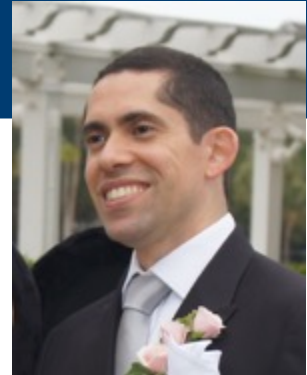
Specialties ACO (Accountable Care Organizations)

Desafios de Implantação no Brasil

Agenda

- Conceito ACO – Accountable Care Organization
- Intervenção em Saúde
- Principais desafios
- Exemplo de resultados
- Próximos Passos

Conflito de Interesse



Joatam L. S. Júnior, MD, MBA, MHCD HBS

- Mestrando pela **FGV EAESP**
- Managing Healthcare Delivery - **Harvard Business School**
- Senior Executive Programme in Global Health Innovation Management – European Union
  - **Strathmore University Kenya - IESE Barcelona – Heindelberg University Germany – INCAE Costa Rica**
- "Behavioral Science of Management" – **Yale School of Management**
- Pós Graduação em Finanças e Controladoria e Gestão de Projetos – **The George Washington University**
- Professor de Pós Graduações
- **Executivo de Inovação na UnitedHealth Group @ Chief Medical Office**
- Médico Cirurgião Cardiovascular e de Terapia Intensiva
- **<u>Sem conflitos de interesses</u>**

INTRODUÇÃO

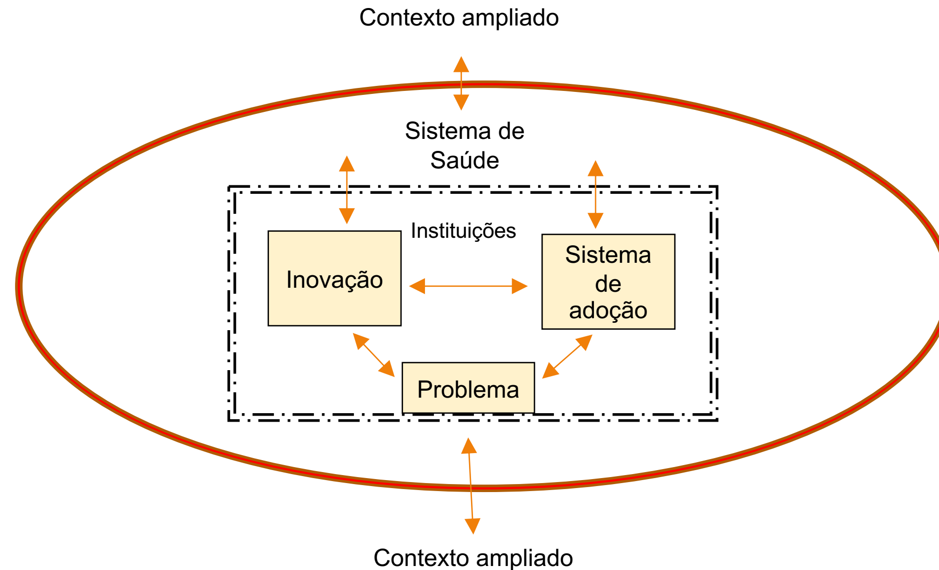
- TEMA DE PESQUISA E INTRODUÇÃO DO ASSUNTO
  - Uma **ACO (Accountable Care Organization)** é formada quando um grupo de prestadores de serviço em saúde (Médicos, Hospitais, Serviços de apoio diagnóstico e terapêutica, etc.) que se reúnem e coletivamente concordam em serem responsáveis pelos desfechos clínicos, financeiro e de qualidade em uma população definida.
  - Novos modelos de pagamento são importantes no momento atual como ferramenta para se encontrar o custo médico adequado com melhor eficiência e menos desperdício.
  - Adicionalmente entregam melhor experiência ao usuário associado a qualidade superior (Mensuração de desfecho Clínico). Permitem correção imediata de desperdícios e de sinistralidade pelo **incentivo a volume estimulado pelo *fee for service***.

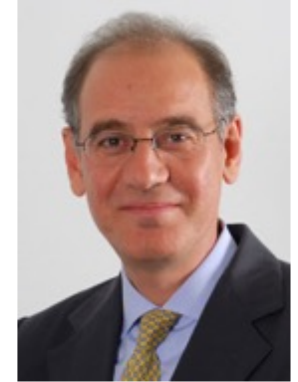
- PROBLEMA DE PESQUISA (*GAP* A SER ESTUDADO)

  Quais os desafios no alinhamento de interesses (Contrato com conceito ACO) com escopo de melhores resultados considerando um melhor gasto per capita, melhor satisfação do usuário e melhor saúde da população?

EVENT-BASED	PROSPECTIVE BUDGET-BASED	VALUE - BASED
FEE FOR SERVICE BUNDLED PAYMENT	CAPITATION GLOBAL BUDGET	ACO Clinical Outcomes PROM PREM Shared Saving
Incentives to Volume	Changing Incentives	Incentives to Value

Framework para análise de adoção e difusão de inovação em Sistemas de Saúde – Adaptado de (ATUN, 2012)





ATUN, R. Health systems, systems thinking and innovation. **Health Policy and Planning**, v. 27, n. suppl 4, p. iv4–iv8, 1 out. 2012.

