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Governance in New Models of Care

PwC / Advancing Quality Alliance

12 October 2017

Welcome and Introductions

Your facilitators today

Harriet Aldridge

Mike Wallace

Catherine Hartley

Please could you introduce yourself and let us know which organisation you are from?

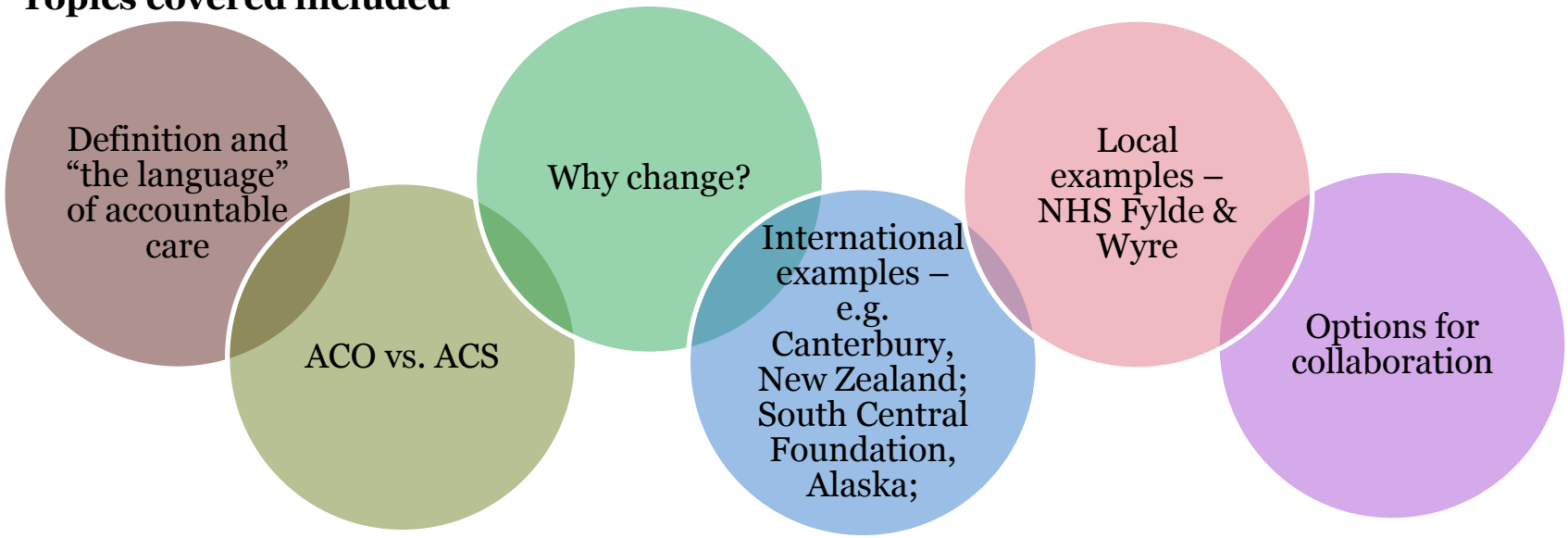
This is the second workshop in a series of three

What you covered last time

Aims of the session were to:

- To provide you with an introduction to Accountable Care
- To explore what Accountable Care is and why this is increasingly significant
- To learn from international and local examples

