

NAACOS PANEL DISCUSSION

# Physician Enablement Strategies to Improve ACO Performance

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# Introductions

## CHAIR

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**Gabriel Drapos**  
CHIEF OPERATING &  
COMPLIANCE OFFICER



## SPEAKERS

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**Jennifer Houlihan**  
VP OF ENTERPRISE  
POPULATION HEALTH



Wake Forest University  
School of Medicine



**Gabe Orthous**  
DIRECTOR OF VBC  
PERF. & ANALYTICS



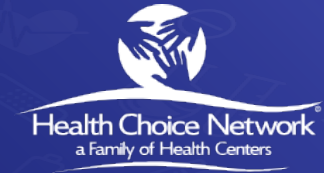
**Robert Mechanic**  
EXECUTIVE DIRECTOR



# Agenda

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- 1 ACO Strategies: Improving Performance Through Physician Enablement
  - **Health System:** Advocate Health
  - **Tech-Enabled ACO:** Pearl Health
  - **FQHC:** Health Choice Network
  - **Research Institute:** IAC
- 2 Panel Discussion
- 3 Audience Q&A



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# Improving Performance *Through Physician Enablement*



Jennifer Houlihan

Vice President of Enterprise Population Health



Wake Forest University  
School of Medicine

# Advocate Health Population Health Platform

Managing Health, Quality, and Total Cost of 2.3M Lives and \$1.6B in capitated risk



**13K+**

Participating  
Physicians



**12**

ACOs / CINs

+4 Owned entities



**2.3M**

Managed Lives



**2 of 7**

CMS ACO REACH  
Health System Participants  
in the Nation



**108**

Value-Based  
Contracts



**\$761.5M**

Total CMS/CMMI  
Taxpayer Savings



**\$1.4B**

Total Value  
Savings Paid Out



**73**

Participating  
Hospitals

Value-Based Care success built-on capabilities fine-tuned over decades of experience managing shared savings, shared risk, professional and global capitation across CMS, commercial and Medicaid contracts.



**Network Management**



**Value Innovation**



**Data Management Infrastructure**



**Advanced Analytics**



**Clinical Programs**



**TPA/MSO**

# Center for Healthcare Innovation

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Wake Forest University  
School of Medicine



The academic core of



**Atrium Health**

# Center for Healthcare Innovation

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## **The Vision**

The Center for Healthcare Innovation is a preeminent leader in the innovative transformation and improvement of human health.

## **The Mission**

To collaboratively leverage the unique talents and capabilities of our innovators, digital health tools, scientific discoveries and clinical care delivery system.

...to improve population health, enhance patient experience, reduce costs and improve care provider work life.

# What We Do



## Identify

Identify new innovations



## Assess

Rigorously and rapidly assess ideas



## Integrate

Rapidly integrating new. Clinical trial results or guidelines



## Evaluate

Thoroughly evaluate the impact of innovations



## Innovators

Recruit like-minded innovators



## Support

Assist in procuring funding and project management support

# Key Initiatives Leveraging in Pop Health

- **Cognitive Phenotype (eCHI):** The electronic cognitive health index is a passive digital marker for early mild cognitive impairment based on the framework created by eFI.
- **eFI:** The electronic frailty index (eFI) is a passive digital marker for frailty – a syndrome of decreased physiological and functional reserve that has been associated with adverse outcomes for older adults.
- **eFRIEND:** The electronic frailty index integrated with social needs (eFRIEND) is a community health worker-led pathway to reduce burdensome healthcare utilization.

# Key Projects/Programs Focused on Medicare Patients

- **(mPATH™):** Patient-friendly digital health platform that empowers patients to participate in their care and facilitates care delivery related to care gaps including Colorectal Cancer screening, Lung cancer screening, behavioral health, social determinants of health and infectious diseases.
- **PATINA (PATient INtegrated Assessment):** A patient-reported platform to support healthy aging and address social isolation which utilizes EMAs (ecological momentary assessments) and wearable devices to assess in home patient health.

# Project Overview: eFI (Electronic Frailty Index)



**Frailty** is a decreased reserve in both physiology and day-to-day function, leading to a vulnerability to acute stressors. This predicts worse health outcomes, including falls, burdensome healthcare utilization, and mortality.

**Why eFI?** Most frailty tools are time consuming and laborious. The eFI mobilizes routine data that already exists in the electronic health record (EHR), in a single, automated, objective score.

## Why test for frailty?

With frailty, we don't "know it when we see it."  
In other words, our "eyeball test" is unreliable over **40%** of the time.

The eFI is a calculation of the proportion of deficits from **>50** data elements in the EHR



BMI, Blood Pressure, and Smoking



Function (e.g., daily activities)



Laboratory Tests (e.g., cholesterol)



Medical Diagnoses



Medication List

The eFI score ranges from 0 to 1:

Fit:  $eFI \leq 0.10$

Pre-Frail:  $0.10 < eFI \leq 0.21$

Frail:  $eFI > 0.21$

## Use Cases for the eFI: Implementing the eFI in clinical care

### Peri-Operative Care

eFI as a risk assessment tool for pre-op counseling and peri-op consultation.

### Advanced Care Planning

eFI to identify patients with complex chronic conditions who have no documented advanced care plans.

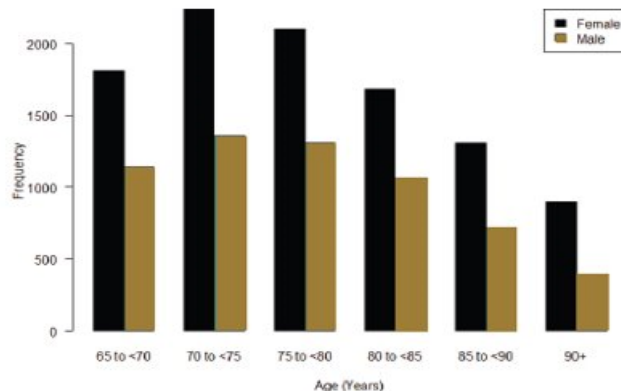
### Optimal Prescribing

eFI as a pragmatic method to identify patients that may benefit from less intensive diabetes management.

