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GOOD HELP CEO SHARES BEST PRACTICES IN DEVELOPING A PREMIER ACO

Announcer: Welcome to Navigant On Healthcare, offering insights for healthcare leaders striving for success in an evolving industry.

Host: Welcome to Navigant On Healthcare. I'm your host, Alven Weil, and today we are joined by Ken Petronis, former CEO of Bon Secours Health System's Good Help accountable care organization. Ken has decades of provider and payer executive experience leading managed care organizations, ACOs, clinically-integrated networks, and large physician groups. With Good Help, he oversaw one of the largest Medicare Shared Savings Programs, or MSSP, ACOs in the country with over 70,000 attributable lives and $630 million in medical costs under management. He currently serves as a senior advisor to Navigant. Welcome, Ken.

Ken Petronis: Good morning, Alven. I'm delighted to be here. Thank you.

Host: Ken, you recently discussed Good Help's journey at Navigant's 2018 clinical integration summit in May of this year in Chicago. Now, you are a founder of Good Help, one of the nation's earliest and most successful ACOs, and you were its CEO for, I believe, five years. If you could, please give us some background on this ACO to include how it was formed, some of the successes under your guidance, and what you believe to be the most important attributes of a successful ACO.

Ken: Sure. I'd be happy to. Thank you. The Good Help ACO is a subsidiary of Bon Secours Health System. We were formed in 2013. Bon Secours is large Catholic health system on the east coast: approximately 15 hospitals, covering five states, over $3.5 billion in revenue. The ACO was one of the few multi-state ACOs in the country. Our ACOs span five states. It was primarily MSSP. We had a few other contracts with Medicare Advantage, commercial, and our own employees. It added up to: over 150,000 lives under management; 70,000 of those under MSSP; 25,000 for our own employees; and another 50,000 lives under management. In 2017, we made the decision to split the ACO into five separate ACOs at the market level.

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The organization was just too big, and none of the local plans felt they had the accountability, or the ability, to affect change, so we split it into five at that point. In terms of execution, we took a bit different approach than most. We did focus on gain share and reducing the total cost of care across the continuum, but we also focused on other areas as well — areas that would support our fee-for-service business, but still be population-health related. Three of those that I'm going to talk about later today include keepage, annual wellness visits, and building a strong preferred post-acute network. Our major successes revolved in these three areas. We also had some of the strongest quality scores in the country for a large ACO.

In terms of successful attributes of an ACO, I think, first and foremost, the organization has to have a clear fit in terms of mission and vision, and strategy with the parent organization. You have to be careful in this business. If you drive down your cost of care across the continuum, it may help the ACO, but it may cannibalize your core business within a health system at too high a rate. So, a careful financial plan is really essential. Secondly, I think physician engagement is really important. Physicians have the power of the pen, and the organizations need to align their incentives with their physicians, and paint a compelling story for them that this is work that can benefit the providers but, more importantly, their patients — to improve their outcomes and make their lives better. Thirdly, similarly, is patient engagement.

We need to change the behavior of the patient to improve their health status, through provider outreach and education, and interventions, and then, also, recent technological advances in direct-to-patient apps. For example, phone-types of apps that will engage the patient directly in terms of trying to get them to change their behavior has been a great help in this business. In order to do all this, you really need a strong analytic engine. You need actionable data for both the patients, and the providers, at the point of care. In a provider setting, it's very important to identify the patients for outreach, and then execute on the outreach, and monitor that those interventions are successful and happening.

Then, back to the strategic issue that I mentioned initially. A payer contracting strategy is very important that it needs to be aligned with all this work, and that the terms and conditions of the contracts fit with the capabilities. For example, if you're new to the business, you don't want to go all the way to capitation. You don't want to go all the way to full risk if you're not ready. So, be intentional in what level of risk you're going to take, what terms and conditions in the contract you can execute upon. It's important to get the feedback from your clinical staff as you're negotiating performance terms in those contracts.

Host: Ken, most providers today are trying to balance value-based strategies while living in a fee-for-service world. How are you able to do so at Good Help?