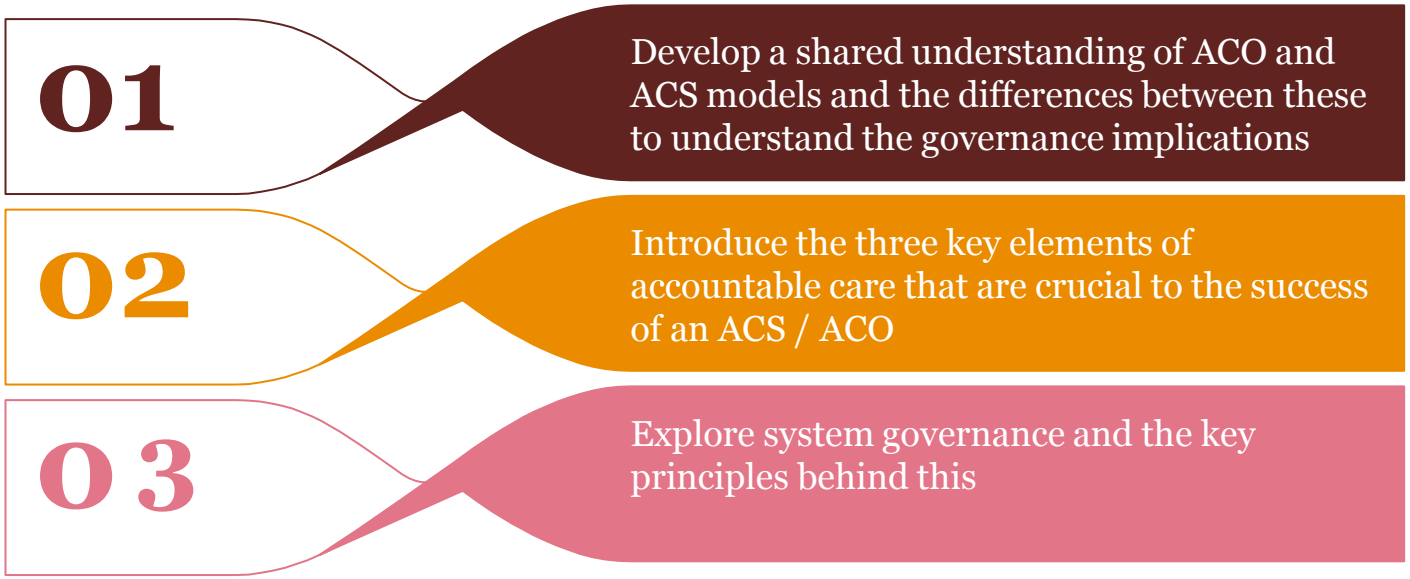
Topics covered included



Questions:
- What are your reflections from the previous event?
- Has anyone been able to put the knowledge gained from the last session into practice?

Aims of this session

This session has three aims:



Questions:
- Is there anything else you would like to cover?

