Understanding Accountable Care Organizations

Wave of the Future

Or

Flash in the Pan

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Gundersen Lutheran Health System La Crosse, WI
• Integrated Delivery System
  – Approximately 6,500 Total Employees
  – 776 providers employed / 474 medical staff
  – 41 clinic locations
  – 325-bed Tertiary Medical Center and 2 smaller hospitals
• Physician-led organization
  • All providers are employees
What about you?

• Tell us where you work
  – Hospital
  – Physician group
  – Integrated System
  – Health Plan
  – Other

• How many of your organizations seriously considered becoming an ACO?
Learning Objectives

• Obtain a basic understanding of why rising healthcare costs are driving change in American healthcare.

• Describe the key components of an accountable care organization.

• Describe Medicare’s approach to operationalizing accountable care organizations.

• Discuss how various organizational initiatives and activities prepare healthcare providers to become an accountable care organization.
A Famous Phrase

Δ

Change
Access  Quality  Cost
The Affordable Care Act

- Focused on increasing access to health care insurance
The Problem of Rising Costs

Why have we been unable to restrain rising costs?
Managed Care
1980s and 1990s

- Attempt slow rate of growth
- Center of control – the insurer
  - Decisions about care
- Emphasis on primary care
  - Gatekeepers
- ‘Capitated’ payment
Two Structural Barriers

1. Fragmented nature of health care industry that doesn’t deliver highly coordinated, efficient care.

2. Reimbursement system pays for illness - not getting or staying healthy
Up until just a few years ago, what percent of American physicians were in solo or single specialty practices*
1. A Fragmented System

80%
Office Practice in Any Where, USA
In some ways, the structure of American health care can be said to be like a...
Health Care is still mostly a cottage industry
2. Reimbursement system incentives treating illness not keeping healthy

Incentives expensive treatment of illness

Dis-incentives activities not found on fee schedule
The Affordable Care Act

• Began process to reform payment and thus delivery system.
  – Restructure healthcare industry to add ‘systems and processes’
  – Reward value rather than volume

• Accountable Care Organizations (ACO)
  – Accountable for the value of the care
What does “Accountable Care” mean anyway?
Depends Upon Who You Ask!

• Healthcare provider or group of providers that accepts accountability for the total cost of care received by a population.

• A set of provider which are held responsible for the health care of a population of beneficiaries.
For today’s purposes...

- An entity that can implement *organized processes* for improving quality and controlling costs of care and be *accountable for those results*. 
The Affordable Care Act

ACO
ACO Essentials

• ACO structure will vary depending upon local markets
• Umbrella-like structure
• Provide continuum of care for patients as a real or virtually integrated delivery systems
• Performance measurement
• Financial management
• Primary care, medical home
• Delivery system improvements
  – Health IT
Strong Emphasis on Primary Care

• Importance of coordinating care

• Primary care would become the revenue driver as we receive payment based on where patients receive their primary care

• Medical Home is integral
Paying for Care in an ACO

• Designed to move from fee for service that rewards higher utilization to reward for good outcomes and elimination of unnecessary care

• Many Possibilities
  – Shared savings model
  – Global payment
  – Other
Delivery System Reform
8) Leadership, Planning, and System of Accountability

1) Electronic Information About Patients & Services
- Hospital Care

2) Capabilities for Population Mgmt. & Coordination of Care
- Primary Care Practice (PCMH)
- Specialty Care

3) Resources for Patient Education & Self-Mgmt Support
- Primary Care Practice (PCMH)
- Ancillary Care

4) Culture of Teamwork Among Staff

5) Capability for Management of Financial Risk

6) Ability to Measure and Report on Quality of Care

7) Coordinated relationships
Electronic Information About Patients and Services

• Timely information

• Information about what types of services patients receive

• Information about the cost of services patients receive
Population Management and Coordination of Care

• Implementation of clinical practice guidelines and monitoring of compliance

• Data analysis on resource use

• Use of registries to ensure patients are receiving recommended care and redesigning processes to support the way care is delivered
Patient Education and Self-Management Support

• Patient education, goal setting and self-management support reduces hospital admissions, readmissions, ER visits
Teamwork

• Efficiency of operations and effectiveness of care can result from a coordinated, team effort

• Culture of teamwork
Management of Financial Risk

• In past, providers paid whether or not the care was appropriate or added value
• More treatment = more pay
• In ACO environment, providers will be taking more ‘risk’
  – Paid some fixed amount for a given patient
  – At risk for overprovision of care
  – The good news...the bad news
Measure and Report on Quality of Care
Coordinated Relationships

• Primary care provider relationships with specialists, hospitals, other providers
  – Referrals for specialty care
  – Follow-up after discharge

• Not a ‘gatekeeper’ mentality
Leadership and Accountability

• Structure that sets value as the top priority and a system of accountability to drive improvement at all levels of the organization.
What pieces of the foundation are already have in place?

