# The Journey to Accountable Care


## Elliott S. Fisher, MD, MPH

**James W. Squires Professor of Medicine**
Geisel School of Medicine at Dartmouth

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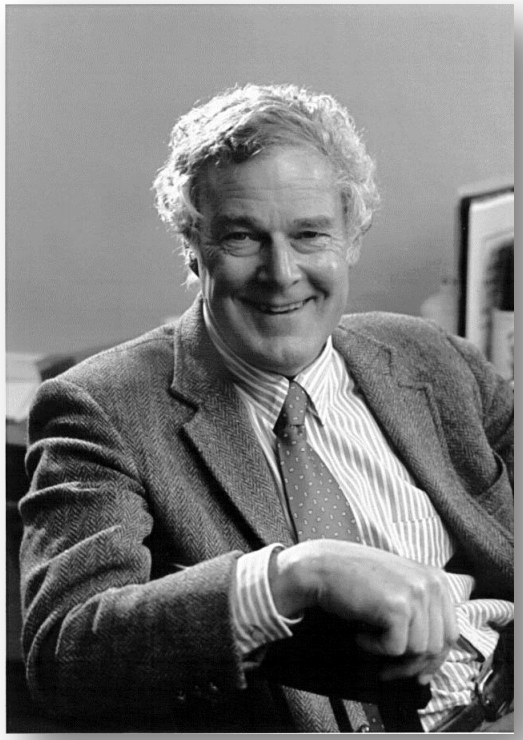
The Dartmouth Institute for Health Policy and Clinical Practice


# Variations in Practice: Origins



## Small Area Variations in Health Care Delivery

**A population-based health information system can guide planning and regulatory decision-making.**

John Wennberg and Alan Gittelsohn

Recent legislation has extended planning and regulatory authority in the health field in a number of important areas. The 1972 amendments to the impact of regulatory decisions on the equality of distribution of resources and dollars and the effectiveness of medical care services.

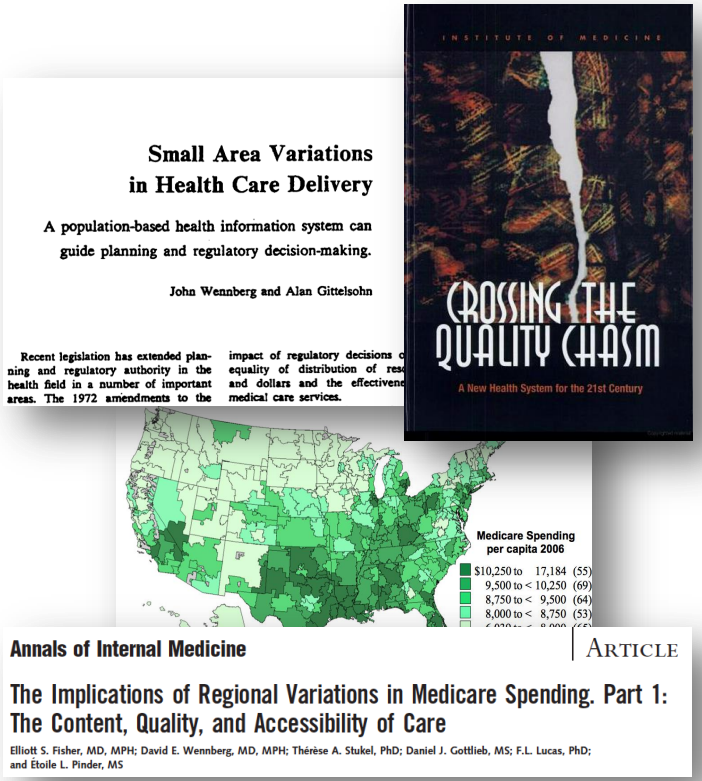
Source: Science, December 14, 1973; Volume 182, pp 1102-08.

# A brief summary

***Health policy (generally) has assumed:***

Science mediated through the professional authority granted to expert physicians produces the best care possible for both individuals and populations

***With disappointing results***




***Science now tells us:***

(1) Evidence for many current treatments is insufficient. Even when evidence is good, failures of "execution" are common.

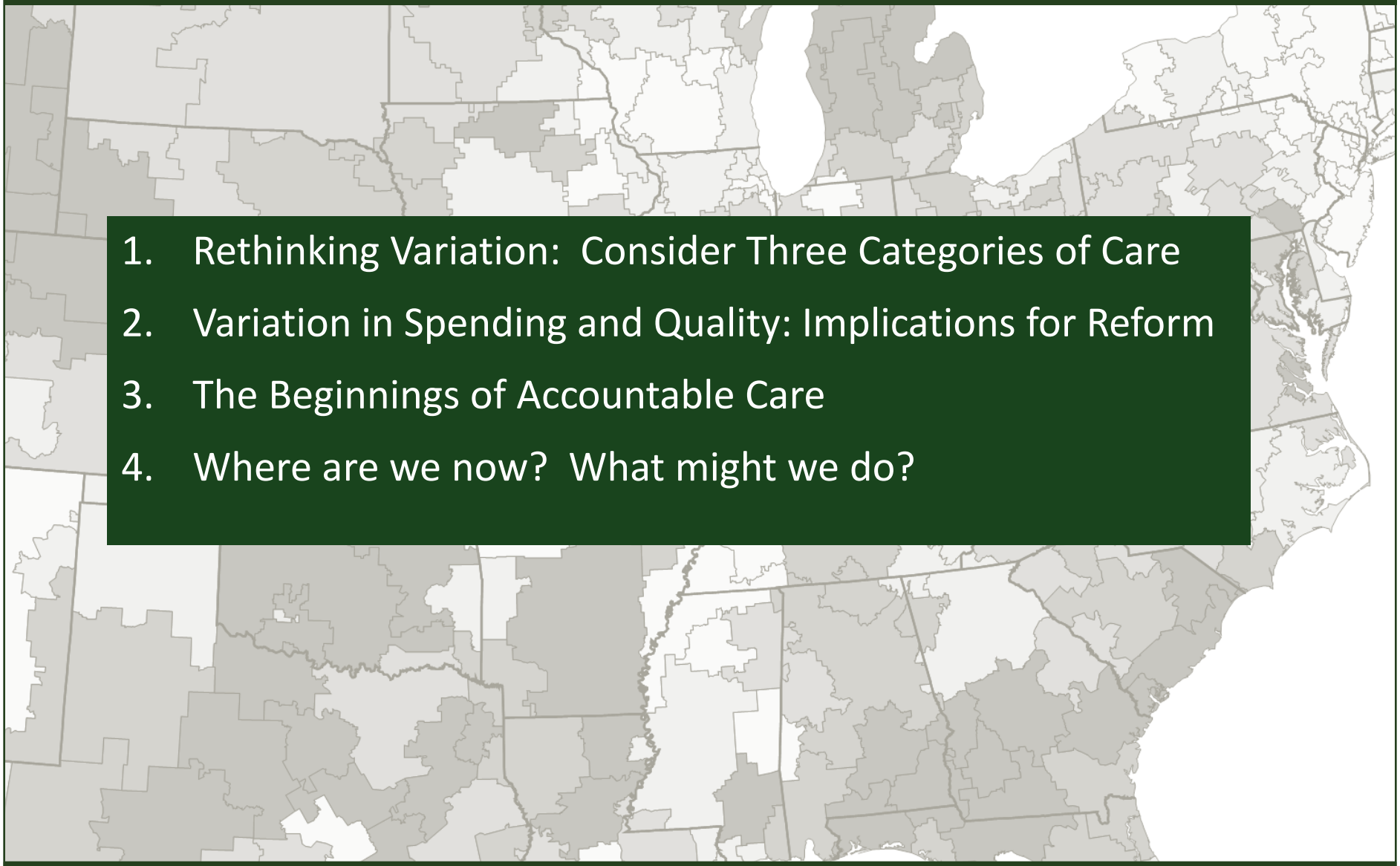
(2) Whether a treatment is right for a patient depends on their preferences and values.

(3) Waste is rampant, because supply and provider opinion determine utilization rates.

***Suggesting an alternative path:***

| | |
|---|---|
| **Doing the right thing – and doing it right** | **A learning system: improvement science** |
| **Doing the right thing – for the right patient** | **Make sure care is aligned with patient preferences** |
| **Doing the right thing – and no more** | **Integrate; monitor performance, align incentives** |

# The Journey to Accountable Care



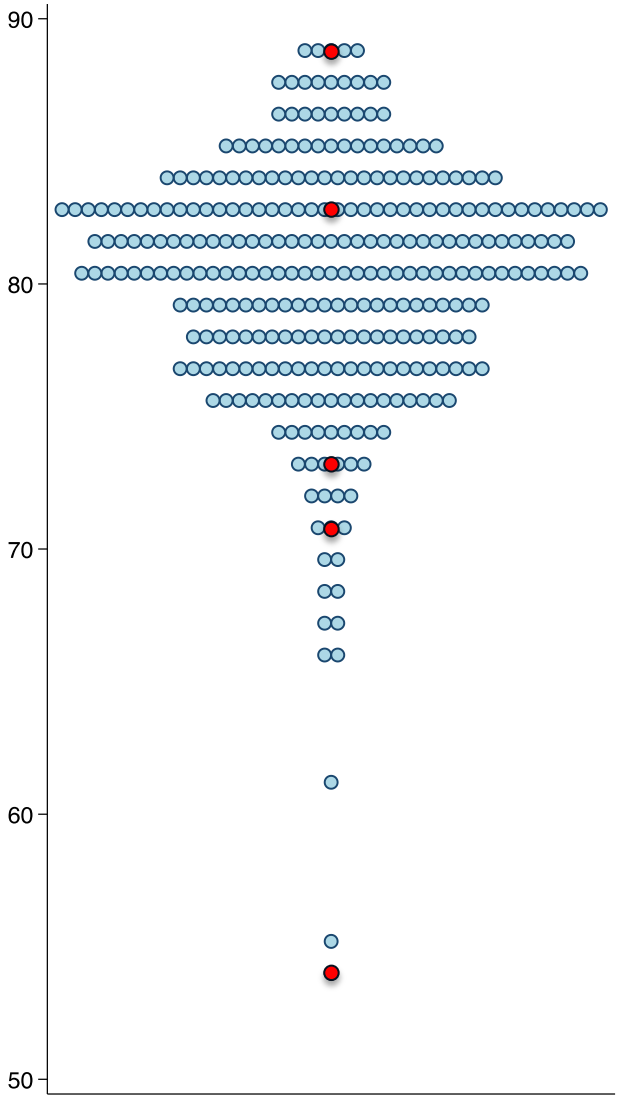
1. Rethinking Variation:  Consider Three Categories of Care
2. Variation in Spending and Quality: Implications for Reform
3. The Beginnings of Accountable Care
4. Where are we now?  What might we do?

# Categories of Variation

| Category | Definition |
|---|---|
| **Effective Care** | *Services of proven effectiveness that involve no significant trade-offs* — all patients with specific medical needs should receive them.<br>• ***Variation in process a major influence.*** |

Source: Wennberg et al., *Health Affairs*, 2002.

# Effective Care: Regional Variation

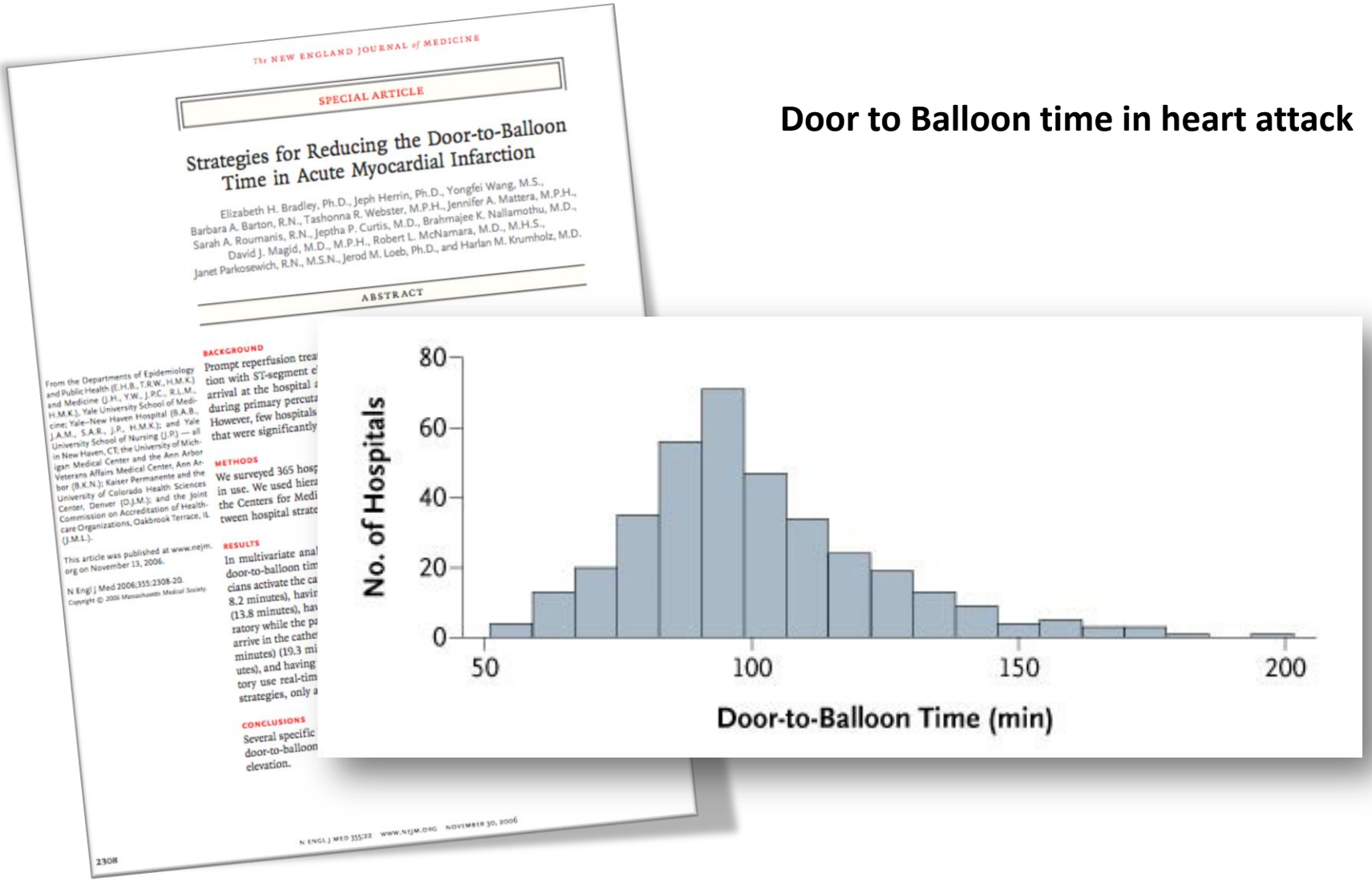



**Percent of Diabetic Medicare Enrollees Receiving Blood Lipids Test (2010)**

| | |
|---|---|
| Ocala, FL | 89% |
| Atlanta, GA | 83% |
| Denver, CO | 76% |
| Grand Forks, ND | 73% |
| Casper, WY | 54% |

