Accountable Care and ACOs

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"It is not the strongest of the species that survives, nor the most intelligent, *but the one most responsive to change*."

Charles Darwin

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The Reality:

The healthcare world is changing in ways that many of us have never seen in our lifetime, with the possible exception of Medicare.

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Drivers of Accountable Care

- Providers, not insurers, who are best placed to make the changes
- Cost and quality problems resulting from the U.S.'s current system of fragmented care
- Variation in practice patterns
- Volume-based payment systems
- Current lack of Integration
- Policymakers understand that the resources that flow from the decisions physicians make with patients account for a major portion of overall health care costs regardless of where that care takes place

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Principles of Accountable Care

- An ACO is a **local health care organization and a related set of providers** (at a minimum, primary care physicians, specialists, and hospitals) **that can be held accountable** for the cost and quality of care delivered to a defined population
- The goal of the ACO is to deliver **coordinated** and **efficient** care. ACOs that achieve **quality** and **cost** targets will receive some sort of **financial** bonus
- Care for patients across the **continuum of care**, in different institutional settings
- Support **comprehensive, valid and reliable measurement** of its performance

Clinical Performance Measurement is Fundamental

- Clinical performance measures are derived from evidence-based practice guidelines
- They can be used for quality improvement, public reporting, accountability or pay for performance.
- Reporting allows for group, regional and national comparison data
- In most cases, optimal performance is not known because we have not been measuring

Measuring and Improving Quality

- Map processes to eliminate waste and remove delays.
- Identify a set of balanced measures.
  - Build performance measurement into your processes.
  - Choose the appropriate statistics to plot.
  - Use sampling when needed to conserve resources.
  - Plot data in time order every month.
  - Develop excellent visual displays.
  - Monitor measurement results.
- Use small-scale, rapid PDSA cycles to continuously improve .

Have fun! Quality is a journey, not a destination

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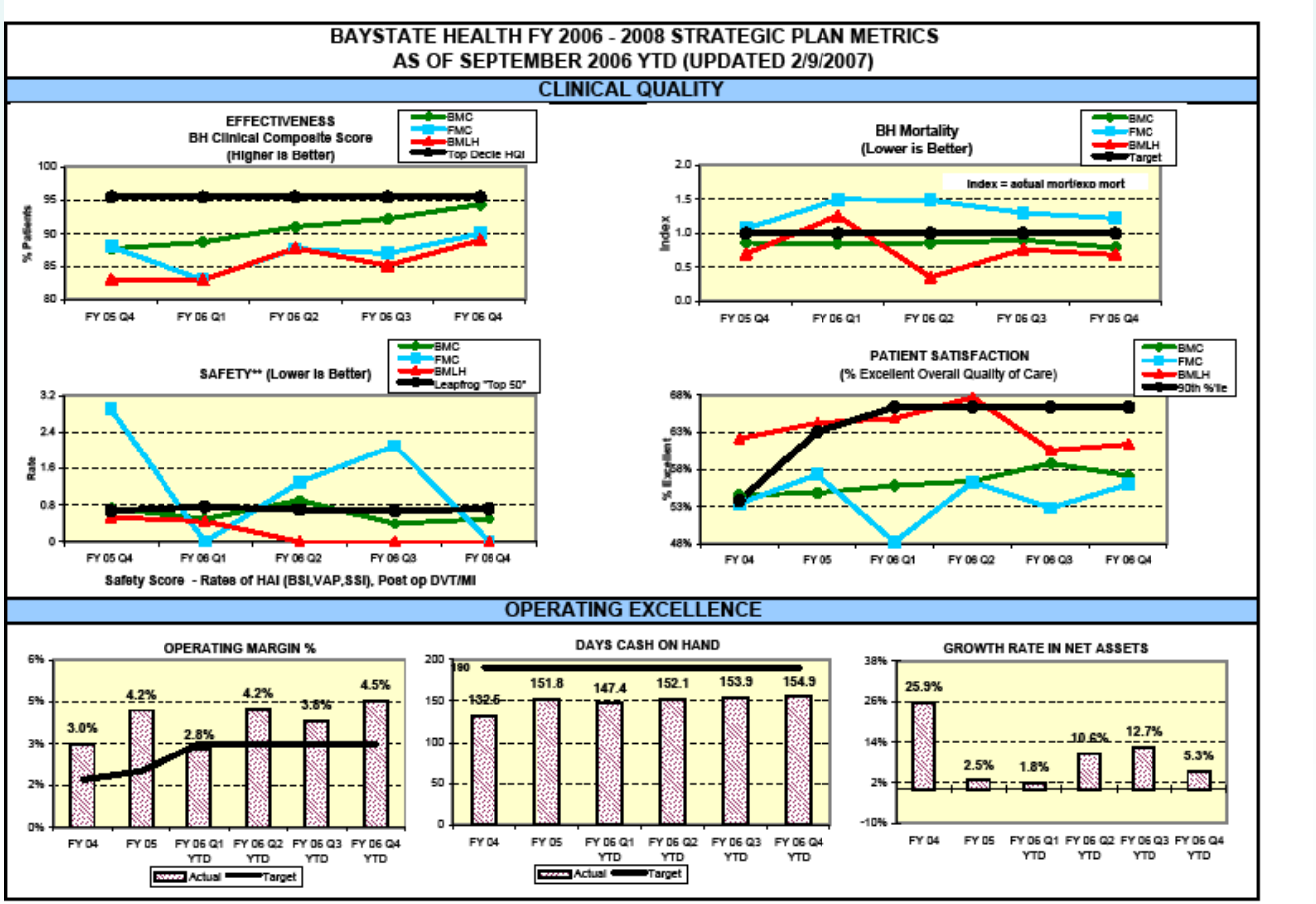
Example: Dashboard



Copy of MasterDASHBOARD-Baystate.xls; BH
5/15/2008

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Conclusion: You Can't Manage what You Can't Measure

- Measurement is the foundation for improvement
- Make measurement and data collection as efficient as possible
- Monitor results using a dashboard that all can see
- Report results and look for best practices

What If ??????

- The healthcare provider had updated information on recent patient/provider encounters
- The healthcare provider had the most recent (even hours old) imaging studies
- The healthcare provider had the most recent lab data
- The healthcare provider actually had accurate medication lists
- The healthcare provider knew who was responsible for coordinating the patient's care
- The healthcare provider could manage and coordinate a patient's care without face to face contact
- Technology was utilized to capacity
- The healthcare provider actually knew which specialists were most effective and efficient

The “Medical Village”

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Principles of The Patient Centered Medical Home

- Personal Physician trained to provide continuous, comprehensive care
- Physician-Directed Medical Practice
- Whole Person Orientation
- Coordinated Care
- Quality and Safety
- Enhanced Access to Care
- Payment appropriately recognizes added value provided to the overall system

