ACOs: LEARNING FROM EXPERIENCE ARE THEY MORE THAN A GUESS?

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Outline

- From unicorns to “multicorns”
- Key issues
- Early lessons
- Emerging evidence
- Some suggestions for spread

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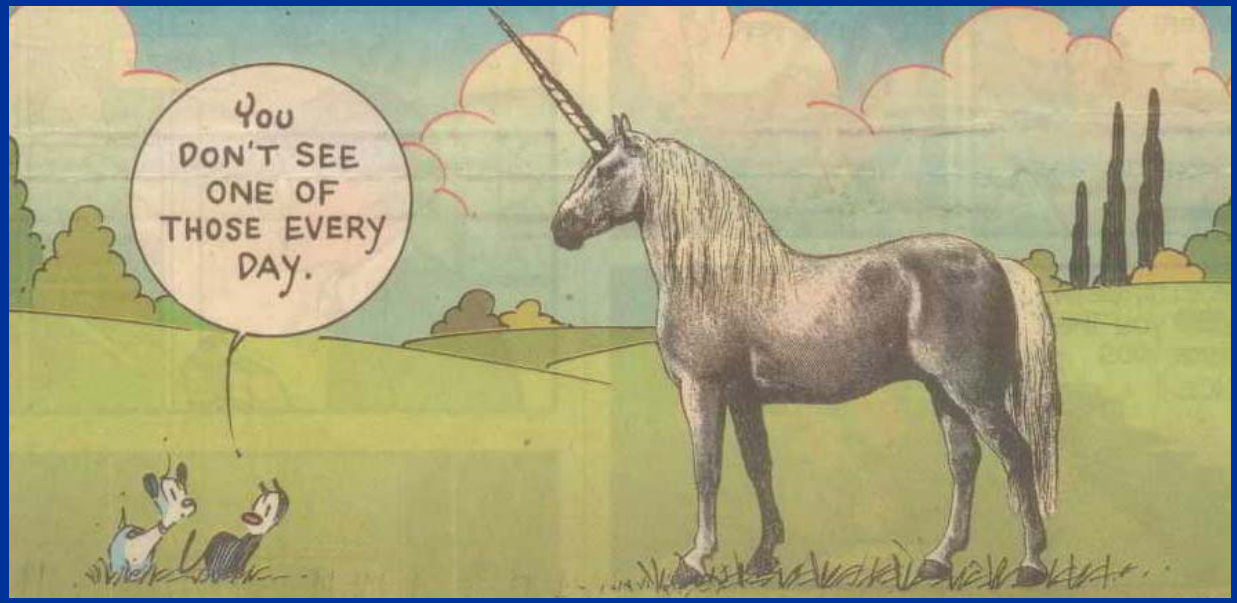
We have gone from…



