Mathematica

Center on Health Care Effectiveness

Innovations in Medicare ACOs' Approaches to Care Delivery Improvement

November 19, 2019

Webinar

Agenda

Welcome and introduction	Sonya Streeter
Overview and highlights of ACO innovation	Sonya Streeter
Montefiore ACO and beneficiary engagement	Vanessa Guzman
Dialysis Clinic Inc. and care coordination	Doug Johnson
ColigoCare ACO and provider engagement	Frank Shipp
Overview of Pathways to Success	Heather Grimsley
Insights from ACO Learning System activities	Terri Postma
Q&A	All

Speakers

Sonya Streeter

Principal Investigator for the Learning System for ACOs at Mathematica

Vanessa Guzman

Associate Vice President of Quality and Network Management at Montefiore ACO

Dr. Douglas Johnson

Director and Vice Chairman of the Board at Dialysis Clinic, Inc.

Frank Shipp

Executive Director at ColigoCare ACO

Speakers

Heather Grimsley

Director of the Division of ACO Finance and Data Analytics at the CMS Center for Medicare

Dr. Terri Postma

Medical Officer and Senior Advisor at the CMS Center for Medicare

Objectives

1. **Describe insights and strategies to improve care delivery that emerged through the CMS Learning System for ACOs**
2. **Share ACOs' experiences and approaches to improve care delivery within value-based care initiatives**
3. **Highlight changes in Pathways to Success, a Medicare policy opportunity for organizations interested in participating in alternative payment models**

Overview and Highlights of ACO Innovation

Sonya Streeter, MPP, MPH

Principal Investigator for the Learning System for ACOs

CMS Accountable Care Organizations (ACOs)

Definition of an ACO

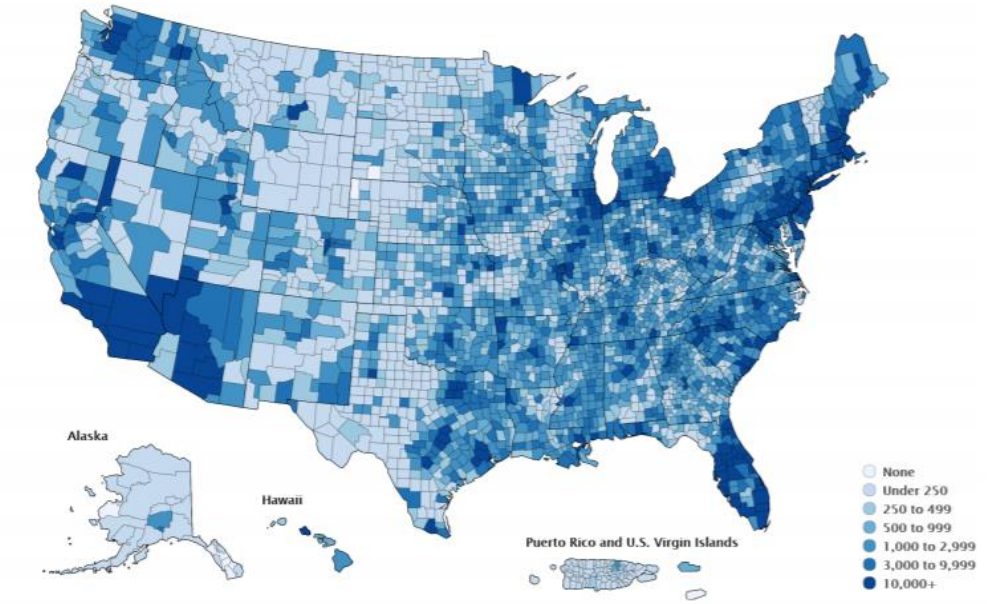
- Doctors and hospitals voluntarily coming together to deliver coordinated and high quality care to patients
- Alternative payment models linked to quality metrics and payer cost savings

Over 500 Medicare ACOs care for more than 11 million beneficiaries

- Medicare Shared Savings Program (SSP)
- Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model
- Next Generation ACO Model
- Vermont All-Payer Model

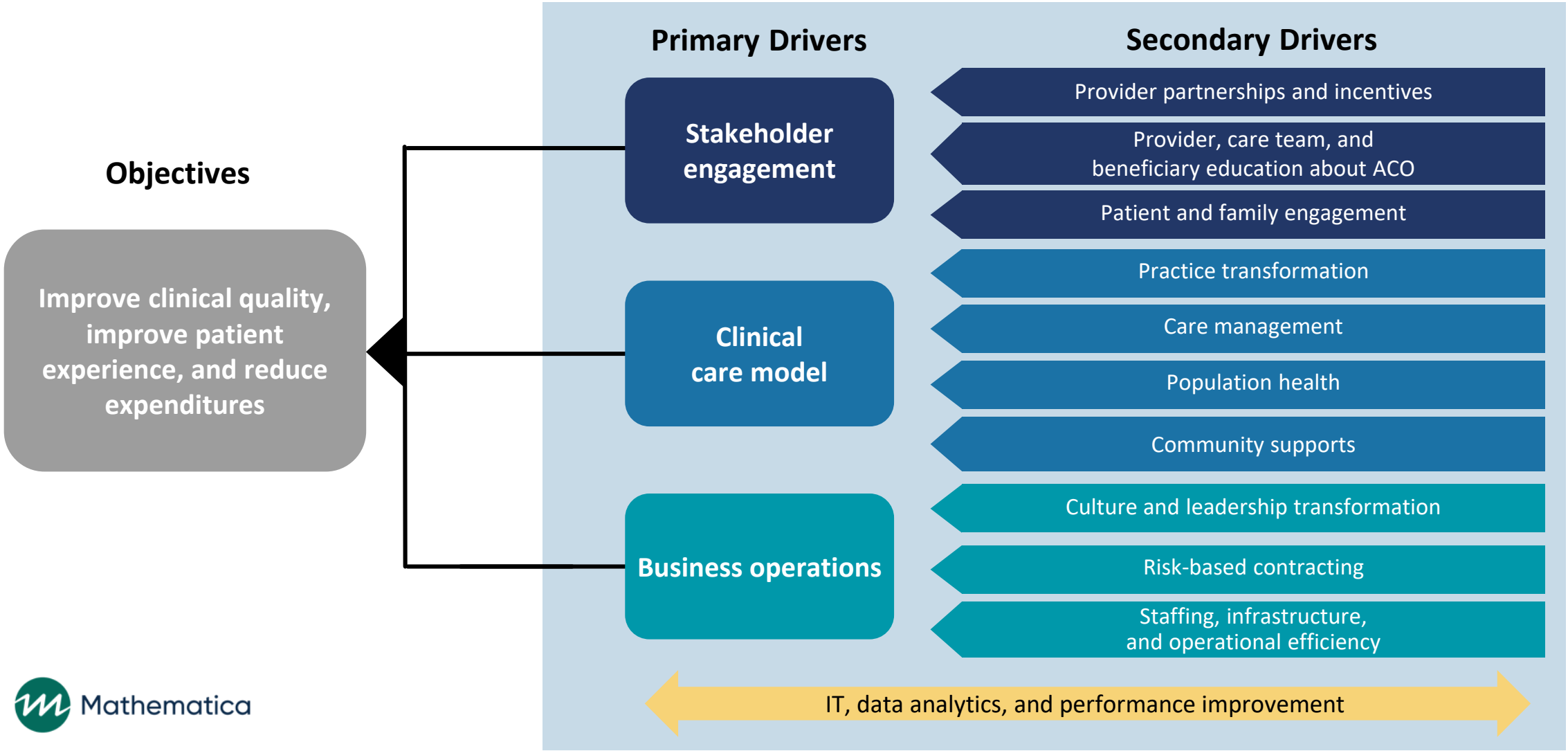
New opportunities:

- Pathways to Success
- Direct Contracting
- Kidney Care First (KCF)
- Comprehensive Kidney Care Contracting (CKCC)



Source: Centers for Medicare & Medicaid Services. "Shared Savings Fast Facts – As of July 1, 2019." https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ssp-2019-fast-facts.pdf (Accessed September 2019)

Integrated Driver Diagram from the Next Generation ACO Model



Common Questions When Learning About an ACO Strategy or Initiative

How will this initiative improve care delivery at my organization?