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A Medical Home for All

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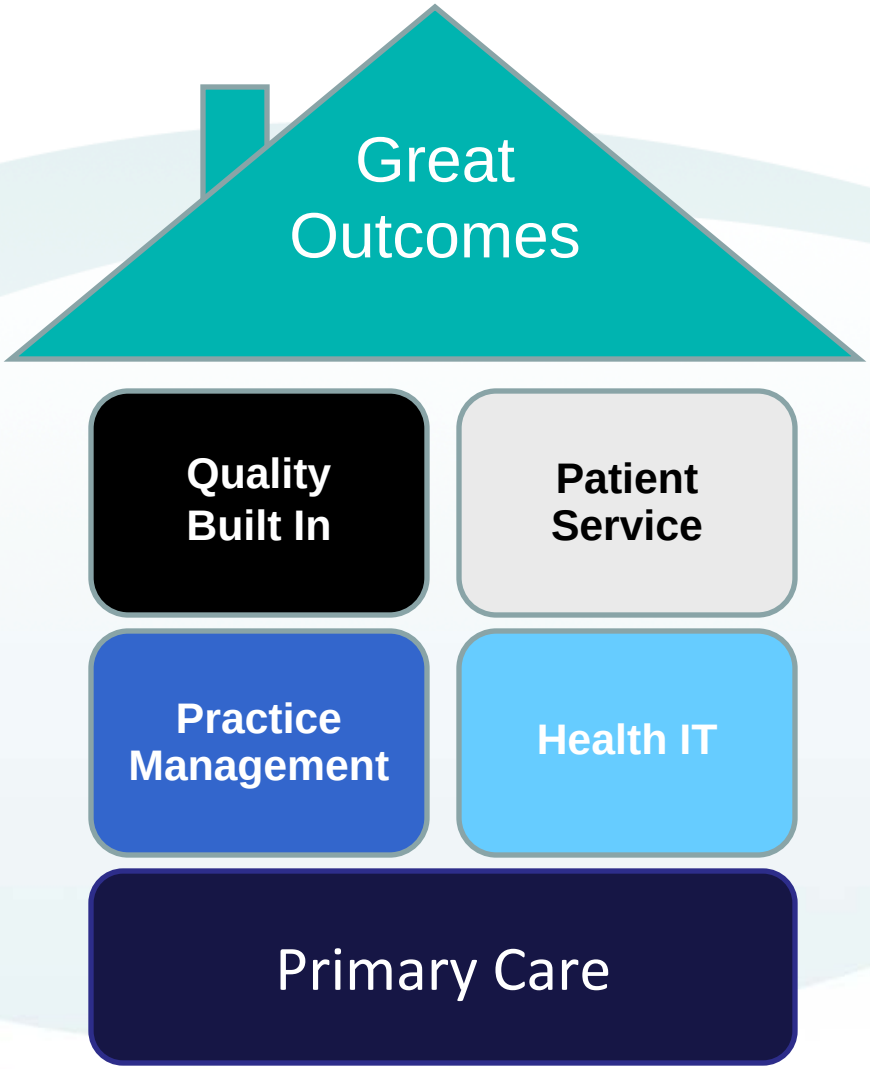

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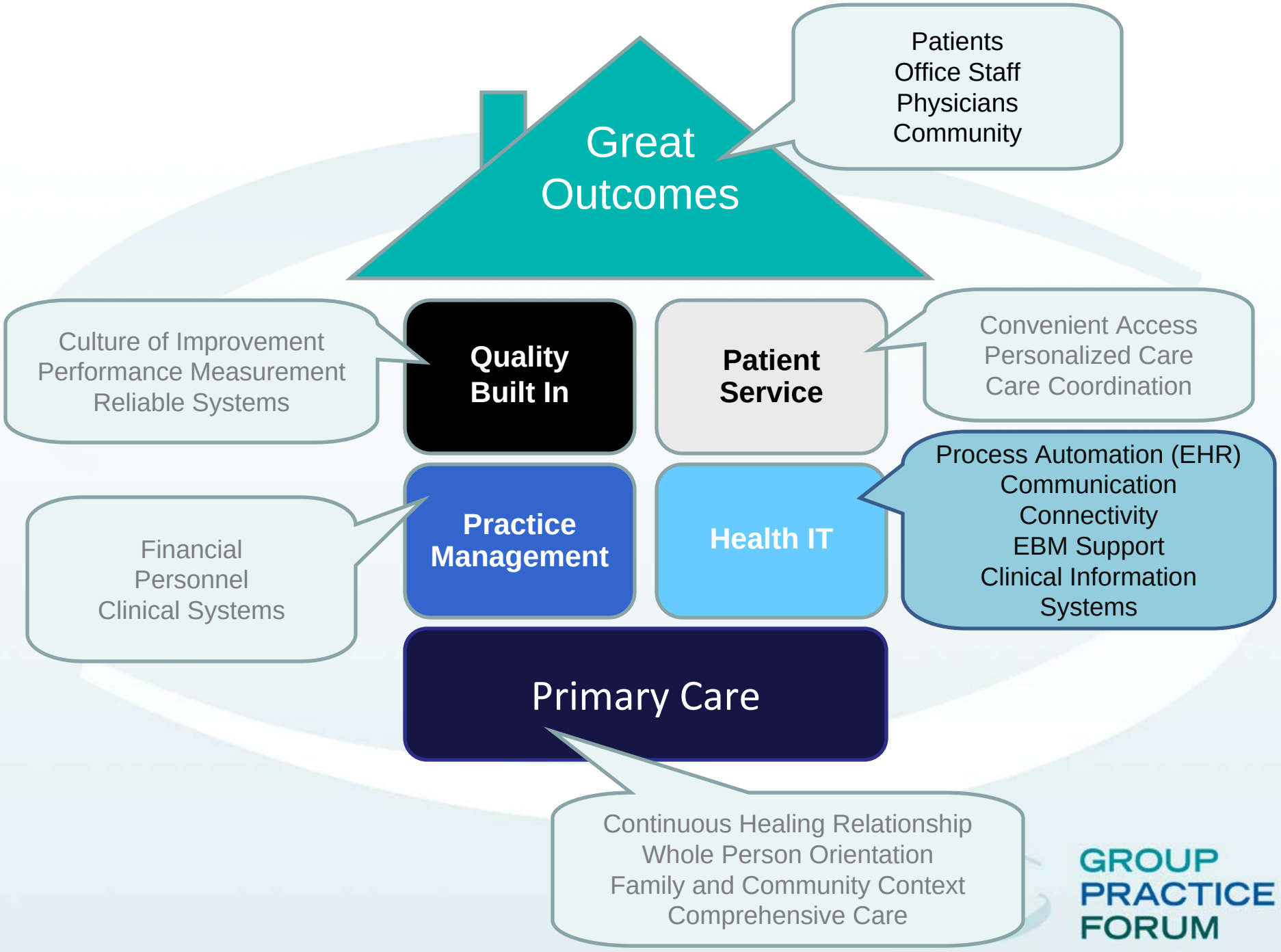
Great Outcomes
Patients
Office Staff
Physicians
Community
Culture of Improvement
Performance Measurement
Reliable Systems
Quality Built In
Patient Service
Convenient Access
Personalized Care
Care Coordination
Financial
Personnel
Clinical Systems
Practice Management
Health IT
Process Automation (EHR)
Communication
Connectivity
EBM Support
Clinical Information Systems
Primary Care
Continuous Healing Relationship
Whole Person Orientation
Family and Community Context
Comprehensive Care
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Principles of The Patient Centered Medical Home/Accountable Care/Clinical Integration

- Personal Physician trained to provide **continuous, comprehensive** care
- **Physician-Directed** Medical Practice
- **Whole Person** Orientation
- **Coordinated Care**
- **Quality and Safety**
- Enhanced **Access** to Care
- **Payment** appropriately recognizes added **value** provided to the overall system

"Better patient care for the best price"