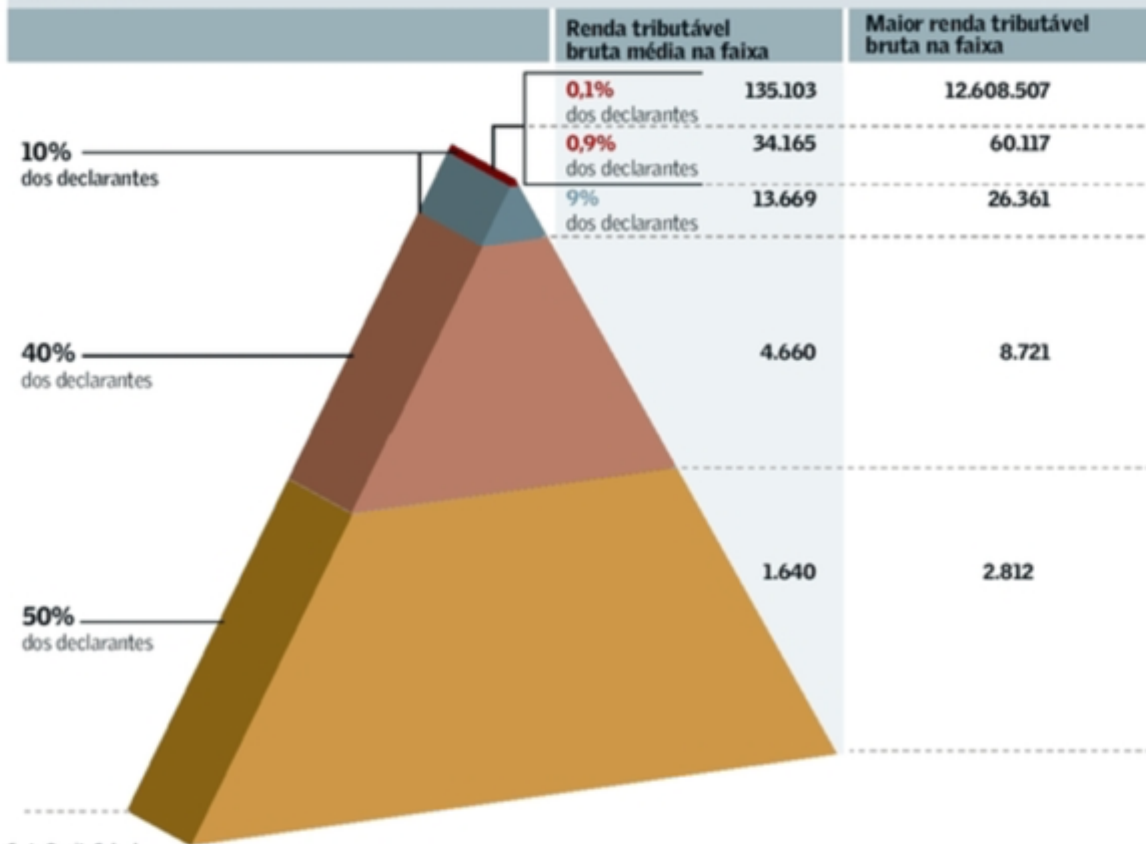
Quarta-feira, 10 de maio de 2017 | Ano 18 | Número 4251 | R$ 5,00

Valor ECONÔMICO

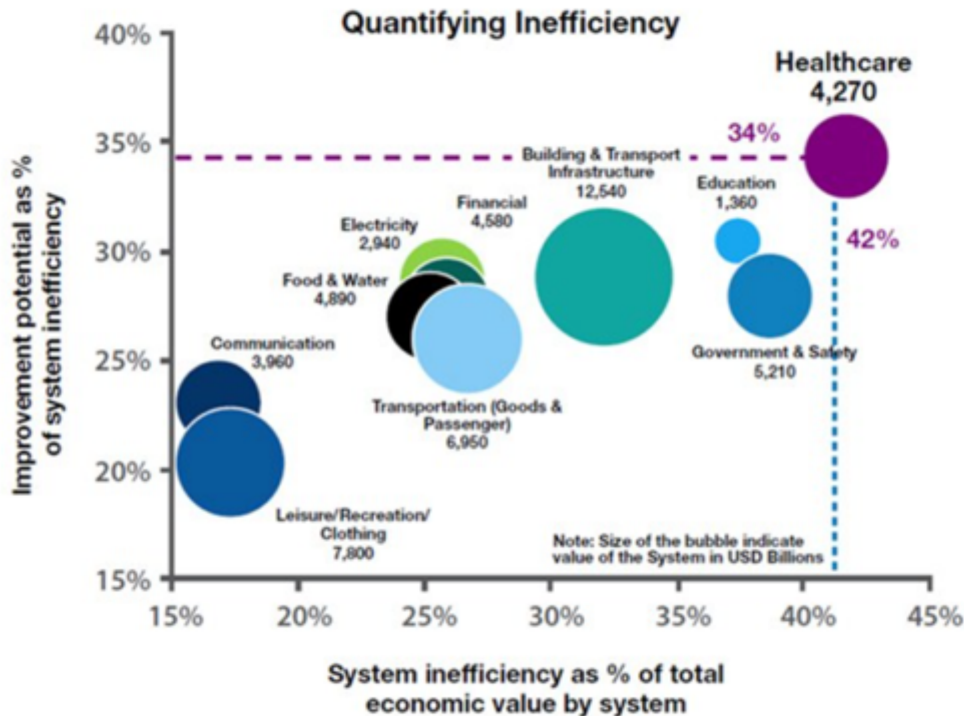
Secretário da Receita faz críticas à concentração da renda no Brasil

