White Paper

Accountable Care/Shared Savings Models:
Why Healthcare Providers Need to Start Preparing NOW

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On March 31, 2011, the Department of Health and Human Services (HHS) released proposed new interim rules to help physicians, hospitals and other providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals and long-term care facilities. They bring together all of the components of a patient's care, including primary care, specialists, hospitals, home health care, etc., and ensure that all of these components work harmoniously. Under the new law, an ACO would agree to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years. The Medicare Shared Savings Program will reward ACOs that lower growth in healthcare costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

The final ACO initiative is scheduled to launch in January 2012, and many hospitals, physician practices and insurers across the country are already scrambling to form ACOs, not only for Medicare beneficiaries but for patients with private insurance as well.

Since ACOs will make providers jointly accountable for the health of their patients, providers will have strong incentives to cooperate and save money by avoiding unnecessary tests and procedures. This collaboration and cooperation will require that members have the ability to seamlessly share information.

There is often confusion over the difference between accountable care models and Patient Centered Medical Home (PCMH) models, and indeed the concepts are similar. Both are patient-centered and rely on coordinated care that is continuously improved in both quality of care and cost savings. The difference, however, is that the PCMH model is centered around a single medical practice, while an accountable care model houses many practices within one entity. Providers who are on the road to one of these models will likely find themselves well prepared for the other as well.

Currently there are approximately 72 ACO innovation models in the United States. While they all look a little different from each other, they all share a common goal: improving healthcare while reducing costs. In the next three to five years, an integrated ACO model will emerge. There is heated debate over what that integrated model should look like, but one thing is for sure: in order to survive and thrive, healthcare providers will need a way to measure their performance and report on it. If they don't begin now to start putting the components of a quality organization into place, they may find themselves behind the curve in a few years.

"There is a significant possibility that the way healthcare providers get paid in four to five years will be dramatically different than it is today," explains Mark Blatt, MD, worldwide medical director at Intel Corporation. "Hospital systems will be moving from a DRG payment system to some type of global capitation system that depends on patient outcomes. As a result, they will no longer just be accountable for providing care, but for the outcomes of that care. Payment will no longer be based on the number of DRGs or the codes that are generated, but rather on their ability to document the quality of care and the outcomes of that care. This is a distinct difference in the way the system has been operating for years, and it will require a drastic transformation in thinking on the part of healthcare providers."

Preparing for this dramatic change in workflow and the emphasis on accountability will take years. The basic concept of providing improved outcomes for patients in the lowest cost setting that is appropriate for their medical conditions will require a different way of organizing thinking at the board level and a fundamental restructuring of the healthcare business model.

"Those providers who believe that they are only responsible for care that ends at their front door are about to discover that they will be accountable in a longitudinal fashion," said Dr. Blatt. "Waiting for folks to show up sick just won't do anymore; rather, they will need to proactively go after patients to take care of them and improve their health."

Though the interim rule on ACOs won't become final until the beginning of next year, it still serves as a good guide for what is to come in the healthcare environment. And those providers that begin to work toward meeting the quality measures dictated by the interim rule will find themselves well-prepared when the final rule is published. As Dr. Blatt says, "Healthcare providers have a choice. They can either wait three to five years and see what happens, or they can begin preparing by making this transformation now. But I have a strong feeling that those who wait will probably wind up being forced to sell or go out of business."

The Technology Required

If a fundamental objective of accountable care models is to be accountable for quality outcomes, then healthcare providers will need to be able to track and measure those outcomes. Doing so on a paper-based system would be almost impossible.

"Having an electronic health record (EHR) system with exquisite reporting capabilities is critical," comments Dr. Blatt. "The more you can measure and digitize, the more easily you can generate outcome reports that document the care that you provide. The interim rule has 65 quality measures that must be reported on. The way the rule is written right now, if you miss on even one of them, you won't get paid. Many argue that the interim rule is too stringent and the final rule will probably be a bit less demanding. However, I still think the interim rule is a good guide to what providers need to prepare for."

