



**THE CAPSTONE CONFERENCE**  
**Fresh-Thinking on Health Care Reform**

**ORGANIZING HEALTH CARE FOR  
HIGHER QUALITY AND LOWER COST**

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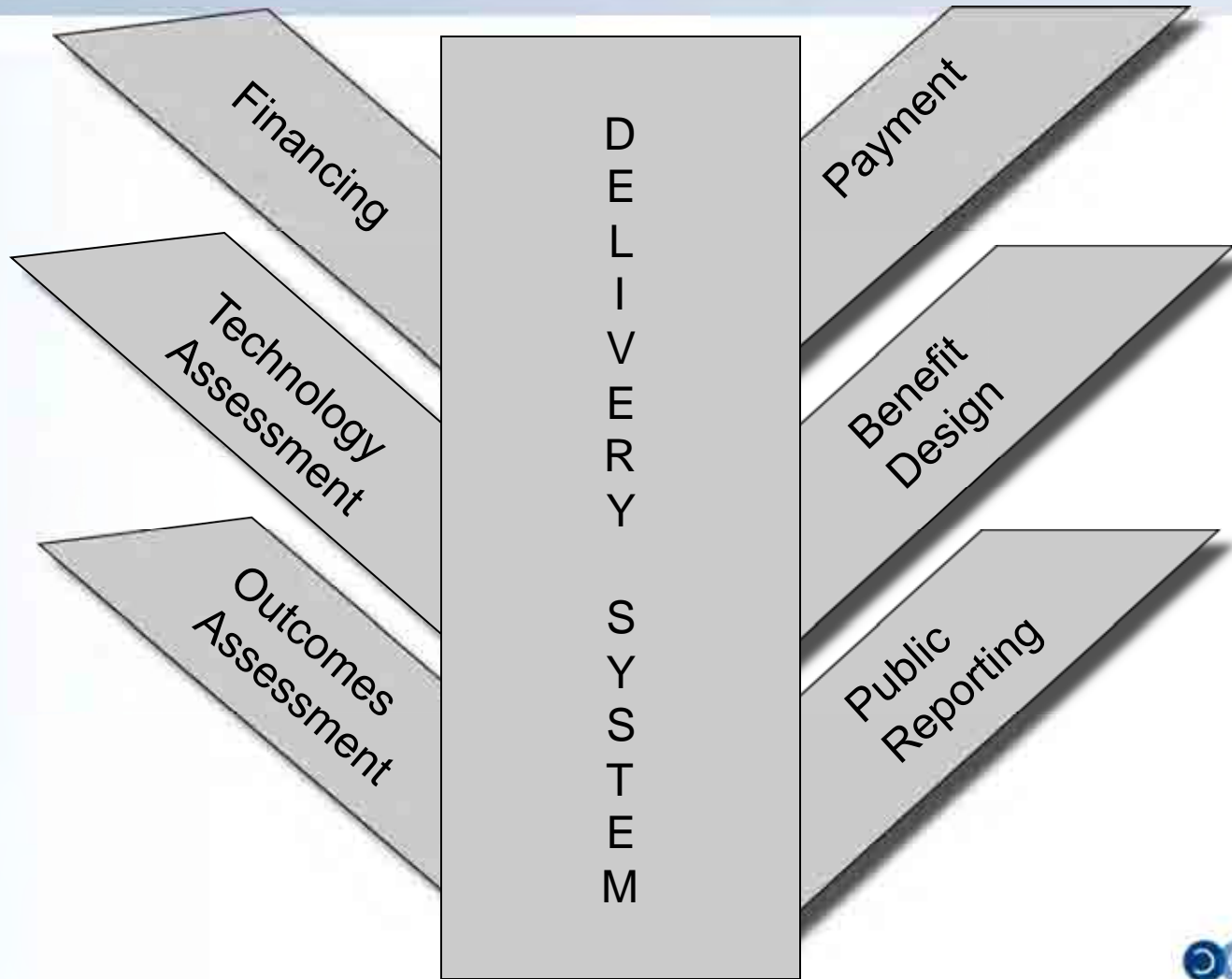
May 14, 2009

**“The current system cannot do the job.  
Changing systems of care will”**

**- Institute of Medicine, Crossing the Quality Chasm, 2001**



# It must all go through the delivery system



Value-Added Care



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# Where Does Your Health Insurance Dollar Go?



\*Includes prevention, disease management, care coordination, investments in health information technologies and health support.  
 \*\*Includes the inpatient costs of hospitals and the outpatient costs of hospitals and free-standing clinics.