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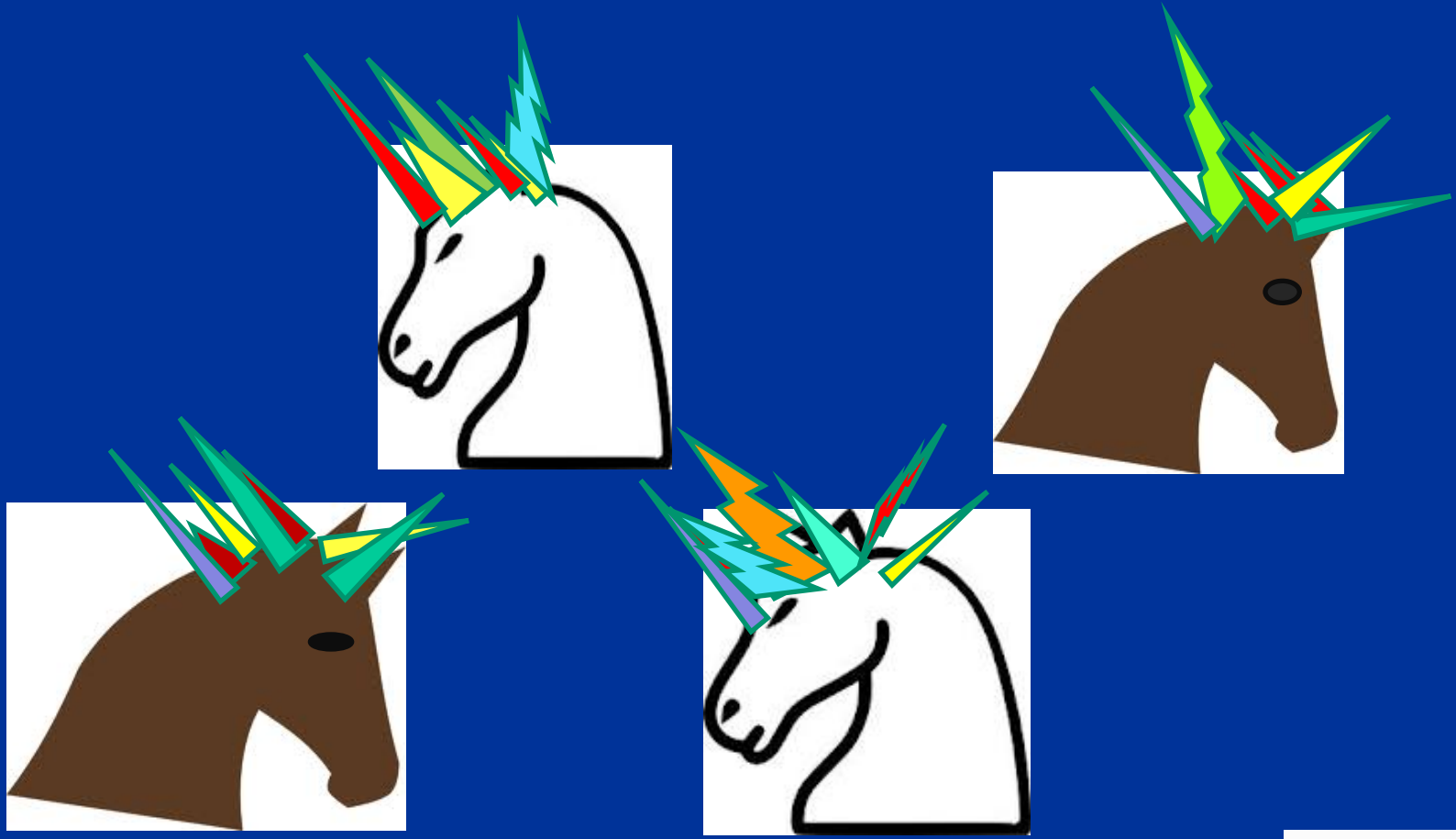
They are almost everywhere

A family of “multicorns”



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Problem:

We have a pervasive, long-standing "chronic illness": fragmented care

Solution:

Create systems of integrated care

Problem:

“But I make my money from fragmented care.”

Solution:

Not any more!

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Some Key Issues

- Enrollment size matters – achieve sufficient savings to spread overhead and related costs
- Care management is key:
  - 5/50 stratification
  - Multiple chronic illness, frail elderly, dual eligibles, mental illness

Some Key Issues (cont'd)

- Building new relationships
  - Business model changes most for hospitals
  - Integrating different professional/social identities
  - Collaborative governance
- New tools required:
  - Information exchange across the continuum
  - Predictive risk modeling

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Some Key Issues (cont'd)

- Patient activation and engagement
- Agreeing on a common set of cost and quality measures and thresholds, across payer contracts

What is Needed?

A New Care Management Platform

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New Care Management Platform

- Reduce office visits
- Expand between-visit at-home care management
- Improve “hand-offs”
- Smoother “glide paths” to health recovery
- **Technology enabled within a foundation of continuous improvement.**

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Some Required Changes

- Inpatient Care Workflow and Redesign
- Care Transition Management
  - e.g. Coleman Care Transition Model
- Physician Referral Patterns
- Interoperable EHRs
- From Inpatient Margin to Total Care Margin

Early Lessons from Brookings-Dartmouth ACO Pilot Studies

Source: “Advancing Accountable Care: Insights from the Brookings-Dartmouth ACO Pilot Sites,” under review, *Health Affairs*, 2012

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Common Challenges:

- Developing the care management capabilities across the entire continuum
- Building trusting relationships with physicians, payers and other partners
- Navigating the legal and contractual relationships

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Common Elements Across All Four Sites:

- Electronic health record functionality
  - Disease registries
  - Data warehouses
  - Predictive modeling to identify high-risk patients
- High-risk patient complex care management programs
- Physician champions
- Mature quality improvement – Six Sigma, LEAN

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Facilitators of ACO Formation and System Transformation

