# Accountable Care

*Managing toward a Sustainable Health Care System*

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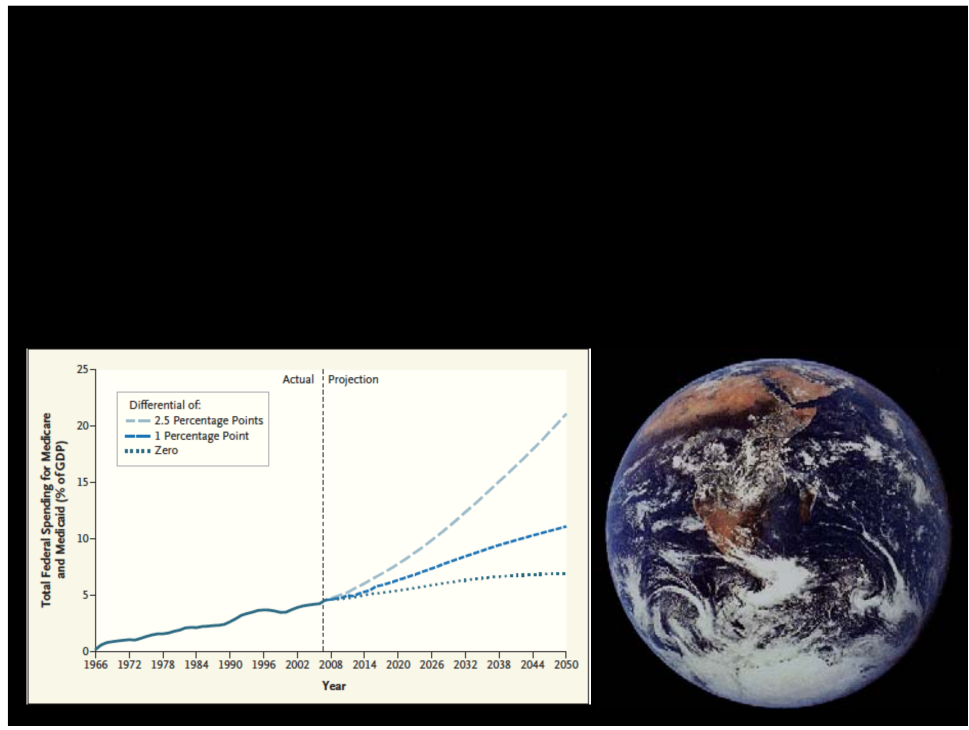
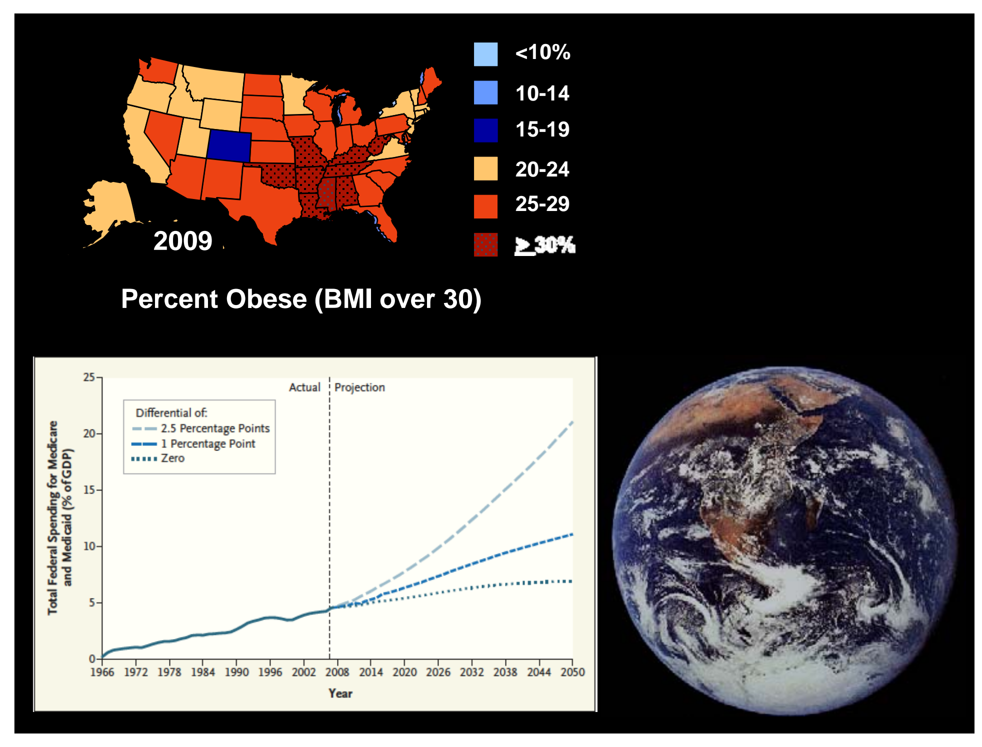
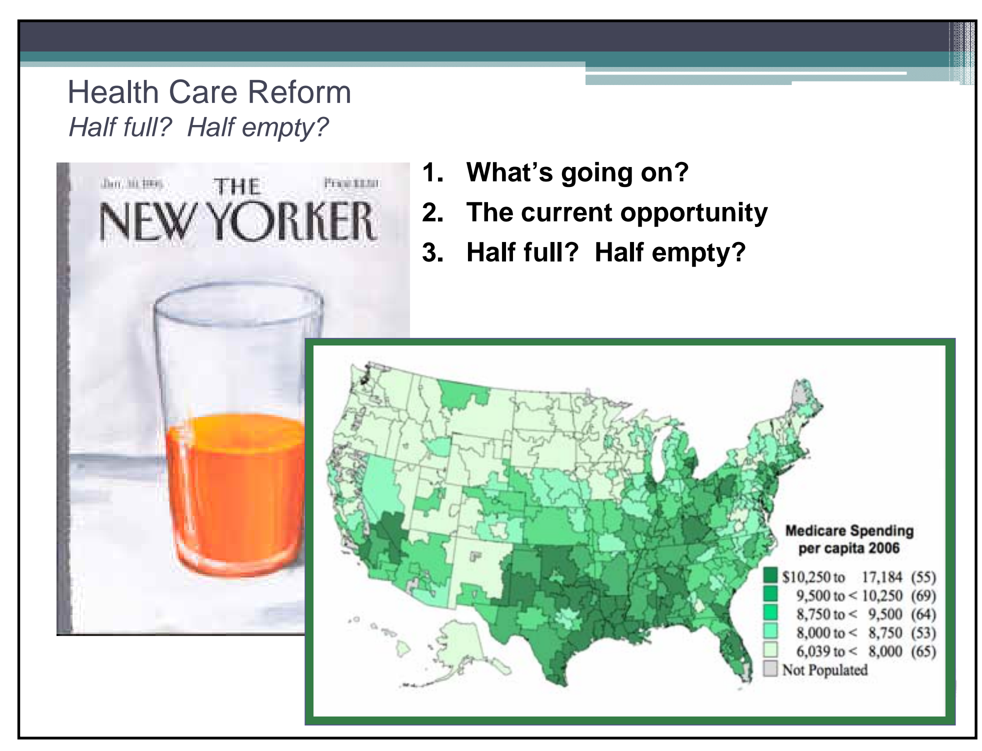
The Dartmouth Institute for Health Policy
and Clinical Practice





<10%
10-14
15-19
20-24
25-29
≥30%
2009
Percent Obese (BMI over 30)
Actual
Projection
Differential of:
2.5 Percentage Points
1 Percentage Point
Zero
Total Federal Spending for Medicare and Medicaid (% of GDP)
Year

