Transforming Care: HIZs, ACOs, Bundling...what does it all mean for AMCs?

Joanne Conroy MD
Chief Healthcare Officer
AAMC
Step by Step

The economics of reform

What is means to be accountable

Enough Alphabet soup!

How will it change our world of education and research?

Next Steps
The Economy

An Unhealthy Trend

As healthcare costs rise, they take an increasing share out of the government’s coffers – and consumers’ wallets – every year. According to the Congressional Budget Office, total U.S. spending on healthcare has more than doubled as a share of GDP over the past 30 years, and that share is projected to double again by 2035 to 31% of GDP. Much of that spending will be on Medicare and Medicaid, which currently accounts for about 4% of GDP, but is projected to more than double to 9% of GDP by 2035.

SPENDING ON HEALTHCARE (AS A PERCENTAGE OF GDP)

Source: Congressional Budget Office
Graphic by Tommy McCall
The Solutions...

Decreasing Costs (not paying for Hospital Acquired Conditions or unnecessary readmissions)

Paying for Quality (Value Based Purchasing)

Focusing on Outcomes (Hospital and Physician Compare)

New methods of delivering/paying for care

- Shared Savings
- Accountable Care Organizations (ACOs)
- Patient Centered Medical Homes
- Bundling
The Changing Business Model of Healthcare

Since Medicare was introduced in 1966, the hospital industry has operated under a model driven by the fee-for-service payment system.

The twin impacts of the financial crisis and the pressure of health care reform (including improved value and increased provider accountability) challenge the current business model. ….the birth of “accountable care”
Step by Step

The economics of reform

What is means to be accountable

Enough Alphabet soup!

How will it change our world of education and research?

Next Steps
Accountability in GME

The Medicare Payment Advisory Commission (MedPAC) is calling for academic medical centers to meet explicit performance goals before they can become eligible for certain federal funds for graduate medical education (GME).

Modify the current system of funding for GME in order to "support medical education that supports skills needed in a delivery system that reduces cost growth while maintaining or improving quality."

Need goal based standards around practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice, and the integration of community-based care with hospital care.
AMCs are also a significant recipient of Federal dollars...at risk

<table>
<thead>
<tr>
<th>Program</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>IME – Medicare</td>
<td>$5.7 billion</td>
</tr>
<tr>
<td>DGME – Medicare</td>
<td>$2.7 billion</td>
</tr>
<tr>
<td>GME – Medicaid</td>
<td>$3.2 billion</td>
</tr>
<tr>
<td>DSH – Medicare</td>
<td>$9.8 billion</td>
</tr>
<tr>
<td>DSH – Medicaid</td>
<td>$11.1 billion</td>
</tr>
<tr>
<td>NIH</td>
<td>$14 billion</td>
</tr>
</tbody>
</table>
What does a health system that is accountable look like?

Healthcare providers that share responsibility for providing care to patients.

Think of it like buying a computer. Dell contracts with many suppliers to build your computer to your specifications. Like Dell, an accountable system would bring together the different component parts of care—i.e., primary care, specialists, hospitals, urgent care, home health, pharmacy, PT/OT, etc.—and ensure that all the partners work together as a team to deliver your care. ...like when you turn your new computer on and boot it up...it works!

Unfortunately, ...many people feel like they are getting a DIY health system or computer. Now some people want to do that...but most do not.
Step by Step

The economics of reform

What is means to be accountable

Enough Alphabet soup!

How will it change our world of education and research?

Next Steps
Alphabet Soup of Payment Reform

- Shared Saving (SS)
- Accountable Care Organizations (ACOs)
- Pioneer ACOs
- HIIZs (Academic ACOs)
- Bundled Payments
Shared Savings

Payment methodology for the Physician Group Practice (PGP) demo that was introduced by legislation in 2000

Providers continue to be paid FFS but can earn a bonus for improving quality and decreasing costs

Upfront costs ( $30-40K for each quality measure) born by providers
Sample Calculations

- PGP patient base year per capita expenditures: $10,000
- Local market expenditure growth rate: 10%
- Target = 110%*$10,000 = $11,000
- PGP patient actual expenditures: $10,600
- Target minus actual: $400 (3.6% of target)
- 2% of target threshold to account for normal variation in expenditures = $220
- Maximum savings shared with PGP:
  \[ 80\% \times ($400 - $220) = $144 \] (1.3% of target)
Imperfections in the concept

More like P4P instead of real payment reform..creating incentives to control savings is more enduring if it is linked to changes to how we deliver and pay for care

Providers bear the cost of start up with no guarantee of “shared savings” revenue

Rewards high spenders rather than high performers

Reductions of revenue are rarely offset by savings

Diminishing returns
Accountable Care Organization: Definition

Experts have proposed using financial incentives to create a new type of health care entity called an accountable care organization (ACO).

