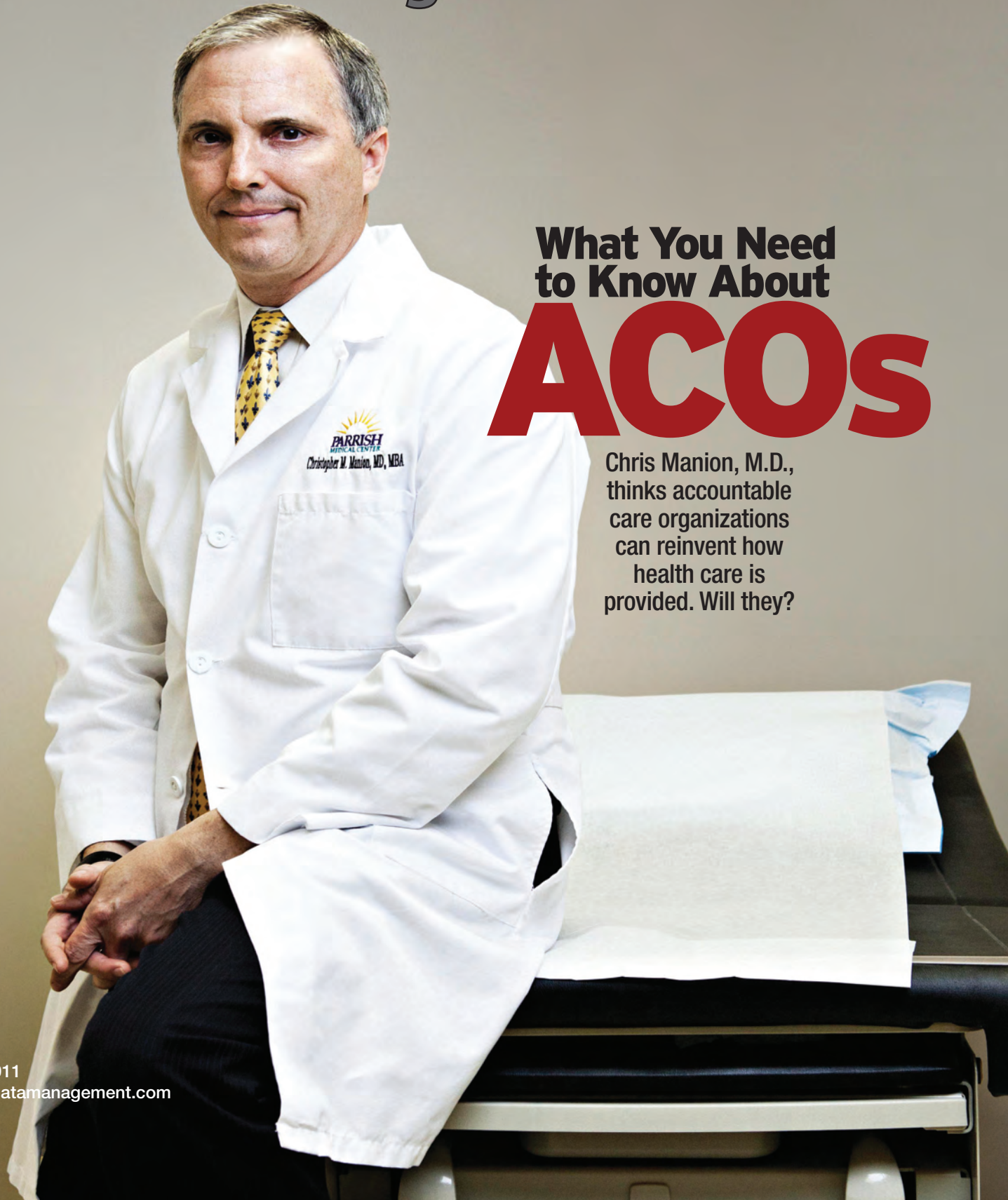


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ACOs

Chris Manion, M.D.,
thinks accountable
care organizations
can reinvent how
health care is
provided. Will they?



Getting Ready for Accountable Care Organizations

By Joseph Goedert

Providers are gearing up for new ways to deliver and pay for care while still waiting for details.

At a February HIMSS11 session on accountable care organizations packed with provider I.T. execs, the speaker asked how many were planning to be part of an accountable care organization. Nearly all raised their hands.

If the health reform law survives its legal challenges, they'll soon have the opportunity. Medicaid and Medicare ACO demonstration programs authorized in the law start in 2012, and several private insurers are getting ready to jump in with their own accountable care models.

That said, a scan of the existing health care information technology landscape suggests many providers remain years away from having the capabilities to operate as ACOs.

