Accountable Care
Managing toward a Sustainable Health Care System

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Director for Population Health and Policy
The Dartmouth Institute for Health Policy
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Percent Obese (BMI over 30)

- <10%
- 10-14
- 15-19
- 20-24
- 25-29
- >30%

Graph showing the actual and projected trends from 1960 to 2000.

Image of a glass of orange juice with the word "THE NEW YORKER".
Health Care Reform
Half full? Half empty?

1. What’s going on?
2. The current opportunity
3. Half full? Half empty?

What’s going on?
Variations in Spending: Is More Always Better?

Health implications of regional variations in spending

Initial study: About 1 million Medicare beneficiaries with AMI, colon cancer and hip fracture

Compared content, quality and outcomes across high and low spending regions

<table>
<thead>
<tr>
<th>Per-capita Spending</th>
<th>Low (pale):</th>
<th>$3,992</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (red):</td>
<td>$6,304</td>
<td></td>
</tr>
<tr>
<td>Difference:</td>
<td>$2,312</td>
<td></td>
</tr>
<tr>
<td>(61% higher)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(2) Buicker et al. Health Affairs web exclusives, Dec
(3) Fisher et al. Health Affairs, web exclusives, Nov
(4) Skirnser et al. Health Affairs web exclusives, Feb
(6) Fowler et al. JAMA: 299: 2406-2412
What's going on?
Variations in Spending: Is More Always Better?

Effective Care: benefit clear for all
- Reperfusion in 12 hours (Heart attack)
- Aspirin at admission (Heart attack)
- Mammogram, Women 65-69
- Pap Smear, Women 65+
- Pneumococcal Immunization (ever)

Preference Sensitive: values matter
- Total Hip Replacement
- Total Knee Replacement
- Back Surgery
- CABG following heart attack

Supply sensitive: often avoidable care
- Total Inpatient Days
- Inpatient Days in ICU or CCU
- Evaluation and Management (visits)
- Imaging
- Diagnostic Tests

Ratio of rate in high spending to low spending regions

If bar on this side higher spending regions get more

What's going on?
Variations in Spending: Is More Always Better?

Health Outcomes
- No gain in survival
- No better function

Physician's Perceptions
- Worse communication
- Greater difficulty ensuring coordination
- Greater perception of scarcity

Patient-Perceived Quality
- Lower satisfaction with hospital care
- Worse access to primary care
- No less sense that care is rationed

(2) Buicker et al, Health Affairs web exclusives, October 7, 2004
(3) Fisher et al. Health Affairs, web exclusives, Nov 16, 2005
(4) Skinner et al. Health Affairs web exclusives, Feb 7, 2006
(6) Fowler et al. JAMA: 2002; 248:6-2412
What’s going on?
Capacity, payment

Hospital Beds
Medical Specialists

Regional Spending

Low High Low High

32% higher
65% higher

Evidence-based decisions:
Doctors sometimes disagreed – but was unrelated to regional differences in spending

Gray area decisions (more judgment required):
For a patient with well-controlled high blood pressure and no other medical problems, when would you schedule the next visit?

Other guideline free decisions:
Referral to specialist
Reflux, angina
Diagnostic testing
Cardiac ultrasound, chest CT
Hospital admission
Angina, heart failure
Admission to ICU
Heart failure
Referral to palliative care
Heart failure

What’s going on?
Capacity, payment, judgment

EXHIBIT 5
Association Between Physician Practice Intensity and Local Health Care Spending
Summary intensity score index

0.4

-0.3

-0.2

-0.1

0.0

0.1

0.2

0.3

20,000 17,500 15,000 12,500 10,000
Local spending (mean dollars)
What’s going on? Capacity, payment, judgment, values

These marketing ploys are wildly successful across the entire country. Patients are viewed as the ball in a pinball machine, popped back and forth, ringing up profits, until finally they escape past the paddles and can no longer render income. I believe that the fingers controlling those paddles, Dr. Fisher, often use those "gray areas of judgment" as an excuse to shoot the patient back to the triple-score bumpers.”

Geoffrey G. Smith, MD, Casper Medical Imaging
May 24, 2007 (email)
“Here … a medical community came to treat patients the way subprime mortgage lenders treated home buyers: as profit centers.”

Atul Gawande

<table>
<thead>
<tr>
<th>City</th>
<th>2006 Spending</th>
<th>92-06 Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>McAllen</td>
<td>$14,946</td>
<td>8.3%</td>
</tr>
<tr>
<td>La Crosse</td>
<td>$5,812</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

“…a culture that focuses on the well-being of the community, not just the financial health of our system.”