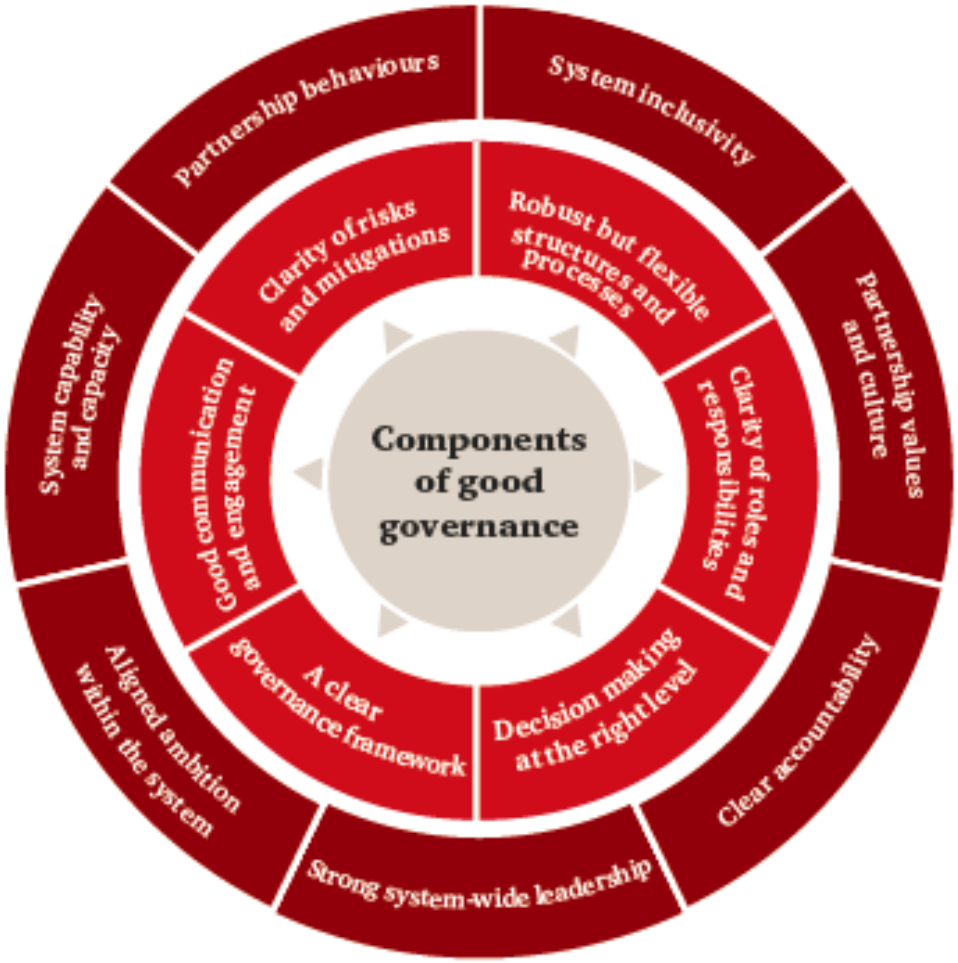
Structure of the morning

No	Session	Time
1	Welcome and Introduction	9.00 – 9.10
2	ACO and ACS models	9.10 – 9.25
3	ACO and ACS models - discussion	9.25 – 9.50
4	Key elements of an accountable care system	9.50 – 10.10
5	Break	10.10 – 10.25
6	Principles for effective whole system working	10.25 – 11.10
7	Group work	11.10 – 11.50
8	Q&A session	11.50 – 12.20
9	Recap of key learning points and close	12.20 – 12.30

Question

In table groups discuss: ‘What does governance mean to you and what are the key features of it?’

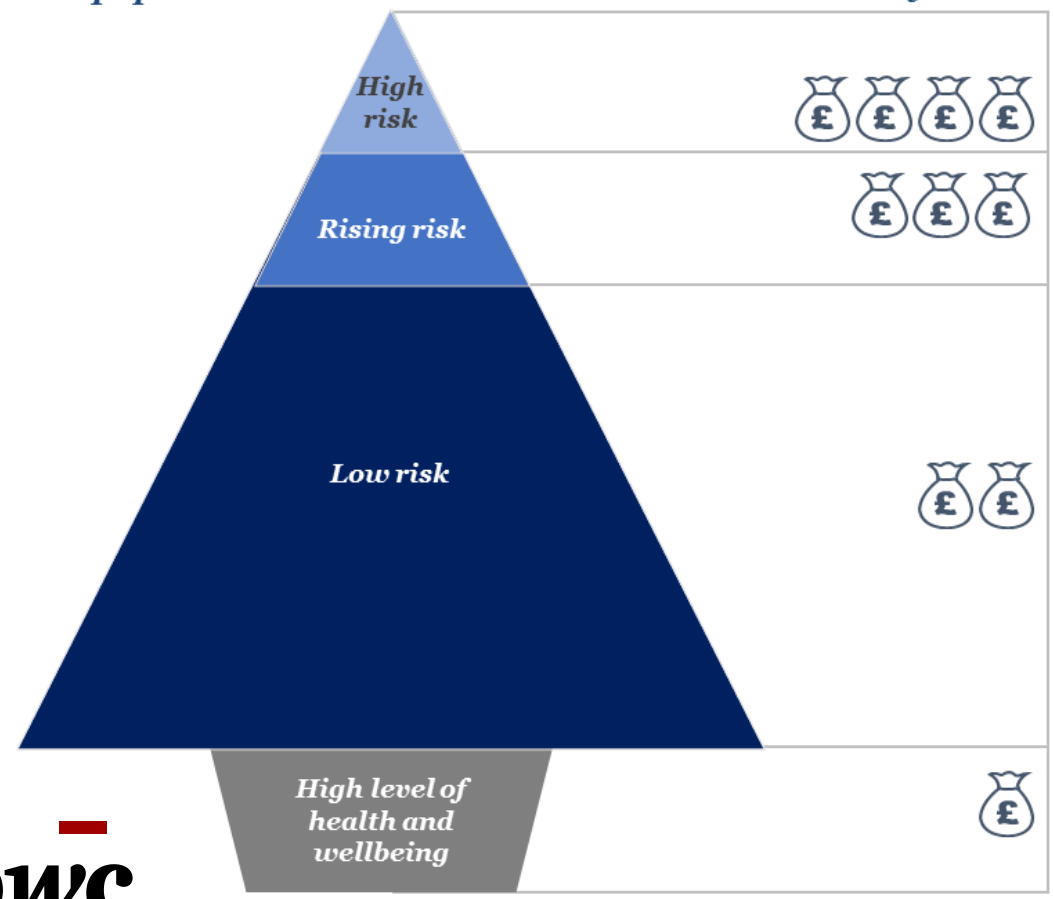
Introduction to system governance



ACO and ACS models

ACOs and ACSs – What are the challenges we are trying to address?

There are many factors driving the crisis in the current health and care system. There is a pressing need to radically shift the way we think about arranging and delivering care.