Available literature describes them as structures dedicated to quality and efficiency, with the infrastructure to use performance, reporting and compensation standards to achieve their goal.

Belief that they will create greater clinical integration of care across care settings, greater financial efficiency, and increased transparency about care cost and outcomes.

In the legislation ACOs are seen as a tool for restructuring traditional Medicare coverage.
Issues for systems in these programs...some changes in the final rule

Attribution...changed to prospective
Minimum numbers...
Savings Threshold....
Anti trust (50% rule)...
Structure and Governance....
IME, DME and DSH in calculations....Out
HIZ definition

“…Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity, deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.”
HIZ and the defined communities would...

Provide fertile ground to test and implement a variety of care-delivery changes and supportive payment methodologies designed to improve quality and constrain overall cost growth in a sustainable manner.

Re-engineering academic health system processes and practices across all three missions

Rapidly evaluate the effects of multiple interventions using their advanced information systems and health services research capabilities.
HIZ Goals

Demonstrate that we are preparing the workforce to use collaborative, team-based approaches to clinical care, education, and research.

Measure our ability to change practice across a region through our graduates (MDs, PhDs, other providers)

Expand research agenda to include community based population health research and implementation science
Bundled Payments

Bundled payment, also known as episode-based payment, episode payment, episode-of-care payment, case rate, evidence-based case rate, global bundled payment, global payment, package pricing, or packaged pricing

It is a defined reimbursement for clinically-defined episodes of care.

It has been described as "a middle ground" between FFS reimbursement (unit of service payment) and capitation (lump sum per covered life per year for all services)

In 1984 The Texas Heart Institute began to charge flat fees for both hospital and physician services The flat fee for CABG was $13,800 versus the average Medicare payment of $24,588.
# Bundled Payments Side-by-Side Comparison

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
<td>Retrospective Acute Care Stay (similar to Gainsharing Demo)</td>
<td>Retrospective Acute Care Stay and PAC</td>
<td>Retrospective PAC</td>
<td>Prospective Acute Care Stay (similar to ACE Demo)</td>
</tr>
<tr>
<td><strong>Services in bundle</strong></td>
<td>Part A inpatient services</td>
<td>Inpatient (initial admission), physician, readmissions, LTCH, IRF, SNF, home health, outpatient, therapy, lab, DME, Part B drugs</td>
<td>Physician, readmissions, LTCH, IRF, SNF, home health, outpatient, therapy, lab, DME, Part B drugs</td>
<td>Inpatient (initial admission), physician services, readmissions</td>
</tr>
</tbody>
</table>
Haven’t we been here before?
Step by Step

The economics of reform

What is means to be accountable

Enough Alphabet soup!

How will it change our world of education and research?

Next Steps
Duke PCMH/ CC of NC

North Carolina and Duke University have been experimenting with the concept of medical homes for many years. In 1998, North Carolina’s Medicaid program starting supporting physician-led networks to offer medical homes to Medicaid enrollees. The program was highly successful both in improving overall health and in saving money. By paying doctors $2-3 a month per Medicaid enrollee to more closely manage care, the Medicaid system saved $60 million in 2003 and $120 million in 2004.

Physicians, nurses, nurse practitioners and physician assistants are trained not only in how to prevent and treat disease but also how to engage patients and manage their care between visits and care settings. Medical, nursing and physician assistant students attend team-based learning sessions together.

In the Family Medicine Residency Program, physicians are trained in team-based healthcare, chronic disease management, community engagement, leadership and quality measurement and improvement.
Organizing for change
Virginia Mason in Seattle

Applied “Lean” to the issue of resident rounding efficiency

Created standards for inpatient encounter

Two day event

Five residents, two attendings

Six simulations
<table>
<thead>
<tr>
<th>Resident Morning Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing time per patient = 135 min / 14 = 9'30&quot;</td>
</tr>
</tbody>
</table>