### eFRIEND

eFI as a trigger for community health worker outreach.

## Number of Frail Older Adults in Wake Forest Accountable Care Organizations by Age and Sex



# Electronic Frailty Index (eFI)- An Automatic, Passive Digital Marker for Frailty at Point of Care

## Elements of eFI: 56 total deficits

- 31 items based on diagnosis codes\*
- 20 laboratory measures:  
BP + BMI + smoking\*
- 8 functional items from Annual Wellness Visit
- Indicator for Polypharmacy
- Required  $\geq 30$  non-missing items and  $\geq 9$  of 20 laboratory measures

## Premise:

- Define a universe of aging-related deficits
- **Frailty Index:** What proportion of these deficits does a person have?
- Scores range from 0 to 1
- Typical maximum of  $\sim 0.6$  to  $0.7$

eFI is based on 2 year look back period

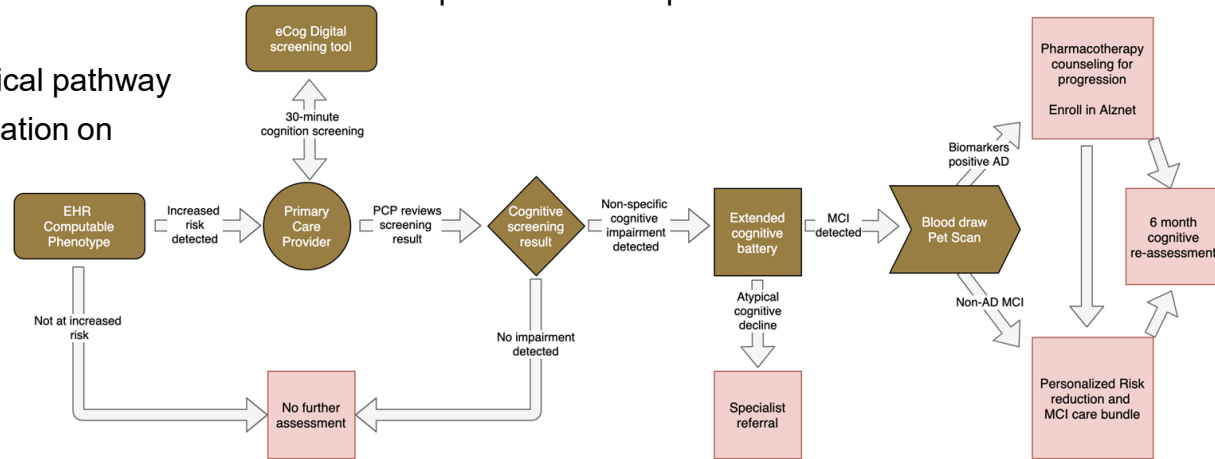
\*Some overlap in items, i.e. glucose and diabetes, BP and hypertension, etc.

# Project Overview: Cognitive Phenotype

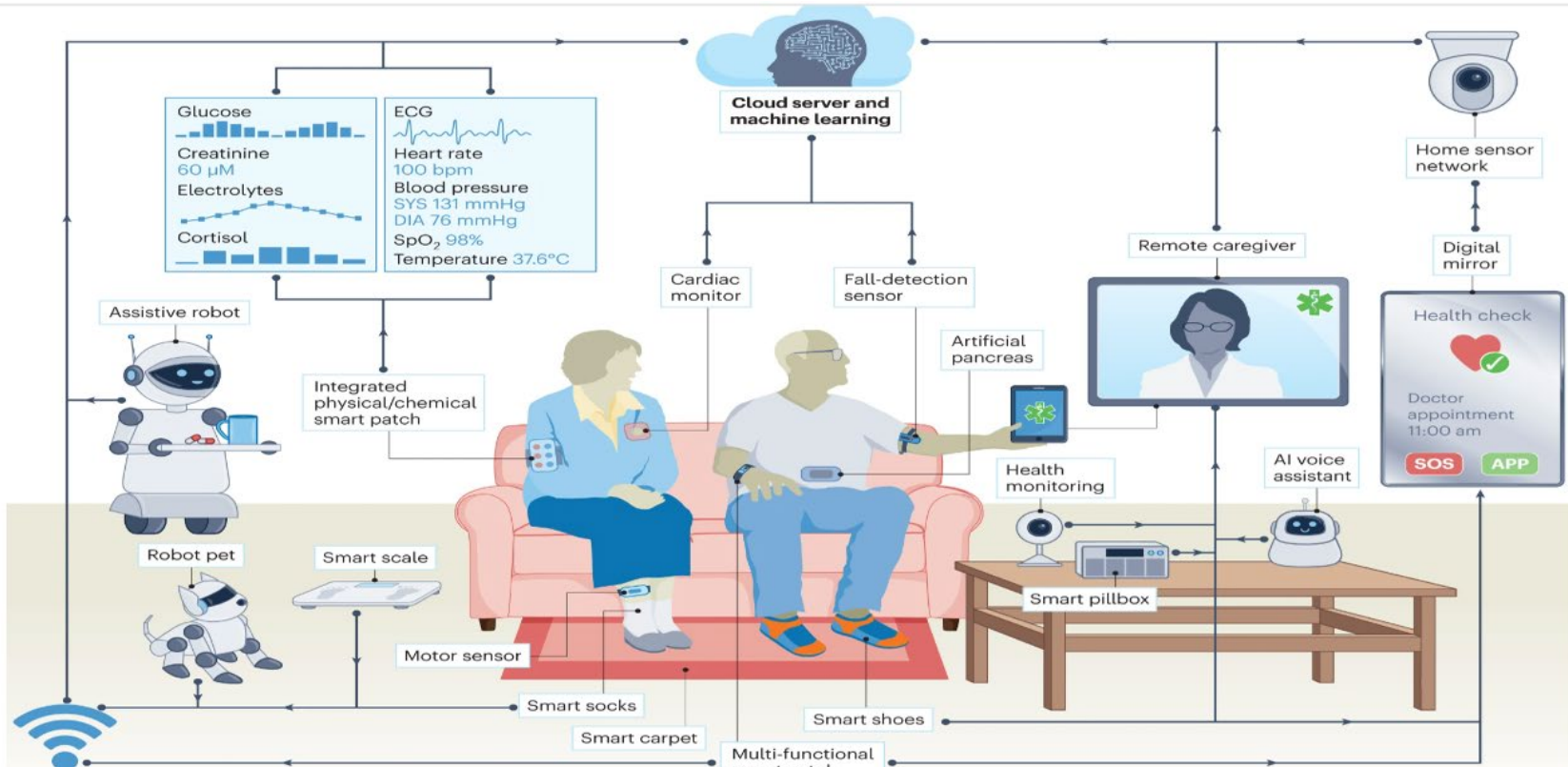
## electronic Cognitive Health Index (eCHI)