• Work with two of your three neighbors to pick a concept and then identify at least one activity occurring within your organization that prepares you to be an ACO.

• You will have 7 minutes and be asked to report out!
8) Leadership, Planning, and System of Accountability

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Primary Care Practice (PCMH)
Examples of How Some Organizations are Preparing

- Primary care, specialty and tertiary hospital
- Medical home
- Care Coordination
- Clinical integration
- Meaningful use compliance
- EMR
- Clinical outcome management
- Chronic disease management
- Community governed
- Collaborative regional model
- Physician led, patient centered
- Quality reporting and performance measurement
Medicare’s Dilemma

• The Triple Aim
  – better care for individuals
  – better health for populations
  – lower expenditures
The Challenges Undertaken by Proposed Regulation

- Lower current costs
- Restructure fragmented health care system
- Bend the cost curve
CMS rewards hospitals based on meeting new Medicare measures

Well done, sweetie. Here's your brother's piggy bank.
Medicare’s Method for Operationalizing the ACO Model
Shared Savings Model

• Intended to apply to healthcare broadly in an attempt to transform American healthcare from a state of fragmentation to one of integration.

• Financial Model
  – Greater financial accountability
  – Based on fee-for-service not population payment
  – Generate Medicare savings

• Quality measures
• Infrastructure requirements
• Beneficiary assignment
Pioneer Model

• Support progressive organizations in the transformation of payment from fee-for-service to one focused on outcomes of care

• Testing a Series of Models
  – Greater financial accountability
  – Provide a transition from fee-for-service to population-based payment
  – Generate Medicare savings

• Quality measures
• Infrastructure requirements
• Beneficiary assignment
Seeking cost reductions at time of significant investment
1) Electronic Information About Patients & Services
2) Capabilities for Population Mgmt. & Coordination of Care
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8) Leadership, Planning, and System of Accountability
Summary

1. Focus on controlling the rate of growth
2. Incent patients for lower cost care
3. Reward improvement and attainment
4. Drive delivery system change first
Now what?

- Innovation Center
  - Bundled payments
  - Primary care initiative
  - Healthcare innovation challenge
- Market consolidation
- Value based payment
- Patient centered medical home
- Electronic health records
The Patient Protection and Affordable Care Act Payment Reform

Value Based Purchasing

Core Measures (Section 3001)

- AMI, PNE, HF, SCIP

Efficiency Measures (Section 3001)

- Medicare spending per beneficiary

Healthcare-Associated Infections (HAI) (Section 3001)

- CLABSI, SSI

At Risk: 1% FY2013, 1.25% FY2014, 1.5% FY2015, 1.75% FY2016, 2% FY2017 and beyond (70% Core Measures + HAI, 30% HCAHPS)

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (Section 3001)

- At Risk: FY 2014

Hospital Acquired Conditions (HAC) (Section 3008)

- CAUTI, Vascular Catheter Associated Infections, Poor Glycemic Control

Medicare Reimbursement

- At Risk: 1% reduction beginning FY2015

Readmission Rates (Section 3025)

- AMI, PNE, HF, COPD, CABG, PTCA, etc.

At Risk: 1% reduction in FY2013, Increases to 3% in subsequent years

Foreign Object Postop, Air Embolism, Blood Incompatibility, Pressure Ulcer, Falls/Trauma
Patient Centered Medical Home

Great Outcomes

- Care Teams
- Quality Measures
- Epic
- Patient Experience

Primary Care
In summary

• Whether or not we call ourselves accountable care organizations in the end, the market is organizing and redesigning itself to fit that model, but at lower cost.

• Our challenge is to quickly make the investment to redesign and be more efficient because we’ll be paid less.
Questions
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