THE
NEW YORKER




## What's going on?

**Variations in Spending: Is More Always Better?**

### Health implications of regional variations in spending

Initial study: About 1 million Medicare beneficiaries with AMI, colon cancer and hip fracture

Compared content, quality and outcomes across high and low spending regions

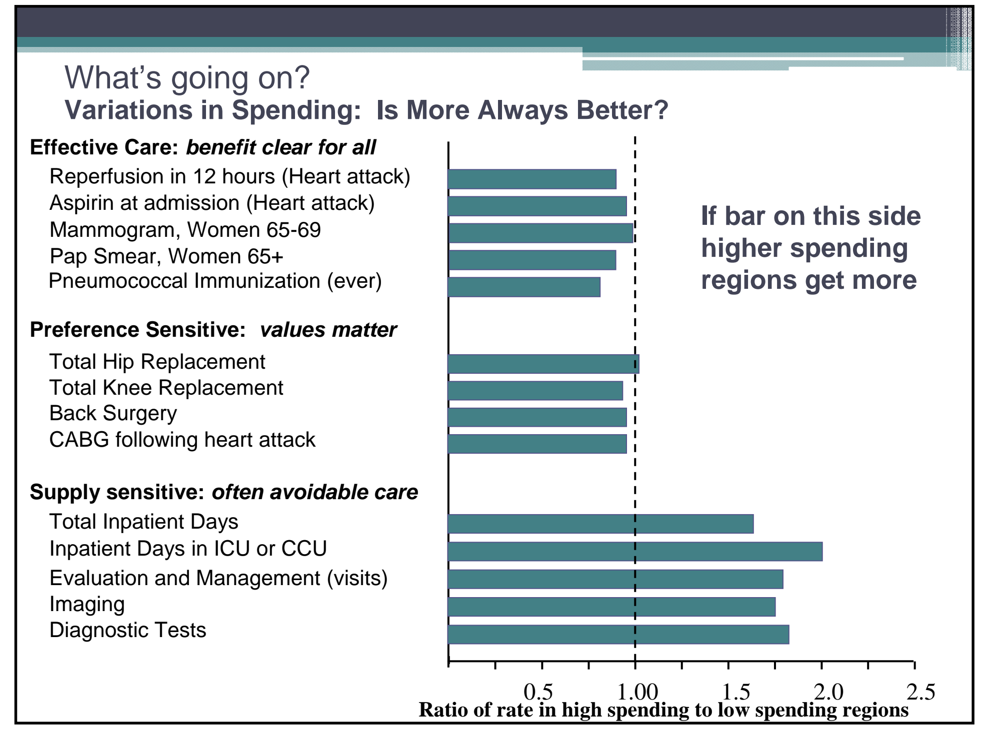
**<u>Per-capita Spending</u>**

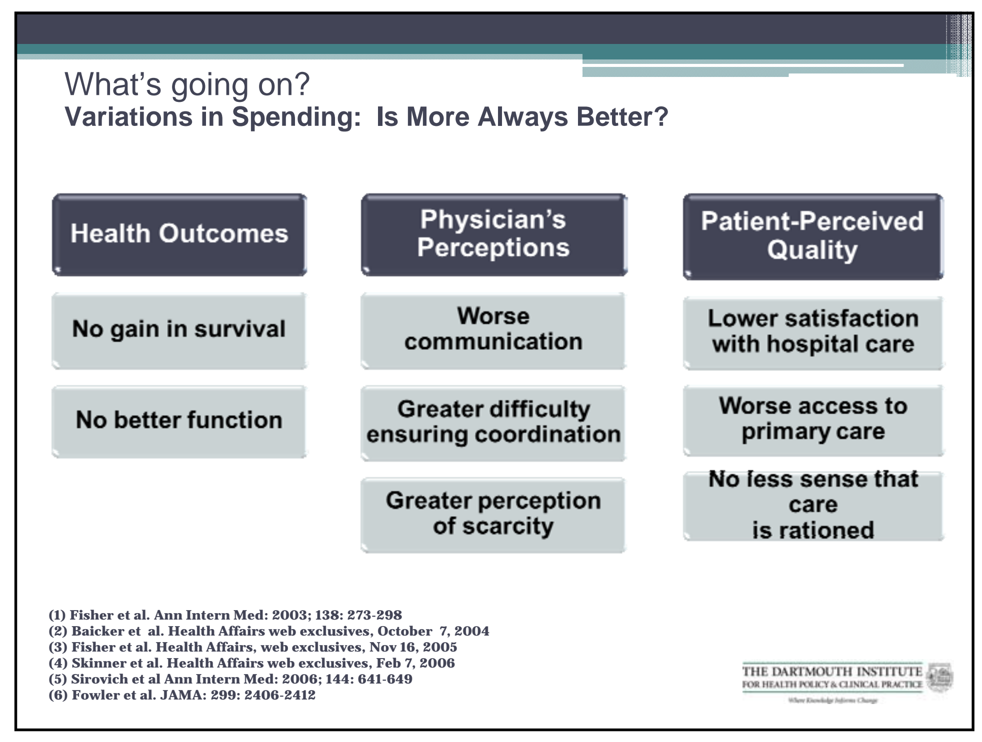
| | |
|---|---|
| **Low (pale):** | **$3,992** |
| **High (red):** | **$6,304** |
| **Difference:** | **$2,312** |
| **(61% higher)** | |

Per-capita
Medicare Spending

| | 1996 | 2000 |
|---|---|---|
| | $ 3,922 | $ 5,229 |
| | $ 4,439 | $ 5,692 |
| | $ 4,940 | $ 6,069 |
| | $ 5,444 | $ 6,614 |
| | $ 6,304 | $ 8,283 |
| Ratio: High to Low: | 1.61 | 1.58 |

(1) Fisher et al. Ann Intern Med: 2003; 138: 273-298
(2) Baicker et al. Health Affairs web exclusives, Oct
(3) Fisher et al. Health Affairs, web exclusives, Nov
(4) Skinner et al. Health Affairs web exclusives, Feb
(5) Sirovich et al Ann Intern Med: 2006; 144: 641-64
(6) Fowler et al. JAMA: 299: 2406-2412


What's going on?
Variations in Spending: Is More Always Better?
Effective Care: benefit clear for all
Reperfusion in 12 hours (Heart attack)
Aspirin at admission (Heart attack)
Mammogram, Women 65-69
Pap Smear, Women 65+
Pneumococcal Immunization (ever)
Preference Sensitive: values matter
Total Hip Replacement
Total Knee Replacement
Back Surgery
CABG following heart attack
Supply sensitive: often avoidable care
Total Inpatient Days
Inpatient Days in ICU or CCU
Evaluation and Management (visits)
Imaging
Diagnostic Tests
If bar on this side higher spending regions get more
0.5
1.00
1.5
2.0
2.5
Ratio of rate in high spending to low spending regions


