THE MEDICAL HOME AND ACO RESEARCH AGENDA: WHAT WE KNOW, DON'T KNOW AND NEED TO KNOW

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Reaching for the Triple Aim

Improved quality and overall patient experience

Constrained costs

Improved population health

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Think:

- Co-Evolution
- Portfolio
- Fast Mistakes
- Accelerated Learning
- “And” not “Either/Or”
- Measurement AND Management
- Spread

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What We Know – Medical Homes

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What is the evidence?

- Quality of care, patient experience, care coordination and access are better
- Reductions in ER visits and hospitalizations
- Increased use of preventive services
- Reduced clinician burnout
- At least cost neutral
- Internationally, systems with greater investment in primary care have better health outcomes at lower costs

Some Specific Examples

Group Health Cooperative of Puget Sound

- 29% reduction in ER visits; 11% reduction in ambulatory care sensitive admissions versus control sites
- Significantly higher patient experience scores and less staff burnout
- $10 PM/PM less cost
- Now being implemented in all 26 primary care clinics serving 380,000 patients

Some Specific Examples (cont'd)

Geisinger Proven Health Navigator Model

- Statistically significant 14% reduction in hospital admissions relative to control and 9% reduction in total costs at 24 months
- Estimated $3.7 million net savings for a ROI of > 2 to 1

Colorado Medicaid and SCHIP

- Median annual costs of $785 for PCMH children versus $1000 for controls due to reductions in ER visits and hospitalizations

Some Specific Examples (Cont'd)

Intermountain Health Care

- Absolute reduction of 3.4% in 2 year mortality in comparison with control group focusing on high-risk elderly
- 10% relative reduction in hospitalizations and even greater among those with chronic illnesses. Net reduction in total costs of $640 per patient per year; $1650 among highest risk patients
- Now being implemented in 75 practices in 6 states

State Medicaid Innovations
n = 17 states

Payment increases to support PCMH models:

- Increases in quality
- Decreases in Medicaid per capita costs
- Increases in physician Medicaid participation
- Increased patient and provider satisfaction

Source: Takach, M. *Health Affairs*, 2011 30(7):1325-34

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“Medical Home Run” Examples – lowered costs by 15 to 25 percent without any diminution in quality.

- Arnie Milstein and Elizabeth Gilbertson

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Common Features

- Exceptional Individualized Caring for Patients with Chronic Illness
  - Care Teams Focused on Preventing Crises
  - Ambulatory “ICUs”
- Efficient Service Provision
  - Standardization of Care Practices and Training of Staff
- Careful Selection of Specialists
  - Concentrated Referrals to Cost / Effective Specialists
- Leadership
  - Persistence
  - Tolerance for Risk
  - Instinct for Leverage on Clinical and Financial Outcomes
  - Strong Sense of Personal Accountability to Prevent Crises

Medical Home Demo – 36 practices

Lessons Learned:

- Takes time – 3 to 5 years
- Internal capability for learning
- Transition from individual autonomy to technology-enabled, team-based care
- Collaborative relationships with many others: "Health Neighborhoods"

Source: P. Nutting, B.F. Crabtree, et al. *Health Affairs*, March 2011, 30(3): 439-445

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What We Know About Accountable Care Organizations

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Our best ACOs currently are selected integrated delivery systems and multi-specialty group practices

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What is the Evidence?

- IDSs and MSGPs provide more preventive care
- Provide more recommended elements of care for patients with chronic illness
- Show greater improvement over time in use of recommended care management processes

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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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Bottom Line

Medicare beneficiaries cared for by CAPP physicians received 5-15% higher quality of care at a cost that was $272 (3.6%) lower.

The cost savings to Medicare would amount to $15 billion a year or $150 billion over 10 years.

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IDSs also have lower physician and hospital costs for Medicare patients and lower hospitalization days and ICU days

Source: J.B. Sterns. “Quality, Efficiency, and Organizational Structure”. Journal of Health Care Finance, 2007;37(1):100-107.

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VA Example

VA outperformed FFS Medicare on 12 out of 13 quality indicators for prevention, acute and chronic care.

“We believe that the re-engineering of VA healthcare which included the implementation of a systematic approach to the measurement of, management of, and accountability for quality, was at the heart of improvement.”

Source: A. Jha, et al. “Effect of the transformation of the VA Health Care System on the Quality of Care”. New England Journal of Medicine, 2003;382(22):2218-2227.

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How Do They Do It?

