Redesigning Care for an Accountable World

National Accountable Care Organization Congress
Los Angeles, California

October 31, 2012
DEFINITION OF ACCOUNTABILITY

the quality or state of being accountable; especially: an obligation or willingness to accept responsibility or to account; for one's actions <public officials lacking accountability
The Institute for Healthcare Improvement: The Triple Aim

The Triple Aim™ set forth by the Institute for Healthcare Improvement:

- Optimal care delivery within and across the continuum
- Focused on improving the health of the population and cost of care
- Right care, Right place, Right time

Source: http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm
An Accountable Care Organization ("ACO")

is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of coordinated health care providers form an ACO, which then provides care to a group of patients. The ACO may use a range of payment models (capitation, fee-for-service with asymmetric or symmetric shared savings, etc.). The ACO is accountable to the patients and the third-party payer for the quality, appropriateness, and efficiency of the health care provided. According to the Centers for Medicare and Medicaid Services (CMS), an ACO is "an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it."

“Drivers” of Readmissions and Variation in Care

Care Delivery/Management
- Central line infections
- Limited/no patient education pre-discharge
- Incomplete/ineffective discharge process
- Limited/ineffective communication in patient hand-off to post-acute provider
- Post-discharge follow-up with PCP lags or unscheduled

Patient Characteristics
- Culture, literacy, language barriers
- Socio-economic status
- Co-morbidities
- Number of medications prescribed and adherence
- Access to social support
- Psychological status
Example of Fragmentation in the Continuum of Care

A patient experience in an episode of care could result in many different Care Models (“CM”) with a perspective of their specific care setting (model) serving the patient.

Fragmented Patient Care Can Lead To:
- Poor patient quality outcomes
- Inefficiencies in transition of care
- High-cost
- Poor patient satisfaction
Stratifying Patients: Not as Simple as “Inpatient” and “Outpatient”

Hospice/Palliative Care

Home Care Management
Provides in-home medical and palliative care management by Specialized Physicians, Nurse Care Managers, and Social Workers for chronically frail seniors that have physical, mental, social, and financial limitations that limits access to outpatient care, forcing unnecessary utilization of hospitals.

High-risk Clinics and Care Management
Intensive one-on-one physician/nurse patient care and case management for the highest risk, most complex of the population. As the risk for hospitalization is reduced, patient is transferred to Level 2. Physicians and Care Managers are highly trained and closely integrated into community resources, physician offices, or clinics.

Complex Care and Disease Management
Provides long-term whole person care enhancement for the population using a multidisciplinary team approach. Diabetes, COPD, CHF, CKD, Depression, Dementia.

Self-management, PCP
Provides self-management for people with chronic disease.

Population Monitoring
Preventive care, education, and monitoring for the community.

Level 4
Home Care Management

Level 3
High-risk Clinics

Level 2
Complex Care and Disease Management

Level 1
Self-management and Health Education Programs

Baseline Preventive Care/Wellness programs

New Care Models Needed

High Cost Patient

Low Cost Patient
Care Model Shifts/Tools Required for Redesign

<table>
<thead>
<tr>
<th>Face-to-Face</th>
<th>Remote monitoring, wireless, allied professionals</th>
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</thead>
<tbody>
<tr>
<td>Physician focused</td>
<td>Patient focused</td>
</tr>
<tr>
<td>Do a lot</td>
<td>Do what’s appropriate</td>
</tr>
<tr>
<td>Little patient self responsibility</td>
<td>Increased patient responsibility</td>
</tr>
<tr>
<td>Silos</td>
<td>Consolidation and collaborative</td>
</tr>
<tr>
<td>Physician as provider</td>
<td>Professionals working to the full extent of their license</td>
</tr>
<tr>
<td>Few integrative technology tools</td>
<td>Health Information technology</td>
</tr>
<tr>
<td>Payment: Fee-for-service, case rates, DSH</td>
<td>Case rates, shared risk pools, bundled payments, ACO</td>
</tr>
<tr>
<td>I think you need...</td>
<td>Cost effective care delivery, evidence-based medicine</td>
</tr>
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</table>
## Care Management Capability

