



ACO Case Study

MedChi Network Services

Provided By:

The National Learning Consortium (NLC)

Developed By:

Health Information Technology Research Center (HITRC)
HITRC Training Team

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The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and resources designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

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The following resource can be used in support of the [EHR Implementation Lifecycle](#). It is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

EHR Implementation Lifecycle



DESCRIPTION & INSTRUCTIONS

The purpose of this case study is to educate Regional Extension Centers (RECs), providers, and other healthcare organizations on how to start and maintain an Accountable Care Organization (ACO) by highlighting the processes and infrastructure MedChi Network Services (MNS) has implemented to support the success of its three ACOs. This case study will also share lessons learned. The case study is intended to aid RECs, providers, and other healthcare organizations with continuing quality improvement.

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1 Executive Summary

The purpose of this case study is to educate Regional Extension Centers, providers, and other healthcare organizations on how to start and maintain an Accountable Care Organization (ACO) by highlighting the processes and infrastructure MedChi Network Services (MNS) has implemented to support the success of its three ACOs. This case study will also share lessons learned.

1.1 BACKGROUND

- MNS is comprised of a public-private partnership between the Medical Society of Maryland (MedChi) and Health Prime International (HPI).
- Each of MNS' ACOs is a recipient of advanced payments through the Medicare Shared Savings Program (MSSP).
- MNS' ACO network consist of the Western Maryland ACO (established July 2012), Eastern Shore ACO (established July 2012), and the Lower Shore ACO (established January 2013).
- The ACO participants are all primary care providers in rural communities throughout Maryland.

1.2 KEY PROCESS AND INFRASTRUCTURE

Some of the key processes and infrastructures that have contributed to MNS' success include:

- **A solid governance structure for the ACOs** that has resulted in synergy around processes, structures, and functions including patient identification, patient stratification, and how funds will be distributed.
- **A robust information technology (IT) infrastructure to support the ACOs** that allows for real-time data sharing in support of population and individual health management across multiple locations. MNS uses a data warehouse that stores administrative data, clinical data from all the ACO practices, claims data from the Center for Medicare and Medicaid Services (CMS), and clinical data from the statewide health information organization, the Chesapeake Regional Information System for our Patients (CRISP), to facilitate access to this data.
- **A structured care management approach at the practice and ACO level** that employs local care coordinators, centralized case managers, and medical directors to establish, implement, and improve care guidelines and practice workflows.
- **Alerts for patient events such as hospital and Emergency Department (ED) admissions to coordinate transitions of care** via the CRISP's Encounter Notification System (ENS) tool. These alerts are in the form of Admission/Discharge/Transfer (ADT) notifications, which CRISP sends in a direct message (secure e-mail) to the participating provider or care manager.
- **Web and mobile technology** that supports secure messaging and communication between the local care coordinator, the provider, and the central care managers which helps identify and close gaps in care.

1.3 LESSONS LEARNED

MNS is constantly working to improve its ACOs and has learned several lessons along the way:

- **Work with practice staff to ensure they are properly documenting clinical data in the electronic health record (EHR) system.** Practices find some of the Medicare Shared Savings Program (MSSP) quality measures difficult to report. These measures are difficult to capture electronically because of how the physicians prefer to document their findings, as well as the disconnect between where the

data needs to be captured in the EHR and when those measures are captured in practice workflows. MNS works both with practices and EHR vendors directly to identify how to best capture the correct documentation for challenging measures.

- **Allow flexibility in how providers engage with population health management support tools.** By providing a variety of methods to access tools, MNS was able to increase the likelihood that providers would use them.
- **Share performance feedback reports with providers.** It can help motivate them to work with their patients and the care team to improve outcomes.

1.4 NEXT STEPS

In the next 18 months, MNS plans to take the following actions:

- **Continue to redesign workflows** as practices become more engaged with population health management
- **Create and train providers** on the use of new reports based on their patient population
- **Continue with change management efforts** as practices continue to transition from volume to value based payments

2 Background

2.1 ACO HISTORY

An ACO is comprised of doctors, hospitals, and other health care providers who voluntarily join together to provide coordinated care to their patients. The goal is to ensure their patients receive the right care at the right time, reduce duplication of services, prevent medical errors, and reduce costs.¹

In 2011, CMS released the final rule for MSSP, which established ACOs for Medicare providers. The MSSP encourages entities to work together to lower health care costs for Medicare beneficiaries and rewards them with savings if they meet the necessary requirements. To participate in this program, eligible providers, hospitals, and suppliers must:

- Create or be a member of an ACO
- Have at least 5,000 Medicare beneficiaries
- Have 75% of its ACO governing board members be from the health care providers participating in the ACO
- Report specific quality metrics to CMS
- Be committed to achieving the triple aim of better patient care, improved population health, and lower health care costs

Shortly after the release of the MSSP, CMS introduced the Advanced Payment ACO model, which allows rural ACOs to receive advanced payments from CMS. Participating ACOs receive three types of payments under this model:

1. An upfront fixed payment (\$250,000)
2. An upfront variable payment (\$36 for each beneficiary)
3. A monthly payment that varies depending on the size of the ACO (\$8 per month, per beneficiary)

¹ <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO>

ACOs are expected to repay these advanced payments through the savings earned at the end of the first three years of operation. If there are no savings, the loan is forgiven. This case study focuses on three Advanced Payment ACO model participants.