Source: The Dartmouth Atlas

# Effective Care: Hospital-Level Variation



The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

## Strategies for Reducing the Door-to-Balloon Time in Acute Myocardial Infarction

Elizabeth H. Bradley, Ph.D., Jeph Herrin, Ph.D., Yongfei Wang, M.S., Barbara A. Barton, R.N., Tashonna R. Webster, M.P.H., Jennifer A. Mattera, M.P.H., Sarah A. Roumanis, R.N., Jeptha P. Curtis, M.D., Brahmajee K. Nallamothu, M.D., David J. Magid, M.D., M.P.H., Robert L. McNamara, M.D., M.H.S., Janet Parkosewich, R.N., M.S.N., Jerod M. Loeb, Ph.D., and Harlan M. Krumholz, M.D.

ABSTRACT

BACKGROUND

METHODS

RESULTS

CONCLUSIONS

From the Departments of Epidemiology and Public Health (E.H.B., T.R.W., H.M.K.) and Medicine (J.H., Y.W., J.P.C., R.L.M., H.M.K.), Yale University School of Medicine; Yale–New Haven Hospital (B.A.B., J.A.M., S.A.R., J.P., H.M.K.); and Yale University School of Nursing (J.P.) — all in New Haven, CT; the University of Michigan Medical Center and the Ann Arbor Veterans Affairs Medical Center, Ann Arbor (B.K.N.); Kaiser Permanente and the University of Colorado Health Sciences Center, Denver (D.J.M.); and the Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL (J.M.L.).

This article was published at www.nejm.org on November 13, 2006.

N Engl J Med 2006;355:2308-20.








**Door to Balloon time in heart attack**

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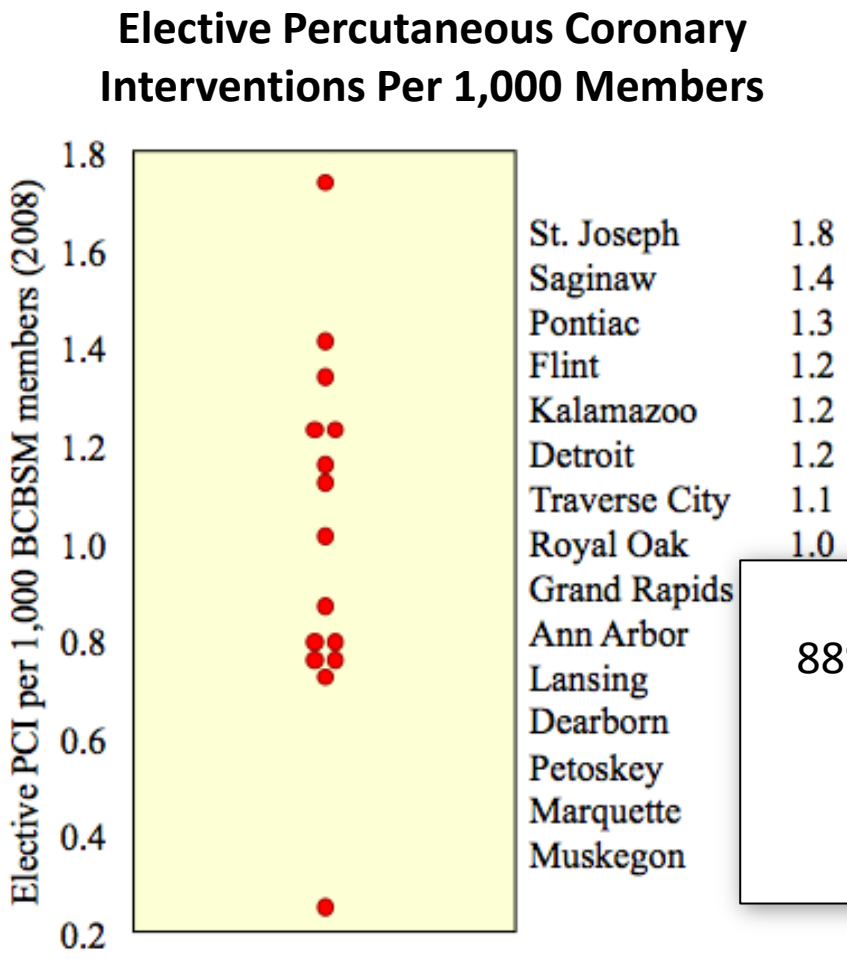
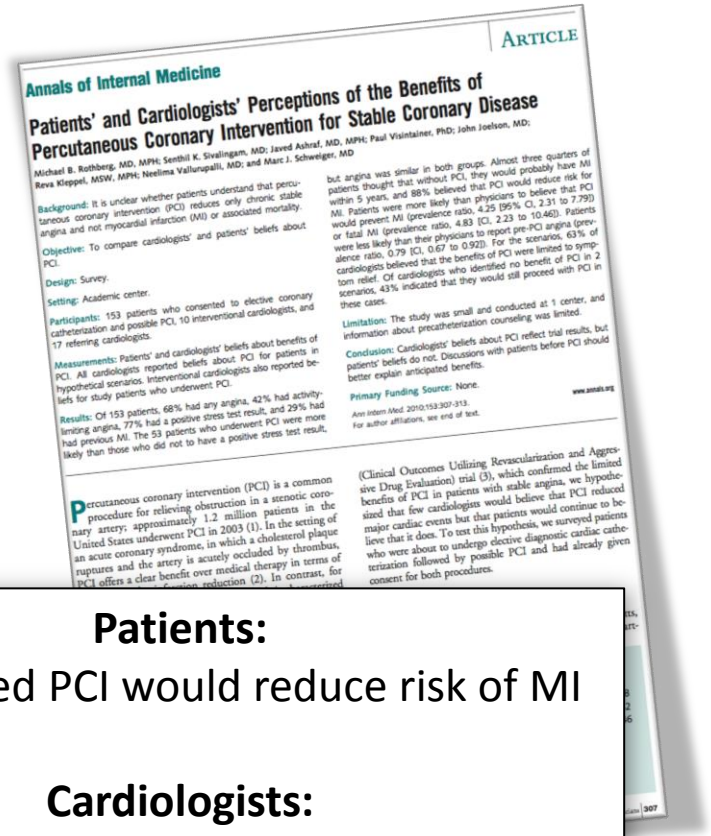
Source: Wennberg et al., *Health Affairs*, 2002.

# Preference-Sensitive Care: Regional Variation





Annals of Internal Medicine

ARTICLE

Patients' and Cardiologists' Perceptions of the Benefits of Percutaneous Coronary Intervention for Stable Coronary Disease

Michael B. Rothberg, MD, MPH; Senthil K. Sivalingam, MD; Javed Ashraf, MD, MPH; Paul Visintainer, PhD; John Joelson, MD; Reva Kleppel, MSW, MPH; Neelima Vallurupalli, MD; and Marc J. Schweiger, MD

**Background:** It is unclear whether patients understand that percutaneous coronary intervention (PCI) reduces only chronic stable angina and not myocardial infarction (MI) or associated mortality.

**Objective:** To compare cardiologists' and patients' beliefs about PCI.

**Design:** Survey.

**Setting:** Academic center.

**Participants:** 153 patients who consented to elective coronary catheterization and possible PCI, 10 interventional cardiologists, and 17 referring cardiologists.

**Measurements:** Patients' and cardiologists' beliefs about benefits of PCI. All cardiologists reported beliefs about PCI for patients in hypothetical scenarios. Interventional cardiologists also reported beliefs for study patients who underwent PCI.

**Results:** Of 153 patients, 68% had any angina, 42% had activity-limiting angina, 77% had a positive stress test result, and 29% had had previous MI. The 53 patients who underwent PCI were more likely than those who did not to have a positive stress test result, but angina was similar in both groups. Almost three quarters of patients thought that without PCI, they would probably have MI within 5 years, and 88% believed that PCI would reduce risk for MI. Patients were more likely than physicians to believe that PCI would prevent MI (prevalence ratio, 4.25 [95% CI, 2.31 to 7.79]) or fatal MI (prevalence ratio, 4.83 [CI, 2.23 to 10.46]). Patients were less likely than their physicians to report pre-PCI angina (prevalence ratio, 0.79 [CI, 0.67 to 0.92]). For the scenarios, 63% of cardiologists believed that the benefits of PCI were limited to symptom relief. Of cardiologists who identified no benefit of PCI in 2 scenarios, 43% indicated that they would still proceed with PCI in these cases.

**Limitation:** The study was small and conducted at 1 center, and information about precatheterization counseling was limited.

**Conclusion:** Cardiologists' beliefs about PCI reflect trial results, but patients' beliefs do not. Discussions with patients before PCI should better explain anticipated benefits.

**Primary Funding Source:** None.

Ann Intern Med. 2010;153:307-313.

For author affiliations, see end of text.

www.annals.org

Percutaneous coronary intervention (PCI) is a common procedure for relieving obstruction in a stenotic coronary artery; approximately 1.2 million patients in the United States underwent PCI in 2003 (1). In the setting of an acute coronary syndrome, in which a cholesterol plaque ruptures and the artery is acutely occluded by thrombus, PCI offers a clear benefit over medical therapy in terms of [illegible] reduction (2). In contrast, for

(Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation) trial (3), which confirmed the limited benefits of PCI in patients with stable angina, we hypothesized that few cardiologists would believe that PCI reduced major cardiac events but that patients would continue to believe that it does. To test this hypothesis, we surveyed patients who were about to undergo elective diagnostic cardiac catheterization followed by possible PCI and had already given consent for both procedures.

