



A Private Foundation Working Toward a High Performance Health System

In Focus: Building Accountable Care Organizations That Improve Quality and Lower Costs—A View from the Field

Summary: *In less than 18 months, Medicare will launch a shared savings program to reward primary care physicians, specialists, and hospitals that form accountable care organizations and collaborate in the redesign of care processes, improve care coordination, and promote high-quality, cost-efficient care. To receive payment, providers must demonstrate the impact their efforts have on specific quality-of-care and cost-reduction goals. Doing so is no small task. Quality Matters asked organizations that have been working toward these goals what advice they have for others.*

By Sarah Klein

An important feature of the health reform legislation passed in March 2010 is a provision that enables Medicare to reward health care organizations that meet quality-of-care and cost-reduction goals with a share of the savings that result. To participate in the program, health care providers must organize themselves into accountable care organizations (ACOs)—a term used to describe entities that take responsibility for the quality, outcomes, and cost of care delivered to a population of patients across institutional settings.¹

Different organizational structures can be leveraged to create accountable care organizations, but the ACO model is intended to encourage participating primary care physicians, specialists, and hospitals to work together (and potentially with long-term care providers) to ensure the care they deliver is well coordinated and designed to benefit patients and reduce waste. Because the savings to be shared are achieved by eliminating unnecessary expenses and improving quality, the model focuses providers' attention on areas of health care delivery that are fragmented, inefficient, and inconvenient for patients. Many physician groups and integrated delivery systems are evolving into ACOs independent of Medicare. In partnership with private insurers, they focus on preventing chronic disease, improving transitions between caregivers, and avoiding preventable hospital readmissions—interventions that offer little financial benefit for providers under the current fee-for-service system.

The Centers for Medicare and Medicaid Services (CMS) has until 2012 to establish the shared savings program for ACOs. Although the cost-reduction targets and quality measures are not yet established, health care organizations ranging from independent practice associations to hospitals and integrated delivery systems are gearing up to participate. Each must agree to be accountable for the overall care provided to at least 5,000 Medicare fee-for-service beneficiaries, have enough primary care physicians to meet the needs of that population, and have a legal structure in place to reward participating providers and suppliers.

For guidance, many health care organizations have joined learning collaboratives such as the Brookings-Dartmouth ACO Learning Network, Premier, Inc.'s ACO Collaboratives, and the American Medical Group Association's (AMGA) Learning Collaboratives, all of which enable organizations to learn from one another how to plan and implement ACOs and achieve quality improvement and cost reduction goals. Many of these collaboratives divide their participants into two groups: those that have legal entities in place to serve as ACOs, coordinate care, and are even prepared to take financial risk for an entire population of patients and those that need support to reach that stage.

The need for such guidance is great, as the organizational, financial, and cultural challenges these health care organizations will face are significant. Operating an ACO "is a very different mindset. It involves prevention and wellness and organized systems of care to basically keep people out of the hospital instead of trying to put people in," says Don Crane, president and CEO of the California Association of Physician Groups, which includes 150 independent practice associations and multispecialty groups that operate as ACOs in California. To do so effectively, hospitals and physicians "have to psychologically and culturally come to grips with making a profit margin based on appropriate utilization that produces savings—utilization less than the capitation or utilization less than the benchmark. It's all about managing the expense side of the profit-and-loss statement rather than the revenue side."

Making this transition is also a challenge when it is not yet clear how committed Medicare is to the model, nor how many other payers will support it. Providers must work carefully to ensure that the programs they design to reduce costs and

improve quality remain within their margins. "They are going to need to know how much it costs to take care of a certain population and how much they can live with for payment," says Julie Sanderson-Austin, R.N., the AMGA's vice president of quality management and research.

While the work of the collaboratives proceeds at quick pace in anticipation of the 2012 deadline, CMS is engaging the 10 health care organizations that participated in its five-year Physician Group Practice (PGP) Demonstration to help resolve some of the outstanding issues related to quality and cost measurement, which run to the core of the shared-savings calculation. The PGP demonstration, which began in 2005 and ended in March of this year, enabled physician groups to share up to 80 percent of the savings they generated above a minimum threshold by improving quality and reducing costs.

CMS is in discussions with the PGP demonstration participants about transitioning them to a shared savings program before 2012. By working with PGP participants who have extensive experience redesigning care processes, implementing care management strategies, and targeting populations likely to benefit from more intensive primary care services, CMS hopes to refine its quality measures so they reflect the needs and priorities of elderly Medicare beneficiaries and account for the quality of care transitions, among other issues. The five-year demonstration focused on highly prevalent conditions such as heart failure and diabetes. Other conditions that might lend themselves to more focus and quality measurement include chronic obstructive pulmonary disease and depression, says John Pilotte, director of the division of payment policy demonstrations at CMS.

"We would all like to have quality measures that produce actual cost savings. That's what we are after," says James T. Rogers, M.D., chair of the department of primary care at St. John's Health System in Springfield, Mo., one of the 10 groups that participated in the demonstration. Examples of such measures include the use of angiotensin-converting enzyme (ACE) inhibitors and beta blockers in patients suffering heart failure and decreases in preventable hospital readmissions.

