HFMA-South Texas Chapter Conference
May 16, 2016

Bumps in the Road:
Seton Health Alliance’s Journey to Building an ACO and a Clinically Integrated Network
We are a team of doctors, hospitals and health care providers in Central Texas. We operate on the principle of cooperation and integration with community physicians and believe patients deserve the best value in health care.
"We've run every test we could think of and the results show that you're out of money."
## Why Accountable Care?

<table>
<thead>
<tr>
<th></th>
<th>Current Needs / Gaps</th>
<th>Key Benefits</th>
</tr>
</thead>
</table>
| **Consumer**        | • Healthy  
                      • Involved in Care  
                      • Affordable Options  
                      • Value  | • Preventive Focus  
                      • Extra Support  
                      • Lower Premiums  |
| **Physician**       | • “Trapped” on Treadmill  
                      • Misaligned Incentives  
                      • Regulations  | • Aligned Incentives  
                      • Assistance for Patients  
                      • Glide Path to Value  |
| **Payer / Employer**| • Sustainability  
                      • Minimize Costs  
                      • Affordable Options  | • Curb Cost Trend  
                      • Productive Employees  
                      • Deliver Value  |
Core components

- Care Management
- Patient Navigation
- Clinical Data Sharing
- Best Practice Protocols and Outcome Measurement
Physician member’s commitment

- Be measured based upon **performance metrics**;
- Participate in **data sharing**;
- Participate in **quality committees** and **governance**;
- Use other network providers for **referrals** to maximize coordination of care; and
- Work to improve the **quality**, reduce the **cost** & enhance **patient experience** of *health* care in the community.
SHA’s commitment to members

- Governance support through **physician-led committees**;
- Regular feedback on **performance measures** (scorecards);
- Access to **value-based reimbursement** without disrupting practice independence;
- Fully-funded **care management programs**; and
- **New patients through payer contracts** which direct patients exclusively to Alliance providers.
Seton Health Alliance

A clinically integrated network of nearly 2,300 providers partnered with four insurance companies to deliver value-based care to over 126,000 Central Texans.
Overarching Goals

Physician Alignment

Lives in Value-based Contracts

Triple Aim: Improve quality; reduce costs; improve patient experience.
# Payer Partners

<table>
<thead>
<tr>
<th>Contract</th>
<th>Contract Type</th>
<th>Membership</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Healthcare</td>
<td>Attribution</td>
<td>70,424</td>
<td>08/01/2013</td>
</tr>
<tr>
<td>Aetna (Aetna Whole Health-Seton Health Alliance)</td>
<td>Product</td>
<td>17,323</td>
<td>09/01/2014</td>
</tr>
<tr>
<td>SmartHealth (Seton Employees)</td>
<td>Default</td>
<td>21,841</td>
<td>11/01/2014</td>
</tr>
<tr>
<td>Seton Insurance</td>
<td>UNDER DEVELOPMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Shared Savings Program (MSSP)</td>
<td>Attribution</td>
<td>16,757</td>
<td>01/01/2014</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>126,345</strong></td>
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Rethinking Collaboration

Patients and Caregivers

- Hospitals
- Physicians – Primary Care and Specialists
- Outpatient Clinic Staff
- Hospitalists/ SNFists
- Community-based resources
- Behavioral Health
- Case/Care Managers, Social Workers
Care Management

- **High Risk Care Management**
  - Frequent calls by Care Manager
  - In-person, in-clinic visit with patient
  - Work in partnership with practices and providers
  - Early intervention for urgent symptoms

- **Complex Care Management**
  - Frequent calls by Care Manager
  - Early identification of patients requiring medical intervention
  - Symptom and disease education

- **Disease Management**
  - Care coordinator outreach
  - Referrals to Care Manager or disease management programs

- **Preventive Health**
  - Outreach to close care gaps
  - Outreach to identify PCP
  - Patient education materials
2016 Scorecard Performance Measures

<table>
<thead>
<tr>
<th>PRIMARY CARE CLINICAL MEASURES</th>
<th>CITIZENSHIP MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 measures ranging from <em>asthma</em> to <em>cancer screenings</em> to <em>hypertension</em>.</td>
<td>CI Orientation</td>
</tr>
<tr>
<td></td>
<td>EMR</td>
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<tr>
<td></td>
<td>Scorecard Viewing</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SPECIALITY CLINICAL MEASURES</th>
<th>CITIZENSHIP MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 measures for cardiology, oncology (palliative care) and spine. <em>Generic prescribing</em> measure applies to all specialties.</td>
<td>CI Orientation</td>
</tr>
<tr>
<td></td>
<td>EMR</td>
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<tr>
<td></td>
<td>Scorecard Viewing</td>
</tr>
</tbody>
</table>
# Performance Metrics

<table>
<thead>
<tr>
<th></th>
<th>% Reduction As Compared to National Averages*</th>
<th>% Reduction As Compared to Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Spend Per Member Per Month (PMPM)</strong></td>
<td></td>
<td>-21%</td>
</tr>
<tr>
<td><strong>Inpatient Costs PMPM</strong></td>
<td></td>
<td>-31%</td>
</tr>
<tr>
<td><strong>Total Spend Per Member Per Month (PMPM)</strong></td>
<td></td>
<td>-9%*</td>
</tr>
<tr>
<td><strong>Post-Acute Facility Costs</strong></td>
<td></td>
<td>-4%*</td>
</tr>
<tr>
<td><strong>Inpatient Admissions/1,000 Members</strong></td>
<td></td>
<td>-12.1%**</td>
</tr>
<tr>
<td><strong>Length of Stay/1,000 Members</strong></td>
<td></td>
<td>-12.4%**</td>
</tr>
<tr>
<td><strong>Rx Scripts/1,000 Members</strong></td>
<td></td>
<td>-13.1%**</td>
</tr>
</tbody>
</table>

*Based on data for non-risk adjusted population from Medicare Shared Savings Program through program’s first four quarters.

**Based on data from United Healthcare contract from August 1, 2013 through December 31, 2014 for non-risk adjusted population; comparison is to population’s baseline performance.
Cost Reductions

Able to reduce total spend for population groups

• Example: Over $5M in shared savings from Medicare

Employers have recognized reduced costs

• Focus on quality measures results in reduced spend.

Consumers have seen reduced costs.

• High performing, narrow network reduces premiums.
Lessons Learned

Shared Governance & Transparency
- Physician-led Governance
- Benefit from existing strong hospital-physician partnerships

Living in Both Worlds: Volume vs. Value
- Success means fewer hospital admissions; better for the community but bad for the bottom line.

Quality Measures
- Quality measures drive shared savings to all providers
- Quality enhancement results in cost reductions.

Organizational Infrastructure Investments
- Human Resources (Care Management team; Provider Engagement team; etc.)
- Data & Analytics (Dashboards; reporting templates; HIE)