Fostering Accountable Care
A path toward improving quality, slowing cost growth

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Per-capita Medicare Spending
Trends: 1992 to 2006

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
What does higher spending buy?  
*More “supply-sensitive services”*

<table>
<thead>
<tr>
<th></th>
<th>Rate of Avoidable Admissions¹</th>
<th>Physician Visits²</th>
<th>Per-beneficiary spending on imaging</th>
<th>Ratio Primary Care to Specialist visits²</th>
<th>Percent seeing 10 or more MDs²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miami</td>
<td>95</td>
<td>106</td>
<td>$1434</td>
<td>0.72</td>
<td>51</td>
</tr>
<tr>
<td>E. Long Island</td>
<td>75</td>
<td>91</td>
<td>$1388</td>
<td>0.97</td>
<td>50</td>
</tr>
<tr>
<td>Boston</td>
<td>81</td>
<td>59</td>
<td>$864</td>
<td>1.20</td>
<td>39</td>
</tr>
<tr>
<td>San Francisco</td>
<td>52</td>
<td>64</td>
<td>$687</td>
<td>1.12</td>
<td>32</td>
</tr>
<tr>
<td>Salem</td>
<td>44</td>
<td>38</td>
<td>$512</td>
<td>1.30</td>
<td>18</td>
</tr>
</tbody>
</table>

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

(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
(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.

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## Principles to guide reform

*Address the underlying causes of rising costs, poor quality*

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

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. This figure represents data for more than 70,000 patients. National guidelines recommend that all patients with diabetes be managed to HA1C levels < 9%, and, ideally, to levels < 7%.
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
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

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.