



Third Annual National ACO Summit

June 6–8, 2012

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The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute

Introducing unicorns...

**There was green alligators and long-necked geese
Some humpty backed camels and some chimpanzees
Noah cried, "Close the door because the rain is falling
And we just can't wait for no unicorns"**

-- the Irish Rovers

Lessons Learned from Private Sector ACO's

Lee B. Sacks, M.D.
CEO Advocate Physician Partners
EVP Chief Medical Officer Advocate Health Care

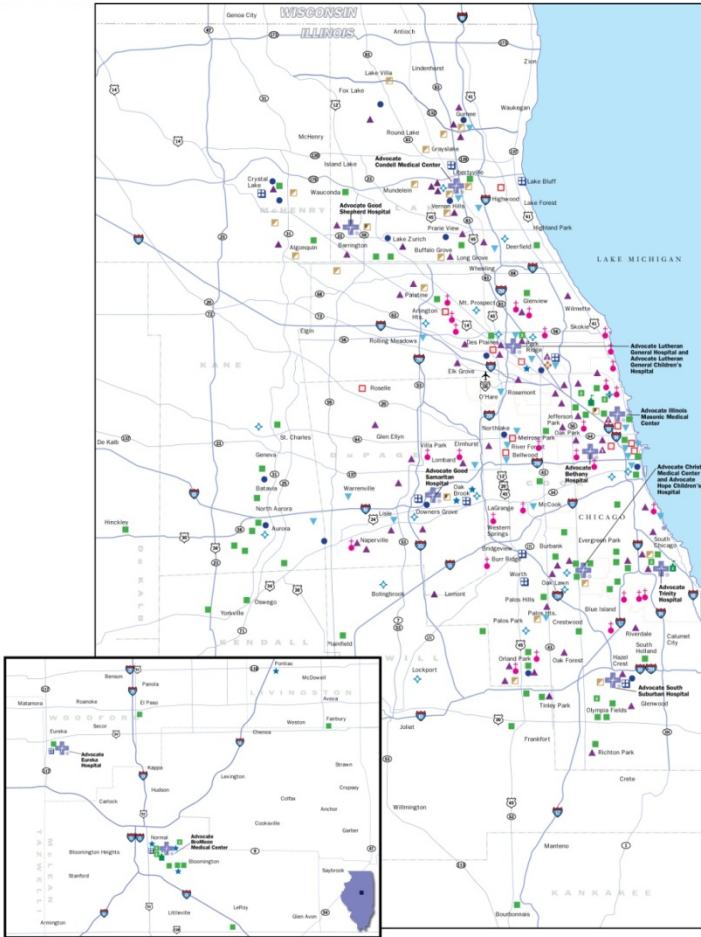
3rd National ACO Summit
Washington, D.C.
June 8, 2012



Agenda

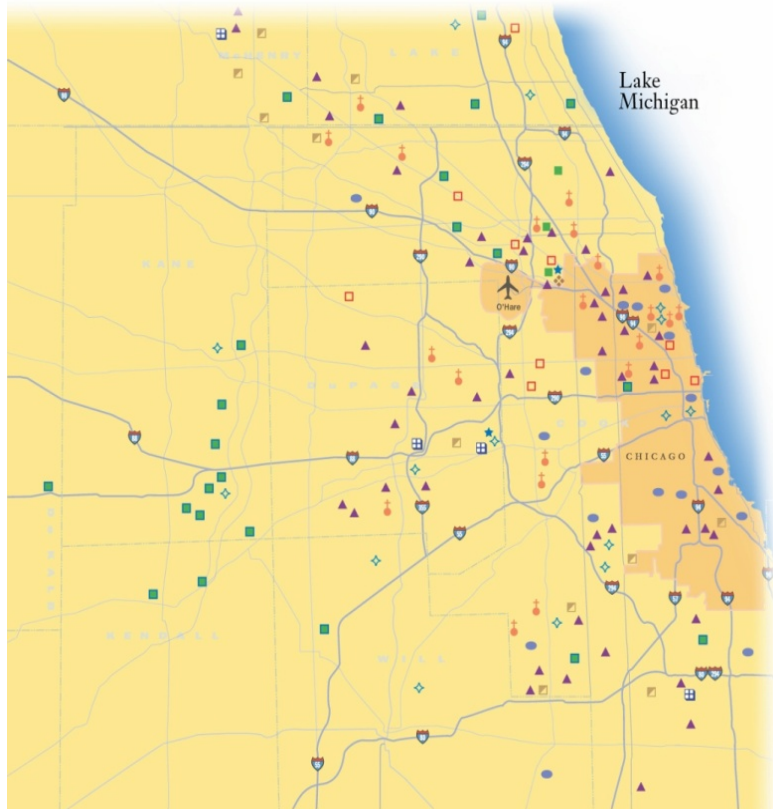
- Overview of Advocate Physician Partners
- Core Competencies that Facilitated Success
- Biggest Challenges Moving Forward
- What Would We Have Done Differently?
- Ideal ACO Partnership
- Payer Role in Supporting an ACO
- Key Differences from Medicare ACO

Advocate Health Care



- \$4.7 Billion Annual Revenue
- AA Rated
- 12 Acute Care Hospitals
 - 2 Children's Hospitals
 - 5 Level 1 Trauma Centers
 - 4 Major Teaching Hospitals
 - 4 Magnet Designations
- Over 250 Sites of Care
 - Advocate Medical Group
 - Dreyer Medical Clinic
 - Occupational Health
 - Imaging Centers
 - Immediate Care Centers
 - Surgery Centers
 - Home Health / Hospice

Advocate Physician Partners



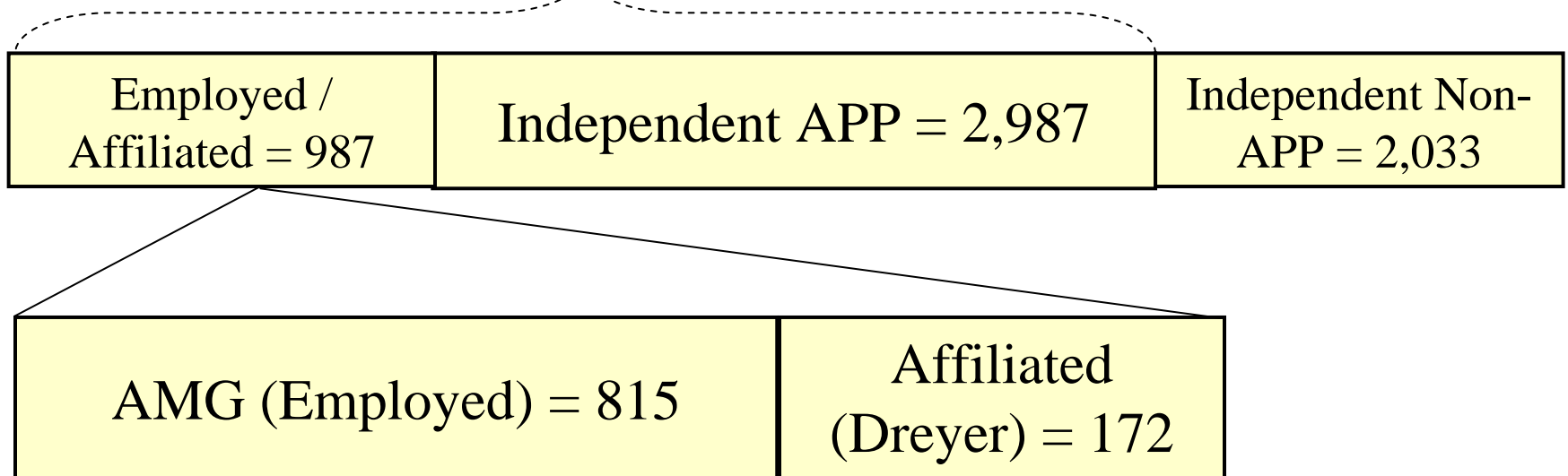
Advocate Physician Partners delivers services throughout Chicagoland and Downstate Illinois.