A2 | Valor | Quarta-feira, 10 de maio de 2017

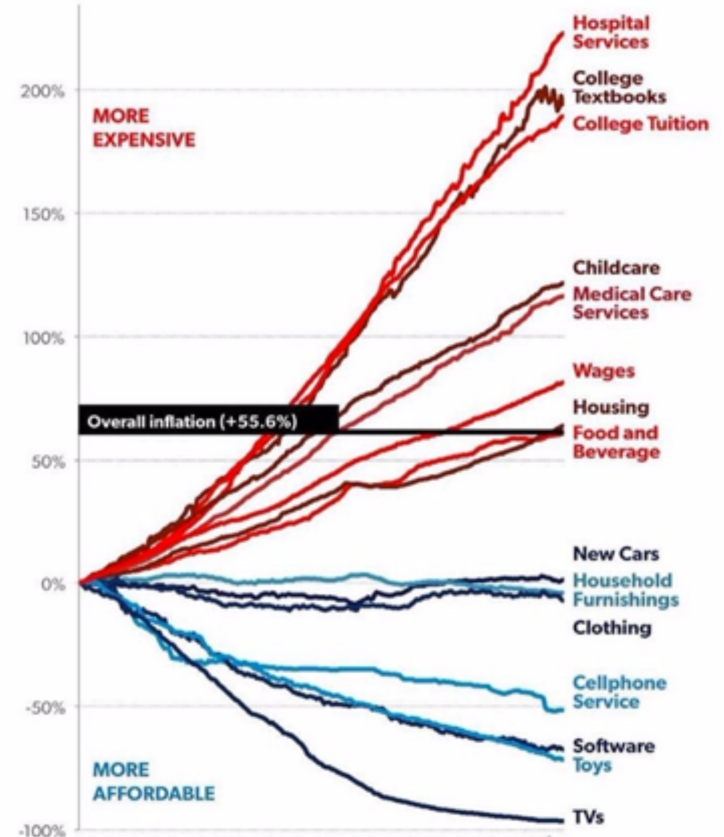
Brasil



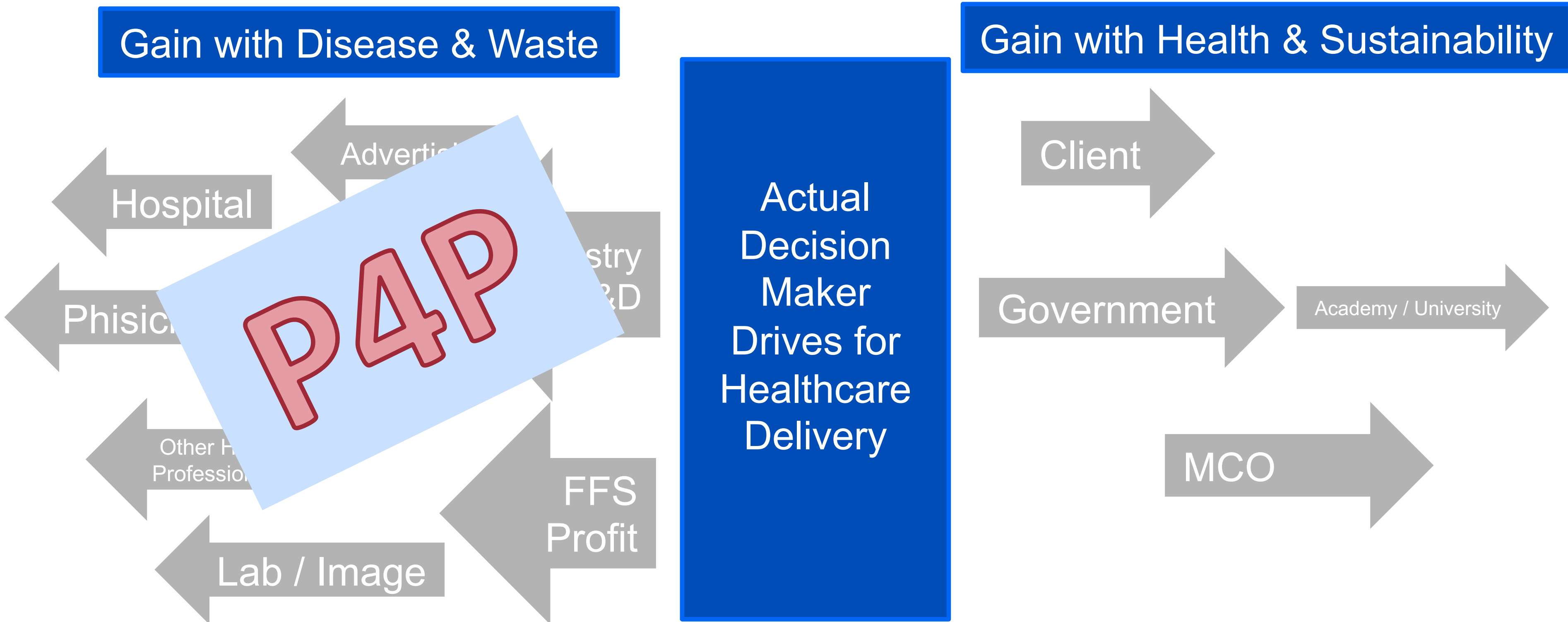
Leading the Pack in In



IBM Care process management: Using BPM tools and methodology in the healthcare environment



Economic Force Field Analysis



Encourage doctors and hospitals to avoid or "fire" sicker patients who drag down quality scores due to factors outside physicians' control

Pay for performance in primary care in England and California: comparison of unintended consequences. Ann Fam Med. 2009 Mar-Apr;7(2):121-7.

Cause some doctors to stop using lifesaving treatments if they don't result in bonuses

Effects of Pay for Performance on the Quality of Primary Care in England. N Engl J Med 2009; 361:368-378.