Based on a PricewaterhouseCoopers' analysis, Factors Fueling Rising Healthcare Costs 2006. © 2006 America's Health Insurance Plans



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# Challenge

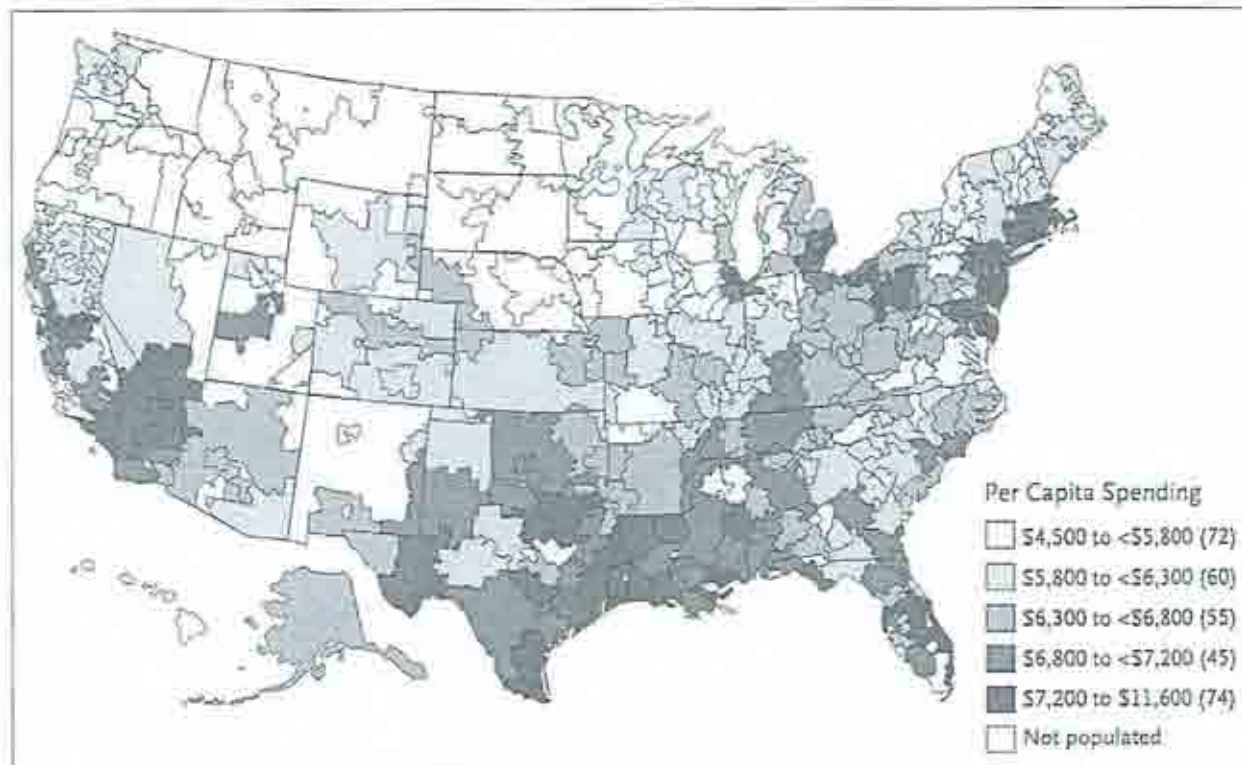
Bringing the 19<sup>th</sup> century “craft-oriented” delivery system into the 21<sup>st</sup> century capable of delivering modern medical advances



