Fostering Accountable Care

A path toward improving quality, slowing cost growth

NCVHS Hearing on Meaningful Use
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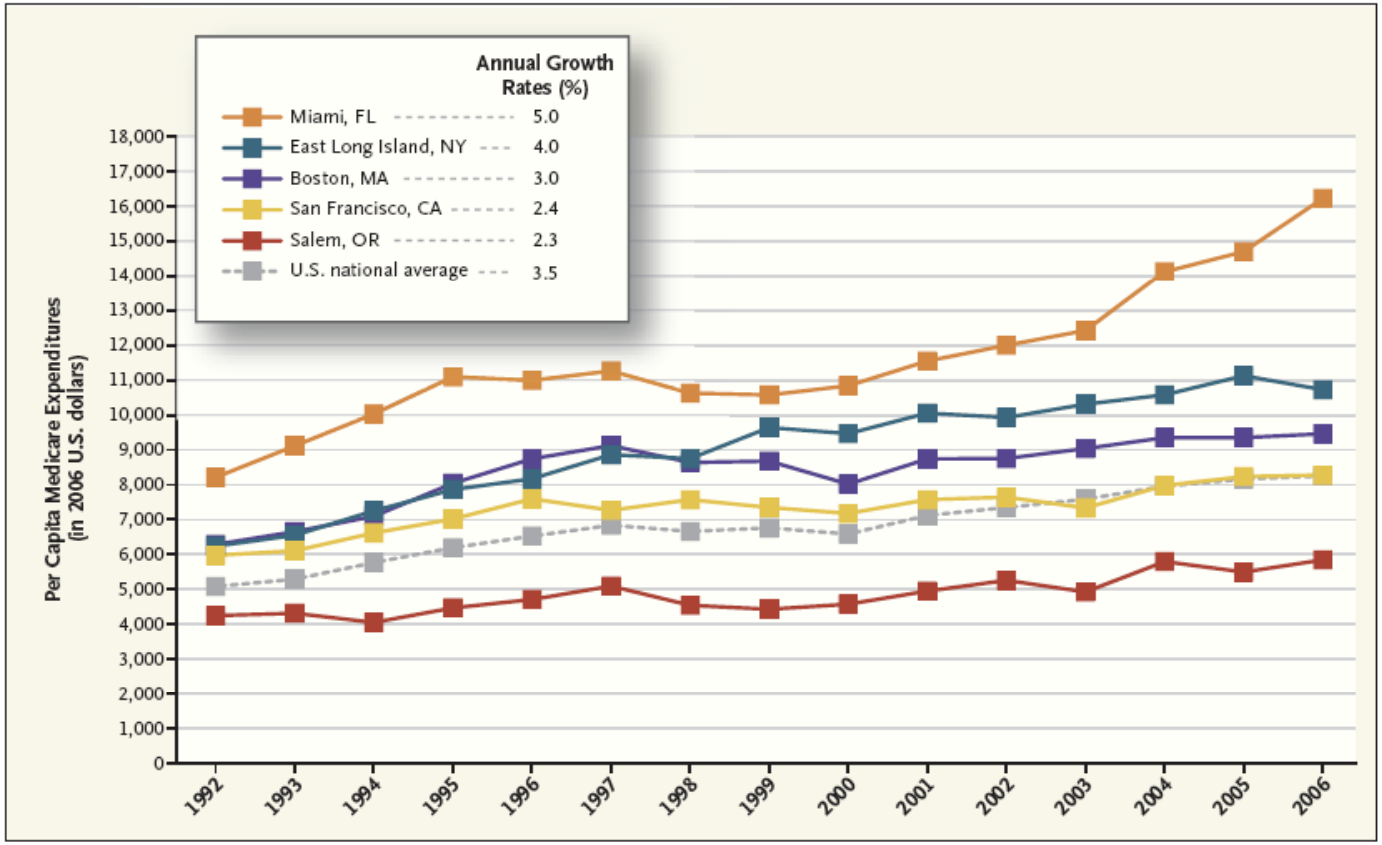
Per-capita Medicare Spending

Trends: 1992 to 2006



Annual Growth Rates of per Capita Medicare Spending in Five U.S. Hospital-Referral Regions, 1992–2006.