- Models are orientated towards reacting to need
- Increased prevalence of multiple long term conditions
- Commissioning approaches incentivise increased provision
- Fragmented approach to commissioning
- Volume and cost of high and rising risk cohorts
- Urgent care system is not effective
- Multiple points of access do not effectively deflect, triage or resolve
- Uncoordinated care
- Lack of effective care/ support options
- System resources are stretched

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ACOs and ACSs – What are the benefits?

ACO and ACS priorities

- Manage the flow of people to the right resources.
- Understand and actively manage the population.
- Actively promote self care, self service and develop community assets.
- Manage those with multiple conditions and complex needs through multi-disciplinary teams.
- Actively divert people to the most effective and efficient access points.
- Support community professionals with resources from the acute sector.
- Invest in areas that will bring longer term benefits.

With an operating model that enables

- Coordinated service planning across a geographic cohort.
- Single database and care records that enables active case management, driven by business intelligence.
- Ability and incentives to invest resources based on local knowledge, for long term benefits.
- Systems and mgt structures to support multi-disciplinary team collaboration for targeted cohorts.
- Control access, consistency and ability to 'signpost' patients.
- Behavioural change – public and care professionals.
- Acute engagement in the community, aligned incentives and contracts.
- Capitated long term contracts.
- Access to investment funds.

ACOs and ACSs – The definition

Accountable Care System	*Accountable Care Organisation*
A set of providers working together to deliver integrated care services, with shared accountability between the ACS and commissioner.	A single provider entity agreeing to take responsibility for the care, and its quality, for a given population.
• Sets of providers enter into a single arrangement with the commissioner(s) to deliver integrated care services. • There is a transfer of collective accountability to these providers which is formalised through an alliance contract • Both commissioners and providers share the risk and reward. • Commissioners retain a key role in the management and responsibility for co-ordination of the alliance.	• The agreement will be for a defined time under a contractual arrangement with the commissioner(s). • The provider is held accountable through risk and reward for achieving a set of pre-agreed quality outcomes within a given budget. • An ACO can be a newly created legal entity made up of different parties owning shares or being members of that entity (Joint venture), or a single, lead provider organisation.

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ACOs and ACSs – The differences

The Difference	ACS	ACO
The ability to transfer accountability	Accountability is not transferred to a single entity through an ACS	Accountability for the health and care of a population is fully transferred to an ACO
The ability to take on long term capitated contracts with clear outcomes	ACS take on an alliance contract	ACO take on a long term capitated contract (10 – 15 years)
The ability to control and re-shape resources	Difficult as no single point of accountability	Will need to do this to meet outcomes stated in the contract
The ability to invest in long term system transformation	No change to resources in this model	Will need to do this to meet outcomes stated in the contract
The ability to move from provider based silos to integrated working	Organisations continue to operate independently in this model	The lead provider or entity will be responsible for shaping care pathways to achieve stated outcomes
The end point	Should be a stepping stone on the journey	Should be the desired destination

ACO and ACS models - discussion

ACO and ACS – Group Discussion

Part 1 - What do you think are the opportunities, benefits or concerns in relation to accountable care from the perspective of the following organisations? Each group will be allocated one organisational type.

Commissioners	GPs / Primary Care	Acute Hospitals	Local Authorities	Community / Voluntary and Community Sector / Mental Heath

Part 2 – What implications might these opportunities, benefits or concerns have on governance?

Key Elements of an Accountable Care System

Irrespective of the type of accountable care you want to progress with, there are three key elements that a system needs to focus on

1 - Defining the Care Models and Pathways that refocus service delivery	***The care model:*** • Sets out the **outcomes and benefits** you want your system to deliver • Can be broken down into care and clinical pathways which are aligned to benefits • Frames the requirements for the type of **interventions and services** required
2 - Designing the System Operating Model that enables you to focus your limited resources and manage the flow of people through the system	***The System Operating Model:*** • Sets out all the **functions and capabilities** that will enable delivery of the care model outcomes • Supports systems to make **decisions and local choices** on how, who and where functions will be delivered and the **requirements** for this – Technology, Process, Workforce, Estates, Data etc. • It enables informed decisions about where you **need to invest**
3 - Realigning the incentives in the system to enable the new model	***Realigned incentives:*** • Built around **keeping people out of hospital** • **Changing the flow of money** across the system • **Contracts, payment schemes and models** aligned with incentives • Need to be underpinned by a **clear framework for measuring outcome based performance**