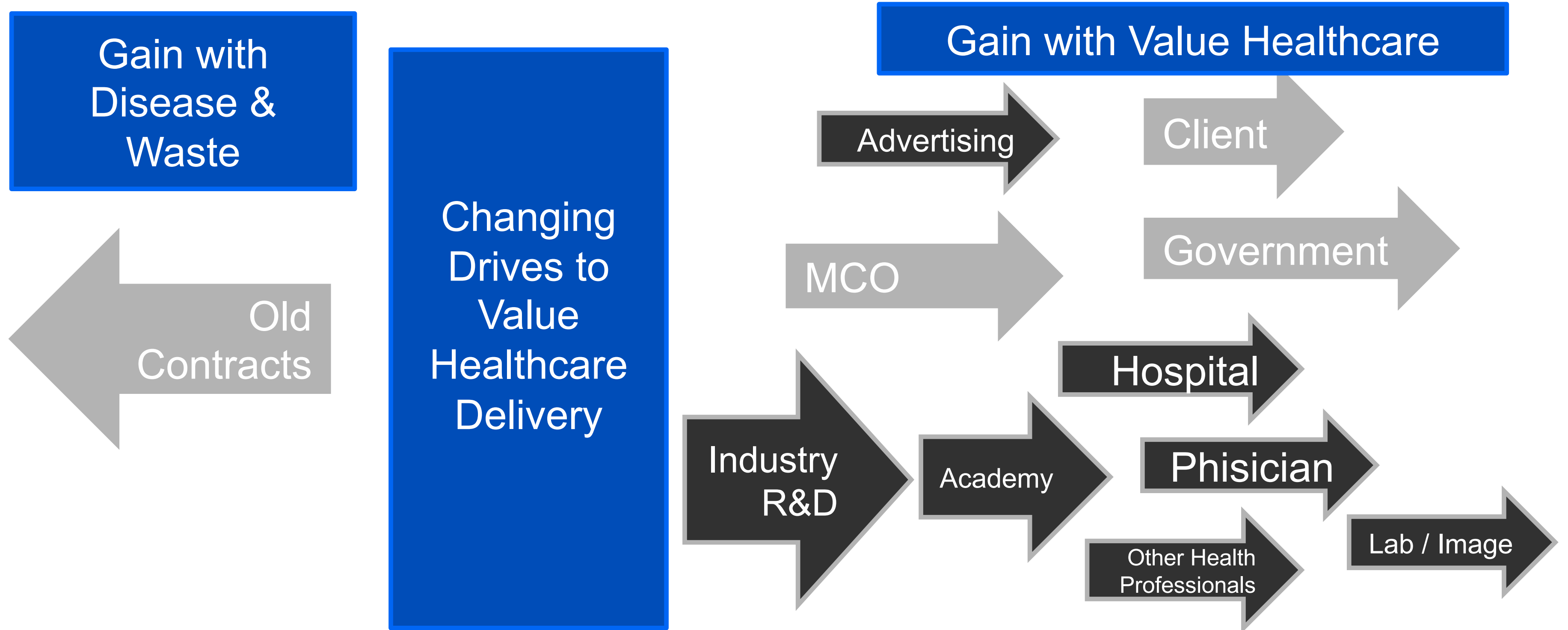
Reduce job satisfaction and undermine altruism and professionalism among doctors

"Will Pay For Performance Backfire? Insights From Behavioral Economics, " Health Affairs Blog, October 11, 2012.

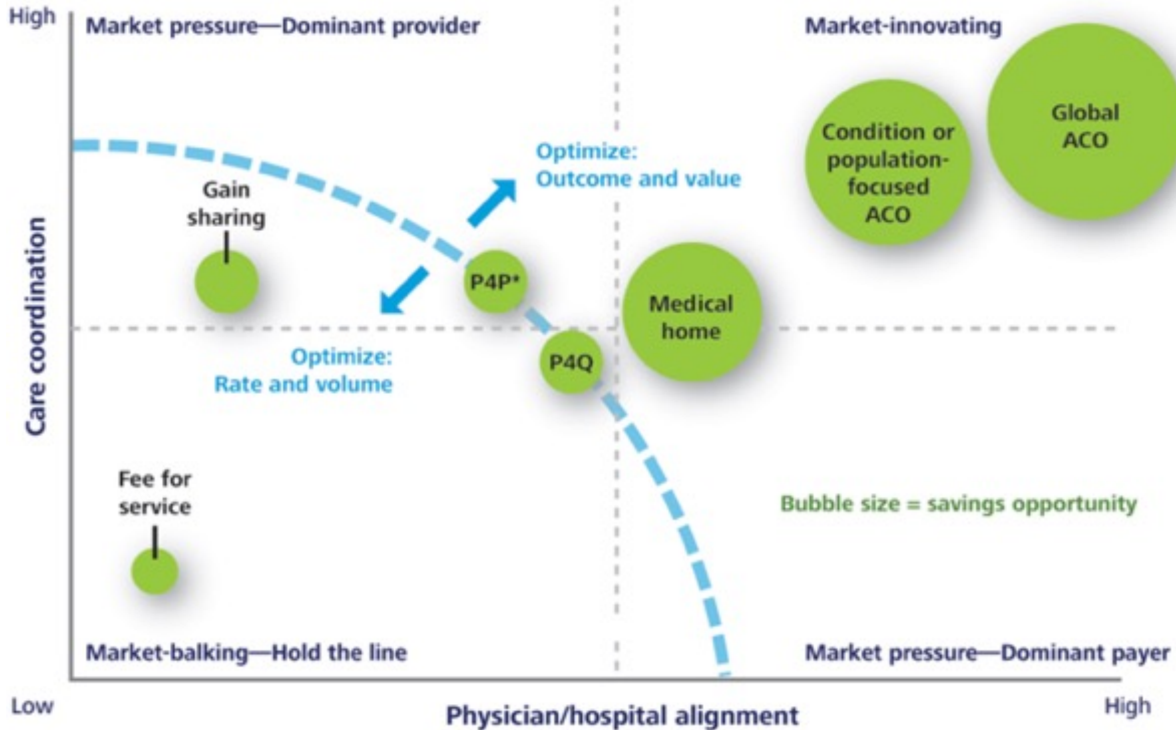
Cause doctors to game quality measures.