- What is the primary goal of the initiative?
- What is the mechanism of change?

How should my organization approach implementation?

- What are best practices to streamline operations?
- What investment is required?

How do I assess whether this initiative is the right match for my organization?

What is the return on investment (ROI) of this initiative?

Highlighting Lessons with Toolkits and Case Studies

Resources on the CMS Website

Series of resources explore ACOs' strategies to provide high-quality and efficient care

- Care Coordination Toolkit- posted April 2019
- Beneficiary Engagement Toolkit- coming soon!
- Over a dozen case studies, as of November 2019
- More to come!

Based on focus groups and interviews with representatives from over 20 organizations participating in SSP, NGACO, and CEC Models

Link to CMS website:
https://innovation.cms.gov/initiatives/aco/

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Overview of Care Coordination Toolkit

Explores ACOs' innovative approaches to provide high quality care and improve outcomes in a risk-based environment for beneficiaries who…

1. Receive emergent care in the emergency department (ED)
2. Require treatment in a skilled nursing facility (SNF)
3. Have been diagnosed with a chronic condition
4. Have conditions affected by the social determinants of health

Coordinating Care for Beneficiaries Who Receive Care in the ED

Hold in-person meetings with hospital leadership and administrators to establish a collaborative relationship before engaging ED staff. ACOs' goals for meetings include:

- Establish common ground between ED clinicians and PCPs about care improvement strategies
- Gather insight and information from the frontline clinicians in the ED, hospital, and primary care settings
- Foster evolving relationships between urgent care providers and PCPs

Embed care management staff within the ED to facilitate timely care coordination between ED clinicians and PCPs by:

- Accessing information on patients' previous health needs from the EHR to share with ED clinicians
- Assisting with discharge and transfer from the ED to another care setting or to the home
- Closing information gaps if beneficiaries and clinicians use EHRs that lack interoperability

Flag beneficiaries' ACO attribution status and their PCPs' contact information for ED clinicians using cards and/or EHR-based alert

ACO Snapshot: Empowering Patients to Initiate Care Coordination After Seeking Urgent Care

Objective: Create a pathway for beneficiaries to contact the ESCO after ED visit

Strategy:

- Beneficiaries receive wristbands and wallet-sized cards with toll-free telephone number for on-call care coordinators who…
  - Work with the beneficiaries' dialysis centers
  - Have access to patients' health history data
- ESCO encourages beneficiaries to reach out to a care coordinator after an ED visit; coordinator then contacts the ED to learn about the beneficiary's care needs and treatment
- Care coordinator informs the beneficiary's care providers of ED visit and supports beneficiaries with ongoing health care needs

Coordinating Care for Beneficiaries Requiring Treatment in a SNF

Establish networks of preferred SNFs that consistently provide high quality care based on available data

- Develop communication resources (for example, brochures and scorecards) to highlight high-performing facilities for beneficiaries and clinicians

Promote continuous quality improvement in the provision of skilled nursing care, for example:

- Meet regularly with SNF administrative and clinical staff
- Establish work groups and collaboratives to enable peer-to-peer learning between SNFs

Identify dedicated staff to oversee the post-acute care plan and coordinate care with SNF clinicians from SNF admission through discharge

ACO Snapshot: Developing a SNF Scorecard to Support Patient Decision Making

Objective: Offer patients and clinicians a clear view of SNFs' performance relative to peers in order to select a facility

Strategy:

- Next Generation ACO developed a scorecard that ranks SNF performance based on ACO-developed measures and data about its attributed population
- Scorecard noted SNFs recommended by patients, using feedback survey data
- Tool supports clinicians when…
  - Considering SNF's performance relative to peers
  - Discussing available facilities with beneficiaries and caregivers

		How good are facilities at		
Rank*	Facility**	Preventing re-hospitalization	Improving patient independence	Cost savings (length of stay)
1	SNF 1 ☺			
1	SNF 2 ☺			
3	SNF 3			
4	SNF 4			
4	SNF 5			
6	SNF 6			
7	SNF 7			
8	SNF 8			
9	SNF 9			
9	SNF 10			
	SNF 11	These participating facilities aren't ranked because we don't have enough information on their performance yet		
	SNF 12			
	SNF 13			
	SNF 14			
	SNF 15			

●●●●●	High Performance
●●●●	Better than Expected Performance
●●●	Expected Performance
●●	Worse than Expected Performance
●	Low Performance

Special Designations	
☺	Most recommended by patients

**Medicare patients may choose any Medicare certified skilled nursing facility. The facilities above participate in the Post-Acute Care Program

*Facilities are listed from highest performing to lowest performing based on the total number of circles. In cases of a tie, facilities that rank the same are listed in alphabetical order. Special designations do not impact facility performance or rank.

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Overview of Beneficiary Engagement Toolkit

Considers strategies to engage beneficiaries in the ACO and their health care, with specific focus on how ACOs…

1. Engage beneficiaries in ACO governance
2. Elicit beneficiary and family feedback
3. Support beneficiaries in self-care management
4. Enhance beneficiary communication in the clinical setting
5. Communicate with beneficiaries about the ACO as a value-based care organization

Engaging Beneficiaries in ACO Governance

Emphasize the beneficiary viewpoint within the ACO board

- Invite beneficiaries to participate on the ACO board to offer perspective on their own experience and refine communications materials
- Ask participating providers for beneficiary representative recommendations, and seek beneficiaries willing to participate in numerous capacities

Establish a patient and family advisory council to efficiently solicit insight from stakeholders

- Solicit insight from diverse set of stakeholders
- Structure the council based on the specific organization's needs: Council size and organization varies by ACO
- Consider approaches to sustaining the patient and family advisory council, such as balanced scheduling or assistance with transportation.

Example Snapshot: Empowering Beneficiaries to Share Insight with ACO Leadership

Objective: Form diverse patient and family advisory council to highlight perspectives of the attributed population for ACO staff

Tactic: Encourage beneficiaries to drive the agenda when engaging with ACO leadership

Strategy:

- Create an advisory council of 15 volunteer beneficiaries and caregivers to provide guidance on ACO-related initiatives and patient-facing communications
- Alleviate travel-related burdens by providing gas cards and lunch
- ACO medical director facilitates discussions that enable participating beneficiaries to drive discussions and voice high-priority concerns

Supporting Beneficiaries with Self-Care Management

Develop resources and distribute directly to beneficiaries

- Create educational materials that focus on adoption of strategies for managing common chronic conditions (e.g., articles for newsletters or magazines)
- Provide access to resources that encourage medication adherence and regular refills

Identify materials for care teams to discuss with beneficiaries

- Provide educational materials clinicians can use to facilitate conversation with beneficiaries
- Resources can come from a variety of places, such as beneficiary advisory committees or evidence-based materials produced by researchers.

Offer beneficiaries group classes to encourage them to take a more active role in their health care

- Clinicians or care teams lead these learning opportunities
- Classes focus on strategies to increase beneficiaries' self-efficacy related to goal-setting, problem-solving, and informed decision-making

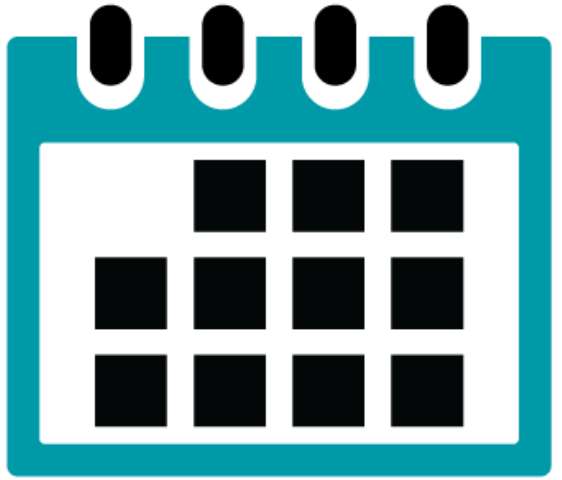
Example Snapshot: Empowering Beneficiaries to Manage their Chronic Care Conditions

Objective: Develop resource to support beneficiaries in adopting self-care management strategies

Tactic: Distribute wellness calendar serve as a tool for organizing and tracking health information

Strategy:

- Develop tool to help beneficiaries track health information such as appointments, treatment, prevention tips, and clinician phone numbers
- Connect with health system leadership to define distribution of calendars related to primary care visits. Create workflows and assign staff to educate beneficiaries about the calendars
- Encourage beneficiaries to bring the calendar to medical appointments and use it as a home reference



CMS Website for New Resources

Information about current ACO Models and Programs

Toolkits

- Care Coordination Toolkit
- Beneficiary Engagement Toolkit (coming soon!)
- Toolkits released in 2020 touch on provider engagement and patient care transformation

Case Studies

- Promoting annual wellness visits
- Investing in staff development and leadership
- Coordinating care in rural areas
- Promoting health literacy
- And many more!