- Building on eFI framework
  - Base framework in place to build new index
  - Data model created will extend to any new digital index
- Future of Brain Health
  - Will provide basis for brain health clinical pathway
  - Partner with Clinicians to further education on pathway and data analysis

- Creating a screening platform
  - Using the expertise of our Aging center experts, creating a digital screening platform to capture MCI
  - Iterative development to accelerate time to clinic and expansion in enterprise



# Transitioning Healthcare Enablement and Linkage in the Home Setting



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# Improving Performance *Through Physician Enablement*



Gabriel Drapos

CHIEF OPERATING & COMPLIANCE OFFICER



# Pearl Overview

We're a rapidly growing technology company led by provider-enablement and risk-bearing experts, with **demonstrated success partnering with PCPs and organizations in risk-based arrangements.**

**ACO REACH**  
*Global Track*



**ACO REACH**  
*Professional Track*



**MSSP**

*Coming in 2025*

PEARL LEADERS COME FROM

BRIDGEWATER



OSCAR



Humana.

stellarhealth



# We Take a Three-Pronged Approach to Physician Enablement

Financial  
Incentives

Align providers' rewards with success in value-based care

Enablement  
Technology &  
Services

Facilitate the right proactive interventions for the right patients

Performance  
Improvement

Provide reporting & coaching to address areas of opportunity

## PHYSICIAN ENABLEMENT CHALLENGE #1

# *Financial Misalignment*

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The **high-upfront investment required** to transition to value, combined with a 12-18 month delay in rewards from shared savings, **creates a barrier to physician engagement**

# Our Response



*Immediate*  
**Implementation  
Incentives**

Support providers' transition to a value-based care model

*Near-term*  
**Value-Based  
Payments**

Reward proactive, high-quality care in a timely manner

*Long-term*  
**Shared  
Savings**

Provide additional incentives for long-term success

## PHYSICIAN ENABLEMENT CHALLENGE #2

# *Proactive Panel Management*

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Many providers lack the **time, tools, and workflows needed to switch from a reactive to a proactive care model** focused on the patients most in need of their attention

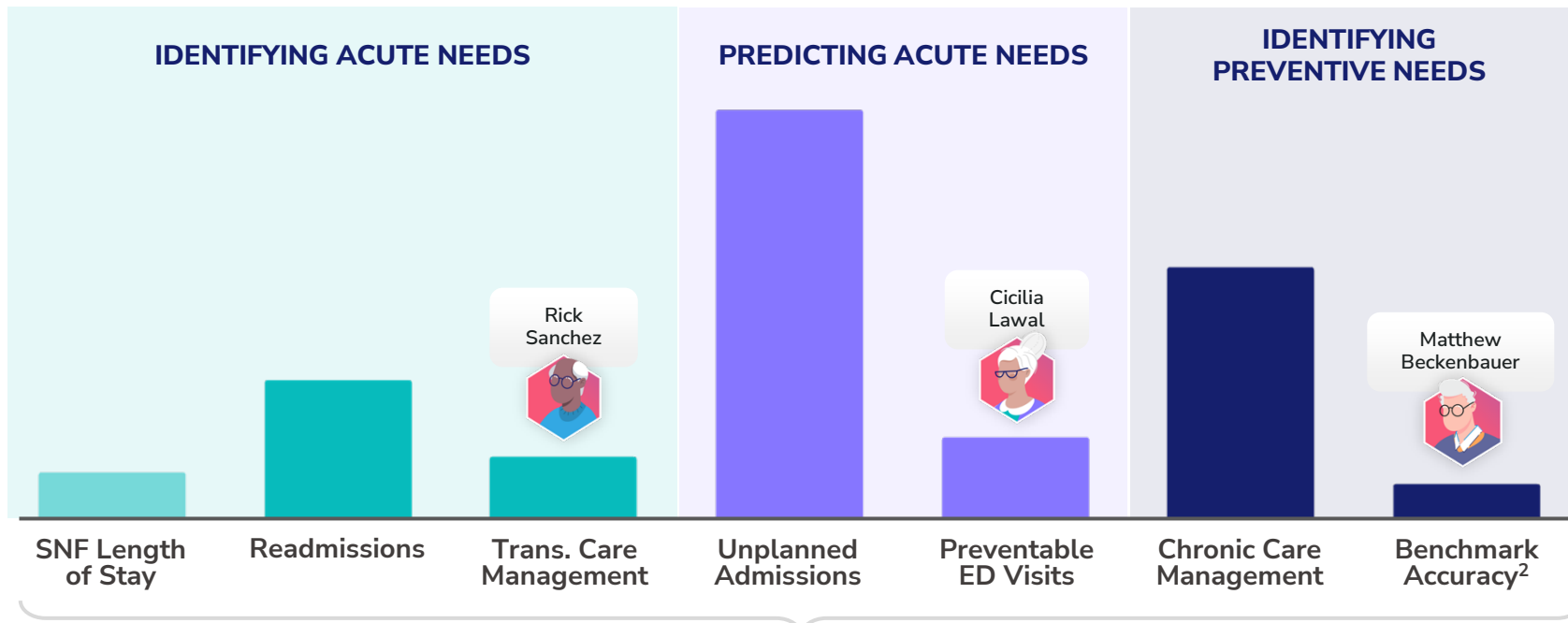
## OUR RESPONSE

A flexible, program —  
*and workflow* —  
agnostic platform  
that highlights  
patient needs and  
recommended  
actions



