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CONFERENCE ABSTRACT

Re-orienting the model of care towards Accountable Care Organizations

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Introduction: Ideally, high performing health systems will try to achieve the 'Triple Aim' of improving population health, enhancing the individual care experience and doing so in a cost efficient way. In reality, developed countries all over the world face challenges to focus their health care actors on these aims. A major reason for that is the financial and organizational fragmentation of health service delivery. A possible solution is seen in Accountable Care Organizations (ACOs), who organize as 'integrators' a close collaboration between all actors and agree to be held accountable for the value they generate for a defined population.

Policy context and objective: In the US the 2010 Affordable Care Act (ACA) has stipulated the establishment of ACOs. Similar initiatives are also on the way in other countries, such as the UK, Spain or Germany. The objective of this contribution is to highlight the distinctive features of the ACO approach and elaborate transferability.

Highlights: Whereas the US counts 923 ACOs covering 32.4 Million lives (March 2017), ACO implementation is still in its infancy in other countries with only selected flagship projects (e.g. Ribera Salud, Spain or Gesundes Kinzigtal, Germany). In total, ACO reforms have led to improvements in care quality without significantly raising costs, so far. The outcomes of individual ACOs on quality and costs varies widely. Preliminary results, suggest that most experienced, physician-led, integrated and smaller ACOs have a greater likelihood of achieving better results. Higher financial benchmarks were associated with greater savings. ACOs serving high proportions of racial and ethnic minorities struggle with quality performance. These preliminary results and further research support the following core principals for ACOs:

Policy context: Set and communicate a clear value- and population-based contracting policy path to be implemented and offer payment models with upfront investment or advance payments to build a financial foundation for the incremental change necessary for value-based approaches.

Contract characteristics: Consistent, prospective, passive population attribution that avoids risk selection, benchmark for shared savings that is regionally and risk-adjusted, and measured against pre-intervention period, patient and quality outcome measures linked to shared savings, long term contract to allow investment in changing care delivery.

Organizational structure: Facilitate the formation of smaller-sized integrators (to allow personal trust and accountability), and combine local provider with general health science and management capabilities.

Performance management: Measure performance and facilitate continuous improvement, utilize technical (HIT) and personnel (physician extenders) support solutions.

Care and coordination processes: Evidence-based and locally adapted care interventions, activation of patients, shared decision making and self-management support, interventions beyond health care, including prevention, public health and the social arena.

Transferability: The core principles of ACOs are widely applicable. The proliferation of ACOs in the US vs. the slow growth in other countries underpins the power of policy.

Conclusions: Re-orienting the model of care towards ACOs has the potential to improve quality, efficiency and patient satisfaction at the same time. The variation in performance of ACOs emphasizes the importance to identify practices employed by successful ACOs, and to find ways for their dissemination.

Keywords: accountable care organizations; population health management; integrated care; value based health care; alternative payment models

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