Data are in 2006 dollars and were adjusted with the use of the gross domestic product implicit price deflator (from the Economic Report of the President, 2008) and for age, sex, and race. Data are from the Dartmouth Atlas Project.

Annual Growth Rate	
US Avg	3.5
Miami	5.0
E. Long Island	4.0
Boston	3.0
San Francisco	2.4
Salem, OR	2.3

Source: Slowing the Growth of Health Care Spending: Lessons from Regional Variation
Fisher, Skinner, Bynum, New England Journal of Medicine, February 26, 2009

What does higher spending buy?

More "supply-sensitive services"

	Rate of Avoidable Admissions[1]	Physician Visits[2]	Per-beneficiary spending on imaging	Ratio Primary Care to Specialist visits[2]	Percent seeing 10 or more MDs[2]
Miami	95	106	$1434	0.72	51
E. Long Island	75	91	$1388	0.97	50
Boston	81	59	$864	1.20	39
San Francisco	52	64	$687	1.12	32
Salem	44	38	$512	1.30	18

Notes

1. Ambulatory Care Sensitive Hospitalizations per 1000 Medicare beneficiaries
2. Utilization during last 2 years of life, Medicare beneficiaries with serious chronic illness.

And more isn't better

(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

What is going on?
What needs to be done?

Most clinical decisions require judgment

- Only small minority can be specified through firm guidelines
- "Gray-area" decisions responsible for most "overuse" (1)

Payment system rewards growth, "overuse", and fragmentation -- and ensures that current (and new) capacity is fully utilized

- Physicians adapt their practices to existing capacity
- Income pressures (price cutting) motivate: the purchase of new technology; recruitment of more specialists, high margin treatments; referral and admission of more complicated patients
- Poor quality a direct consequence of fragmentation.

(1) Sirovich B, et al. Discretionary decision making by primary care physicians and the cost of U.S. health care. Health Affairs 2008;27:813-23.

Principles to guide reform

Address the underlying causes of rising costs, poor quality

Underlying cause	Key principles
Lack of support for improvement, care management and coordination.	**Organizational support:** Develop virtual or real integrated systems to support practice
Failure to recognize role of local system (e.g. capacity) as cost-driver	**Organizational accountability:** Foster accountability for total costs – and capacity.
Assumption that more is better Equating less care with rationing	**Measurement:** (1) Comparative effectivenes (2) Comprehensive performance measures
Payment system that rewards more care, increased capacity, high margin treatments, entrepreneurial behavior	**Payment reform:** foster accountability for overall spending, capacity and behavior: comprehensive care management fees or global shared savings

Organizational Support & Accountability

Foster Development of Accountable Care Organizations

Essential attributes of an Accountable Care Organization

- Provides (or can manage) continuum of care as a real or virtually integrated local delivery system that can provide support to clinicians and improve care coordination (e.g. through interoperable electronic health records)
- Sufficient size to support performance measurement & shared savings payment approaches

Potential Accountable Care Organizations

- Physician-Hospital Organizations / Practice Networks
- Integrated delivery systems
- Regional Collaboratives

Feasible to establish, would entail little disruption of practice

- All physicians practice within easily defined “Physician-Hospital Networks”, which provide 70% or more of the care to their patients.

Fisher ES, Staiger, DO, Bynum JP, et al. Creating Accountable Care Organizations, Health Affairs 26(1) 2007:w44-w57.
Fisher ES, McClellan MB, Bertko J, et al. Fostering Accountable Health Care: Moving Forward In Medicare. Health Affairs 2009 w219-231.

Organizational Support & Accountability

Foster Development of Accountable Care Organizations

Intermountain Health Care

Focus on managing defined clinical populations

Care pathways defined by multi-disciplinary team

Protocols implemented through EHR with process and outcome tracking

Scientific review / updating on monthly basis.