CMS website to download ACO resources:
https://innovation.cms.gov/initiatives/aco/

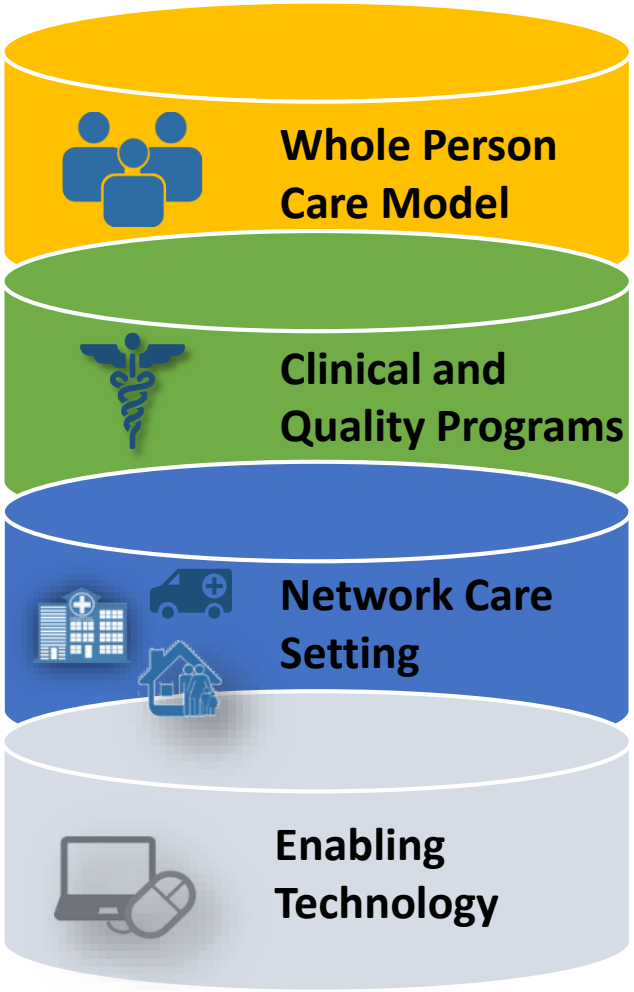
Montefiore ACO: Beneficiary Engagement

Vanessa Guzman, MS

Associate Vice President of Quality and Network Management at Montefiore ACO

Montefiore ACO's Population Health Management Foundational Architecture

Developed over twenty years of experience managing highly complex and diverse patient populations



- **Integrated Medical / Behavioral Health**
- **Social determinants of health**
- **Episodic and Longitudinal Care Management**

- **Focused clinical care designed to treat advanced needs**
- **Cancer, Renal, Cardiac, Respiratory, Transplant, etc.**

- **Acute care**
- **Sub-acute and post-acute care**
- **Transitions to home**

- **Seamlessly connect providers, patients and caregivers**
- **Consumer-centric platforms to improve patient experience**

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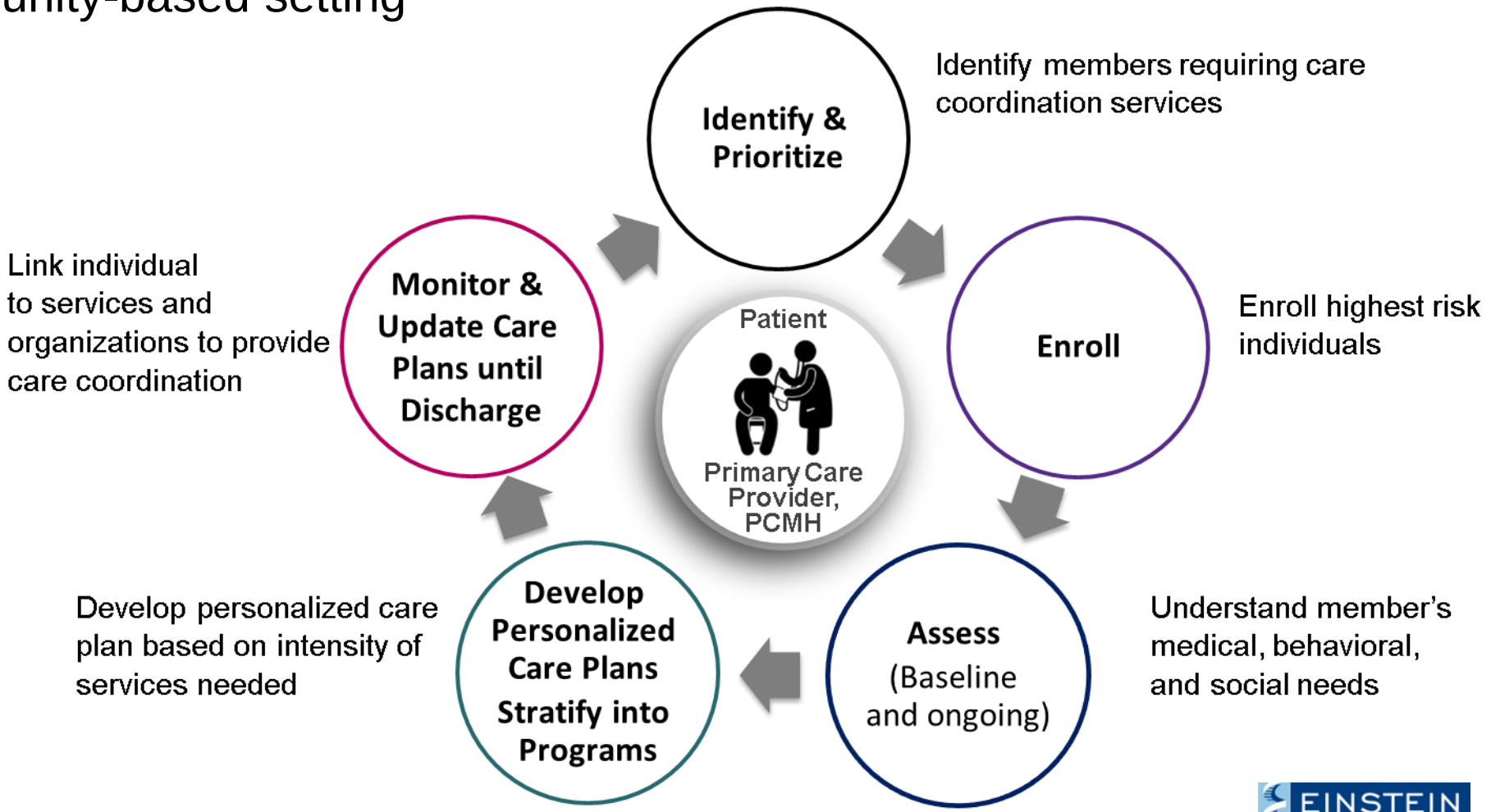
Montefiore's Care Management Organization: Care Coordination & Management Model

Care Guidance^{TM} Process Lifecycle

Time-limited interventions averaging six months aiming to stabilize individual in a community-based setting



Community Partnerships

Engaging youth groups, schools and local community-based organizations around advocacy for improved food access in their communities