- Physician Membership
 - 1,085 Primary Care Physicians
 - 2,889 Specialist Physicians
 - Total Membership Includes 987 Advocate-Employed Physicians
- 10 Acute Care Hospitals and 2 Children's Hospitals
- Central Verification Office Certified by NCQA
- 230,000 Capitated Lives/700,000 PPO Lives
- 245,000 "Attributable" Lives

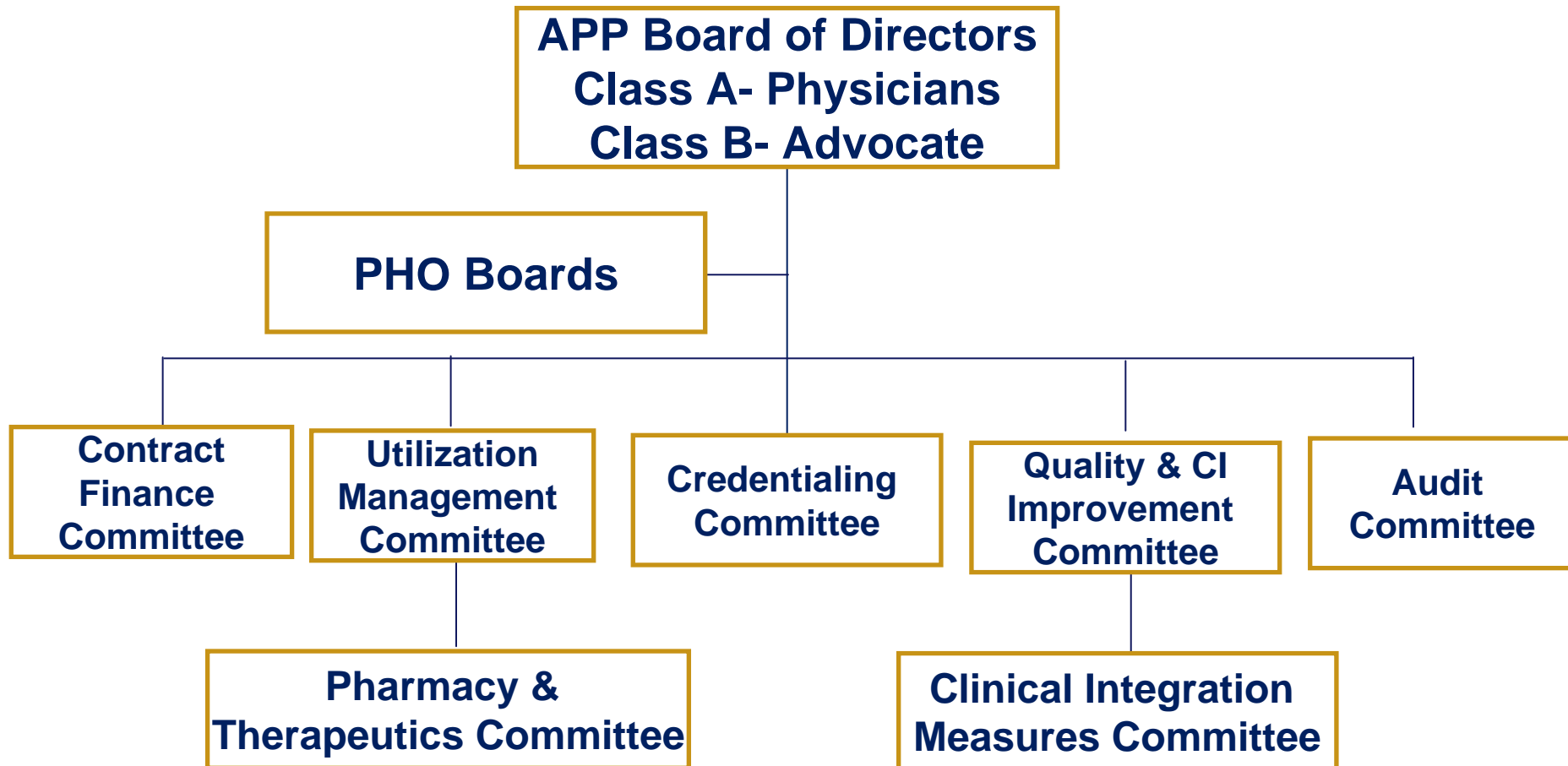
Advocate's Physician Platform

Total Physicians on Medical Staffs = 6,007

Total APP Physicians = 3,974



More Than 100 Physicians Involved in APP Governance



Value Based Volumes From 30-65%

Contract	Lives	Total Spend
Blue Cross	325,000	\$2.0 B
Medicare Advantage	32,000	\$0.3 B
Advocate Employee	21,000	\$0.1 B
Medicare ACO	150,000	\$2.0 B
Total	528,000	\$4.4 B

Blue Cross PPO Results Thru Q3

Utilization Metrics(PPO)		Advocate Attributed	Non-Advocate Attributed
Inpatient	Admit Rate/1000	(11.3%)	(8.0%)
	Length Of Stay	(1.2%)	(0.7%)
	Days/1000	(12.6%)	(8.6%)
	Readmit Rate	4.3%	(4.7%)
Outpatient	OP Surgery/1000	(9.4%)	(8.9%)
	OP Other/1000	1.0%	(0.2%)
	Advance Imaging	(6.0%)	(5.7%)
Professional	Office E&M/1000	(7.0%)	(5.6%)
RX	Scripts/1000	(0.9%)	(3.2%)

Core Competencies that Facilitated Success

- Culture that evolved over decades
- Clinical Integration Program
- Disease Registries
- History of Managing Capitation
- Over 100 physicians engaged in governance
- Local Physician Hospital Organizations

Biggest Challenges Moving Forward

- Redesigning Primary Care-Advanced Medical Practice
- IT Connectivity
- In Network Care Coordination
- Discipline to create a standard approach
- Management / Governance Succession Planning
- Patient Experience

What Would We Have Done Differently?