FIGURE 7-2. **Percentage of Intermountain Healthcare System Diabetic Patients with Glycolated Hemoglobin (HA1C) > 9%, June 1999–March 2006**

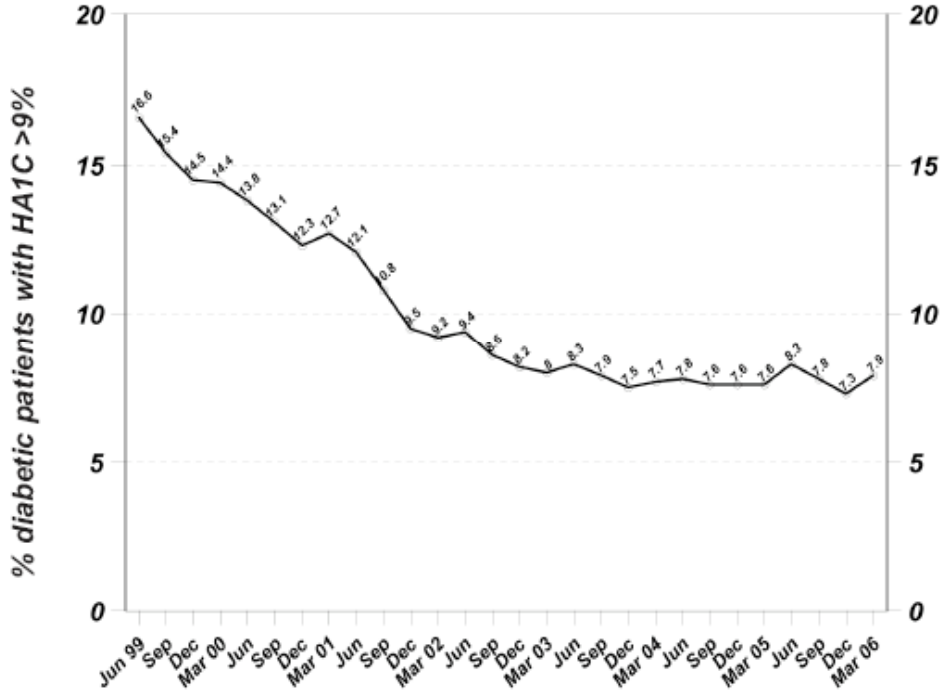


Figure 7-2. This figure represents data for more than 20,000 patients. National guidelines recommend that all patients with diabetes be managed to HA1C levels < 9%, and, ideally, to levels < 7%.

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.

Organizational Support & Accountability

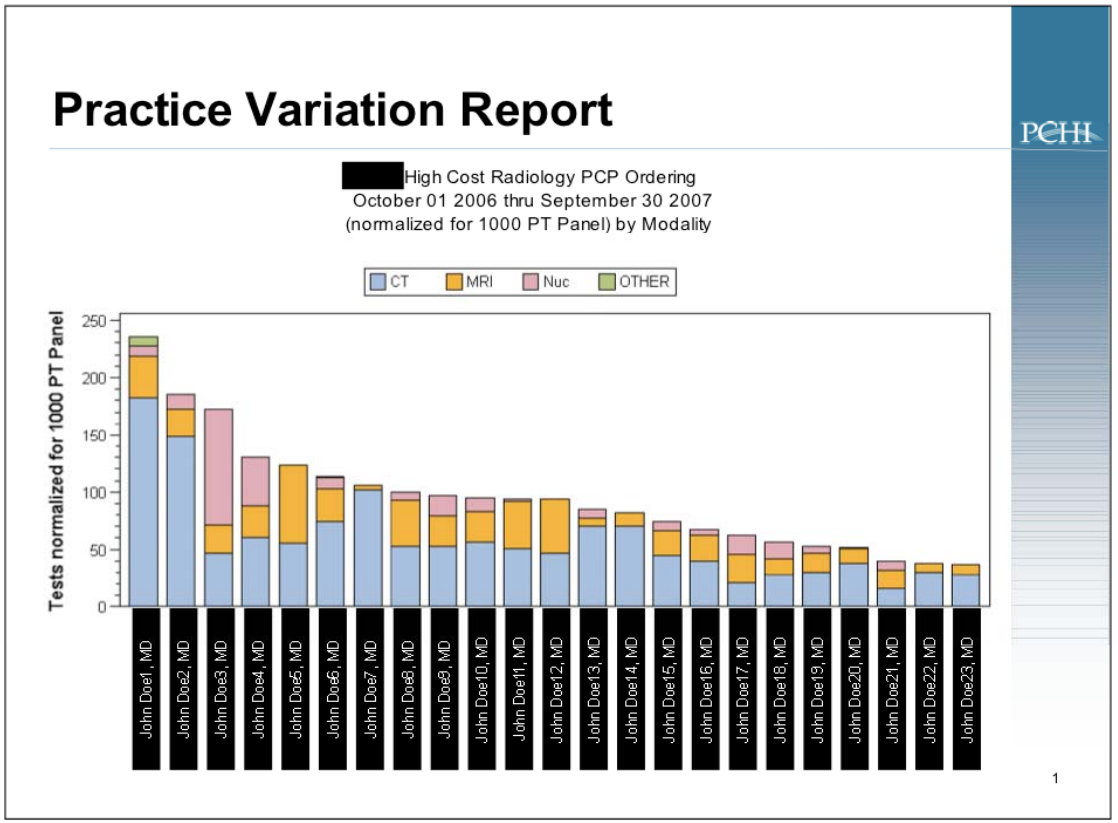
Foster Development of Accountable Care Organizations

