The ABCs of ACOs

Thomas Koshy, Ph.D. Sr. Director for Scientific Affairs

December 5, 2013
Disclaimers

I don’t really know everything about ACOs.....

No one really knows everything about ACOs.....

Is anyone here in an ACO?
Typical ACO talk

Healthcare today

Healthcare tomorrow
US Health Care = Bad Restaurant?
US Health Care = Auto Repair?

- Transactional, reactional care for a specific “repairs”
  - FFS, not FFV/P4P
- Ironically, the same repair shop can provide the preventive services that would reduce high cost transactions
- We need to transition from transactional care to preventive care and coordination of care, especially for chronic conditions.
The Care We Get...
“Flip of the Coin” Health Care Quality, 6-6-03

“Our results indicate that, on average, Americans receive about half of recommended medical care processes”

Nearly 70,000 Americans die needlessly each year because they are not given optimal heart failure therapy.
95% of px with ankle injuries get x-rays

A simple rule-out tool would be handy

85% of ankle x-rays show no fracture

Ottawa Ankle Rules

X-rays are only required if there is any pain in the malleolar zone and:

- Bone tenderness along the distal 6 cm of the posterior edge of the tibia or tip of the medial malleolus, OR
- Bone tenderness along the distal 6 cm of the posterior edge of the fibula or tip of the lateral malleolus, OR
- An inability to bear weight both immediately and in the emergency department for four steps.

Foot X-ray series is indicated if there is any pain in the midfoot zone and:

- Bone tenderness at the base of the fifth metatarsal (for foot injuries), OR
- Bone tenderness at the navicular bone (for foot injuries), OR
- An inability to bear weight both immediately and in the emergency department for four steps.

Despite spending 2x more than anyone else. The US is…

- Life Expectancy: 31st
- Infant Mortality: 36th
- Male Healthy Life Expectancy: 28th
- Female Healthy Life Expectancy: 29th
Something’s Gotta Give

Because unaccountable care is no longer sustainable

It just comes down to who the accountable party is…
What is an ACO?
Accountability Defined

*IHI’s Triple Aim Describes Accountable Care’s Trifecta*

- Whether participating in Medicare’s ACO program or collaborating with private payors, virtually all health systems are on some pathway to greater accountability.
- This journey goes by many names: clinical integration, integrated care, collaborative patient-centered care, physician-hospital alignment, but their fundamental goals invariably include improving clinical outcomes, efficiency, and satisfaction with care.
Triple Aim

Population Health
- Education
- Health Management
- Wellness
- Disease Management
- Preventive Care

Experience of Care
- Care Coordination
- Patient Involvement
- Pre-patient Involvement
- Doctor Involvement

Per Capita Costs
- Reduce Costs AND
- Improve overall health of the care group
Moving away from FFS, volume-based reimbursement to value-based compensation (P4P, risk sharing, global budgets)

Proactive anticipation of individual patient and prepatient needs, and plan to address these needs in coordinated, expeditious manner

Taking responsibility for care processes and care outcomes, including cost, quality, and experience of care

Built on a strong base of primary care, ideally arranged as “patient-centered medical homes” or similar forms using care teams to coordinate and deliver care

Connecting data from all care sites, providers, institutions into a longitudinal, personal health record with health decision guidance/support for patients, in addition to clinical decision support for providers
Responsibility

Accountability
CMS says…

ACOs are formed under the Medical Shared Savings Program (MSSP).

Designed to reduce costs and improve quality of care.

MSSP provides ACOs with two, 3-year shared saving options. Both require meeting cost benchmarks and specific quality standards.

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
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<tbody>
<tr>
<td>Earn up to 50% of savings with no downside risk if costs are reduced below the ACO’s benchmarks.</td>
<td>Earn up to 60% of savings with a potential penalty if costs don’t reduce</td>
</tr>
</tbody>
</table>
Cost Benchmarks and Quality Measures

Each ACO gets a benchmark based on the previous 3 years performance (with weighting towards the last year and other adjustments).
Cost Benchmarks and Quality Measures

Year 1
- Simply report on the 33 measures to get the bonus of any shared savings.