To gain a sense of the challenges health care organizations are likely to face as they work to establish accountable care organizations, *Quality Matters* interviewed leaders of several organizations that participated in the PGP demonstration and/or are participating in ACO learning collaboratives. We asked them to discuss the challenges they faced and offer advice for those just beginning the process of creating an ACO. The message from these leaders and other experts was fairly consistent: prepare for resistance from providers to a sea change in culture; invest in financial measurement systems that enable reliable cost estimates; and don't underestimate the challenges of reaching agreement between hospitals and physicians.

St. John's Health System

Springfield, Mo.–based integrated health system with 460 physicians and six hospitals that participated in the Medicare Physician Group Demonstration.

Interventions include:

- Uses a registry to track patient information, identify gaps in care, and ensure timely care is delivered. The registry includes a visit planner, which reminds physicians of needed tests and interventions at the time of the patient visit.
- Reviews all hospital readmissions that occur within 30 days of discharge and follows up with physicians to point out how the readmission might have been avoided. In some instances, the reviewers suggest that physicians consider hospice care as an alternative to hospitalization.
- Deployed a case manager to the emergency department to serve as a bridge between the emergency and primary care physicians. "Frequently they could find a way to provide service to the patient that did not require hospitalization," Rogers says.

Moving forward: Plans to build a similar bridge between the nursing homes and health system's hospitals to avoid unnecessary admissions and improve communication between nursing home and hospital providers. Rogers believes having a call-in center that enables nursing home staff to consult physicians before sending a patient to the hospital will avoid admissions on nights and weekends, when there are fewer nursing home clinical staff.

Everett Clinic

Everett, Wash.–based multispecialty medical group with 300 physicians. Participated in the Medicare Physician Group Practice Demonstration.

Interventions include:

- Increased the use of evidence-based guidelines for medical imaging by embedding a checklist into the electronic medical record, which reduced variation among providers and led to a 10 to 20 percent decline in imaging orders in one year.
- Uses a hospital-based transition coach modeled on the Care Transitions Program at the University of Colorado Denver to support patients with complex needs after discharge from the hospital. The coach, who makes home visits, performs medication reconciliation services, and follows up with patients via telephone, helps to increase

continuity across settings and ensure patients understand how and when to obtain follow-up primary and specialty care. This program led to a 7 percent reduction in costs in one year.

- Provides electronic patient reports to physicians to improve cancer screening rates and treatment of chronic conditions, including diabetes and heart disease.
- Through a separate initiative with Boeing Corp., the clinic also implemented a care model that intensified primary care services for patients with complex chronic conditions. The program provides these patients with psychosocial and behavioral health services. A nurse case manager plays a key role by planning visits, interviewing patients, and helping to facilitate weekly team rounding by the physician, care manager, and the pharmacist to discuss patient progress. The program saved Boeing 20 percent after program costs and case management fees, primarily by reducing hospitalizations and emergency department visits.

Moving forward: Will expand its use of the complex case management program to other populations and expand its use of end-of-life planning programs.

Billings Clinic

A Billings, Mont.–based integrated health care delivery system with one hospital, more than 250 physicians, and a long-term care facility. The clinic participated in the Physician Group Practice Demonstration.

Interventions include:

- Increased focus on delivering preventive services at the time of patient visits and identifying gaps in care.
- Improved management of diabetes with the use of disease registry and electronic medical record modules. A majority of the clinic's primary care physicians have achieved recognition from the National Committee for Quality Assurance for their outcomes.
- Redesigned heart failure care program, which includes a nurse-directed patient monitoring system. The program reduced all-cause hospitalization for participants by 40 percent. The results have been sustained over three years.

Moving forward: Will increase the number of primary care physicians in its system and expand on its financial reporting system. "You have to do some sophisticated modeling of where you are going to make your investments in change and care processes," to determine if you will have a return on your investment, says F. Douglas Carr, M.D., medical director, education and systems initiatives at Billings Clinic.

Carilion Clinic

A Roanoke, Va.–based integrated delivery system that includes eight hospitals and 525 employed physicians (as well as 75 affiliated physicians), undergraduate and graduate medical education, and home care operations. The clinic is affiliated with Virginia Tech.

Partial summary of interventions:

- Increased physician leadership and accountability for quality, patient satisfaction, and efficiency of operations using a scorecard that monitors patients' access to care, performance on core measures, patient satisfaction, and measures of resource management. Its physician leaders are paired with administrative counterparts and focus on achieving quality and cost reduction goals. The neonatal intensive care unit team engaged a multidisciplinary team of providers in reducing the length of stay for premature infants. By scouring the medical literature for information on when it is safe to send a premature baby home, increasing outpatient primary care and specialty care after discharge, and developing a loaner program for in-home monitoring equipment, the unit has reduced its average length of stay from 29–30 days to 24–25 days in one year.
- Increased primary care capacity by adding nurses and nurse practitioners to practices to serve as care coordinators and established a culture focused on teamwork, shared success, and collaborative, integrated planned care. "You have to speak to that just constantly and look for ways to reinforce that," says Mark Werner, M.D., Carilion Clinic's chief medical officer.
- Improved population management by focusing on patients with heart failure and coronary heart disease, epilepsy, and stroke. For example, a team of specialists and primary care physicians developed guidelines for how to approach the care of heart failure patients in both primary and specialty care settings along with guidelines establishing when patients should receive additional workup and when they should be referred from primary to specialty care.