# Three fold variation in per capita spending

PERSPECTIVE

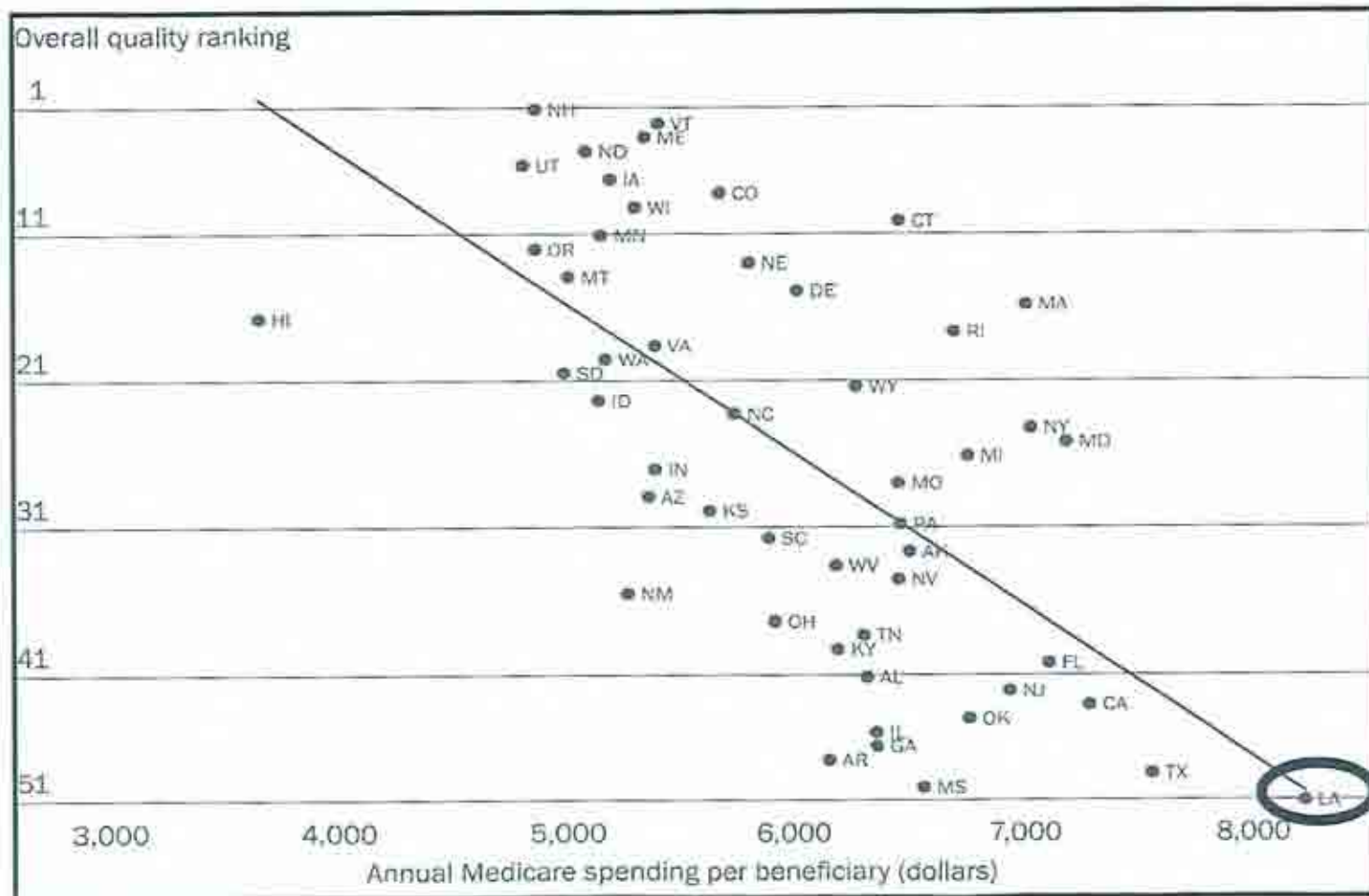
THE CHALLENGE OF RISING HEALTH CARE COSTS — A VIEW FROM THE CONGRESSIONAL BUDGET OFFICE



Medicare Spending per Capita, According to Hospital Referral Region, 2003.

Data are from the Dartmouth Atlas of Health Care. Numbers in parentheses are the numbers of hospital referral regions with that level of per capita spending.

# Higher healthcare spending is not associated with better quality



Source: Baicker et al. Health Affairs web exclusives, October 7, 2004

# UC Berkeley Study

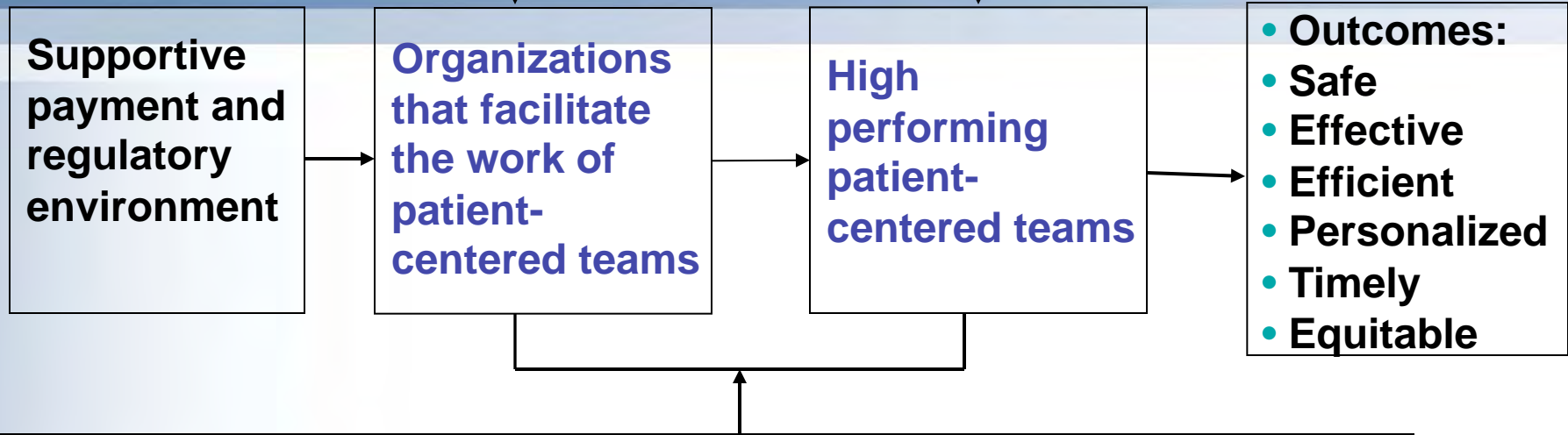
## Use of Care Management Processes by Type of Chronic Condition