- **Nutrition education and "train the trainer" programming**
  - **Sugary beverage education**
  - **Food label reading workshops**
  - **Food prep/Cooking demos**

- **"Don't Stress, Eat Fresh" joint Marketing Campaign with other Bronx-based bodega projects through Bronx Bodega Partners Workgroup**

Peer-to-Peer Mentorship program

Peer-to-Peer Mentoring Program

Patients with poorly-controlled (HbA1c>9%) diabetes receive:

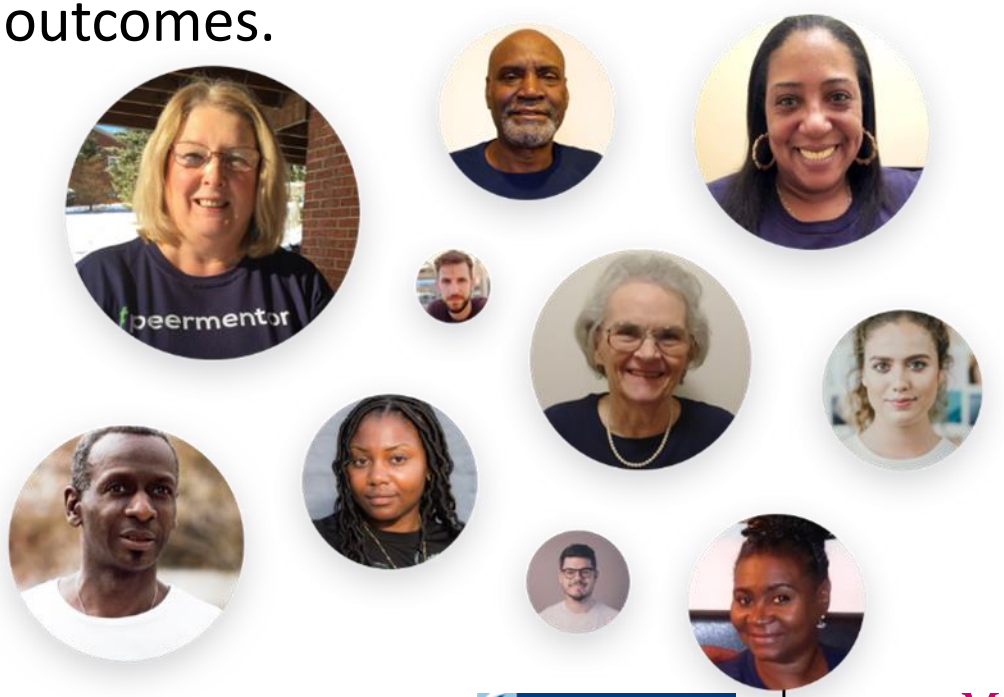
Tailored Program

Phone + smartphone-based program customized based on each patient's social determinants and behavior change needs.

+

Matched Mentor

Each patient matched 1-on-1 with a culturally and clinically similar mentor to guide each patient 1-on-1 to better health outcomes.



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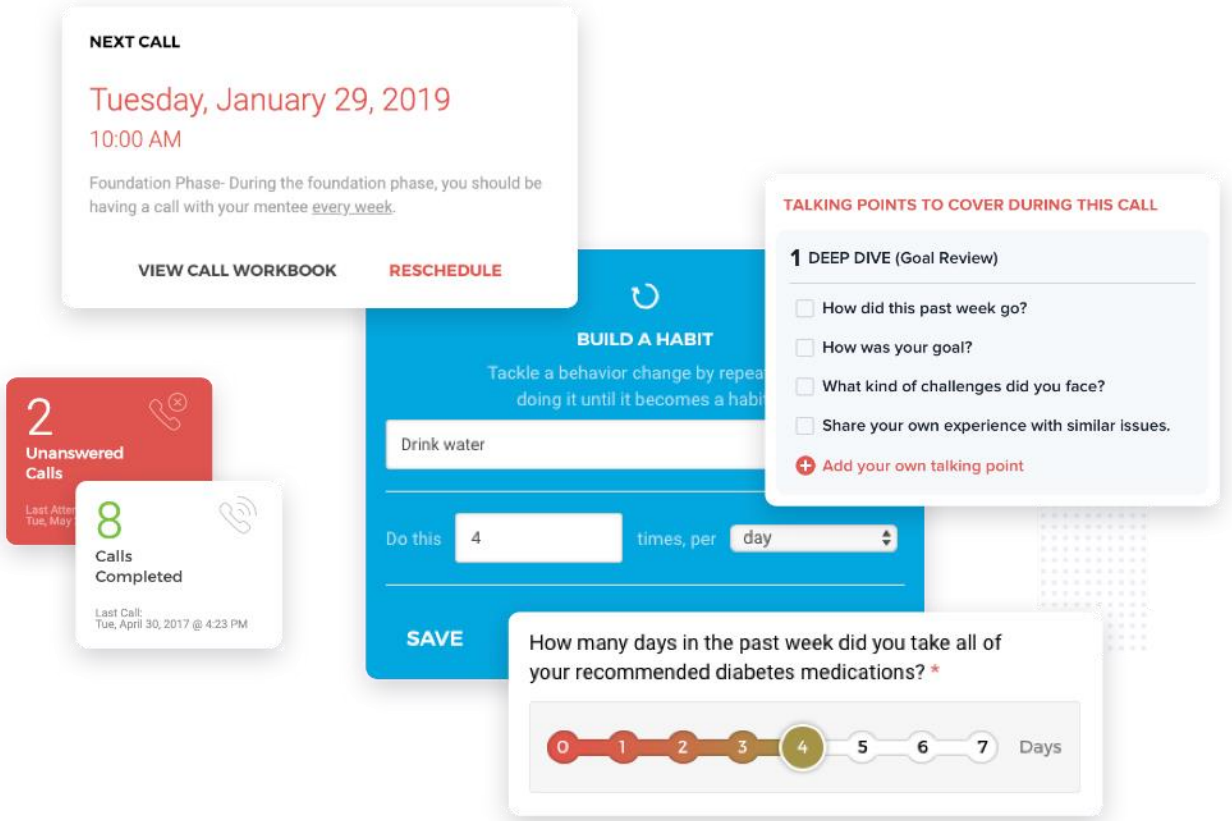
1-on-1 Mentoring Process

Core objectives

1. Fill in knowledge gaps
2. Translate knowledge into action
3. Address underlying Social and Behavioral Determinants of Health



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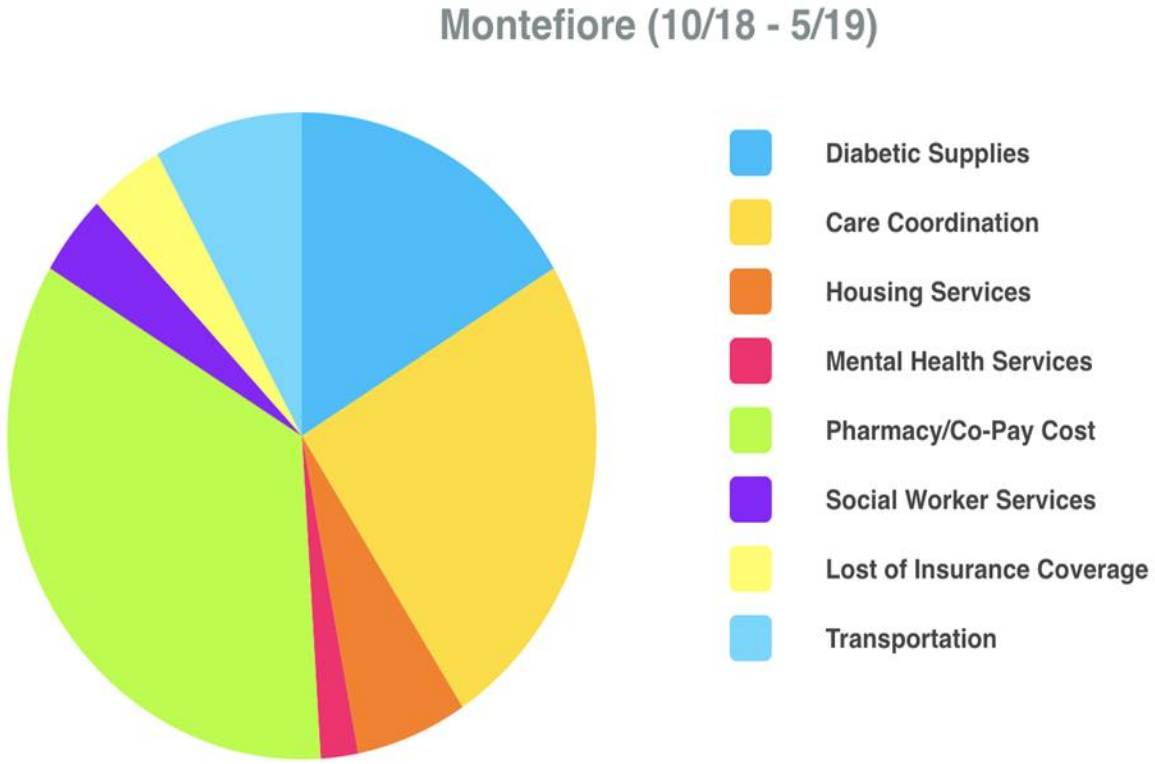
Outcomes and Social and Behavioral Determinants of Health Escalations