307

**Patients:**

88% believed PCI would reduce risk of MI

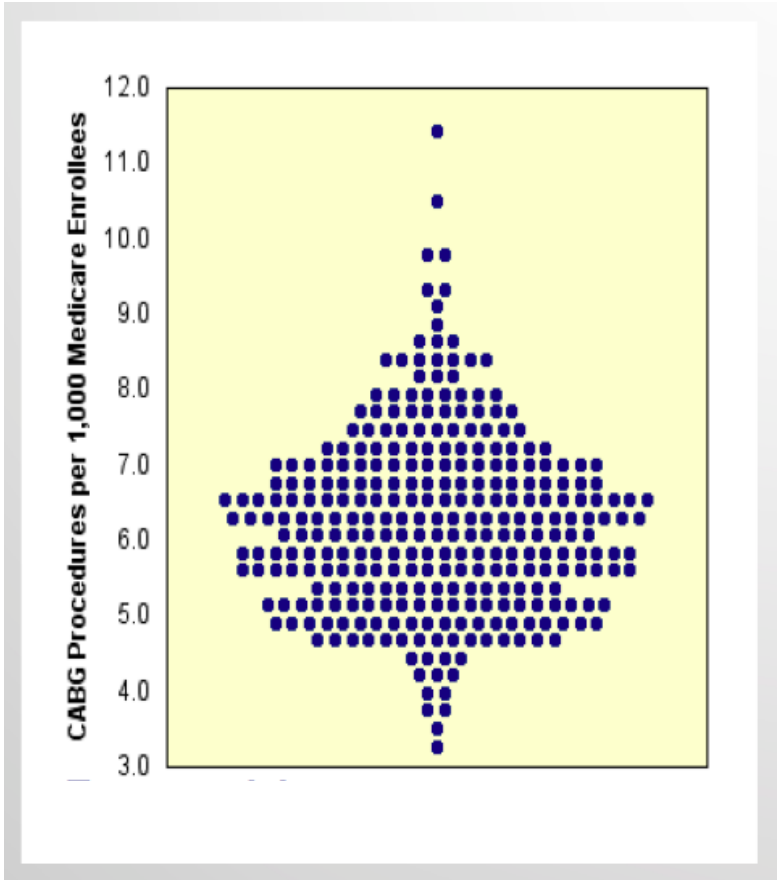
**Cardiologists:**

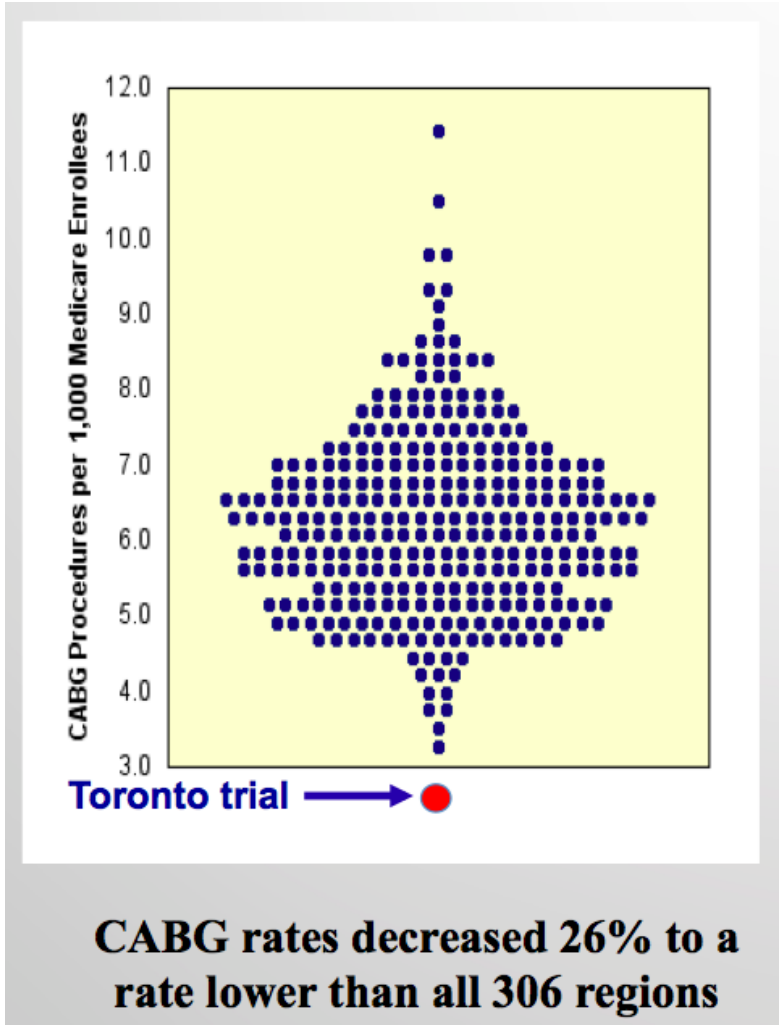
43% would do PCI *even if no benefit*

Source: Center for Health Care Research and Transformation Issue Brief: Variation in Interventional Cardiac Care in Michigan (April 2012)

# Preference-Sensitive Care: Role of shared decision-making

How many open heart programs might be needed in the U.S.?




**CABG rates decreased 26% to a rate lower than all 306 regions**

# Categories of Variation

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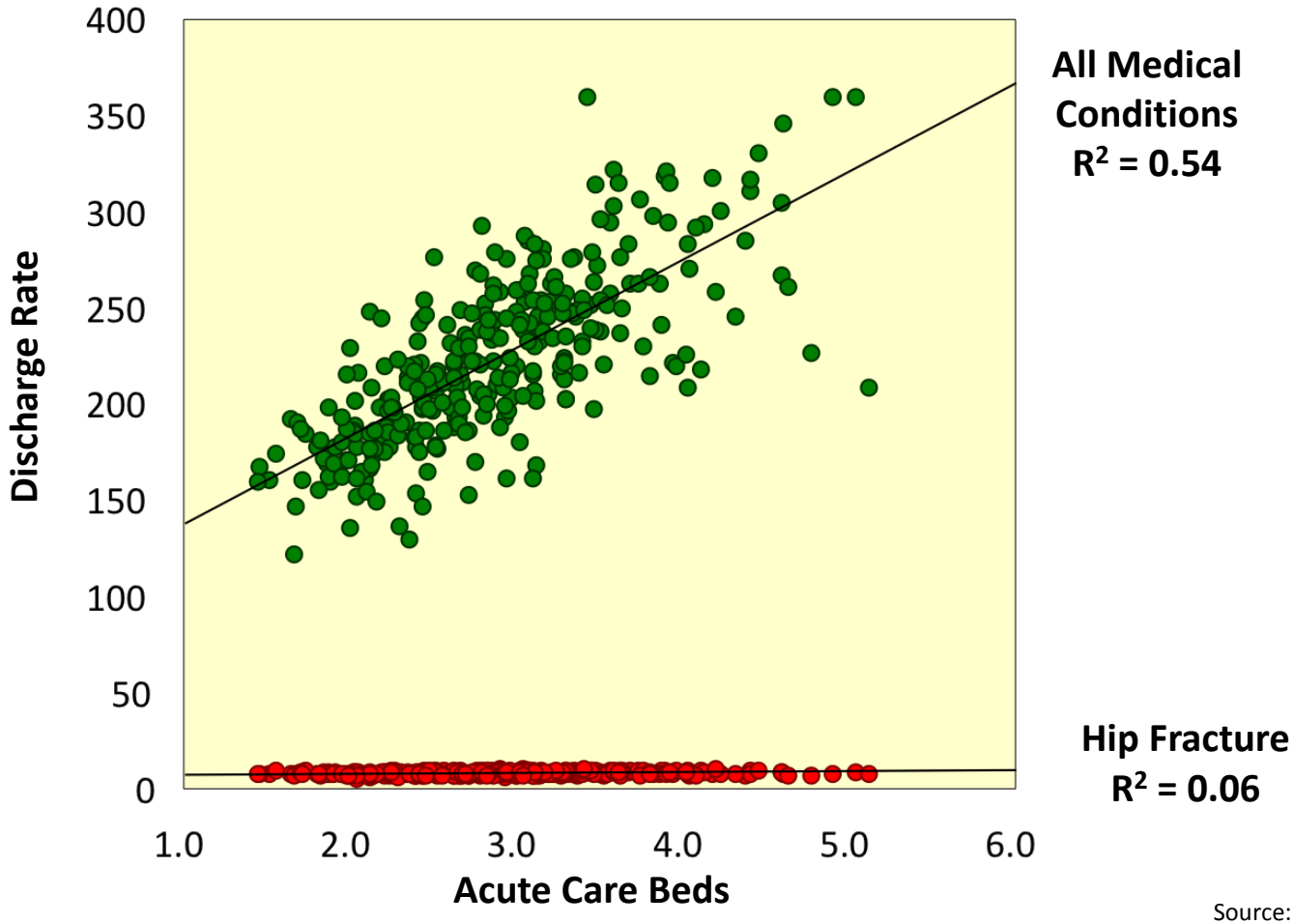
| **Supply-Sensitive Care** | *Little or no clinical evidence on use, so judgment required* (visits, hospital stay). Use rates strongly influenced by supply.<br>• ***Capacity (and provider opinion) a strong influence.*** |

Source: Wennberg et al., *Health Affairs*, 2002.

# Supply-Sensitive Care: Regional Variation

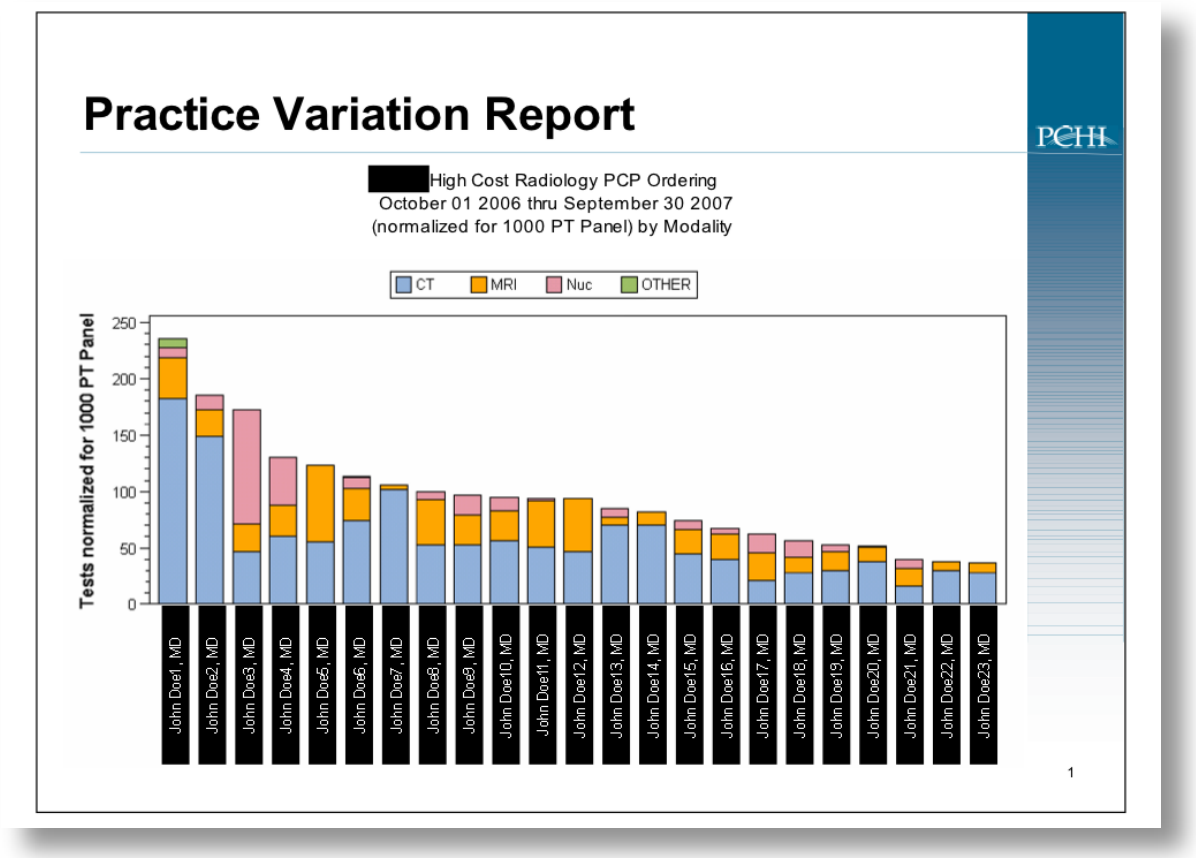
**Association Between Hospital Beds per 1,000 and Discharges per 1,000 Among Medicare Enrollees: 306 Hospital Regions**




Source: The Dartmouth Atlas

# Supply-Sensitive Care: Physician-Level Variation

## Frequency of High Cost Imaging among Physicians in a Medical Group




Source: May 29, 2008 Presentation at Federal Trade Commission, Tom Lee, MD (Partners Healthcare System) (used with permission)

# Categories of Variation

**Doing the right thing – and doing it right**

**Doing the right thing – for the right patient**

**Doing the right thing – and no more**

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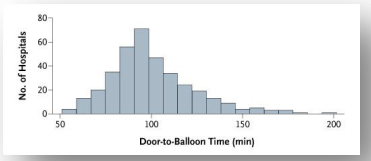
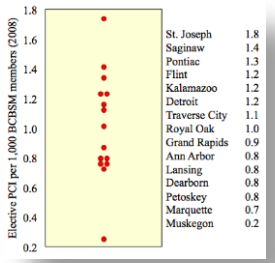
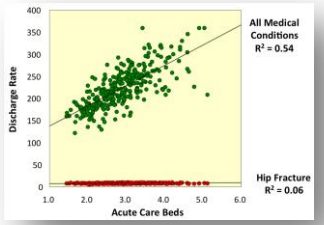
| **Effective Care** | *Services of proven effectiveness that involve no significant trade-offs* — all patients with specific medical needs should receive them.<br>• ***Variation in process a major influence.*** |  |
| **Preference-Sensitive Care** | *Involves trade-offs;* decisions should therefore be based on patients' preferences and values. Supporting evidence may be weak or strong.<br>• ***Provider opinion (and capacity) a powerful influence.*** |  |
| **Supply-Sensitive Care** | *Little or no clinical evidence on use, so judgment required* (visits, hospital stay). Use rates strongly influenced by supply.<br>• ***Capacity (and provider opinion) a strong influence.*** |  |

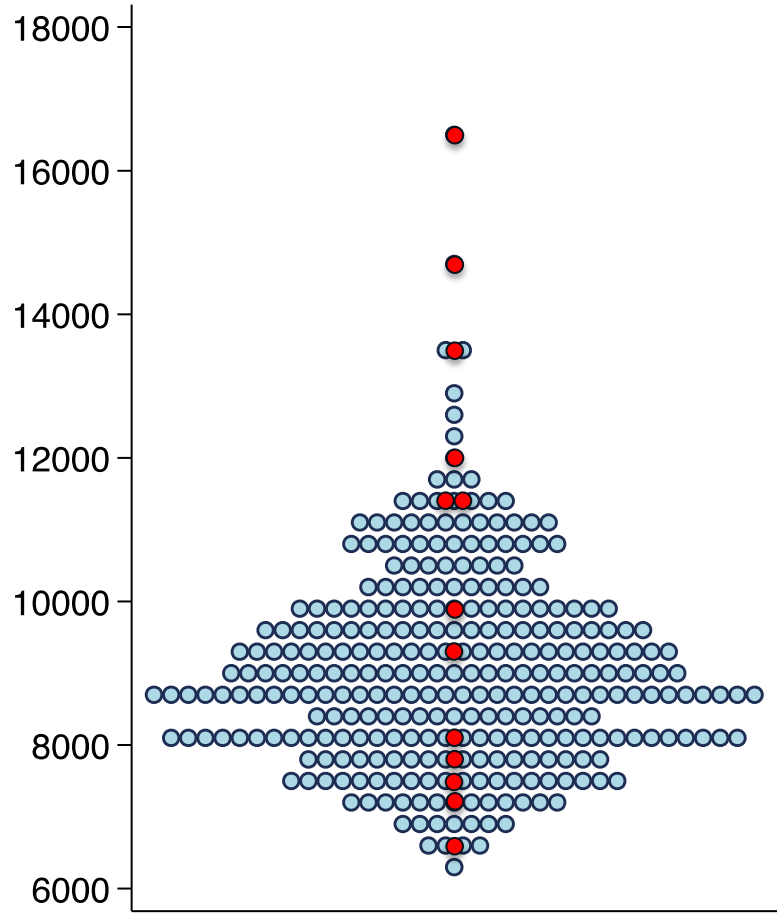
Source: Wennberg et al., *Health Affairs,* 2002.