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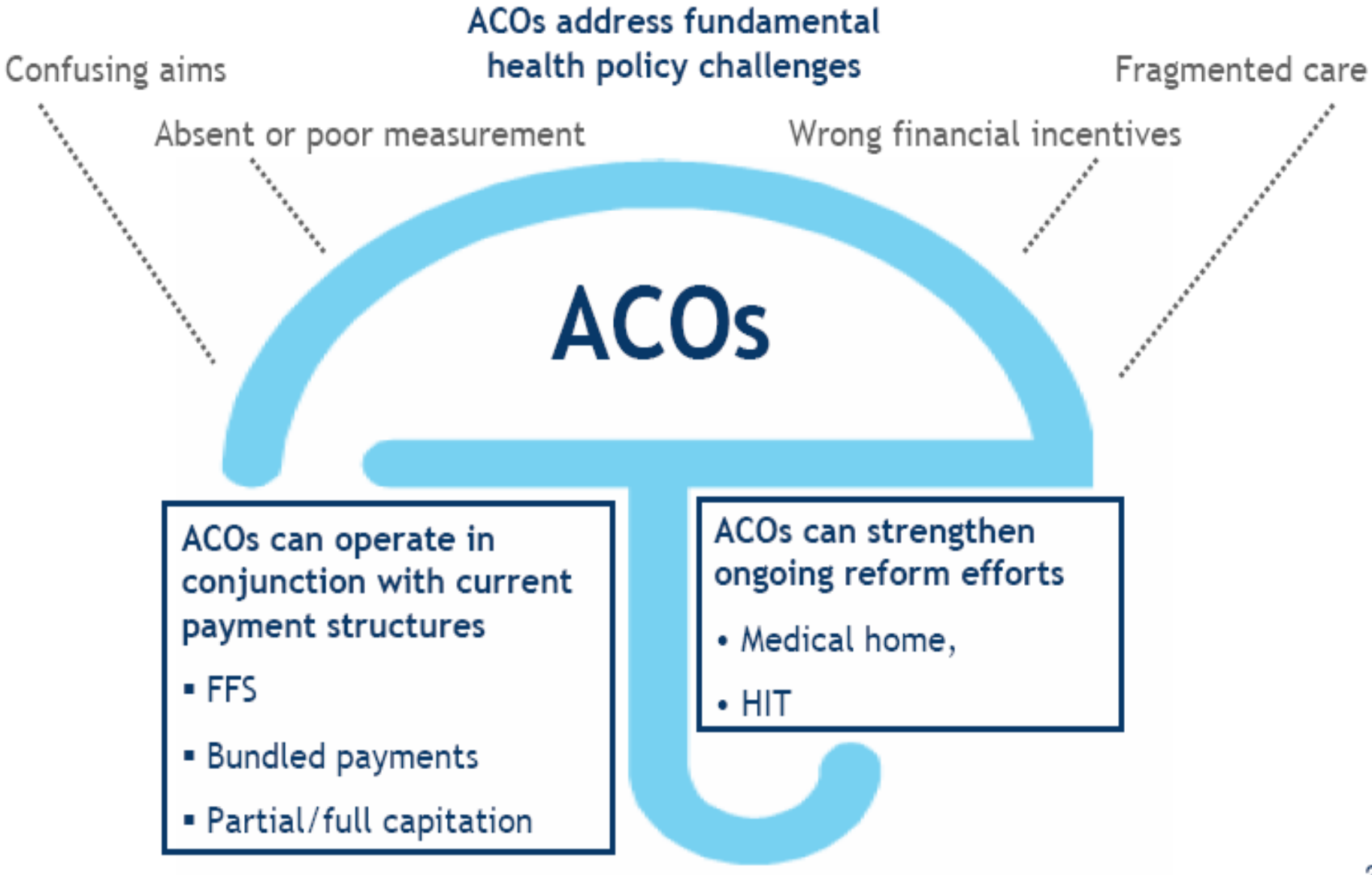
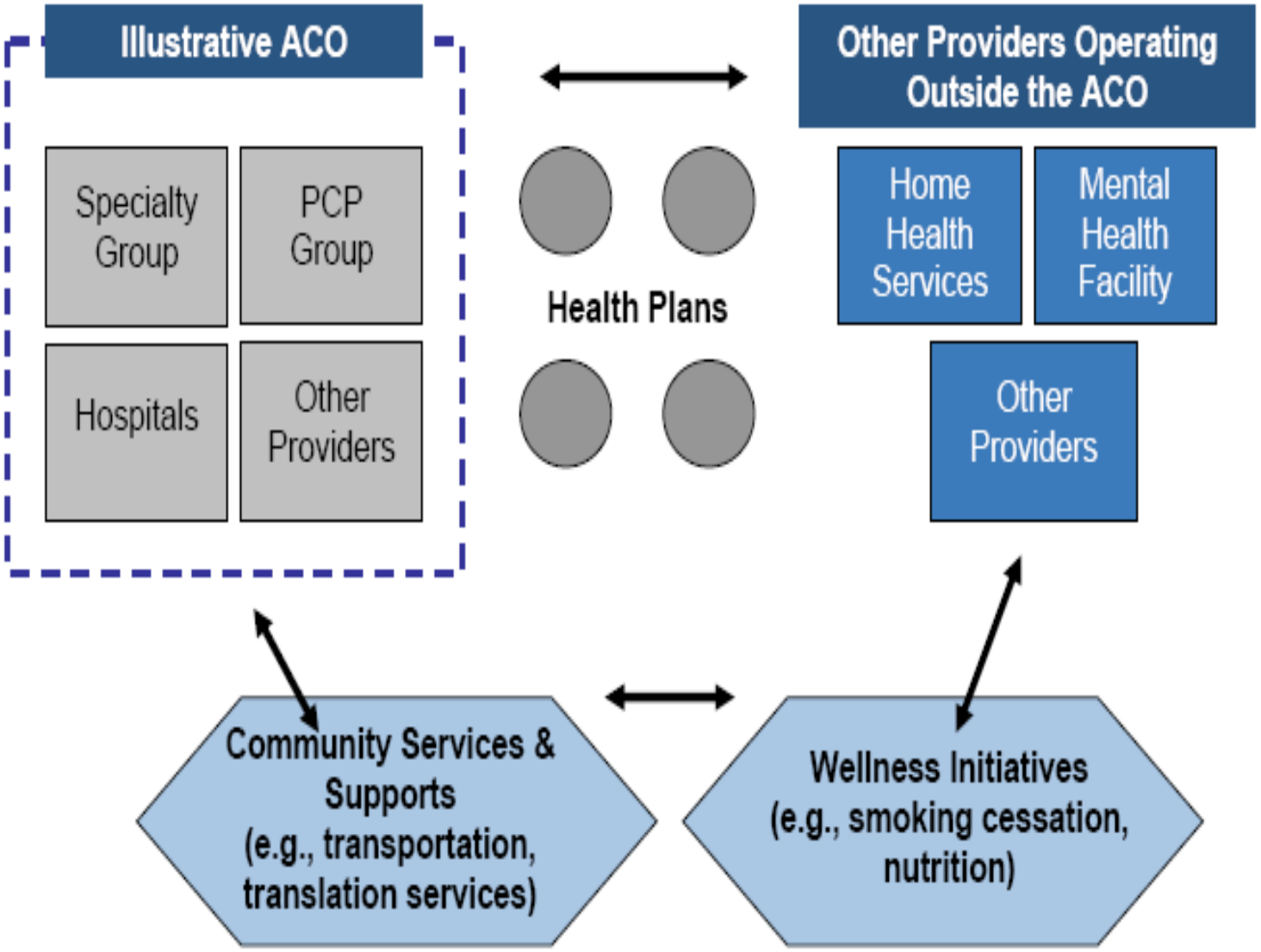
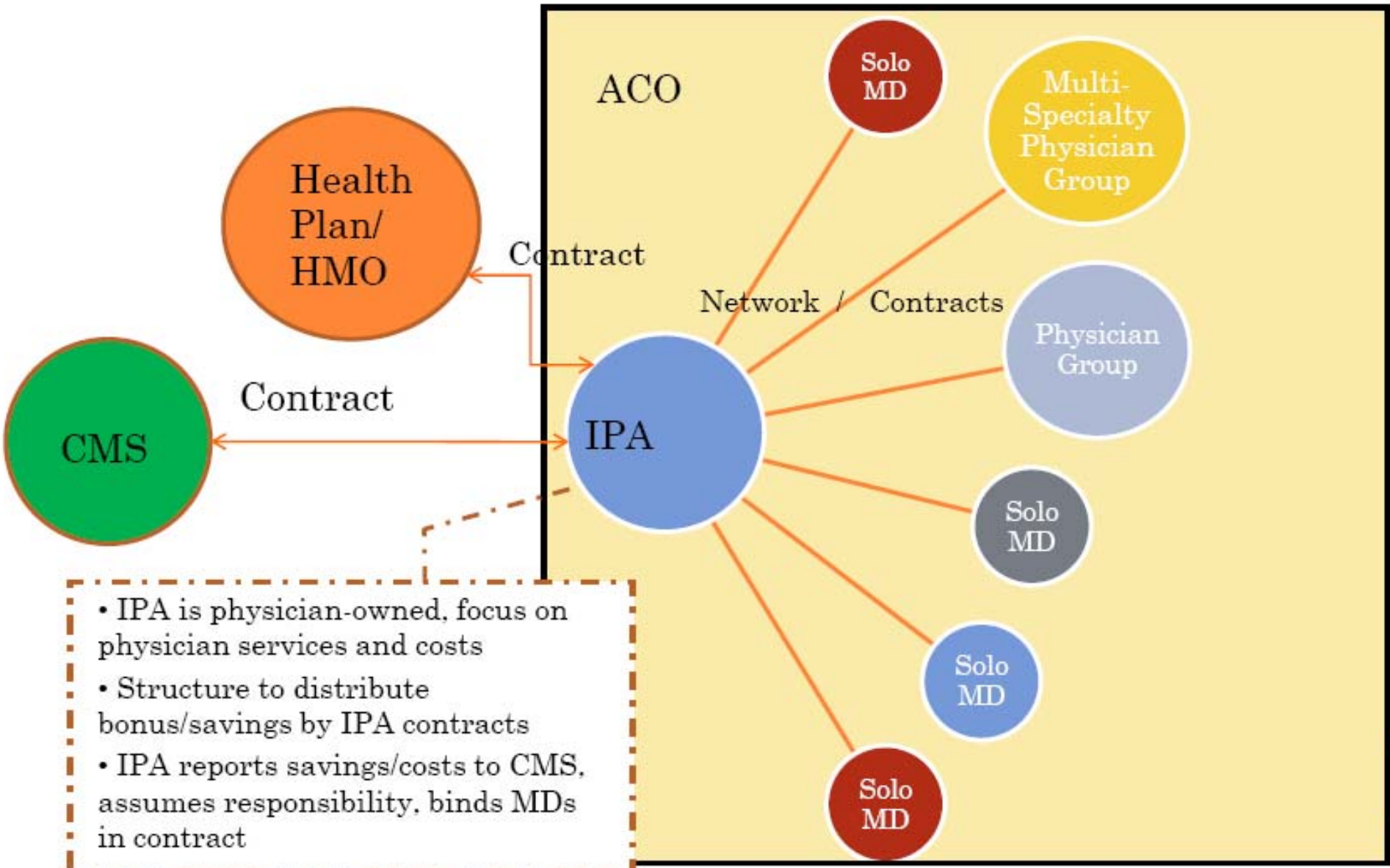
ACO Reform Consistent With Other Reforms