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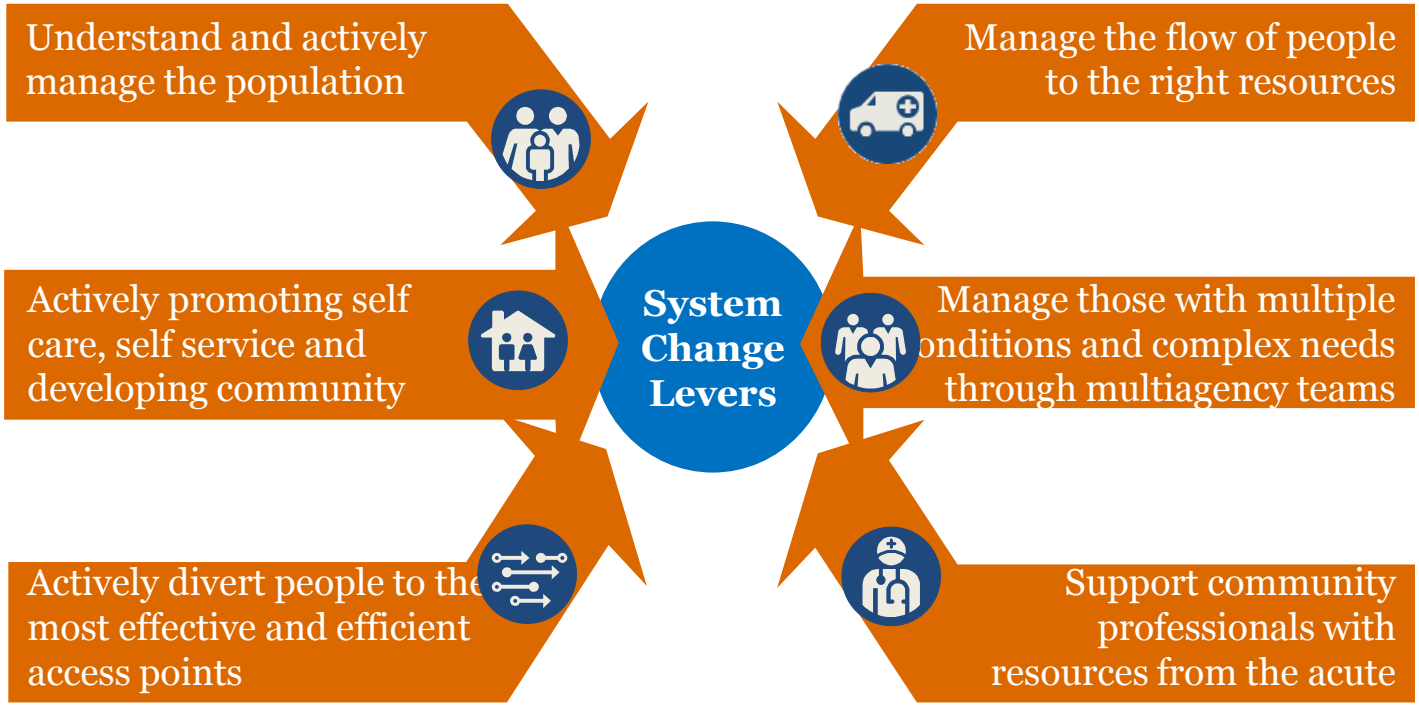
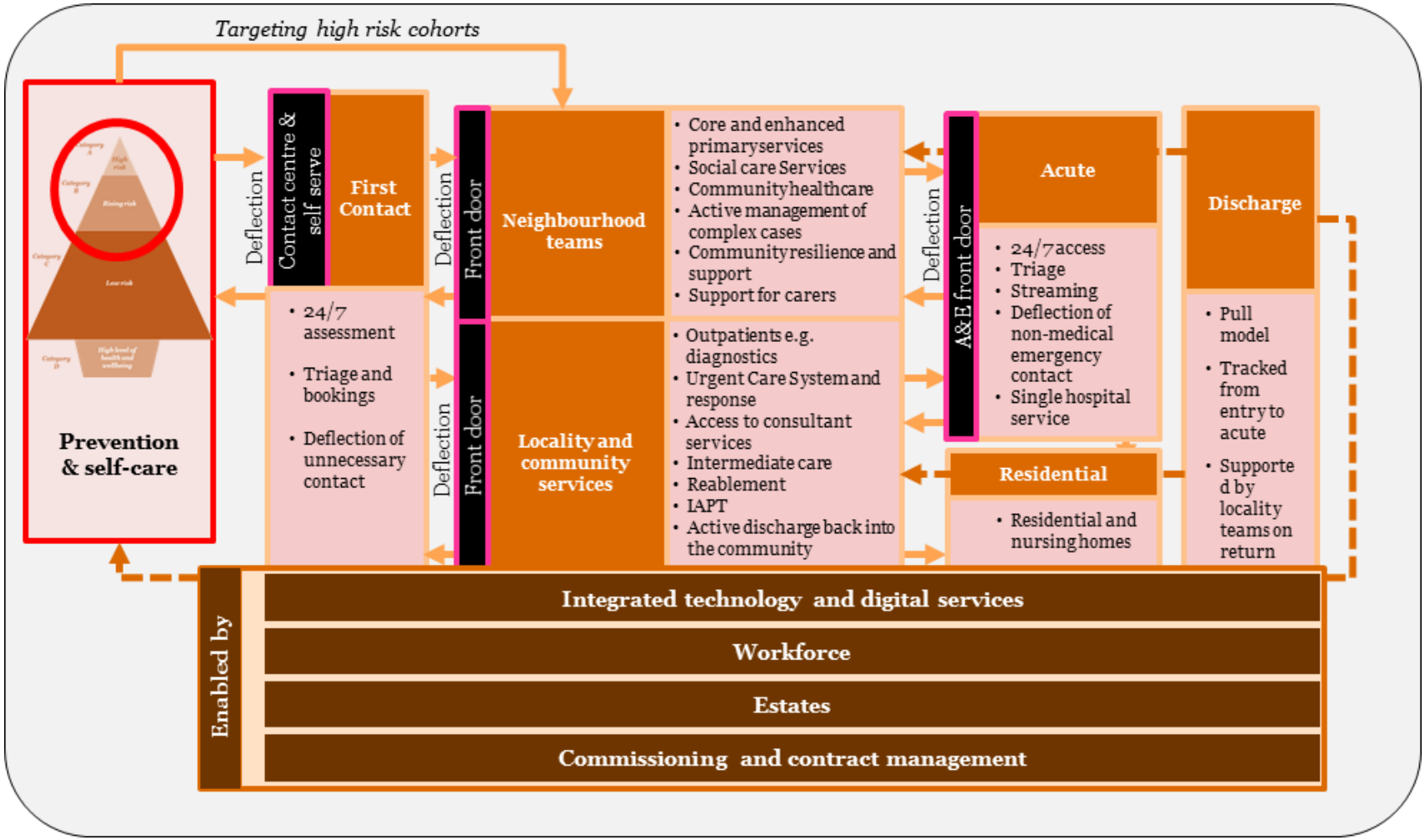
Only through focusing in this will you be able to achieve the desired change levers