- More lead time to build infrastructure
- Even more communication on what's changing
- Fund infrastructure out of prior year incentives
- Share in first dollar savings

Ideal ACO Partnership

- C Suite Leadership Engaged
- Transparency
- Regular, frequent meetings at various levels
- Full Data set exchange
- Multi Year Commitment
- Financial arrangement has to be win-win
- Grows market share

Payer role in supporting an ACO

- Aligning incentives
- Sharing data
- Benefit Plan Design
- Communicating value to employers
- Not replicating functions best done by provider system
- Timely Reporting

Key Differences from Medicare ACO

- Utilizes existing governance structure
- Specialty Physicians are not exclusive
- Regular meetings between leaders, and at operations level
- 11 page Letter of Agreement vs. 600 plus pages of rules
- Patients cannot opt out of data sharing



THE THIRD
NATIONAL

Accountable Care Organization Summit

THE LEADING FORUM ON ACCOUNTABLE CARE ORGANIZATIONS
AND RELATED DELIVERY SYSTEM AND PAYMENT REFORM

Track 5: Accountable Care in the Private Sector

Panel 1: Lessons Learned from Private Sector ACOs

George Isham, MD, MS, Chief Health Officer and Plan Medical
Director, HealthPartners

Charles D. Kennedy, MD, MBA, Chief Executive Officer, Accountable
Care Solutions, Aetna

Kristen Miranda, Vice President, Provider Network Management, Blue
Shield of California

Lee B. Sacks, MD, Executive Vice President and Chief Medical Officer,
Advocate Health Care; Chief Executive Officer, Advocate Physician Partners

S. Lawrence Kocot, JD, LLM, MPA, Deputy Director, Engelberg Center for
Health Care Reform, The Brookings Institution; Senior Counsel, SNR Denton
(Moderator)



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ACOs: Delivering on the Promise

3rd Annual Accountable Care Organization Summit

Presented by Joyce Dubow
June 8, 2012



Take-away thoughts

- **To create a person-centered health care system, we must reform service delivery**
- **Emerging models of care have the potential to respond to the health care and related challenges people face**
- **ACOs can deliver on the promise of the 3 aims by transforming their cultures and engaging patients “where they are at”**

ACO: a generic definition

A group of clinicians/institutions who accept responsibility and are held accountable for the quality and cost of care a population of individuals receives

Juliet:

**"What's in a name? That which we call a rose
By any other name would smell as sweet."**



“Patient-centered” defined

- **IOM- “Focus on patient’s experience of illness and health care and on the systems that work or fail to work to meet individual patient’s needs ... Encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient.” (IOM, *Crossing the Quality Chasm*)**
- **“They give me exactly the help I need and want exactly when and how I need and want it” D. Berwick,**

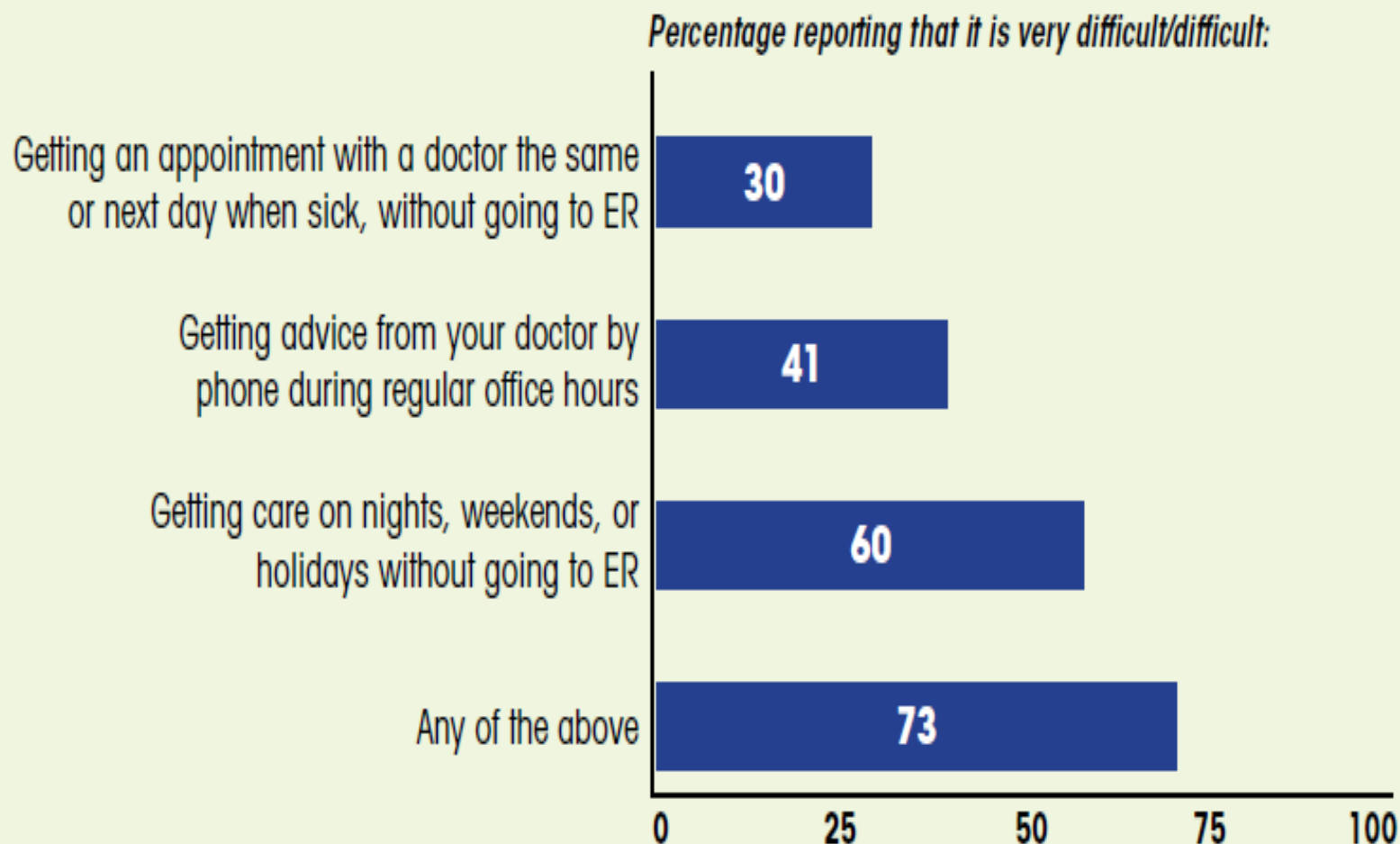
Patient-centered

National Strategy for Quality Improvement in Health Care

- **Health care that gives each individual and family an active role in their care;**
- **Care that adapts readily to individual circumstances as well as differing cultures, languages, disabilities, health literacy levels, and social backgrounds;**
- **Sees a person as a multi-faceted**
- **Requires a partnership between the provider and the patient with shared power and responsibility**
- **Giving the patient access to understandable information and decision support tools**
- **Determining whether patients achieve their desired outcomes.**