Integrating Care through ACOs

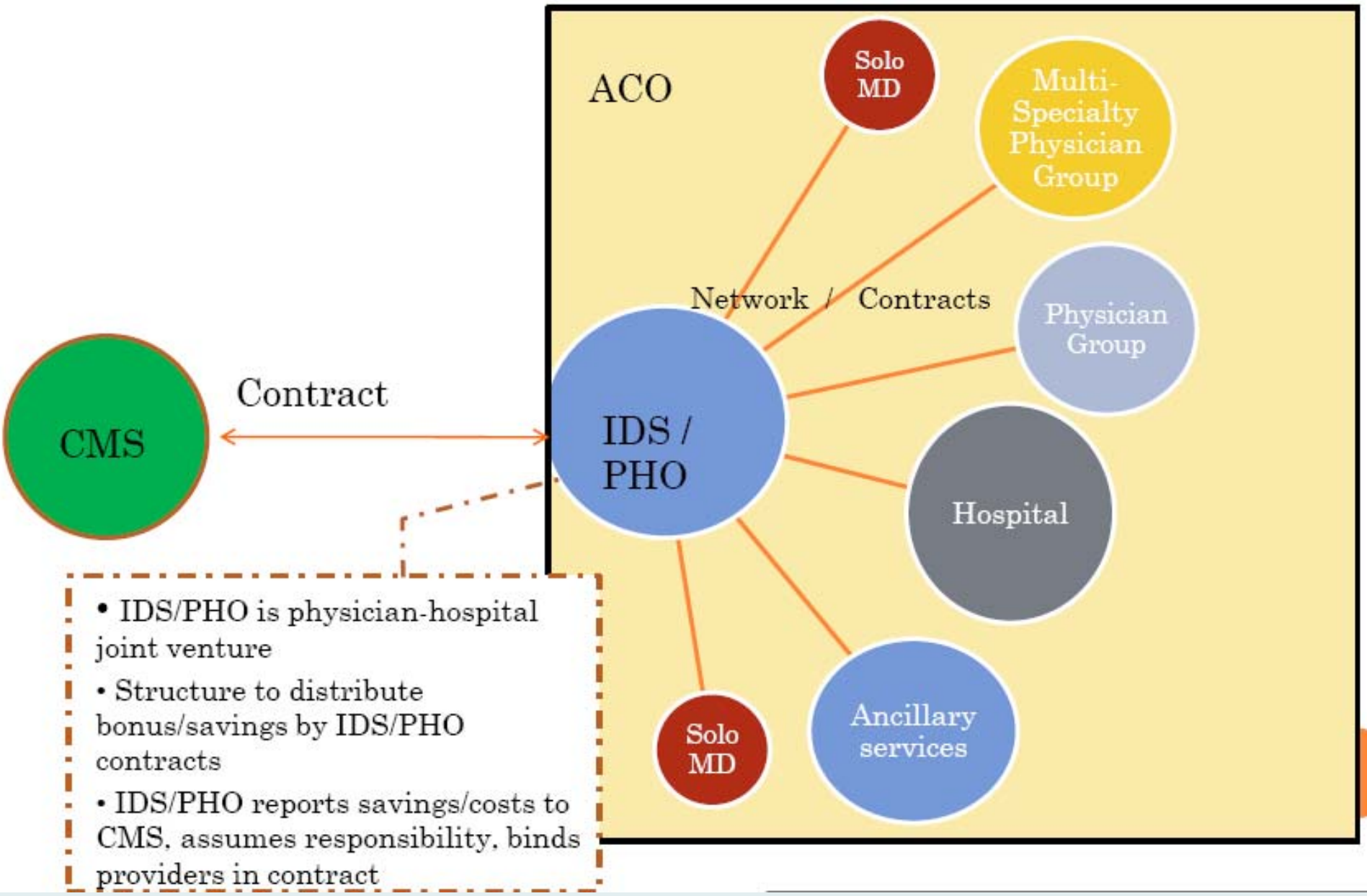


IPA as Basis for an ACO

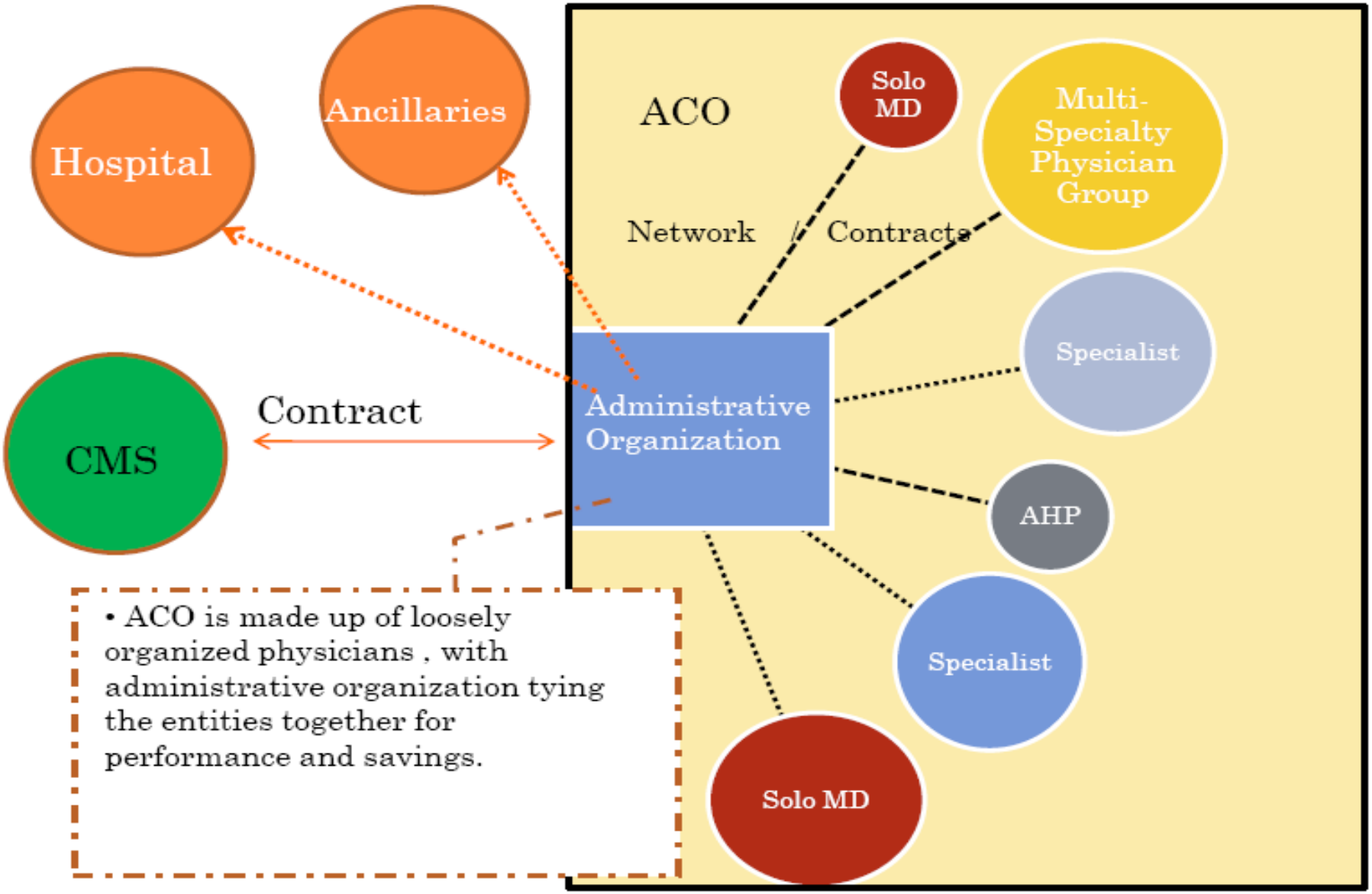


- IPA is physician-owned, focus on physician services and costs
- Structure to distribute bonus/savings by IPA contracts