# Our Algorithms Focus on Opportunities to Impact MLR

## Actionable MLR Opportunities<sup>1</sup>

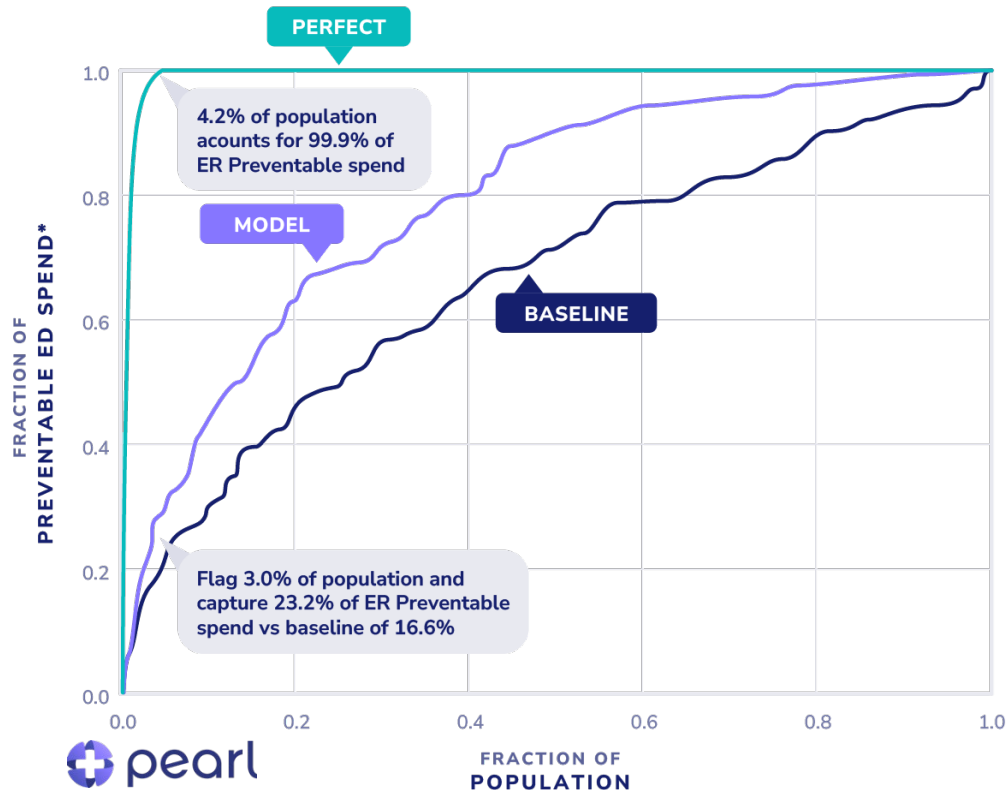


1. Representative analysis based on 2023 data.  
2. Impacts benchmark the following Plan Year.

SIGNALS DEPLOYED IN PEARL PLATFORM

# Preventing ED Spend

## IDENTIFICATION OF PREVENTABLE ED SPEND

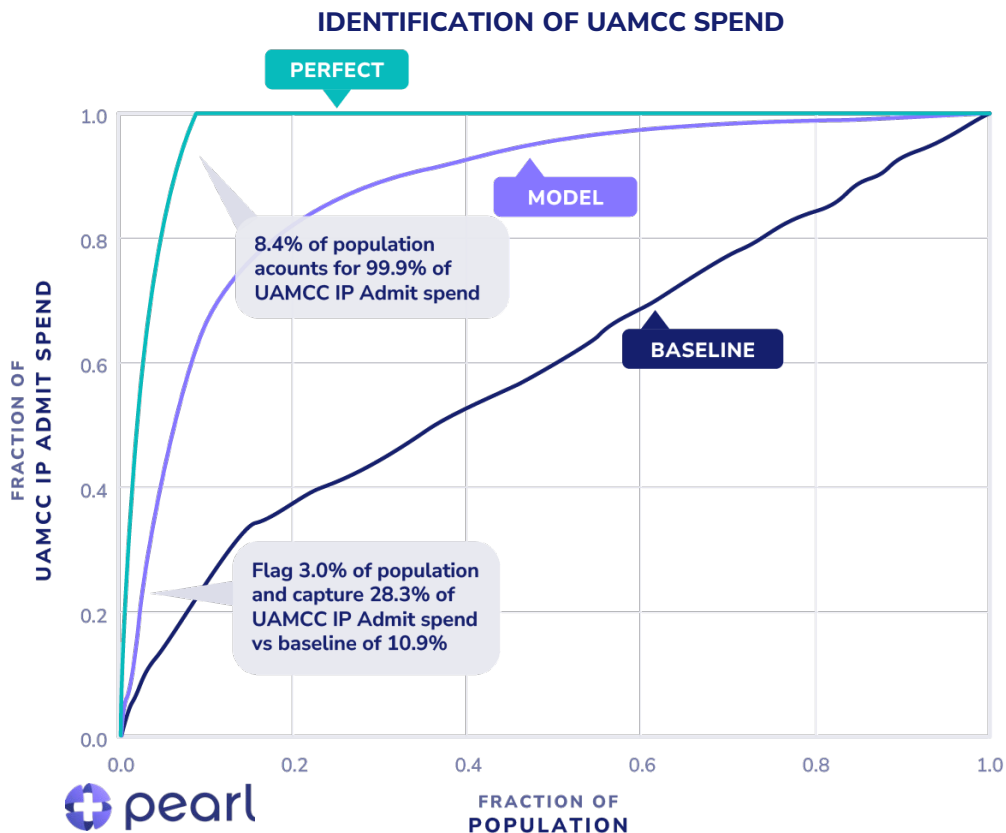


*Pearl algorithm can help reduce preventable ED visits by 1.4x\*\**

- Pearl’s advanced machine learning algorithms identify patients most at risk of costly ED visits and suggest actions to avoid the visits
- This model shows that Pearl can identify 1.4x more opportunities for providers to reduce unnecessary ED utilization vs. baseline models