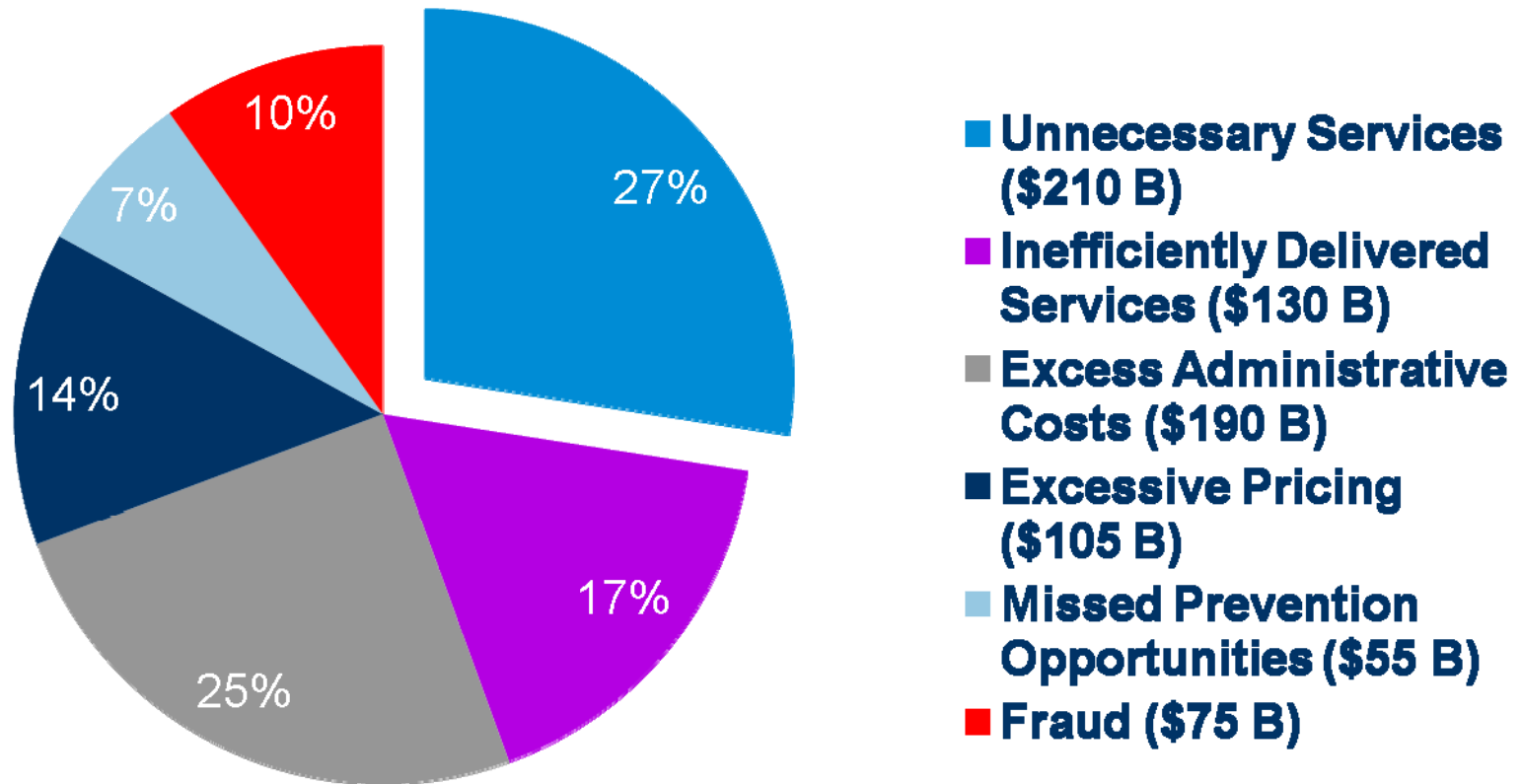
Access

Access Problems: Three of Four Adults Have Difficulty Getting Timely Access to Their Doctor



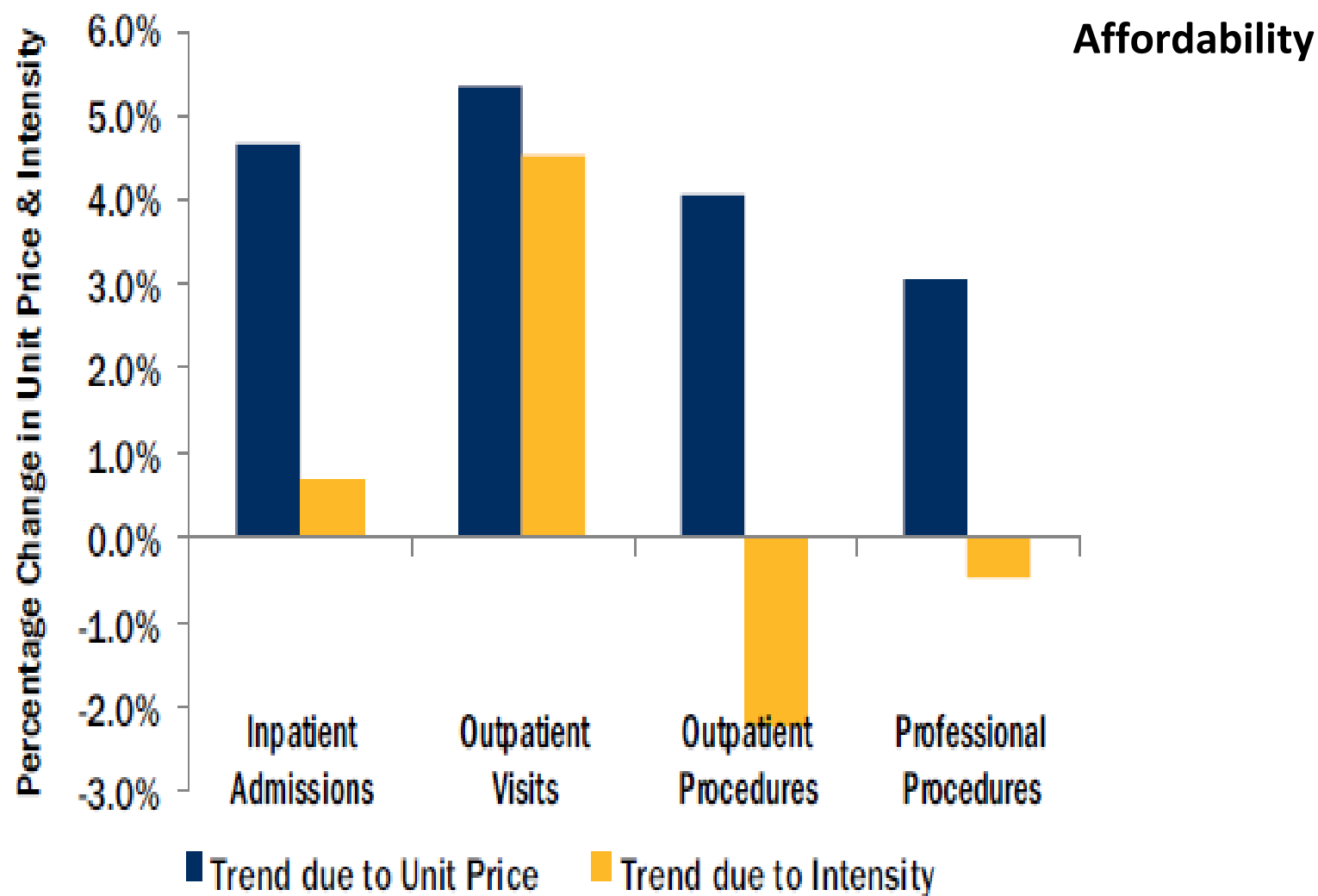
Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