Ken: Yeah, Alven, a really, good question. All right. Sorry, I mentioned earlier that we focused in three areas around there. One was the network keepage. The second was to focus on improving our annual wellness visit, execution strategy and, finally, billing a high performing skilled nursing preferred network. So, I'll take these one at a time. First, in terms of keepage, a bit of a background: in our MSSP plan, and we were finding this in other contracts, as well, that we found that over 50 percent of our business for our attributed lives were going out of network. So, for a $600 million MSSP plan, that meant that $300 million worth of business was going out of our system. So, after seeing this, this became a major focus for us. It was a major opportunity. In fact, we thought, and it played out, that this was a bigger opportunity than any potential danger that we could realize.

We embarked on a major effort to move our keepage. First of all, and I think this was very important, we aligned the incentives of our senior executives. We set a 4 percent target for movement of the metric, and all the senior executives in the company had the same metric, so there were definitely aligned incentives, and everybody was pulling in the same direction. So, then we went to very detailed analysis, and the MSSP dataset is unique in that all the claims are in one place. Providers don't usually have this opportunity to see out-of-network activity. Their own EMRs don't allow to see when one of their patients shows up at a different facility, so the claim set allows that broad picture. So, that's a very, very valuable data input that we would have not have had if we weren't in the MSSP program.

We had a wonderful analytics team identify out-of-network usage down to the individual PCP level and that's very important, in my opinion, to get the accountability down to individual level, and you can have individual discussion. So for each primary tier-attributed panel, we knew what percent of their business, by specialty, was leaving our network.

We profiled the data primary care physicians against their peers, and identified the outliers, and we had an ability to drill down to the patient-specific level in this database, if the primary care doctor challenged the data. That was also very important. Once we had this data, we went out and just started to knock on doors. We had detailed discussions with our outlier physicians about why they were outliers. They were usually one-on-one, pretty-sensitive discussions.

It would be my ACO staff. We had service line managers from the health system, business development staff from the health system and, in some instances, all the way up to the CEOs of the hospitals, depending on the magnitude of the issue. It was important to take a non-threatening tone. For example, a question we would ask would be: "We see your patterns are different. Explain why and how can we improve to change those patterns?" The conversations were very successful, very open and honest feedback, real issues that were identified. Interestingly enough, very rarely were the issues clinical in terms of the referral patterns. They were almost always administrative in nature. For example, access: "I couldn't get in to see your patient soon enough. I'm sorry, I couldn't get in to the see the doctor soon enough. You don't get your clinical notes back to me quick enough."

That was really the nature of most of the comments, and so after this major focus outreach, we looked for common themes and we set up detailed teams, mostly using lean approaches, to remedy the issues identified. We worked them, reported back to the physicians over time, and the net result from the initiative is that we did hit our 4 percent target, and 4 percent doesn't sound like a lot, but for us that was a $12 million increase in net revenue over time and, again, that was much more than we could have got under the gain share program with MSSP.

Okay. The second strategy that we took was to focus on increase in annual wellness visits for our Medicare population, and the question is: "Why to focus on such a specific initiative?"

Well, annual wellness visits are one of those rare win-win-win opportunities for everybody. First of all, we just believed as a system that it's good quality care. An annual wellness visit is a comprehensive review of health status looking for gaps in treatment, both chronic and wellness related gaps. Secondly, annual wellness visits benefit the coding accuracy for RAF and HCC coding, which is very important in the Medicare Advantage world, and it gives you an opportunity to capture those diagnoses in the visit. Finally, they're economically profitable. On their own, the visits pay approximately $150, which is a very fair reimbursement level for the effort required.

When we started the program in 2014, 11 percent of our patients were getting an annual wellness visit. We set the target to get to 65 percent by 2017, and we swallowed hard when we did it, when we agreed to that, but we embarked on the journey. We had a very intensive program. First and foremost, kind of a broken record here. We aligned the incentives with our senior executives. Everybody had the same goal to hit the 65 percent mark, and that was for all senior executives across the organization. Secondly, we developed an educational program upon rollout for our primary care doctors. There were really two misconceptions we had to overcome. One was that it wasn't worth it clinically. This visit was kind of a new concept that was rolled out by CMS and around 2013, and a lot of doctors didn't know about it.