Effect of Nonpayment for Preventable Infections in U.S. Hospitals. N Engl J Med 2012; 367:1428-1437.

Economic Force Field Analysis



Value Based Care Opportunity



* Delloite University Press

Who Gets the Savings from Waste Reduction?

With most health care payment methods, much of the savings from waste cuts goes into the pockets of payers (mainly insurers and, to a much lesser degree, employers and patients), not to the care delivery groups behind the quality improvement initiatives. That undermines the groups' finances and ability to invest in further innovations that rein in spending. Population-based payment is the only system that allows groups to benefit from reducing all three categories of waste.

TYPE OF WASTE	% OF ALL WASTE	PAYMENT METHODS			
		Cost-plus	Fee for service	Per case	Population-based payment
Production level Inefficient production of individual care units, such as drugs, tests, nursing support	5%	Payer	Provider	Provider	Provider
Case level Use of unnecessary or suboptimal services in treating a case	50%	Payer	Payer	Provider	Provider
Population level Unnecessary or avoidable patient cases	45%	Payer	Payer	Payer	Provider

SOURCE INTERMOUNTAIN HEALTHCARE
FROM "THE CASE FOR CAPITATION," JULY–AUGUST 2016

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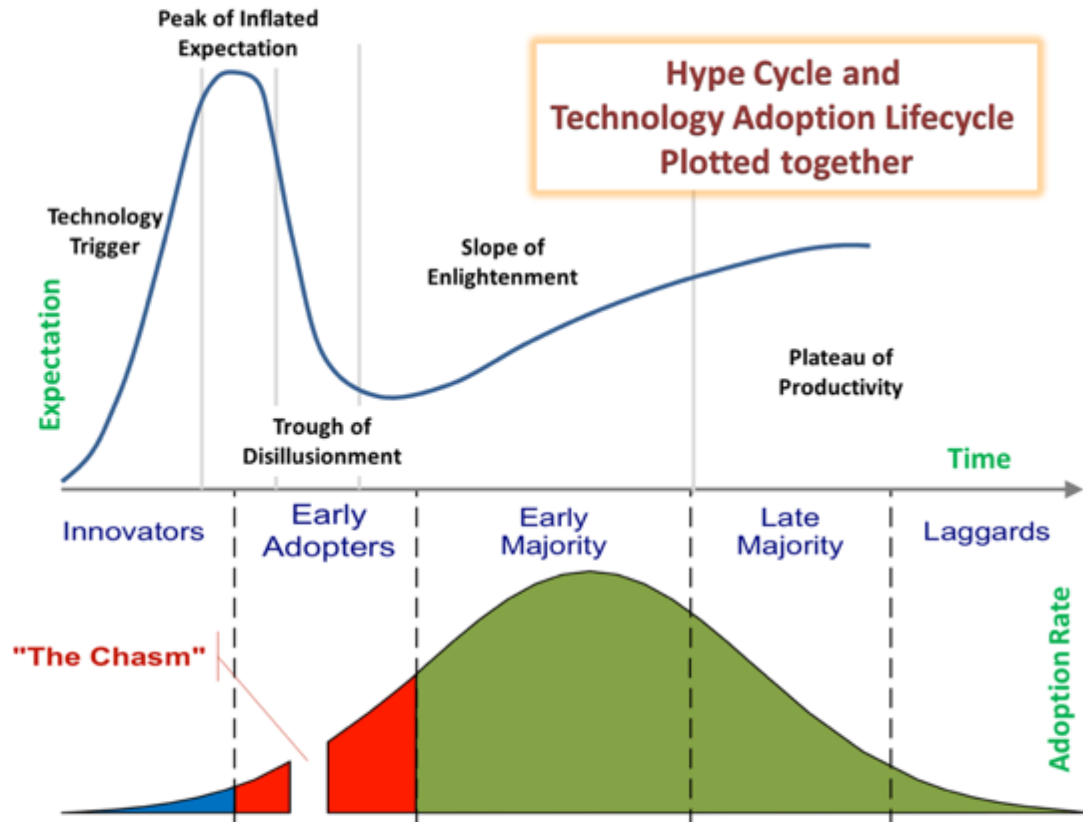
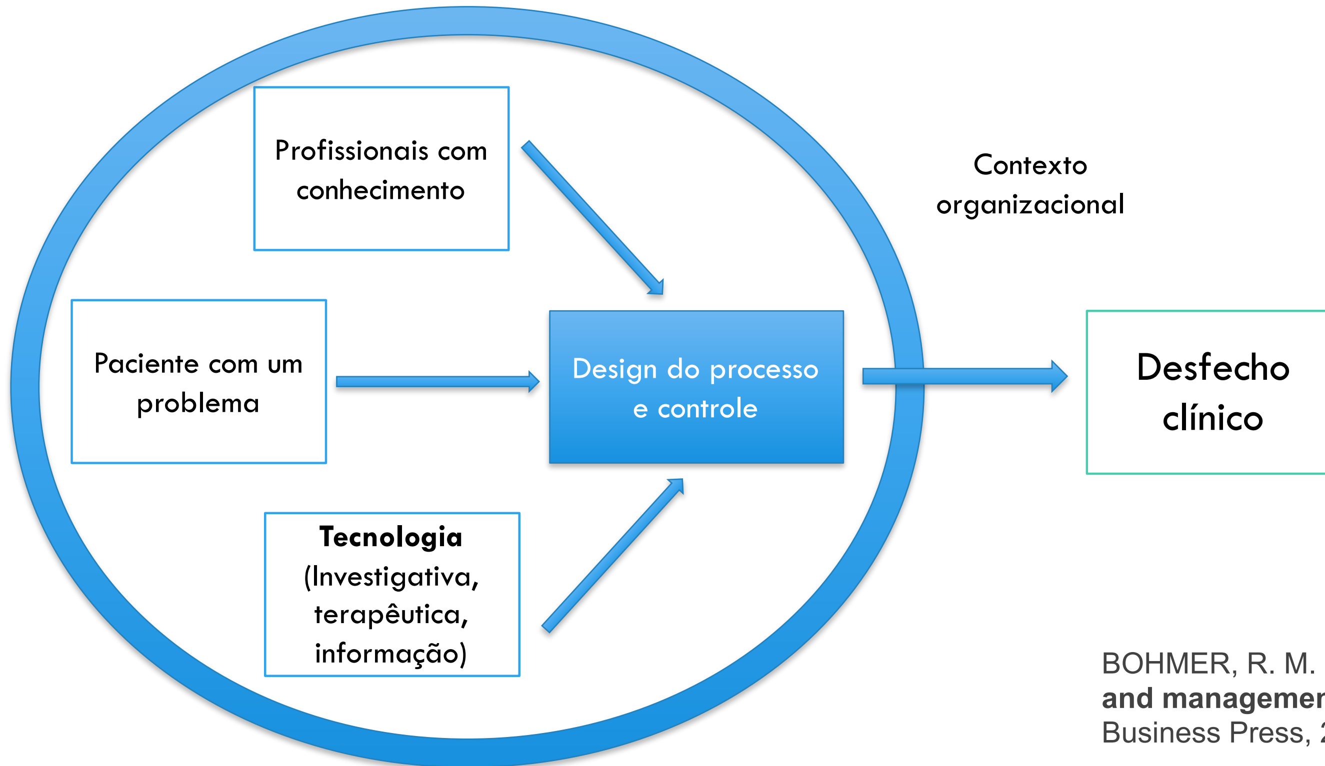


