ACOs, Bundled Payment, and Improvement Science: The Aims and The Aspirations

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What Outcome Are We Aiming For?

To improve health and the value of health care.

The Assumptions

1. The outcome can be defined and measured using the IHI Triple Aim as an operating definition.

2. Bundled payment can be important as an incentive to improve value and as a fair system of compensation

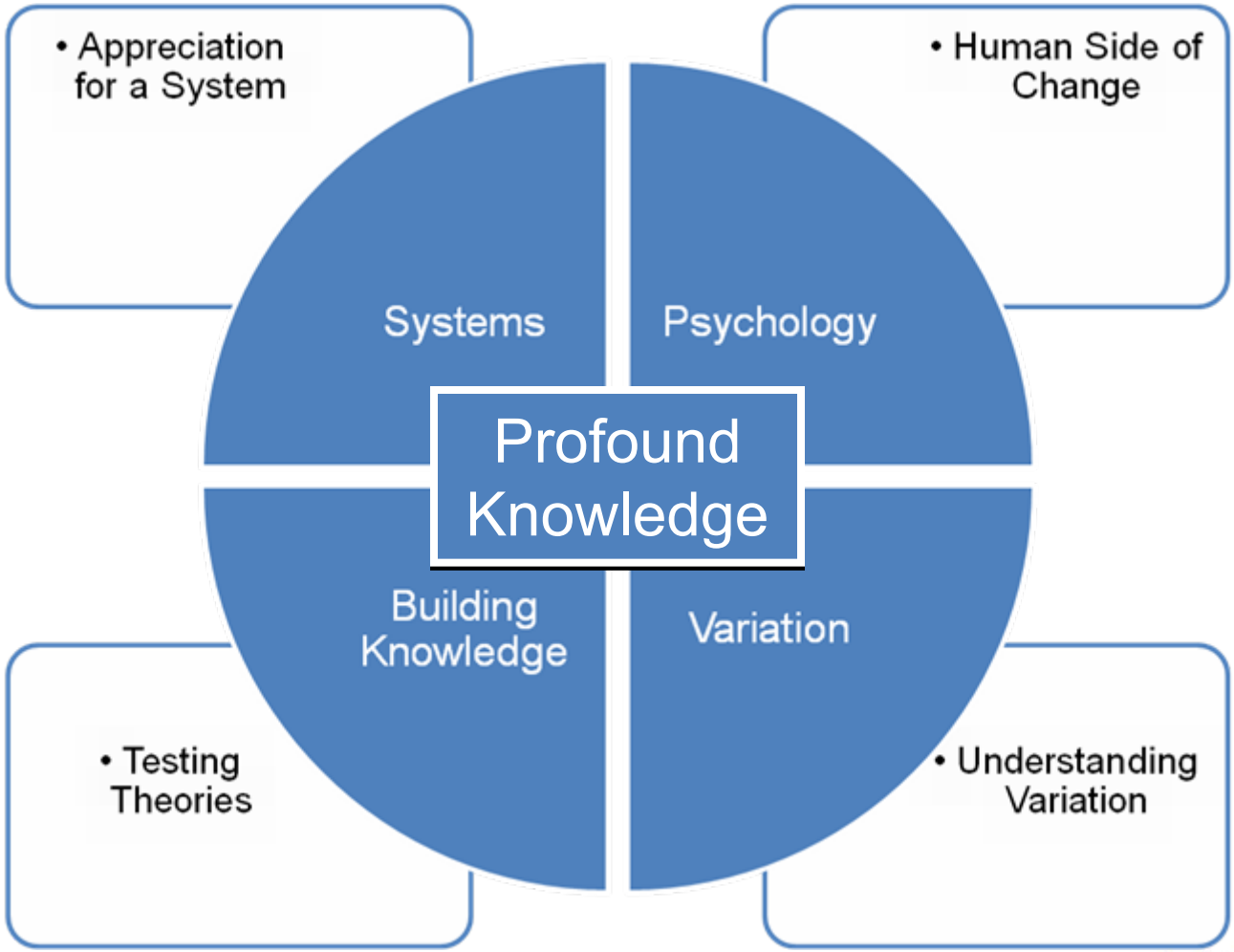
The Assumptions, continued

3. ACOs can be an effective structure to accept bundled payment and improve the value of health care.

4. The effective application of improvement science will be critical to the success of bundled payment as a system and ACOs as a structure to improve value.

THE ROLE OF IMPROVEMENT SCIENCE

Deming's System of Profound Knowledge



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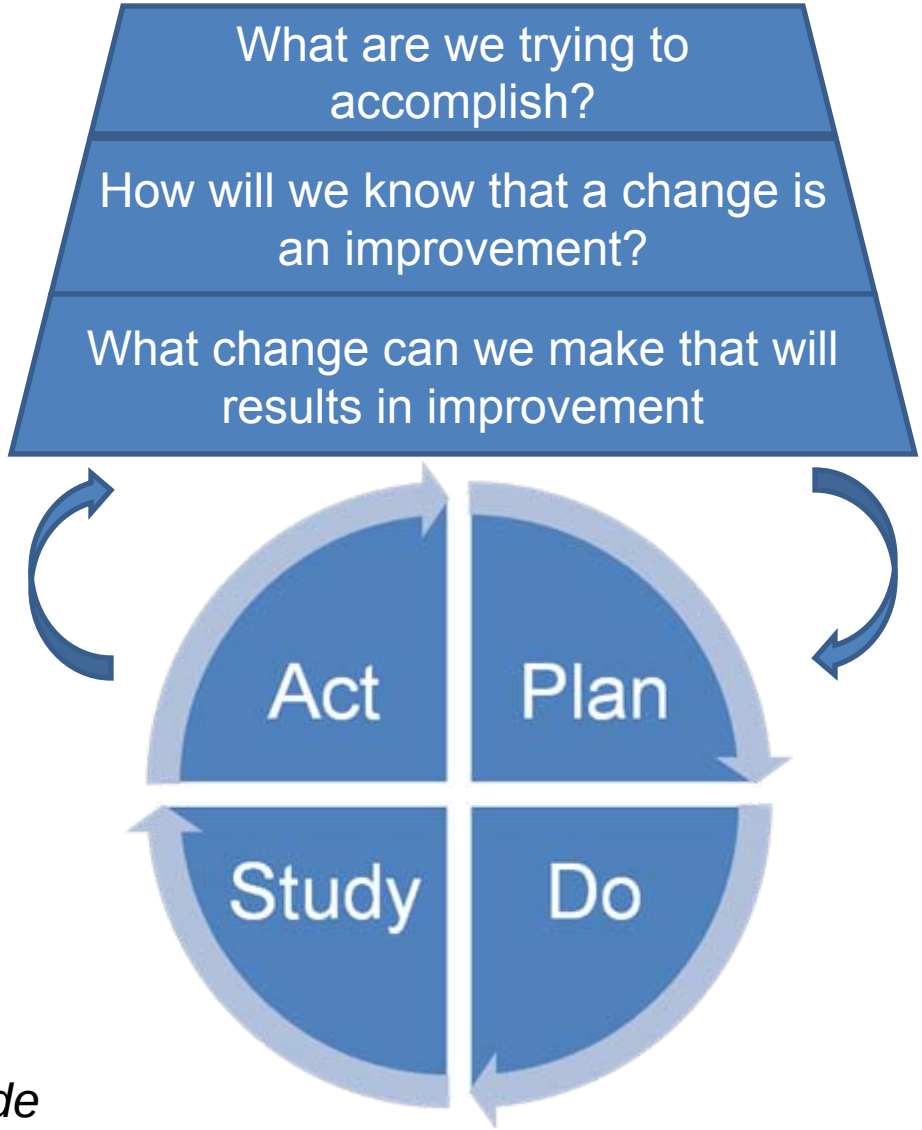
System of Profound Knowledge (Deep Insight)

The Interplay of:

- Appreciation of a System
  - Interdependent group of items, people, or processes working toward a common purpose.
- Understanding Variation
  - Making interpretations based on observations
- Building Knowledge
  - Comparing predictions to results
- The Human Side of Change
  - Understanding motivations of people and their behavior.

The Model for Improvement



The Improvement Guide

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Improvement Science (Summary)

- Disciplined process
- Outcome is defined and measured
- The systems and processes are identified and documented
- Small tests of change are planned, piloted, studied, and acted upon in a continuous cycle (PDSA)

Assumption 1

THE OUTCOME: DEFINED AND MEASURED USING THE IHI TRIPLE AIM

The IHI Triple Aim

- Improve Population Health
- Enhance the patient experience of care
- Lower, or at least maintain, per capita cost of health care.