What's going on?
Variations in Spending: Is More Always Better?
Health Outcomes
Physician's Perceptions
Patient-Perceived Quality
No gain in survival
Worse communication
Lower satisfaction with hospital care
No better function
Greater difficulty ensuring coordination
Worse access to primary care
Greater perception of scarcity
No less sense that care is rationed
(1) Fisher et al. Ann Intern Med: 2003; 138: 273-298
(2) Baicker et al. Health Affairs web exclusives, October 7, 2004
(3) Fisher et al. Health Affairs, web exclusives, Nov 16, 2005
(4) Skinner et al. Health Affairs web exclusives, Feb 7, 2006
(5) Sirovich et al Ann Intern Med: 2006; 144: 641-649
(6) Fowler et al. JAMA: 299: 2406-2412
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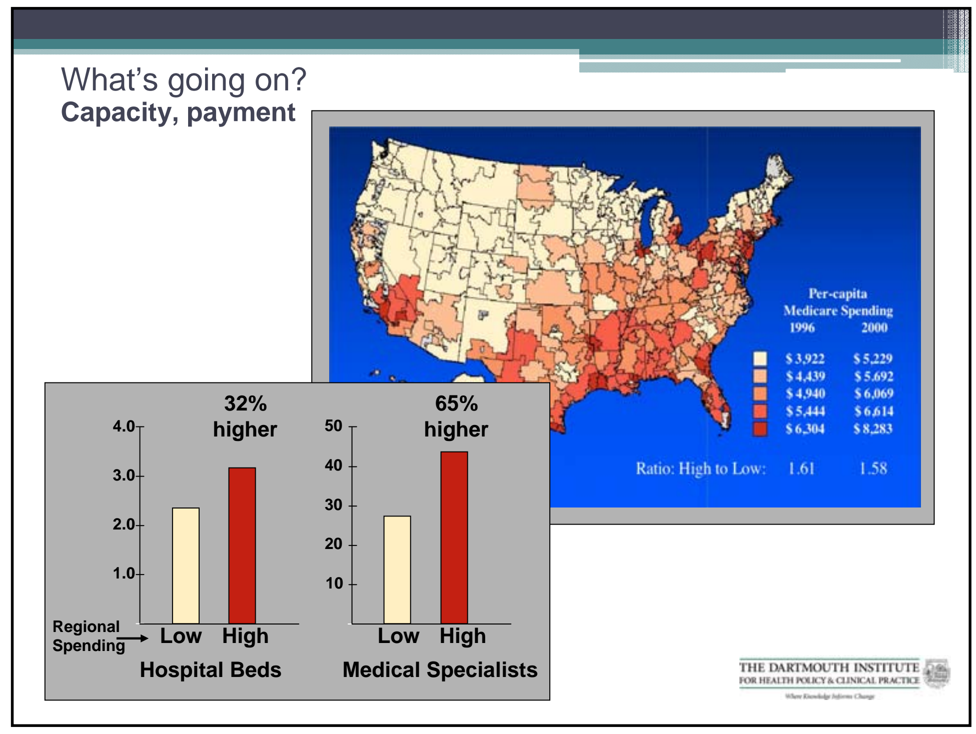
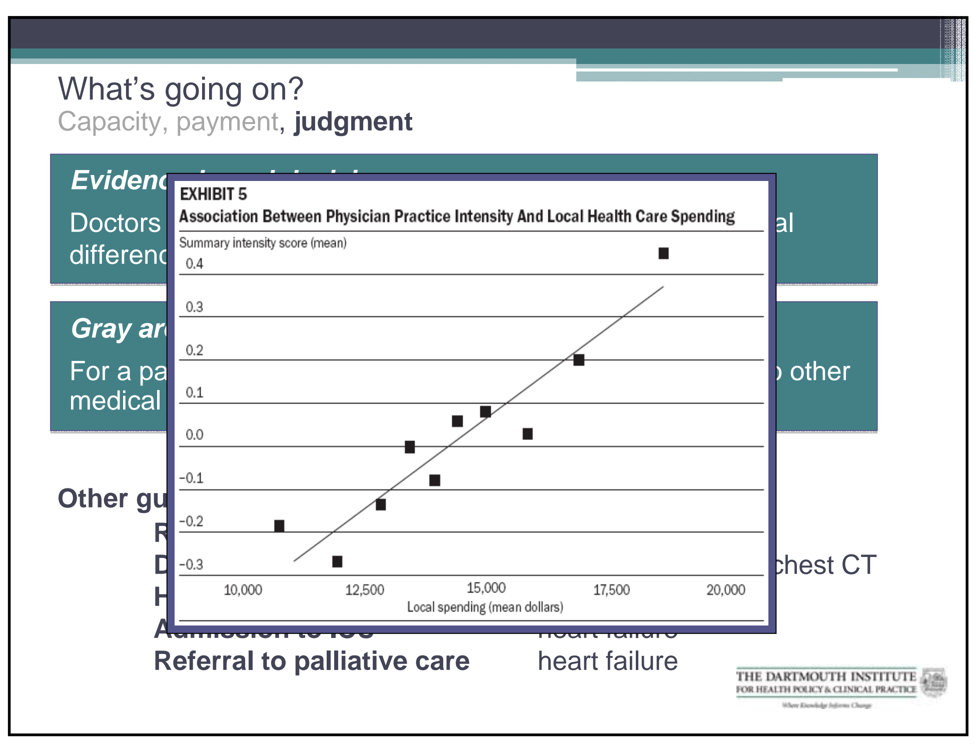
FOR HEALTH POLICY & CLINICAL PRACTICE


What's going on?
Capacity, payment
Per-capita
Medicare Spending
1996 2000
$ 3,922 $ 5,229
$ 4,439 $ 5,692
$ 4,940 $ 6,069
$ 5,444 $ 6,614
$ 6,304 $ 8,283
Ratio: High to Low: 1.61 1.58
32% higher
65% higher
4.0
3.0
2.0
1.0
50
40
30
20
10
Regional Spending
Low High
Low High
Hospital Beds
Medical Specialists
THE DARTMOUTH INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE


What's going on?
Capacity, payment, judgment
Evidenc
Doctors
differenc
al
Gray ar
For a pa
medical
other
Other gu
chest CT
Referral to palliative care
heart failure
EXHIBIT 5
Association Between Physician Practice Intensity And Local Health Care Spending
Summary intensity score (mean)
0.4
0.3
0.2
0.1
0.0
-0.1
-0.2
-0.3
10,000
12,500
15,000
17,500
20,000
Local spending (mean dollars)
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## What's going on?

Capacity, payment, judgment**, values**

| | Procedures Per Day | Days Per Month | Average CPT | Income | FMVL Cost | ROI* Per Month | ROI for 5 Years |
|---|---|---|---|---|---|---|---|
| A | 1.8 | 20 | $220 | $7,950 | $7,950 | Break Even | Break Even |
| B | 5 | 20 | $220 | $22,000 | $7,950 | $14,050 | $843,000 |
| C | 10 | 20 | $220 | $44,000 | $7,950 | $36,050 | $2,163,000 |

*Sample computation – Basic SOMATOM Spirit configuration, based on a 5-year Fair Market Value Lease (FMVL). Prices will vary with additional options. Please consult your Siemens Account Executive for details.*
**Return on Investment.*

## What's going on?

Capacity, payment, judgment**, values**

"These marketing ploys are wildly successful across the entire country. Patients are viewed as the ball in a pinball machine, popped back and forth, ringing up profits, until finally they escape past the paddles and can no longer render income. I believe that the fingers controlling those paddles, Dr. Fisher, often use those "gray areas of judgment" as an excuse to shoot the patient back to the triple-score bumpers."

**Geoffrey G. Smith, MD, Casper Medical Imaging**
**May 24, 2007 (email)**

## What's going on?

Capacity, payment, judgment, values, **community culture**

"Here … a medical community came to treat patients the way subprime mortgage lenders treated home buyers: as profit centers."