The bottom line is that in order to become an effective participant in an accountable care or shared savings organization, healthcare providers need technology. Blatt recommends that as providers think about what types of technology will be appropriate for their practices, they should keep three things in mind: choosing the right IT infrastructure for the right work in the right venue. In other words, they should try to select solutions that are appropriate for how and where they operate their business. Flexibility is important too, in order to be able to adapt to future practice changes. And, of course, they will need to keep costs in mind, implementing the most appropriate solutions at a price that is within their long-term budget plans.

According to Dr. Blatt, the following core IT components will be necessary to prepare to meet the quality measures that will be demanded for accountable care and PCMH models:

1. **Electronic Health Record (EHR)** – At the very minimum, an EHR with documentation and reporting capabilities will be necessary.

2. **Computerized Physician Order Entry (CPOE)** – If all of the physicians in a practice aren't on a CPOE, it will be extremely difficult to capture outcomes.

3. **Patient Registries** – Registries will be helpful in better managing disease; and having a clinical decision support system to support the EHR in a robust fashion can provide real-time data analytics and reporting at all levels of an organization, which will be a key competitive advantage.

4. **Patient Portal** – Since the new healthcare models will require physicians to be accountable for patient behavior, the more ways physicians can communicate with patients electronically, the better. Patient portals can be invaluable in sending patients remote reminders, scheduling appointments, refilling medication, sending lab reports and other test results, targeting education or simply allowing patients to ask questions.

5. **Health Information Exchange (HIE)** – While ACOs will build a private computing cloud behind a firewall, at some point they will need to reach out to the public with cloud services that go beyond the firewall. For example, they will need to communicate with the first-responder system in their community. Three words will come into play: Gather, Share and Mobilize. Through the EHR, CPOE and registries, information can be gathered; an effective HIE will allow the sharing of that information and mobilization in response to it.

A Pioneer in Quality Healthcare

WVP Health Authority of Salem, Ore., is an association of over 500 primary and specialty care physicians that includes three community hospitals and one critical access hospital, all covering a two-county service area. Approximately 90,000 covered lives are represented by WVP (either through its own plans or through direct contracts with other medical insurers). Though WVP is not yet part of an accountable care model, the fundamental concepts of the ACO model, including providing quality care efficiently and cost-effectively, are nothing new at WVP. In fact, the organization has been headed in the direction of quality care since long before the passage of the Affordable Care Act or the coining of the term "Accountable Care Organization."

"As an extension of our longstanding medical management activities, for many years we've been putting into place a number of patient-centered initiatives in order to improve care and lower costs," said Greg Fraser, MD, Chief Medical Information Officer at WVP. "We've done it not because it was legally required, but because it's the right thing to do for the people in the communities we serve. An added benefit of these initiatives is that we are now in a better position for all of the changes that are imminent in the healthcare industry. The combination of our experience in medical management and in the clinical information system infrastructure has prepared us well for the mandates of Meaningful Use, Patient Centered Medical Home and Accountable Care Organizations."

Indeed, WVP (formerly Mid Valley Independent Physicians Association) has a long history of putting patient-centered initiatives in place to improve care and lower costs. In

the 1990s, the organization contracted to provide medical management for a variety of HMO plans in the state of Oregon. Since 2000, WVP has had a fully capitated health plan for Medicaid under the Oregon Health Plan, and more recently, a Medicare Advantage Plan and a commercial Medicare plan.

"The doctors in our association have a lot of experience in working together to improve care and manage limited resources effectively, which is coincidentally the foundation to preparing for healthcare reform initiatives," explains Dr. Fraser. "In fact, long before anyone ever heard of the terms 'Patient Centered Medical Home' or 'Accountable Care Organization,' many of our physician members had already begun investing in the clinical information systems that are now proving necessary to become a quality organization."

Oregon recently passed legislation that will allow the state to leverage its purchasing power with respect to Medicaid by forming its own version of an ACO called the Coordinated Care Organization. "We are watching the ACO model closely as it evolves, along with what is happening at the state level, so that we are aware of the IT requirements and can prepare to meet them," said Dr. Fraser.