- IPA reports savings/costs to CMS, assumes responsibility, binds MDs in contract

IDS or PHO as Basis for an ACO



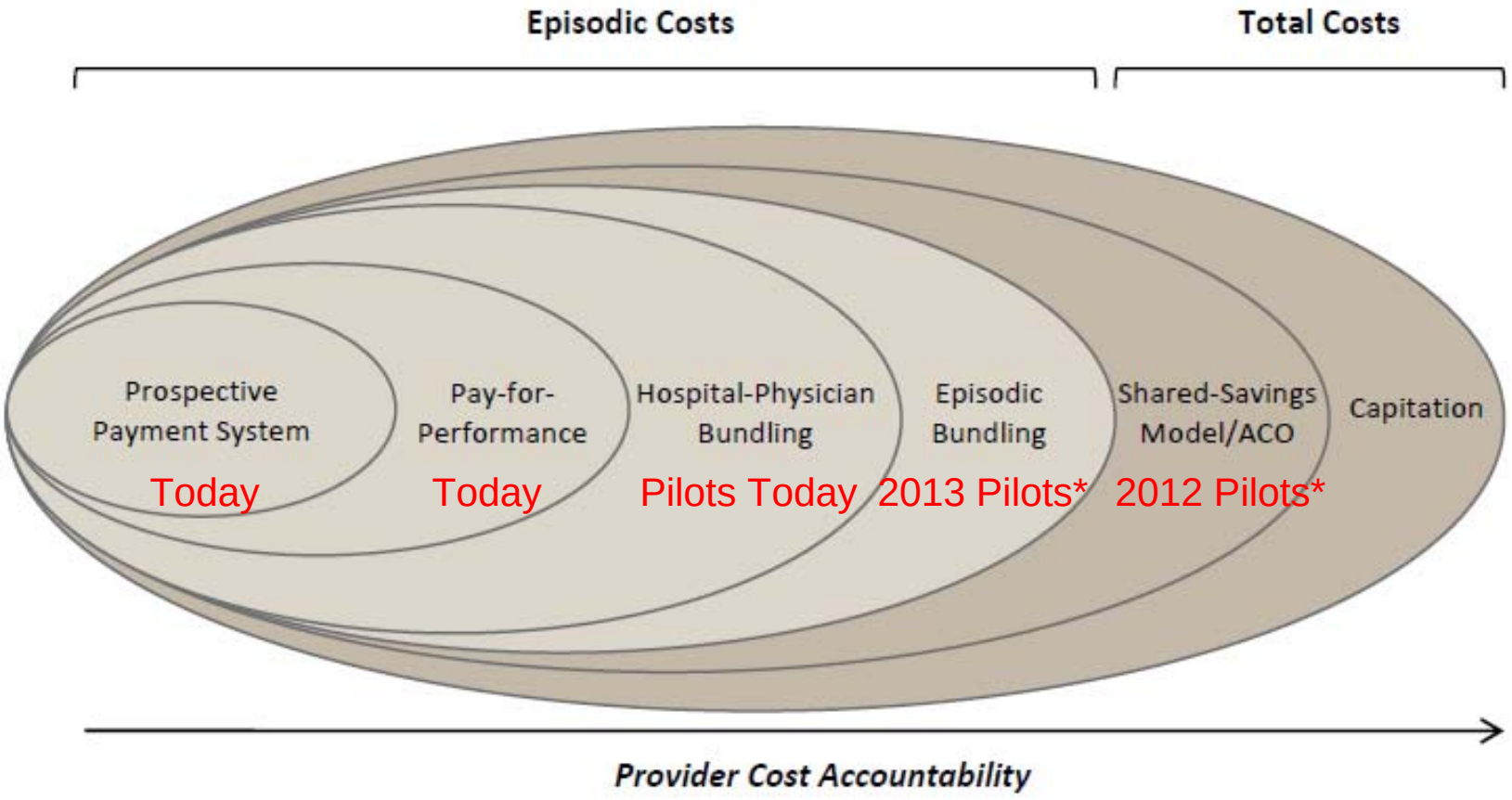
ACO of Loosely Organized Physicians and Physician Organizations