2.2 MEDCHI NETWORK SERVICES HISTORY AND SERVICES

MedChi is a non-profit organization that serves as an advocate and resource to Maryland’s physicians, patients, and the general public. Its history dates back to 1799, when a team of 101 physicians banded together to establish a society that fostered educational opportunities for practitioners and the design of universal standards in the field of medicine. HPI is a private, for-profit practice management organization that provides back office business solutions and technology to over 1,000 physicians across the country. In 2011, MedChi and HPI established a joint venture named MedChi Network Services (MNS).

MedChi and HPI brought unique yet complementary services to their partnership (refer to Figure 1). MedChi’s combination of practice workflow support, care management, and clinical quality improvement techniques, along with HPI’s back office and technology service offerings provide practitioners with a full range of support services

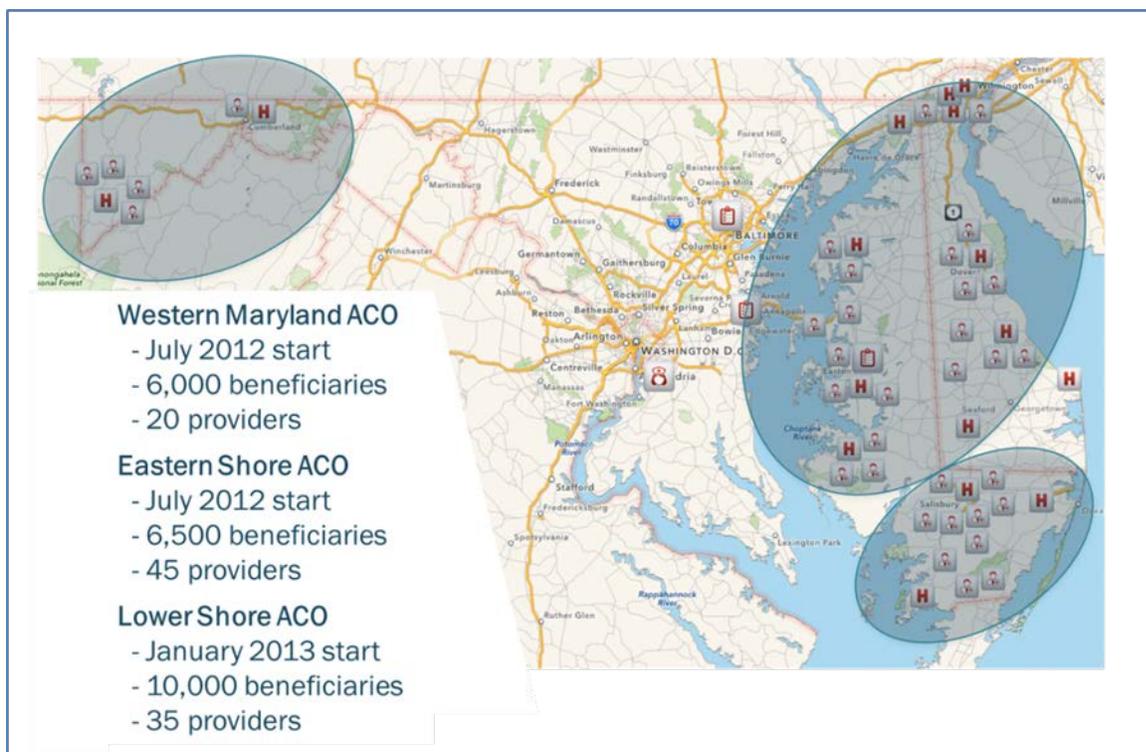
Figure 1: MNS Service Offering

MNS Service Offerings to ACOs	
Enabling practices to be more efficient so they can focus on medical practice changes	
<ul style="list-style-type: none"> Care Management and Coordination Clinical Decision Support Governance 	<ul style="list-style-type: none"> IT Infrastructure – clinical data to enhance administrative data Reporting and Analytics Training Workflow Assistance
MedChi <ul style="list-style-type: none"> Meaningful Use Assistance (REC sub-recipient) Physician Relationships and Membership 	HPI <p>Back Office Functions</p> <ul style="list-style-type: none"> Coding and compliance support Consulting and practice management support EHR implementation Full service contact center staffing IT infrastructure and data warehousing Revenue cycle management Transcription services

2.3 MNS ACO CHARACTERISTICS

MNS is the owner and operator of three MSSP Advanced Payment ACOs located in rural parts of Maryland with residents as well as participants in neighboring states (refer to Figure 2). The participants are all primary care, independent physicians with practice sizes ranging from one to five doctors. Practice participation in these ACOs is both voluntary and free.

Figure 2: MNS ACOs Locations and Characteristics



2.3.1 Emphasis on Primary Care and Rural Locations

Primary care providers in Maryland’s rural communities comprise the entire population of MNS’s ACO participants. While this population is likely to change in the future, MNS’s initial emphasis on rural primary care providers was a requirement for qualifying for the Advanced Payment ACO model.

Through MedChi’s leadership, Maryland physicians already understood the potential benefits of ACO participation. MNS offered the right opportunity by providing physicians with support services and infrastructure (e.g., assistance with EHR implementation), and helping with care management and processes/workflow redesign. In addition, being part of an ACO provides physicians with a means to participate actively in the changes occurring in health care. If there are cost savings, MNS and the practices split the savings.