"The concepts of better coordination of care, quality improvement and accountable care are not going away. We can be certain that the purchasers of healthcare, whether it be government or large employers, will be driving the transformation to accountable care in whatever final form it takes."

For a number of years, Dr. Fraser has been heading up a community EHR project. Currently, he and his team at WVP are rolling out a data center-hosted community EHR to its member practices. Though the adoption rate of the EHR among WVP physicians is not at 100 percent yet, it is quite high compared to state and national averages. Despite this, Dr. Fraser says that WVP will need even more robust technological capabilities in the future in order to achieve Meaningful Use, PCMH and the clinical integration pertaining to coordinated care. WVP is currently working with NextGen Healthcare, the provider of its EHR system, to determine a clear technological path to meet these future goals. "We know we will need better HIE capabilities, better data aggregation and normalization capabilities, and robust data analytic capabilities, because the majority of quality improvement programs will be data driven."

While none of the WVP practices have technically sought PCMH, many of them already meet or exceed tier 1 PCMH mandates. According to Dr. Fraser, it's just a matter of facilitating the application and recognition processes that are required. WVP is planning to act as a sponsor with the NCQA in order to facilitate PCMH on the part of its primary care practices. WVP has also been collaborating with the state QIO on the DOQ-IT Preventative Care Initiative and worked with its participating practices on the requirements for that program.

"The NCQA 2011 PCMH requirements have been modified to align with federal requirements for Meaningful Use," said Dr. Fraser. "Therefore, achieving Meaningful Use will get us pretty far along the road to PCMH and vice versa."

Since implementing the EHR, many WVP clinics have reported improved efficiencies and cost savings in overhead, personnel and revenue cycle management. And many have been performing their own practice-level measurements and have reported improvements in disease management and preventative care activities. The EHR has allowed WVP to assist these practices in pulling the clinical data they need for these reporting efforts.

Patients of WVP practices seem pleased with the abilities of the EHR as well. "Patients are very accepting of EHR, and we've found that patients want and expect doctors to use technology to securely communicate with them and with other doctors," said Dr. Fraser.

When asked what advice he would give to other providers that want to prepare for the future, Dr. Fraser emphasizes that being informed is paramount. "Doctors have a habit of focusing on the day-to-day work of being doctors and they tend to not pay attention to the big picture," he said. "They need to be informed and participate now while decisions are still being made, or else they won't have a say in the outcome. I think the public is counting on doctors to assume a leadership role in creating improvement in the healthcare system. Providers who haven't started investing in IT infrastructures need to get on board fast, because it will be impossible to meet the expectations of those paying for healthcare if they can't measure their performance against the quality measures that are being put into place."