Atul Gawande

| | 2006 Spending | 92-06 Growth |
|---|---|---|
| **McAllen** | **$14,946** | **8.3%** |
| **La Crosse** | **$5,812** | **3.9%** |

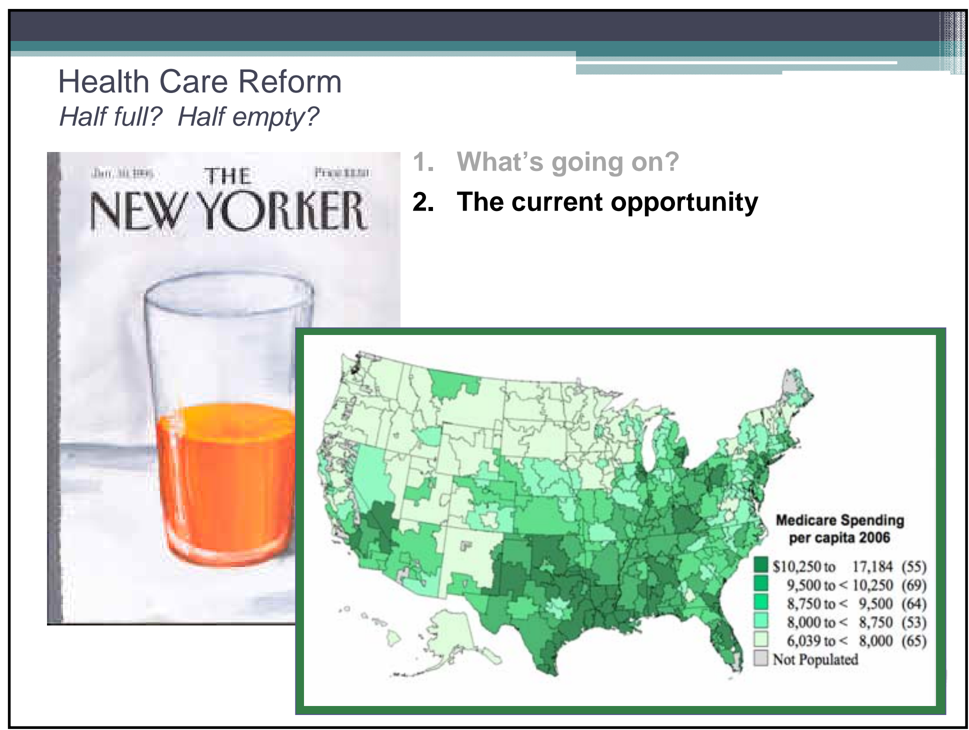
"…a culture that focuses on the wellbeing of the community, not just the financial health of our system."

Jeff Thompson, MD
CEO Gunderson-Lutheran
La Crosse, WI

## What have we learned?

Principles guiding the development of Accountable Care

| **Underlying problem** | **Key principles** |
|---|---|
| **Confusion** about aims | **Clarify aims:** Better health, better care lower costs – for patients and communities |
| **Absent or poor data** leaves practice unexamined and public assuming that more is always better. | **Better information** that engages physicians, supports improvement; informs consumers and patients |
| **Flawed conceptual model.** Health is produced only by individual actions of expert (specialist) physicians. | **New model: It's the system.** Establish organizations *accountable for aims* and capable of *redesigning practice* and *managing capacity* |
| **Wrong incentives** reinforce model, reward fragmentation, induce more care and entrepreneurial behavior. | **Rethink our incentives:** Realign incentives – both financial and professional – with aims. |




## The Opportunity

National quality strategy – guiding principles

**Person-centeredness and family engagement will guide all strategies, goals, and improvement efforts**

**The strategy and goals will address all ages, populations, service locations, and sources of coverage**

**Eliminating disparities in care – including but not limited to those based on race, ethnicity, gender, age, disability, socioeconomic status and geography**

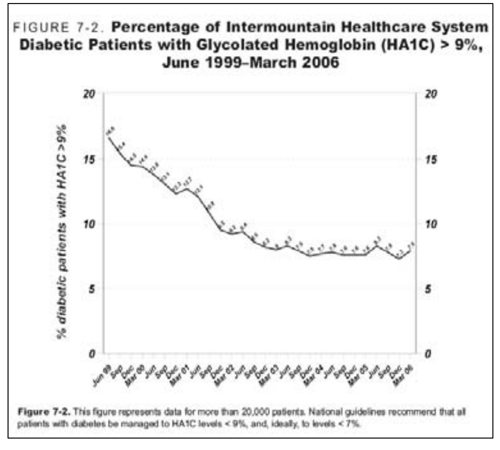
**The design and implementation of the strategy will consistently seek to align the efforts of public and private sectors**

## The Opportunity

The science of improvement has advanced dramatically

**If Health Care is Going to Change, Dr. Brent James' Ideas will Change it**

**David Leonhardt, New York Times Magazine, November 3, 2009**



## The Opportunity

Federal legislation creates policy window – and new money

### American Recovery and Reinvestment Act (ARRA)

- ***Health Information Technology***: financial support for adoption – linked to "meaningful use" 2011 rules established; 2013, 2015 pending
- ***Comparative Effectiveness Research***: investment in research to improve evidence on effectiveness of both biotechnology and delivery system innovations

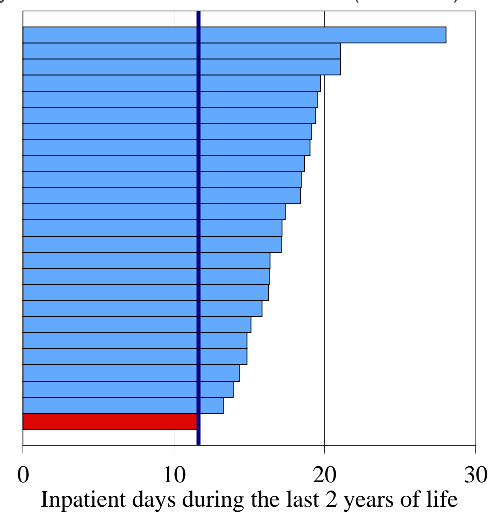
### Affordable Care Act

- ***Leadership & support for improvement***: National strategy
- ***CMS Innovation Center:*** (2011) Testing and dissemination of new payment and delivery models: $10 billion *appropriated*
- ***New models of care and payment***
  - Accountable Care Organizations
  - Episode / bundled payments
  - Medical Home
  - Shift toward value-based payment

## The Opportunity

Avoidable hospital stays

Inpatient days per patient during the last two years of life in California HRRs (2001-05)




| Area | Ratio to benchmark | Surplus/ deficit |
|---|---|---|
| Los Angeles | 2.39 | 1,503,127 |
| Orange County | 1.79 | 271,676 |
| Ventura | 1.79 | 92,904 |
| Alameda County | 1.68 | 114,051 |
| Palm Sprgs/Rancho Mir | 1.66 | 49,357 |
| Contra Costa County | 1.65 | 75,926 |
| San Bernardino | 1.63 | 154,164 |
| Bakersfield | 1.62 | 100,127 |
| San Francisco | 1.59 | 115,334 |
| San Diego | 1.57 | 226,556 |
| San Jose | 1.57 | 93,681 |
| Salinas | 1.48 | 38,298 |
| Fresno | 1.46 | 84,871 |
| Modesto | 1.46 | 61,683 |
| San Mateo County | 1.39 | 41,194 |
| Chico | 1.39 | 40,524 |
| Stockton | 1.38 | 32,395 |
| Redding | 1.35 | 41,010 |
| Sacramento | 1.29 | 100,670 |
| San Luis Obispo | 1.27 | 16,109 |
| Santa Cruz | 1.26 | 13,017 |
| Napa | 1.23 | 19,086 |
| Santa Rosa | 1.19 | 15,084 |
| Santa Barbara | 1.13 | 10,466 |
| **La Crosse, WI** | **1.00** | -- |