Patient population: HbA1c>9%
Enrollment: 552 patients
Intervention: 42 peer mentors worked with each patient 1-on-1 for up to 12 months
Methods: Pre-/post- HbA1c lab data was analyzed
Results:

- 21,983 Interactive Voice Response (IVR) calls
- 21,168 Phone calls
- 26,652 Phone minutes
- 7,098 Goal updates
- 19,337 Check-ins
- 575 Mailed educational packets
- 253 Mailed personalized dietary consults
- 163 App users
- **-1.7 point change in HbA1c** [ongoing analysis]



Quasi-Control: Certified Diabetes Educator/Nurse intervention from November 2013 - June 2014 demonstrated a -0.4 point change in HbA1c

Chronic Disease Management Reward: Medication Adherence Program

Chronic Disease Management Reward

Interactive medication adherence and monitoring platform via technology program.

Pilot duration: July through Dec 2019

Population: Patients with diagnosis of Heart Failure discharged from inpatient facility.

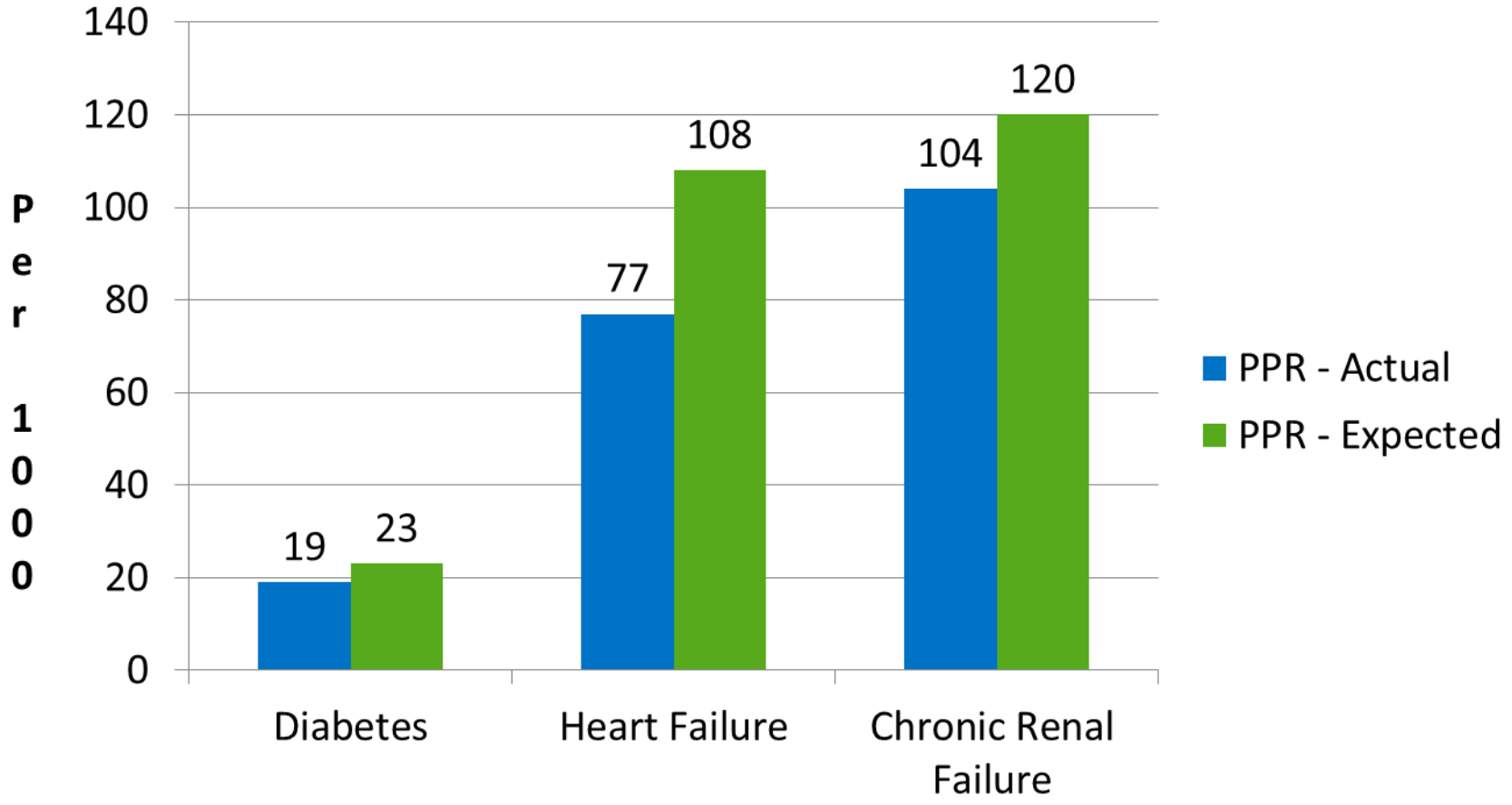
Beneficiary reward: Program participants will receive up to $50 of incentives for participating in the Adherence Program in the form of a reloadable Rewards Card. The Rewards balance becomes available to patients for redemption at the end of 30 days on the Adherence Program, for each day of the Adherence Program that the Participant does not complete their required medication and treatment plan tasks, the available Reward balance will be decreased by $2.

Report and analytics: Key Performance Indicators will be tracked to assess impact to (re)admissions, ED use, medication and program adherence.

Pilot results and outcomes will be evaluated to determine sustainability and program expansion.

33

2018 Potentially Preventable Readmissions (PPR) Lower than Expected for Diabetes, Heart Failure and Chronic Renal Failure



Source: Montefiore Internal ACO Data Analysis via 3M/Treo data

Lessons Learned and Emerging Challenges

- Technology alignment with value-based payment model concepts and requirements
  - Content/Functionality
  - Project prioritization
  - Budget
- Maximizing and sustaining CMS and VBP initiatives as we continue facilitating achievement of goals
- Balancing decreased high-cost services such as ER and inpatient admissions
- Setting stakeholder accountability for performance and ongoing measurement of clinical processes and cost of care

Dialysis Clinic Inc.: Care Coordination

Douglas S. Johnson, MD

Vice Chair of the Board for Dialysis Clinic, Inc.