Factor	Role and Importance
Facilitators of ACO Formation	
Facilitators of Executive Leadership and Strong Governance	Supports development of shared aims, prioritizes resources and removes obstacles to allow for transformational change
Strong Payer-Provider Relationship	Facilitates trust and recognition of shared aims to overcome challenges in developing the ACO infrastructure
Experience with Performance-Based Payment	Develops capability to bear risk, aligns financial incentives and drives performance

Source: “Advancing Accountable Health Care: Insights from the Brookings-Dartmouth ACO Pilot Sites,” August 2012

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Facilitators of ACO Formation and System Transformation (cont'd)

Factor	Role and Importance
Facilitators of System Transformation	
Robust Health Information Technology Infrastructure	Supports data collection and reporting to identify waste, coordinate care, improve performance, and measure outcomes
Strong Care Management Capabilities	Provides tools and infrastructure to manage population health and improve care coordination
Performance Measurement and Transparency	Improves population health, supports care coordination, eliminates waste, and ensures accountability
Effective Physician Engagement	Perpetuates awareness and support throughout the system and develops physician champions for the model

Source: "Advancing Accountable Health Care: Insights from the Brookings-Dartmouth ACO Pilot Sites," August 2012

ACO Governance: Some Early Findings

- Governance structures reflect the history of integration: the longer the history, the more formal the governance structure
- Patients/consumer groups are largely not represented. Their role is not clear.
- Number of accountability relationships is increasing

Source: R. Addicott and S.M. Shortell, "Collaborative Governance Through Accountable Care Organizations: Recommendations for Policy and Practice." UC Berkeley School of Public Health, October, 2012

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ACO Governance: Some Early Findings (cont'd)

- Primary mechanism of accountability was pay-for-performance, usually tied to savings
- Primary individual physician performance accountability:
  - Out-of-network referrals
  - Patient satisfaction

Source: R. Addicott and S.M. Shortell, "Collaborative Governance Through Accountable Care Organizations: Recommendations for Policy and Practice." UC Berkeley School of Public Health, October, 2012

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Early ACO Governance Findings (cont'd)

- General consensus on performance criteria ***but*** much contention around setting thresholds

- Sanctions/consequences:
  - Informal peer influence
  - Transparent credible data
  - Predictive risk modeling for each physician's group of patients
  - "Coaching"
  - Last resort -- removal from network

Early ACO Governance Key Lessons

- Shared goals and incentives
  - Directly linked to performance criteria and individual physician objectives
  - Based on value rather than volume
  - More difficult for hospitals who are not exclusive to specific ACO
- Governance model should reflect function
  - Long history – more formal and integrated
  - Shorter history – more reliance placed on managerial interaction
  - Need to first establish a culture of trust and supportive decision-making processes
  - Need structures that accommodate flexibility

Early ACO Governance Key Lessons (cont'd)

- Align measures and thresholds across payers
  - Reduce the complexity and costs involved
- Credibility and transparency of data
  - Risk-modeling tools for presenting comparative data help
  - Promote physician sense of interdependency for achieving ACO goals

Source: R. Addicott and S.M. Shortell, "Collaborative Governance Through Accountable Care Organizations: Recommendations for Policy and Practice." UC Berkeley School of Public Health, October, 2012

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Importance of Managing Social Identities

- Balance organizational identity/socialization with professional identity/socialization
- Use ACOs as a framework or mechanism or vehicle for promoting more integrated coordinated care

See: S.A. Kreindler, B.K. Larson, F.M. Wu, J. K.L. Carluzzo, A.D. Van Citters, S.M. Shortell, E.C. Nelson, and E.S. Fischer. “Interpretations of Integration in Early Accountable Care Organizations,” Milbank Quarterly, Vol, 90, No. 3, 2102, pp. 457-483.

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ACO's Are in the Eye of the Beholder

- **An IDA:** it's about better coordinated care, not integration
- **A medical group**: it's about integration for employed physicians, but not affiliates
- **A hospital system**: it's about developing an equal partnership between physicians and the hospital
- **An integrated delivery system**: it's about a cultural change, not a structural change

See: S.A. Kreindler, B.K. Larson, F.M. Wu, J. K.L. Carluzzo, A.D. Van Citters, S.M. Shortell, E.C. Nelson, and E.S. Fischer. "Interpretations of Integration in Early Accountable Care Organizations," Milbank Quarterly, Vol, 90, No. 3, 2102, pp. 457-483.

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Are ACOs More Than a Guess?

