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INSIDE EDGE

Accountable Care Organizations: Managing Populations, both Patient and Physician

EXECUTIVE SUMMARY

Welcome to the next era of population health management, aka accountable care organizations or ACOs. As one of the payment-reform pilots included in The Affordable Care Act of 2010, ACOs are local healthcare organizations that are accountable for the entire care and costs of a defined population of patients. They differ from traditional managed care in that they give providers much more autonomy as well as financial incentives to practice better care. ACOs are also more flexible in framework, which meets the particular American need to maintain local patterns while achieving higher quality at lower cost.

While it will likely take a decade for ACOs to replace the current fragmented-care and fee-for-service system, the advent of the ACO model promises a new era of management and governance. Managing population health is inherent in the ACO concept, but so is managing physician practice. The difference is that clinicians will be largely in charge of their own management—and will do so armed with sophisticated, authoritative data generated by robust IT platforms and data warehouses.

For this issue of Inside Edge we talked to experts at health systems on the West Coast, East Coast and in the Midwest who are deeply involved in their organizations' thinking and planning for the ACO vision. While many details are yet to be published by the Secretary of HHS, most aspects of an ACO are familiar but only now viable. For a less anecdotal, more didactic review of ACOs, excellent teleconference presentations are available to SI members on the Scottsdale Institute website by SI sponsors CSC ("Accountable Care Organizations," Tom Enders, Bob Reese, 9.21.10) and Deloitte ("Can Accountable Care Organizations Control Costs and Improve Quality?" Robert Williams, William Copeland, 10.6.10). Log in at www.scottsdaleinstitute.org and go to "Members Only, Teleconferences."

Accountable in Cleveland

University Hospitals Health System (UH) in Cleveland, a nine-hospital system serving northeast Ohio, owned its own health plan until four years ago when it divested itself of the unit due to a lack of scale. However, the organization's experience with the insurance arm taught it a valuable lesson that shapes its approach to accountable care.

"When we were presented with the prospect of ACOs," says Tom Zenty, UH's CEO, "we wanted to make certain that as both provider and payer we could analyze and impact both sides of the ACO equation." Without a health plan and yet self-insured, UH found the ACO model offered a great way to combine that dual role for its employees and their dependents. UH will enroll more than 20,000 employees and their dependents in the new ACO framework on January 1, 2011.

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University Hospitals

Tom Zenty, CEO, University Hospitals Health System

The health system launched the analysis in July 2010.

"We analyzed claims information of more than $100 million annually for our employees and their dependents. This gave us tremendous clarity on our healthcare costs and trends which allowed us to focus on future wellness initiatives, identify areas for acute and chronic care intervention, and measure outcomes."

The ACO demands hard-eyed business acumen.

"We're treating this as a $100-million corporation," says Zenty, who serves on the board of the American Hospital Association and is past chair of Health, Research, Education and Trust (HRET). "It needs to be longitudinally managed and well understood prior to the implementation of a CMS Eligible Program."

Branding an ACO

To that end, UH has created a separate legal organization with its own leadership structure, including the role of president, who will oversee provider relations as well as a staff that includes nurse practitioners and nurse care coordinators for patients.

The initiative required UH to thoroughly examine all its insurance claims to determine who is receiving and providing care and to understand healthcare patterns. This was followed by a thorough review of the health system's IT infrastructure to support ACO processes and a subsequent selection of a third-party to provide web tools for critical functions like health-risk assessments and disease management.

A robust reporting mechanism is critical to an ACO. "We want to make certain we give executives the right dashboard," he says.

To get an edge, UH joined the Premier Healthcare Alliance, which is sponsoring an ACO collaborative. "We signed on with the Premier Collaboration and we're only one of 21 organizations in this Nationwide Collaborative," says Zenty.

Identifying outliers

UH has also closely examined its employee population to determine their employees who rely on doctors outside its provider network. While the vast majority stay within the network, the health system is working closely with individual practitioners, group practices, and faculty to include them in their ACO.

Under the ACO Model, employees will have to select a PCP and undergo a health assessment in the first quarter of 2011 which will include biometric screening and will encourage participation in wellness and prevention programs. "This data will help us risk-stratify our population to identify employees that will benefit from our Coordinated Care Program," he says.