Year 2, 3, etc.
- Sliding scale for continuous improvement.
It’s Gotta Start with the Data
Accountable Health Outcomes Management

Accountable Care Organization

Patient-Centered Medical Home

Meaningful Use

• Single Provider
• Office Transformation
• FFS + Bonus
• Data Capture

• Team-Based Care
• Incentive Payments (P4P)
• Quality Reporting

• Collaboration Among Multiple Providers
• Shared Risk
• Reporting Against Quality, Cost, and Patient Experience

• Population Health Risk Assessment
• Health Risk Mitigation Workflows / Coaching
• Care Coordination Workflows
• Chronic Condition Monitoring
• Treatment Plan / Rx Adherence Monitoring
• Field-based Complex Case Management

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This **can** be done
Stepwise Path to Accountable Health

Accountable Health Outcomes Management

Accountable Care Organization

Patient-Centered Medical Home

Meaningful Use

• Collaboration Among Multiple Providers
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• Data Capture

Data

Information

Action

• Population Health Risk Assessment
• Health Risk Mitigation Workflows / Coaching
• Care Coordination

• Field-based Complex Case Management

Data

Information

Action
The Physician Quality Reporting System (PQRS)

Incentive payments and payment adjustments to promote reporting of quality information by eligible healthcare professionals. The program provides incentive payments for reporting data on quality measures. Beginning in 2015, the program also applies a payment adjustment to professionals who do not satisfactorily report data on quality measures for covered professional services.
<table>
<thead>
<tr>
<th>Year</th>
<th>Payment Adjustment</th>
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<tr>
<td>2011</td>
<td>1-1.5% bonus payment</td>
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<td>2012</td>
<td>0.5-1% bonus payment</td>
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<tr>
<td>2013</td>
<td>0.5-1% bonus payment</td>
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<tr>
<td>2014</td>
<td>0.5-1% bonus payment</td>
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</table>
| 2015 | 1.5% cut of physician unsuccessfully reports on PQRS measures  
No bonus payment for physicians who successfully report on PQRS measures |
| 2016 | 2% cut of physician unsuccessfully reports on PQRS measures  
No bonus payment for physicians who successfully report on PQRS measures |
| 2017 | 2% cut of physician unsuccessfully reports on PQRS measures  
No bonus payment for physicians who successfully report on PQRS measures |
Clinical Registry and Guidelines

Connected registries facilitate the creation of coordinated care teams, who all have access to care plans and status. Customizable evidence-based guidelines suggest recommended care. Integration with EMRs/EHRs and HIEs through connectivity capability. Supports and provides extensive reporting and analytics. Facilitates development and deployment of Patient-Centered Medical Homes and ACOs.

- Diabetes
- Heart / stroke
- Pediatric ADHD
- COPD
- Hypertension
- Pediatric obesity
- Heart failure
- Adult and pediatric asthma
- Adult and pediatric prevention
- Diabetes
- Heart / stroke
- Pediatric ADHD
Collaborative Care Platform® (CCP)
Success Takes More Than EHRs

Installing EHRs and exchanging data is not enough; ACOs must have the right information at the point of care to support care decisions and to properly intervene in ways that address patients holistically.

- Predictive modeling to define risk strata
- Evidence-based gaps in care information
- Real-time data access across care settings
- Care coordination among providers, staff, patients
- Patient-facing care plans, education, motivation, skills
- Remote telemedicine for monitoring high risk populations
- Primary care extenders, tools to manage select subpopulations
- Analytic tools for managing operational, clinical, financial metrics
- Tracking and managing quality metrics for operations, reporting, CQI
Our Unbalanced Health Care System
Specialization Without Better Integration is Unsustainable

Specialization
- Uncoordinated care
- Process focus
- Poor handoffs
- Navigation hard
- Continuity lacking
- Little data exchange
- Waste, duplication
- Curing vs. caring
- Volume-based pay
- Incentives to do more

Integration
- Teamwork
- Triple Aim
- Care transitions
- EMR, PHR, HIE
- Accountable care
- Medical homes
- Participatory care
- Cost-effectiveness
- Value-based pay
- Incentives to do better
Support Across Continuum of Health
Comprehensive, Integrated Approach to Improving Population Health

<table>
<thead>
<tr>
<th>Health &amp; Wellness</th>
<th>Condition Mgmt</th>
<th>Diagnostics</th>
<th>Case Mgmt</th>
<th>Women’s &amp; Children’s</th>
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<td>• Nurse 24</td>
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<td>Support</td>
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<td>Connected Health Ecosystem</td>
<td>Point of Care Health Decision Support</td>
<td>Personal Health Support Services</td>
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Personal Health Support Model

Our Patient-Centric Approach Adapts to Needs of Individuals

Collaborative consumer-centric model delivers care and measurable value across the health care continuum.

