THE EVOLUTION OF ACOs:
SOME EARLY LESSONS

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Outline

• From unicorns to “multicorns”

• Key issues

• Early lessons

• Emerging evidence

• Some suggestions for spread
We have gone from...
They are almost everywhere

A family of “multicorns”
Some Key Issues

• Enrollment size matters – achieve sufficient savings to spread overhead and related costs

• Care management is key:
  • 5/50 stratification
  • Multiple chronic illness, frail elderly, dual eligibles, mental illness
Some Key Issues (cont’d)

• Building new relationships
  • Business model changes most for hospitals
  • Integrating different professional/social identities
  • Collaborative governance

• New tools required:
  • Information exchange across the continuum
  • Predictive risk modeling
Some Key Issues (cont’d)

• Patient activation and engagement

• Agreeing on a common set of cost and quality measures and thresholds, across payer contracts
What is Needed?

A New Care Management Platform
New Care Management Platform

- Reduce office visits
- Expand between-visit at-home care management
- Improve “hand-offs”
- Smoother “glide paths” to health recovery
- Technology enabled within a foundation of continuous improvement.
Some Required Changes

- Inpatient Care Workflow and Redesign
- Care Transition Management
  - e.g. Coleman Care Transition Model
- Physician Referral Patterns
- Interoperable EHRs
- From Inpatient Margin to Total Care Margin
Challenges and Lessons Most Frequently Mentioned by Existing ACOs

- Importance of focusing on high cost/high risk patients
- More attention needs to be given to the post-acute care continuum
- Challenge of engaging specialists
- Difficulty of managing contracts with multiple payers
Challenges and Lessons Most Frequently Mentioned by Existing ACOs (cont’d)

• Dealing with patient choice – patients can receive care outside the ACO

• Little patient activation/engagement so far

• Continual communication and transparency with all involved is really important

• Big-time cultural change

• “It’s like deciding whether or not you are ready to be a parent. At some point, you just decide to have kids.”
Early Lessons from Brookings-Dartmouth ACO Pilot Studies

Common Challenges:

- Developing the care management capabilities across the entire continuum
- Building trusting relationships with physicians, payers and other partners
- Navigating the legal and contractual relationships
Common Elements Across All Four Sites:

• Electronic health record functionality
  • Disease registries
  • Data warehouses
  • Predictive modeling to identify high-risk patients
• High-risk patient complex care management programs
• Physician champions
• Mature quality improvement – Six Sigma, LEAN
## Facilitators of ACO Formation and System Transformation

<table>
<thead>
<tr>
<th>Factor</th>
<th>Role and Importance</th>
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<tbody>
<tr>
<td><strong>Facilitators of ACO Formation</strong></td>
<td></td>
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<tr>
<td>Facilitators of Executive Leadership and Strong Governance</td>
<td>Supports development of shared aims, prioritizes resources and removes obstacles to allow for transformational change</td>
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<tr>
<td>Strong Payer-Provider Relationship</td>
<td>Facilitates trust and recognition of shared aims to overcome challenges in developing the ACO infrastructure</td>
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<tr>
<td>Experience with Performance-Based Payment</td>
<td>Develops capability to bear risk, aligns financial incentives and drives performance</td>
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### Facilitators of ACO Formation and System Transformation (cont’d)

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<tr>
<td><strong>Facilitators of System Transformation</strong></td>
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<tr>
<td>Robust Health Information Technology Infrastructure</td>
<td>Supports data collection and reporting to identify waste, coordinate care, improve performance, and measure outcomes</td>
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<tr>
<td>Strong Care Management Capabilities</td>
<td>Provides tools and infrastructure to manage population health and improve care coordination</td>
</tr>
<tr>
<td>Performance Measurement and Transparency</td>
<td>Improves population health, supports care coordination, eliminates waste, and ensures accountability</td>
</tr>
<tr>
<td>Effective Physician Engagement</td>
<td>Perpetuates awareness and support throughout the system and develops physician champions for the model</td>
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ACO Governance: Some Early Findings

• Governance structures reflect the history of integration: the longer the history, the more formal the governance structure

• Patients/consumer groups are largely not represented. Their role is not clear.

• Number of accountability relationships is increasing

ACO Governance: Some Early Findings (cont’d)

- Primary mechanism of accountability was pay-for-performance, usually tied to savings

- Primary individual physician performance accountability:
  - Out-of-network referrals
  - Patient satisfaction

Early ACO Governance Findings (cont’d)

• General consensus on performance criteria *but* much contention around setting thresholds

• Sanctions/consequences:
  • Informal peer influence
  • Transparent credible data
  • Predictive risk modeling for each physician’s group of patients
  • “Coaching”
  • Last resort -- removal from network
Early ACO Governance
Key Lessons

• Shared goals and incentives
  • Directly linked to performance criteria and individual physician objectives
  • Based on value rather than volume
  • More difficult for hospitals who are not exclusive to specific ACO

• Governance model should reflect function
  • Long history – more formal and integrated
  • Shorter history – more reliance placed on managerial interaction
  • Need to first establish a culture of trust and supportive decision-making processes
  • Need structures that accommodate flexibility
Early ACO Governance
Key Lessons (cont’d)

• Align measures and thresholds across payers
  • Reduce the complexity and costs involved

• Credibility and transparency of data
  • Risk-modeling tools for presenting comparative data help
  • Promote physician sense of interdependency for achieving ACO goals

Importance of Managing Social Identities

• Balance organizational identity/socialization with professional identity/socialization

• Use ACOs as a framework or mechanism or vehicle for promoting more integrated coordinated care

ACO’s Are in the Eye of the Beholder

• **An IPA:** it’s about better coordinated care, not integration
• **A medical group:** it’s about integration for employed physicians, but not affiliates
• **A hospital system:** it’s about developing an equal partnership between physicians and the hospital
• **An integrated delivery system:** it’s about a cultural change, not a structural change

Are ACOs More Than a Guess?