Opening eyes

Greater scrutiny comes with the ACO turf. "One of the benefits from this ACO initiative is that it requires the organization to rigorously focus on how our healthcare dollars are being allocated. We found some employees actively using the ER for their primary care. We also found instances of very expensive care that could have been provided at much less cost if managed appropriately," Zenty says. "It forces you to look carefully. It's opened our eyes to create

that baseline to better enable caregivers to provide the best care in the most appropriate setting."

UH plans to continue using a third-party administrator for its self-insurance program and to run aspects of its ACO. "The ACO model requires you to not only be self-insured but be self-reliant. By some measures we're combining outsourced and insourced approaches. A Physician Executive, Dr. Eric Bieber, has been selected to oversee the unique operation and also serve as the Health System's Chief Medical Officer," he says.

While it's difficult to predict the cost involved in the ACO effort, says Zenty, "We're expecting to see a slight increase in costs. There will be more visits to primary care physicians early. However, through preventive strategies like colonoscopies and other appropriate screenings, overall costs should ultimately decline."

Medicare ACO Demonstration Projects will begin January of 2012, notes Zenty, "So, we wanted to be early to market. Regardless there's no doubt that we'll have a better coordinated healthcare system for our employees and their dependents."

Norcal ACO

When Jeff Burnich, M.D., arrived at Sutter Health three years ago, he was charged with achieving clinical integration from the physician side, a logical next stage in a career devoted to improving quality of care through sharing best practices. He is now responsible for exploring an even larger potential integration effort—that of determining whether the Sacramento, Calif.-based Sutter Health will seek some form of ACO status as one way to embrace the characteristics of a truly patient-centered healthcare network.

"Shifting the focus from episodic to integrated care is fundamental to providing quality and affordable care—where, when and how patients want to receive it. Whether or not we seek ACO status, this is a longstanding element of Sutter Health's integration strategy," Burnich says. "Health care reform simply increases the urgency to transform the way we care for patients and manage healthcare delivery."

Sutter Health
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Jeff Burnich, MD, senior VP, Sutter Health

Burnich's role as SVP & Executive Officer of the Sutter Medical Network, made up of nearly 5,000 Sutter-affiliated physicians who work in foundations and IPAS, has guided collective efforts around quality, consistency, service and affordability—a natural connection to the patient-centered, integrated ACO.

"I was brought aboard to bring IPAs and Sutter's five medical foundations together to provide a convenient, organized care system for patients," Burnich says. "We prioritized aspects of care important to patients' overall experience, like quality, wait times, online services and overall patient satisfaction. Then we set standards of participation in the Network, with each physician organization agreeing to meet or exceed these standards.

"We take these commitments seriously and, as a Network, hold each other accountable. When a physician organization falls below the standards, they are required to submit a performance improvement plan."

"Shifting the focus from episodic to integrated care is fundamental to providing quality and affordable care—where, when and how patients want to receive it."

This work, among other efforts, has favorably positioned Sutter Health as they consider applying for ACO status.

In California, some systems are choosing to partner with commercial payers to ramp up for ACO eligibility. In April the California Public Employees' Retirement System (CalPERS) launched a Sacramento pilot to reduce costs while improving quality led by Blue Shield of California, Hill Physicians Medical Group, a San Ramon-based IPA, and Catholic Healthcare West (CHW), a San Francisco-based 41-hospital health system that operates the local Mercy hospitals. The effort aims to provide comprehensive healthcare services to CalPERS members using a "virtual integrated model" of coordinated care in which all players will share information--and financial risk.

Need for clarity

Also, in May, HealthCare Partners, a Torrance-based medical group and IPA, and Monarch HealthCare, an Irvine-based medical group IPA, announced they were collaborating with Anthem Blue Cross to form an ACO pilot led by the Engleberg Center for Health Care Reform at Brookings and The Dartmouth Institute for Health Policy and Clinical Practice.

The federal CMS stipulates that interested organizations submit an ACO plan by April 2011 for implementation beginning January 2012. The potential ACO must commit to being responsible for the care, quality and costs of a defined Medicare population of at least 5,000 Medicare beneficiaries with an initial contract term of three years.

To help guide its ACO work, Sutter Health joined two ACO collaboratives: the American Medical Group Association and the Brookings-Dartmouth collaborative, which is led by Elliott Fisher, MD, and Mark McClellan, MD, PhD.

Brainstorming

As Sutter Health considers ACO status, leaders across the organization (half of whom were physicians) gathered in September for a visioning session—not so much about how to form an ACO—but to further the organization's vision for elements critical to an ACO, including population management, care coordination, quality improvement and affordability.