Key Insight:

They create a system of learning that is not possible or very difficult for other delivery models to achieve

No “Secret Sauce,” But Here Are the Nutritional Elements

- EHR Functionality
- Practice Redesign
- Systems Engineering Tools
  - Statistical Process Control
  - PDSA Cycles
  - Quality Functional Deployment
  - Lean Production

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Nutritional Elements

- Teams
- Leadership
- Culture

Aligned payment incentives drives all. Puts everyone “on the same page.”

Strong Ties Among All Entities

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What we don't know, but need to know

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Major Challenges:

How do we bring ACOs and PCMHs to scale across the country?

How do we spread innovation?

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Some Key Questions

- Can accountable care organizations become affordable care organizations?
- How fast can payment move away from fee-for-service? How quickly can the tipping point be reached?
- How quickly can physicians and other providers develop the capabilities needed to manage risk?

Some Key Questions (cont'd)

- Can hospitals and physicians "play nice" for mutual gain?
- Can sufficient clarity be achieved on accountable to whom? For what? And how?
- Will insurers provide sufficient incentives for consumers/patients to choose cost-effective ACOs and PCMHs?

Other Key Questions and Areas for Research

- What will be the new primary care base, given the shortage of primary care physicians?
- What mix or portfolio of payment incentives will best induce desired individual behavior changes among providers?

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Most important:

Can a learning system be created to learn quickly from mistakes?

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Ten Mistakes Fledgling ACOs Will Make

- Overestimate Ability to Manage Risk
- Overestimate Ability to Implement Electronic Health Records
- Overestimate Ability to Collect, Analyze and Report Performance Measures
- Overestimate Ability to Standardize and Improve Care
- Failure to Balance the Interests of Key Shareholders – Physicians, Hospitals, Insurers, Other Providers, Patients

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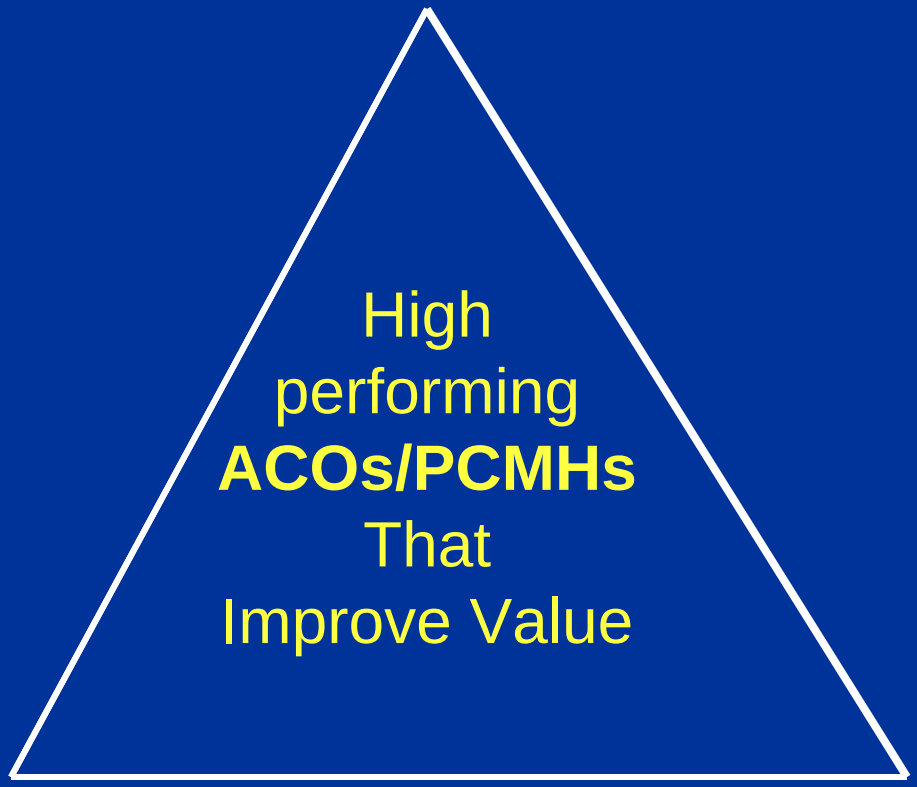
Ten Mistakes Fledgling ACOs Will Make (cont'd)

- Failure to Sufficiently Engage Patients in Self-Care and Informed Choice
- Failure to Make Contractual Arrangements with the Most Cost-Effective Specialists & Other Providers
- Failure to Navigate the New Legal and Regulatory Environment
- Failure to Integrate Care Beyond the Structural Level – Missing Change Management Skills
- Failure to Recognize the Interdependencies of the Above Mistakes

ACCOUNTABILITY
Performance Measurement



INCENTIVES
Results-Based
Payment

CAPABILITIES
EHR Functionality
Practice Redesign

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Thank You!

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