# The Journey to Accountable Care

1. Rethinking Variation:  Consider Three Categories of Care
2. Variation in Spending and Quality: Implications for Reform

# Variations in Practice and Spending: Implications for Reform

## Per-Capita 2009 Medicare Spending by HRR (Age, Sex, Race Adjusted)



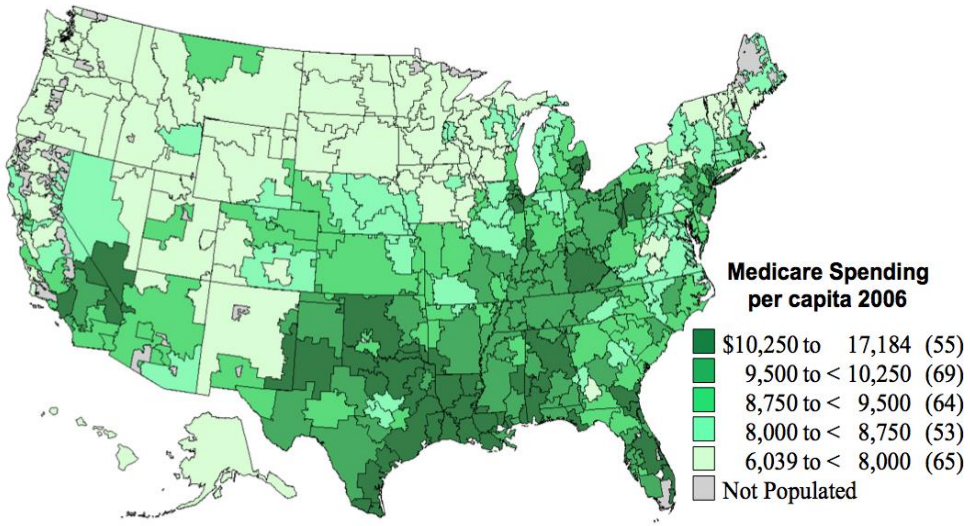

| | |
|---|---|
| Miami, FL | $16,639 |
| McAllen, TX | $14,576 |
| Manhattan, NY | $13,453 |
| Los Angeles, CA | $12,711 |
| Detroit, MI | $11,647 |
| Chicago, IL | $11,646 |
| San Francisco, CA | $9,913 |
| Cincinnati, OH | $9,388 |
| Lebanon, NH | $8,124 |
| Minneapolis, MN | $7,734 |
| Des Moines, IA | $7,382 |
| Rochester, MN | $7,120 |
| La Crosse, WI | $6,532 |

Source: The Dartmouth Atlas

# Variations in Practice and Spending: Implications for Reform

## Health Implications of Regional Variations in Spending

- Initial study: 1 million Medicare beneficiaries with AMI, colon cancer, and hip fracture
- Compared content, quality, and outcomes across high and low spending regions




**Per-Capita Spending**

Low (pale): $3,992

High (green): $6,304

**Difference: $2,312 (61%)**

Source: See slide notes.

# Variations in Practice and Spending: Implications for Reform

**Effective Care**: *Benefit clear for all*

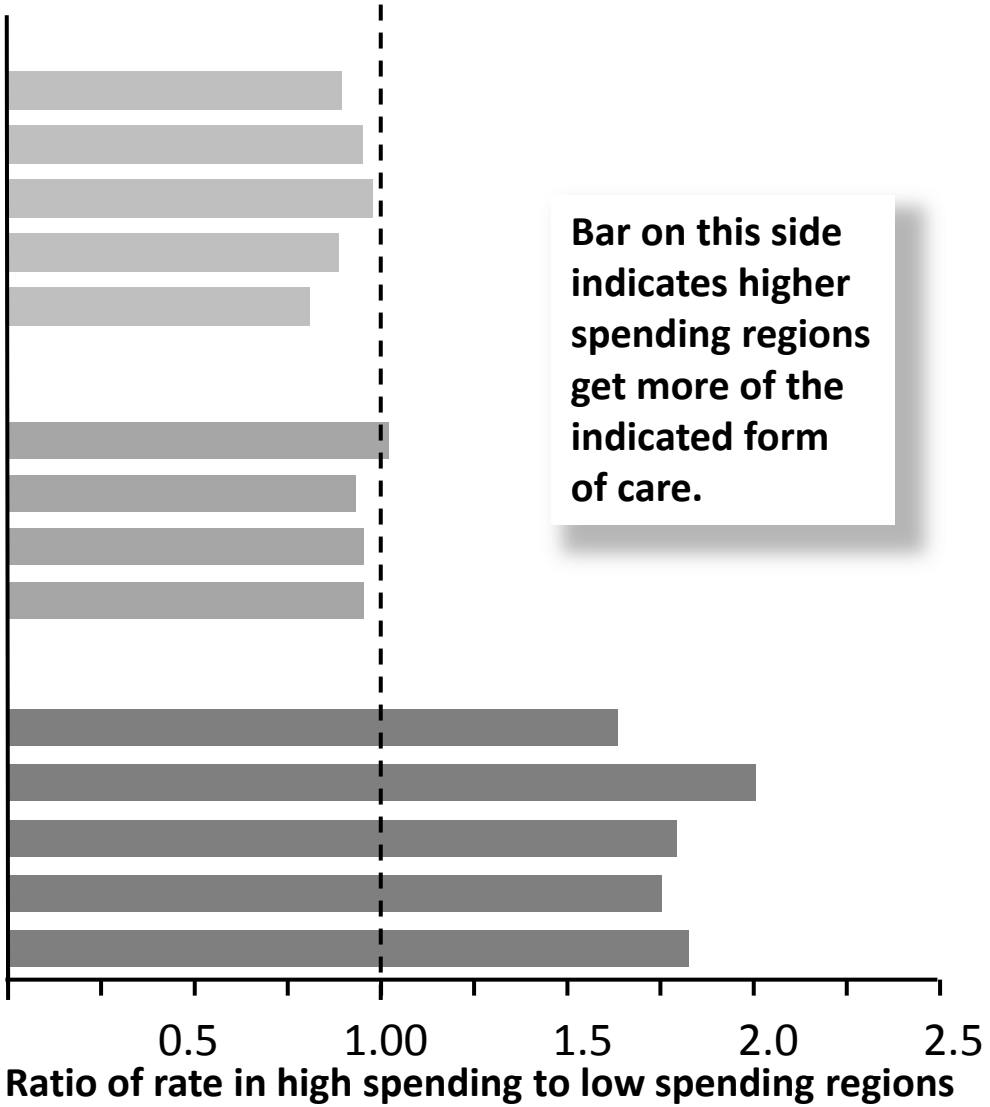
- Reperfusion in 12 hours (Heart attack)
- Aspirin at admission (Heart attack)
- Mammogram, Women 65-69
- Pap Smear, Women 65+
- Pneumococcal Immunization (ever)

**Preference Sensitive**: *Values matter*

- Total Hip Replacement
- Total Knee Replacement
- Back Surgery
- CABG following heart attack

**Supply Sensitive:** *Often avoidable care*

- Total Inpatient Days
- Inpatient Days in ICU or CCU
- Visits (mostly to specialists)
- Imaging
- Diagnostic Tests




**Bar on this side indicates higher spending regions get more of the indicated form of care.**

Source: The Dartmouth Atlas

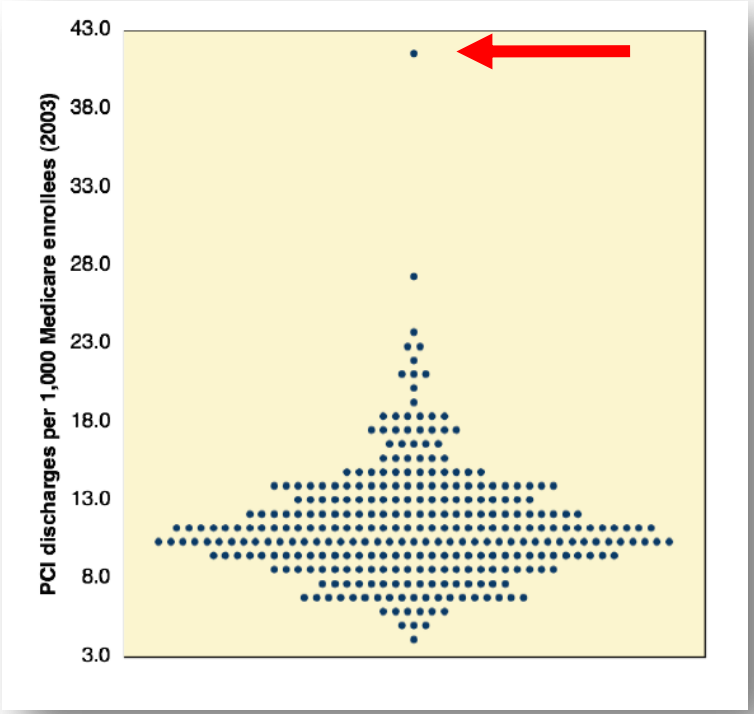
# Variations in Practice and Spending: Implications for Reform

| Health Outcomes | Physician's Perceptions | Patient-Perceived Quality |
| --- | --- | --- |
| No gain in survival | Worse communication | Lower satisfaction with hospital care |
| No better function | Greater difficulty ensuring coordination | Worse access to primary care |
| | Greater perception of scarcity | No less sense that care is rationed |

# Why the variations?

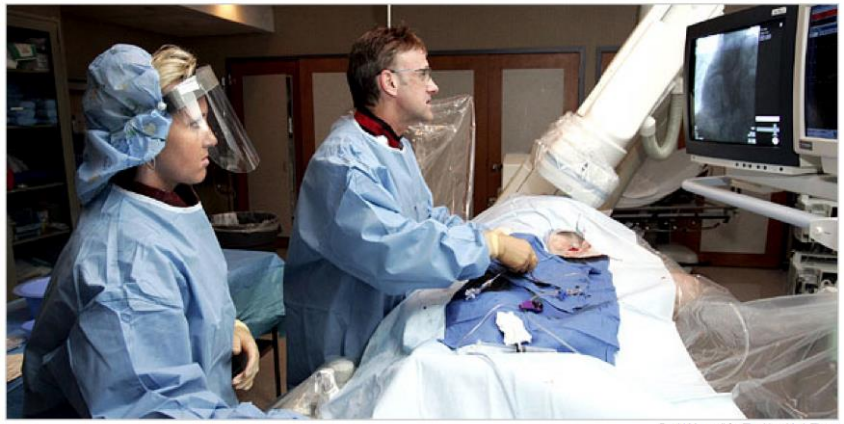
- Not patient preferences or malpractice
- Capacity important, but explains less than half of the difference
- Clinical decision-making for preference and supply-sensitive care clearly important

# Variations in Practice and Spending: Implications for Reform




SIDE EFFECTS

## Heart Procedure Is Off the Charts in an Ohio City



David Maxwell for The New York Times

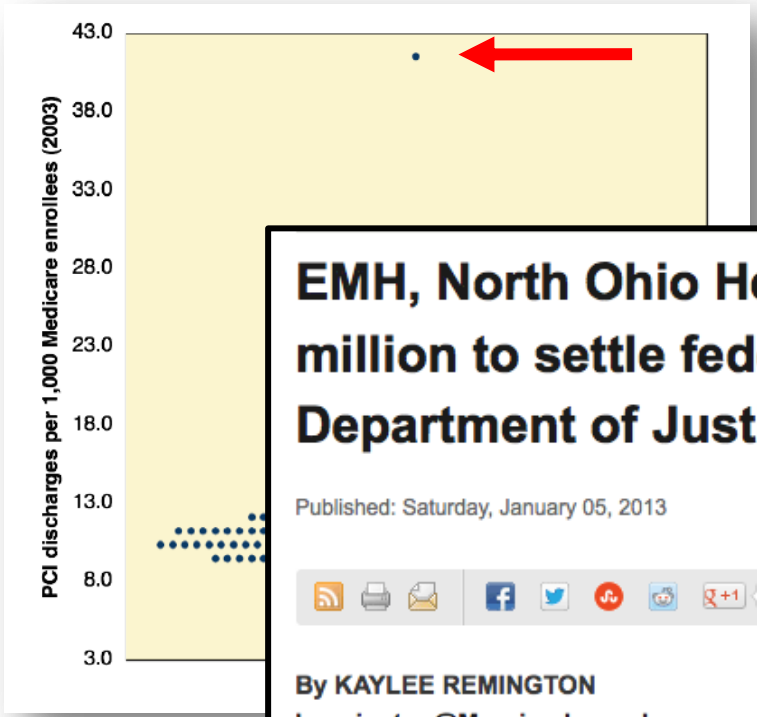
Dr. Charles D. O'Shaughnessy of North Ohio Heart Center does an angioplasty at EMH Regional Medical Center in Elyria, Ohio, with Susan Croston, a radiology technologist.