Better

Care for Chronic Kidney Disease

REACH Kidney Care

In-person care + Strong relationship + Trust = Enduring patient engagement

As a person with kidney disease builds a trusting relationship with the care coordinator, the person becomes more engaged in her care, her clinical outcomes improve, and her cost of care decreases

Trusting patient and family relationship

We are at the patient's side to guide and empower her and her family throughout her entire kidney disease journey

Scott Gongaware

Improved Care
>3,000 patients, 8 locations, 7 states

Measure	National Average	REACH	Savings
More Choose To Not Start Dialysis	2% (?)	10.5%	
Increase Preemptive Transplant Rate	2.8%	6.6%	$50,000 per patient per year. Excludes cost of surgery
Delay Start By Six Months			$30,000 per start
Decrease Dialysis Start GFR ≥ 15	11.3%	<5%	Spartanburg, SC
Increase Dialysis Start GFR 5-10	47.3	70%	Spartanburg, SC
First Dialysis Treatment *Not* In Hospital	33%	55.2%	$25,000 per avoided hospitalization
Start Dialysis on a Home Therapy	10%	22.9%	$45,000 per patient per year
Start Dialysis with Permanent Access	20%	51.3%	$45,000 per patient per year

Increased

Transplantation

Jose Perez

Increased Transplantation

DCI Donor Services:

- - Tennessee Donor Services
- - New Mexico Donor Services
- - Sierra Donor Services

- - 625 people received a kidney transplant in 2018

Music City Kidney Care Alliance

- ESCO
- CKD Care Coordination with transplant care coordinator
- OPO
- Nephrologists
- Transplant Programs

- 12% pre-emptive transplant rate (national average 2.8%)
- Home program
  - -Of 60 total patients, 27 people from home program with a transplant since 1/1/17

Increased

Home Dialysis

Bill Peckham

ColigoCare ACO: Provider Engagement

Frank Shipp, MBA
Executive Director at ColigoCare ACO

Our Current Value-based Programs

Payor	Program Type	Total Participating Providers	Primary Care Providers	Patient Attribution
Medicare	**Shared Savings ACO** **CPC+** **Bundles**	535	121	23,000+
Horizon	**Shared savings** **Episodes of Care** **Medicare Advantage**	496	110	28,000+
Cigna	**Shared savings** **Episodes of Care**	540	115	12,000
United Healthcare	**Shared savings** **Medicare Advantage**	547	117	15,000
Aetna	**Shared savings**	565	123	14,000
5 Payors	**11 Programs**	**592**	**134**	**100,000+**

Our Strategic Focus on Provider Engagement

1. Communicate our value proposition to both employed & independent practices
2. Educate providers on value-based concepts, programs and strategies for success
3. Facilitate meaningful networking and communication among our providers
4. Provide actionable data to facilitate behavioral change

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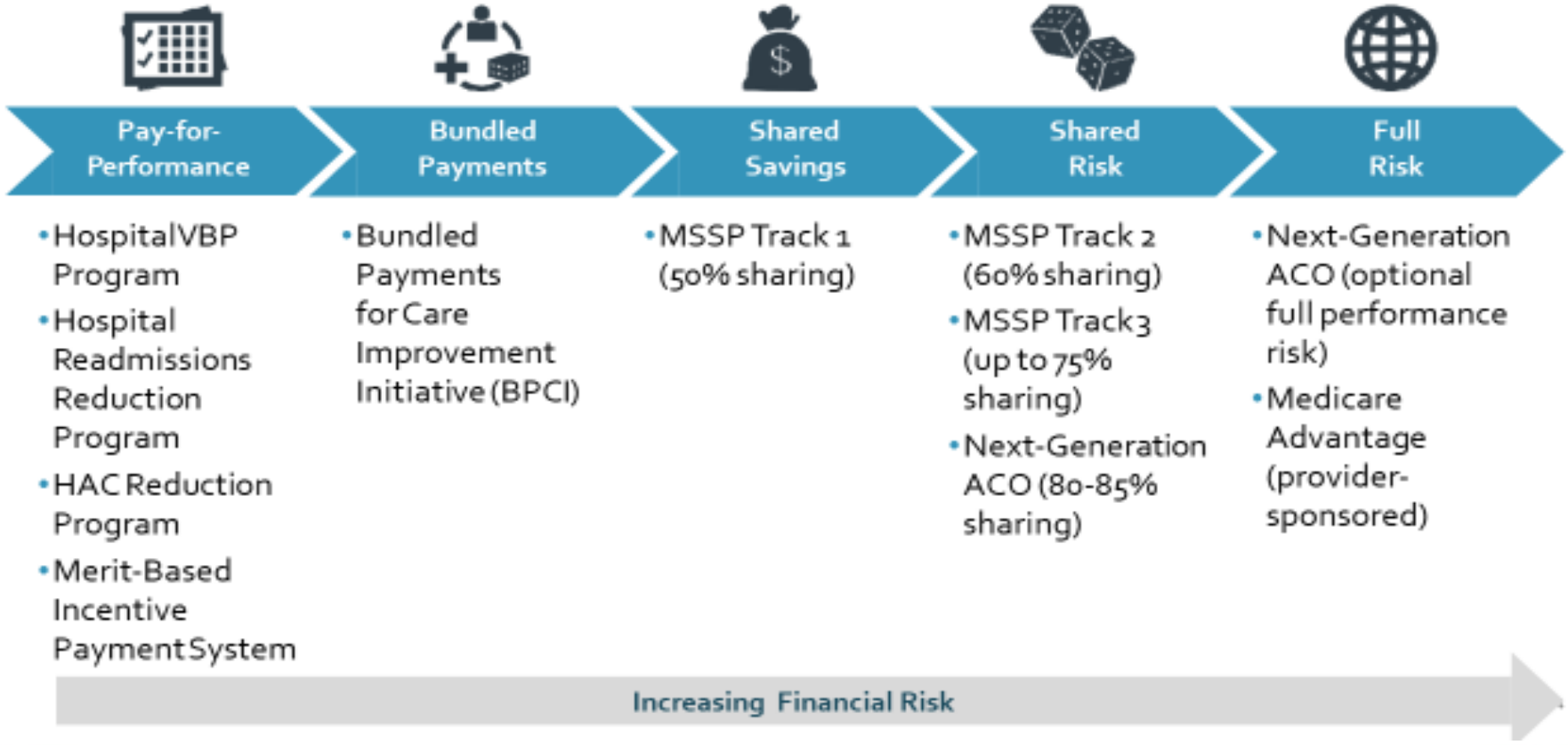
Engagement vs. Alignment

There Are Many Ways To Create Clinical Alignment



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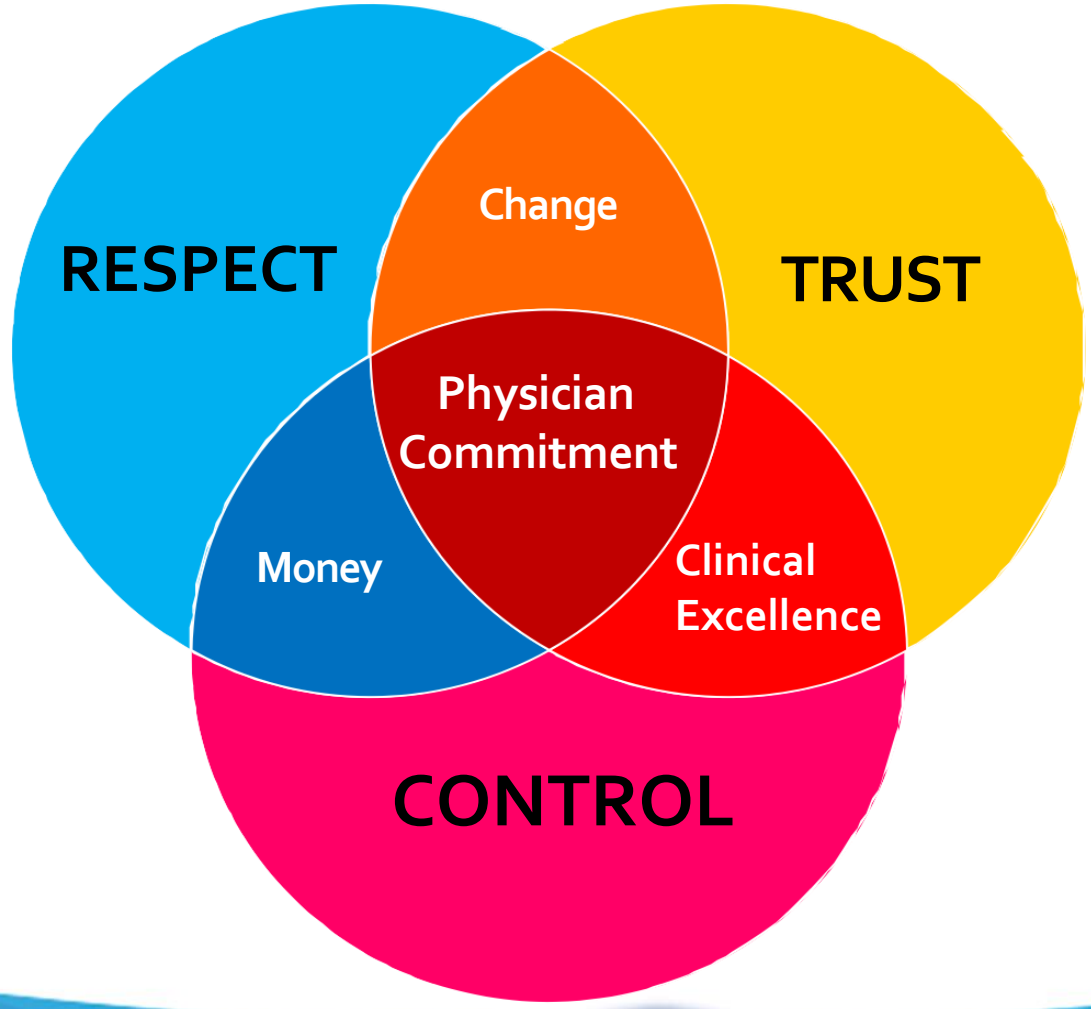
Understanding the Motivators of Engagement