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It’s Not Easy Being Patient-Centric

Even For Patients Who Are Striving for Optimal Health
This Would Be Nice

Primary care “home”

Electronic health record

Specialty care referrals

Public report cards

Ancillary care providers

Urgent care facility

Online health information

Nutritionist

Wellness health coach

Retail clinic

Fitness center

Care reminders

Care coordinator

Worksite health program

Personal health record

Imaging center
This is What We Want!

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It Takes More than Health Care Providers

Factors Contributing to Health
Based on figures from the National Center for Health Services, Centers for Disease Control and National Institutes for Health.

- Heredity: 20%
- Medical Care System: 10%
- Environment: 20%
- Personal Lifestyle Choices: 50%

Proportional Contribution to Premature Death

- Genetic predisposition: 30%
- Behavioral patterns: 40%
- Social circumstances: 15%
- Environmental exposure: 5%


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Why Doesn’t Care Change Behavior?

- Information is a prerequisite for changing behavior, but itself is insufficient; sustained motivation and appropriate behavioral skills are also necessary.
- The classic “medical model” focuses on providing information via hierarchical authority and expertise, with little attention to motivation and requisite skills.
- When unsuccessful, clinicians tend to add shame, guilt, &/or intimidation to the message, further demotivating patients and defeating our original purpose.

*Most physicians and nurses are not ideally socialized, trained, or supported to provide sustained motivation and good behavioral skills*
Value Chain For Accountable Care
A Virtuous Cycle of Population Health Management

- Improved Health Outcomes
- Complete Population Health Data
- Integration & EBM Gap Analyses
- Impactful Health Decision Support
- Shared Care Plans w/ Better Use of What Works
- Information, Motivation, Behavioral Skills
- Better Health Behaviors

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It’s Gotta Start with the Data
Who are these ACOs?
(2) Leavitt Partners ACO report, June 2012
(3) Brookings Institute ACO Learning Network webinar, Jan 2013

4 million Medicare beneficiaries (3)

25-31 million total lives (3)
What do ACOs Look Like?
HMOs
• Ended up focusing on contracts and setting payment rates

ACOs
• Intend to use incentives and long term arrangements to improve quality in ways that reduce costs.

HMOs vs. ACOs

Quality/Patient Experience Required Measures

Preventive Health
- Influenza immunization
- Pneumococcal vaccination
- Adult weight screening/Follow up
- Tobacco use assessment and cessation
- Depression screening
- Colorectal cancer screening
- Mammography screening
- Proportion of adults with blood pressure screen in past two years

At-Risk Populations
- Diabetes
  - A1c control
  - Low density lipoprotein
  - Blood pressure
  - Tobacco non-use
  - Aspirin use
  - Hemoglobin A1c
- Hypertension
  - Blood pressure control
- IVD
  - Complete lipid profile and LDL control
  - Use of aspirin/antithrombotic
  - Heart Failure – Beta Blocker for LVSD
- CAD
  - Drug Therapy for Cholesterol
  - ACE and ARB Therapies

Care Coordination/Safety
- COPD (PQI#5)
- Congestive heart failure (PQI#8)
- Risk standardized, all condition readmission
- % of PCP qualify for EHR incentive payment
- Med reconciliation after inpatient discharge
- Screening for fall risk

Patient Experience (CAHPS)
- Timely care, appointments & info
- Doctor communication
- Patient rating of doctor
- Access to specialists
- Health promotion & education
- Shared decision making
- Health status/Functional status
Are they working?
A Success Story

- Reduce LDL targets for high risk patients.
  - 100 mg/dL $\rightarrow$ 70 mg/mL

However

- Several studies show only 15-30% reach this goal

Kaiser (Denver) project

- 7427 patients managed by nurses, pharmacy and MDs
  - Meds, diet and lifestyle
  - EHR and disease registries were key to coordinate patient care

NCEP

Results

- 43% achieved target goal
- 87% could use generic drugs

Credit

Authors credit the integrated care delivery model, supported by electronic medical records and health information technology

Early Report: Blue Shield, CA

Dignity Health, Blue Shield of CA and Hill Physicians ACO collaboration begun in Jan 2010

Each organization shares clinical and case management information in order to tightly coordinate care.