| Total time per patient = 24'45" |

| Pre-rounding time per patient = 105 min / 7 = 15" |

| Batch and Queue |

| Patient 1 | 1 |
| Patient 2 | 2 |
| Patient 3 | 3 |
| Patient 4 | 4 |
| Patient 5 | 5 |
| Patient 6 | 6 |
| Patient 7 | 7 |
| Patient 8 | 8 |
| Patient 9 | 9 |
| Patient 10 | 10 |
| Patient 11 | 11 |
| Patient 12 | 12 |
| Patient 13 | 13 |
| Patient 14 | 14 |
|-------|---------|------|------|------|------|------|------|------|------|-------|-------|-------|-------|-------|-------|-------|-------|
|       | 1       | 3    | 1    | 5    | 3    | MDR  | 7    | 5    | 9    | 7     | 11    | 9     | 13    | 11    | 13    | 13    |       |
|       | 2       | 2/4  | 4    | 2    | 6    |      | 4    | 8    | 6    | 10    | 8     | 12    | 10    | 14    | 12    | 14    |       |
|       | Patient 1| 1    | 2/4  | 2    | 3    |      | 4    | 5    | 6    | 7     | 8     | 9     | 10    | 11    | 12    | 13    | 14    |
|       | Patient 2| 2    | 2    | 3    | 4    |      | 5    | 6    | 7    | 8     | 9     | 10    | 11    | 12    | 13    | 14    |       |
|       | Patient 3| 3    | 4    | 5    | 6    |      | 7    | 8    | 9    | 10    | 11    | 12    | 13    | 14    |       |       |
|       | Patient 4| 4    | 5    | 6    | 7    |      | 8    | 9    | 10   | 11    | 12    | 13    | 14    |       |       |       |
|       | Patient 5| 5    | 6    | 7    | 8    |      | 9    | 10   | 11   | 12    | 13    | 14    |       |       |       |       |
|       | Patient 6| 6    | 7    | 8    | 9    |      | 10   | 11   | 12   | 13    |       |       |       |       |       |       |
|       | Patient 7| 7    | 8    | 9    | 10   |      | 11   | 12   | 13   |       |       |       |       |       |       |       |
|       | Patient 8| 8    | 9    | 10   | 11   |      | 12   | 13   |       |       |       |       |       |       |       |       |
|       | Patient 9| 9    | 10   | 11   | 12   |      | 13   |       |       |       |       |       |       |       |       |       |
|       | Patient 10| 10  | 11   | 12   | 13   |      |       |       |       |       |       |       |       |       |       |       |
|       | Patient 11| 11  | 12   | 13   |       |       |       |       |       |       |       |       |       |       |       |       |
|       | Patient 12| 12  | 13   |       |       |       |       |       |       |       |       |       |       |       |       |       |
|       | Patient 13| 13  |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
|       | Patient 14| 14  |       |       |       |       |       |       |       |       |       |       |       |       |       |       |

Pre-rounding time per patient = 150 min / 7 = 21'15"

Staffing time per patient = 195 / 14 = 13'45"

Total time per patient = 35'

One Patient at a Time

2011 Annual Meeting

AAMC
New innovative approaches

Incentivizing Residents to achieve specific quality and utilization goals: Robert Baron M.D. Associate Dean for GME and CME, UCSF

Residents were eligible for up to $1200 in incentives for hitting performance goals in 3 areas…institution wide areas and program specific

Avg resident earned approx $750

http://www.medschool.ucsf.edu/gme/residents/incentives.html
PATIENT SATISFACTION:
For the period of June 2010-July 2011, on the patient satisfaction survey likelihood of recommending question, maintain an annual average mean score of 90.5.

PATIENT SAFETY AND QUALITY:
For the period of July 2010-June 2011, achieve 85% hand hygiene compliance for at least six of twelve months.

LAB UTILIZATION:
By June 2011 residents will decrease by 5% the aggregated utilization of common laboratory tests (defined as tests/inpatient day). Common tests will include, CBC, CBC with differential, electrolytes (Na, K, Cl, CO2, HCO3, Mg, Ca, Phos), BUN, Cr, AST, ALT, total bilirubin, alkaline phosphatase and albumin.
Regardless of the successes, more work still be to done to

<table>
<thead>
<tr>
<th>Goal</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease cost growth rate</td>
<td>Provide residents with real time cost of care data</td>
</tr>
<tr>
<td>Decrease administrative costs</td>
<td>Include residents in system reengineering teams</td>
</tr>
<tr>
<td>Decrease variations in care</td>
<td>Agree on what can be standardized and what can not in the educational environment</td>
</tr>
<tr>
<td>Reduce medical errors</td>
<td>Create a safe place for reporting</td>
</tr>
<tr>
<td>Make better decisions about end-of-life care</td>
<td>Teach residents that it is important to know when not to do something as it is to know when to intervene</td>
</tr>
</tbody>
</table>
Pathway to transformation

1. **Provide current state assessment and gap analysis (R4R 1.0)**
2. **Build capacity for health care delivery transformation (R4R 2.0)**
3. **Identify care innovations and rapidly disseminate for adoption (HOMERUN)**
4. **Pilot new care delivery models: HIzs/ACOs**
5. **Fast track quality through data sharing and practice improvements**
6. **Test new payment models**
7. **Redefine community commitments and patient engagement**

Pilot new care delivery models: HIzs/ACOs

Build capacity for health care delivery transformation (R4R 2.0)

Fast track quality through data sharing and practice improvements

Test new payment models

Redefine community commitments and patient engagement

Identify care innovations and rapidly disseminate for adoption (HOMERUN)

Pilot new care delivery models: HIzs/ACOs

Provide current state assessment and gap analysis (R4R 1.0)
The Challenges

You cannot change your destination overnight, but you can change your direction overnight.”

Jim Rohn

It is not necessary to change. Survival is not mandatory.

W. Edwards Deming