Some emerging evidence

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Medicare Physician Group Practice Demonstration

- Annual savings per beneficiary/year were modest overall
- But significant for dual eligible population – over $500 per beneficiary, per year
- Improvement on nearly all of 32 quality of care measures

Source: CH Colla, DE Wennberg, E. Meara, et al. “Spending Differences Associated with the Medicare Physician Group Practice Demonstration.” JAMA, September 12, 2012, 308 (10) 1015-23.

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Preliminary Results of Massachusetts Alternative Quality Contract (AQC)

- 2.8% lower costs ($90 per member, per year)
- Savings much larger among groups with no prior experience with risk sharing
- Savings largely from reduced spending for procedures, imaging, and lab tests
- Greatest savings come from patients with highest health risks
- 10 of 11 participating physician groups spent below their targets, earning a budget surplus payment. All earned a quality bonus.

Source: Karen Davis, Commonwealth Fund, July 21, 2012

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Comparison of Accountable Physician Practices Versus Other Practices

	Crude measures			Adjusted measures	
Quality Measures	**U.S**	**CAPP**	**Non-CAPP**	**Relative risk ratio**	**Relative risk ratio**
Mammography in women ages 65-69	50.4%	57.9%	53.1%	1.11	1.12
Completion of all three diabetic tests	53.9%	63.4%	57.1%	1.12	1.15
ACS admission rate; rate per 100	8.3	6.9	8.4	0.82	0.92
Cost Measures	**U.S**	**CAPP**	**Non-CAPP**	**Relative risk ratio**	**CAPP-non-CAPP difference**
Standardized MD in 2005	$2,881	$2,764	$3,003	-$239	-$176
Standardized hospital spending in 2005	$2,405	$2,193	$2,428	-$235	-$103
Total standardized CMS payments in 2005	$7,406	$7,053	$7,593	-$540	-$272

Source: Weeks WB, Gottlieb DJ, Nyweide, DJ, et al. "Higher Health Care Quality and Bigger Savings Found at Large Multispecialty Medical Groups," Health Affairs. May 10, 2010, 29(5): 991-997

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Early Evidence from Primary Care Medical Home Interventions

Group Health Cooperative of Puget Sound (Seattle, Washington)

- 29 percent reduction in ER visits; 11% reduction ambulatory sensitive admissions

Health Partners (Minnesota)

- 39% decrease ED visits; 24% decrease hospital admissions

Geisinger Health System (Pennsylvania)

- 18 percent reduction in all-cause hospital admissions; 36% lower readmissions
- 7 percent total medical cost savings

Source: Karen Davis, Commonwealth Fund, July 21, 2012

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Early Evidence from Primary Care Medical Home Interventions (cont'd)

Mass General High-Cost Medicare Chronic Care Demo (Massachusetts)

- 20 percent lower hospital admissions; 25% lower ED uses
- Mortality decline: 16 percent compared to 20% in control group
- 4.7% net savings annual

Intermountain Healthcare (Utah)

- Lower mortality; 5% relative reduction in hospitalization
- *Highest $ savings for high-risk patients*

Source: Karen Davis, Commonwealth Fund, July 21, 2012

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Sacramento Blue Shield: Dignity-Hill-Calpers Experience

- 42,000 Calpers Members
- Set target premium first – no increase in 2010– and then worked backward to achieve it
- Saved $20 million -- $5 million more than target, while meeting quality metrics
- Package of interventions:

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Sacramento Blue Shield: Dignity-Hill-Calpers Experience (cont'd)

- Package of interventions:
  - Integrated discharge planning
  - Care transitions and patient engagement
  - Created a health information exchange
  - Found that top 5,000 members accounted for 75% of spending
  - Evidence-based variance reduction
  - Visible dashboard of measures to track progress

Some Ideas to Promote "Spread"

- "Twinning" – organizational mentoring
- "Collaboratories" emphasizing customized technical assistance
- Aligning Forces for Quality (AF4Q) – 16 communities - measurement, QI processes, consumer engagement, public reporting, "community checkup report"
- In-person meetings and team travels