By REED ABELSON
Published: August 18, 2006

"We do manage very aggressively the patients we care for… We have excellent outcomes."

Dr. John Schaeffer

# Variations in Practice and Spending: Implications for Reform

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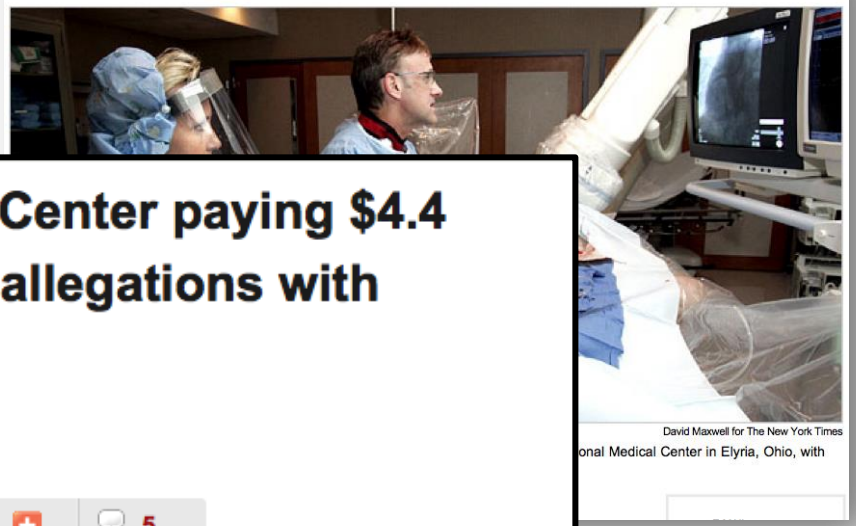

David Maxwell for The New York Times

onal Medical Center in Elyria, Ohio, with

e patients we
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n Schaeffer

## EMH, North Ohio Heart Center paying $4.4 million to settle federal allegations with Department of Justice

Published: Saturday, January 05, 2013

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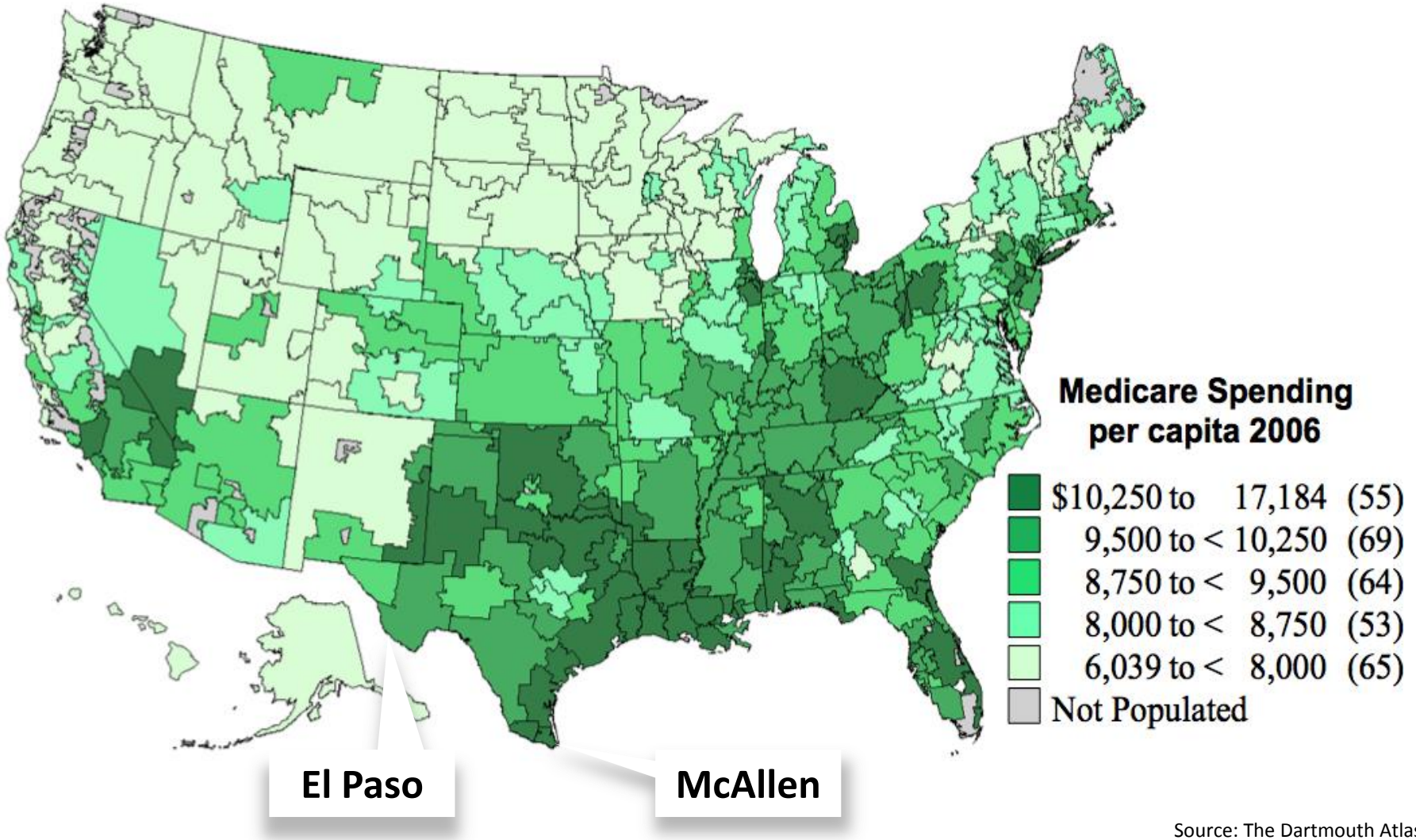
**By KAYLEE REMINGTON**
**kremington@MorningJournal.com**
**@MJ_KRemington**

**ELYRIA** — EMH Regional Medical Center and the North Ohio Heart Center have agreed to pay the federal government $4.4 million to settle allegations that between 2001 and 2006, EMH and NOHC performed unnecessary cardiac procedures on Medicare patients.

# Variations in Practice and Spending: Why clustered regionally?




Source: The Dartmouth Atlas

# Variations in Practice and Spending: Implications for Reform

THE NEW YORKER

ANNALS OF MEDICINE

## THE COST CONUNDRUM

*What a Texas town can teach us about health care.*

BY ATUL GAWANDE

JUNE 1, 2009

It is spring in McAllen, Texas. The morning sun is warm. The streets are lined with palm trees and pickup trucks. McAllen is in Hidalgo County, which has the lowest household income in the country, but it's a border town, and a thriving foreign-trade zone has kept the unemployment rate below ten per cent. McAllen calls itself the Square Dance Capital of the World. "Lonesome Dove" was set around here.

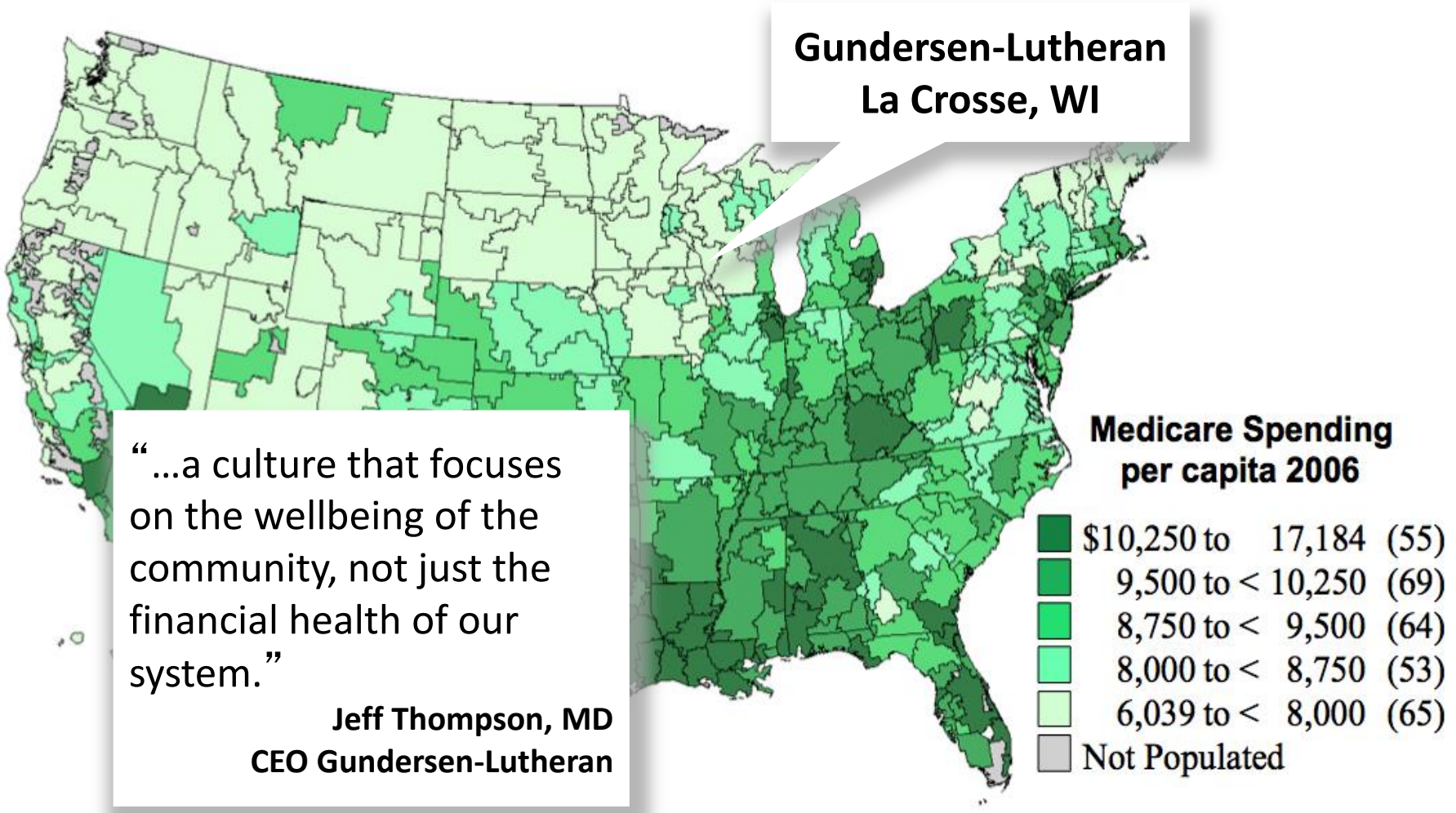
McAllen has another distinction, too: it is one of the most expensive health-care markets in the country. Only Miami—which has much higher labor and living costs—spends more per person on health care. In 2006, Medicare spent fifteen thousand dollars per enrollee here, almost twice the national average. The income per capita is twelve thousand dollars. In other words, Medicare spends three thousand dollars more per person here than the average person earns.


*Costlier care is often worse care. Photograph by Phillip Toledano.*

The explosive trend in American medical costs seems to have occurred here in an especially intense form. Our country's health care is by far the most expensive in the world. In Washington, the aim of health-care reform is not just to extend medical coverage to everybody but also to bring costs under control. Spending on doctors, hospitals, drugs, and the like now consumes more than one of every six dollars we earn. The financial burden has damaged the global competitiveness of American businesses and bankrupted millions of families, even those with insurance. It's also devouring our government. "The greatest threat to America's fiscal health is not Social Security," President Barack Obama said in a March speech at the White House. "It's not the investments that we've made to rescue our economy during this crisis. By a

**"[McAllen] … a medical community came to treat patients the way subprime mortgage lenders treated home buyers: as profit centers."**

# Variations in Practice and Spending: Implications for Reform




"…a culture that focuses on the wellbeing of the community, not just the financial health of our system."

