- **Social**
  determinants such as where one is born, grows, lives, works and ages have direct impact on an individual’s overall health and well being.

- **Clinical**
  factors such as specific medical symptoms, history, medications, diagnoses, etc are indicators of an individual’s health.
In Catalonia they are building a Smarter Care System
They have to address an increasing number of Elderly

In 2050 almost 1/3 population will be over 65 and 12% over 80

Source: INE, projections 2011
Catalonia are implementing a new health plan

3 pillars of transformation

I. Health Programs: Better health and quality of life for everyone

II. Transformation of the care models: better quality, accessibility and safety in health procedures

III. Modernisation of the organisational models: a more solid and sustainable health system

New lines of action

1. Objectives and health programs

2. System more oriented towards chronic patients

3. A more responsive system from the first levels

4. System with better quality in high-level specialties

5. Greater focus on the patients and families

6. New model for contracting health care

7. Incorporation of professional and clinical knowledge

8. Improvement of the government and participation in the system

9. Improvements to information, transparency and assessment

For each line of action, a series of strategic projects will be developed, which make up the 31 strategic projects of the Health Plan.

The pilot focus is on 2 complexity profile

**PCC**: Patient with **multimorbidity** or unique/singular disease or **condition which are related to difficult clinical management**

**MACA**: Limited life prognosis, high needs, **palliative orientation**, advanced care planning

Approximately 5% of the population in complex or advanced stages
The “MECASS project” allows Catalonia to holistically address PCC and MACA patients (multi chronic conditions)

360º vision

Health Programmes

Case Management

Clinical Station
"360º Patient Centered Vision"

"Clinical Risc Groups" Stratification

Description of condition/situation

Service Utilization: PHC/Hospital/A&E

Lab results

Multidimensional assessment

Medication

Planned activities
Multidisciplinary Team Portal:

- Assign multiple professionals
- Open discussions
- Agenda of MDT meetings
- Meeting minutes & agreements
Catalonia is an example of the IBM Smarter Care Vision