- ACO is made up of loosely organized physicians , with administrative organization tying the entities together for performance and savings.

On the Path Toward Accountability

Uncertainty of Timing, Not Direction, Our Principal Strategic Challenge

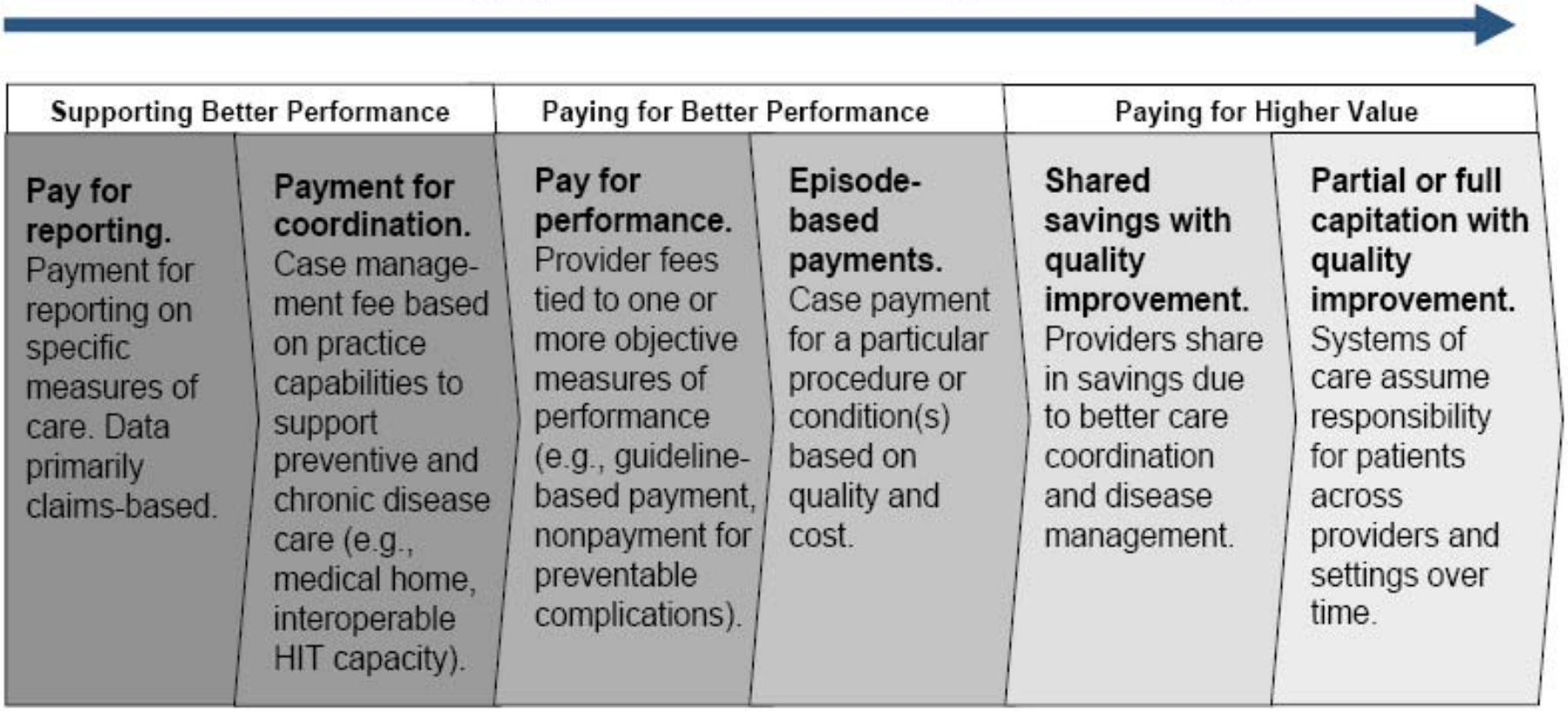


Source: The Advisory Board, 2010

*Medicare Pilots – waiver of anti-trust & anti-kickback

Evolution of payment reform

Past and Emerging Models of Accountability in Provider Payments



Payment Methodologies

- Enhanced fee for service
- Care management fees
- Capitated, no risk models
- Shared savings
- Targeted incentives for quality and efficiency
- Global or bundled payments
- Accountable care organizations
- HIT stimulus incentives

Shared Savings/ACO Model

- Downward pressure on hospital days and ER visits
- Concept is to share savings from reduced hospital days and other costs with referring physicians
- Opportunity for “hospital at home” concept
- Component of CMS pilot and some Medicare advantage projects and potentially Medicaid Managed Care

Global/Bundled Payments

- Hospitals might control total revenue from admission based on diagnosis based on Diagnosis –DRG to include physician component
- Reimbursement for hospital admission may include 3 days before admission and 30 days after
- Focus on networks and systems by the government
- Hospital Systems are becoming active in PCMH discussions

Practice Payment Methods

- **Enhanced FFS** (Fee for Service)
- Enhanced FFS +P4P (outcomes based)
- Enhanced FFS + Care Management Fee (CMF)
- Enhanced FFS + CMF + incentives (outcomes = quality and efficiency (cost savings) and PCMH recognition)
- **CMF** (care management fee)+ incentives
- CMF + incentives + grants
- CMF + incentives + shared savings
- **Capitation, no-risk** + incentives
- Capitation, no risk with FFS carve outs for procedures and incentives

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Let’s Make It Real for You:

- Prevention and Wellness
- Chronic Diseases
- Population Management
- Care Teams
- Your Patients