2.4 MNS OPERATING MODEL

2.4.1 Guiding Principles and Goals

The four guiding principles that MNS follows in regards to its ACOs are:

1. Avoid overburdening practices
2. Capture data consistently for analysis and reporting
3. Exchange health information safely and effectively

4. Contribute resources where possible

Key Finding

MNS found it easier and more cost-efficient to help practices become more effective on the platforms they currently use than to create one uniform technology for all ACO practices.

MNS set specific goals for the first three years of each ACO. During Year 1 (July 2012 – June 2013), MNS sought to develop a solid IT infrastructure as a foundation. MNS partnered with several companies—including Amazon Web Services, ONC funded Regional Extension Center (REC), CRISP, Covisint, and other third-party vendors—to improve the collection and exchange of patient health information in their ACO geographies. Fortunately for MNS, the majority of its ACO practices were already using an EHR; however, there are over 10 different EHR systems in use across the ACOs. MNS found it easier and more cost-efficient to help practices become more effective on the platforms they currently use than to create one uniform technology for all ACO practices.

During Year 2 of the MSSP (July 2013 – June 2014), MNS's ACOs are increasing their capacity to manage population health by expanding their care management staff, processes, and reporting capabilities.

The goal in Year 3 (July 2014 – June 2015) is to transition to predictive care analytics. At its optimal use, physicians can use these predictive care analytics to identify at-risk patients or patterns that generally lead to specific patient behaviors. MNS plans to use predictive analyses to forecast a number of patient trends, including patients' likelihood of being readmitted to a hospital or the percentage of patients who are likely to visit an emergency room. After identifying those patients, MNS can help practices use that information to inform practice workflows and patient education outreach efforts.

2.4.2 Quality Improvement Strategy

The clinical strategies for the ACOs' quality and cost targets are:

- Ensure preventive services are offered consistently for the entire population
- Decrease ED utilization
- Support transitions of care to prevent readmissions

MNS provides resources to the practices to address these strategies. The medical directors of each ACO make the goals known to the practices, and then each practice develops strategies to comply.

2.4.3 Local Governance

All three of MNS's ACOs are physician-led, each with a governance board comprised of ACO members. Each ACO has the flexibility to create policies and processes that are suitable to its individual practices and more often than not, these statutes are consistent across the ACOs despite their diverse governance composition. There is a lot of synergy among the ACOs regarding governance, patient identification, patient stratification, and how funds will be distributed. This synergy has enabled MNS and the ACOs to rapidly build their governance structure, enabling them to quickly focus on other goals.

3 Programs and Processes Established to Support MNS's ACOs

Key factors in positioning MNS's ACOs for success include:

- A robust IT infrastructure to support the ACOs
- An auditable process for notifying patients about their membership in an ACO
- A structured care management approach at the practice and ACO level
- Alerts for patient events such as hospital and ED admissions to coordinate transitions of care
- Identifying and closing care gaps
- Increasing patient engagement
- Enhanced tools and processes for population health management
- An enhanced and streamlined reporting process to highlight care gaps and enable population health management as well as meeting CMS reporting requirements
- Strong privacy and security functions to ensure data integrity