Goals at the Macro Level: Population Health

EXECUTIVE SUMMARY Exhibit 1

Indicators of State Child Health System Performance

	Dimension and indicator	Year	All states median	Range of performance (Bottom state rate—Top state rate)	Best state
	Access & Affordability				
1	Children ages 0–18 insured	2008–09	91.4	82.0–96.7	MA
2	Parents ages 19–64 insured	2008–09	83.7	65.5–95.6	MA
3	Currently insured children whose health insurance coverage is adequate to meet needs	2007	77.0	68.7–83.8	HI
4	Average total premium for employer-based family coverage as percent of median income for family household (all members under age 65)	2009	18.6	24.9–13.9	CT
	Prevention & Treatment				
5	Children with a medical home	2007	60.7	45.4–69.3	NH
6	Young children (ages 19–35 months) received all recommended doses of six key vaccines	2009	74.4	64.6–84.1	IA
7	Children with a preventive medical care visit in the past year	2007	87.8	76.7–97.7	RI
8	Children ages 1–17 with a preventive dental care visit in the past year	2007	79.1	68.5–86.9	HI
9	Children ages 2–17 needing mental health treatment/ counseling who received mental health care in the past year	2007	63.0	41.7–81.5	PA
10	Young children (ages 10 months–5 years) received standardized developmental screening during visit	2007	18.8	10.7–47.0	NC
11	Hospital admissions for pediatric asthma per 100,000 children ages 2–17	2006	128.7	251.0–44.1	OR
12	Children with special health care needs who had no problems receiving referrals when needed	2005–06	80.3	70.3–89.8	RI
13	Children with special health care needs whose families received all needed family support services	2005–06	72.8	56.7–83.0	IN
	Potential to Lead Healthy Lives				
14	Infant mortality, deaths per 1,000 live births	2006	6.8	11.9–4.7	WA
15	Child mortality, deaths per 100,000 children ages 1–14	2007	20.0	34.0–9.0	RI
16	Young children (ages 4 months–5 years) at moderate/ high risk for developmental or behavioral delays	2007	25.8	35.2–18.6	ME & MN
17	Children ages 10–17 who are overweight or obese	2007	30.6	44.4–23.1	MN & UT
18	Children ages 1–17 with oral health problems	2007	25.8	31.6–20.0	MN
19	High school students who currently smoked cigarettes	2009	18.3	26.1–8.5	UT
20	High school students not meeting recommended physical activity level	2009	56.0	66.7–46.4	ID

Source: Commonwealth Fund State Scorecard on Child Health System Performance, 2011.

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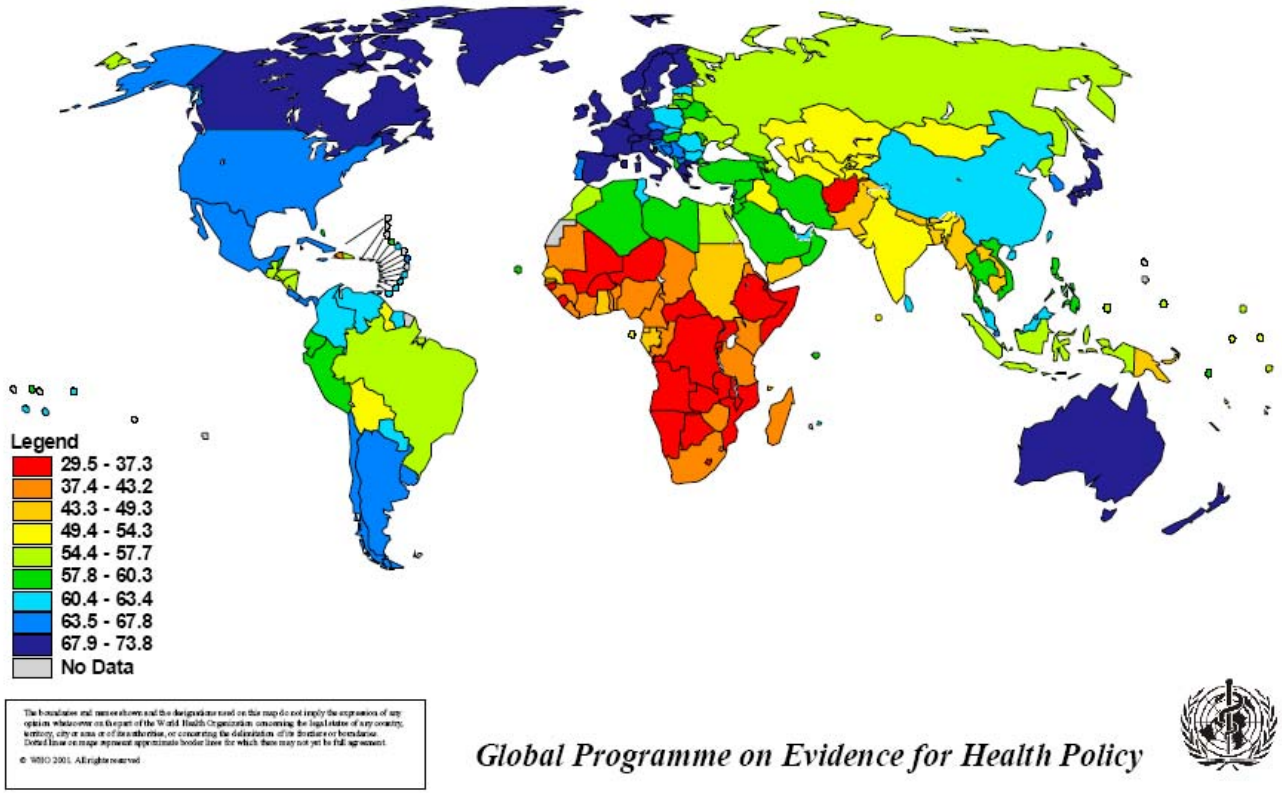
Variation in Global Life Expectancy

Healthy Life expectancy at birth, both sexes



Global Programme on Evidence for Health Policy

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County Health Rankings

Mobilizing Action Toward Community Health

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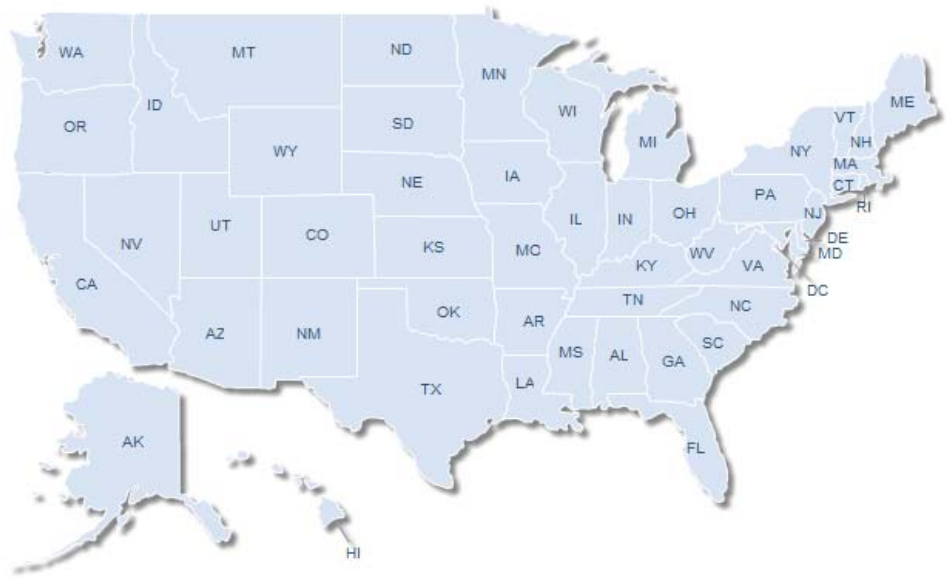
Health Outcomes | Health Factors | Take Action



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Associated Press: Improving Americans' health takes a community

The government's new 10-year blueprint to improve Americans' health aims to help whole communities get in better shape, not

In the Spotlight

Acsys Interactive Wins the County Health Rankings Health 2.0 Developer Challenge

At the Health 2.0 Conference in San Francisco on October 10, 2010, the Robert Wood