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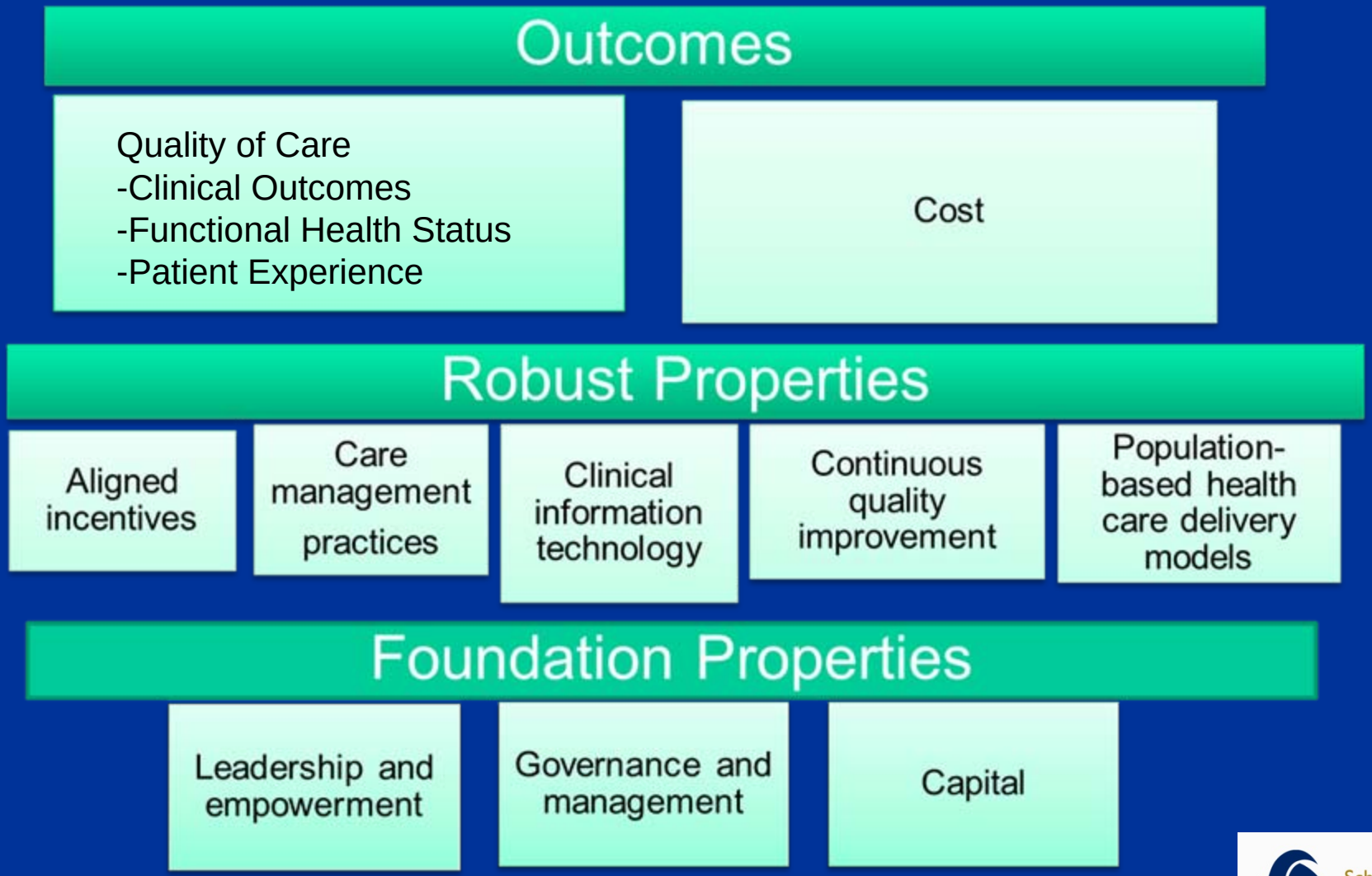
Some Ideas to Promote "Spread" (cont'd)

- HHS Chartered Value Exchange Program
- ONCHIT – Beacon Community Program
- Clinical coaches (Rosenberg) – translate organizational goals to changes in individual physician behavior
  - Face-to-face and phone interaction with physicians
  - 25 MD's per MD coach
  - Targeted to helping individual physicians achieve quality and cost metrics

Some Ideas to Promote "Spread" (cont'd)

- University of Best Practices – California's Right Care Initiative
  - San Diego and Sacramento
  - Reduce deaths from heart attacks and stroke by better management of blood sugar, blood pressure, and lipids

Building Blocks for Success



Source: Shortell S.M., et al. Achieving the Vision: Structural Change, in *Partners in Health* 2010,

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Thank You

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