3.1 ROBUST IT INFRASTRUCTURE

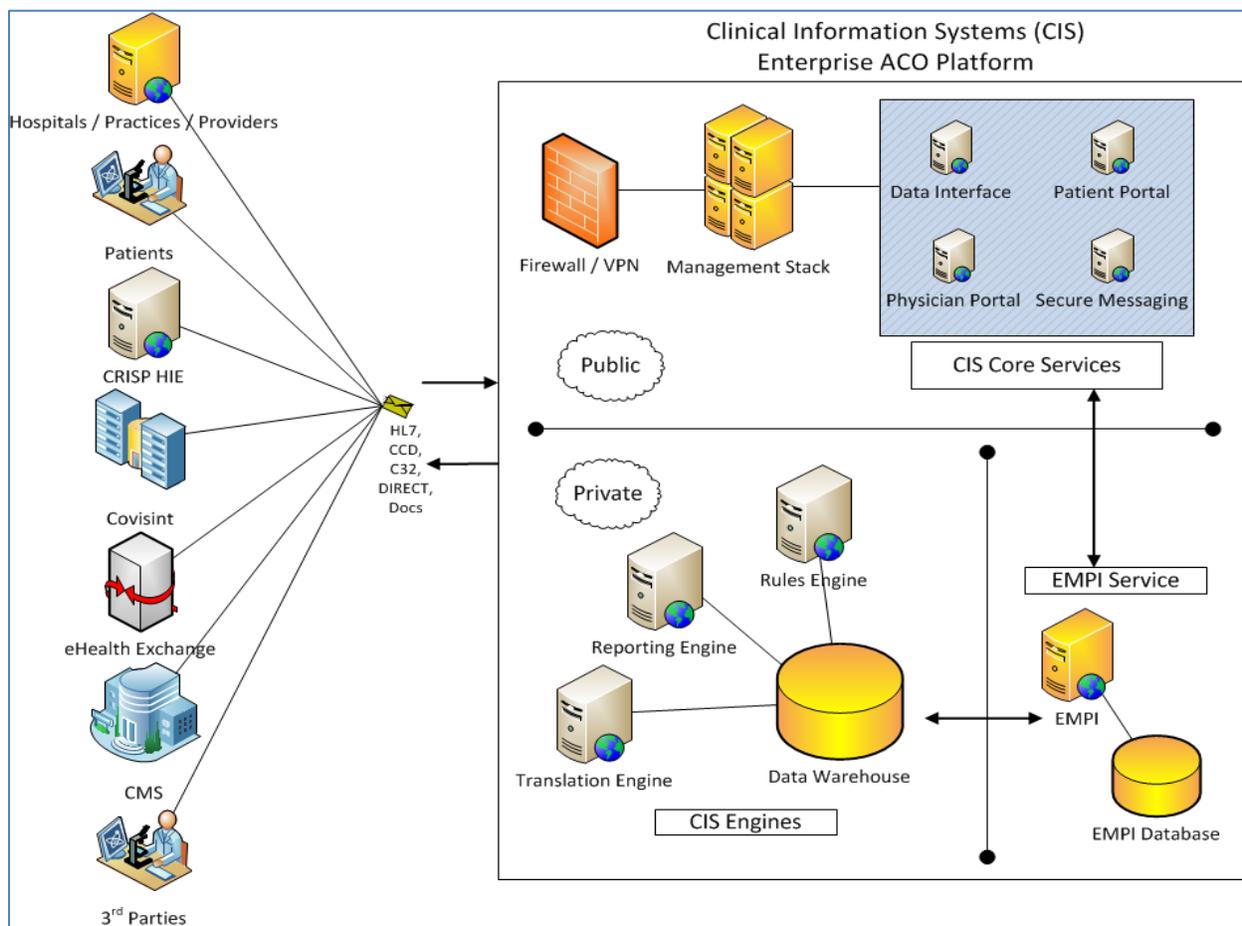
Having a comprehensive IT infrastructure is critical to MNS's ACOs as it allows for real-time data sharing in support of population and individual health management across multiple locations. Prior to launching the Maryland ACOs, HPI already had a data warehouse in place. HPI collected mostly administrative data from Practice Management Systems (PMS) and clinical data from a few of the EHR vendors that were able to interface with HPI. They used the data to support physician back office functions, such as managing revenue cycle, measuring practice growth, and understanding patient demographics. To support the needs of the ACOs, MNS expanded the infrastructure (refer to Figure 3 for a graphical representation of the infrastructure). In addition to the already existing administrative data, MNS added clinical data from all the ACO practices, claims data from CMS, and clinical data from the statewide health information organization, CRISP.

One of the greatest challenges in aggregating data across disparate data sets involves assuring a high level of accuracy in patient matching. To enhance their infrastructure, MNS partnered with a vendor that provided Enterprise Master Patient Index (EMPI) services. Additionally, MNS built translation services to normalize the data sets.

A number of core applications—referred to as clinical information systems in Figure 3—leverage the data warehousing infrastructure including a provider portal, an internally developed care management/messaging application, a commercial risk management/care management application, and eventually, a patient portal.

MNS partnered with Covisint to provide the tools and reports to manage care gaps, risk stratification, and population health management. Currently, data can only be fed one way from the data warehouse into Covisint; however, MNS is working on a method to also extract the data. MNS's team of business intelligence analysts continue to create other reports (e.g., cost and utilization reports) with the data contained within the data warehouse, which allows for an enterprise-wide view of patients and the ability to overlay financial data on quality metrics.

Figure 3: MNS' ACO IT Infrastructure



3.2 AUDITABLE PROCESS FOR NOTIFYING PATIENTS

ACOs enrolled in the MSSP must distribute a standardized letter to each assigned fee-for-service beneficiary, informing them of their rights as a patient to deny the ACO the ability to share patient information across provider practices and other health care service organizations. For MNS, this process proved more challenging than anticipated. To create a master patient mailing list, MNS received data from the practices and CMS in various formats, which significantly increased data entry time. Once all the data was entered, MNS had to cross-reference all of it to ensure the accuracy of the information before the mailing process could begin.

MNS used a mailing house for the letters, but they had to switch vendors after MNS's internal audit team became concerned about the first vendor's ability to produce detailed information on the letter delivery process. MNS wanted granular tracking information from the vendor, such as the date each letter was sent to each patient. MNS also set up a separate mailbox for returned letters and developed a detailed process to log the letter responses into their system.

For the first ACO, it took several months to distribute the letters and receive responses. For the third ACO, MNS's cycle time was greatly reduced due to their streamlined processes, including ensuring all practices were aware of and adhered to the patient mailing data format.

3.3 STRUCTURED CARE MANAGEMENT APPROACH

MNS created a structure that supports care management, both at the practice level and the ACO level. MNS requires that each practice identify a care coordinator within the practice who does not need to have a clinical background. This person focuses on day-to-day patient interactions, data recording, and customer service. At the ACO level, a group of care managers (one registered nurse, one social worker, and five licensed practical nurses) focus on a high-risk subset of the total population, manage telehealth pilots, build care plans, and provide training sessions to the physician office staff to help them understand how to use and adhere to the care management processes and templates. The care managers work with medical directors on care guidelines and practice workflows. They are an added resource for a practice, not a substitute for community-based care.