They agreed to contribute to cost savings and bear the financial risk for any variance from the project's cost reduction goals.

Success depends on taking cost out of the delivery system, not by shifting risk to other partners.
Cost-saving strategies

• Manage utilization through coordinated operational infrastructure and clinical processes.

• Personalize care and disease management to eliminate unnecessary utilization and noncompliance with evidence-based care.

• Reduce physician clinical and resource variation through quantitative analysis and targeted interventions.

• Reduce pharmacy costs through directed member outreach, drug purchasing and contracting strategies.

• Facilitate communication of patient medical information through integrated electronic health information.
In patient readmissions: 15%
Inpatient days: 15%
Inpatient stays of 20+ days: 50%
Average LOS: half a day

$15.5 Million saved

But what about patient quality???

In 2010-2011 the parties shared a savings pot of $8 Million
ACE Bundle Demonstration

CMS project

Acute Care Episodes

Jan 2009

5 health systems

Specific DRGs (cardiac and orthopaedic)

Inpatient costs only
Bundle Demonstration Sites

- Baptist Health System
  San Antonio
- Oklahoma Heart Hospital
  Oklahoma City
- Exempla Saint Joseph Hospital
  Denver
- Hillcrest Medical Center
  Tulsa
- Lovelace Health System
  Albuquerque
## ACE Bundle Demo Scope

<table>
<thead>
<tr>
<th># DRGs</th>
<th>Acute Care Episode</th>
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<tbody>
<tr>
<td>6</td>
<td>Cardiac Valve and other Major Cardiothoracic Procedures</td>
</tr>
<tr>
<td>2</td>
<td>Cardiac Defibrillator Implant</td>
</tr>
<tr>
<td>6</td>
<td>Coronary Bypass</td>
</tr>
<tr>
<td>8</td>
<td>Pacemaker Procedures</td>
</tr>
<tr>
<td>6</td>
<td>Percutaneous Cardiovascular Procedure</td>
</tr>
<tr>
<td>2</td>
<td>Bilateral or multiple major joint procedures of lower extremity</td>
</tr>
<tr>
<td>2</td>
<td>Revision of hip or knee replacement</td>
</tr>
<tr>
<td>2</td>
<td>Major joint replacement</td>
</tr>
<tr>
<td>2</td>
<td>Knee procedures</td>
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ACE Bundle Results-Hillcrest

$1.59 MM savings in cardiac and orthopaedic services

CMS is paying $450 less per knee replacement

Key quality measurements remained strong, and some — such as readmission rates, use of prophylactic antibiotics and length of stay — improved

ACE Bundle Results-Hillcrest and Lovelace

7 percent savings on orthopedics implants

$300,000 per year

Similar savings were achieved on cardiology implants

Observations

Bundled payments create a tighter connection to physicians

• "Probably the most significant area of [success] was physician involvement,"
• When physicians see the costs and ramifications of the entire episode of care, they are more likely to be more economical and efficient in their choice of implants, testing and other areas of clinical decision making.

Cost Savings without rationing of care

• Level of treatment and quality measures were unaffected.
• Outcomes metrics are unchanged.
• Standardizing processes reduces variability in outcomes and improves quality.

The ROI for standardization has its limits

• Bundling will be a greater challenge for complex medical cases such as diabetes, congestive heart failure and other chronic conditions.
Another Variable

Retail Clinics

- MinuteClinic and UCLA are starting to integrate their EHRs
- Pro: cost visibility
- Con: doctor-patient relationship

Accountable Care is about population health management. Retail clinics may be a good way to increase access to connected care and to monitor chronic conditions.
Welcome to the Illinois Health Information Exchange Website

Introducing ILHIE’s Services

The Illinois Health Information Exchange (ILHIE) is a statewide network for sharing patient health information electronically between health care providers to improve patient care. The ILHIE currently offers three services for the secure exchange of patient health information: 1. EHR Connect – A secure, electronic, patient health record request and retrieval service; 2. ILHIE Direct – A web-based, HIPAA-compliant, secure messaging solution; and 3. Integrated Direct – An EHR-integrated, HIPAA-compliant, secure messaging solution. Click on the image or the headline above to learn more.