## Health Care Reform

***Half full? Half empty?***

***It's up to us***

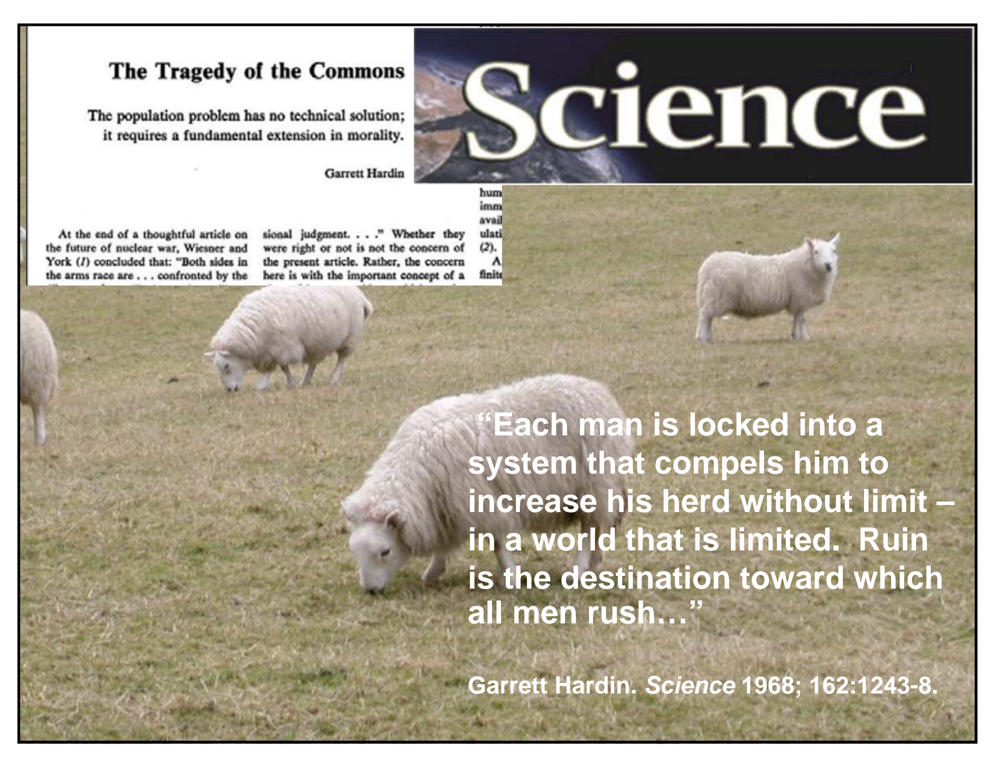
**Health care reform (& ACOs) could fail**

- Public fearful – and could reject the model
- Payers worry about market power
- Providers could see as zero-sum game

**We have a choice**

**What might we do?**

- Consider our role as stewards of our community's health and well-being
- Step forward to help reforms succeed
- Recognize that health and health care are produced locally (work together)


The Tragedy of the Commons
The population problem has no technical solution; it requires a fundamental extension in morality.
Garrett Hardin
At the end of a thoughtful article on the future of nuclear war, Wiesner and York (1) concluded that: "Both sides in the arms race are . . . confronted by the
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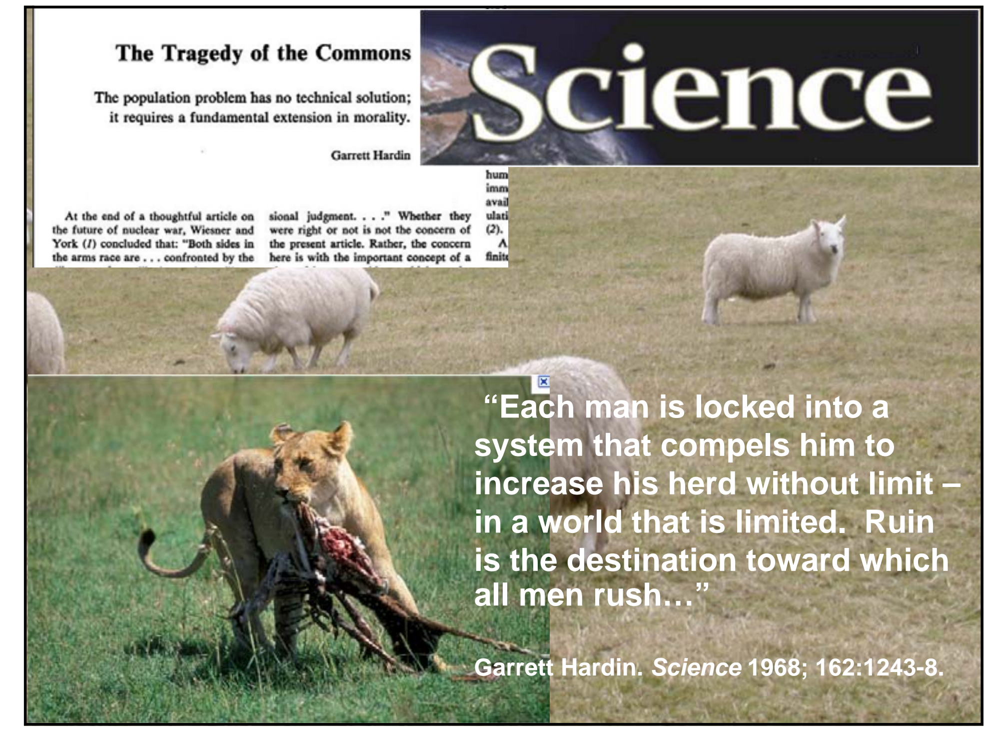
Science
"Each man is locked into a system that compels him to increase his herd without limit – in a world that is limited. Ruin is the destination toward which all men rush…"
Garrett Hardin. Science 1968; 162:1243-8.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## Governing the Commons

Elinor Ostrom

***Design principles for managing "common pool resources"***

(1) Defined boundaries, known "appropriators"