**Jeff Thompson, MD**
**CEO Gundersen-Lutheran**

Source: The Dartmouth Atlas

# Variations in Practice and Spending: Implications for Reform

| Underlying Problem | Key Principles |
| --- | --- |
| **Confusion about aims**: Is it about money or something more? | **Clarify aims**: Better health, better care, lower costs – for patients and communities. |
| **Absent or poor data** leaves practice unexamined and unable to improve; choices uninformed by evidence. | **Better information:** to support improvement & shared decision-making; ***and determine true demand*** |
| **Flawed conceptual model**: Health is produced by face-to-face visits with physicians. Care is fragmented. | **New model**: *It's the system*. Establish organizations capable of redesigning practice , right-sizing capacity |
| **Wrong incentives** reinforce model, reward fragmentation, induce overuse of unnecessary care. | **Rethink our incentives**: Realign incentives – both financial and professional – with aims. |

# The Journey to Accountable Care

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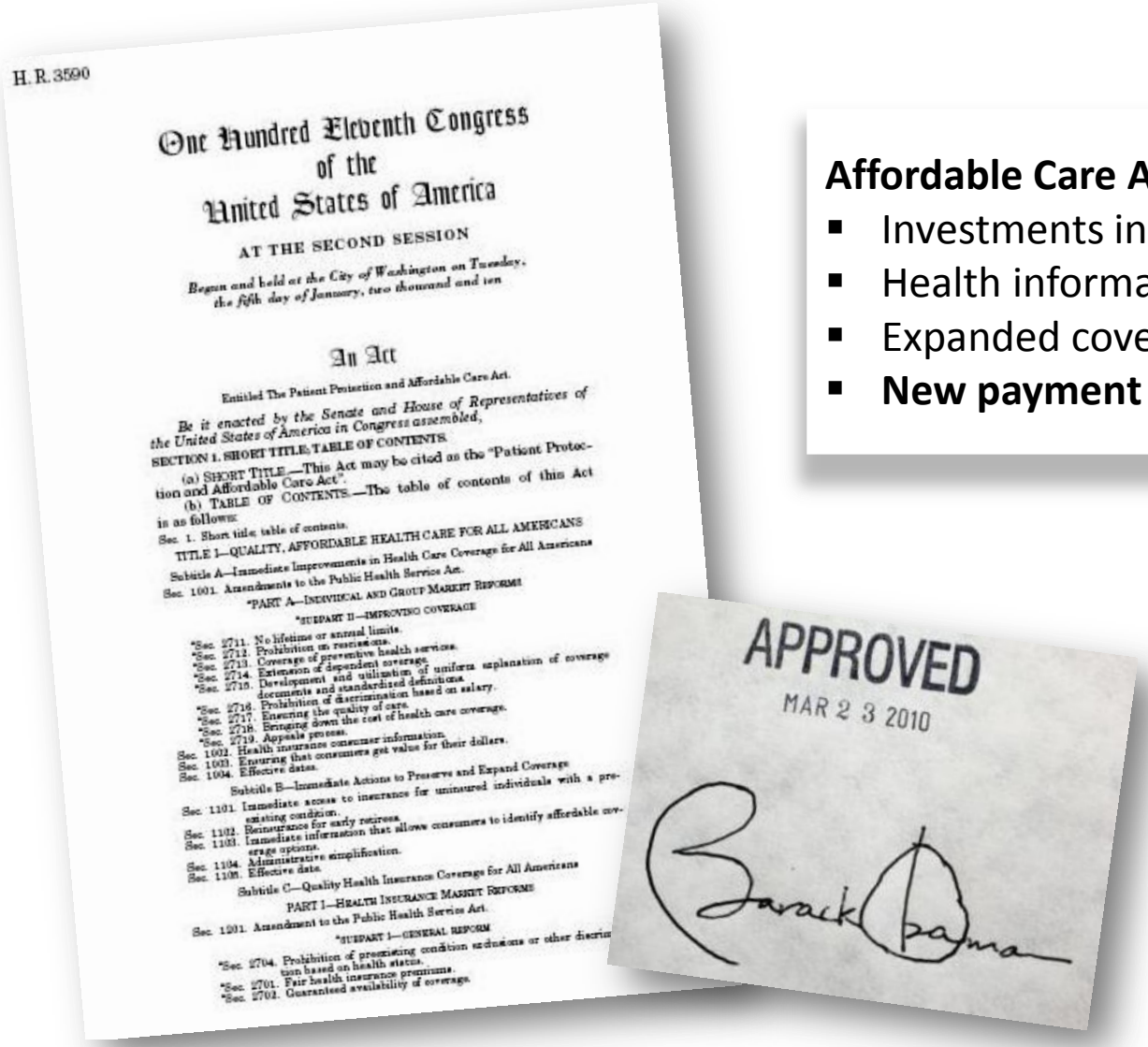
# The Current Opportunity: Health Care Reform



H. R. 3590

One Hundred Eleventh Congress
of the
United States of America

AT THE SECOND SESSION

*Begun and held at the City of Washington on Tuesday, the fifth day of January, two thousand and ten*

An Act

Entitled The Patient Protection and Affordable Care Act.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Protection and Affordable Care Act".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001. Amendments to the Public Health Service Act.

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS

"SUBPART II—IMPROVING COVERAGE

"Sec. 2711. No lifetime or annual limits.
"Sec. 2712. Prohibition on rescissions.
"Sec. 2713. Coverage of preventive health services.
"Sec. 2714. Extension of dependent coverage.
"Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.
"Sec. 2716. Prohibition of discrimination based on salary.
"Sec. 2717. Ensuring the quality of care.
"Sec. 2718. Bringing down the cost of health care coverage.
"Sec. 2719. Appeals process.
Sec. 1002. Health insurance consumer information.
Sec. 1003. Ensuring that consumers get value for their dollars.
Sec. 1004. Effective dates.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1101. Immediate access to insurance for uninsured individuals with a pre-existing condition.
Sec. 1102. Reinsurance for early retirees.
Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.
Sec. 1104. Administrative simplification.
Sec. 1105. Effective date.

Subtitle C—Quality Health Insurance Coverage for All Americans

PART I—HEALTH INSURANCE MARKET REFORMS

Sec. 1201. Amendment to the Public Health Service Act.

"SUBPART 1—GENERAL REFORM

"Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.
"Sec. 2701. Fair health insurance premiums.
"Sec. 2702. Guaranteed availability of coverage.

APPROVED
MAR 2 3 2010

**Affordable Care Act**

- Investments in public health
- Health information technology
- Expanded coverage
- **New payment models**

# The Current Opportunity: New Payment Models

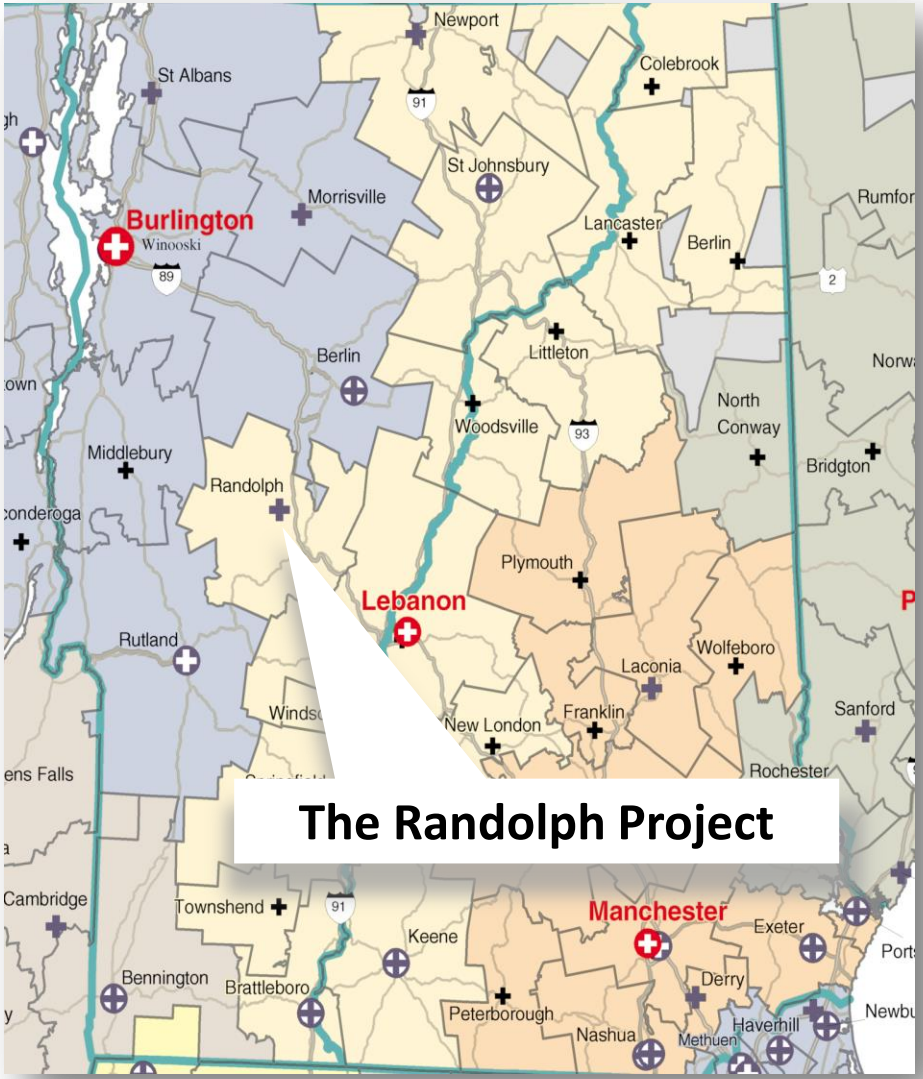
## Episode (Bundled) Payments

- **Theory:** Single payment encourages integration to improve care
- **Practice:** Many payers testing this approach
- **Limitations:** Boundaries contentious, incentive to do more remains
- **Evidence:** No evidence yet

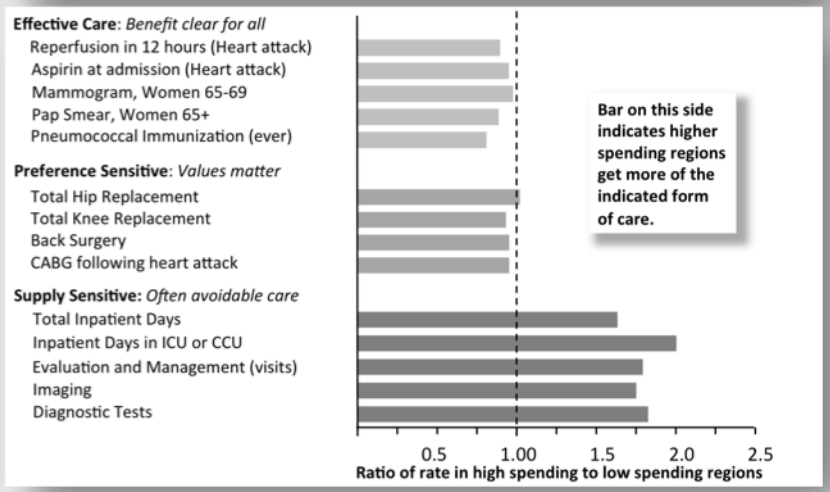
## Medical Home

- **Theory:** Payment to support (currently unfunded) primary care functions
- **Practice:** Adoption underway with federal and private payers
- **Limitations:** Leaves responsibility with PCP; no incentive for specialists or hospitals to support improvement
- **Evidence:** No evidence yet in fee-for-service practice; emerging evidence within integrated systems under global payment

# Origin: Population-Based Accountability for All Categories of Care



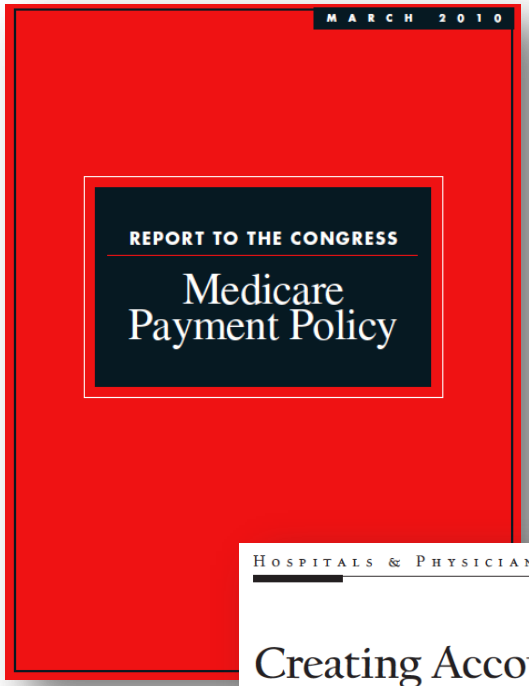

## Higher vs. Lower Spending Regions

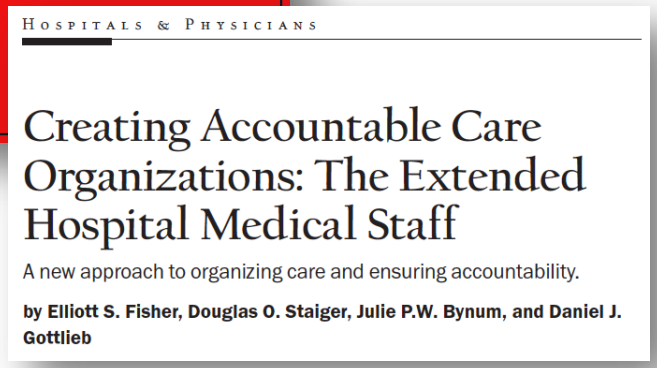



## Purpose

- Ensure delivery of effective care
- Shared decision-making to get patients the care they want *and* right-size capacity
- Continually eliminate waste

