in New Brunswick, N.J., in order to better serve patients by relocating the obstetrics/gynecology and orthopedics offices from the main hospital. Because these services are done on an outpatient basis only, giving them their own space removed the need for patients to find parking and walk through the main building for short visits. The new facility will include a reception and waiting area for patients, five exam rooms, an X-ray room, and physicians’ and staff offices.

In the future, Robert Wood Johnson administrators plan to convert the newly freed space into its next best usable version.

**Relationship with Community**

Because of increasing life spans, more people are in need of geriatric care, bringing medical practitioners and caretakers out of the hospital and office environment and into the communities. Off-campus space can play an important role in a hospital’s commitment to continue to be part of the healthcare team for this demographic. These spaces are often off-site and can be in different counties and regions, adding new buildings and staff to the budget.

**Location**

Once a hospital decides that it is time to expand off-campus, location, as with any real estate decision, is the most important feature of a building. Hospital leaders can work with the architect and planner to find a location that both existing and new patients can get to easily, either on their own or via public transportation.

**Conclusion**

The decision to build on campus or retrofit existing hospital spaces requires consideration of cost, patient and community reach, and interconnectivity between practices. Early planning and realistic cost expectations can lead to healthcare facilities that provide excellent patient care and experience for many generations to come.

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**ACO Strategies**

**The Legacy of a Medicare ACO**

*By Lauren Phillips*

John Muir Health turns its focus to care coordination.

John Muir Health decided last fall that it was not renewing its commitment to the Medicare Shared Savings Program (MSSP) once its three-year contract was up at the end of 2015. The health system made the decision despite the fact that it was the top-performing Medicare ACO in California in the first and second performance years, one of only 92 out of 333 nationally to earn bonuses. (Quality data for 2015 are not due until after publication date of this issue of Strategic Financial Planning.)

In 2014, it was the only California Medicare ACO to perform well enough to share in savings with the Centers for Medicare & Medicaid Services (CMS). Over the first two years of the program, the health system achieved more than $20 million in savings and learned a number of important lessons.

So why drop out of the program? Does this mean the health system’s interest in ACOs has waned? Far from it, says Keith Pugliese, John Muir Health’s vice president of contracting and risk operations.

“Participation in ACOs is well aligned with our efforts to reduce the cost of care for consumers, enhance quality and service, and increase access to John Muir Health as part of what we call Vision 2022—our road map for the future.”

**Focusing on Medicare Advantage Rather Than Shared Savings**

John Muir Health is an integrated delivery system dedicated to improving the health of the communities it serves. It includes two of the largest medical centers in Contra Costa County—the John Muir Medical Centers in Walnut Creek and Concord—and 24 ambulatory care locations that are owned and operated by the 1,000-member John Muir Physician Network.

“We have been working diligently to achieve the Triple Aim—improving the patient experience of care [quality and satisfaction], improving the health of populations, and reducing the cost of care—as we move from a fee-based payment system to population-based models,” says Pugliese. “ACOs are one way that we can translate these efforts into working with health plans to provide competitive premiums for patients who want to access John Muir Health for their care.”

The fact is, the system is in a competitive market with a number of large providers, giving patients who are shopping for the best value a lot of options.

“We could see that fewer and fewer MSSP ACOs were achieving shared savings,” says Pugliese. “We looked ahead and saw diminishing returns and decided it just didn’t seem like a long-term program for us.”

On the other hand, John Muir Health participates in several Medicare Advantage programs, which reward providers proactively on a per-member-per-month payment model. It sees Medicare Advantage as the better model for beneficiaries and is investing accordingly. And while John Muir Health may have ended its association with the MSSP, it still participates in two commercial ACOs with Blue Shield of California and with Health Net, which together have 23,000 enrollees.

All of these enterprises are informed by the system’s experiences with the Medicare ACO, which brought the system and its physician network together and prompted them to think about how to move more closely coordinate care across the continuum. The organization benefits from the case management, disease management, and home health management services and initiatives that emerged from those efforts. In fact, the system is currently putting in place a physician-led governance process that treats the Medicare Advantage programs as if they were ACOs.
Applying Lessons Learned

By the end of its second year in the MSSP, John Muir Health had lowered the amount spent on each member from $10,938 to $10,577 annually—a difference of $361—while simultaneously meeting CMS’s requirements for improved quality and patient satisfaction.