\* Preventable ED spend is calculated for a 3-month look forward period  
 \*\* Improvement compares our algorithm with Traditional ED Frequent Flier Models, which identify 16.6% of preventable ED spend. Frequent Flier Models flag patients who had ED visits 3+ times in 12 months

# Preventing UAMCC Spend



*Pearl algorithm can help reduce UAMCC by 2.6x\**

- Unplanned admissions for patients with multiple chronic conditions (UAMCC) drives up healthcare costs and is an ACO REACH quality metric
- Pearl identifies patients at risk for UAMCC and suggests interventions
- This model shows that Pearl can identify 2.6x more opportunities for providers to reduce UAMCC vs. baseline models

\* Improvement compares our algorithm with the Risk Adjustment Factor (RAF), which identifies 11% of UAMCC spend.

## PHYSICIAN ENABLEMENT CHALLENGE #3

# *Accountability & Improvement*

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**Without transparent reporting** into progress and areas of opportunity, as well as high-touch coaching, **providers struggle to improve their performance over time**

## OUR RESPONSE

# Performance Insights & Coaching for Continuous Improvement


## PILLARS OF PERFORMANCE

### Proactive Management

91.5%  Past 4 Weeks

▲ Target: 90.0% or more

### Acute Intervention


76.2%  Past 4 Weeks

▲ Target: 90.0% or more

Keep a closer eye on your most urgent reds, and log action within 2 business days to help reduce costly readmissions.

[View details >](#)

### AWV Completion

68.0% 

● 42.0% Completed ● 2

▲ Target: 65.0% or more

## COST OF CARE & QUALITY TRENDS

### All Condition Readmissions

On Track • 12.0% (3 out of 25 discharges)

Aim for 14.0% or less. Impacted

### Unplanned Admissions

On Track • 22 per 100 person

Aim for 28 or less. Impacted by 0%

### Timely Follow-Up

On Track • 9

Aim for 85.0%

### Tracking below budget

As of June, your year-to-date spend based on available claims data was approximately 3.0% below budget.

Year-to-date

APPROX -3.0%

## BESPOKE ANALYSIS & PERFORMANCE COACHING

### Year in Review

#### 2023 Medical Spend Network Performance

As of October here's how your risk-adjusted spend per beneficiary per month compares to practices across the Pearl network.

Category	Target	Actual	Delta
Overall Medical Spend	100%	103.31%	+3.31%
Home Health	100%	126.31%	+26.31%
Facilities Driving Spend	100%	100%	0%

Home Health 26.31% above Pearl network average

Facilities Driving Spend

- 312567 - Harmony Home Health Services
- 784930 - Evergreen Home Care Solutions
- 659281 - Comfort Keepers Home Health

pearl

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# Improving Performance *Through Physician Enablement*



Gabe Orthous

**DIRECTOR OF VBC PERFORMANCE & ANALYTICS**



# FQHC Led MSSP Accountable Care Organizations



**HEALTH CHOICE CARE**  
Physician driven accountable care

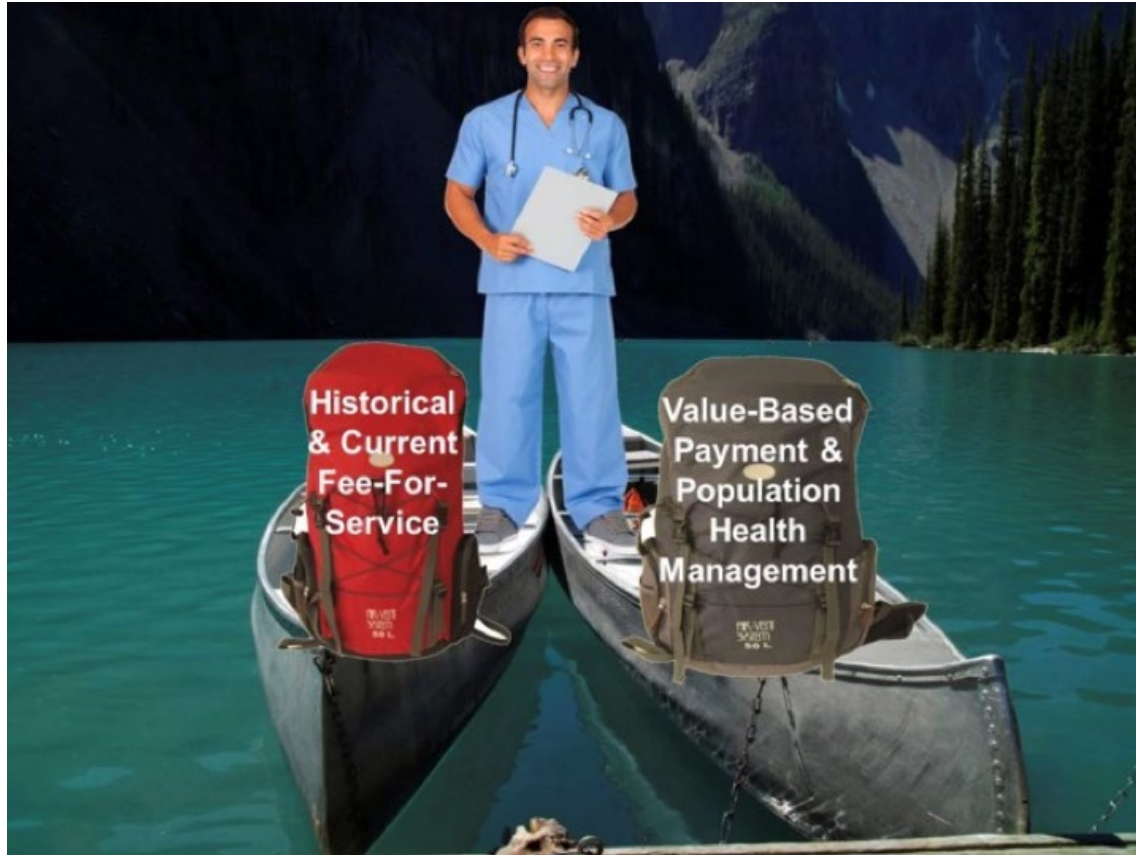
- Launched January 1, 2014
- 14 Participating Centers
- 9,000 Medicare FFS Patients
- 5 States (Florida, Hawaii, North Carolina, Rhode Island, Missouri)
- Two-Sided Risk
- \$50M is shared savings, earning more than \$23M for our health centers