Moving forward: Developing partnerships with other payers to support its accountable care model.

Lessons from the Field

Each of these organizations has spent close to five years implementing these interventions and redesigning care models,

which should serve as a caution to others of the investment in time and resources required to orchestrate such changes. "We've been doing this full-court press for four years and we're not done yet," says Ed Murphy, M.D., president and CEO of Carilion Clinic. "It's a decade-long transformation. If you think you have a 10-year horizon [before the business/payment model has to change], don't wait."

For many of the organizations, one of the most difficult lessons was that quality improvement and cost savings do not go hand in hand. Indeed, while all 10 of the physician groups in the demonstration hit their quality targets, only six met the cost-savings goal required to qualify for shared savings. "If everyone gets 100 percent of the quality measures and that's the only thing they do, I guarantee, they don't receive cost savings," Rogers says. Achieving savings may require substantial redesign in care models to prevent hospitalizations and care transitions programs to prevent unnecessary readmissions. Even then savings are not guaranteed.

To qualify for the PGP demonstration, all of the groups had to demonstrate extensive clinical and administrative integration, as well as organizational leadership. What the demonstration proved was that while those are important factors, they alone are not enough to qualify for shared savings, says CMS' Pilotte. "It seems that the groups that have been most successful under [the PGP demonstration] have multiple initiatives under way. It's not just limited to a specific chronic condition or some specific area. There are organization-wide changes under way that are multifaceted," he says. Key elements include: having strong leadership and buy-in throughout the organization.

Health information technology also played an important role, Pilotte says. "Most of these groups have or have put in place some sort of electronic health record system, as well as patient registries and other tools to help them aggregate data that they can use for population management, as well as feedback to their physicians—many on a real-time basis and at the point of care."

It's also important for physicians and other providers to be able to carefully model the cost of programs. Not all physicians have the capacity to do so. Those affiliated with health plans have an advantage because they have access to claims data with which to forecast costs. It will be much harder for organizations that are not affiliated with health plans or hospitals to do the same. CMS reports such data, but the reports are delayed. "Figuring out what it costs to take care of a population of patients in total is not easy, especially if you are not providing all of the care," Sanderson-Austin of the AMGA says. "Let's say you are a multispecialty practice and the hospital has never been willing to share how their charges are [set] or what kind of discount they are going to give. This is new territory," she says. Such information sharing must not run afoul of antitrust laws.

James Lee, M.D., associate medical director of Everett Clinic, believes CMS can play an important role in promoting cooperation between free-standing hospitals and physician groups by offering incentives for effective care transitions, as an example. Indeed, many hope CMS will send a strong signal that this is the payment model of the future to encourage robust hospital participation. "It could be done rapidly if CMS wants to," Crane says.

Nancy Foster, vice president of quality and patient safety policy for the American Hospital Association, says experimentation will help identify how ACOs can succeed. She believes they'll have a large impact on quality by helping to improve transitions in and out of hospitals. "I would expect to see fewer patients in the emergency room or their physicians' offices because they've made some misstep in their use of medications or have failed to follow through on some aspect of care for themselves after discharge. I would expect fewer times when patients come into the hospital for elective surgery but haven't had the appropriate diagnostic tests," she says.

Many also predict more team-based approaches to care and less compartmentalization of roles. "The old mindset is I have a specific job to do. It is not my responsibility what happens to the patient next," Sanderson-Austin says. That will have to change as providers learn to build teams of caregivers around them and give up some control over some aspects of care. That said, "those are difficult things to change in people," she says.

Nonetheless, Sanderson-Austin echoes the thoughts of others who see the potential in accountable care organizations to raise quality and lower costs. "It is an exciting time. I think that we all feel really energized by this. We just feel like for a change we're really going to do something in health care that results in a better system for patients."

Note

¹ The term accountable care organization was coined during a November 2006 meeting of the Medicare Payment Advisory Commission, which had gathered to discuss and recommend alternatives to using the Sustainable Growth Rate formula to calculate Medicare payments, as charged by Congress. One of the proposals was to create accountable care organizations, which would receive financial incentives for making investments in infrastructure, coordinating inpatient and outpatient care, and making improvements in quality of care. Unlike many other programs that encourage collaboration among physicians, hospitals, and other providers in legally entwined entities, the accountable care organization—as envisioned—would be more flexible, allowing for virtual integration.

[« Previous](#)

[Next »](#)

Copyright 2010 © The Commonwealth Fund | [Privacy Policy](#) |  [RSS](#) | [Twitter](#) | [Facebook](#) | [Mobile](#)

The Commonwealth Fund New York City Headquarters: 1 East 75th Street, New York, NY 10021 Phone: 212.606.3800 Fax: 212.606.3500; Washington, D.C., Office: 1150 17th Street, NW, Suite 600, Washington, D.C., 20036; E-mail: info@cmwf.org