Care Management Components

- Local care coordinators who are chosen from current office staff, charged with day-to-day patient interactions, data recording, and customer service
- Central care managers who focus on a high-risk subset of the total population, manage telehealth pilots, build care plans, and provide training
- Robust IT infrastructure that allows real-time data sharing in support of population and individual health management across multiple locations

The central care managers work with the local care coordinators and physicians to proactively serve patients. The care managers review practices' schedules to determine which patients will be coming in for a visit. They then review the patient data in the care management system to determine if they need to collect additional information during the patient's visit, or if there are any guidelines that they want the physician to review or take into consideration. The care manager's guidance/data request is transmitted to the practice's care coordinator via a secure web or iPad application. During a typical workday, the local care coordinator may have two to five patients that require them to gather additional data and/or notify the doctor of the guidelines that the care managers have highlighted. The additional data that is gathered during the patient's visit is submitted by the local care coordinator to be added to the care management system (Covisint/DocSite) and the data warehouse. Refer to the Identifying and Closing Care Gaps section for more information.

3.3.1 Restructuring Practice Workflows

MNS is currently in the beginning stages of helping its ACO practices improve care delivery transformation. Initially, MNS focused on supporting practices and physicians by helping them incorporate fundamental elements missing from their current workflows to support disease management and care coordination. Over the next several months, MNS plans to help practices examine their current workflows and strategize how best to improve them via practice transformation services.

They will start by engaging physicians and nurses in discussions to determine workflow best practices. Once these modifications have been agreed upon and shared with individual practices, MNS will meet with each practice to assist them with implementation. The central care management team, IT team, and executive management team, will work with the local medical director and network relations director to support the practice as needed.

3.4 STRUCTURED APPROACH TO QUALITY IMPROVEMENT AND POPULATION MANAGEMENT

3.4.1 Alerts for Patient Events

CRISP's Encounter Notification System (ENS) is an important tool for enrolled providers to address in-patient and ED utilization and readmissions, which are tied directly to MNS's quality goals—decrease ED utilization and support transitions of care to prevent readmissions

ENS alerts indicate to the participating provider or care manager whether one of their patients is admitted to or discharged from a hospital or had an ED visit. These alerts are in the form of ADT notifications, which CRISP sends in a direct message (secure e-mail) to the participating provider or care manager. Currently, the CRISP notification does not include any clinical data, so the practice still needs to log into CRISP's portal to get additional information about the patient. Providers can sign-up directly with CRISP to enroll in the ENS system. To encourage participation, the Maryland Healthcare Commission offers incentive payments to eligible providers.

MNS determined that most of their ACO practices had not signed up for the ENS service. The ACO approached participating practices, collected their patient lists and provided those to CRISP so that alerts could be sent directly to MNS care managers. The care managers used the information to work with local practices on how to best respond to the notifications. For example, if their patients had standing orders, the care manager can ensure that the patient is adhering to the orders.

"The key to reducing readmissions is appropriate follow-up care for patients upon discharge. Many patients today do not receive necessary follow-up care for the simple reason that their primary care and specialist physicians are not made aware of the hospitalization. **A simple and scalable solution is needed to provide automatic notifications to physicians when their patients are admitted to and discharged from hospitals.** Such systems, based on national standards for universal adoption, are emerging in several forms, making headway in reducing preventable hospital readmissions."

- Daniel Kazzaz, "Preventable Readmissions and Physician Notifications," Journal of Hospital Administration (2013)²

3.4.2 Identifying and Closing Care Gaps

As part of their quality improvement plan, data gathering and meeting quality metrics are some of MNS's highest priorities. In the first year, CMS advised MNS to focus on preventive medicine measures, such as annual mammograms and flu shots. Building on this early experience with collecting quality metrics for preventive care MNS is transitioning to a focus on chronic care management. There are a number of processes and key tools that MNS provides to practices to assist them in the identification and management of gaps in care:

- **DocSite by Covisint:** This tool is used as the primary source for gaps in care, risk stratification, and missing data for reporting quality metrics. DocSite supports the care management workflow. Whiling

² <http://dx.doi.org/10.5430/jha.v3n1p1>

seeing a patient, providers can print out and view a visit planner that shows missing quality metric data.