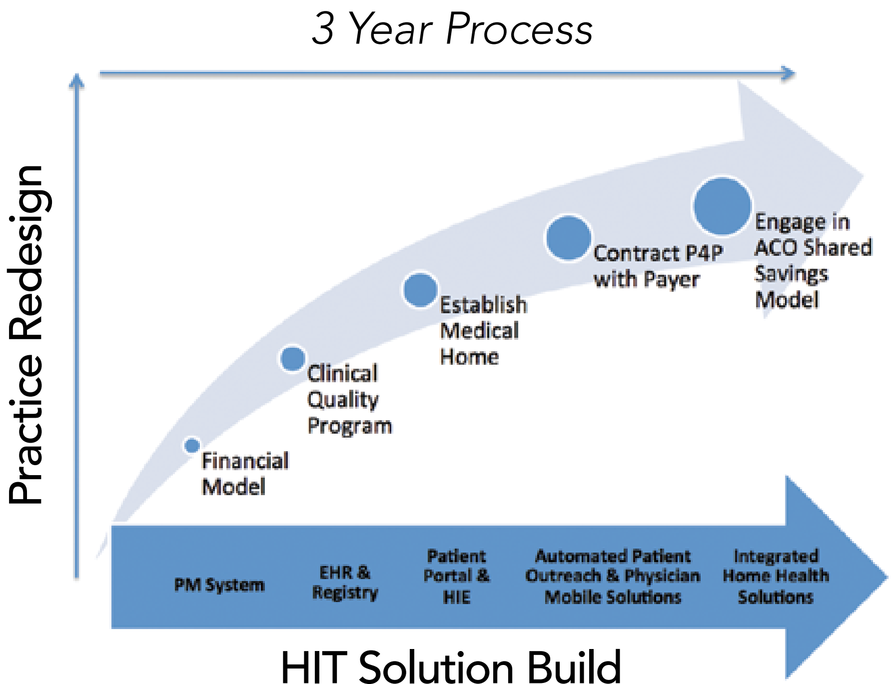
An Evolutionary Process

"All accountable care/shared savings models emphasize patient outreach and patient retention," explains Lora Baker, Manager, PCMH, ACO and PACE products for NextGen Healthcare. "The key is for healthcare providers to figure out which technological solutions are the appropriate vehicle for their specific operations and for their particular patient population. What works in St. Louis won't necessarily work in Tucson. Once providers determine what technology they need, they can begin to redesign their practices to work toward becoming quality organizations."

Baker explains that there is a fairly common evolutionary process that healthcare providers take in their endeavor to carry out the practice redesign and transformation that will be necessary to eventually meet accountable care and other health reform mandates. The average timeline for the process is about three years and can be summarized in the following steps:

1. Evaluate the current business model for the practice in terms of current costs and contracts with payers. Before going any further, a solid practice management system is needed.
2. On the clinical side, evaluate how the practice is actually delivering care. Most practices start by implementing a registry and an EHR and select three or four measures or chronic conditions that significantly impact their patient population, since patients with these conditions generate the highest costs. These conditions will vary with the geographic area of the practice. Through a registry and an EHR system, the practice can assess how it is doing in those three or four important measures. This process normally takes about a year to establish a baseline for quality and begin to show improvement. Baker says that most practices are over-confident about how well they are doing and are surprised by what the registry reveals.
3. At this point, the practice is ready to begin on the road to the PCMH model. The practice will need to select an EHR that supports PCMH with strong case management and referral management, implement a patient portal and either join a Health Information Exchange (HIE) or form one of their own so that they can begin collaborating with other physicians in the community.
4. Once a practice has transformed itself into the PCMH model, it is ready to begin negotiating P4P contracts with payers for both outcomes and medical home. As practices begin to achieve success in improving the healthcare of their patient population, the natural next step is participation in an ACO or shared savings model.

Evolution of Participation: Shared Savings Model.



Turning Fear into Increased Revenue

Many healthcare providers are intimidated by what is involved in transforming into a patient-centered care model. They wonder how they will ever have the money to purchase the necessary IT solutions or the time needed to provide such high levels of patient care. But Baker points out that, ironically, after taking the steps in the evolutionary process listed above, providers often find that they actually experience an increase in revenue.

"Putting the patient at the center of care requires adding services, and a by-product of that is the increased revenue that comes from seeing more patients," said Baker. "It's hard for many practices to understand that business can actually get better unless they actually go through the process. The team-based approach that goes along with a patient-centered model means that nurses and medical assistants do a lot more than they did in the past, and the number of patient touch-points increases dramatically."

Baker cites NextGen Healthcare client Desert Ridge Family Physicians in Phoenix as an example. Though the practice is not certified as a PCMH yet, nor has it joined an ACO, it has already cut calls to patients by 50 percent since implementing a patient portal. Patients can now get answers to their questions through quick emails rather than waiting for callbacks, and doctors have more time to spend with patients in the office.

Vendor Selection

In choosing a vendor to provide the technology to prepare for healthcare reform, Baker says that a good place to start is by evaluating whether a particular vendor's products can support NCQA guidelines for PCMH. In addition, they should extend those capabilities out to their specific patient population, making sure that the technology they choose is flexible and customizable enough to accommodate their community at the practice and physician level.

"Data is king," comments Baker. "Providers must look at the technology's ability to capture the discrete data points required to meet the quality measures in the various models out there. They should also talk to other practices that have already achieved Medical Home. Many vendors say that their technology supports Medical Home, but the proof is in the pudding."

