**Central Maine Healthcare – ACO Lessons Being Learned**

*(Updated: 11/19/2013, Jim Kane & Dr. Ned Claxton)*

\* The transition from “Episodic Care” to “Population Health” … is very difficult and takes time.

 ED physician example.

\* The “Missing Link” … many patients not taking primary responsibility for their health improvement.

 Diabetes, Pre-diabetes … the “who is responsible for maintaining your car?” example.

 Assessment of “willingness to change”.

\* Focus on where the $’s are.

 Re-admissions ($48.34 pmpm) vs Level 1 & 2 ED use ($5.50 pmpm ~ 1/4th of $22.34 pmpm)

\* Think financial incentives thru

 PCP incentives … to drive behavior change toward “Population Health”, etc.

 If the thought was to financially incentivize the PCP … do the $’s actually go to the PCP ?

\* Change is heavily influenced by the structure of physician’s annual compensation.

 1% Satisfaction, 5% Quality (individual, practice, group), 94% Work RVU’s

\* PCP Practices are an important economic engine for Heath Systems.

 PCP Practices are moving quickly toward standard work and standard infra-structure.

 PCP Practices … are not … an improvement “playground” for Payor A, Payor B, Payor C !

Program: MHMC ACO Lessons Learned 11\_2013.docs Page 1 of 2

**Central Maine Healthcare – ACO Lessons Being Learned**

*(Updated: 11/19/2013, Jim Kane & Dr. Ned Claxton)*

\* Payor and provider “Tools” are now pretty good … there is now plenty of data … turning the data into important, “non-duplicative”, actionable information … takes time and staff resources to “filter” this data from up to 8+ somewhat different clinical and claims based sources.

\* IT “tools” stuck in 1st gear … are the IT “tools” being used to their maximum ?

 EMR … alerts for Rx not picked up or re-filled

 Work flow processes, skilled staff to do analysis, reflect on results, drive PDSA

\* Some PCP resources work best with practice level deployment but with centralized management.

 LCSW, Care Coordinators

\* Population Health … attribution methodologies are OK but not great

 Which provider is primarily responsible ?

\* Quality metrics … let’s stick to the CMS 33 + a very small number of OB, Pedi and BH metrics.

 At last count PCP’s are being measured on 122+ metrics !

Program: MHMC ACO Lessons Learned 11\_2013.docs Page 2 of 2