The Patient Pathway

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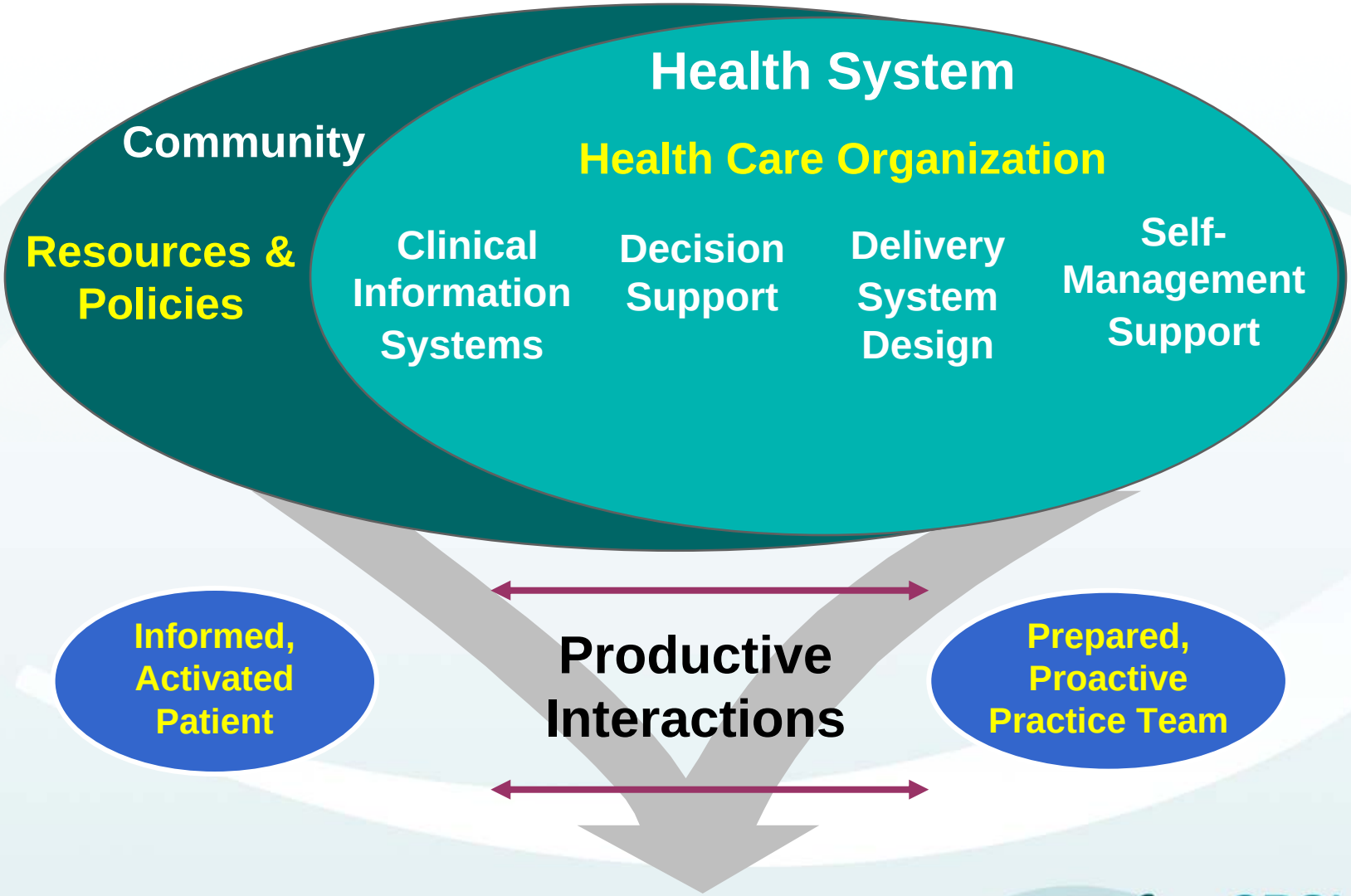
Chronic Care Model (CCM)



Slide from E. Wagner

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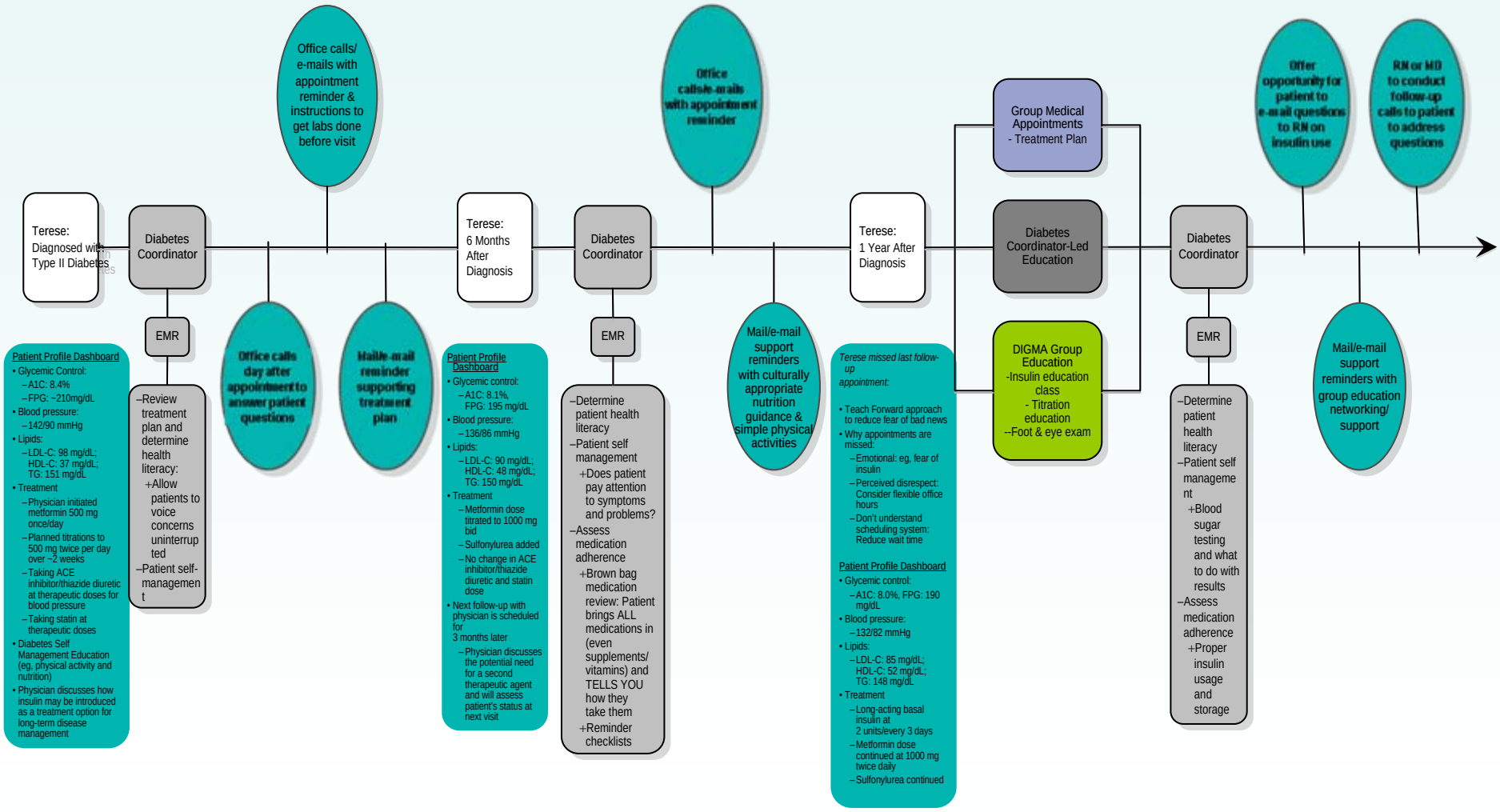
The Patient Pathway Model