# The Current Opportunity: ACOs



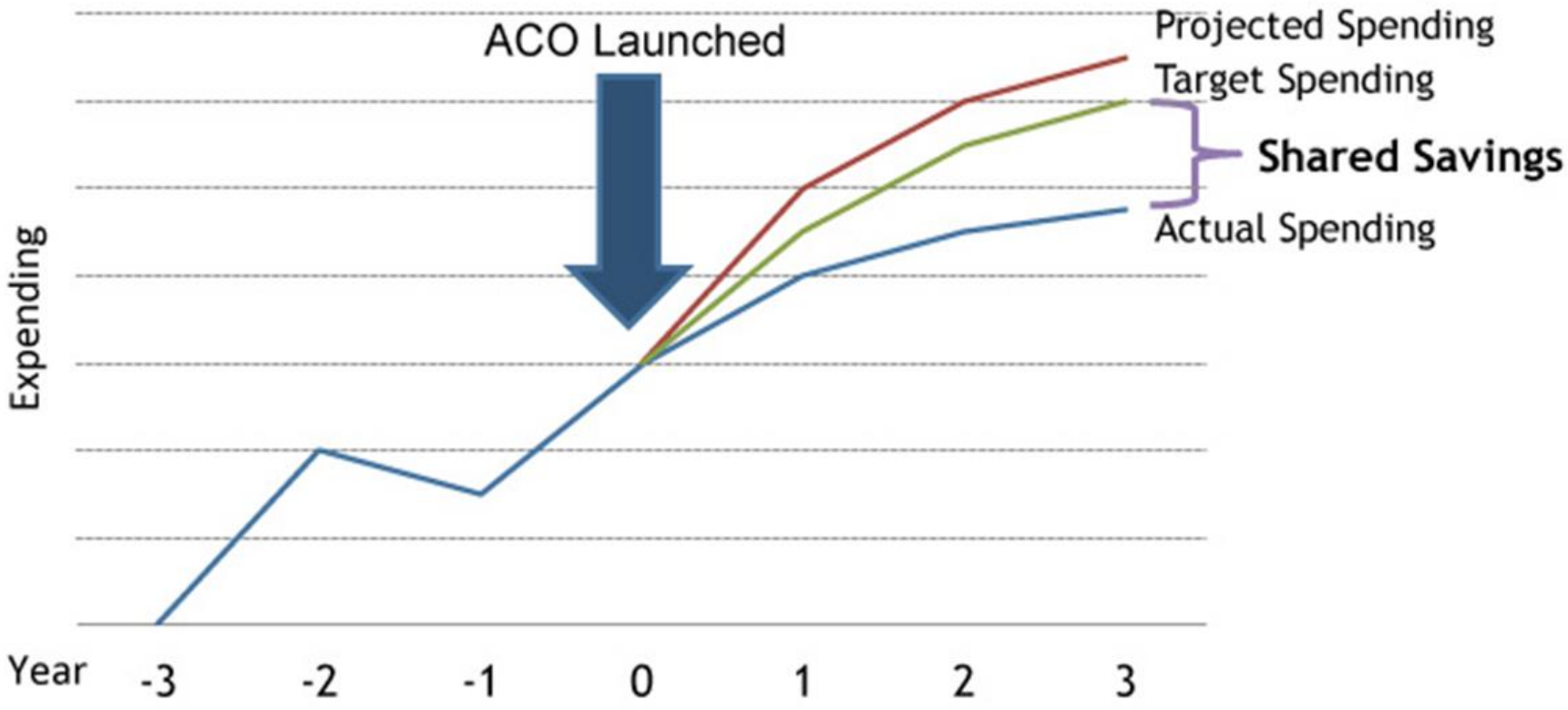




**Core Ideas**

- Population-based virtual budgets
- Real *or* virtual organizations
- Performance measurement
- Patient choice
- Accommodate diversity

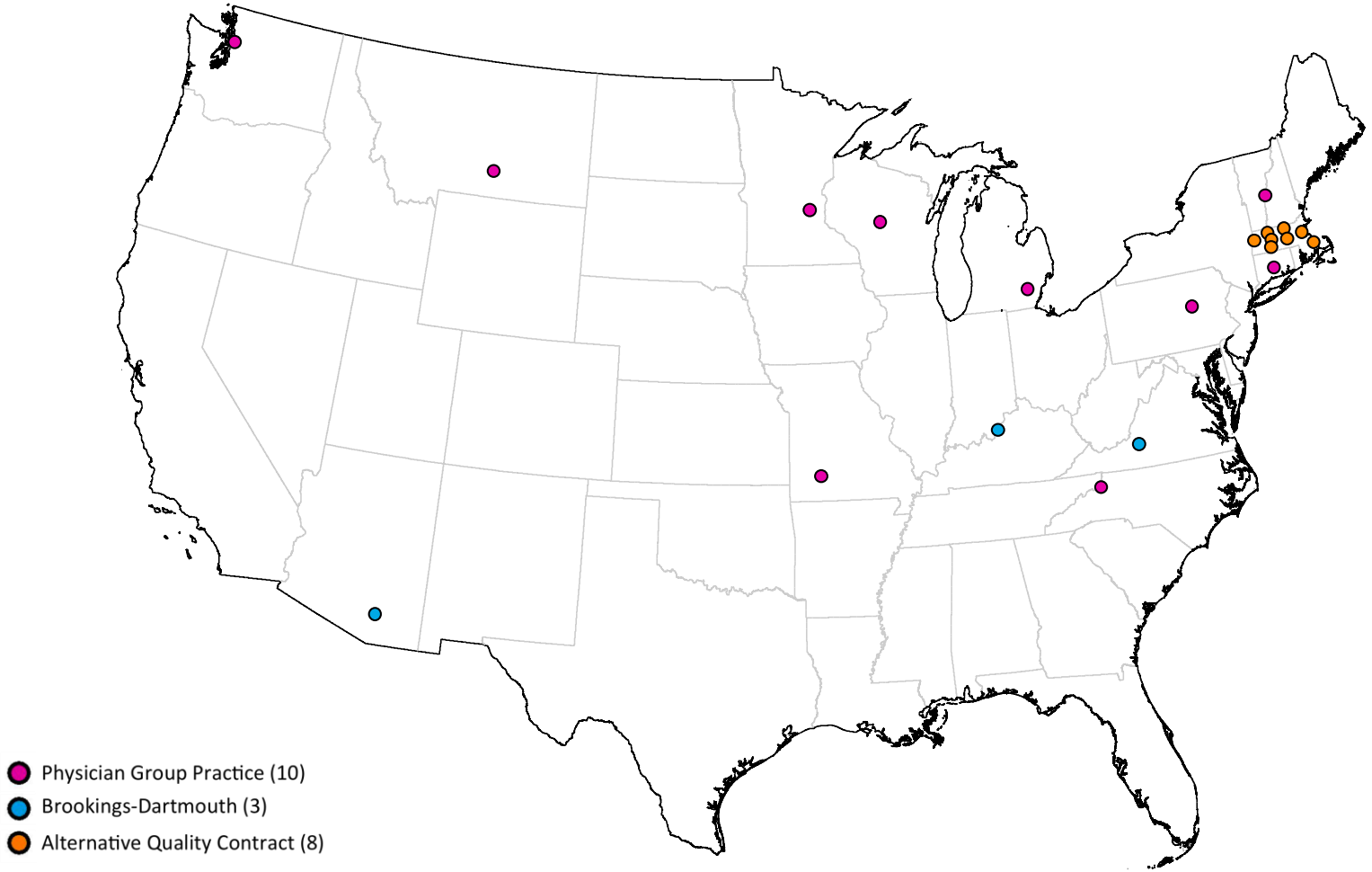
# The Current Opportunity: ACOs

## The ACO Shared Savings Opportunity



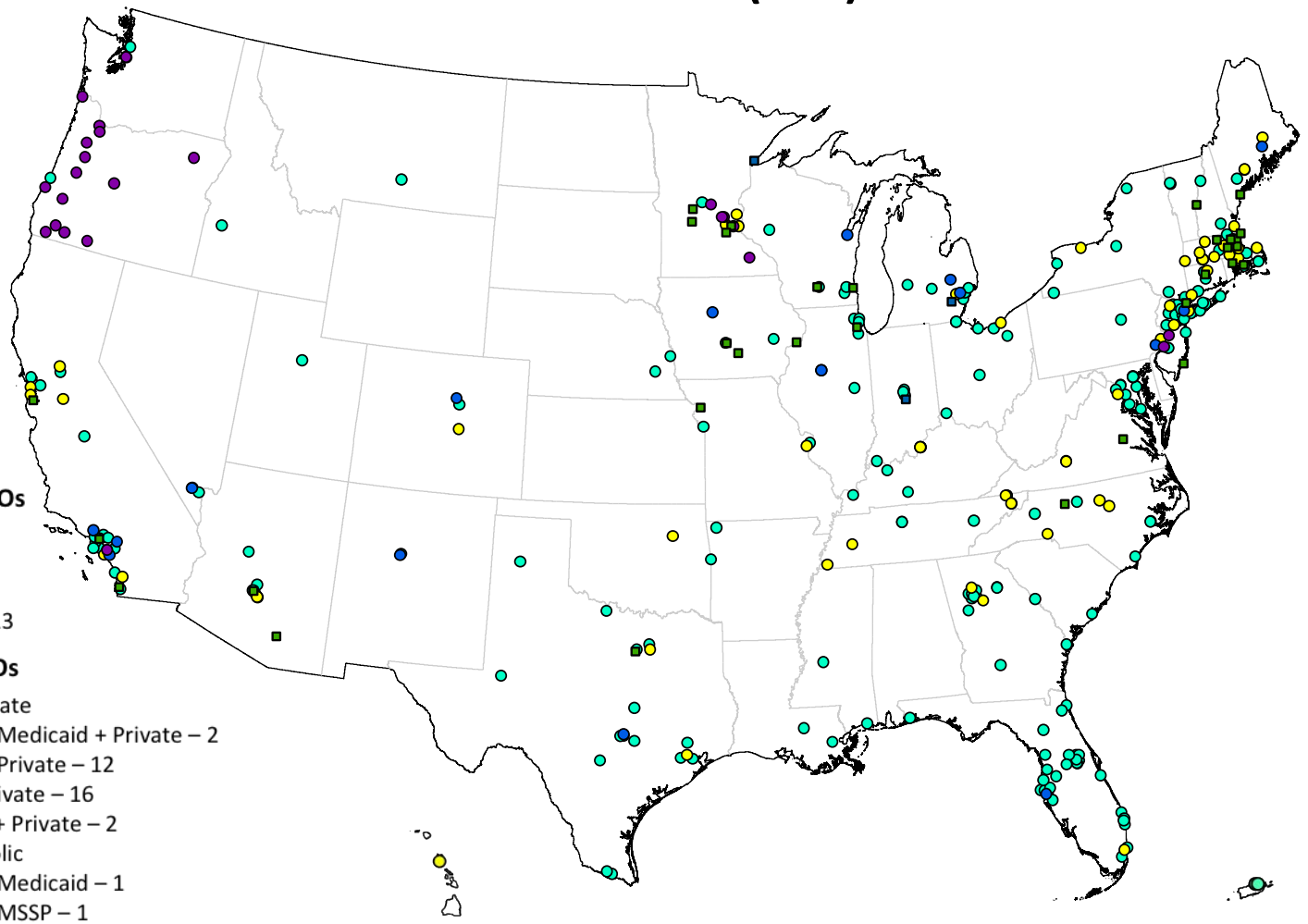
# The Current Opportunity: ACOs

## ACOs: 2009 (21)



# The Current Opportunity: ACOs

## ACOs: 2013 (328)



**Single-Payer ACOs**

- Private – 53
- Pioneer – 16
- MSSP – 201
- Medicaid – 23

**Multi-Payer ACOs**

- Public & Private
  - Pioneer + Medicaid + Private – 2
  - Pioneer + Private – 12
  - MSSP + Private – 16
  - Medicaid + Private – 2
- Multiple Public
  - Pioneer + Medicaid – 1
  - Pioneer + MSSP – 1
  - MSSP + Medicaid – 1

**Note:** The sum of ACOs reflects the total number of unique, publicly identifiable, confirmed private-payer ACOs as of 08/2012 and public-payer ACOs as of 01/2013.