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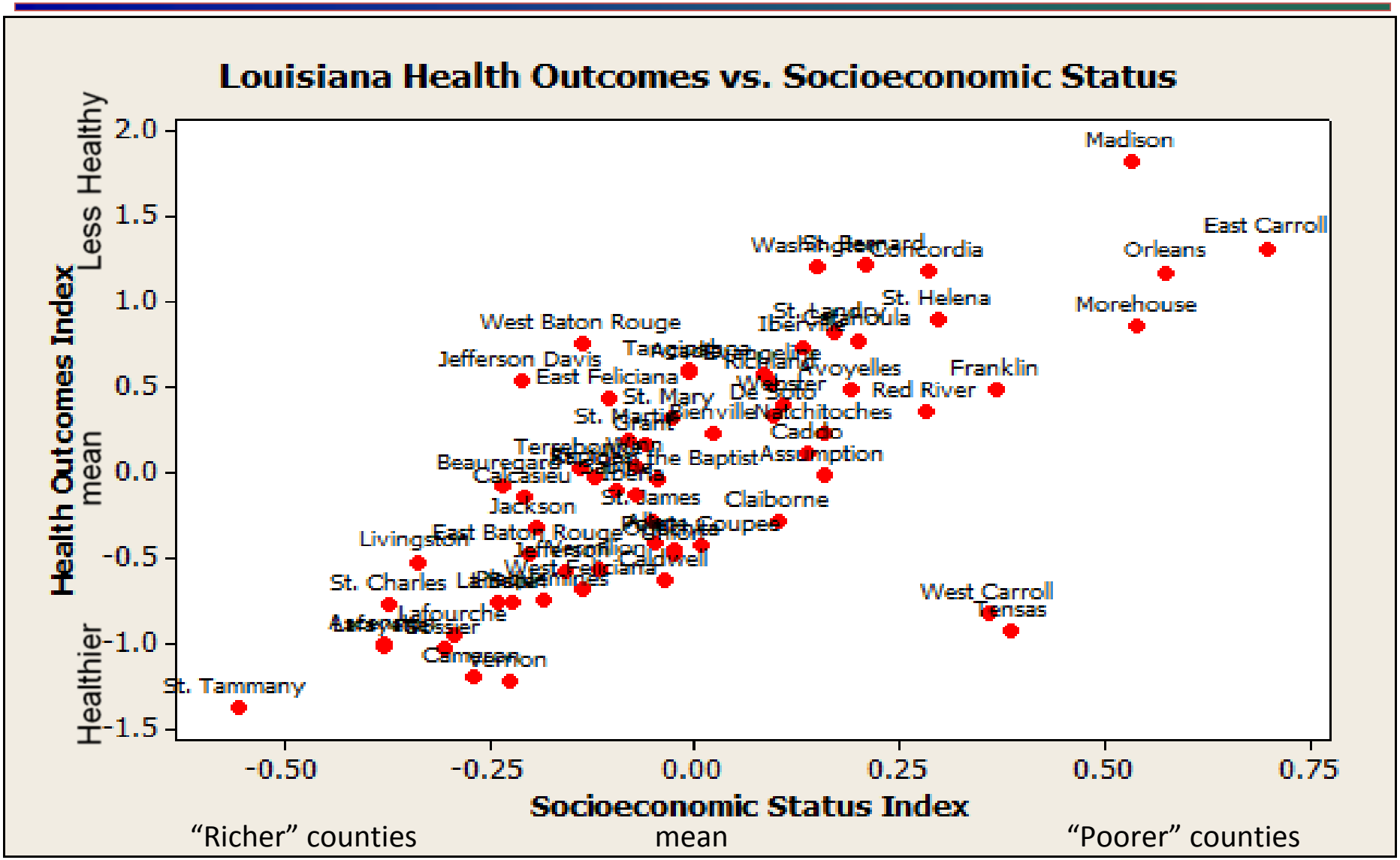
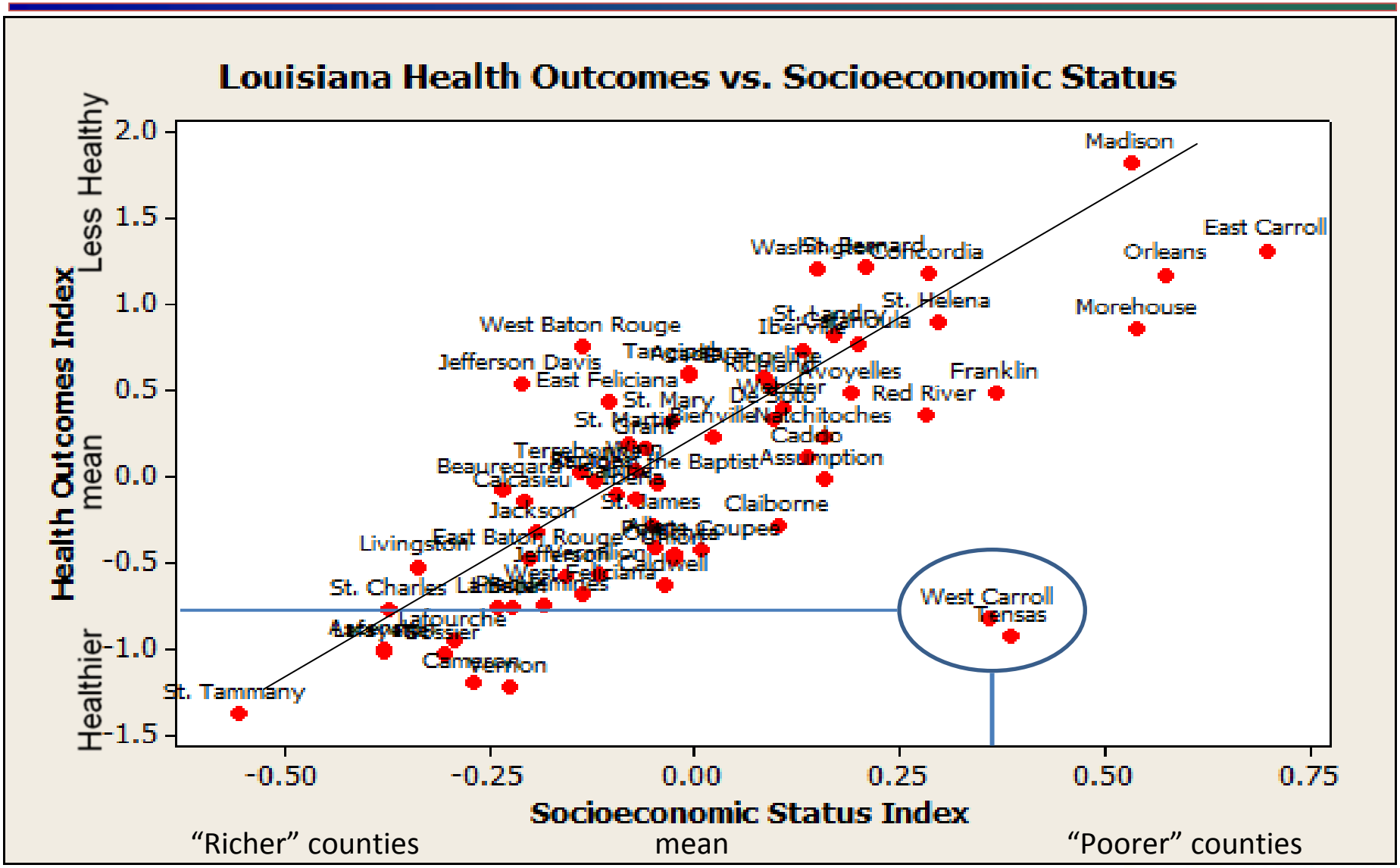
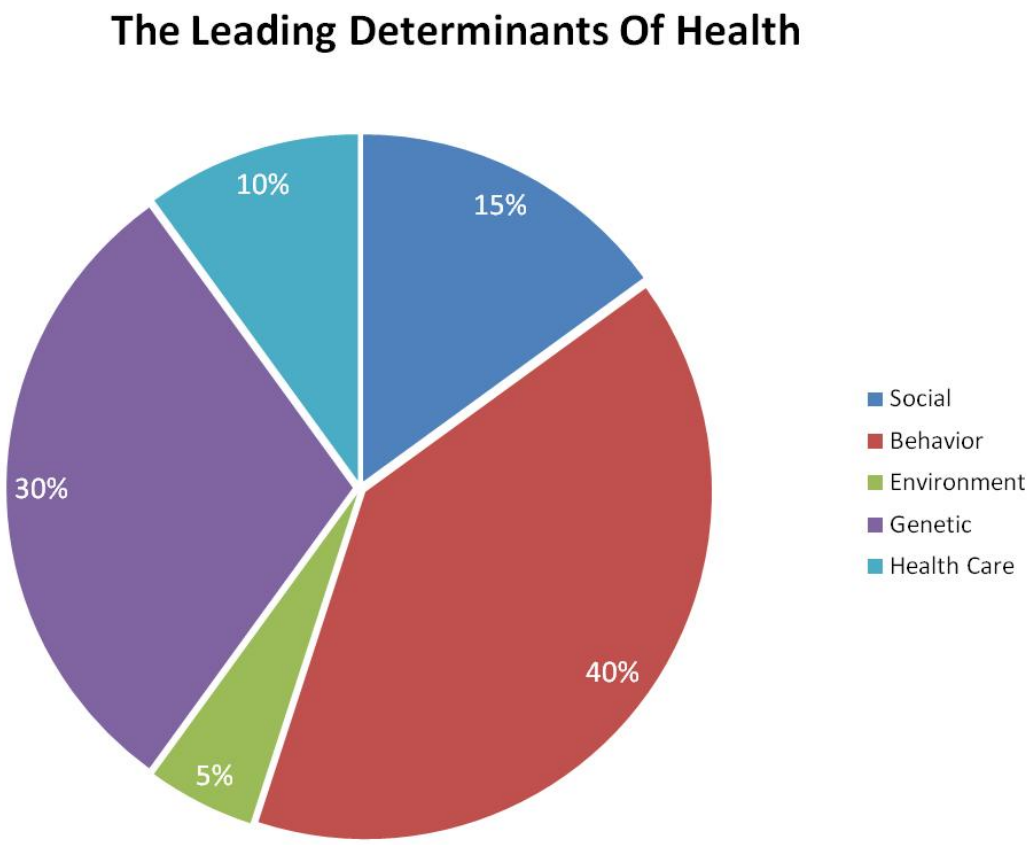
Poorer Counties Have Poorer Health