The key to accomplishing these aims, according to Pugliese, was moving from fee-for-service, “which promotes fragmented and uncoordinated care,” to capitation, which provides a strong incentive for physicians, other healthcare practitioners, hospitals, and system leaders to collectively focus on meeting patients’ full spectrum of care needs, starting with wellness and prevention programs and extending through rehab facilities, nursing homes, and home health.

This care coordination model includes clinical nurse specialists, registered nurses, and social workers, says Pugliese. Each is liaison to multiple doctors.

“If Dr. Smith has an 85-year-old patient, Keith, who is depressed, dehydrated, diabetic, and housed inappropriately, she can say to that patient, I think you will benefit from a number of our programs, including our diabetes care program, and I’m going to hook you up with Chuck, my care coordination specialist. Chuck will call you to talk about resources within our health system and in the community that may be of help, and he will act as your coordinator for all the care you need. I will be in the loop, and if you have any questions or concerns, you can always call me,” Pugliese says.

Say Keith then comes to a John Muir Health emergency department. He may need to be admitted as an inpatient, or observation may suffice. He gets the hydration he needs and within 24 hours he’s ready to go home. Whether he was admitted or not, he’s going to leave with instructions for his caregiver at home to guard against a recurrence. And maybe the care coordinator will send out a home health nurse to do a patient safety check and medication reconciliation and make sure protocols established by Keith’s primary care physician are being followed—or changed if they’re no longer appropriate.

Other factors contributed to John Muir Health’s success with the MSSP. For one thing, it developed standardized, evidence-based medical protocols that cover all the bases in the care continuum for a number of common diseases such as diabetes.

Pugliese also points to the system’s hospitalist program, which likewise emphasizes care coordination. Hospitalists round the inpatients, and case managers make sure that, prior to discharge, arrangements are made for ongoing care of chronic diseases and that patients have follow-up appointments with their primary care physicians.

Finding the Right Programs for the Right Population

Patients covered by commercial health plans and Medicare differ, sometimes substantially, not just in their actuarial statistics but in their health characteristics and medical conditions. For a health system increasingly interested in pursuing risk-based insurance contracts, which John Muir Health is, a major part of reducing those risks is improving outcomes, improving patient satisfaction, and lowering costs. This can only be done if hospitals and health systems first identify and differentiate among populations.

“For example, an older population is more likely to have multiple comorbidities, such as depression and heart failure,” says Pugliese. “For younger people and middle-aged people, obesity and hypertension are more common. All three groups may have high levels of diabetes, but you can’t take a cookie-cutter approach in programming services for them.”

John Muir Health’s model, which Pugliese says is still being fleshed out, is designed to support the pyramid of population health, in which the bottom layer has the largest number of patients and the lowest cost (think wellness and prevention) and the top has the smallest number of patients with the greatest cost (end-of-life care).

The system uses any number of tools to get a handle on who is at risk for what. All of its foundation physicians use the John Muir Health electronic health record system, and many of its independent physicians do as well.

“Within our electronic health record there are tool sets that provide us with analytics,” says Pugliese. “In addition, we have a tool that allows us to interpret diagnosis codes and other factors in the data that help us assign risk scores and identify key areas of concern. These are predictive models that we can use to support our physicians and care managers so they can reach out to their patients at the appropriate time and place.”

Engaging Patients and Providers

Remember when Dr. Smith explained to Keith about Chuck being his care coordinator and said that Chuck would call him? That type of exchange represents a critical point in the managed care process at John Muir Health. If the care coordinator simply cold calls a person, says Pugliese, it can feel like it’s coming from an insurance company. The transition to a broader base of services needs the imprimatur and encouragement of patients’ primary care physicians.

“The physicians are the key component, the primary source of care recommendations. "It’s up to them to establish the care plan and decide how and where to engage the patients in the process, introducing them to both the concept of coordinated care and the individual coordinator.”

There’s no secret sauce, says Pugliese. It’s all about setting a path to health or the closest thing to it for each patient and helping each navigate the journey.”

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