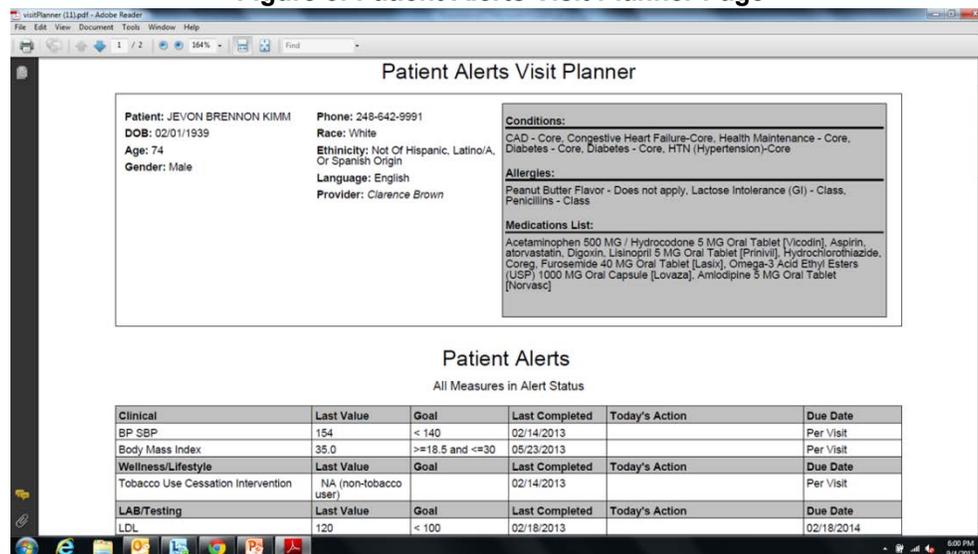
- **Care Management Application:** Available through a secure portal, MNS created a care management application to support the day-to-day needs of the remote care management team as well as the care coordinators and providers at the practice site. Although some of the functionality is duplicative of the Covisint tool, it integrates more easily into the practice's workflow. Alerts from CRISP's ENS system also flow into the care management application.
- **Provider Portal and iPad Application:** These applications support secure messaging and communication between the local care coordinator at the provider and the central care managers.
- **DocBooks MD:** MNS is piloting the use of DocBooks MD to allow secure messages to be sent to the ACO physicians' mobile devices.

To assure complete patient data is collected at each encounter; MNS created a care management form that each participating practice can access via a web portal (refer to Figure 4). The form is filled out for scheduled patients that participate in the ACO. The form is prepopulated with EHR data, and the care manager or practice can fill in any missing information. The form also captures data for other measures/programs in which the practice participates, such as Physician Quality Reporting System (PQRS) or Patient Centered Medical Home (PCMH). If the practice does not have an EHR system then either practice employees or hired nursing students enter the information into the portal. Care managers can use the information collected to create outreach strategies and follow up with patients where care gaps exists.

Figure 4: Web Portal Page

For ongoing care management, DocSite displays quality metrics based on national guidelines and alerts can be customized for significant measures (refer to Figure 5). Care managers have access to a number of reports, such as outreach reports by condition or patient and program, which help guide their outreach and intervention strategies. The care managers can view alerts specific to a patient and then take action on those alerts.

Figure 5: Patient Alerts Visit Planner Page



In addition to the alerts provided to care managers, the quality measures are aggregated at the ACO level and then shared with the practices to determine quality improvement opportunities and to continue to close care gaps (refer to Figure 6 below). For instance, after the first round of reporting from CMS, MNS found that one of their identified care gaps, around complying with guidelines regarding aspirin at discharge, was instead a documentation gap. Providers with low compliance scores in this area indicated that they placed the patient on an aspirin regiment, which complied with the guideline; however, because the documentation of that action was inadequate, it showed as non-compliant, a clear example of where poor documentation created care gaps in the reporting tool.

To address such documentation gaps, MNS works with the frontline staff at participating practices to ensure that their clinical workflows are streamlined for data gathering and proper documentation. As part of workflow redesign, the team ensures that the use of the care management interface via the secure web portal becomes integrated into the workflow as well. The frontline staff logs into the portal using a web or iPad application and can see for their office who is on their daily schedule. A streamlined workflow increases practices' bandwidth, giving them more time to focus on closing care gaps.

It can be difficult to get physicians to alter their processes; however, sharing a performance feedback report with their data and peer performance can help motivate them to work with their patients and the care team to improve outcomes. Performance feedback reports comprise high-level population data and are not patient specific. Initially, MNS wanted providers to know what data they are getting, any gaps in documentation, and where the data is coming from. MNS's goal over the next few months is to improve the quality score per metric reported to CMS, and to make sure physicians are adhering to any protocol the practice establishes. Helping physicians adhere to standardized protocols will not only help to streamline workflows, but will also help convince physicians that care management should be an extension of the practice. Presently, MNS sends each ACO a quarterly report for review during board meetings or other clinical leadership meetings; in the next few months, they will start sending physicians their reports via the secure web portal.

Figure 6: Sample Performance Report

Last Measure Result Averages by Provider

Report Run Date: 6/28/2011 4:01:30 PM
 Report Current As Of: 6/25/2011 2:57:35 PM
 Condition: Diabetes
 Measure: HbA1c Good Control
 Measure Goal: Less Than 7
 Measure Interval: 180 days
 Denominator: Patients with at least one HbA1c Good Control measure
 Site: FAHC
 Patient Status: Active

Provider Name	% Patients At Goal	# of Patients	Average
Rxxxx, Lxxxx	0.00%	1	
Axxxx, Gxxxx	0.00%	2	6.00
Axxxx, Dxxxx	0.00%	6	6.30
Axxxx, Exxxx	0.00%	2	6.30
Ixxxx, Lxxxx	33.33%	9	6.34
Axxxx, Exxxx	25.00%	4	6.43
Nxxxx, Lxxxx	66.67%	3	6.70
Axxxx, Axxxx	24.85%	165	6.71
Ixxxx, Wxxxx	2.56%	78	6.76
Oxxxx, Rxxxx	18.18%	33	6.78
Axxxx, Rxxxx	30.84%	107	6.89
Ixxxx, Dxxxx	38.89%	162	6.90
Rxxxx, Qxxxx	11.11%	9	6.91
Exxxx, Lxxxx	40.14%	147	6.94
Yxxxx, Ixxxx	9.68%	62	6.98
Lxxxx, Nxxxx	28.68%	129	7.00
Cxxxx, Rxxxx	22.73%	154	7.00
Axxxx, Ixxxx	34.39%	189	7.01
Axxxx, Exxxx	31.06%	161	7.02

3.4.3 Patient Engagement

As an owner and operator of three relatively new ACOs, MNS’s approach to patient engagement is evolving. To date, MNS has begun strategizing the rollout of a community-based patient portal and has received the results from the first set of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Below is more information about the portal and CAHPS results.