Jeff Thompson, MD
CEO Gunderson-Lutheran
La Crosse, WI

What have we learned?
Principles guiding the development of Accountable Care

**Underlying problem**
- Confusion about aims
- Absent or poor data leaves practice unexamined and public assuming that more is always better.
- Flawed conceptual model. Health is produced only by individual actions of expert (specialist) physicians.
- Wrong incentives reinforce model, reward fragmentation, induce more care and entrepreneurial behavior.

**Key principles**
- Clarify aims: Better health, better care, lower costs – for patients and communities
- Better information that engages physicians, supports improvement; informs consumers and patients
- New model: It’s the system. Establish organizations accountable for aims and capable of redesigning practice and managing capacity
- Rethink our incentives: Realign incentives – both financial and professional – with aims.
Health Care Reform

Half full? Half empty?

1. What’s going on?
2. The current opportunity

The Opportunity
National quality strategy – guiding principles

- Person-centeredness and family engagement will guide all strategies, goals, and improvement efforts
- The strategy and goals will address all ages, populations, service locations, and sources of coverage
- Eliminating disparities in care – including but not limited to those based on race, ethnicity, gender, age, disability, socioeconomic status and geography
- The design and implementation of the strategy will consistently seek to align the efforts of public and private sectors
The Opportunity
The science of improvement has advanced dramatically

If Health Care is Going to Change, Dr. Brent James’ Ideas will Change it

The Opportunity
Federal legislation creates policy window – and new money

**American Recovery and Reinvestment Act (ARRA)**
*Health Information Technology*: financial support for adoption – linked to “meaningful use” 2011 rules established; 2013, 2015 pending
*Comparative Effectiveness Research*: investment in research to improve evidence on effectiveness of both biotechnology and delivery system innovations

**Affordable Care Act**
*Leadership & support for improvement*: National strategy
*CMS Innovation Center*: (2011) Testing and dissemination of new payment and delivery models: $10 billion *appropriated*

**New models of care and payment**
Accountable Care Organizations
Episode / bundled payments
Medical Home
Shift toward value-based payment
The Opportunity
Avoidable hospital stays
Inpatient days per patient during the last two years of life in California HRRs (2001-05)

<table>
<thead>
<tr>
<th>Area</th>
<th>Ratio to benchmark</th>
<th>Surplus/deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>2.39</td>
<td>1,505,127</td>
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<tr>
<td>Orange County</td>
<td>1.79</td>
<td>271,076</td>
</tr>
<tr>
<td>Ventura</td>
<td>1.79</td>
<td>92,904</td>
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<tr>
<td>Alameda County</td>
<td>1.68</td>
<td>118,051</td>
</tr>
<tr>
<td>Palm Springs/Rancho Mir</td>
<td>1.66</td>
<td>49,337</td>
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<tr>
<td>Contra Costa County</td>
<td>1.65</td>
<td>75,926</td>
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<tr>
<td>San Bernardino</td>
<td>1.63</td>
<td>154,164</td>
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<td>Bakersfield</td>
<td>1.62</td>
<td>100,127</td>
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<tr>
<td>San Francisco</td>
<td>1.59</td>
<td>115,334</td>
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<td>San Diego</td>
<td>1.57</td>
<td>226,556</td>
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<td>San Jose</td>
<td>1.57</td>
<td>93,681</td>
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<tr>
<td>Salinas</td>
<td>1.48</td>
<td>38,298</td>
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<tr>
<td>Fresno</td>
<td>1.46</td>
<td>84,871</td>
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<tr>
<td>Modesto</td>
<td>1.46</td>
<td>61,085</td>
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<td>San Mateo County</td>
<td>1.39</td>
<td>41,194</td>
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<td>Chico</td>
<td>1.39</td>
<td>40,524</td>
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<td>Stockton</td>
<td>1.38</td>
<td>32,395</td>
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<tr>
<td>Redding</td>
<td>1.35</td>
<td>41,010</td>
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<td>Sacramento</td>
<td>1.29</td>
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<td>San Luis Obispo</td>
<td>1.27</td>
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<td>Santa Cruz</td>
<td>1.26</td>
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<td>Napa</td>
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<td>Santa Rosa</td>
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<td>Santa Barbara</td>
<td>1.13</td>
<td>10,466</td>
</tr>
<tr>
<td>La Crosse, WI</td>
<td>1.00</td>
<td>-</td>
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Health Care Reform
Half full? Half empty?