(2) Rules reflect local conditions and knowledge

(3) Those affected determine and modify rules

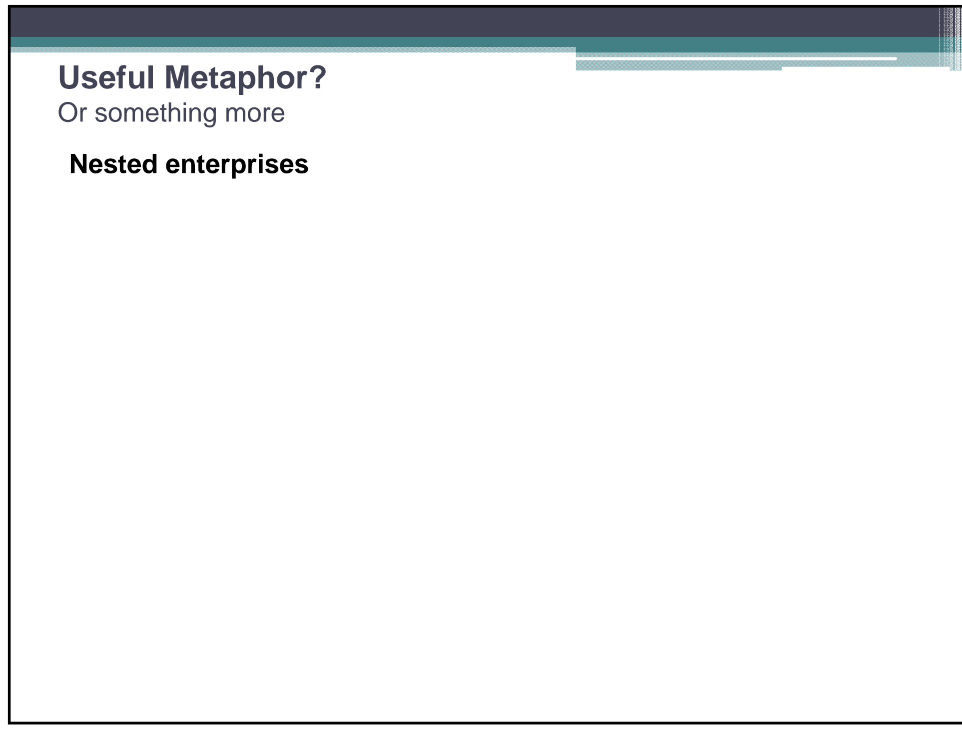
(4) Monitoring of performance

(5) Graduated sanctions

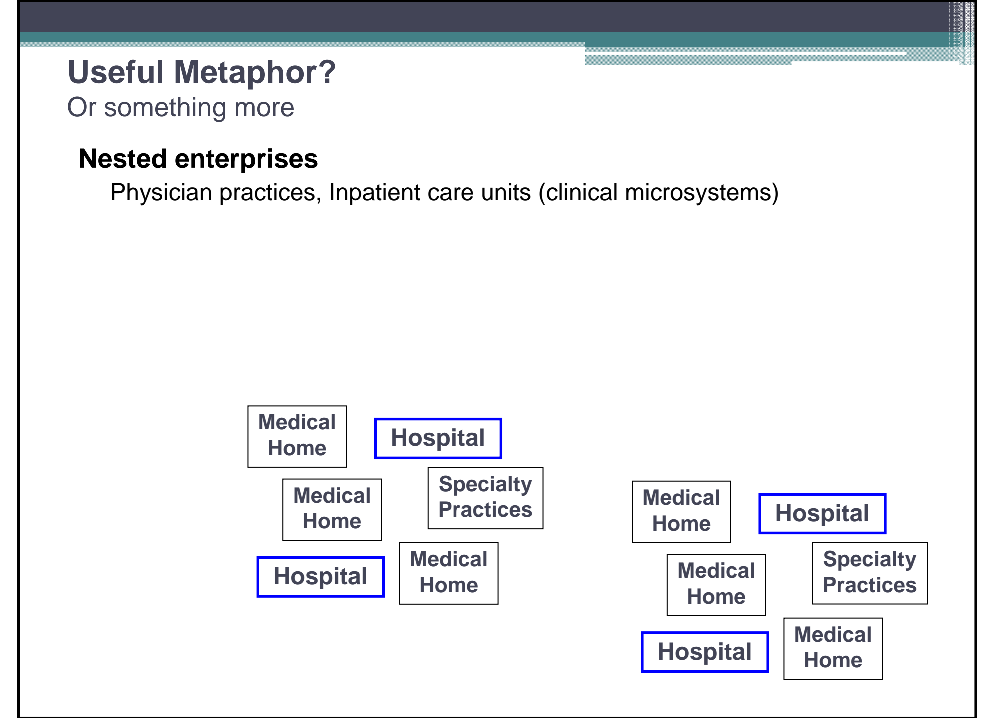
(6) Conflict resolution mechanisms

(7) Right to self-organize is recognized by authorities

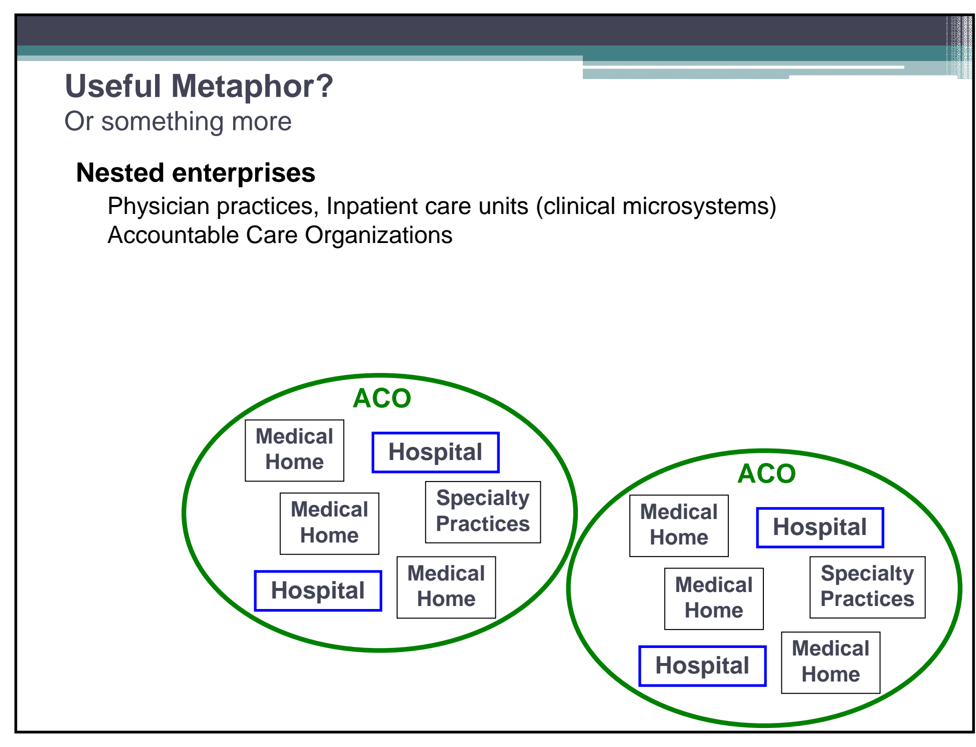
(8) Nested enterprises



Useful Metaphor?
Or something more
Nested enterprises

Useful Metaphor?
Or something more
Nested enterprises
Physician practices, Inpatient care units (clinical microsystems)
Medical Home
Hospital
Medical Home
Specialty Practices
Hospital
Medical Home
Medical Home
Hospital
Medical Home
Specialty Practices
Hospital
Medical Home


Useful Metaphor?
Or something more
Nested enterprises
Physician practices, Inpatient care units (clinical microsystems)
Accountable Care Organizations
ACO
Medical Home
Hospital
Medical Home
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Medical Home
ACO
Medical Home
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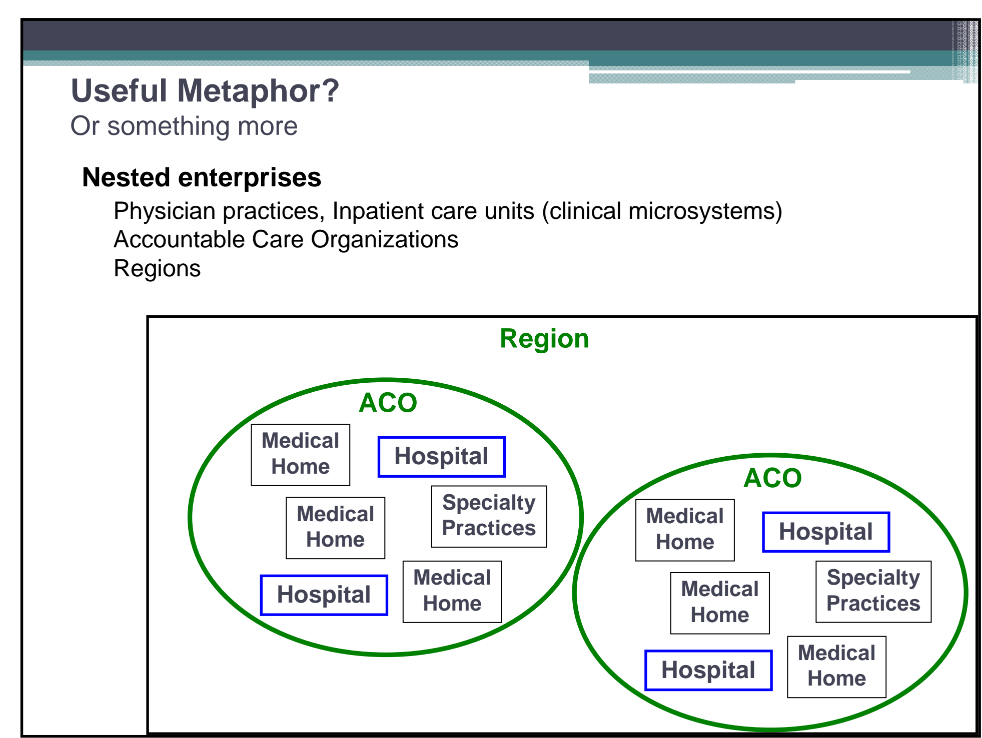
Medical Home