Some emerging evidence
Medicare Physician Group Practice Demonstration

• Annual savings per beneficiary/year were modest overall

• But significant for dual eligible population – over $500 per beneficiary, per year

• Improvement on nearly all of 32 quality of care measures

Preliminary Results of Massachusetts Alternative Quality Contract (AQC)

- 2.8% lower costs ($90 per member, per year)
- Savings much larger among groups with no prior experience with risk sharing
- Savings largely from reduced spending for procedures, imaging, and lab tests
- Greatest savings come from patients with highest health risks
- 10 of 11 participating physician groups spent below their targets, earning a budget surplus payment. All earned a quality bonus.

Source: Karen Davis, Commonwealth Fund, July 21, 2012
## Comparison of Accountable Physician Practices Versus Other Practices

<table>
<thead>
<tr>
<th>Quality Measures</th>
<th>U.S</th>
<th>CAPP</th>
<th>Non-CAPP</th>
<th>Relative risk ratio</th>
<th>Relative risk ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography in women ages 65-69</td>
<td>50.4%</td>
<td>57.9%</td>
<td>53.1%</td>
<td>1.11</td>
<td>1.12</td>
</tr>
<tr>
<td>Completion of all three diabetic tests</td>
<td>53.9%</td>
<td>63.4%</td>
<td>57.1%</td>
<td>1.12</td>
<td>1.15</td>
</tr>
<tr>
<td>ACS admission rate; rate per 100</td>
<td>8.3</td>
<td>6.9</td>
<td>8.4</td>
<td>0.82</td>
<td>0.92</td>
</tr>
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<th>Cost Measures</th>
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<th>Relative risk ratio</th>
<th>CAPP-non-CAPP difference</th>
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<td>Standardized MD in 2005</td>
<td>$2,881</td>
<td>$2,764</td>
<td>$3,003</td>
<td>-$239</td>
<td>-$176</td>
</tr>
<tr>
<td>Standardized hospital spending in 2005</td>
<td>$2,405</td>
<td>$2,193</td>
<td>$2,428</td>
<td>-$235</td>
<td>-$103</td>
</tr>
<tr>
<td>Total standardized CMS payments in 2005</td>
<td>$7,406</td>
<td>$7,053</td>
<td>$7,593</td>
<td>-$540</td>
<td>-$272</td>
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Early Evidence from Primary Care Medical Home Interventions

Group Health Cooperative of Puget Sound (Seattle, Washington)
• 29 percent reduction in ER visits; 11% reduction ambulatory sensitive admissions

Health Partners (Minnesota)
• 39% decrease ED visits; 24% decrease hospital admissions

Geisinger Health System (Pennsylvania)
• 18 percent reduction in all-cause hospital admissions; 36% lower readmissions
• 7 percent total medical cost savings

Source: Karen Davis, Commonwealth Fund, July 21, 2012
Early Evidence from Primary Care Medical Home Interventions (cont’d)

Mass General High-Cost Medicare Chronic Care Demo (Massachusetts)
• 20 percent lower hospital admissions; 25% lower ED uses
• Mortality decline: 16 percent compared to 20% in control group
• 4.7% net savings annual

Intermountain Healthcare (Utah)
• Lower mortality; 5% relative reduction in hospitalization
• *Highest $ savings for high-risk patients*

Source: Karen Davis, Commonwealth Fund, July 21, 2012
Sacramento Blue Shield: Dignity-Hill-Calpers Experience

- 42,000 Calpers Members
- Set target premium first – no increase in 2010– and then worked backward to achieve it
- Saved $20 million -- $5 million more than target, while meeting quality metrics
- Package of interventions:
Sacramento Blue Shield: Dignity-Hill-Calpers Experience (cont’d)

- Package of interventions:
  - Integrated discharge planning
  - Care transitions and patient engagement
  - Created a health information exchange
  - Found that top 5,000 members accounted for 75% of spending
  - Evidence-based variance reduction
  - Visible dashboard of measures to track progress
Some Ideas to Promote “Spread”

- “Twinning” – organizational mentoring
- “Collaboratories” emphasizing customized technical assistance
- Aligning Forces for Quality (AF4Q) – 16 communities - measurement, QI processes, consumer engagement, public reporting, “community checkup report”
- In-person meetings and team travels
Some Ideas to Promote “Spread” (cont’d)

- HHS Chartered Value Exchange Program
- ONCHIT – Beacon Community Program
- Clinical coaches (Rosenberg) – translate organizational goals to changes in individual physician behavior
  - Face-to-face and phone interaction with physicians
  - 25 MD’s per MD coach
  - Targeted to helping individual physicians achieve quality and cost metrics
Some Ideas to Promote “Spread” (cont’d)

• University of Best Practices – California’s Right Care Initiative
  • San Diego and Sacramento
  • Reduce deaths from heart attacks and stroke by better management of blood sugar, blood pressure, and lipids
Building Blocks for Success

Outcomes
- Quality of Care
  - Clinical Outcomes
  - Functional Health Status
  - Patient Experience
- Cost

Robust Properties
- Aligned incentives
- Care management practices
- Clinical information technology
- Continuous quality improvement
- Population-based health care delivery models

Foundation Properties
- Leadership and empowerment
- Governance and management
- Capital

Thank You

“Healthier Lives In A Safer World”