Health care reform (& ACOs) could fail
- Public fearful – and could reject the model
- Payers worry about market power
- Providers could see as zero-sum game

We have a choice
What might we do?
- Consider our role as stewards of our community’s health and well-being
- Step forward to help reforms succeed
- Recognize that health and health care are produced locally (work together)

It’s up to us
“Each man is locked into a system that compels him to increase his herd without limit – in a world that is limited. Ruin is the destination toward which all men rush…”

Design principles for managing “common pool resources”

1. Defined boundaries, known “appropriators”
2. Rules reflect local conditions and knowledge
3. Those affected determine and modify rules
4. Monitoring of performance
5. Graduated sanctions
6. Conflict resolution mechanisms
7. Right to self-organize is recognized by authorities
8. Nested enterprises
Useful Metaphor?
Or something more

**Nested enterprises**

Physician practices, Inpatient care units (clinical microsystems)
Useful Metaphor?
Or something more

**Nested enterprises**
- Physician practices, Inpatient care units (clinical microsystems)
- Accountable Care Organizations

Useful Metaphor?
Or something more

**Nested enterprises**
- Physician practices, Inpatient care units (clinical microsystems)
- Accountable Care Organizations
- Regions
**Useful Metaphor?**
Or something more

**Nested enterprises**

**Monitoring, feedback, graduated sanctions:**
*Shared responsibility*

**A focus on stewardship**
*Better care, better health, lower costs*

**Leadership**

Parker Palmer  “A leader is someone with the power to project either shadow or light onto some part of the world and onto the lives of the people who dwell there. A leader shapes the ethos in which others must live, an ethos as light filled as heaven or as shadowy as hell.”

Ronald Heifitz: A leader helps us know where we want to go, clarifying values and fundamental interests, resolving conflicts, helping bridge the gap between current and desired state.

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**Physician Practices (and other micro-systems)**

*Care redesign, monitoring, peer-to-peer feedback*

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**Figure 1:** Percentage of Intermountain Healthcare System Diabetic Patients with Glycated Hemoglobin (HbA1C) > 9%

June 1999-March 2005

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**Practice Variation Report**

May 29, 2008 Presentation at Federal Trade Commission
Tom Lee, MD (Partners Healthcare System) (used with permission)
Physician Practices (and other micro-systems)
Group Health Cooperative – Medical Home Pilot

Accountable Care Organizations
Provider organizations accountable for care across continuum

Leadership models to achieve system-wide change are emerging

Changing culture:
- Work units as microsystems
- Balanced priorities
- Modern improvement methods
- Get everyone involved
- Cooperation within and across

Strategic change:
- Breakthrough performance goals
- Portfolios of projects
- Adequate resources
- Oversight and learning

Nolan TW. Execution of Strategic Improvement Initiatives to Produce System-Level Results. Institute for Healthcare Improvement; 2007.
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Per-capita cost = Volume × Price

Inpatient days per patient during the last two years of life in California HRRs (2001-05)

Avoidable Hospital Stays

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Accountable Care Organizations
Provider organizations accountable for care across continuum

Better care, better health, lower costs – for patients and community

Per-capita cost = Volume x (Cost + Margin)

Redesign
Cleveland Clinic
Dartmouth-Hitchcock

Refer Wisely
B-D Pilots
Kaiser-Permanente

What is reasonable?
How would we know?
Accountable Care Organizations
An optimistic scenario

**ACO’s should seek:**
- To improve primary and specialty care through redesign
- To reduce costs by eliminating unneeded services and reducing unit costs
- *To make careful “buy vs build” decisions*
- To be fairly rewarded (and thus open about their margin and how it’s used)

**Referral centers should seek:**
- To manage their own primary care populations as ACOs
- To demonstrate value (and deliver high quality / low cost episodes)
  - *Capture market share for wanted, needed episodes*

**A virtuous cycle?**
- ACOs continually re-engineer their care, referring wisely to others
- *Referral centers specialize appropriately, (fewer centers, higher volumes)*
- Poor quality, high cost providers forced to improve or find new work….
- *Costs stabilize, per-capita costs fall, quality improves*

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**Accountable Care Organizations**
An optimistic scenario

**Is there any evidence?**

**Geisinger Health System**
- Medicare spending fell by 13% relative to US (92-96)
  - *(savings achieved through reduced use of hospital)*
- Teachers given $7,000 raise (over 3 years)
Regional Initiatives
Could contribute to sustainability of reform

“How Will We Do That?”
May 26-27, 2010

Grand Junction, CO  Newark, NJ
Tallahassee, FL  Buffalo, NY
Cedar Rapids, IA  Rochester, NY
Portland, ME  Asheville, NC
Grand Rapids, MI  Bend, OR
Cedar Rapids, IA  Everett, WA
Manchester, NH

Key elements:
Regional platform for stakeholders
Shared aims, accountable to community
External constraint – (Everett, WA)
Use of data to drive change
Physicians as partners in leadership
Reduced use of hospital (Asheville)

Local leadership
Likely to be critical to success

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“There, there it is again—the invisible hand of the marketplace giving us the finger.”
“How Will We Do That?”
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Everett, WA

Key elements:
Regional platform for stakeholders
Shared aims, accountable to community
Constraint – some form of pressure
Use of data to drive change
Reduced use of hospital (Asheville)
Physicians as partners in leadership

“Self-efficacy” If not us, who?

Local leadership
Likely to be critical to success