Using a rapid-cycle development process used in many high-tech industries, Sutter Health leaders agreed upon the vision and roadmap to further its efforts toward delivering accountable care to a population.

"Population management requires a broad mindset with an emphasis on quality, service, affordability and patient satisfaction. Just like within our current integrated system, patients will want to stay with an ACO if it was great at offering those things," Burnich says.

Sutter Health has a major initiative focused on variation reduction that is meant to both create a more consistent patient experience and cut unnecessary costs. Through the Sutter Medical Network physicians have access to tools that generate data so they can have conversations around where to target care variation reduction efforts.

"Physicians typically don't have behavior-changing conversations about patterns of care, even within group practices. But, we give them the tools to identify variations in care. This is valuable data that starts positive, constructive conversations and encourages agreement on where to emphasize care variation efforts collectively," he says.

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Information Security Issues and Trends
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- Derek Han, senior manager and certified HITRUST practitioner, Deloitte & Touche, LLP

November 11
Auditing RACS: Examining Provider Perceptions
- Paul Pitcher, director, Financial Systems, KLAS Enterprises

November 15
SI-Cerner Users Collaborative No. 28
- Debbie Carter, RN BSTM, director, Clinical Decision Support, Banner Health
- Joel Shoolin, DO, VP, Clinical Information, Advocate Healthcare

November 17
Meaningful Use: Implications for Hospital Systems Integration
- Mary Sedivec, principal, CSC
- Al Byrd, senior architectural specialist, CSC

To register for any of these teleconferences or to listen to ones from our archives, go to www.scottsdaleinstitute.org

Sutter Health hospitals and doctors were shown to operate more efficiently than most in a 2006 Dartmouth study that examined hospital efficiency and the quality of care provided to a particular population of patients. The results were reaffirmed with additional data in 2008.

Also important to this ability and to operation of the ACO as a whole is the EHR, which Sutter Health has used to improve physician connectivity.

"Although providing high quality integrated care to our patients is already at the core of what we do as a system, there is still much work ahead," says Burnich of the process. "By working together across the system with a common vision in the interest of best serving our patients, we will be best positioned to make decisions that are right for our patients."

Hospitals circling wagons

A slew of competing IPAs dot Sutter Health's Northern California service area. One of these IPAs is the Walnut Creek, Calif.-based Muir Medical Group, of which John Knight, MD, is a past president and past board member. He is also an orthopedic surgeon, sports-medicine specialist and CFO at Muir Orthopaedic Specialists, a 24-physician orthopedic practice in Walnut Creek that participates in the IPA.

All those hats make Knight keenly interested in the ACO concept. "The ACO is driving changes in healthcare. It's managed patient care but doing it in a coordinated fashion in terms of global billing, shared risk and cooperation between physicians and hospitals. That's why we're looking at a Kaiser model," he says.

"The issue," Knight says, "is what's the best model under which we physicians

MUIR ORTHOPAEDIC SPECIALISTS
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can work together? We're seeing a concern on the part of hospitals that they're going to be left out. My concern with hospitals leading ACO development is are docs going to be adequately represented? Each hospital seems to be circling the wagons. We need to look at the larger scale so as not to be locked into a single inpatient facility."

Part of the problem is that the federal government is still feeling its way as to what makes an appropriate ACO, he says. In the meantime, Knight is cognizant that the next 18 months are critical in filling the gaps in an ACO framework in which the Muir IPA can thrive.

Communication will be the hallmark

"We don't have any governance yet other than the existing IPA. The Hill Physicians/CHW/Blue Shield ACO is starting with an organizational structure in place. That still may be the best model, but we're being a bit circumspect about a specific model at this point," he says.

IT will be critical because whatever ACO model emerges, Knight says, "The hallmark will be communication. There has to be a much freer flow of information." Specifically communication between specialists and primary care doctors—especially between their office staffs—will require open-architecture IT. "That's going to be the challenge," says Knight. "Are you going to be able to develop that integration?"

"My concern with hospitals leading ACO development is are docs going to be adequately represented? Each hospital seems to be circling the wagons."

Internet technology companies like Google just may provide the answer. "IT platforms are changing, becoming so fluid. That's going to be a huge factor," he says.

Culture change is an even bigger factor

"ACOs are going to require a new level of coordination and collaboration between doctors and hospitals. That said, younger doctors are less and less interested in the business aspect of healthcare. But it's incumbent upon doctors that they get involved," says Knight.