Partners Healthcare System

EHR / data warehouse provides feedback to clinicians.

Decision-support developed to improve evidence-based care

Discussion and feedback on “gray area” decisions



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

Better information

key role for electronic health records

Better information: for CER and for performance measurement

- Evaluation of treatment outcomes and provider performance requires longitudinal framework (1, 2)

Key HIT capacities – embedded in EHRs and data warehouses:

- Registry: with clinical and patient reported risks and baseline health
- Specific treatments, other services (and costs) over time
- Patient follow-up– patient experience and health outcome assessment
- Analytic and organizational capacity:
  within organizations - for feedback and improvement
  across organizations - for performance measurement and CER

Essential infrastructure

- Common definitions of populations and core measures
- Patient / population follow-up methods; survey tools

(1) National Quality Forum. Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care. 2009
(2) Fisher ES, Health Care and the Evidence Base pp 50-62 in McClellan MB, McGinnis JM, Nabel EG and Olsen LM. Evidence based medicine and the changing nature of health care, Institute of Medicine, National Academy Press, Washington DC 2008

Payment Reform

The third critical element

Current payment system has two effects

- Fosters unprofessional behavior in some
- Presents barrier to aligning care with better value for most providers.

Payment reforms should support high value care:

- Episode-based payment: potential to improve care and lower costs, but only with adequate outcome measures and within global accountability for costs (risk: stinting on care; more episodes, cost-shifting outside episode)
- Global shared savings: establish spending and quality benchmarks for ACOs; measure performance; shared savings if benchmarks met.
- Prospective global payments: partial or full capitation to medical homes or integrated systems (ACOs) accountable for defined populations

Successful implementation requires comprehensive outcome and cost tracking: EHRs, registries, data analysis and feedback

Aligning incentives

Establish vision: integration, accountability and shift to value-based payment. Align interim policy steps toward that vision

Support for electronic health records

- Require advancing standards to support key functions within 3-5 years
- Make full subsidy contingent upon degree of local network participation

Performance measurement:

- Advance performance measurement expectations to encourage (require) registries and longitudinal outcome and cost reporting

Payment reform

- Bonus payments / updates gradually limited for providers choosing not to participate in ACO or other integrated models
- Medical home and episode payments eventually required to be within framework of accountability for overall costs and quality
- Eligibility for substantial payment updates and shared savings payments only within ACO or other integrated model.

Fisher ES, McClellan MB, Bertko J, et al. Fostering Accountable Health Care: Moving Forward In Medicare. Health Affairs 2009 w219-231