So, we educated them on the clinical efficacy of the visit, and that was very helpful. Secondly, we worked hard on the workflows around the visit to make it economically viable. We had a team across the system that mapped out a very intentional workflow. We changed our EMR templates to support the workflow, and then we also worked in a heavy usage of advanced practice clinicians and RNs to be the main provider in terms of interfacing with the patient during the visit. So, we were able to get the financial structure of the visit to a very strong level. So, like I said, it was one of those rare win-win-win opportunities.

Once the objectives were overcome, it was just a matter of execution. We put a monitoring system in place. We got monthly totals from each of our markets, each of our practice sites, each of our physicians, to monitor how we were doing. The net results — we moved our performance from out into the 11 percent level — we hit the 65 percent target in 2017, so our patients got better care. We actually did a study of the patients that had wellness visits, versus those that didn't and those that did had markedly better quality scores in terms of the ACO 33 measurement that we submitted to CMS. Their scores were way better. Secondly, our market share went up with MSSP. We grew the number of lives attributed to us by 20 percent over that three-year contract period, from 57,000 to over 70,000.

Finally, just better financial results. You know, that incremental number of visits resulted in over $9 million in additional incremental net revenues.

Okay, the final initiative that we went into was developing a preferred skilled nursing facility network. Why? For our Medicare patients, approximately 10 percent of the overall claims spend is for skilled nursing costs and, secondly, our performance. Honestly, our cost structure was very high in this regard, so we saw it as a good opportunity. How did we do it? How did we succeed in this area? First and foremost, it was important the selection process to be very data driven. This was harder than it sounded. There were a lot of legacy referral relationships that we had to break, and we used data analysis to break those referral patterns.

There were a lot of facilities that were either higher cost than folks thought, or the quality was suspect, so that was very helpful. Once we got the network selected, we went to managing the network tightly, and there were a couple of key components there. One was in terms of electronic leakage between our preferred network skilled facilities, and Bon Secours' EMR, and so we had 42 preferred facilities in our five markets along the east coast, and each one of those is now linked electronically to our medical record, and they can see summary medical records, and that's been a huge help. We thought that the skilled nursing facilities wouldn't like this. We actually mandated that this happen if they wanted to stay in our network, but they loved it, and continue to love it, the clinical folks, especially.

Just medication reconciliation benefits alone have made this worth it. We've seen the readmission rates go down between SNF and acute, so that's been very gratifying. Secondly, we had regular care management meetings between our care managers and the skilled nursing clinical staff. That was mandated, and those continue. It's a weekly call to make sure that our patients are appropriately cared for in the facilities, and that they're staying for the appropriate period of time. The net effect here is our skilled nursing facility length of stay went down. The PMPM costs went down, and, most importantly, the readmission rates went down for the patients, which is really gratifying to know that you can make the elderlies' lives better and keep them out of the acute facility.

Host: Ken, where do you think we're headed with the value-based movement? What would you tell provider executives about the value of ACOs and other value-based models, the value they bring regardless of federal mandates?

Ken: Yeah, you know, that's a really good question. The HHS Secretary Azar used one of his first public appearances to suggest that value-based care needs to accelerate dramatically. I just don't see us going backwards. The private sector momentum continues to grow. The nation's largest payers are now paying out approximately half of their own reimbursements, versus value-based models. While the pace of future value-based contracting is foggy, the industry remains committed to the value-based concept, and we have to — given how much we spend in healthcare with a consistent fall in the outcomes and return. Expense is rising faster than revenues, even for the largest performing systems. All of this during booming economic times. Providers have a minimal margin of error to make value-based investments that don't yield a positive return.

Host: Ken, fantastic information. Thanks so much for joining us today.

Ken: It was a pleasure. Thank you, Alven.

Announcer: That concludes today's episode. Be sure to check in with us for future installments of the Navigant On Healthcare Podcast Series on navigant.com/healthcarepodcast. Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share with friends and colleagues on social media. Learn more at navigant.com.