- Click Here to Watch a Demo of How EHR Connect Works
- Click Here to Watch a Demo of How ILHIE Direct Works

Health Information Technology is improving health care in Illinois and across the country. Today, most health care providers write medical information on paper charts which are not easily accessible and are difficult to share with other care providers. Health information technology.
This Would Be Nice

Primary care “home”
Electronic health record

Specialty care referrals
Public report cards

Ancillary care providers
Urgent care facility

Online health information
Nutritionist

Wellness health coach
Retail clinic

Fitness center
Care reminders

Care coordinator
Worksite health program

Personal health record
Imaging center
This is What We Want!

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What Else Might We Need?

- Tort reform
- Personal Accountability
- Payment reform
Another Obstacle?
The Care We Get...
"Flip of the Coin" Health Care Quality, 6-6-03

"Our results indicate that, on average, Americans receive about half of recommended medical care processes"

Mean performance

The Quality of Health Care Delivered to Adults in the United States
Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D., Joan Keesey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H., and Eve A. Kerr, M.D., M.P.H.

BACKGROUND
We have little systematic information about the extent to which standard processes involved in health care—a key element of quality—are delivered in the United States.

METHODS
We telephoned a random sample of adults living in 12 metropolitan areas in the United States and asked them about selected health care experiences. We also received written consent to copy their medical records for the most recent two-year period and used this information to evaluate performance on 45 indicators of quality of care for 30 acute and chronic conditions as well as preventive care. We then constructed aggregate scores.

RESULTS
Participants received 54.9 percent (95 percent confidence interval, 54.3 to 55.5) of recommended care. We found little difference among the proportion of recommended preventive care provided (54.9 percent), the proportion of recommended acute care provided (55.5 percent), and the proportion of recommended care provided for chronic conditions (56.1 percent). Among different medical functions, adherence to the processes involved in care ranged from 52.2 percent for screening to 58.5 percent for follow-up care. Quality varied substantially according to the particular medical condition, ranging from 78.7 percent of recommended care (95 percent confidence interval, 73.3 to 84.2) for senile cataract to 10.5 percent of recommended care (95 percent confidence interval, 6.8 to 14.6) for alcohol dependence.

CONCLUSIONS
The deficits we have identified in adherence to recommended processes for basic care pose serious threats to the health of the American public. Strategies to reduce these deficits in care are warranted.

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Nearly 70,000 Americans die needlessly each year because they are not given optimal heart failure therapy.

“Nearly 70,000 Americans die each year because they do not receive optimal therapy as called for in guidelines promoted by national health authorities, researchers said Monday. Physicians have been slow to implement many of the procedures called for in the guidelines, according to the first national study of adherence to the treatment goals, the team reported in the June edition of the American Heart Journal.”
The Care We Want…
Organized Around a Person-Centric Health Ecosystem

- **Aligns** care services/providers by being person-centered
- **Defragments** health silos
- **Personalizes** health decision support for each individual
- **Links**
  - Sites of care, all care over time
  - Integrated care plans via PHRs
- **Delivers**
  - Ease of use, clear navigation
  - Effective information, motivation, health skills support
  - Shared accountability between delivery system and patients
- **Provides**
  - High value, sustainable system to optimize individual / societal health

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Accountable Care Lingo Quiz

Moving away from FFS, volume-based reimbursement to value-based compensation (P4P, risk sharing, global budgets)

Proactive anticipation of individual patient and prepatient needs, and plan to address these needs in coordinated, expeditious manner

Taking responsibility for care processes and care outcomes, including cost, quality, and experience of care

Built on a strong base of primary care, ideally arranged as “patient-centered medical homes” or similar forms using care teams to coordinate and deliver care

Connecting data from all care sites, providers, institutions into a longitudinal, personal health record with health decision guidance/support for patients, in addition to clinical decision support for providers
“We can't sustain a system that rewards how much is done to patients instead of how much is accomplished for patients.

The Affordable Care Act will help us pay for quality and outcomes, not volume, with innovative tools such as bundled payments, incentives for hospitals that prevent readmissions, and accountable care organizations in which health-care providers who work in teams deliver better care with lower costs.”

Donald M. Berwick
CMS Administrator
September 3, 2010
Op-Ed in The Washington Post
Today is the youngest you’ll be for the rest of your life. Act like it.