But Some Do Better Than Expected



Health and Mortality



Source: McGinnis , JM et al Health Affairs Apr2002

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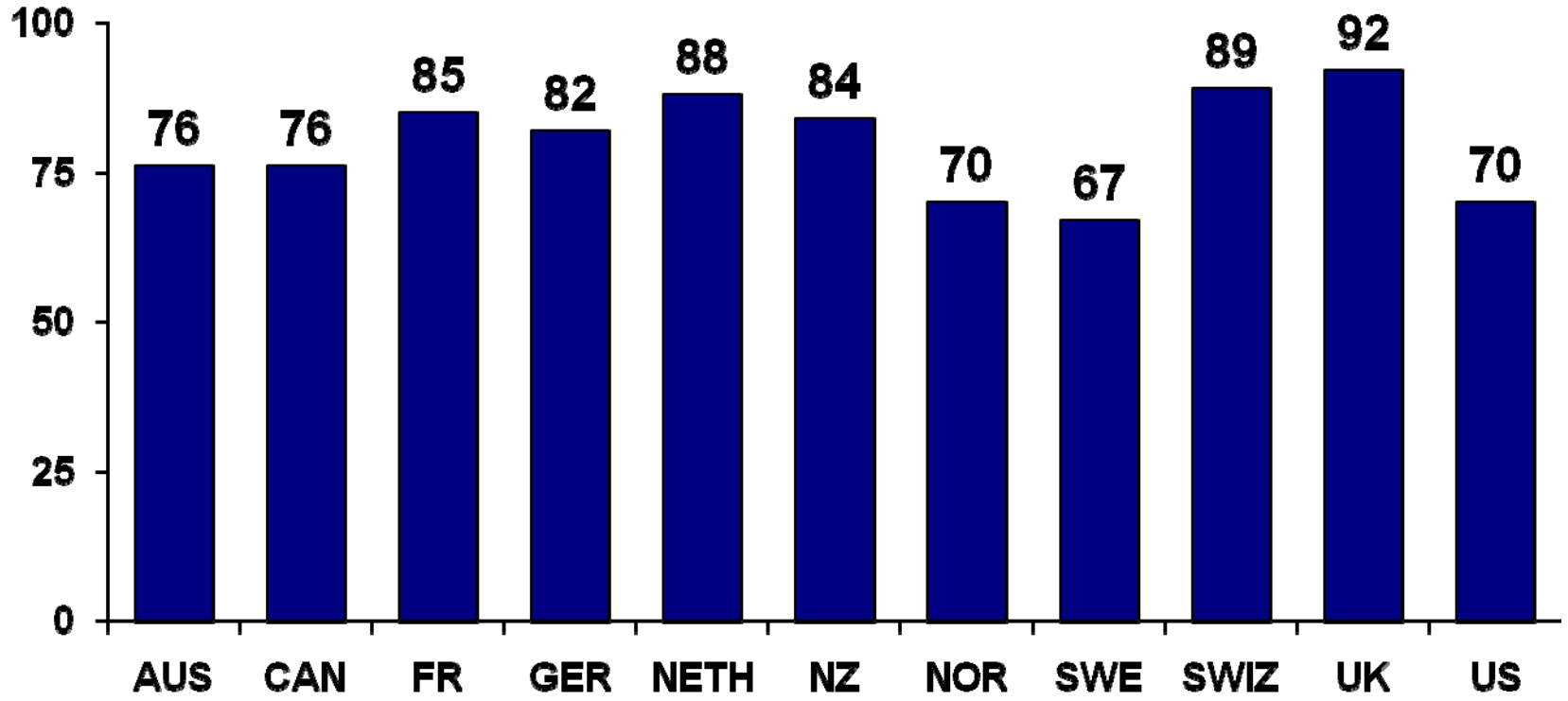
Consumer Confidence in Effective Treatment

Percent responded, if they became seriously ill, *confident/very confident* they would get most-effective treatment, including drugs and diagnostic tests



2010 International Health Policy Survey in Eleven Countries
The Commonwealth Fund, November 2010

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Qualitative Assessment of US Health System

Strengths	Weaknesses
Adoption of New Technologies	Adopting new technology without evaluating marginal benefits
Innovating in the delivery and management of health care	Below average Life Expectancy based on per capita wealth
Premium care	Preventable Mortality is Higher
Aggressive end of life treatment	Future implications of Obesity
Notable Measures of Convenience	
Cancer Care	

"The system may deliver superior quality for only a select group of the population"
McKinsey & Company

A nice way of saying we have a disparity problem

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Goals at the Macro Level: Experience of Care

- Institute of Medicine – Six Aims
  - Safe
  - Effective
  - Patient Centered
  - Timely
  - Efficient
  - Equitable

Goals at the Macro Level: Per Capita Costs

Prevent health care costs from increasing as a share of GDP.

We Cannot Afford Rising Costs

Year	National Health Expenditures	NHE % GDP	GDP
2008	$2,338,700,000,000	16.2%	$14,441,400,000,000
2009	$2,473,000,000,000	17.3%	$14,282,500,000,000
2010	$2,600,200,000,000	17.5%	$14,853,800,000,000
2015	$3,538,200,000,000	18.2%	$19,431,100,000,000
2019	$4,571,500,000,000	19.6%	$23,283,000,000,000

Total National Debt
$13,796,668,548,103

National Health Expenditure Projections 2009-2019
cms.gov, September 2010

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If Costs Remain Constant

Year	Savings Per Year	NHE % GDP	GDP
2010	$193,884,400,000	16.2%	$14,853,800,000,000
2015	$390,361,800,000	16.2%	$19,431,100,000,000
2019	$799,654,000,000	16.2%	$23,283,000,000,000

National Health Expenditure Projections 2009-2019
cms.gov, September 2010

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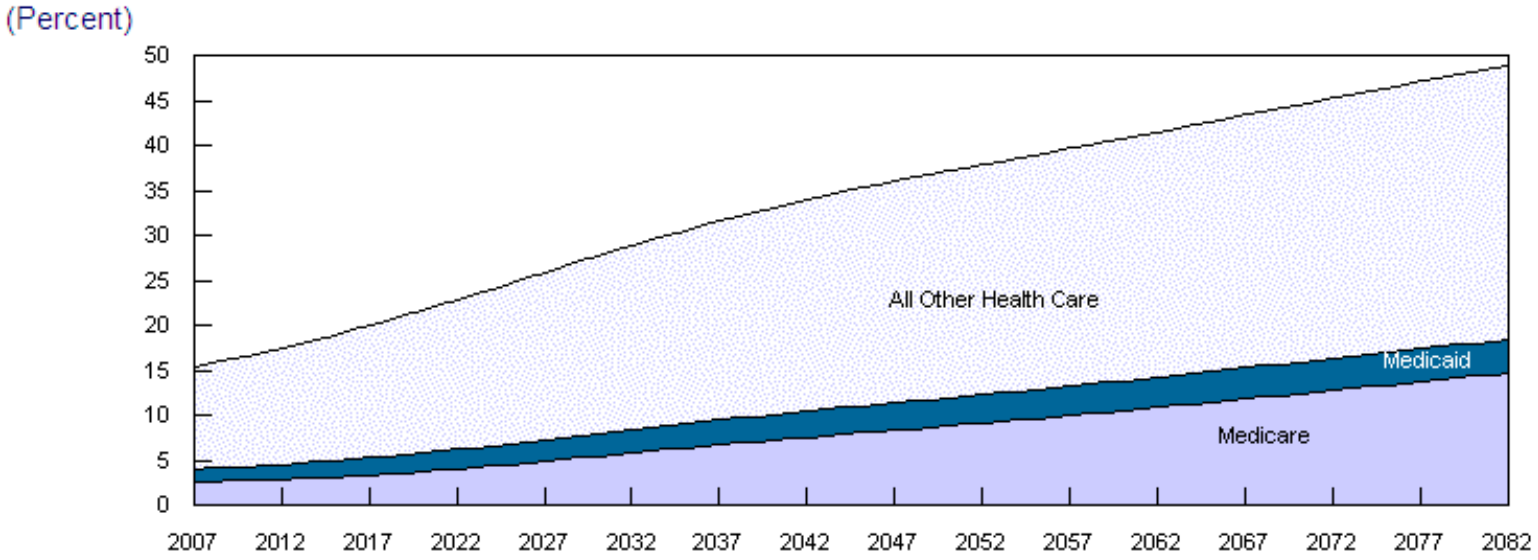
We Cannot Afford Costs to Grow as a Share of GDP

Figure 4.

Projected Spending on Health Care as a Percentage of Gross Domestic Product



Source: Congressional Budget Office.