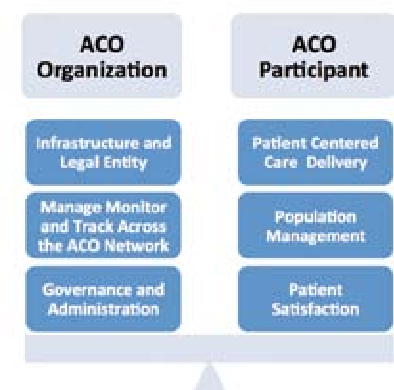
Dr. Blatt adds that practices should think about whether the ACO they join will want all its members on the same technology, and what costs are involved when updates are required. Also, be careful of hidden vendor costs, he says adding, many vendors will give one price quote for an EHR system, and then double that price when a practice decides to pursue Meaningful Use.

"Before signing up with an ACO, it's important to find out beforehand what the technological requirements will be, how you will connect and share data and whose system you will be expected to use to do so," said Blatt.

The Yin and the Yang of an ACO

There are two components to an ACO: the governance side and the participant side. The governance side is the legal entity that provides the ACO infrastructure and is responsible for managing and tracking the provider participants, working with payers and ensuring that data is integrated and pushed down to the participants. The participant side, in turn, actually provides the quality patient care.

"Both sides of an ACO must be in balance in order for it to work," said Baker. "If the ACO governance isn't providing the proper infrastructure and following the guidelines or if the participants aren't doing their part to provide and track quality outcomes, the whole system will fall apart."



Will the Healthcare Industry Get Social?

Social media has become embedded in society, affecting virtually every aspect of our lives, from relationships to business endeavors and everything in between. Most businesses are finding that in order to compete effectively in today's marketplace, they need to develop some type of presence in the social media networks, such as Facebook and Twitter. When it comes to making purchasing decisions, more and more consumers are looking to the social media for honest, reliable information on products and services. Yet while most businesses scramble to establish a social media presence, the healthcare industry has been slow to jump on the bandwagon. This is partially due to the conservative nature of the industry. In addition, the need for confidentiality in healthcare seems to fly in the face of the very public nature of the social networks.

Yet Mark Blatt, MD, and worldwide medical director at Intel Corporation, believes that the social networks offer a vital opportunity for healthcare providers as they harness technology to keep in step with the changing face of their industry.

"The healthcare industry of the future is going to depend on providing and documenting quality care," said Dr. Blatt. "It will no longer work to simply wait for patients to come in the door sick. In order to survive, providers are going to have to go after patients and try to prevent them from getting sick or sicker. It will require a high level of communication with patients and with other doctors for the coordination of care. The social networks are the perfect vehicle for this type of communication."

Dr. Blatt understands the need for privacy in healthcare, but he believes there is a way to use the social networks and still maintain discretion. Admittedly, this is a challenge, but the solution may be as simple as obtaining permission from patients to communicate and share information with them over the social networks.

"I'm not sure exactly how it would work, but I think the possibilities are unlimited and exciting," said Dr. Blatt. "Imagine a practice having a Facebook page for all of its patients with diabetes, so that they can track things like insulin usage and sugar levels. Or imagine allowing patients to join a practice's Tweet list to get health updates and news. The possibilities are endless!"

The social networks are here to stay and promise to become an even more embedded element in the fiber of our society. And that means that, like it or not, healthcare providers are going to have to begin thinking about ways to use the social media in their business operations as they face the inevitable demand to become quality care organizations.

Conclusion

We are facing a revolution the likes of which we haven't seen in generations. As with any unknown situation, it's an intimidating time. But it's also an exciting time. Most healthcare professionals agree that the existing fee-for-service payment system and the spiraling costs that go with it are no longer sustainable and that change is long overdue. While they may disagree on exactly what form that change should take, the general principles that underlie it are universal: healthcare providers need to find ways to provide better care to the people they serve, and to do it in a more cost-effective manner. The most optimistic among them strongly believe that if healthcare providers work together, they can find the best way to not only survive, but to help create the healthcare system of tomorrow.

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