Overview

Ontario Health Teams (OHTs) at maturity will share many features with what are called 'accountable-care organizations' (ACOs) in the U.S. RISE updated and extended a rapid synthesis about ACOs to inform the design and implementation of OHTs. This RISE brief summarizes the key findings from the rapid synthesis.

 OHTs can learn from:
1) ACOs' evolution over time;
2) ACOs' similarities to and differences from what OHTs are anticipated to look like at maturity;
3) ACOs' effects on the quadruple aim; and
4) ACOs' technical supports at maturity compared to OHTs' supports at launch.

As OHTs initially develop, they can build on what has gone well with ACOs and improve on what has gone less well. For example, ACOs' effects on the quadruple aim can give insights into where OHTs may need to pay particular attention in order to achieve desired effects. (On the other hand, ACOs' evolution over time and differences from OHTs at maturity make it difficult for OHTs to use the effect estimates to predict the effects of OHTs.) As OHTs mature, they can build on one another's successes and learn from one another's failures.

> **Box 1: Coverage of OHT building blocks & relevance to sections in the OHT full application form**
>
> This RISE brief addresses **building block #6**:
> 1) defined patient population
> 2) in-scope services
> 3) patient partnership and community engagement
> 4) patient care and experience
> 5) digital health
> 6) **leadership, accountability and governance**
>   o **accountable-care organizations, including clinical and financial accountability frameworks (domain 45)**
> 7) funding and incentive structure
> 8) performance measurement, quality improvement, and continuous learning
>
> It is relevant as background to **section 4** (how will your team work together?) as well as all **other sections** in the OHT full application form.

ACOs' evolution over time

ACOs emerged from the model used for commercial health-maintenance organizations, but their growth accelerated rapidly with the introduction of the *Patient Protection and Affordable Care Act, 2010* (which is often shortened to the Affordable Care Act and nicknamed 'Obamacare'). ACOs supported by Medicare (which funds care for people who are 65 and older, certain younger people with disabilities, and people with end-stage kidney disease) have evolved with the most intentionality and based on insights from the technical support and evaluations provided or funded by the Centre for Medicare and Medicaid Services. In addition to the permanent program that encourages the formation of ACOs (the Medicare Shared Savings Program), three time-limited Medicare ACO programs were supported:
1) Pioneer ACOs, which operated from 2012 to 2016 with an option to extend to 2018;
2) Advanced Payment ACOs, which operated from 2012 to 2015 and were designed specifically to address challenges in rural and northern areas; and
3) Next Generation ACOs, which began in 2016 and are ongoing.

The four major changes in ACO design features between the Pioneer and Next Generation models were:
1) increased use of payment models with downside risk;
2) changes to benchmarking (e.g., from a three-year baseline to a one-year baseline) and remuneration (e.g., from predominantly fee-for-service to a mix of options);
3) enhancements to benefits (e.g., including 'virtual care'); and

4) focusing on fewer, and greater alignment of, quality measures.

There are now more than 900 ACOs in the U.S. As of 2017, these ACOs cover 32.4 million people, including:
1) 19.1 million in commercial ACOs;
2) 9.4 million in ACOs supported by Medicare (described above); and
3) 3.9 million in ACOs supported by Medicaid (which is a means-tested program for low-income Americans that is jointly funded by federal and state governments and managed by state governments).

Commercial ACOs and Medicaid ACOs are far more variable in their design features than the federal government-funded Medicare ACOs.

ACOs' similarities to and differences from OHTs

ACOs have four overarching features that they will share with OHTs at maturity:
- voluntary participation;
- goal of achieving the quadruple aim of improving care experiences and health outcomes at manageable per capita costs, and with positive provider experiences;
- focus on delivering integrated care to a defined population; and
- operating under a single clinical and fiscal accountability framework.

They will also share many but not all features related to the eight OHT building blocks (see Table 1).

Table 1: ACOs compared to OHTs at maturity

OHT readiness criteria	Key features of OHTs at maturity	Examples of key features of ACOs

Defined patient population (who is covered and what does 'covered' mean?)	• OHTs will be responsible for the health outcomes and other quadruple-aim metrics of a population within a geographic area that is defined based on local factors and how patients typically access care (with no targets set for population size)	• ACOs are responsible for the health outcomes and other quadruple-aim metrics of a population that meets specific beneficiary requirements (e.g., Medicare or Medicaid requirements)
		• For Medicare and Medicaid ACOs, population sizes vary:
		  ○ 17% serve less than 10,000 people
		  ○ 57% serve between 10,000 and 50,000 people
		  ○ 15% serve between 50,001 and 100,000
		  ○ 11% serve more than 100,000.
		Commercial ACOs tend to be larger

In-scope services (what is covered?)	• OHTs will provide a full and coordinated continuum of care for all but the most highly specialized conditions	• Large ACOs (commercial, Medicare or Medicaid) provide an average of 11 of a possible 15 service types, while smaller (usually physician-led) ACOs provide an average of five of the 15 service types • The five most common in-scope services among all ACOs are primary care (94%), labs and imaging (77%), specialty care (74%), inpatient care (71%) and emergency-department care (62%)
Patient partnership and community engaged (how are patients engaged?)	• OHTs will uphold the principles of patient partnership, community engagement, and system co-design, which include appointing patients, families and caregivers to boards and leadership positions	• Medicare and Medicaid ACOs must involve patients in governance
Patient care and experience (how are patient experiences	• OHTs will provide high-quality integrated care, including 24/7	• 95% of all ACOs employ a care coordinator to fill a range of roles from follow-up after discharge