Beal, George M., Everett M. Rogers, and Joe M. Bohlen (1957) "Validity of the concept of stages in the adoption process." *Rural Sociology*22(2):166–168

Fonte: Prêmio Valor Inovação Brasil 2019-2020. Valor Econômico e Strategy& PwC

Desenho do Processo



BOHMER, R. M. J. **Designing care: aligning the nature and management of health care**. Boston, Mass: Harvard Business Press, 2009.

Educating Physicians About Responsible Management of Finite Resources

Shantanu Agrawal, MD
Julie Taitsman, MD
Christine Cassel, MD

About 18% of the US gross domestic product is consumed by health care—more than that of any other industrialized country—and that number is expected to increase to 20% by 2020. Physicians are principal gatekeepers who decide when, how, and what health care services are delivered, with some estimates that at least 60% of health care costs are determined or influenced by physicians. Despite the enormous resources at stake, physicians receive little education in how to manage and steward finite resources, making formal education of physicians in "program integrity" an essential component of medical professionalism.

Program integrity—a term frequently used by payers for

not meet coverage and medical necessity criteria, were not correctly coded, or for which submitted documentation did not support the ordered service.[4]

While defensive medicine is frequently cited as a driver of overutilization, incentives in the fee-for-service payment structure are motivating factors as well.[5] Increasing evidence suggests that economic pressures, including those from employers, affect physician decision making and health care utilization. For example, studies have evaluated the use of various discretionary diagnostics and found an association between physician ownership of imaging

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Author Affiliations: Center for Program Integrity, Centers for Medicare & Medicaid Services, Baltimore, Maryland (Dr Agrawal); Office of Inspector General, Department of Health and Human Services, Washington, DC (Dr Taitsman); and American Board of Internal Medicine, Philadelphia, Pennsylvania (Dr Cassel).
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special"

Go for Quantity

Copyright Kerry Plemmons

Thinking 3 perspectives - remember the *patient*, they are not in the room, but should be on our minds

PCP

Patient

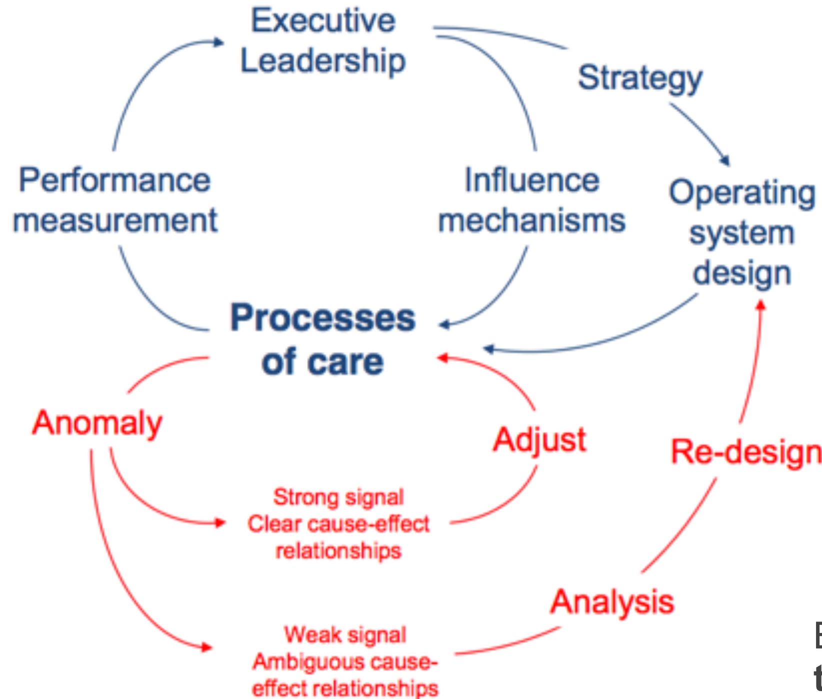
Specialist

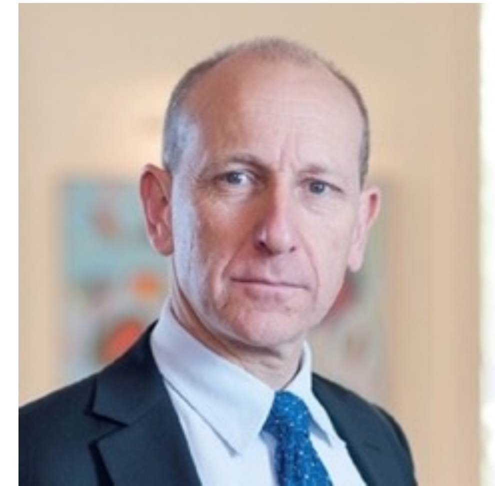
Time efficient - Increases Trust – reduce knowledge gap – pt friendly