Type of CMPs	Diabetes (n = 523) <sup>+</sup>	Asthma (n = 522)	CHF (n = 526)	Depression (n = 497)
Patient list or registry	70.2%	62.4%	58.5%	40.8%
Provide patient educators	73.9%	53.8%	53.6%	35.4%
Physician feedback on quality	66.1%	56.1%	50.8%	32.8%
Nurse care managers	54.7%	42.7%	47.5%	25.1%
Patient reminders	51.4%	35.2%	35.0%	19.7%
Point-of-care reminders	51.2%	36.4%	33.1%	22.9%
No. (%) using all 6 CMPs	21.6%	10.5%	10.1%	4.4%
Mean CMP Use (out of 6)	3.7	2.9	2.8	1.8

Source: D. Rittenhouse et al., "Improving Chronic Illness Care: Findings From National Study of Care Management Processes in Large Physician Practices," 2008, Under Review.

# Making change possible

## CARE SYSTEM



### 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

Source: Institute of Medicine, Crossing the Quality Chasm, p. 127, 2001.

An **Accountable Care Organization** is an entity that is clinically and fiscally accountable for the entire continuum of care that patients may need.



# An accountable care organization has only two jobs →

- To continuously improve the value  
$$\left( \frac{\text{quality + outcomes + satisfaction}}{\text{costs}} \right)$$
  
of the care it delivers
- To provide the evidence (i.e. the data) on the above

# ACOs must have...

- A governance structure that is focal point for accountability
- Able to measure costs, productivity, quality and outcomes of care
- Able to aggregate the data from individual units
- Have sufficient number of patients to detect statistically significant differences in performance from established targets
- Able to report the data to external groups
- Have the information technology and work process design capability to improve care on a continuous basis



# Some Models of Accountable Care Organizations

- Integrated Health Systems (e.g. Kaiser Permanente, VA)
- Multi-Specialty Group Practices (e.g. Mayo Clinic, HealthPartners, Sharp Rees-Stealy)
- Extended Hospital-Physician Referral Network (e.g. Fisher et al, 2007)
- Physician-Hospital Organization (PHO) (e.g. Advocate)
- Interdependent Physician Organization (IPO) (e.g. Brown and Toland, Hill Physician Group, Monarch)

Source: Adapted from S.M. Shortell, L.P. Casalino, "Health Care Reform Requires Accountable Care Systems", *JAMA*, 2008, 300(1):95-97.

