ON THE “CUSP” OF A BREAKTHROUGH?

NAM’s Vital Directions for Health and Health Care Series

- Increasing Demand and Unsustainable Costs
- Lack of Alignment – Payment, Providers, Patients
- Many Innovations – Payment, Technologies, Precision Medicine/Public Health, Delivery Models, Patient Engagement
- Population Health, Wellness, Prevention
CROSSING THE QUALITY CHASM 2001

CARE SYSTEM

Supportive payment and regulatory environment
Organizations that facilitate the work of patient-centered team
High performing patient-centered teams

• Outcomes:
  • Safe
  • Effective
  • Efficient
  • Personalized
  • Timely
  • Equitable

REDESIGN IMPERATIVES: SIX CHALLENGES
• Redesigned care processes
• Effective use of information technologies
• Knowledge and skills management
• Development of effective teams
• Coordination of care across patient conditions, services, and settings over time
• Use of performance and outcome measurement for continuous quality improvement and accountability

We have started to build the bridge.

But...

Will it be a bridge to nowhere?

We retreat to the old legacy organizations and payment systems of the past two centuries.

OR

Integrated Person-Centered Continuous Care Improvement

Fragmented Wasteful Sub-Optimal Care

Will we get to the other side?
SLAYING A SACRED COW

“FORM FOLLOWS FUNCTION”
Maybe Does Not Work When Faced with
Major Turbulent Changes such as those
Associated with Health Care Reform
Instead
Need to Change the Form First to
Facilitate Changes in Care Delivery
THE ACCOUNTABLE CARE ORGANIZATIONS (ACO)

Entities that Accept Accountability for the Cost and Quality of Care provided to a defined population of potential patients

KEY:
Is Calibrating the Co-Evolution of Payment Reform and Delivery System Reform.
The Incentives with the Capabilities to Address the Incentives to Succeed Under Them.
“Payment Reform and Delivery Reform are like a pair of skis. Policymakers often want to see immediate results and push the policy ski as far forward as possible, but forget about the lagging delivery ski. If progress in Payment Reform is not matched by progress in Delivery Reform, the misaligned skis will cause a crash or, in this case it will cause ACOs to leave the voluntary program and revert to Non Value-Based Models”

ACOs Have Grown more Extensively and Rapidly in the 21\textsuperscript{st} Century than HMOs did in the 20\textsuperscript{th}

ACOs Over Time

Figure 2 | Estimated ACO Penetration by State

MAJOR ACO CHALLENGES

• Setting of Benchmarks
• Measurement Consolidation and Standardization
• Behavioral Health Integration
• Post-Acute Care Coordination
• Patient Engagement
Evidence to date is mixed

- First cohort of shared savings ACOs saved an average of 1.4% 1st year, but 2nd year, essentially none.
- First year of Pioneer ACOs saved 1.2%, but smaller in 2nd year.
- In both programs, ½ achieved some savings, but only ¼ enough to receive bonuses.
- Those led by Primary Care Physician Groups achieved greater savings than those integrated with Hospitals.
- Commercial Sector – the Massachusetts Alternative Qualitative Contract show savings increase from 1.9% in year One to 6.8% in year Four.
- ACOs that earned shared savings had modestly better quality scores.
Exhibit 1. Medicare Shared Savings Program: Year 1 Performance of Participating Accountable Care Organizations (2013)

- 24 percent (52 ACOs) earned shared savings bonus
- 27 percent (60 ACOs) reduced spending, but not enough to earn shared savings bonus
- 3 percent (6 ACOs) achieved savings, but did not successfully report quality measures
- 46 percent (102 ACOs) did not achieve savings

220 Medicare Shared Savings Program ACOs

Relationship of savings (benchmark spending minus actual spending as a percentage of benchmark) versus quality (aggregate quality score) for MSSP ACOs in 2015.

Percentage of ACOs Qualifying for Shared Savings Based on Their Benchmark per Beneficiary

The Percentage of ACOs Earning Shared Savings Bonuses as a Function of Years in the Program

Rate of Shared Savings Bonus for Different Types of ACOs (Hospital Systems, Physician Groups, or Integrated)

EVIDENCE TO DATE

IS THE GLASS HALF EMPTY OR HALF FULL?
FOUR WAYS TO REDUCE COSTS

1) Provide Care in Lower cost Settings
2) Provide Care Using Lower Cost Personnel
3) Eliminate Waste – Non-Value Producing Activities
4) Do Not Provide Care at All - Keep People Well

Accountable Communities for Health
For 1) above: Physician Organizations 52%
             Hospitals            33%
             Health Systems       26%

Key Pillars or Robust Properties for any Model to Succeed

- Persistent Adaptive Leadership
- Continuous Improvement Cultures Mindset
- Empowered Front Line Workers
- Effective Healthcare Teams
- Information Technology EHRs Predictive Analytics Visual Management
- Patient Activation Engagement

Better Healthcare Performance Outcomes

Aligned Financial Incentives Multilevel and Across Functions

CHOIR Center for Healthcare Organizational Innovation Research

Berkeley School of Public Health
**ACO Tennis Analogy**

Some are Playing to Win
- “All In”
- Hit Long, Hard and Aim for the Corner Lines, Take Risk, Think Next Gen and Pioneers

Some are Playing to Avoid Losing
- Just Keep the Ball In Play – Hope your Opponent Makes a Mistake
- Do not Go Deep or To the Corners, Think Shared Savings
**ACO FLOWER ANALOGY**

Some are like **Dandelions** — Will grow anywhere under any soil conditions

Some are like **Orchids** — Are fragile and require very special care and nurturing

Some are like **Roses** — Not as hardy as Dandelions; Not as fragile or delicate as Orchids. Require some attention (sun, water, feeding balance) but not a lot

**Suggestion** — Neither trying to confirm the Dandelion hypothesis or the orchid hypothesis will get us over the bridge. Perhaps, greater attention should be focused on growing a beautiful rose garden but watch out for the thorns!
RELEVANT REFERENCES


YOUR QUESTIONS

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Thank You!