

Austin Regional Clinic Seton Health Alliance

Building the Components of Accountable Care

Washington, DC

October 22, 2012

Norman H. Chenven, M.D.

Founder & CEO

chenven@arcmd.com

512-231-5514



Austin Regional Clinic (ARC) brought managed care to Central Texas in 1980. ARC spent its first two decades focused on delivering high quality capitated care. Multiple environmental factors dictated a retreat from capitation in Austin and Central Texas in 2000. The passage of PPACA and the decision of Seton Healthcare Family to apply for Pioneer ACO designation drew ARC back to its future to participate in Seton Health Alliance in 2012.



- The conditions required to provide value based care are:
 - Motivated customers – commercial or governmental
 - Committed leadership in the provider community
 - Significant capital to build infrastructure
 - And ideally pricing mismatches

These conditions existed in 1980 and appear to be reoccurring with the catalyst of PPACA.



Profile of Austin Regional Clinic

- Physician owned/Physician governed
- 320 physicians
- 18 outpatient facilities in 3 counties
- 350,000 unique patients (seen within an 18 month period)
- 1,200,000 annual encounters (inpatient and outpatient)
- Multi-specialty group built on a primary care base
- Joint venture MSO with Seton Hospital (since 1999)
- Approximately \$200M in annual revenue



Our History in a Nutshell

- Founded 1980 - in an exclusive contract with PruCare HMO (group model).
- Strong growth from onset (17,000 health plan members within first 18 months).
- Health plan/medical group alignment started to fray in 1987 with Prudential management changes.
- Termination of 'exclusive' PruCare contract in 1993 (80,000 fully capitated lives).
- 1993-2000: contracted with 7 regional and national health plans (HMO).



Our History in a Nutshell, *cont'd*

- 1999: MSO formation with Seton Hospital provided a capital infusion allowing ARC to recover, reinvest & grow.
- 2000-2003: unwinding of all capitated contracts
- 2007: Physician's Health Choice (2,000 Medicare Advantage patients) contract. Purchased by UHC (2012).
- 2011: BCBSTX PCMH pilot (44,000 patients)
- 2012: SHA Pioneer ACO (11,500 patients).
- Currently: PCMH discussions with United, Humana, Aetna and large employers in progress.



Questions:

1. What challenges were faced in developing SHA – the hospital/physician contracting entity?
2. What does the hospital need?
3. What do the physicians need?
4. What inherent challenges and conflicts exist?
5. What are the opportunities for alignment and future success?

Developmental Challenges Faced by SHA

- All capital came from the Seton system – physicians wouldn't (couldn't) participate.
- Physician leadership and commitment is an existential requirement.
- Austin physician community largely “oblivious” to concepts of care management and/or triple aim goals.
- IT systems and data analytic capability almost nil at outset.
- Resources for post acute coordination and/or palliative care relatively basic (primitive).
- Governance and physician incentive challenges.



Our mission inspires us to care for and improve the health of those we serve with a special concern for the poor and the vulnerable. We are called to be a sign of God's unconditional love for all and believe that all persons by their creation are endowed with dignity. Seton continues the catholic tradition of service established by our founders: Vincent de Paul, Louise de Marillac and Elizabeth Ann Seton.

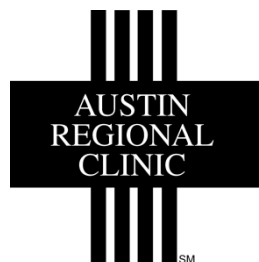
**Seton Health Alliance Board
AGENDA**

**October 16, 2012
Seton Administration Office Building -- St. Elizabeth Ann Seton Conference Room
7:30am – 9:00am**

Subject	Action	Presenter	Attachment	Time
I. Reflection	Information	TBD	NHO	7:30am
II. Approval of Prior Minutes: August 21, 2012 meeting minutes	Approval	Norman Chenven, MD	II.A	7:35am
III. Conflict of Interest Declaration	Declare	Norman Chenven, MD	NHO	7:40am
IV. Consent Agenda- Approve addition of provider groups to SHA network <ul style="list-style-type: none"> o Lone Star Circle of Care o SAIMS o National House Calls practitioners o Austin Geriatric Specialists o Texas Geriatrics 	Approval	Greg Sheff, MD	NHO	7:45am
V. Strategic Items Discussion <ul style="list-style-type: none"> o Organizational Goals o Commercial Contracts o Bundled Payment Program o Clinical Integration Physician Value Proposition 	Information	Jeff Cook & Greg Sheff, MD	V.A V.B V.C	7:50am
VI. Management Reports <ul style="list-style-type: none"> o Operations Update 	Information	Meredith Duncan	V.C	8:30am
VII. Financial Report <ul style="list-style-type: none"> o Financial Report 	Information	Faraz Khan	V.C	8:40am
VIII. Future Agenda Items	Information	Jeff Cook	NHO	8:55am
IX. Adjournment		Norman Chenven, MD		9:00am
Next Meeting: December 12, 2012 Seton Administrative Office St. Louise de Marillac Conference Room				

What Does The Hospital System Need?

- Must be able to grow market share.
- Must have a committed primary care base.
- Must identify committed specialty groups.
- Must move down a path toward true “clinical integration” for both operational and FTC reasons.
- Must be prepared to integrate IT systems (\$\$).
- Must be committed to invested in data analytics (\$\$).
- Committed leadership and competent management.



What's Needed for Physician Success?

- Committed and sophisticated physician leadership.
- Funding for currently un-reimbursed professional services.
- Comprehensive, accurate, convenient, real time clinical data.
- Nurse navigators, behavioral health specialists, outreach staff to support patient engagement.
- Predictable financial reward for predefined quality goals.



High-Performing Health System

Organized System of Care

- Continuum of care provided for populations
- Integrated or has partnerships
- Physicians as principal leaders of medical care
- Shared responsibility for non-clinical activities
- Accountable for care transitions

Efficient Provision of Services

- Manage per capita cost of care
- Improve patient care experience
- Improve health of populations

Quality Measurement & Improvement Activities

- Preventive care & chronic disease management
- Patient outreach programs
- Continuous learning & benchmarking
- Research to validate clinical processes & outcomes
- External & transparent internal reporting
- Patient experience surveys

Care Coordination

- Team-based approach with team members working at the top of their field
- Single plan of care across settings & providers
- Shared decision making

Compensation Practices

- Incentivize improved health & outcomes of populations
- Affiliate with patient experience or quality metrics

Use of IT & Evidence-based Medicine

- Meaningfully use IT, scientific evidence, & comparative analytics
- Aid in clinical decision making
- Improve patient safety
- Aid in the prescribing of Rx

Accountability

- Shared financial & regulatory responsibility & accountability for efficient provision of services



Inherent Challenges and Conflicts for ACOs

- Revenue decline is certain and cost of care savings aren't.
- Culture trumps strategy – always.
- Patients have no skin in the game.
- IT sucks (and costs a lot).
- Analytics are over-rated.
- The industry remains fragmented with powerful vested interests.
- National politics preclude rational consensus driven change.

What Are The Real Opportunities?

- Coordination and control of post acute care.
- End of life and palliative care.
- Behavioral problems as they affect compliance.
- Redirecting care to a redesigned outpatient environment.
- Closed (narrow) networks.
- Clinical Integration across care silos.
- Patient engagement (\$\$).