# Some Ideas

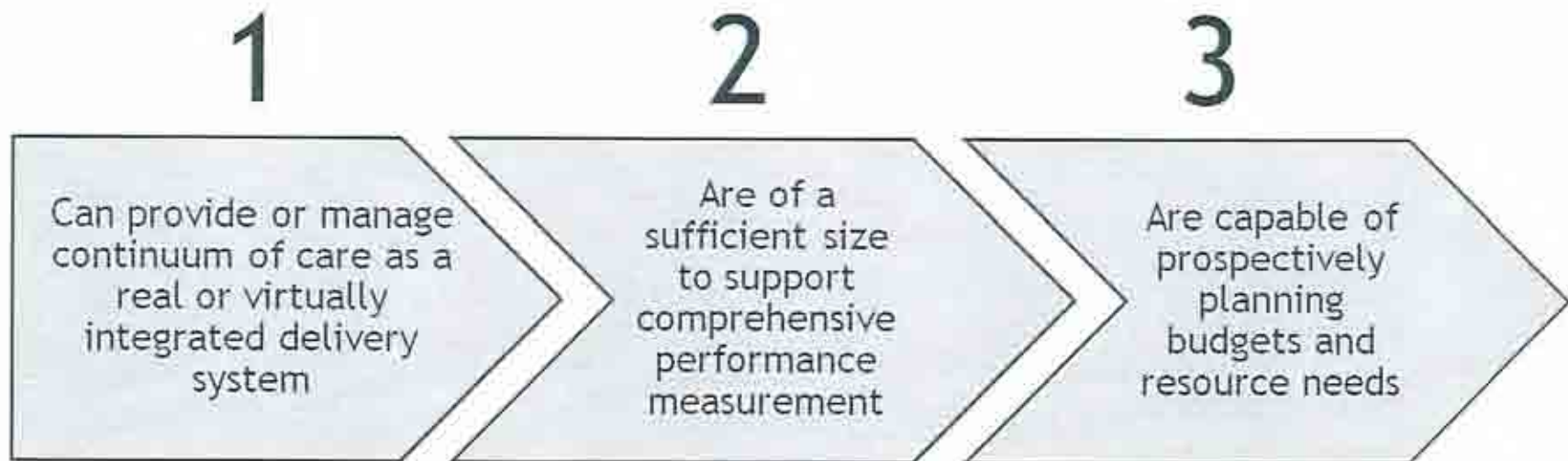
- Patients encouraged but not required to choose an ACS as a medical home
- Physicians could choose to practice in an ACS but not required to do so
- Offer more potential payment for improving quality and controlling cost for providers that are a part of an ACS
- Create tiered incentives for patients choosing highest value-added ACSs





# ACOs will look very different, but a few characteristics are essential

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# What providers comprise an ACO? It varies.