Note: Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

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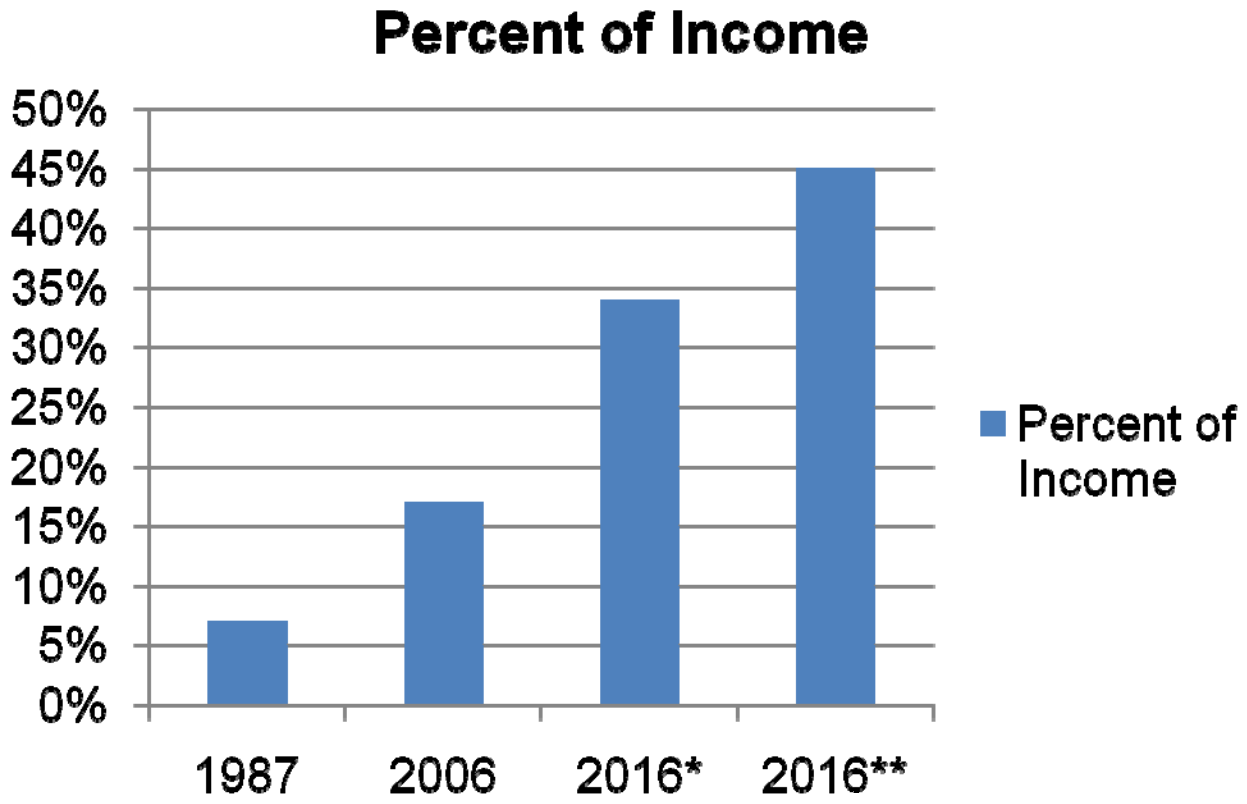
Percent of Median Family Income Required to Purchase Family Health Insurance



Source: Len Nichols' calculations, using KFF and AHRQ premium data, CPS income data, plus projections from Carpenter and Axeen. The Cost of Doing Nothing, 2008.

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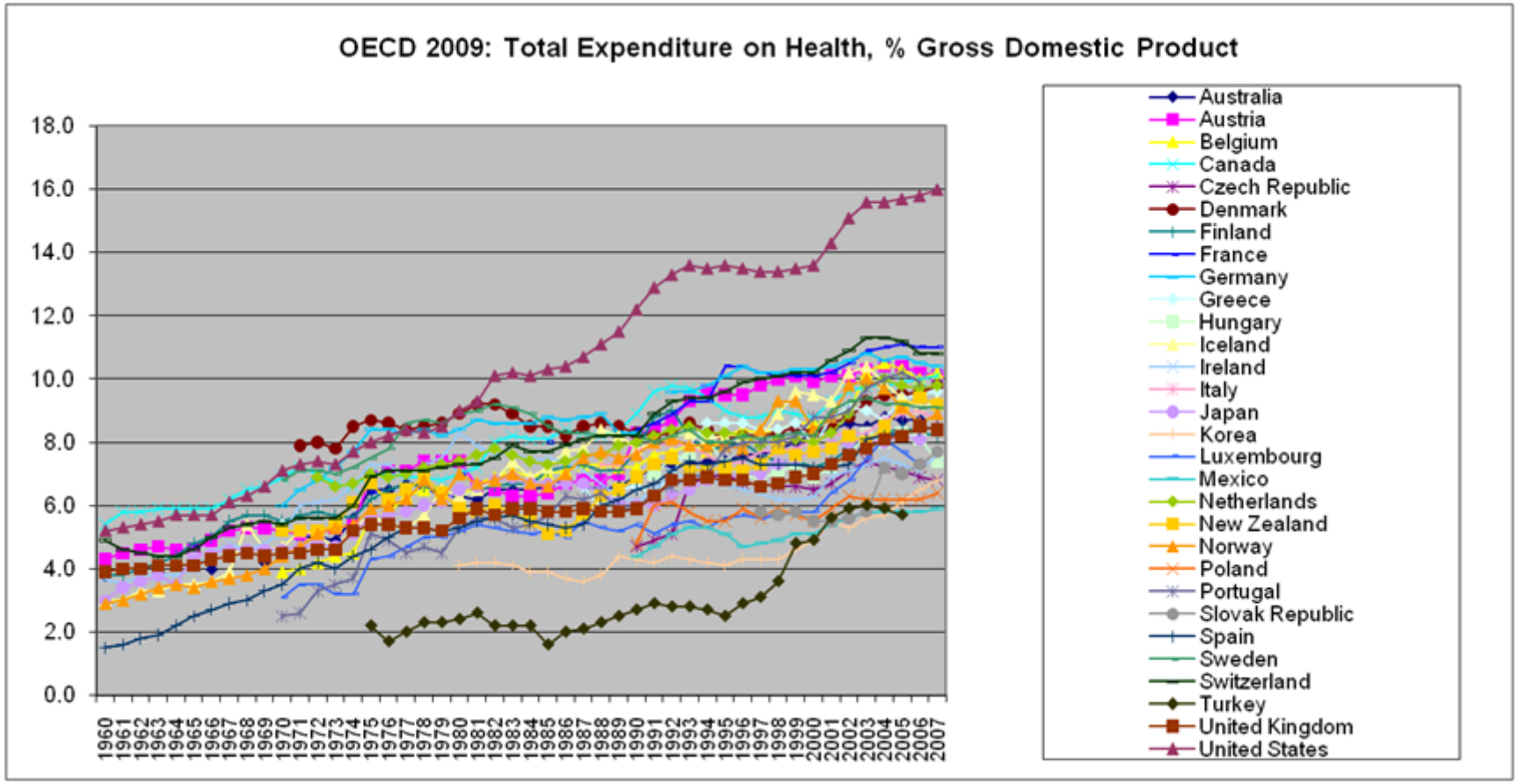
Rising Expenditures



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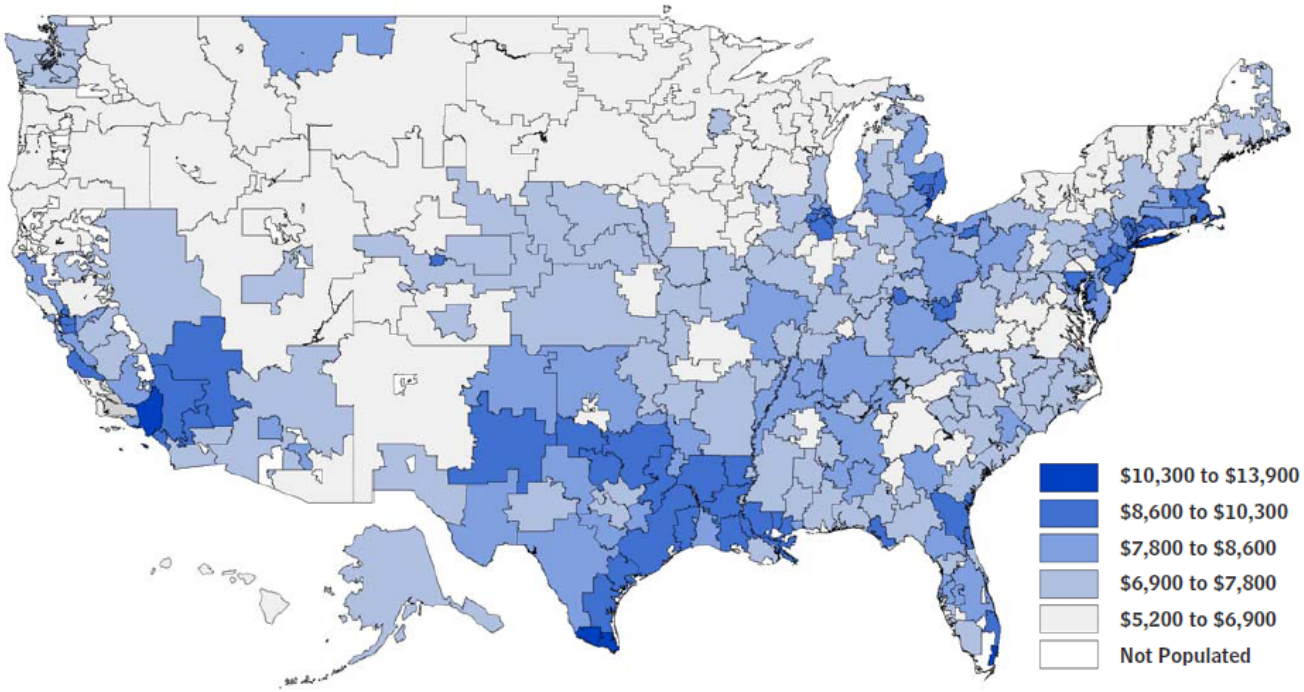
Variation: Nationally

Figure 2.