OHT readiness criteria	Key features of OHTs at maturity	Examples of key features of ACOs
and outcomes measured and supported?)	coordination and system-navigation services	from hospital or other facilities to health-education phone calls
Digital health (how are data and digital solutions harnessed?)	• OHTs will use digital-health solutions (e.g., patient portal, electronic health record, and e-consultations for patients and among providers) to support effective healthcare delivery, ongoing quality and performance improvement, and better patient experience	• More than 80% of Medicare and Medicaid ACOs report having adopted patient portals or personal health records (an add-on to an electronic medical record), e-prescribing, and population analytics • At least 50% of primary-care providers included in a Medicare Pioneer or Next Generation ACO must have an electronic health record (i.e., a record that is interoperable between providers and sites)

Leadership, accountability and governance (how are governance and delivery arrangements aligned and how are providers engaged?)	• OHTs will determine their own governance structure, have physicians and other clinical leaders in governance and/or leadership positions, and work within a single clinical and fiscal accountability framework	• Medicare and Medicaid ACOs have a range of governance/leadership models:
		  o jointly (coalition)-led
		  o hospital-led
		  o physician-led
		  o integrated delivery system (e.g., parent or overarching governance structure)
		• Physicians and other clinical leaders typically hold governance and/or leadership positions in Medicare and Medicaid ACOs
		• Medicare and Medicaid ACOs work within a single clinical and fiscal accountability framework

Funding and incentive structure (how are financial arrangements aligned?)	• OHTs will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations, and they can re-invest savings to improve patient care	• All ACOs face both upside and downside risk sharing
Performance measurement, quality improvement and continuous learning (how is rapid learning and improvement supported?)	• OHTs will provide care according to the best available evidence and clinical standards, with an ongoing focus on quality improvement • OHTs will have their performance measured according to a standard set of indicators aligned with the quadruple aim	• Medicare and Medicaid ACOs report annually on a series of quality metrics grouped into four domains: patient/carer experience, care coordination, preventive health, and chronic disease management

ACOs′ effects on the quadruple aim

One systematic review and 60 single studies have examined ACOs' effects on the quadruple aim (see Table 2 below for a high-level summary, and for those who want to know more, see Table 5 in the accompanying rapid synthesis, which can be accessed by clicking on the link below under 'Key resources'). While evolutions in ACOs and differences in their design compared to OHTs complicate the picture, OHTs as a model offer promise, but teams will need to rapidly learn and improve about how to 'move the needle' for all key quadruple-aim metrics.

Table 2: ACOs' effects on the quadruple aim

Aim	ACOs' effects
Improving care experiences	Quality indicators (e.g., access to care, level of coordination and communication, length of stay, etc.), may improve after ACO implementation, but changes are often small and metrics such as hospital readmissions or care for specific disorders may not be affected
Improving health outcomes	Results appear to be mixed, with some evaluations of ACOs finding improvements in the health of patients receiving care from them (e.g., slight reductions in mortality among cancer patients and pneumonia patients, fewer depressive symptoms, and better physical health scores, among others), and other evaluations finding no improvements or poorer population health outcomes
Keeping per-capita costs manageable	ACOs may help reduce costs without reducing quality, and the cost reductions may be largely attributable to savings in outpatient expenses among the most medically complex patients, and to reductions in the use of low-value services
Achieving positive provider experience	Little evidence was found on the effects of ACOs on provider experiences, with two studies finding that improved collaboration as part of ACOs may help to increase providers' available time, however, in another study primary-care providers suggested that quality targets associated with ACOs hinder their focus on patient needs

ACOs' technical supports compared to OHTs' supports

The technical supports that have been provided to ACOs informed the design of RISE supports. Four key observations are worth noting:
1) technical support to ACOs was highly segmented compared to the 'one window' of supports being provided to OHTs:
   a) Medicare ACOs have been supported through a national effort led by CMS Innovation (part of the U.S. government) and with the principal contract held by Mathematica on behalf of a number of partners,
   b) Medicaid ACOs have been supported largely through state-level efforts and through a Commonwealth Fund contract to the Center for Health Care Strategies to provide a national infrastructure, and
   c) commercial ACOs and some Medicare and Medicaid ACOs have also been supported by independent initiatives that emerged over time (e.g., the National Association for ACOs that supports the ACO Learning Collaborative);
2) timing of support, particularly the front-end loading of support for applications and early development, is similar to the timing of the 'one window' of supports;
3) modalities for support are also very similar to the 'one window' of supports, with the exceptions of an annual ACO conference (which may be added to the 'one window' over time) and a dashboard to allow ACOs to benchmark against one another (which is not currently being planned for OHTs); and
4) content of the support is also very similar to the 'one window' of supports, with the exception of the 'one window' of supports giving attention to research evidence as a complement to data and to tacit and experiential knowledge.

Key resources

Waddell K, Wilson MG, Evans C, Lavis JN. Rapid synthesis: Learning from the experiences of accountable-care organizations in the U.S. Hamilton, Canada: McMaster Health Forum; 2019.

Moat KA, Waddell K, Lavis JN. RISE brief 11: Accountable-care organizations. Hamilton, Canada: McMaster Health Forum; 2019.

RISE ⌃
Rapid-Improvement Support and Exchange

McMaster University · HEALTH FORUM

The Ottawa Hospital | L'Hôpital d'Ottawa
RESEARCH INSTITUTE | INSTITUT DE RECHERCHE

Trillium Health Partners

INSTITUTE FOR BETTER HEALTH

>> Contact us
1280 Main St. West, MML-417
Hamilton, ON, Canada L8S 4L6
+1.905.525.9140 x 22121
rise@mcmaster.ca

>> Find and follow us
OHTrise.org
forumHSS