Excess Cost Domain Estimates



Total = \$765 billion

Components of Price per Service Trend: 2009–2010

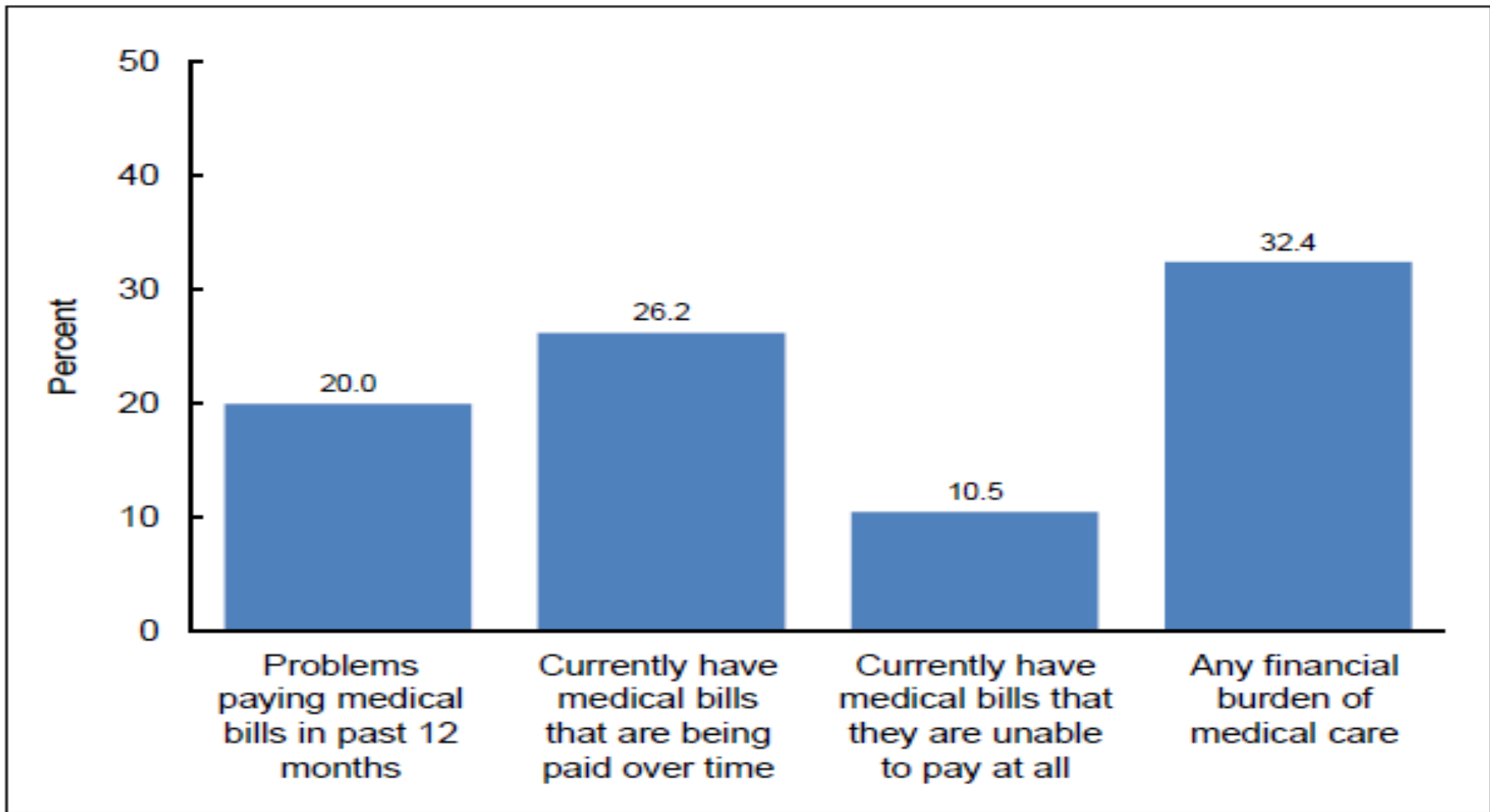


Source: Health Care Cost Institute, May 2012

One in three persons was in a family experiencing financial burden of medical care.

Affordability

Percentages of persons in families with selected financial burdens of medical care: United States, January–June 2011



SOURCE: CDC/NCHS, National Health Interview Survey, Family Core and Supplemental components, 2011.