Putting it together: design and re-design

Evidence based medicine

Evidence creating medicine





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Harvard Business Review

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Apple leaders are expected to possess deep expertise, be immersed in the details of their functions, and engage in collaborative debate.

ARTICLE
ORGANIZATIONAL CULTURE

How Apple Is Organized for Innovation

It's about experts leading experts.

by Joel M. Podolny and Morten T. Hansen

Right Care 1

Evidence for overuse of medical services around the world

Shannon Brownlee, Kalipso Chalkidou, Jenny Doust, Adam G Elshaug, Paul Glasziou, Iona Heath*, Somil Nagpal, Vikas Saini, Divya Srivastava, Kelsey Chalmers, Deborah Korenstein

Overuse, which is defined as the provision of medical services that are more likely to cause harm than good, is a pervasive problem. Direct measurement of overuse through documentation of delivery of inappropriate services is challenging given the difficulty of defining appropriate care for patients with individual preferences and needs; overuse can also be measured indirectly through examination of unwarranted geographical variations in prevalence of procedures and care intensity. Despite the challenges, the high prevalence of overuse is well documented in high-income countries across a wide range of services and is increasingly recognised in low-income countries. Overuse of unneeded services can harm patients physically and psychologically, and can harm health systems by wasting resources and deflecting investments in both public health and social spending, which is known to contribute to health. Although harms from overuse have not been well quantified and trends have not been well described, overuse is likely to be increasing worldwide.

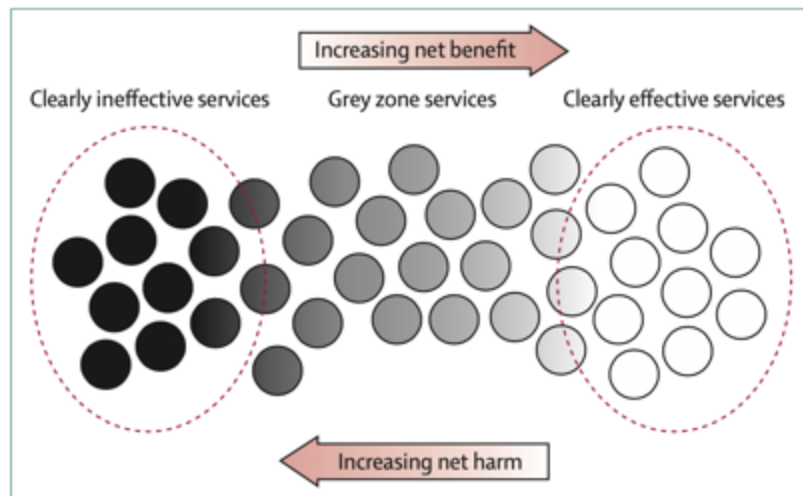


Figure 1: Grey zone services

www.thelancet.com **Published online January 8, 2017 http://dx.doi.org/10.1016/S0140-6736(16)32585-5**

STRATEGY

The Strategy That Will Fix Health Care

by Michael E. Porter and Thomas H. Lee

From the October 2013 Issue

6 BUILD AN ENABLING INFORMATION TECHNOLOGY PLATFORM

A value-enhancing IT platform has six essential elements:

1. It is centered on patients
2. It uses common data definitions
3. It encompasses all types of patient data
4. The medical record is accessible to all parties involved in care
5. The system includes templates and expert systems for each medical condition
6. The system architecture makes it easy to extract information

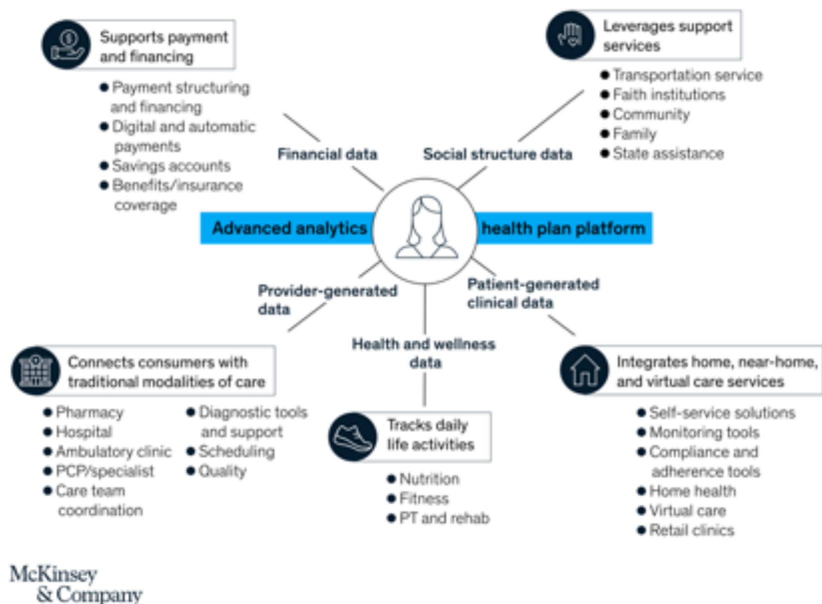
IESE Business School University of Navarra

NEWS

Digital Density: Reshaping Business Models and Organizations

BY JAVIER ZAMORA

Posted on 25/10/2013



ABOUT JAVIER ZAMORA

Javier Zamora is currently senior lecturer in the Department of Information Systems. He received his Ph.D. in Electrical Engineering from Columbia University, and his M.Sc. in Telecommunications Engineering from the Universitat Politècnica de Catalunya. He holds also a PDG from IESE.