Useful Metaphor?
Or something more
Nested enterprises
Physician practices, Inpatient care units (clinical microsystems)
Accountable Care Organizations
Regions
Region
ACO
Medical Home
Hospital
Medical Home
Specialty Practices
Hospital
Medical Home
ACO
Medical Home
Hospital
Medical Home
Specialty Practices
Hospital
Medical Home

## Useful Metaphor?
Or something more

**Nested enterprises**

**Monitoring, feedback, graduated sanctions**:
*Shared responsibility*

**A focus on stewardship**
*Better care, better health, lower costs*

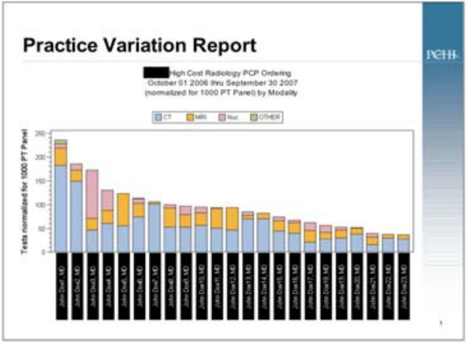
**Leadership**

**Parker Palmer** "A leader is someone with the power to project either shadow or light onto some part of the world and onto the lives of the people who dwell there. A leader shapes the ethos in which others must live, an ethos as light filled as heaven or as shadowy as hell."

**Ronald Heiffitz:** A leader helps us know where we want to go, clarifying values and fundamental interests, resolving conflicts, helping bridge the gap between current and desired state.

## Physician Practices (and other micro-systems)
*Care redesign, monitoring, peer-to-peer feedback*

Ch 7. BC James, JS Lazar. A health system's use of clinical programs to build quality infrastructure. In: Practice-Based Learning and Improvement Second Edition. EC Nelson, PB Batalden, JS Lazar, Eds.




**May 29, 2008 Presentation at Federal Trade Commission**
**Tom Lee, MD (Partners Healthcare System)**
**(used with permission)**

## Physician Practices (and other micro-systems)

*Group Health Cooperative – Medical Home Pilot*

MEDICAL HOMES: A SOLUTION?

By Robert J. Reid, Katie Coleman, Eric A. Johnson, Paul A. Fishman, Clarissa Hsu, Michael P. Soman, Claire E. Trescott, Michael Erikson, and Eric B. Larson

**The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers**

## Accountable Care Organizations

*Provider organizations accountable for care across continuum*

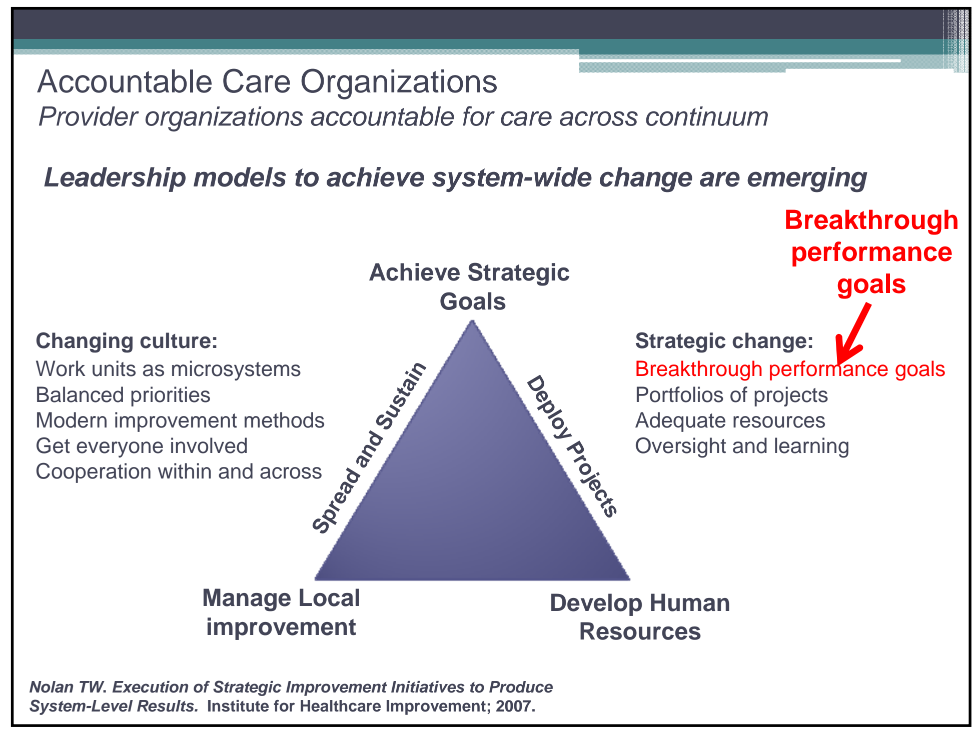
***Leadership models to achieve system-wide change are emerging***

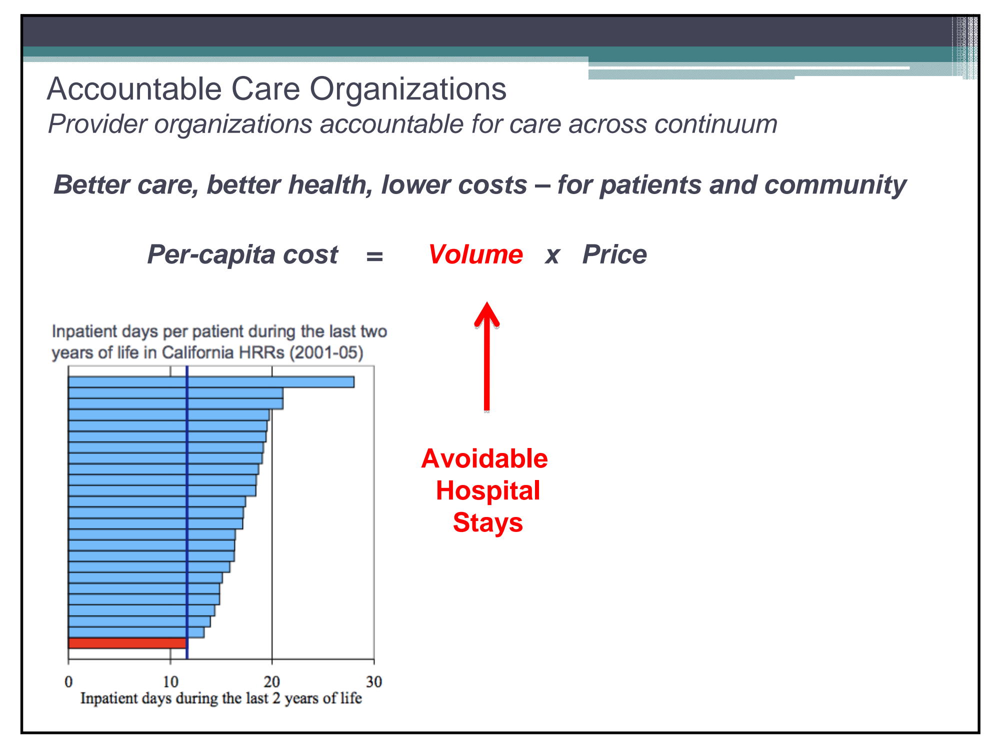
**Changing culture:**
Work units as microsystems
Balanced priorities
Modern improvement methods
Get everyone involved
Cooperation within and across



**Strategic change:**
Breakthrough performance goals
Portfolios of projects
Adequate resources
Oversight and learning

*Nolan TW. Execution of Strategic Improvement Initiatives to Produce System-Level Results.* Institute for Healthcare Improvement; 2007.