Consequences of unaffordable care

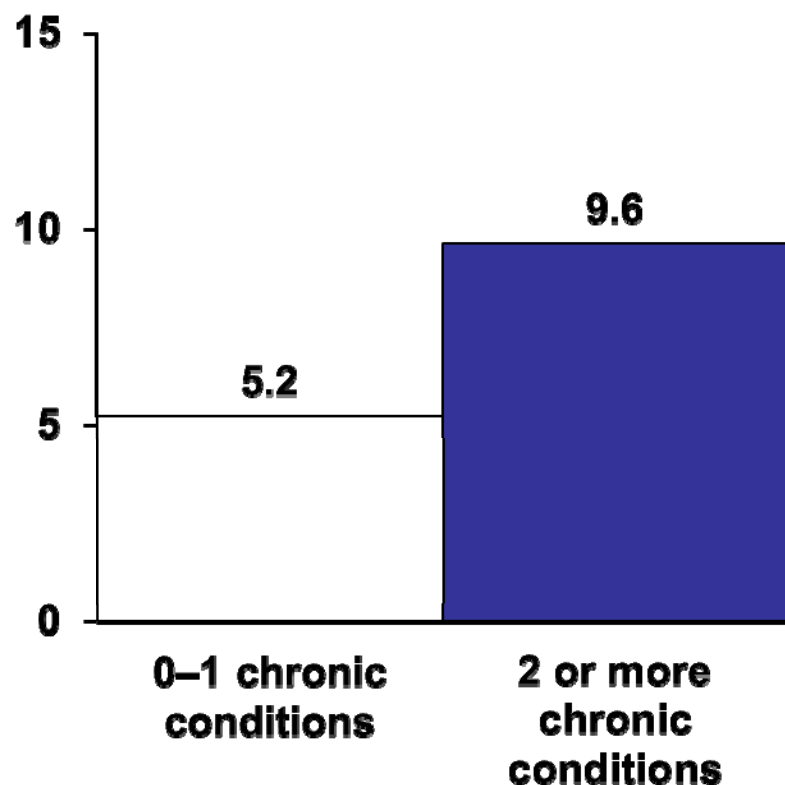
- **57% considered their budget before making health-related decisions**
- **31% attempted to be frugal by skipping or reducing annual physician visits**
- **32% passed up or cut back on follow-up appointments**
- **Almost 27% went without or decreased visits to specialists**
- **Almost 21% refrained from lab visits because of cost**
- **19 % went without an imaging test**

More chronic illness underscores need for coordination

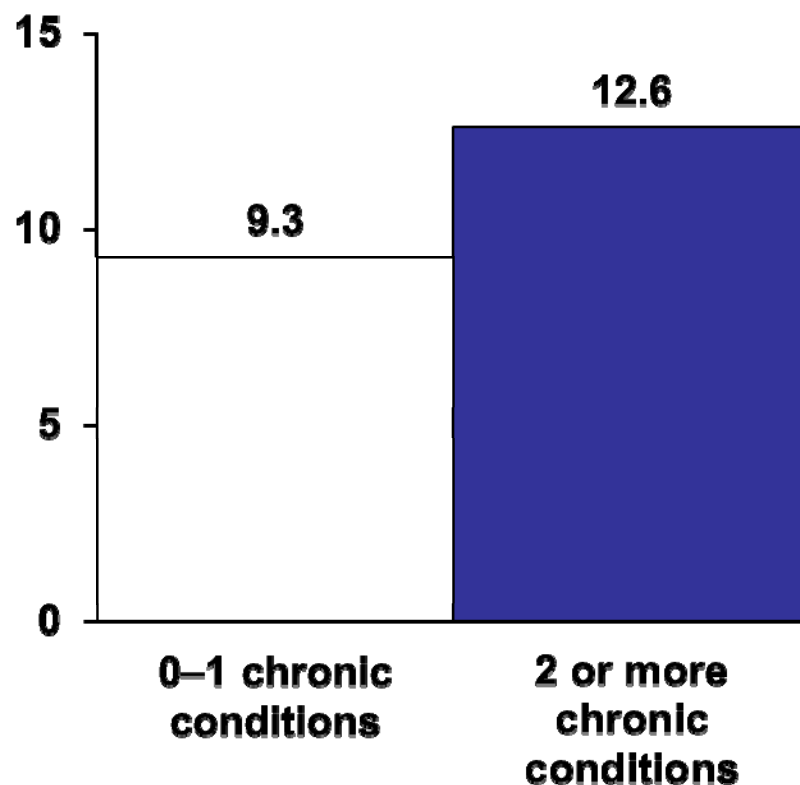
- **Nearly half of all Americans live with 1 chronic condition**
- **One in 4 patients with a chronic condition will see at least 3 physicians**
- **The typical primary care physician coordinates care with 229 other physicians in 117 different practices.**
- **People with chronic conditions are at high risk of poor care coordination, leading to test duplications, medical errors, and adverse health outcomes**

Patients with Multiple Chronic Conditions More Likely to Undergo Adverse Drug Event or Medical Error

Percent reporting wrong medicine or wrong dose



Percent reporting a medical mistake

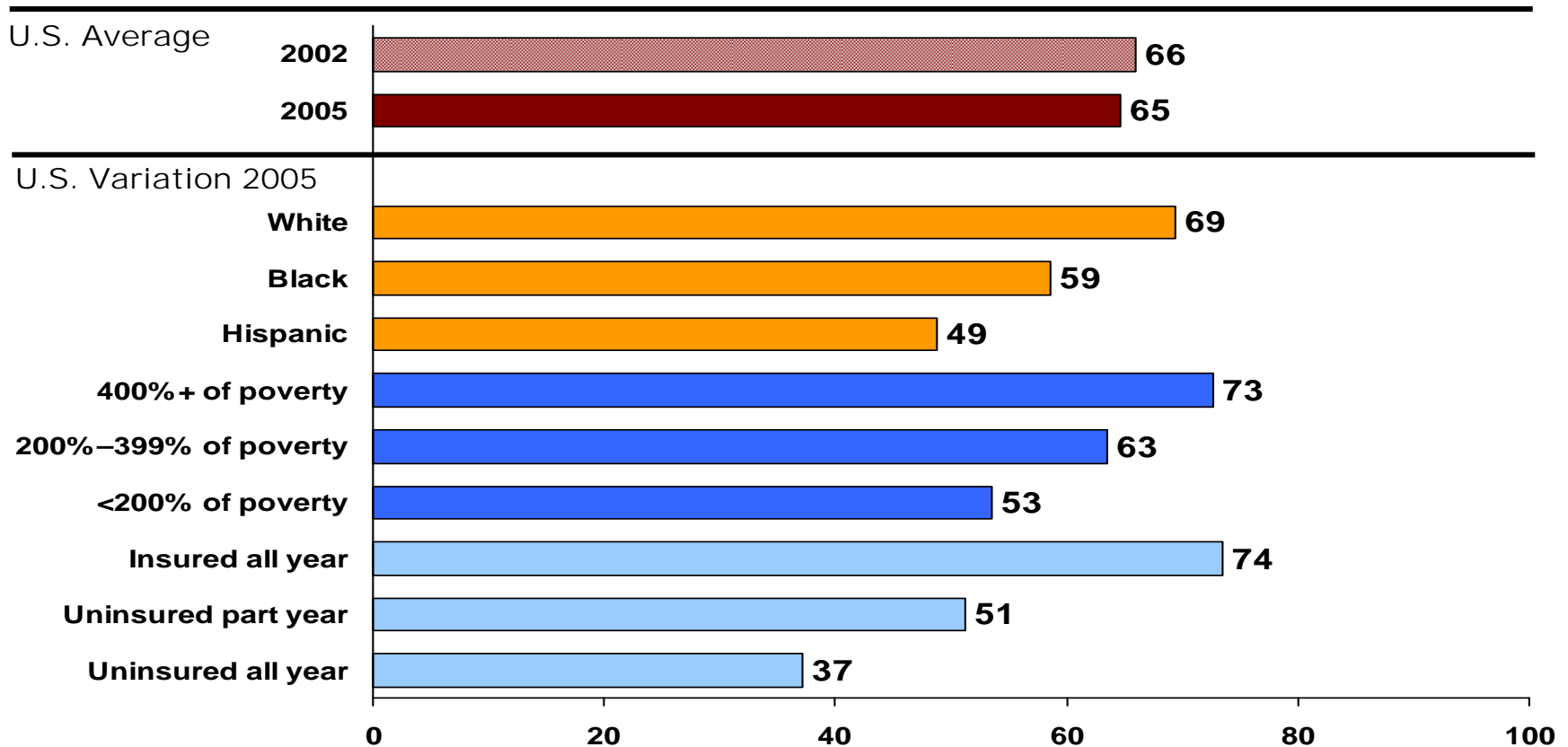


Note: U.S. patients only.