An integrated view: the dichotomy evolves

	"Art" (R & D)		"Science" (Production)
Activity	Unique	←→	Repetitive
Task structure	Non-routine	←→	Routine
Process	Iterative	←→	Sequential
Organization	Organic	←→	Mechanistic
Control	Loose	←→	Tight
Control mechanism	Professionalism	←→	Measurement
Value emphasized	Creativity	←→	Efficiency
Time horizon	Long	←→	Short

Source: adapted from K. Clark and T. Fujimoto. Product development performance. HBSP, Boston, 1991

© Richard Bohmer, 2012

INDICADORES

Resumo da revisão de indicadores

07 Excluídos

- Conformidade ao protocolo **ICHOM**
- Conformidade aos protocolos específicos de linha de atenção
- Percentual de pacientes tratados (*Coord. do Cuidado*)
- Visitas do Pronto Socorro
- Tx. de conversão de UTI
- Tx. de mortalidade na especialidade
- Tx. de internação em conformidade com condições sensíveis a Atenção Primária

04 Mantidos

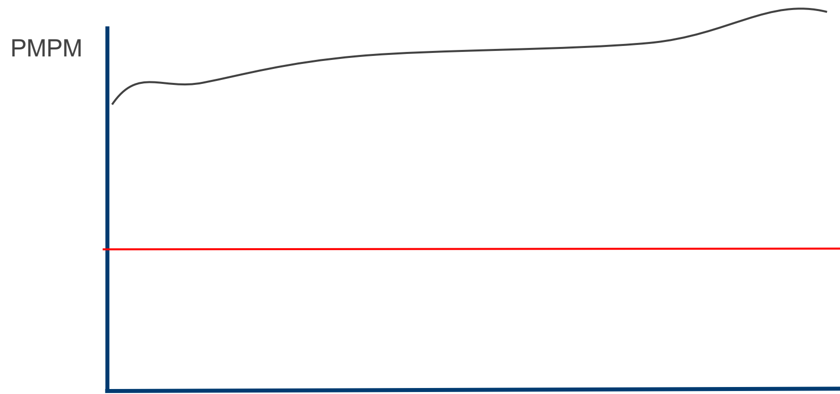
- NPS “Net Promoter Score
  Meta: > ou igual a 80%
- Qualidade de apresentação da conta
  Meta: Menor ou igual a 5%
- Ocorrência de NIPs
  Meta: Zero
- Taxa de readmissão hospitalar em 30 (trinta) dias
  Meta: Até 10%

13 Inseridos

- Atendimentos de PA e PS
- Tx. de internação (urgência e eletivas)
- Tx. de óbito de pacientes em cuidados paliativos na UTI
- Tx. de quimioterapia 30 dias antes do óbito
- Tx. de doença metastática na primeira consulta
- Tempo (dias) entre a primeira consulta diagnóstica e o início do tratamento
- Tx. de pacientes em estágio IV em acompanhamento de cuidados paliativos
- Tx. de toxicidade grau III e IV por tratamento quimioterápico
- Sobrevida em 1 Ano
- Suporte psicológico
- Suporte nutricional
- ***BREAST-Q (somente Ca Mama)***
- ***EORTC QLQ- C30 (somente Ca Mama)***

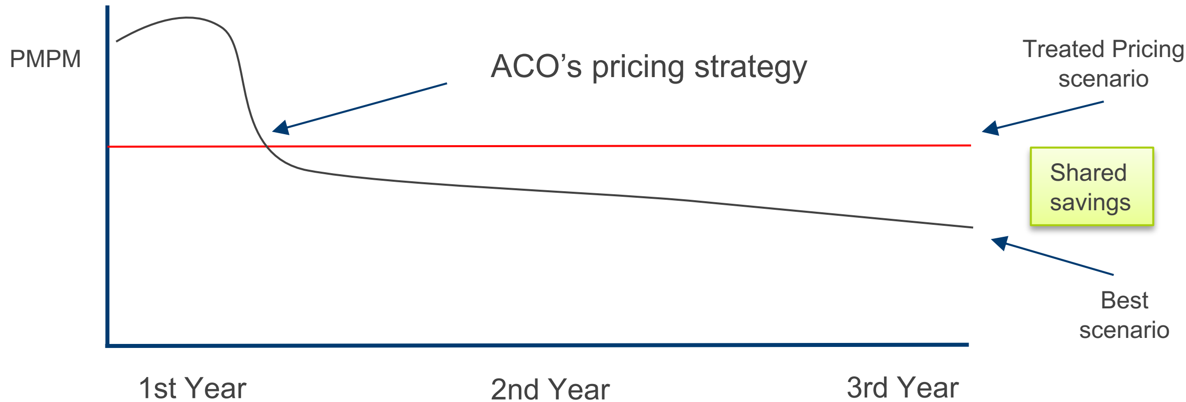
**** Indicadores de Monitoramento para formação de Baseline e Benchmarking de contratos futuros***

Ind. Processo Adm* | *Satisfação* | *Ind. Processo Assistencial* | *Ind. Desfecho Valor



Today's Fee for Service

- Low Steerage
- Few Network changes
- Fragmentation, No integration
- Waste



New Model

- Pop. Care Coordination
- Value Based Payment
- Integration
- Lean
- NPS

Obrigado pela oportunidade