Medicare Spending per Beneficiary, by Hospital Referral Region, 2005



Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Note: The data are for Medicare spending per beneficiary in the fee-for-service program on the basis of beneficiaries' residences and adjusted for age, sex, and race. The geographic unit is the hospital referral region, as defined by the Dartmouth Atlas of Health Care. Areas labeled "Not Populated" include places without residents, such as national parks, forests, lakes, and islands.

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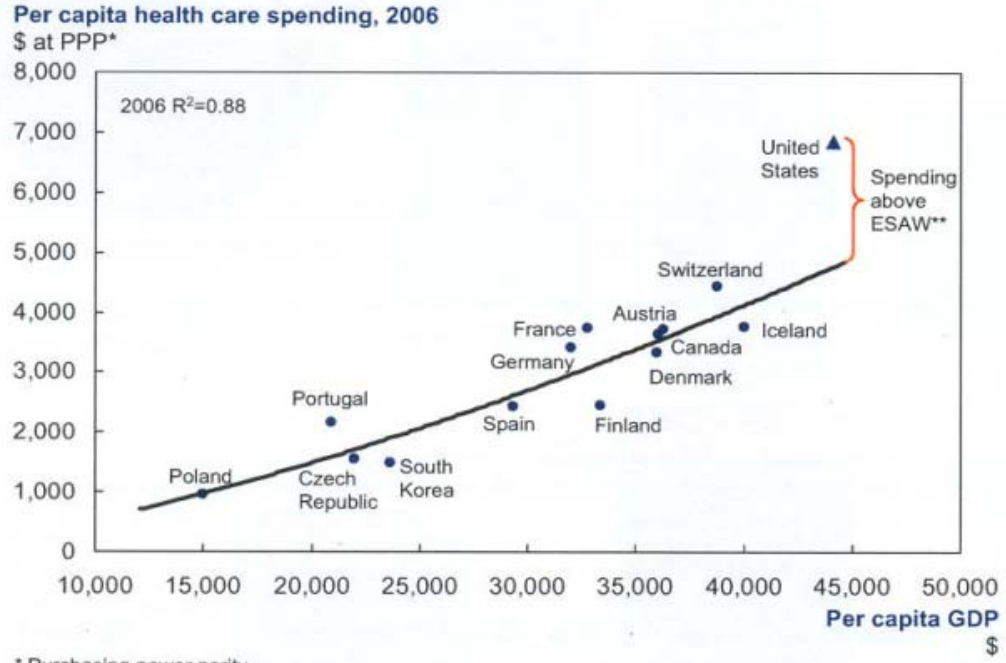
Exploring Variation Internationally

Exhibit 1

The United States spends far more on health care than expected even when adjusting for relative wealth



* Purchasing power parity.

** Estimated Spending According to Wealth.

Source: Organisation for Economic Co-operation and Development (OECD)

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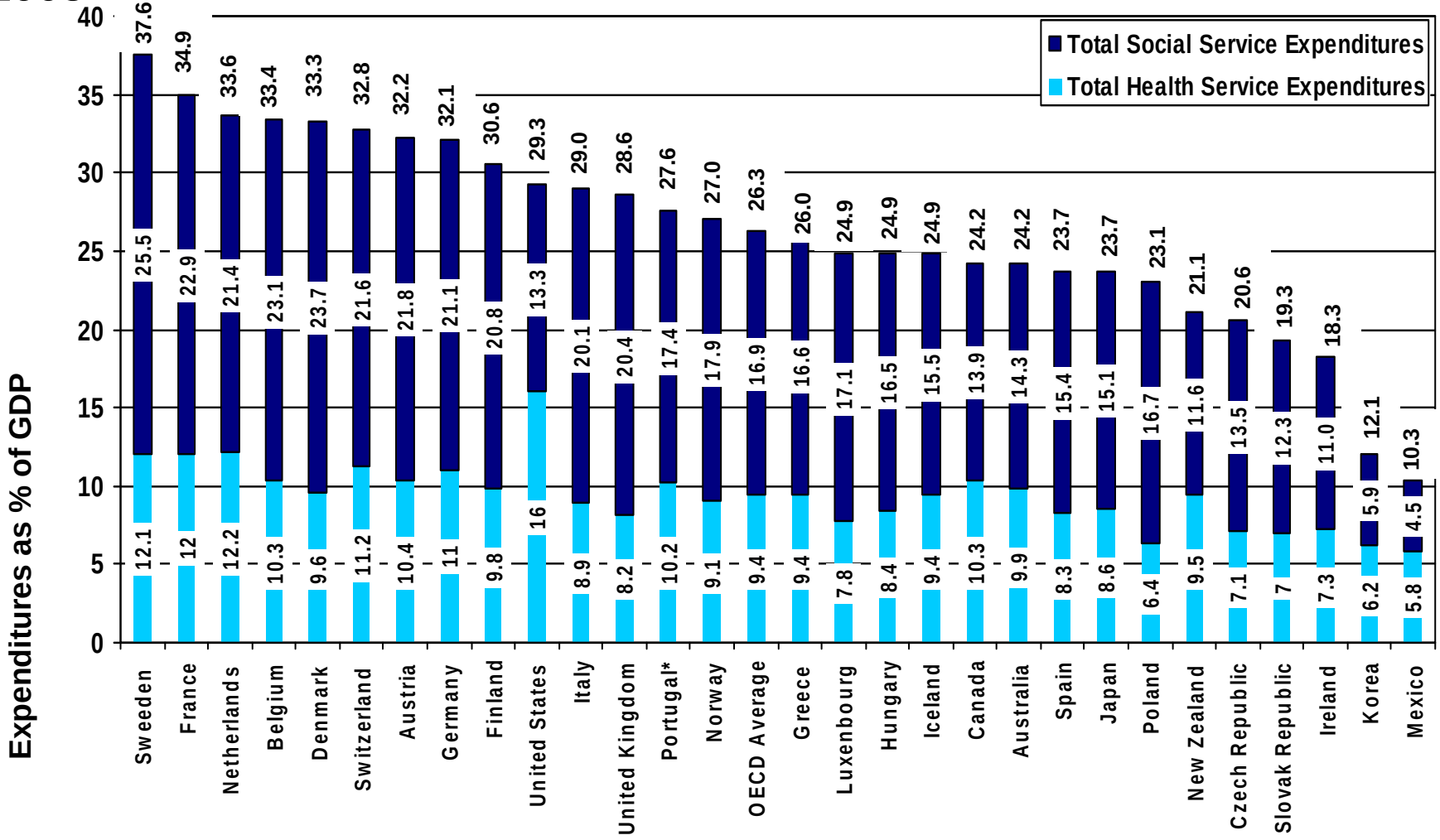
Total Health Service and Social Service Expenditures for OECD Countries 2005



*Expenditures for Portugal are from 2004 due to missing data for 2005.

Source: OECD Health Data 2009 (Accessed June 2009); OECD Social Expenditure Dataset (Accessed Dec 2009); *Health and Social Service Spending; Associations with Health Outcomes* Article by Elizabeth Bradley, Ph.D, Benjamin Elkins, MPH, Brian Elbel, Ph.D.

Assumption 2

BUNDLED PAYMENT IS IMPORTANT TO IMPROVE VALUE

The Status Quo

- Fee For Service provides little incentive for aggressive cost management related to units of service and the relationship of the service to each other.