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Characteristics</th>
</tr>
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</table>
| **A. Role of Chief Medical Officer** | - CMO leads team in protocol development  
- CMO assists in design of economic incentives to drive physician compliance with protocol development  
- A very good understanding and knowledge base of what is required to successfully integrate and manage care  
- Comfortable with providing feedback and coaching physicians to improve performance |
| **B. Use of hospitalists (SNFists)** | - Hospitalist program is taking care of most of the inpatients  
- Aligned primary care physicians use hospitalists  
- Coordinating communication between case managers, hospitalists, and physicians is the norm  
- Hospitalists review, consult, or approve admissions from the ED |
## Care Management Capability

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| **C. Use of evidence-based guidelines and protocols** | - Use evidence-based protocols within the EMR, aEMR, or CPOE  
- Admitting order sets are used, as well as clinical pathways/protocols  
- Leadership envisions a point-of-care care model/care plan that supports clinical decision-making and assesses/stratifies the patient into the appropriate care management program, but not there yet  
- Have a call center that works well |
| **D. Stratification of patients (e.g., use of disease registries and predictive modeling)** | - Registry tool to identify patients and place in care management programs  
- Expands to other care sites and physicians  
- Predictive analytics identify the complex, high risk patients for care management programs |
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| E. Availability and adoption of clinical decision support | ■ Embedded care plans in the EMR/CPOE  
■ Viewing capability and order sets exist including commenting or data from post-acute or outpatient providers  
■ Care alerts at the point-of-care – physician practices and inpatient care |
| F. Use of data reporting to track and trend performance and type of metrics used | ■ Detailed reporting and quality measurement at entity, group, and individual physician level  
■ Reporting is used to improve physician behavior (consequences exist)  
■ Value-based clinical and payment models (PCMH, BP, P4P, etc.) are underway |
### Care Management Capability

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| **G. Physician and patient engagement** | - There is physician capacity in the system to care for the volume of patients – need to ensure network of physicians is secured prior to start  
- Patient portals through the HIE are being built  
- Benefit plans incentivize patients to use those providers engaged in clinical integration and accountable care |
| **H. Care management capability/ transitions of care** | - Use of value-based care and payment models: disease management and transition follow-up that targets high risk  
- Utilize embedded nurses in some physician practices and/or centralized resource that is accessible and utilized by physician members |
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| I. Care management along the continuum of care                            | - Focus on complex, at-risk populations, with defined programs to reduce risk of hospitalization or readmission  
- There has been a system-wide commitment to care management; programs exist in the hospital, medical home, emergency room, behavioral health, home care, hospice, ambulatory, and post-acute care  
- System-wide Care Management Oversight Committee reviews the work across the programs; establishes mechanisms for accountability through metric setting, reporting structure changes, and the strategic alignment of the programs |
ACOs and Care Models

- ACOs – clinical integration around a product
- PCMH – primary care medical home
- Bundled Payments
- Hospitalists
- Transitional Care
- SNFist
- Extender Models
- Population Models
Clinical Integration – Aligning to Achieve the “Triple Aim”

- Patients
- Payers
- Hospitals
- Physicians
- Post-acute and Other Community Providers

Reduce Costs
- Care Management

Enhance Health
- Health Information Technology

Aligned Incentives

New Care Delivery Models

Improve Experience of Care
The Triple Aim™ set forth by the Institute for Healthcare Improvement:

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Source: [http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm](http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm)
## Opportunities for Improving Healthcare Costs

<table>
<thead>
<tr>
<th>Cost Opportunity</th>
<th>Savings Impact</th>
<th>Ability to Influence</th>
<th>Timeline to Realize Change</th>
</tr>
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<tbody>
<tr>
<td>Reducing readmissions</td>
<td>High</td>
<td>High</td>
<td>Short</td>
</tr>
<tr>
<td>Decreasing ambulatory sensitive conditions</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Lowering length-of-stay (per diem)</td>
<td>High</td>
<td>High</td>
<td>Short</td>
</tr>
<tr>
<td>Variation in clinical practice</td>
<td>High</td>
<td>Medium</td>
<td>Long</td>
</tr>
<tr>
<td>Decreasing emergency department utilization</td>
<td>Medium</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Increasing generic drug use</td>
<td>Medium</td>
<td>Medium</td>
<td>Short</td>
</tr>
<tr>
<td>Lowering length-of-stay (prospective payment)</td>
<td>Low</td>
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## Historic Payment Models to Providers: Physicians