Source: 2011 Commonwealth Fund International Health Policy Survey.

Only 65 Percent of Adults Report Having an Accessible Personal Clinician

Percent of adults ages 19–64 with an accessible primary care provider*



* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, referrals, and who is easy to get to.

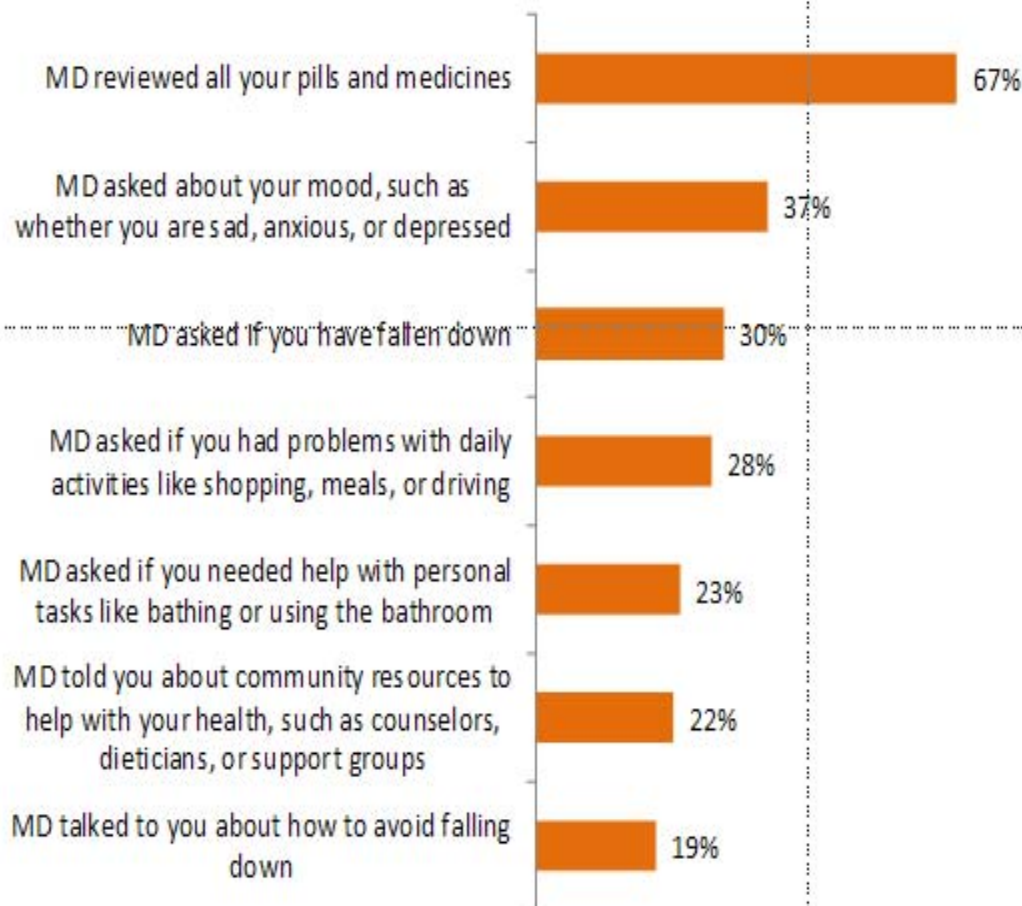
Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

Source: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008).

Many Have Not Received Key Services

Older adults, 65+

Percent saying "yes" has happened in past 12 months



7% have received all of these services.

52% have received none or only one of these services.

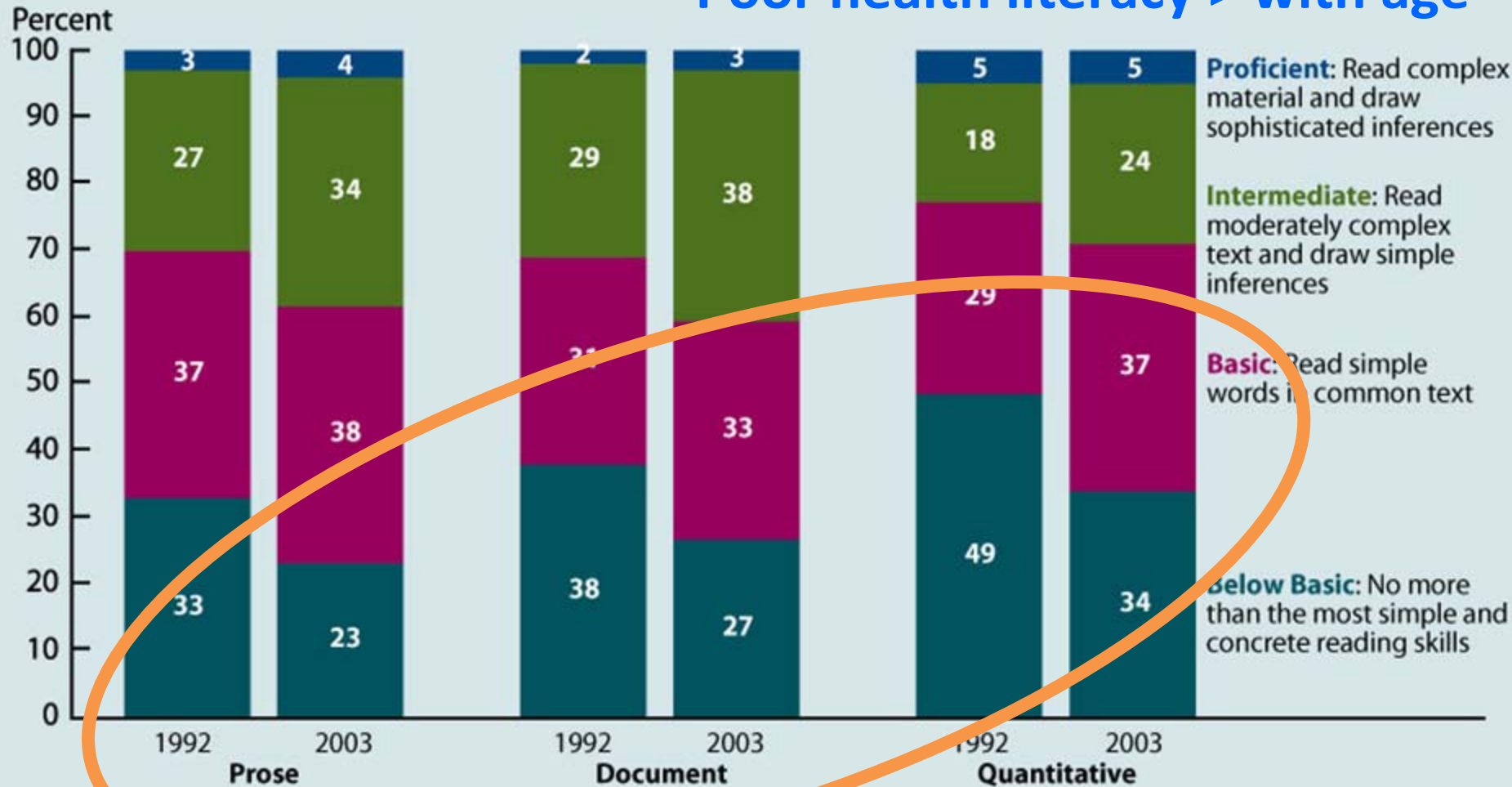
76% have received less than half of the seven key services.