## Accountable Care Organization

Primary Care



Hospital



Specialists



**Other Possible  
Components:**

Home Health

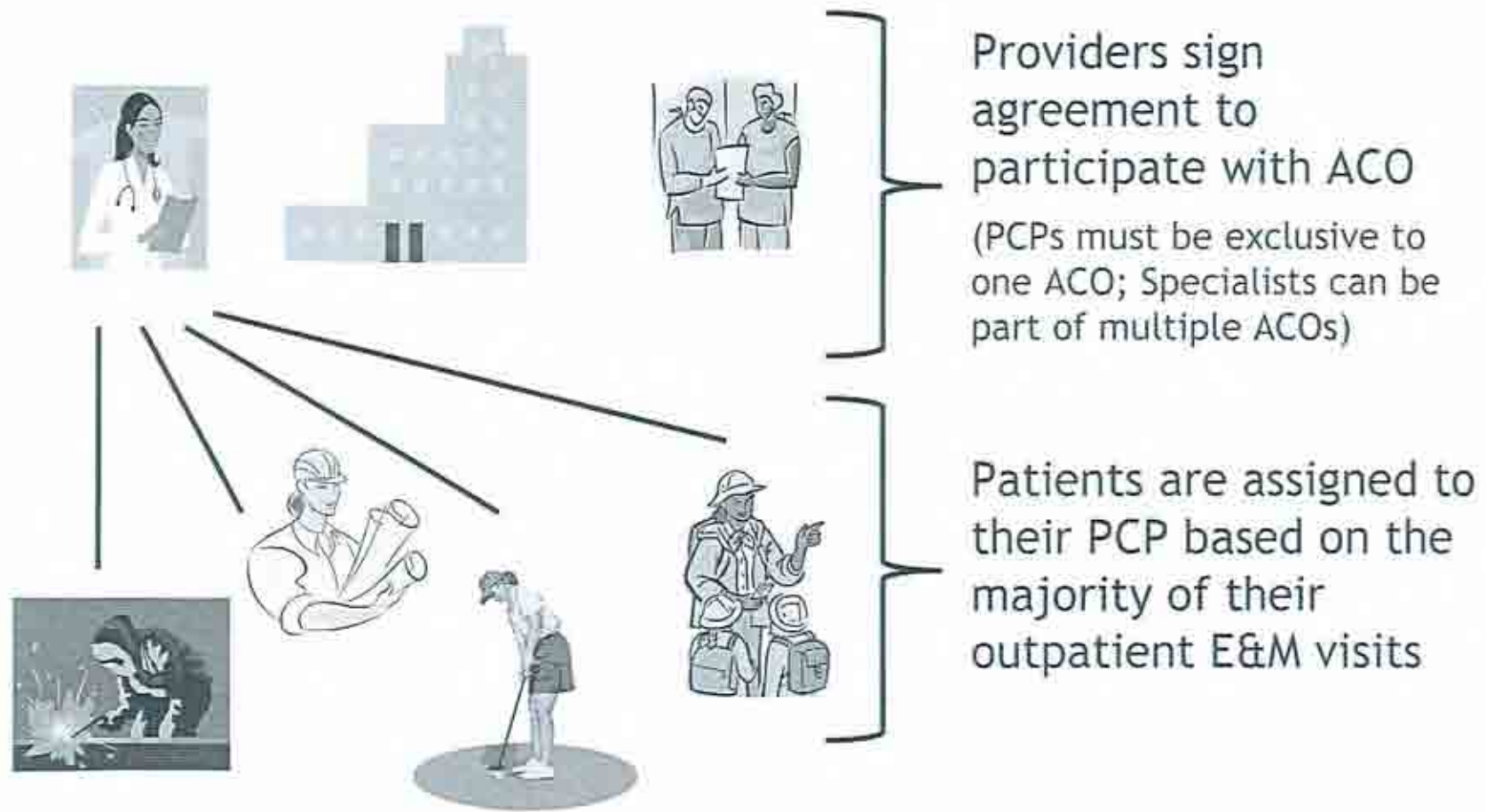
Mental Health

Rehab

Facilities




# How are patients assigned to the ACO?





## Three components of ACO infrastructure

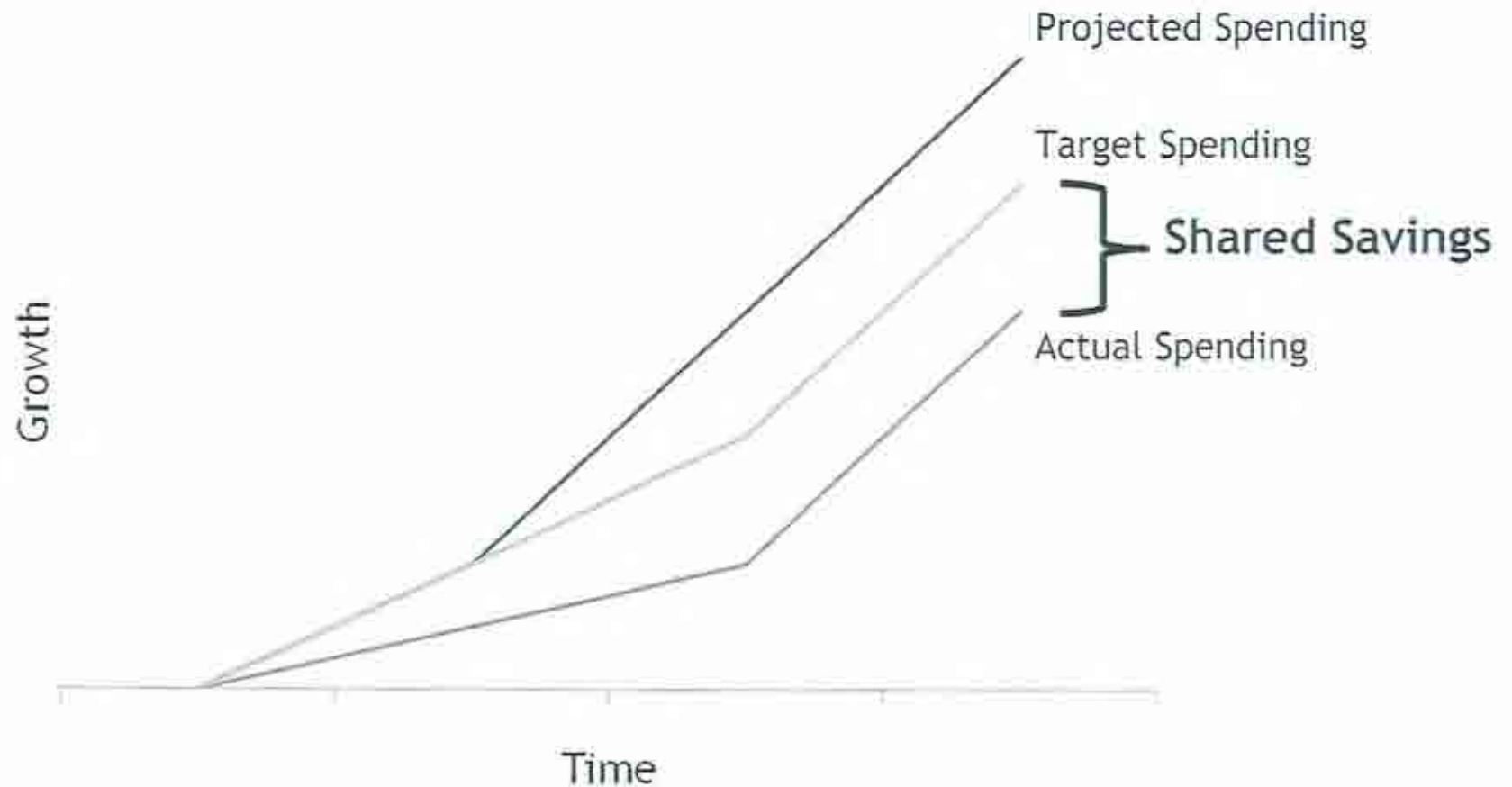
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- Local Accountability for Cost, Quality, and Capacity
  - Shared Savings
  - Performance Measurement