# The Current Opportunity: Accountable Care

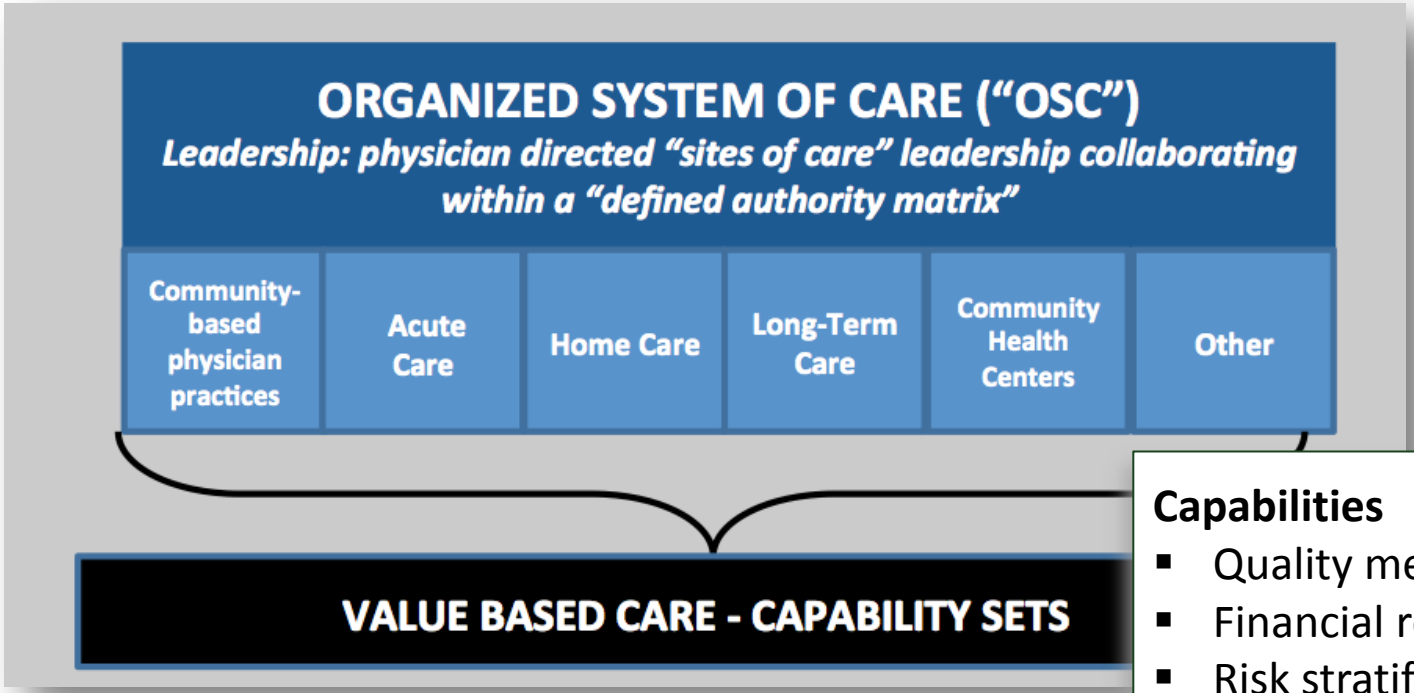
**A payment model focused on performance – not structural requirements – and focused on the overall care of a population**

**Diverse organizational forms are enabled**

- **Integrated delivery systems**
- **Physician groups and networks**
- **Hospitals** (employing or contracting with their physicians)
- **Community clinics**
- **Pharmacy-supported MD networks**

# The Current Opportunity:  Accountable Care

# The Current Opportunity: Accountable Care




**Capabilities**

- Quality measurement
- Financial reporting
- Risk stratification
- Population management
- Chronic disease management
- Care coordination
- Advanced IT tools
- Community-health provider collaboration

# ACOs: Might this work for patients?

ORIGINAL CONTRIBUTION

## Spending Differences Associated With the Medicare Physician Group Practice Demonstration

Carrie H. Colla, PhD
David E. Wennberg, MD, MPH
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Jonathan S. Skinner, PhD
Daniel Gottlieb, MS
Valerie A. Lewis, PhD
Christopher M. Snyder, PhD
Elliott S. Fisher, MD, MPH

**Context** The Centers for Medicare & Medicaid Services (CMS) recently launched accountable care organization (ACO) programs designed to improve quality and slow cost growth. The ACOs resemble an earlier pilot, the Medicare Physician Group Practice Demonstration (PGPD), in which participating physician groups received bonus payments if they achieved lower cost growth than local controls and met quality targets. Although evidence indicates the PGPD improved quality, uncertainty remains about its effect on costs.

**Objective** To estimate cost savings associated with the PGPD overall and for beneficiaries dually eligible for Medicare and Medicaid.

**Design** Quasi-experimental analyses comparing preintervention (2001-2004) and postintervention (2005-2009) trends in spending of PGPD participants to local control groups. We compared estimates using several alternative approaches to adjust for case mix.

**Setting** Ten physician groups from across the United States.

**Patients and Participants** The intervention group was composed of fee-for-service Medicare beneficiaries (n=990 177) receiving care primarily from the physicians in the participating medical groups. Controls were Medicare b
(n=7 514 453) from the same regions who received care largely from nonp
sicians. Overall, 15% of beneficiaries were dually eligible for Medicare a

**Main Outcome Measure** Annual spending per Medicare fee-for-servi

**Results** Annual savings per beneficiary were modest overall (adjusted me
CI, $12-$216). Annual savings were significant in dually eligible beneficiaries
$532, 95% CI, $277-$786), but were not significant among nondually el
ries (adjusted mean $59, 95% CI, $166 in savings to $47 in additional spe
justed mean spending reductions were concentrated in acute care (overall
$65-$170; dually eligible: $381, 95% CI, $247-$515; nondually eligible: $
$138). There was significant variation in savings across practice groups.
overall mean per-capita annual saving of $866 (95% CI, $815-$918) to a
penditures of $749 (95% CI, $698-$799). Thirty-day medical readmission
all (−0.67%, 95% CI, −1.11% to −0.23%) and in the dually eligible (−
−1.73% to −0.41%), while surgical readmissions decreased only for the dual
95% CI, −3.07% to −1.34%). Estimates were sensitive to the risk-adj

**Conclusions** Substantial PGPD savings achieved by some partici
were offset by a lack of saving at other participating institutions. M
were concentrated among dually eligible beneficiaries.

JAMA. 0;0(10):1015-1023

poprotein cholesterol level < 130 mg/dL; to convert from mg/dL to mmol/L, multiply by 0.0259).[5,6] According to public reports, all 10 organiz
ity benchmarks requi
savings[2] and some ach

**Author Affiliations:** Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth, Lebanon, New Hampshire (Drs Colla, Wennberg, Meara, Skinner, Lewis, and Fisher and Mr Gottlieb); Norris Cotton Cancer Center, Manchester, New Hampshire (Dr Colla); Department of Economics, Dartmouth College, Hanover, New Hampshire (Drs Skinner and Snyder); and National Bureau of Economic
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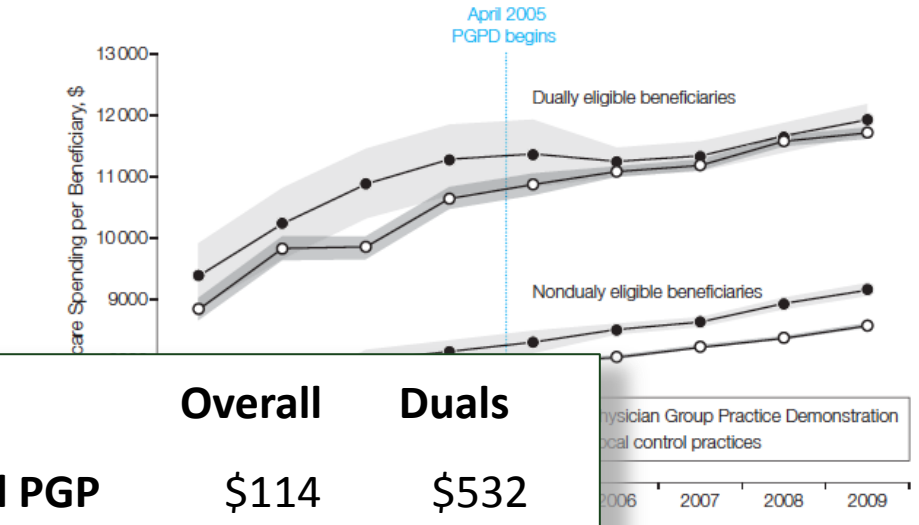
JAMA, September 12, 201
Corrected on September 1



**Figure.** Medicare Spending per Beneficiary: Physician Group Practice Demonstration Participants and Local Controls




| | Overall | Duals |
|---|---|---|
| **All PGP** | $114 (1%) | $532 (5%) |
| **Marshfield** | $642 (9%) | $987 (11%) |
| **D-H** | $-132 (- 2%) | $397 (3.2%) |

# The Journey to Accountable Care

1. Rethinking Variation:  Consider Three Categories of Care
2. Variation in Spending and Quality: Implications for Reform
3. The Beginnings of Accountable Care
4. Where are we now?  What might we do?

# Insights, Opportunities and Challenges

## Underlying problem

**Limited knowledge** about what works, how, for whom, in what contexts

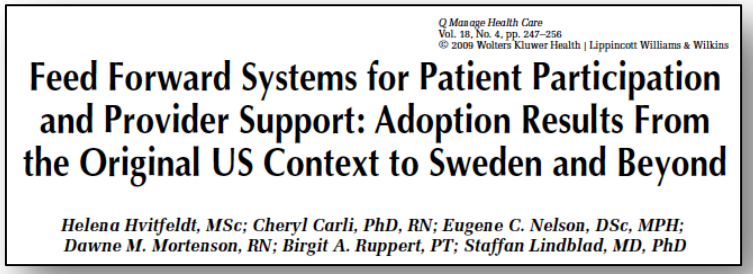
## Possible approach

**A learning health care system** embedding measurement and improvement

- Practice networks
- Meaningful measures (PROMs, costs)
- Comparative effectiveness research
- Advanced technology and analytics

**Opportunity**:
Improvement in knowledge and care

**Challenge**:
Balancing public and private good
Addressing all 3 categories of variation



# Insights, Opportunities and Challenges

## Underlying problem

**Flawed model: professional autonomy**
Science mediated by expert physicians (in face-to-face visits) produces the best care possible

## Possible approach

**New model: organized care**
Consumers empowered by technology and teams engage in self-care and informed decisions to achieve their goals

**Opportunity**:
Patients receive care aligned with goals
Capacity determined by true demand

**Challenge**:
Retraining the healthcare workforce
Right-sizing, redesigning physical plant

# Insights, Opportunities and Challenges

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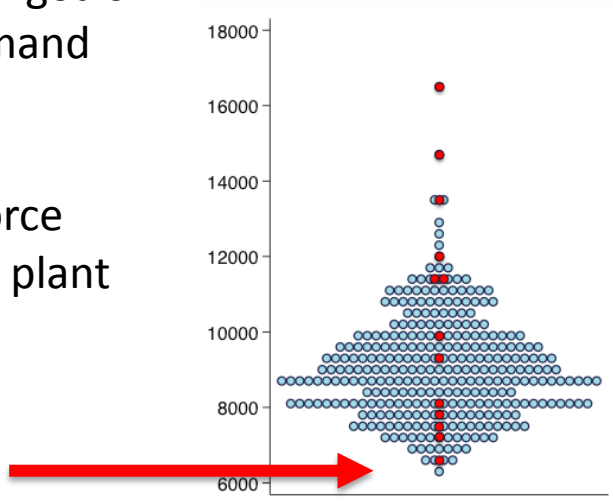
**Per-Capita 2009 Medicare Spending by HRR (Age, Sex, Race Adjusted)**



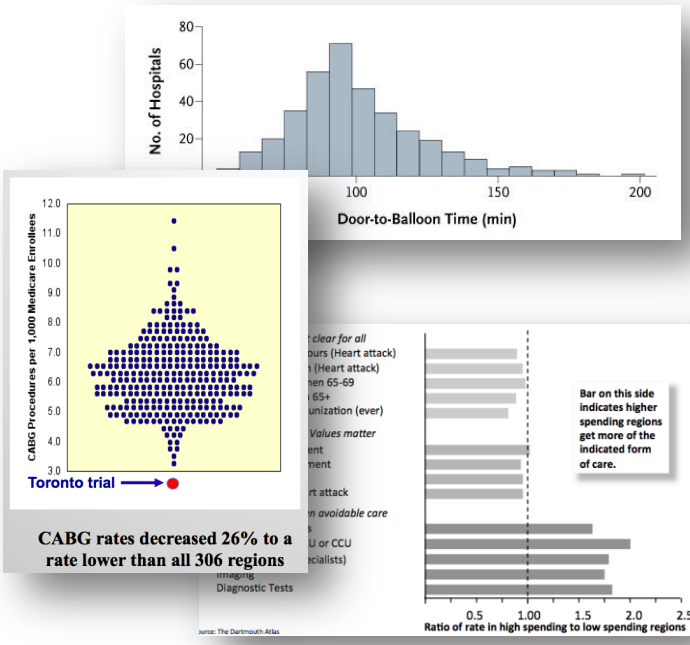

| | |
|---|---|
| Miami, FL | $16,639 |
| McAllen, TX | $14,576 |
| Manhattan, NY | $13,453 |
| Los Angeles, CA | $12,711 |
| Detroit, MI | $11,647 |
| Chicago, IL | $11,646 |
| San Francisco, CA | $9,913 |
| Cincinnati, OH | $9,388 |
| Lebanon, NH | $8,124 |
| Minneapolis, MN | $7,734 |
| Des Moines, IA | $7,382 |
| Rochester, MN | $7,120 |
| La Crosse, WI | $6,532 |

# A brief summary

***Health policy (generally) has assumed:***

Science mediated through the professional authority granted to expert physicians produces the best care possible for both individuals and populations

***With disappointing results***




***Science now tells us:***

(1) Evidence for many current treatments is insufficient. Even when evidence is good, failures of "execution" are common.

(2) Whether a treatment is right for a patient depends on their preferences and values.

(3) Waste is rampant, because supply and provider opinion determine utilization rates.

***Suggesting an alternative path:***

| | |
|---|---|
| **Doing the right thing – and doing it right** | **A learning system: improvement science** |
| **Doing the right thing – for the right patient** | **Make sure care is aligned with patient preferences** |
| **Doing the right thing – and no more** | **Integrate; monitor performance, align incentives** |

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