Many lack skills to navigate health care

- Literacy, health literacy, numeracy
- Problem solving and making tradeoffs (conflicting goals and bringing together multiple factors)
 - Humans process only 5-6 variables
 - with $>$ variables, likelihood of conflicting information forcing tradeoffs among personal preferences
- Confidence/self-efficacy (ability to deal with health problems)

Percentage of people age 65 and over in each literacy performance level, by literacy component, 1992 and 2003

Poor health literacy > with age



Note: Literacy is measured using three different components: prose literacy is the ability to search, comprehend, and use information from continuous texts (e.g., reading a newspaper); document literacy is the ability to search, comprehend, and use information from noncontinuous text (e.g., bus schedules); and quantitative literacy is the ability to identify and perform computations using numbers embedded in printed materials (e.g., calculating numbers in tax forms).

Reference population: These data refer to people residing in households or prisons.

Source: U.S. Department of Education, National Center for Education Statistics, National Assessment of Adult Literacy.

Patient engagement

Center for Advancing Health- “actions individuals must take to obtain the greatest benefit from the health care services available to them” (Jessie Gruman, et al., 2010)

Judy Hibbard, University of Oregon- Consumers taking on new roles and behaviors, such as choosing high performing providers; selecting evidence-based treatments; collaborating with their providers; taking preventive actions; self-management; being vigilant to prevent errors

Patient Engagement- ACA

(as required by section 1899(b)(2)(F) of the ACA.)

ACO functions that would demonstrate patient engagement including:

- **Patient involvement in governance**
- **Use of a patient experience survey**
- **Process for evaluating and addressing needs of population served**
- **Systems to identify high-risk individuals**
- **Mechanisms in place to coordinate care via enabling technologies**
- **Written standards for beneficiary access and communication**
- **Process to allow for shared decision making**
- **Communicating clinical knowledge in a way that is understandable to patients**

Engaging patients: making ACOs work for patients

- **Inclusion of patients on policy bodies**
- **Openness to practice transformation—“patient care oriented to needs of patient, as defined by the patient” (Edgman-Levitan)**
- **Willingness to share information within *and* outside of the ACO**
- **Commitment to:**
 - **population health without compromising personalized care**
 - **accept responsibility to steward resources ACO and participating providers direct and manage**
 - **improve patient outcomes by creating an environment of trust and respect for patients**

Making ACOs work for patients

- Willingness to participate in partnerships with patients
 - readiness to integrate their preferences and circumstances; (*not* “what is the matter with you, but rather, “**what matters to you?**”
- Commitment to ongoing quality improvement
 - use of evidence-based interventions
 - collection of performance information in areas that matter to patients
- Use information to:
 - measure performance
 - improve care
 - publicly report results
 - support patient decisions
 - detect disparities

Consumer-focused measurement: measures that matter to patients

- **Outcomes (over time)**: function, symptom relief, quality of life, complications
- **Episodes**- follow pts over time and setting
 - Current measures are setting and condition-specific—not responsive to chronic care and encourage fragmentation
- **Patient experience**- honoring preferences especially important for people with complex conditions or who are very sick
- Patient-centered care plans/support for self-management
- **Physician-level performance** (who is the best doctor to do “x”; how good is my doctor?)
- **Cost to me**
- **Resource use/efficiency**

Barriers to consumer engagement

- **Current system is clinician-focused**
- **The public does not believe there are quality problems**
- **Many see choice as a proxy for quality**
- **Many believe more is better**
- **Information gaps**
 - **performance information often not available, or when it is, understandable—people in dark about levels of performance which leads to belief that the information is not important**
 - **difficult for many people to process and use the information due to its complexity and heavy cognitive burden**

Bridging the barriers

- **Leadership**
- **Knowledge**
- **Motivation**
- **Self-efficacy for patients**
- **Environmental supports and reinforcements**

Where we need to go



Current system

- (Too) often, unsafe
- Fragmented, uncoordinated, unnecessary care
- Provider-focused
- Timely, rushed
- Inefficient, wasteful
- Disparate (geography, gender, age, race, ethnicity)
- Costly, >unaffordable

IOM Aims for improvement

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable



The
Triple Aim™

OPTIMIZING HEALTH, CARE EXPERIENCE, AND COSTS FOR POPULATIONS

Improve
individual
experience

The best
care

Improve
population
health

For the
whole
population

At the
lowest cost

Control
inflation of
per capita
costs

D. Berwick: 3 maxims to achieve patient centeredness

- 1. The needs of the patient come first**
- 2. “Nothing about me without me”**
- 3. “Every patient is the only patient”**

D. Berwick, “What ‘Patient-Centered’ Should Mean: Confessions of an Extremist”, *Health Affairs*, Web Exclusive , w555-w565



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Track 5: Accountable Care in the Private Sector

Panel 2: Patient Participation in ACOs

Joyce Dubow, PhD, Senior Health Care Reform Director, Office of Policy and Strategy, AARP

Michael J. Barry, MD, President, Informed Medical Decisions Foundation, Clinical Professor of Medicine, Harvard Medical School

Stuart Levine, MD, MHA, Medical Innovations Consulting

Michael L. Millenson, President, Health Quality Advisors LLC

Mark McClellan, MD, PhD, Director, Engelberg Center for Health Care Reform, The Brookings Institution (Moderator)



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