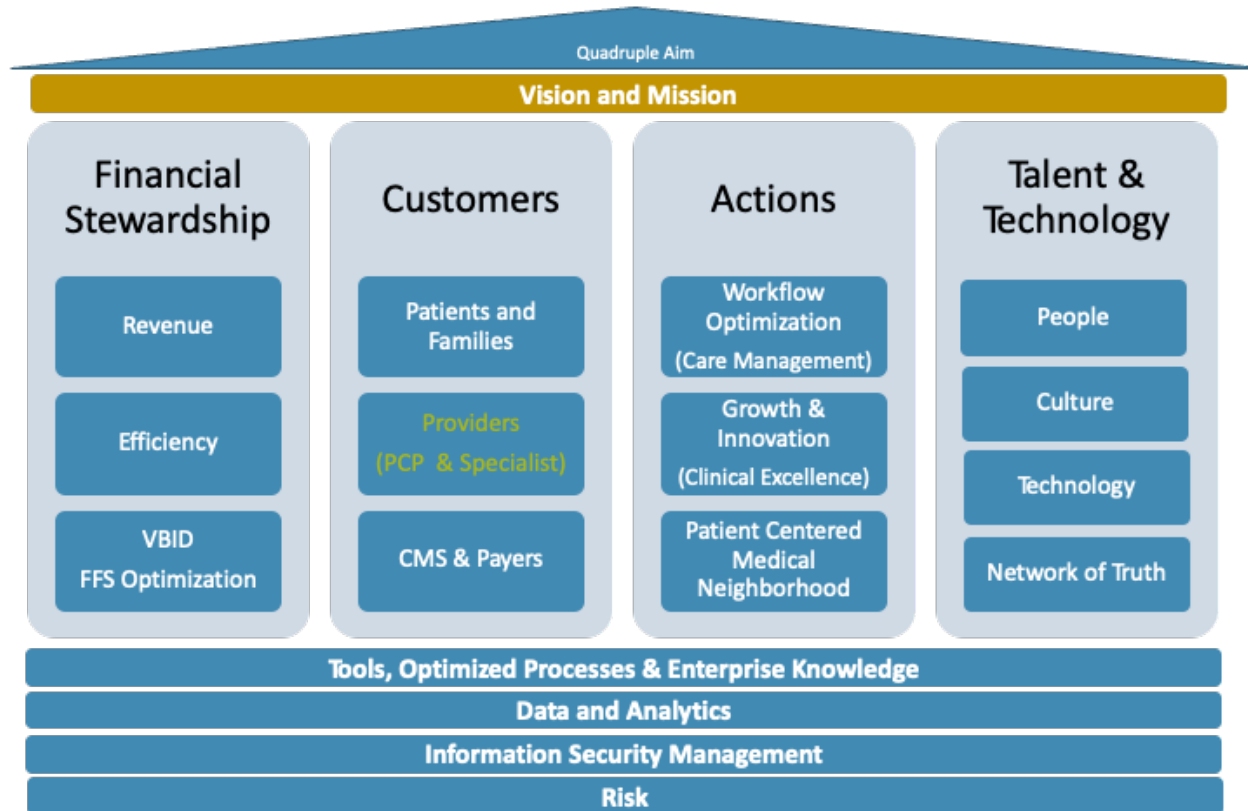
**HCCP**  
Health Choice Community Partners

- Launched January 1, 2023
- 7 Participating Centers
- 12,000 Medicare FFS Patients
- 7 States (Arkansas, Florida, Kentucky, Illinois, Mississippi, Texas, Rhode Island)
- Glidepath to Shared-Risk
- 100% Participant Investment

# Dr. Nash: Foot in two canoes



# Value Based Is a Team Sport: Providers as Quarterback



# Provider Engagement Analytics: 3 Levels

## Recommended

### Strategic Analytics

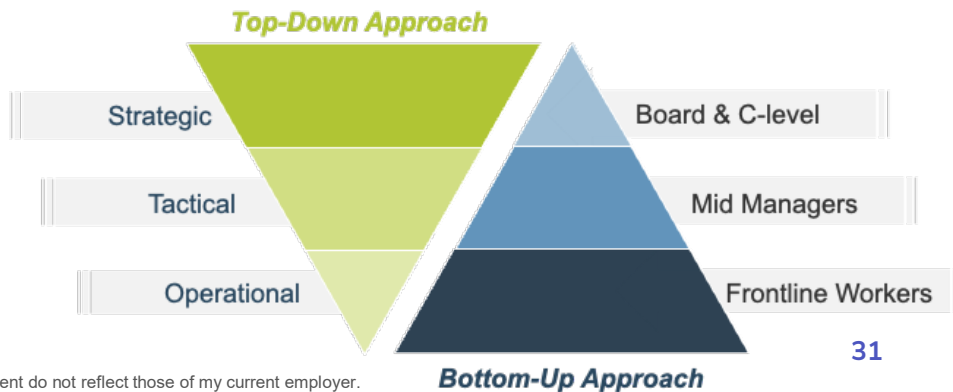
- Typically focused on predictive modeling
- Leverages data integrated from multiple sources (structured through unstructured)
- Assists in identifying trends that may shift organizational focus and direction
- Sample objectives:
  - Drive market share growth
  - Identify new markets, products, services, locations, and acquisitions
  - Build wider and deeper customer relationships earning more wallet share and keeping more customers