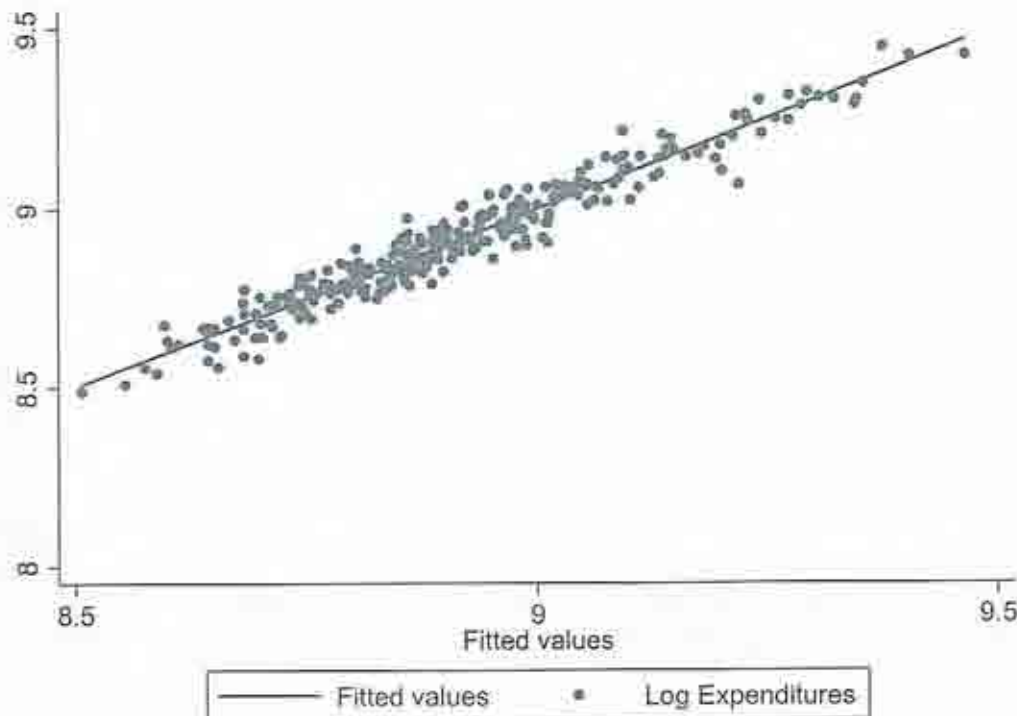




# Calculating savings based on spending targets



# Ability to predict spending is strong



Predicted and actual  
log age-sex-race  
Medicare  
expenditures, 2003-  
05, for EHMSs with  
at least 5000 people.