Accountable Care Organizations
Provider organizations accountable for care across continuum
Leadership models to achieve system-wide change are emerging
Breakthrough performance goals
Achieve Strategic Goals
Changing culture:
Work units as microsystems
Balanced priorities
Modern improvement methods
Get everyone involved
Cooperation within and across
Spread and Sustain
Deploy Projects
Strategic change:
Breakthrough performance goals
Portfolios of projects
Adequate resources
Oversight and learning
Manage Local improvement
Develop Human Resources
Nolan TW. Execution of Strategic Improvement Initiatives to Produce System-Level Results. Institute for Healthcare Improvement; 2007.


Accountable Care Organizations
Provider organizations accountable for care across continuum
Better care, better health, lower costs – for patients and community
Per-capita cost = Volume x Price
Inpatient days per patient during the last two years of life in California HRRs (2001-05)
0
10
20
30
Inpatient days during the last 2 years of life
Avoidable Hospital Stays

## Accountable Care Organizations

*Provider organizations accountable for care across continuum*

***Better care, better health, lower costs – for patients and community***

***Per-capita cost = Volume x (Cost + Margin)***

**Redesign**
**Cleveland Clinic**
**Dartmouth-Hitchcock**

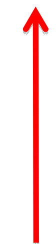
**Refer Wisely**
**B-D Pilots**
**Kaiser-Permanente**

## Accountable Care Organizations

*Provider organizations accountable for care across continuum*

***Better care, better health, lower costs – for patients and community***

***Per-capita cost = Volume x (Cost + Margin)***



**What is reasonable?**
**How would we know?**

## Accountable Care Organizations
*An optimistic scenario*

**ACO's should seek:**

- To improve primary and specialty care through redesign
- To reduce costs by eliminating unneeded services and reducing unit costs
- *To make careful "buy vs build" decisions*
- *To be fairly rewarded (and thus open about their margin and how it's used)*

**Referral centers should seek:**

- To manage their own primary care populations as ACOs
- To demonstrate value (and deliver high quality / low cost episodes)
  - *Capture market share for wanted, needed episodes*

**A virtuous cycle?**

- *ACOs continually re-engineer their care, referring wisely to others*
- *Referral centers specialize appropriately, (fewer centers, higher volumes)*
- *Poor quality, high cost providers forced to improve or find new work….*
- ***Costs stabilize, <u>per-capita costs fall</u>, quality improves***

## Accountable Care Organizations
*An optimistic scenario*

**Is there any evidence?**

**Geisinger Health System**

- Medicare spending fell by 13% relative to US (92-96)
  (savings achieved through reduced use of hospital)
- Teachers given $7,000 raise (over 3 years)

## Regional Initiatives

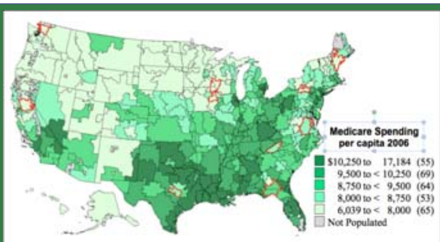
*Could contribute to sustainability of reform*

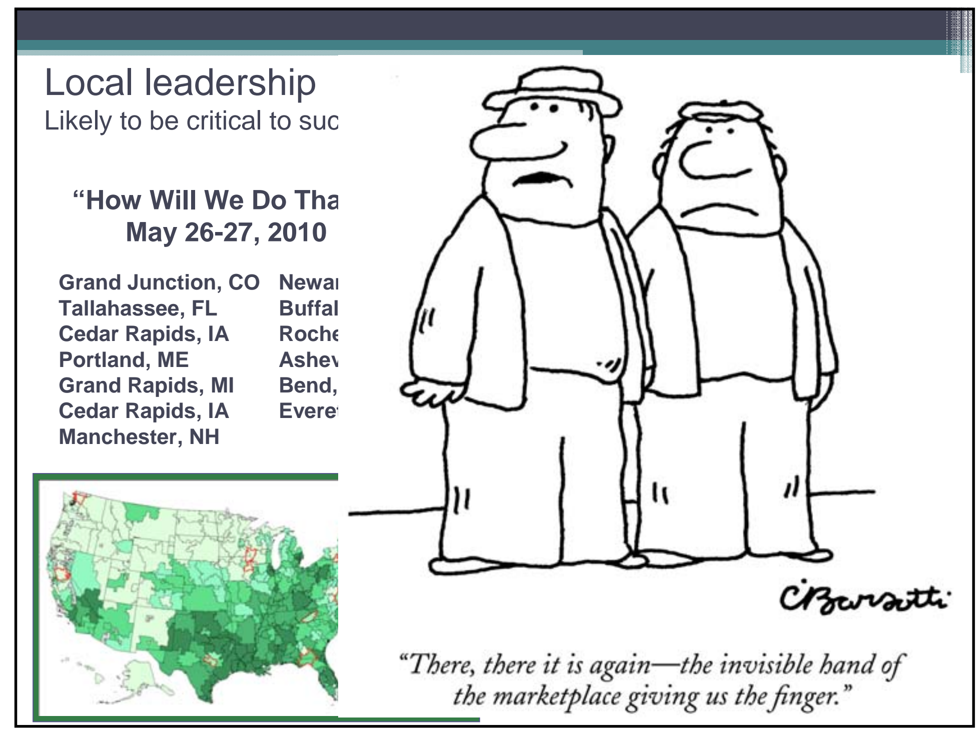
**"How Will We Do That?"**
**May 26-27, 2010**

**Grand Junction, CO**
**Tallahassee, FL**
**Cedar Rapids, IA**
**Portland, ME**
**Grand Rapids, MI**
**Cedar Rapids, IA**
**Manchester, NH**
**Newark, NJ**
**Buffalo, NY**
**Rochester, NY**
**Asheville, NC**
**Bend, OR**
**Everett, WA**

**Key elements:**

**Regional platform for stakeholders**
**Shared aims, accountable to community**
**External constraint – (Everett, WA)**
**Use of data to drive change**
**Physicians as partners in leadership**
**Reduced use of hospital (Asheville)**



## Local leadership
Likely to be critical to success

**"How Will We Do That?"**
**May 26-27, 2010**

Grand Junction, CO
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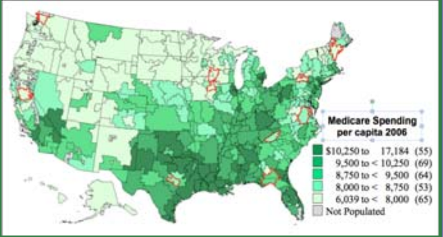


**Key elements:**

- Regional platform for stakeholders
- Shared aims, accountable to community
- Constraint – some form of pressure
- Use of data to drive change
- Reduced use of hospital (Asheville)
- Physicians as partners in leadership

**"Self-efficacy" If not us, who?**