### Tactical Analytics

- Often considered Response Analytics and used to react to situations that arise or opportunities at a department level
- Sample objectives:
  - Staff productivity or cost analysis
  - Heuristics/algorithms for better risk management
  - Product bundling and packaging
  - Customer satisfaction response techniques

### Operational Analytics

- Analytics that drive business process improvement whether internal, with external partners, or customers
- Sample objectives:
  - Process step elimination
  - Best opportunities for automation



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# Improving Performance *Through Physician Enablement*



Robert Mechanic, MBA  
EXECUTIVE DIRECTOR



# Institute for Accountable Care

An independent 501(c)(3) research institute formed in 2018 to help build the evidence base on the impact of accountable care delivery strategies to support care transformation and inform public policy.

Policy Analysis

Custom Data Analytics

Research & Collaboratives

## Medicare Data

100% of FFS Claims  
Annual and Quarterly  
Through Q4 2022

- Part A, B, D claims
- MDS assessments
- ACO provider file
- ACO beneficiary file
- MD-PPAS
- MA encounters (18)



**HEALTH PLANS & PROVIDERS**

By Robert E. Mechanic, Palmira Santos, Bruce E. Landon, and Michael E. Chernew

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**DOI:** 10.1377/hlthaff.2011.0264  
HEALTH AFFAIRS 30,  
NO. 9 (2011): 1734-1742  
©2011 Project HOPE—  
The People-to-People Health  
Foundation, Inc.

# **Medical Group Responses To Global Payment: Early Lessons From The 'Alternative Quality Contract' In Massachusetts**

# It Takes a Team

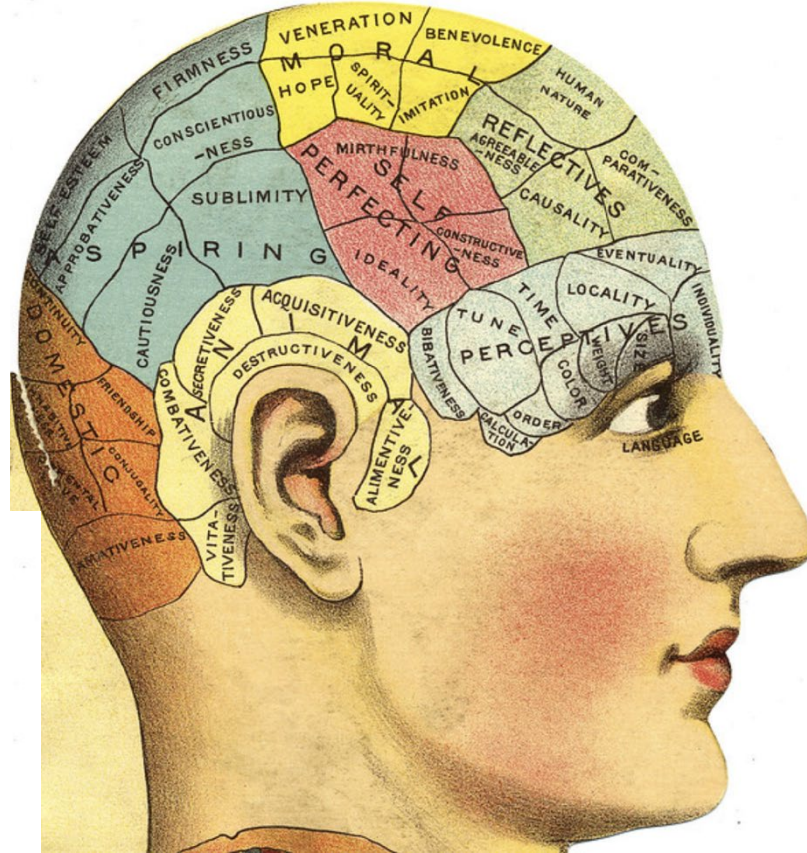
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# What do docs really want?