<table>
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<tr>
<th>How to Pay Physicians</th>
<th>PCP</th>
<th>Specialists</th>
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<td>FFS</td>
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<tr>
<th>Incentivized Behavior</th>
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<td>Keeps patient; doing more increases revenue</td>
<td>Keeps patient; continue to do more. No control of costs</td>
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<tr>
<th>Overall Effect</th>
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<td>Overall utilization and cost increases. PCPs and specialists both increase utilization; costs go up accordingly. Requires timely data and information for PCPs and specialists if utilized in models.</td>
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<th>Utilization/ Cost</th>
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<td></td>
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<td>Overall cost and specialist utilization increases. Nothing to change specialists’ behavior, resulting in increased utilization and cost.</td>
<td></td>
<td></td>
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<td><strong>Overall Effect</strong></td>
<td>PCP has ability to increase revenue with appropriate care; Specialists keep what is appropriate for them to treat. Specialty costs decrease – one of the larger drivers of healthcare cost. Potentially most cost effective, but limits PCP choice of specialist.</td>
<td></td>
</tr>
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<td><strong>Utilization/ Cost</strong></td>
<td>↑/↑</td>
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<td>Overall Effect</td>
<td>Overall utilization and cost decreases; patient satisfaction could be lower, since there is incentive to send patient back and forth between providers and potentially withhold care.</td>
<td></td>
</tr>
<tr>
<td>Utilization/Cost</td>
<td>↓↓/↓↓</td>
<td>↓↓/↓↓</td>
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Potential Payment Models to Providers: Hospitals and Other Facilities

- How hospitals and other care continuum components are paid from the shared risk pool have a direct impact upon physician behavior. Community specialists, hospitalists, and intensivists have the largest influence on the care of patients at the hospital or other facilities. Their stake of the remaining dollars in the risk pool can compel behavior change.
## Potential Payment Models to Providers: Hospitals and Other Facilities

<table>
<thead>
<tr>
<th>How to Pay Hospital and Other Facilities</th>
<th>Case Rate</th>
<th>Per Diem</th>
<th>CAP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialists (including Hospitalists, Intensivists)</strong></td>
<td>Reduce number of patients they send to hospital</td>
<td>Reduce number of patients they send to hospital and the number of days the patients stay there</td>
<td>No change in admission/discharge/resource consumption behavior</td>
</tr>
<tr>
<td><strong>Utilization/Cost</strong></td>
<td>Admissions decrease</td>
<td>ALOS and Admissions Decrease</td>
<td>No Change (likely increased utilization and cost)</td>
</tr>
<tr>
<td><strong>Conclusion</strong></td>
<td>Physician has incentive to reduce the number of admissions to the hospital/other provider to increase the likelihood that there will be dollars remaining in the pool to share</td>
<td>Physician has incentive to manage resource consumption to increase the likelihood that there will be dollars remaining in the pool to share</td>
<td>Physician has no incentive to manage resource consumption because nothing will impact the PMPM payment to hospital/other provider</td>
</tr>
</tbody>
</table>
Volume-driven to Value-driven Payment Transition

Source: Center for Healthcare Quality and Payment Reform
Key Elements for Accountability

- Financial success will require a new focus: reducing over-utilization of services and reducing variability in the cost of providing care.

- Robust IT infrastructure that supports real time reporting, point-of-care support, care coordination, population management.

- A compensation structure that appropriately incentivizes quality and cost effectiveness.

- Ability to aggregate clinical and financial data from all components of the care continuum, including community physicians, hospitals, skilled nursing facilities, home health, pharmacies, etc.

- Access to capital to create and support the necessary Clinical Integration ("CI") infrastructure.

- Need financial infrastructure to receive and distribute payments.
Value-based Reporting Requirements

- Critical to have ability to aggregate data from internal/external sources
  - Need active reporting vs. historic reporting
- Need standardized, flexible metrics that incorporate both outcomes and process
  - Population reports that show utilization, costs, and quality metrics
  - Hospital-based reports that communicate inpatient cost/resource utilization vs. benchmarks/targets
  - Physician group-based reports that track quality metrics, outcomes, and referral patterns
- Ensure any measures related to cost containment are linked to measures that ensure quality not compromised
Critical Success Factors – Becoming “Integrated”

- Access and allocation of capital
- Establish the vision
- Create the structure
- Develop the leadership structure and talent
- Articulate and build the culture
- Align performance measures and incentives
- Develop the resources and tools