Tufts Health Care Institute

Mini-Rotation on the Health Care System

Theme: Cost, Access, Care Management and New Models of Care

Topic: Accountable Care Organizations

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Objectives:
By the end of this session, participants should be able to:

- Define Accountable Care Organization (ACO) from several perspectives
- Understand the economic and financial underpinnings of the ACO concept
- Explain several programs and processes utilized by a Medicare ACO
- Describe some of the cultural/social changes required of physicians to become a successful ACO

Overview of the presentation (August 2015):

Description of speaker's organization, Atrius Health

Health care context: challenges

- U.S. and other countries: health care compared to gross national product; spending vs, life expectancy
- Rising health insurance premiums and worker payments
- Local data: Massachusetts state budget and healthcare expenditures

Response of commercial payers and employers

- Consumer Driven Products (cost sharing)
- Tiered physician and hospital networks
- Limited networks
- Increased pre-authorization programs
- Increased risk sharing with providers (ACO)
- Employers: Employee Wellness Programs

Response of federal government

- Accountable Care Organizations
- Payment reform
- Bundled payments

Response of state government
- Massachusetts legislation to control costs
- Municipalities' insurance plans

Marketplace response
- Limited service and retail clinics
- Best Doctors – expert opinion program
- Video visits,
- Find a doctor when needed
- Potential use of out-of-state MDs for telemedicine
- Employee wellness companies

Response from providers
- Hospitals, health systems, physician groups
- Accountable care and risk-based contracting models
- Integration across the spectrum to optimize care management
- Consolidation of health systems to achieve advantages of size

Accountable Care Organizations
- Origins and history of the concept
- Definitions from various sources
    - The ability to provide, and manage with patients, the continuum of care across different institutional settings
    - Organization of health care providers that agrees to be accountable for the quality, cost, and overall care of beneficiaries
- Radical transformations for providers and payors

Implications for providers
- Health care delivery systems require integration across the spectrum of care
- Consolidation to fewer large health care systems

Outcomes
- Medicare Share Savings ACO Program: reported data
- Fundamental changes in health care delivery
    - Increase in population management – registries, outreach
    - Increased use of data to manage cost and quality
    - Use of nurses to coordinate care for high-risk patients
    - Use of community health workers
    - Creation of preferred post-acute provider network (SNF and VNA)
    - Connecting with local community elder service agencies to provide community-based supports

    - Systematic ways to honor, across the care continuum, patients' wishes around end of life care
    - Delivery of a proven post-discharge "bundle" of services to prevent readmission
    - Increase in disease management programs
    - Patient engagement in shared decision making

Financing models for an ACO

- Global payments provide stimulus for more efficient operations, adoption of Lean to reduce waste
- Payments fund innovations, e.g., e-portals and connections to patients at home
- Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract as early model for ACO
    - Providers and systems adapted to new incentives to focus on quality and cost outcomes

Participation in Medicare's Pioneer ACO program

- Benefits for delivery system: spillover from Medicare to commercial patients
- Move towards 100% global payment
- Key features of Pioneer ACO program and performance measures
- Financial measures: shared saving/loss
- Quality measures including patient/caregiver experience, care coordination/patient safety, clinical measures, preventive health

Population management in ACOs

- Population segmentation: healthy; chronic illness; advanced chronic illness; end of life
- Different outcome targets for each group
- Tight coordination of 5% highest risk group
- Medical management of chronic conditions
- Preventive care for "well" patients

Population health initiatives

- Overview: identify gaps - design programs - develop tools - implement - track and measure - continuous improvement
- Key initiatives (especially for senior population)
    - Geriatric care model
    - Care management
    - Acute/post acute preferred providers strategies
    - Data analytics and reporting
    - Electronic health record and health information exchange
    - Quality & safety metrics and reporting
    - High risk patient roster review; multidisciplinary roster reviews
    - Advanced care planning initiatives
- Illustration: chronic kidney disease
- Post-acute home workgroup in collaboration with VNA
- Integration of local elder services

- Skilled nursing facility network and programs

Outcomes at speaker's organization
- Financial performance
- Clinical measures

Keys to success:
- Leadership and facilitation
    - Create the data-based hypothesis
    - Identify evidence-based best practice
    - Develop standards & tools to close gaps
    - Measure and track
- Core competencies
    - Small team with operational credibility
    - Diverse clinical expertise
    - Share resources clustered together (no silos)
    - Home for shared values
    - Exploratory mindset
    - Laser focus on triple aim

Lessons learned
- MD engagement key to driving change
- Wide adoption of Lean problem solving methodology created strong foundation for change
- " One Model, One Contract" provided burning platform
- Making long-lasting change takes time
- Our ability to partner effectively is key

Two kinds of change
- Technical: problem is well defined, solution identified, implementation is clear
- Adaptive: complex challenge; require learning, new way of thinking, new relationships