- **Patient Portals:** MNS plans to implement a community-based portal for the ACOs within its network in 2014. This portal will enable practices to benefit from a community-wide patient portal and to meet Meaningful Use Stage 2 modular certification. MNS is also helping some of its practices that have already implemented tethered portals which are part of their EHR platforms.
- **CAHPS Survey:** MNS recently received its first set of CAHPS surveys results for Year 1. At a glance, the results indicated that MNS has been performing as expected, although extensive analysis of the data has not been completed. MNS plans to use this data to inform patient engagement activities, but will need further analysis to determine which strategies to deploy.

3.4.4 Population Health Management

MNS has a proactive strategy for population health management. At its core, this strategy is designed to help practices identify all their at-risk patients with chronic illnesses and address their needs through a diverse approach. With MNS’s ACO network, population health management begins with building upon their infrastructure and working with vendors to create health IT tools that enable practices to engage in population health management. MNS is focused on changing the culture of practices so they value population health management and assisting practices in the adoption of internal processes that make population health management feasible and effective. MNS’s comprehensive care management strategy is a major component of its population health management strategy, encouraging its practices to place as much value on the development of patient treatment plans as the office visit; this ultimately improves not only the individual patient’s health, but also the health of the practices’ patient population as a whole.

As with many of the ACO projects underway, MNS’s population health efforts are still in their infancy; however, a major component of their strategy integrates the reports and tools provided through DocSite, along with a proactive care management approach. DocSite tracks all needed care and events at a community level or patient level. If a DocSite alert identifies a patient as needing care (e.g., follow-up appointment needed for diabetic patient), that information, including any protocols in which the patient is enrolled, is transmitted back to the web portal and iPad application. In the next year, MNS plans to integrate care alerts and notifications directly into the physicians’ EHRs. This will streamline the workflow since they will have the information when they see the patient, rather than having to log into an application or have their staff tell them what needs to be captured.

For patients that are not currently scheduled to see a provider, the care management team sees the alerts when there is an event requiring action. Depending on the practice and their relationship with the practice, the care manager will call the patient and schedule a follow-on appointment, which is logged into DocSite, or the care manager will notify the care coordinator in the practice who will initiate the follow up outreach.

“Population Health Management will require a significant change in the way of thinking and the practice patterns of providers. Instead of doing more to earn more, providers will be rewarded for efficiency and quality. They will have to become accustomed to thinking in terms of caring for an entire population and not just for the individual patients who actively seek care.”
- Population Health Management, A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation³

3.4.5 Flexibility in Regards to Accessing Data

Given that CMS prescribes the ACO performance measures, MNS recommends that providers agree upfront to the risk stratification methodology and standard care protocols to apply to these measures. Once that has been agreed to, an ACO needs to be flexible in how providers engage with the various tools to support population health management. Early on, MNS realized that providing flexibility with the tools used to access patient registries would yield the greatest successes in population health management. The MNS solution was designed to give providers options: direct access to DocSite, access to the care management system via a web portal or iPad application, or ability to receive messages directly from the care management team.

“Tools to identify patients needing care and doing the reporting are great, but if providers can’t access this patient data in a way that works for them, then no action will be taken.” – MNS Executive

3.5 REPORTING

In addition to the reports created to help drive quality improvement, MSSP participants must report specific measures to CMS. To make this process as fluid and efficient as possible, MNS created a centralized data infrastructure that collects, stores, normalizes, and reports the appropriate data to CMS for its ACOs. This data infrastructure is not only used to report against clinical quality measures for the MSSP, but other practice transformation initiatives as well. As a MNS ACO participant, practices can opt

³<http://www.ihealthtran.com/blast372.html>

to have MNS assist with their reporting requirements for other initiatives to the extent they deem necessary.

3.5.1 MSSP Reporting Requirements

CMS requires ACO participants in the MSSP to report on 33 quality measures during each of the ACO's performance years. These quality measures are grouped in four key domains: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations. ACOs must demonstrate quality performance in each of the areas and report on their progress through a combination of mechanisms, including CAHPS, clinical quality measures using the Group Practice Reporting Option (GPRO) web interface, and CMS claims and administrative data. Below is additional data about the various reporting mechanisms.

- **Patient Experience of Care Surveys (7 measures):** For each year of the program, MNS's ACOs must administer and report on the CAHPS survey.
- **ACO GPRO Web Interface (22 measures):** The ACO GPRO web interface, another method of data submission, provides a way for ACOs to collect and submit quality measures to CMS during a given calendar year. CMS designed the interface to include aspects from various CMS projects, including the PQRS GPRO.
- **CMS Claims and Administrative Data (4 measures):** For the claims-based measures, the CMS ACO Program Analysis Contractor (PAC) is responsible for coordinating with CMS to collect the necessary Medicare claims and EHR data. The CMS ACO PAC then calculates the measure rates for each ACO.