Bundled Payment

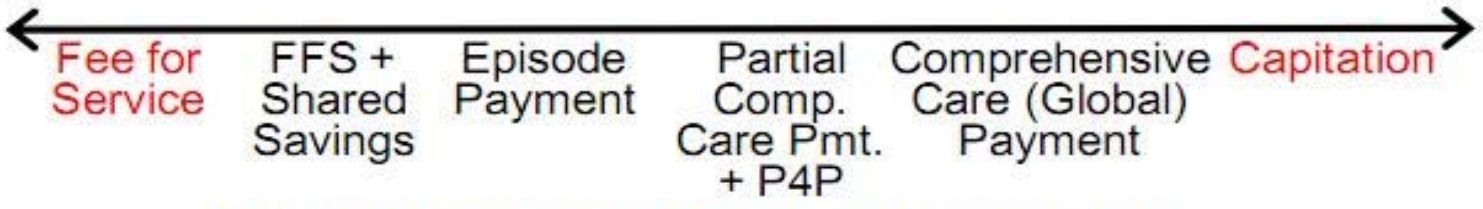


FIGURE 7

Miller, Harold. *How to Create Accountable Care Organizations, 2009*

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Goals of Payment Reform

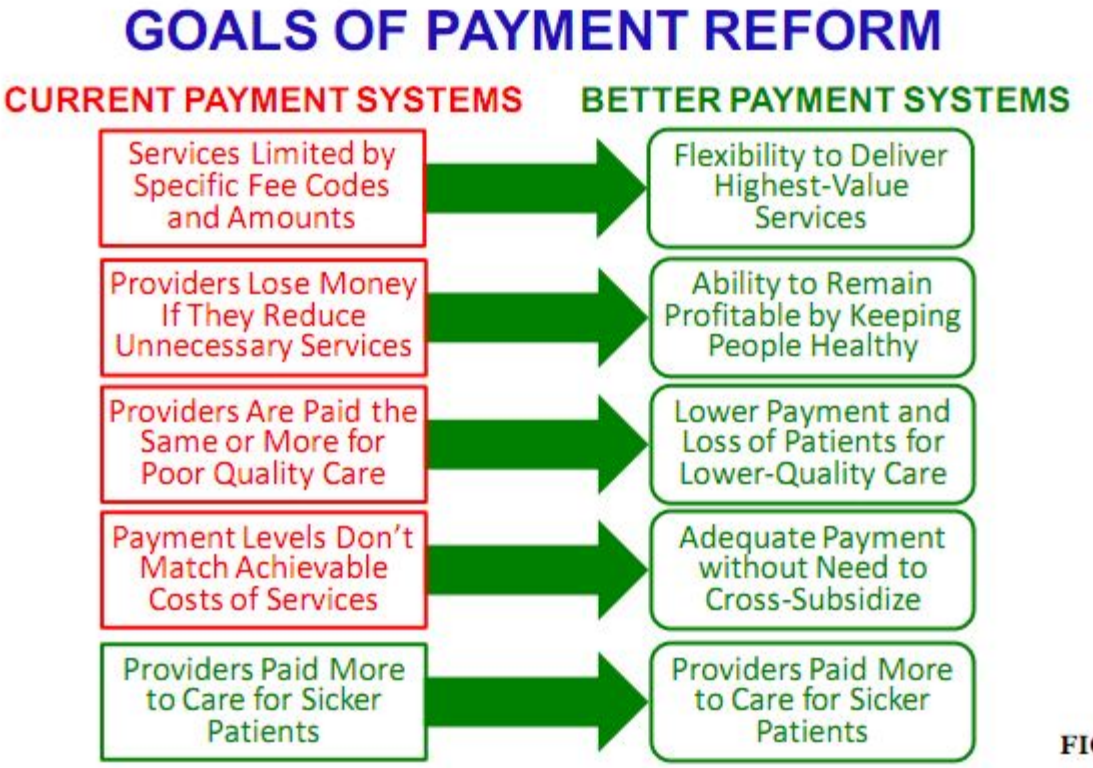

FIGURE 6

Miller, Harold. *How to Create Accountable Care Organizations, 2009*

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Payment Reform

Why is this not scaling?

Assumption 3

ACCOUNTABLE CARE ORGANIZATIONS

The Assumption

- Integrated care generates higher value and integrating structures facilitates integrating care.
- Is this being realized?
- What data do we have?

Accountable Care Organizations

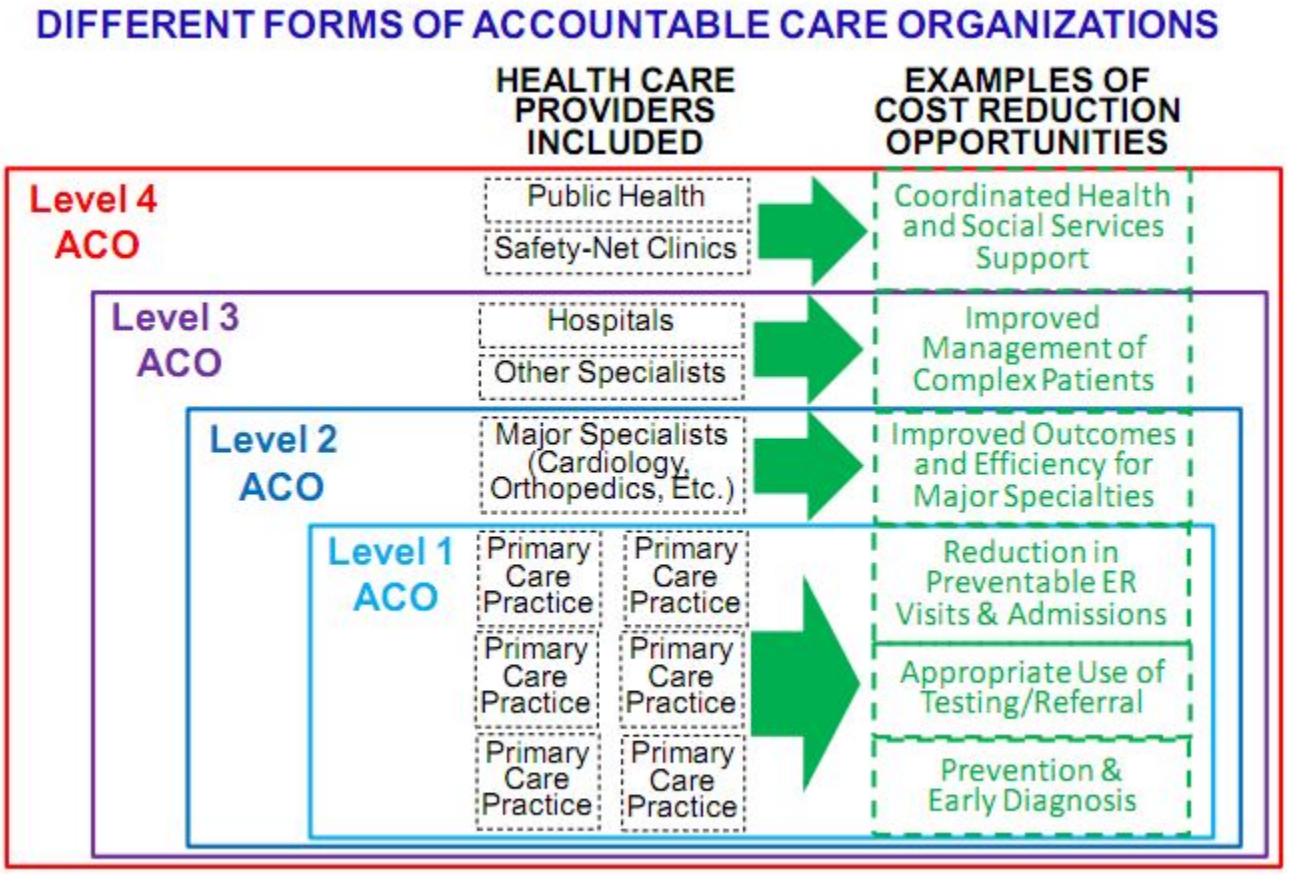

FIGURE 4

Miller, Harold. *How to Create Accountable Care Organizations, 2009*

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Accountable Care Organizations

"… is not a structure, or even

a process, but an outcome – reducing or controlling the costs of health care for a population of

individuals while maintaining, or preferably improving, the quality of that care."

Miller, Harold. Pathways for Physician Success Under Healthcare Payment and Delivery Reforms, 2010

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Accountable Care Organizations

- Table of Contents: The Brookings Institution Toolkit
  - —Part 1: Overview and Key Principles of ACOs
  - —Part 2: Organization and Governance
  - —Part 3: Accountability for Performance
  - —Part 4: ACO Infrastructure
  - —Part 5: Health Care Delivery Transformation for Achieving High-Value Health Care
  - —Part 6: Legal Issues for ACOs

McClellan & Fisher, The Dartmouth Institute, 2001

Capabilities Emphasis (Updated Draft)

Providers will need to augment/add to their capabilities as their amount of risk-based reimbursement increases