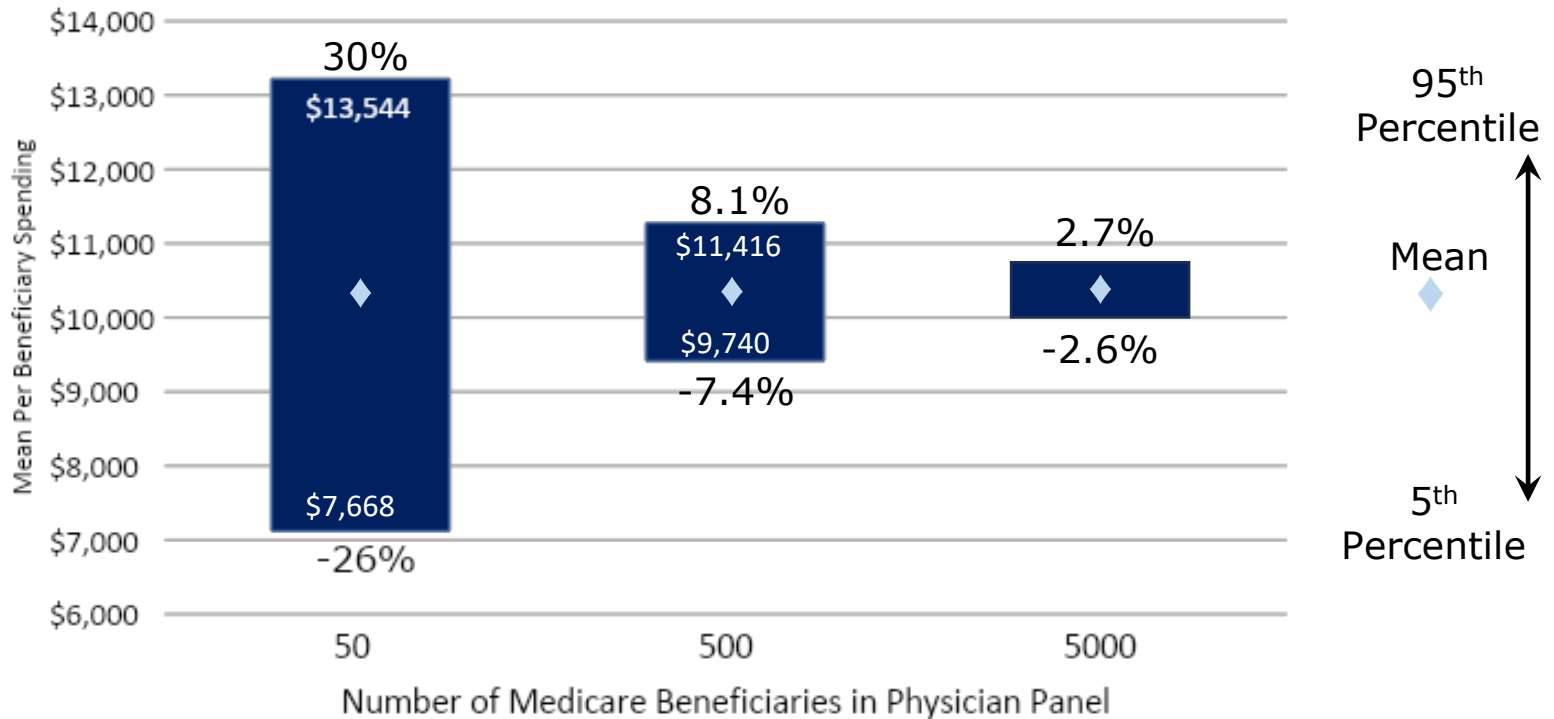
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*Improve quality  
Save me time  
Boost my income*



# Performance Measurement: Size Matters

Distribution of 2021 Risk-Standardized PBPY Spending by Physician Panel Size

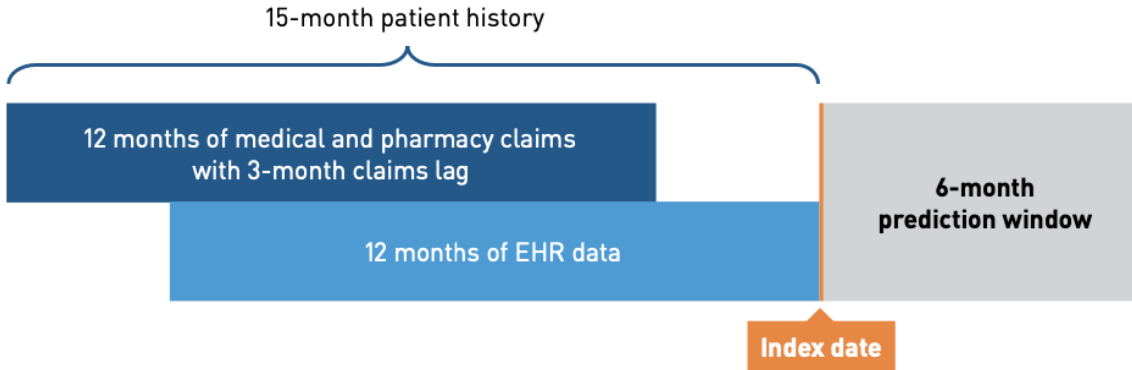


Source: Institute for Accountable Care analysis of 2021 Medicare claims data. Risk standardization uses HCC scores.

# One Approach: Atrius Health

## Predicting Hospitalizations From Electronic Health Record Data

Kyle Morawski, MD, MPH; Yoni Dvorkis, MPH; and Craig B. Mosen, MD, MS



Data Source	Variable Types Included	Testing Set: AUC (95% CI)
Claims and EHR combined	Demographics alone	0.796 (0.788-0.805)
	Diagnoses alone	0.762 (0.751-0.772)
	Medications alone	0.746 (0.735-0.757)
	Utilization alone	0.749 (0.738-0.760)
	All together	0.846 (0.838-0.853)
EHR only	Demographics alone	0.796 (0.788-0.805)
	Diagnoses alone	0.737 (0.726-0.747)
	Medications alone	0.743 (0.732-0.754)
	Utilization alone	0.738 (0.727-0.749)
	All together	0.840 (0.831-0.848)
Claims only	Demographics alone	0.787 (0.778-0.795)
	Diagnoses alone	0.732 (0.721-0.742)
	Medications alone	0.602 (0.591-0.612)
	Utilization alone	0.721 (0.710-0.733)
	All together	0.840 (0.832-0.848)

Source: American Journal of Managed Care. January 2020.

## Accountable Care Organization Initiatives to Improve the Cost and Outcomes of Specialty Care

*Robert E. Mechanic, MBA; Louise Secordel, MBA; Sam Sobul, MPA; and Jennifer Perloff, PhD*

**The American Journal of Managed Care**    May 2024

*Challenges to specialist alignment with ACOs include the fee-for-service orientation of most specialist physicians, lack of good data to evaluate specialist performance, and insufficient organizational bandwidth.*

# Attributes of High Performing Organizations



- Culture of quality, value and professionalism
- Systems that make it easy to do the right thing
- Investment in developing high performing teams
- Incentives that reinforce organization values

# Panel Discussion

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# Audience Q&A

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Thank You!

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