The underpinning thinking behind these levers is to :

- Move to active population health management
- Manage flows of people and resources through the system
- Focus resources on the risk stratified cohorts that drive demand / cost
- Enable investment in early intervention / prevention



Example - System Operating Model functional view



PwC's View Of Key capabilities and functions

The PwC ACS functions and capabilities framework

1. Strategy and vision

2. Leadership and governance

3. Population Management	4. Resource and delivery management	5. Care Model Service delivery	6. Strategic and financial management
• Call triage and management • Referral management • Booking and scheduling • Information gathering and Assessments • Care coordination • Care Management • Health and care analytics	• HR and Workforce Development • Workforce planning and scheduling • Service capacity management • Commissioning, payments and incentives • Contracts and provider management • Staff management and supervision • Quality and Assurance	• Services and interventions	• Business and locality planning • Financial management and control • Costing and actuarial analysis • Outcome measurement • Capital planning and investment • Local and national reporting

7. Data, information and technology

Contact Management System	Single shared record	Capacity and demand management system	Screening /algorithm system	Diary Management	BI and analytics	Case Management system	Tele-phony	Mobile working technology	Digital apps

8. Continuous quality improvement

.....some of these may be found in current providers and commissioning organisations; some are new and will need to be developed

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Principles for effective whole system working

Principles for effective whole system working

1	2	3	4
Compelling core shared purpose	Strong clinical / non clinical leadership	Capability and capacity to deliver	High quality interpersonal relationships
5	6	7	8
Communication	Engagement and accountability	Agreed approach to arbitration, collaboration and competition	Shared risks and benefits supported by clear agreed data

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Q&A Session

Over to you…

Are there any challenges you are facing in your organisation / system that you would like to put to the PwC panel / colleagues in the room for discussion?

Recap of key learning points and key concerns and close