ACO roots

More than 3,000 miles to the east, a provider organization with over forty years of experience in managed care has established a framework it says is an ACO in everything but name. Atrius Health, a Newton, Mass.-based non-profit alliance of five medical groups grew out of a collaboration between Harvard Vanguard Medical Associates (the descendant of the health centers division of Harvard Community Health Plan, one of the country's first HMOs) and four other multi-specialty groups with managed care experience, so it already serves as a natural precursor to an ACO.

Atrius Health, emerged in 2004 as a way for the medical groups to engage in clinical integration to expand services, to share an EHR and a corporate data warehouse and to enter into risk-sharing contracts with payers. "We take the full risk for our patients care beyond the ambulatory services that we provide directly," says Marci Sindell, chief external affairs officer. "We care for more than 200,000 patients with full risk for their medical expenses out of the total of almost 700,000 patients whom we serve."

The alliance includes 800 physicians and 1,250 other healthcare providers in 35 medical specialties at 30 locations in eastern Massachusetts. "So, when we talk about ACOs, we believe this is the right approach to improving quality in a cost-effective way," she says.

Marci Sindell, chief external affairs officer, Atrius

Zeev Neuwirth, MD, Atrius Health's chief of clinical effectiveness and innovation, agrees. "We have a very long legacy of being ACO-like." Part of that stems from experience focusing on medical management even before today's sophisticated data management was available. "We've been tracking physician practice patterns for many years, long before the time of the first IOM report."

If it walks like a.....

Atrius Health, Sindell notes, has all the earmarks of an accountable care organization. "If you look across an ACO, we've already got the legal structure to take risk and manage care, relationships with 15 hospitals, hospitalists, a clinical pharmacy service, complex chronic disease management programs, case management and intensive home-based care. These are a lot of the elements people are saying should be incorporated into an ACO."

In an example of an ACO-like relationship with a payer, Atrius has become the largest single provider group participating in Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract (AQC). Under the five-year contract that began in 2009, Atrius Health has agreed to decrease the rate of growth in healthcare expenses while making improvements in about 60 quality measures over that period.

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Upcoming issues will cover these topics:

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Contact Chuck Appleby, cappleby@scottsdaleinstitute.org with expert sources, case studies or ideas.

Zeev Neuwirth, MD, chief, Clinical Effectiveness, Atrius

"It's not just pay-for-performance," says Neuwirth. "We're contractually committed to quality improvement based on an algorithm for both ambulatory and hospital care."

Sindell says IT is key. "The linchpin really is our comprehensive data warehouse and use of our EHR to identify where patients are, do outreach to them, and proactively target patients like those with diabetes and hypertension."

Personalized medicine

The idea is to offer care tailored to individual needs at just the right level. For example, an elderly Medicare patient might require care management, or intensive home-based care including post-discharge home visits by nurses.

IT supports the collaborative care inherent in this approach with tools like "The Magic Button," a computer-display icon provided by hospital partner Beth Israel Deaconess Medical Center (BIDMC) that enables providers at Atrius Health to follow their patients' progress during a visit to BIDMC. "We also give patients print-outs of after-visit summaries that highlight what was recommended, referrals, test results and educational material," notes Neuwirth. Patients have the option of accessing the summary by visiting the "MyHealth" web portal where they can also securely e-mail their physician or track health trends.

"We have a patient-centered medical home approach. We're trying to create a system that has no cracks through which the patient could fall," he says, adding that innovation is critical to creating a better and more efficient patient-care experience.

For example, Atrius Health is one of the leaders in using shared medical appointments in which a group of patients with the same or different condition meet for 90 minutes with a physician or nurse practitioner. Within that meeting the physician balances individualized mini-visits with each patient with addressing the entire group about their common needs. "It's a unique intervention," says Neuwirth. "There are tremendous time savings at a time of physician shortage while providing patients with a built-in support group. Additionally, the physician has a team that includes a documenter, nurse, medical assistant and a facilitator to provide support during the group visit."

Conclusion

Accountable care organizations present our best vision of a healthcare system that provides individualized patient care while managing the health of the population as a whole. ACOs also require management of providers to ensure quality and cost control. The beauty of the ACO concept is that it gives providers the autonomy to manage themselves. The challenge is to do this in a way that emphasizes collaboration among all the players in the care delivery system. IT will be critical to establishing the fluid communication required in this collaborative framework. But as they say, the technology is the easy part.

"We're trying to create a system that has no cracks through which the patient could fall."

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