		Lower ← Cost, Quality, and Payment Alignment → Higher					
Organizational Capabilities	**Capability Component**	**Fee for Service**	**Pay For Performance**	**Penalties for Adverse / Preventable Events**	**Episodic Bundling**	**Disease / Chronic Care Management**	**Total Health Management**
People & Culture	*Culture and Change Management*	*Establishing Learning Organization*		*Leading with Quality*		*Managing Long-Term Conditions*	*Engaging the Community*
	Management and Governance	*Informal Physician Leadership*		*Formal Acute-Care Physician Leadership*		*Communities of Practice*	
	Operating Model	*Department Structure*		*Episode-Focused Service Lines*		*Cross-Continuum Product Lines*	*Community Collaboratives*
	Compensation and Incentives	*Productivity-Based*		*Outcomes-Based*			
Business Intelligence	*Financial Reporting and Costing*	*Procedure-Level*		*Activity-Level*	*Longitudinal*	*PMPM*	
	Quality Reporting	*Core Measures*	*Process Measures*	*Outcome Measures*		*Condition Measures*	*Population Indicators*
	Business Case	*Supply/Drug & Productivity*		*Medical / Surgical Interventions*		*Lifestyle Interventions*	
	Decision Support Systems	*Financial Data*	*Acute Quality Data*	*Ambulatory Indicators*	*Claims and Prescription Info*	*Health Risk Assessment, Biometrics, and Predictive Modeling*	
Performance Improvement	*Process Engineering*	*Identifying Service Variability*		*Increasing Reliability within Care Bundles*		*Optimizing Care Pathways across the Continuum*	
	Evidence-Based Medicine	*Patient Safety*		*Clinical Value Bundles*		*Condition Management*	*Wellness*
	Consumer Engagement	*Creating Transparency*		*Informing Patient Alternatives*		*Developing Accountability*	
Contract & Risk Management	*Payer and Provider Contract Mgmt*	*Negotiating Pricing*		*Balancing Cost and Quality Aims*		*Network Development / Funds Distribution*	
	Actuarial			*Estimating Exposure*		*Predicting Outcomes*	
Enabling Technology	*Medical Technology*	*Facility-Based*		*Ambulatory-Focused*		*Home-Based*	
	Information Systems	*Standardizing Patient Accounting*		*Supporting Clinical Work Flows / Connecting Data from Disparate Systems*		*Enabling Medical Management*	

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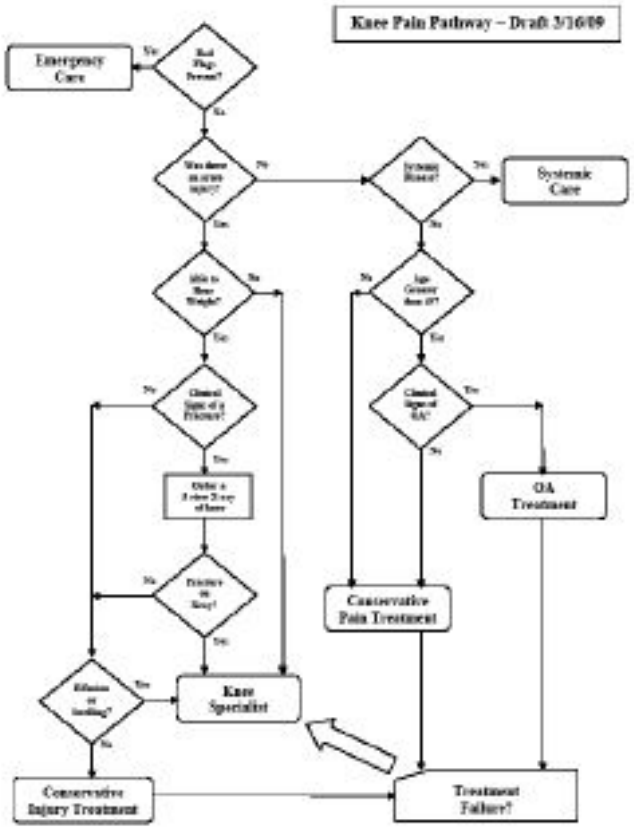
HFMA Value Project, 2011

Evidence-Based Medicine

Knee Pain

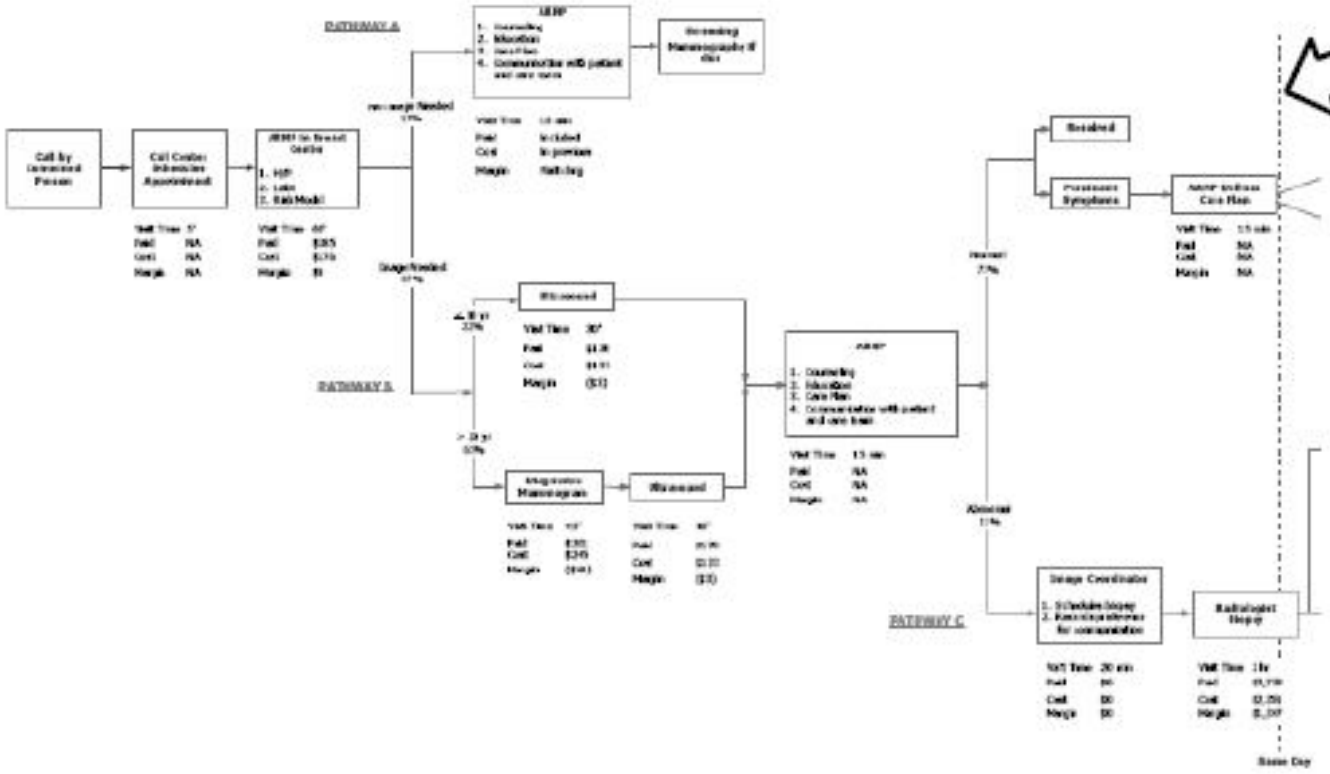
Translating evidence appraisal into standardized clinical practice



TEAM MEDICINE VIRGINIA MASON

Breast Clinic

Same-day Access and Rapid Return to Function



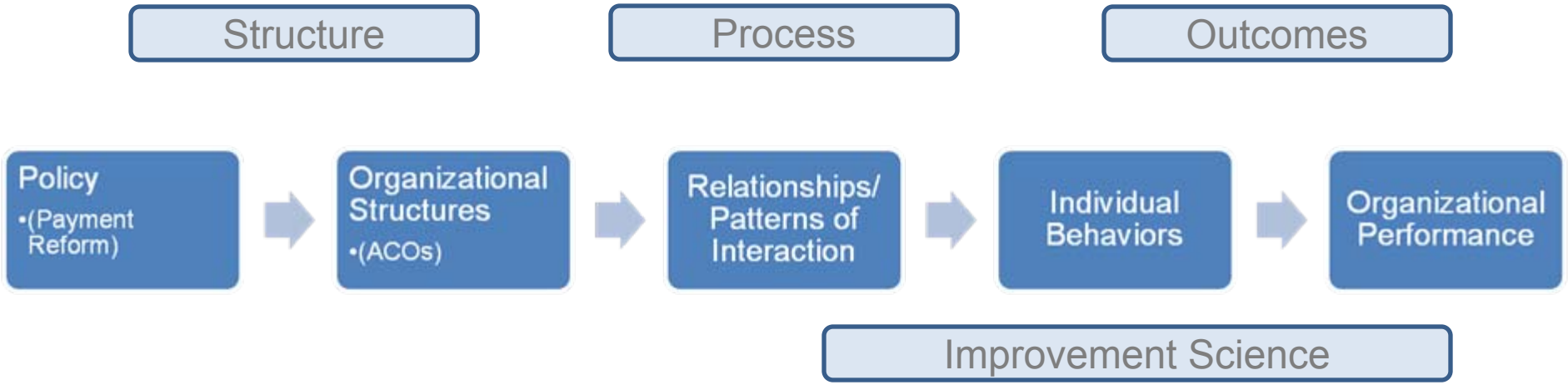
Evaluation complete for 90% of patients in one day.

TEAM MEDICINE VIRGINIA MASON

Push Back

- Employers and health plans fear that ACOs are more about market concentration than improving value.
  - Does that suggest higher costs?

The Construct For The Aim and Aspiration



Hoffer-Gittlell, Heller School
Brandeis University

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Conclusion

Bundled Payment and ACOs show promise.

But, it depends
on whether the Will-Ideas-Execution

Will be directed to improving health and health care
Vs.
Consolidating and integrating for market control

Conclusion

The health of our people and the health of our nation depend on our

willingness and capacity to improve.