$N = 287$

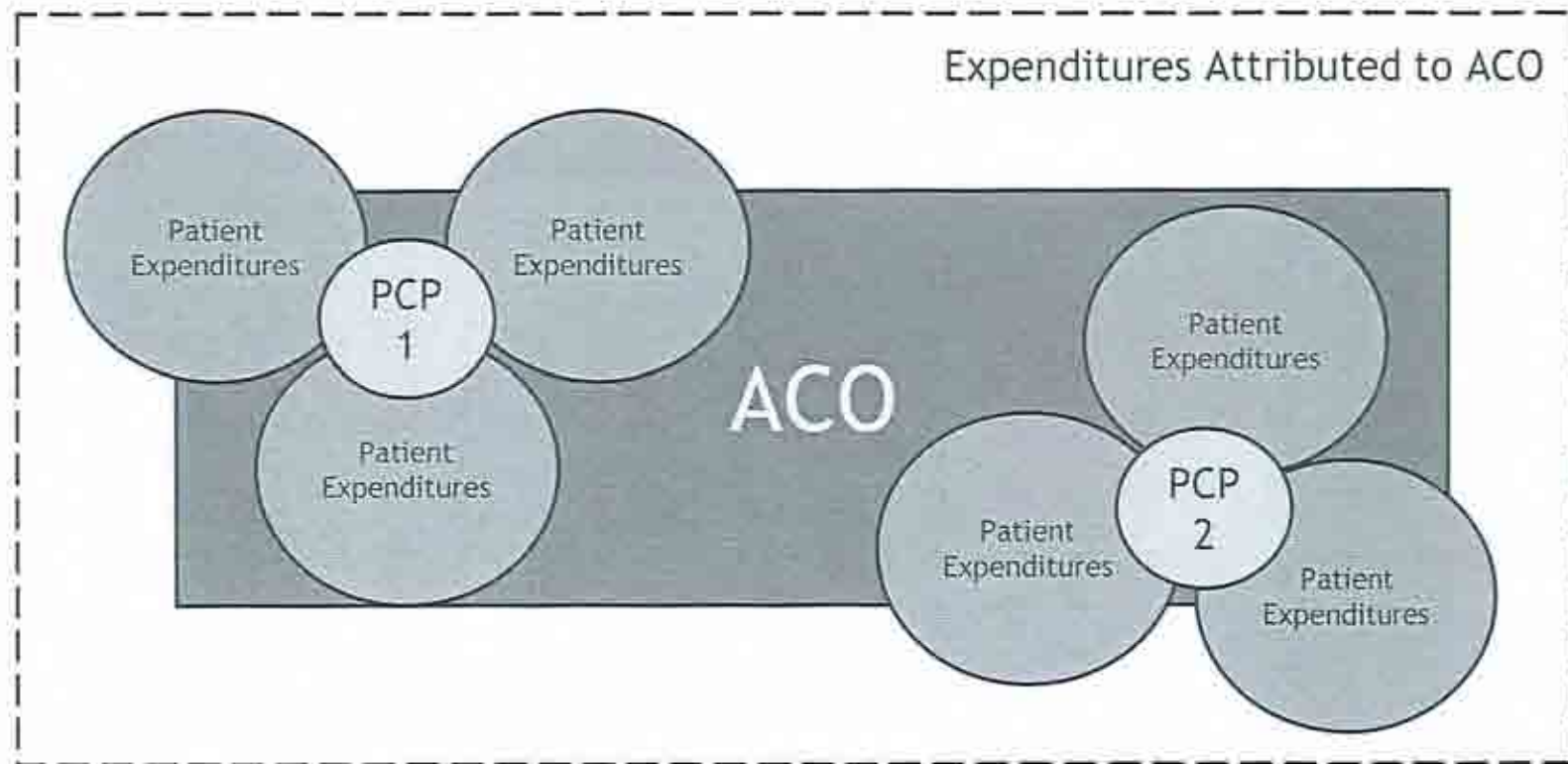
$R^2 = .94$

Error = .04 Percent





# ACO is responsible for all patient expenditures



## Multiple initiatives within the ACO model:

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### \$800M (Target Expenditures)

- \$525M (Traditional Fee for Service Payments)
  - \$115M (Bundled Payments for Specific Conditions)
  - \$150M (PMPM Payments for Medical Home)
- 

### \$10M (Available Shared Savings)



(80/20 agreed upon split)



\$8M to the Providers

\$2M to the Payers





## ACOs will look different across local markets

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- ▶ Negotiation points among stakeholders:
  - ▶ Setting expenditure target for ACO
  - ▶ Distribution of shared savings (i.e. 80/20, 50/50)
  - ▶ Will there be a threshold for savings (i.e. under 2%)
  - ▶ Withholds or penalties for spending over target
  - ▶ Start-up or interim payments to providers





## How do ACOs reduce expenditures?

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Through systematic efforts to improve quality and reduce costs across the organization:

- ▶ Using appropriate workforce (increased use of NPs)
- ▶ Improved care coordination
- ▶ Reduced waste (i.e. duplicate testing)
- ▶ Internal process improvement
- ▶ Informed patient choices
- ▶ Chronic disease management
- ▶ Point of care reminders and best-practices
- ▶ Actionable, timely data
- ▶ Choices about capacity



# Audacity of Hope

That over time we will have a delivery system that can sustain insurance coverage for all by providing quality care at a more avoidable cost.



# So...what might happen?

“If we fail to seize this unique opportunity to adopt a pragmatic, integrative approach to health care, it will constitute a failure and we must not fail. It is my intention to change our health care system and to place integrative health care at the heart of the reform legislation that we will pass this year”

– Senator T Harkin (D-Iowa)  
February 27, 2009