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Our Key Engagement Tactics

1. Identify & leverage physician champions and influencers
2. Facilitate communication & connection among providers
3. Be transparent with data

   - don’t be reluctant to share data but know its limitations!

   - positive and supportive messaging is essential

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Leveraging Physician Champions & Influencers

1. Find providers who are passionate about educating their peers on value-based healthcare (e.g.: Quality metrics, HCC training)
2. Must be respected by their peers (independent / employed)
3. Not necessarily in leadership roles
4. Meet on their terms
5. Establish a core group of non-provider practice champions

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Technology for Effective Provider Communication

- Searchable Physician Directory
- VHS Directory
- Secure messaging
- Availability and Coverage
- News, Events and Announcements
- Clinical BestPractice
- Surveys and feedback
- Education
- Training
- Support

Typical monthly report:
- **14,000 messages sent**
- **94% read rate**
- **58% read < 5 minutes**

**** Direct link between push messages and archived documents on our website***

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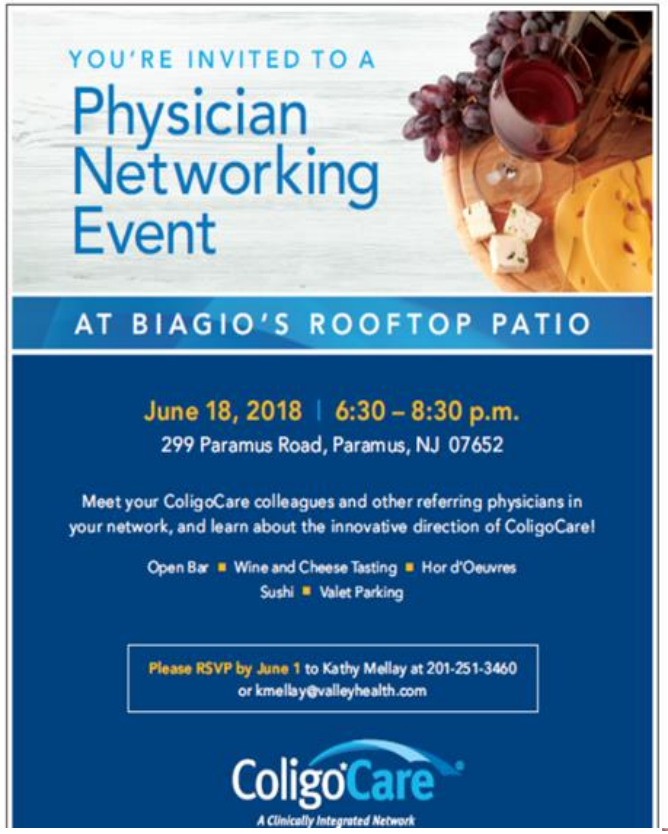
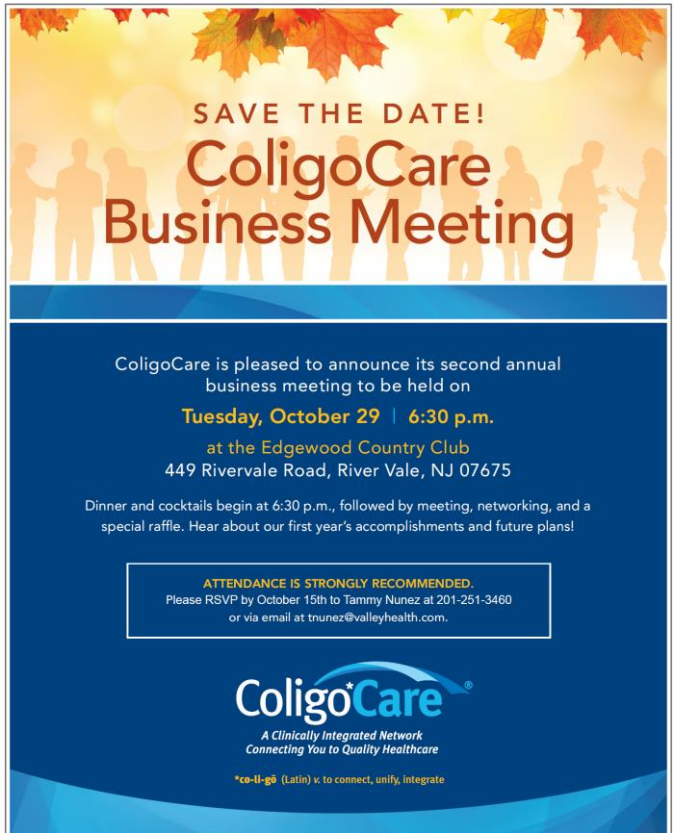
Network Collaboration Events



- ✓ 70 PCPs & 6 Orthopedic practices
- ✓ individual bio introductions
- ✓ panel discussion on LBP



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Provide Value at Each Interaction

… our approach to conducting face-to-face visits

"You can get a lot farther with a kind word and some data than with a kind word alone."

- Shari Welch

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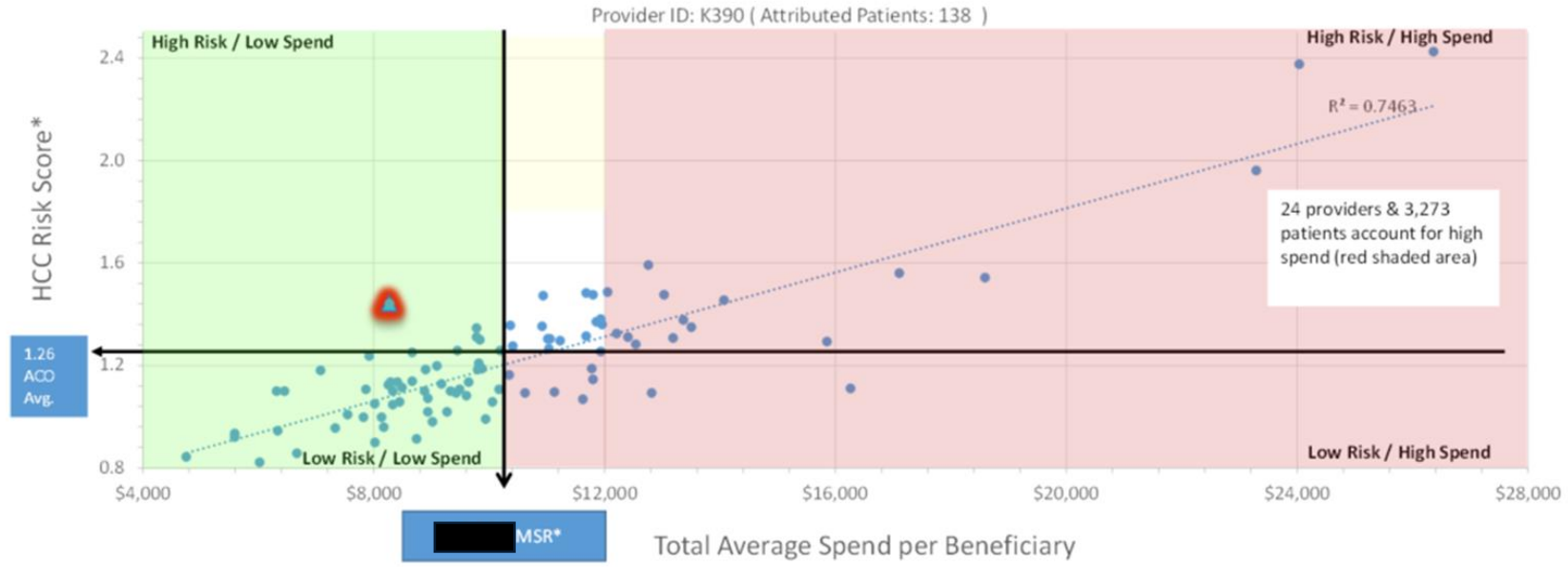
Transparency at the ACO and Provider Levels