3.5.2 Data Infrastructure for Clinical Quality Reporting

Reporting for MNS's ACOs is consolidated at an enterprise level. Each practice submits their data, typically through their EHR, to a MNS centralized data warehouse. Practices that use EHR systems that do not make clinical data accessible submit manually through a secure web portal. MNS keeps the source files, normalizes the data, and formats the data according to CMS requirements. Once the data has been formatted properly, it is sent to CMS via the ACO GPRO web interface.

MNS is flexible with practices regarding how they submit their data; however, many practices do rely heavily on the EHR vendor capabilities to report the clinical quality measures. Since practices' EHRs have varying capabilities, MNS does not require practices to submit their data using common health information content exchange standards such as HITSP C32 or HL7 messages. A small percentage of MNS's practices are also without EHRs and collect their data manually; those practices submit data in an Excel spreadsheet.

Practices find some of the quality measures (e.g., fall risk screening, diabetic foot exam, and depression screening) difficult to report. More often than not, these measures are difficult to capture electronically because of how the physicians prefer to document their findings, as well as the disconnect between where the data needs to be captured in the EHR and when those measures are captured in practice workflows. MNS works with practices directly to identify how to best capture the correct documentation for challenging measures. This might entail working with the EHR vendor to create order sets or special templates to improve ease of documentation, or having practices collaborate with one another on best practices, especially if they use the same EHR.

3.5.3 Gaps in the Current Reporting System

There are a number of areas where MNS continues to enhance its reporting capability, or would like to see improvements in the CMS process. Some of those areas include the following:

- Although the CMS batch claims download process functions well for MNS, when managing patients in an ACO, moving to a real-time claims feed would be better. Specifically, knowing when a patient has been admitted to a hospital—especially when they seek care outside of the ACO network—would be extremely beneficial to the providers. Under the current system a provider might not know about an admission that occurred out of state for four to six weeks after the event, which provides limited opportunity to intervene.
- MNS is using claims information received from CMS to augment their clinical records, if needed. For example, if claims data states that a patient had lab work done, but this data is missing from the patient's medical record, the information is added to the medical record.
- The biggest hurdle for reporting quality measures to CMS is receiving the data from the practices as MNS still receives some of the providers' data manually in Excel spreadsheets.

3.5.4 Avoid Overburdening Providers: Reporting on Multiple Initiatives

While ACO participants are required to report on quality measures for the MSSP program, many of MNS's providers are also involved in various other practice transformation initiatives, such as the CMS EHR Incentive Payment Program or Meaningful Use, PCMH, and PQRS. These initiatives have unique reporting requirements, which add to the provider's reporting workload and reduce the time they have to care for their patients and operate a successful practice. To minimize the burden for these providers, MNS assists its ACO participants in reporting to these initiatives as well. MNS helps their providers select the measurements they need to report on and strategize how best to report the measures. The extent to which they assist providers is dependent on the need and desires of the individual practices. CMS also aligned quality measures required for the ACOs with other incentive programs, such as PQRS, to reduce the reporting burden.

3.6 PRIVACY AND SECURITY

As with any organization that is involved in health care data sharing, MNS is committed to ensuring the privacy and security of patient information. MNS accomplishes this primarily through adhering to HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, implementing increased encryption protocols, and requiring ACOs to sign data use agreements that outline how patient information will be shared with providers within and outside MNS's ACOs. Details about these approaches to privacy and security are below.

- **HIPAA Compliance:** MNS partners with reliable, credible organizations to collect, store, and share patient information within its ACO networks. MNS partners (e.g., Amazon Web Services, CRISP, DocBook and various EHR vendors) that enable MNS to provide core services to its ACO participants are all compliant with HIPAA.
- **Encryption Protocols:** MNS works to ensure all patient information transmitted is encrypted accurately and sufficiently. Patient health information sent within the ACOs is encrypted during transit and at rest. This additional at-rest encryption increases practice confidence in the protection of their patient health information.
- **Data Use Agreements:** Each ACO signs data use agreements with CMS and MNS to share patient information within and between each of the ACOs. In the CMS data use agreement, MNS's ACOs agree to share patient information provided by CMS with providers within the ACO. In the event a patient is seen by a provider in a different ACO, MNS is working with CRISP to develop the capability to share that patient's data with the provider rendering care through the HIO.

4 Looking Ahead

After 18 months of concerted effort, MNS's three ACOs have achieved significant progress. MNS has: implemented a robust IT infrastructure, which enables data to be shared between the ACO practices and MNS; established an ACO care management system and associated processes; and developed strong relationships between the ACOs, practices, and MNS. In the next 18 months, the focus will be on building and launching ACO patient portals, continuing to implement population health management strategies, and moving towards predictive care analytics. Specific actions to support these efforts include:

- Continue to redesign workflows as practices become more engaged with population health management
- Creating and training providers on the use of new reports based on their patient population
- Continue with change management efforts as practices continue to transition from volume to value based payment
- Initiate and maintain strong, positive communications regarding patient portals to promote rapid uptake