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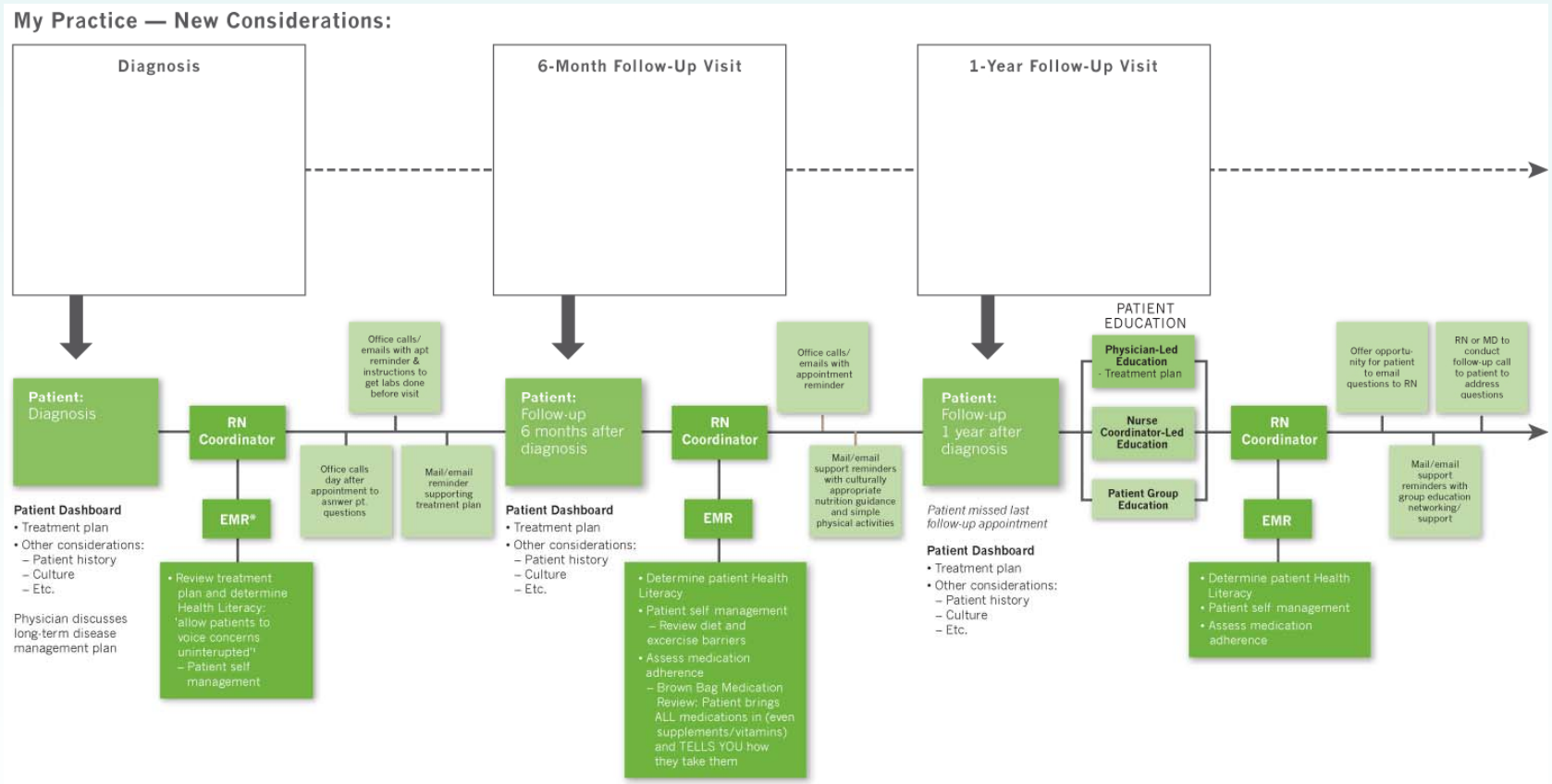
Patient Care Pathway Creates a Map of the Patient Experience through the Healthcare System



Coordinated care team | **Patient empowerment** | **Health literacy** | **Patient population management** | **Electronic medical records**

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The Patient Dashboard: A Means to Assess, Monitor, and Modify

Initial Visit

Patient Dashboard

Test	Data
Height	5´6"
Weight	160 lbs
BMI	25.8 kg/m² (overweight)
Average of 3 office BP measurements	140/89 mm Hg
Treatment	• HTN management: ACE inhibitor (ramipril 10 mg qd); (second medication of choice) • Diabetes management: metformin 850 mg bid

6-Week Visit

Patient Dashboard

Test	Data
Height	5´6"
Weight	155 lbs
BMI	25.0 kg/m² (slightly overweight)
Fasting blood glucose	110 mg/dL
Average of 3 office BP measurements	127/78 mm Hg
Treatment	• No change to meds • Continue nonpharmacologic interventions • Focus on lifestyle changes to control blood glucose

The information presented in this case is a hypothetical example and not based on an actual patient

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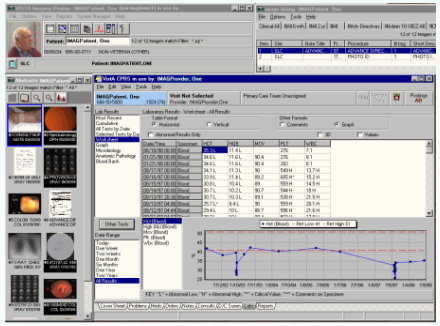
The Patient Pathway Highlights HIT/EHRs

Include diagnosis at current visit: uncontrolled blood pressure despite ACE inhibitor therapy

Input findings from the patient assessment



Additional information

- Patient portal referral and explanation
- Nonpharmacologic measures
- Adherence assessment
- Self-management tools and tips

Input change in treatment

- Add 2nd BP medication to ACE inhibitor
- Reminder: email/call patient in 2 to 3 days to assess tolerability

Referrals

- Nonpharmacologic measures
- Group visit

Patient Reminders

- Measure and record blood pressure weekly
- Office visits
- Blood work
- Other

The information presented in this case is a hypothetical example and not based on an actual patient

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The Patient Pathway Highlights Team-Based Care Models: Every Member Plays A Part

Shared Responsibilities to Reach a Common Goal

	Patient Registry	Motivational interview	Checked medication adherence	Updated EMR	Distributed educational tools	Lifestyle SMBG (diet/exercise)	Outreach to patient after appointment
MD		✓ date	✓ date				
Nurse/NP/PA	✓ date			✓ date	✓ date	✓ date	
Office Staff	✓ date			✓ date		✓ date	✓ date
Pharmacy CDE		✓ date	✓ date		✓ date	✓ date	

Sample Task List

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Evolution of Expectations for Physicians—Clinical Integration

- Team-based care
- Focus on the top of license/training & interest
- Improved communication
- Improved data flow & access
- Right patient at the right time
- Patient-centered aligned incentives – outcomes, quality, cost
- External accountability – outcomes, quality, cost

The result of the goals of higher quality, better coordinated, more efficient care via PCMH

Improved Outcomes!

- Quality
- Chronic Disease
- Transitions in care
- Satisfaction
- Efficiency
- System cost savings

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The Value of Primary Care and PCMH

One year data from payer pilots has demonstrated that individual practices can provide the equivalent of higher quality at lower cost as published data from large integrated systems

The Bottom Line: Value

- Quality / Cost
  - Maximize the numerator
  - Decrease the denominator

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L E A D E R S H I P

The leader always sets the trail for others to follow.

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