Confidential: [redacted]

2018 Utilization Metrics: Graph of Annual Average Medicare Spend and HCC Risk Score
(Each dot represents a PCP with 25 or more attributed beneficiaries)

					Per Beneficiary					Per 1,000 Beneficiaries					
Provider ID	Attributed Patients	Adjusted Composite Quality Score	2018 Avg. HCC Dynamic Score	HCC % Change from 2017 -2018	Total Average Annual Spend	Total Spend Delta*	Inpatient Total	SNF Total Annual Spend	Part B Physician Annual Spend	SNF Discharges	CT Events	MRI Events	30-Day All-Cause Readmits	Emergency Dept (ED) Visits	PCP to Specialist Visits Ratio
		Range is between 0.0 -1.0	1.26 (All Coligo Care ACO pts.)	NA	NA	[redacted] (CMS MSR Target*)	$3,670 (National FFS Avg.)	$876 (National FFS Avg.)	$3,622 (National FFS Avg.)	52 (ACO National Avg.)	662 (National FFS Avg.)	240 (National FFS Avg.)	NA	669 (ACO National Avg.)	1 : 1.24 (National FFS Avg.)
ColigoCare Aggregate	21,901	NA	1.26	3.3%	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
K390	138	1.00	1.44	10.7%	$8,267	-$2,055	$1,261	$506	$4,570	36	377	297	105	471	1 : 1.5



Source: CMS Claims files uploaded into [redacted]

*Total Spend Delta = Total average annual spend minus $10,322
(CMS MSR (Minimum Savings Rate) Target in order to qualify for shared savings

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Lessons Learned

- Before every physician office visit, stop and ask yourself: *"What value am I bringing to this practice today?"*
- Provide "actionable data" to practices: (suspect conditions, annual wellness visit outliers, frequent ED utilizers)
- Ask providers for their input regarding reasons for results and potential improvement strategies
- Acknowledge barriers & challenges that the practice faces and provide support to help them overcome

$$E = Q * A$$

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Overview of Pathways to Success

Heather Grimsley

Director of the Division of ACO Finance and Data Analytics at the CMS Center for Medicare

Introduction to the Medicare Shared Savings Program

- The Medicare Shared Savings Program (Shared Savings Program) was established in 2012 and is an important innovation for moving CMS' payment systems away from paying for volume and towards paying for value and outcomes.
- It is a voluntary national program that encourages groups of doctors, hospitals, and other health care providers to come together as an "Accountable Care Organization" (ACO) to lower growth in expenditures and improve quality.
  - An ACO agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population.
  - ACOs that successfully meet quality and savings requirements share a percentage of the achieved savings with Medicare. ACOs under two-sided models are accountable for sharing in losses.
- Currently over 10.9 million beneficiaries in FFS Medicare (of the 38 million total FFS beneficiaries) receive care from providers participating in a Medicare ACO.

BASIC Track's Glide Path Design

Five Levels of Risk and Reward

Level	Risk Model	Shared Savings (once MSR** met or exceeded)	Shared Losses (once MLR* met or exceeded)	Advanced APM
Level A and Level B	One-sided	First dollar savings at a rate up to 40% based on quality performance; not to exceed 10% of updated benchmark	N/A	No
Level C	Two-sided	First dollar savings at a rate up to 50% based on quality performance; not to exceed 10% of updated benchmark	First dollar losses at a rate of 30%; not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	No
Level D	Two-sided	First dollar savings at a rate up to 50% based on quality performance; not to exceed 10% of updated benchmark	First dollar losses at a rate of 30%; not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	No
Level E	Two-sided	First dollar savings at a rate up to 50% based on quality performance; not to exceed 10% of updated benchmark	First dollar losses at a rate of 30%; for 2019 and 2020, not to exceed 8% of ACO participant revenue capped at 4% of updated benchmark (general policy, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program capped at 1 percentage point higher than the expenditure-based nominal amount standard)	Yes

* MSR is the "minimum savings rate"; MLR is the "minimum loss rate."

ENHANCED Track

- Highest level of risk/reward in the Shared Savings Program.
- References to the ENHANCED track apply to Track 3 ACOs, unless otherwise noted.

Shared Savings (once MSR met or exceeded)	Shared Losses (once MLR met or exceeded)	Advanced APM
No change. First dollar savings at a rate of up to 75% based on quality performance; not to exceed 20% of updated benchmark.	No change. First dollar losses at a rate of 1 minus final sharing rate, with minimum shared loss rate of 40% and maximum of 75%; not to exceed 15% of updated benchmark.	Yes

Resources

Resource	Description
Shared Savings Program website	Overview of the Shared Savings Program including helpful information and resources
Shared Savings Program Regulations: 42 CFR part 425	Regulatory authority for the administration of the Shared Savings Program
Pathways to Success Final Rules	Final rules released in November 2018 (refer to CY 2019 Physician Fee Schedule Final Rule) and December 2018 finalizing changes to the Shared Savings Program
Applications Types & Timeline webpage	Key deadlines and resources to help complete the application including sample applications
Application Toolkit	Quick access to guidance and other materials relevant to all application types

Insights from Learning System for ACOs

Terri Postma, MD

Medical Officer and Senior Advisor at the CMS Center for Medicare

Characteristics of Successful ACOs

- Leadership with vision
  - Clinician and patient centric
  - Align financial and quality incentives
- Using data effectively
  - Identify actionable opportunities at all levels of care
  - Enhance data sharing through interoperability
- Coordinating care
  - Use Medicare covered primary care services effectively
  - Team based approaches that include community based services. Address social determinants of health
- Engaging clinicians and beneficiaries
  - Education

ACO Pearls of Wisdom

- **Play a long game** – health system redesign takes time but is worth the effort.
- **Plan ahead** – develop and articulate a clear plan for care transformation.
- **Hit the ground running** – don't waste the first year of the agreement period getting organized.
- **Start small** – identify a few key problem areas to work on and then build on success.
- **Identify and leverage strengths –** each ACO has unique strengths on which to capitalize.
- **Think outside the box** – develop processes that are right for your ACO's unique set of characteristics, unique set of clinicians, and unique patient population needs.

Questions?

You can submit written questions via the Q&A box or dial 5* on your telephone to “raise your hand” to orally ask a question.

For more information

For more information on the CHCE Forum, contact:

Sonya Streeter at sstreeter@mathematica-mpr.com

For more information on the ACO presentations, contact:

Vanessa Guzman at vaguzman@montefiore.org

Doug Johnson at Doug.Johnson@dciinc.org

Frank Shipp at fshipp@Valleyhealth.com

For more information on Pathways to Success, contact:

SharedSavingsProgram@cms.hhs.gov

Access “Remembering Bill Peckham” video:

https://www.youtube.com/watch?v=HqdNDZ5EWzI&feature=youtu.be