The HITECH Act of 2009 was designed to position the health care industry to have the information technology infrastructure necessary to support health reform. Nowhere is this more clear than in the I.T. capabilities needed to support ACOs, a model where organizations band together to tightly coordinate patient care, improve quality and population health while reducing the unsustainable annual increases in costs. ACOs that reach those goals will be rewarded via shared savings programs or other reimbursement incentives that divvy up the financial rewards.

But to attain the necessary level of care coordination and embed electronic safety checks, clinical analytics and data exchange into every step of a patient's clinical journey will require an extremely sophisticated I.T. infrastructure.

Jim Adams, managing director at the Advisory Board Company consultancy and a former leader of HIMSS Analytics, says even Stage 7 hospitals—the highest level under the HIMSS Analytics scale of health I.T. capabilities—aren't ready for ACOs. Consequently, providers should beware of I.T. vendors touting their products as fully capable today of supporting ACOs, says

Marion Jenkins, CEO at QSE Technologies, an Englewood, Colo.-based systems integrator with more than 150 ambulatory I.T. implementations. "There's a lot of Kool-Aid getting served up."

To support ACOs even in their early stages requires use of an electronic health records system with advanced support for data standards and connectivity—advancements that have built into EHR products only in the past two years, Jenkins contends.

And ACOs over time will require a lot more I.T. firepower, including pervasive connectivity, data analytics and predictive modeling technology supported with robust disease, care and utilization management applications to support care across the continuum while identifying opportunities to reduce costs.

Factor that in, and it will take four years of ACO building to get to data analytics and five years for predictive modeling, predicts Adams.

In recent months, providers have been encouraged to join prospective ACOs and accept bundled payment for an episode of care—split among all providers participating in the care—or receive a share of savings that should result from tightly coordinated care.

However, the encouragement comes *before* public and private insurers have specified what the bundled payments or shared savings will be. Government officials in February said proposed ACO rules for Medicare and Medicaid were imminent, but in the government mindset that could mean several more months.

Consequently, providers preparing to be early ACO adopters are flying blind on the financial ramifications of their decision. There clearly is not a lot of structure around how ACOs will work in the reform law, says Ken Wilson, system vice president of clinical effectiveness and quality at Norton Healthcare

in Louisville, Ky., which launched an ACO pilot last July with insurer Humana Inc. after a year of preparation. The reason for moving early was simple, adds Norton CMO Steve Heilman, M.D. "Either build it the way you want it or have it presented to you."

Norton Healthcare is partnering with Humana to figure out incentives that make sense and get access to payer claims data to analyze gaps in care, patient adherence to treatment regimens and inefficiencies such as over-utilization of medical imaging, among other issues.

Payer data is important to reaching the overarching goal of ACOs: reducing costs while improving health status. Medicare's ACOs likely will require a patient population of 5,000, but what most counts is knowing the 200 patients in the pool who are the sickest and most costly to treat, says Steve Tolle, senior vice president of physician solutions at software vendor Ingenix Inc. "This is payer data that needs to be refocused for providers," he notes.

Norton-Humana is one of five national pilot sites developing an ACO through an initiative of the Engelberg Center for Health Care Reform at Brookings Institution and The Dartmouth Institute for Health Policy and Clinical Practice. The other sites are Carilion Clinic in Roanoke, Va.; Tucson (Ariz.) Medical Center; HealthCare Partners Medical Group in Torrance, Calif.; and Monarch HealthCare in Irvine, Calif.

Some organizations, such as Parrish Medical Center and its physician/hospital organization in Titusville, Fla., initially are building an ACO on their own to learn how to do it, demonstrate benefits, then solicit expanded participation to other stakeholders in the region.

However an ACO starts, it cannot be formed in a vacuum where only a handful of top leaders make decisions, warns consultant Adams. During a HIMSS11 presentation in February, he recalled a CIO telling him that the CEO and CFO were figuring out how to set up an ACO—they'd tell him what they wanted from I.T. and he'd put it in. "That's a dangerous position because you may not be able to do what they want," Adams says.

Dave Garets, executive director at The Advisory Board Company, said a CEO recently proclaimed that his hospital was going to become an ACO and expected to be fully ready by August. But just getting the information technology infrastructure in place to fully support an ACO is a five-year project, he estimates, although ACOs can and will start with more limited I.T. capabilities.

Regardless of the pace that providers will launch their ACO initiatives, CIOs and I.T. depart-

ACO Leadership Roles for Hospital Executives

CEO: Set strategic priorities and drive change management efforts.

CFO: Secure financing for information systems implementation and provide guidance on new revenue cycle management technologies.

CMO: Drive rapid physician adoption of new I.T. systems and set new credentialing rules to ensure that future physician utilization is mandated.

CIO: Identify gaps in I.T. staff skill sets to determine employee and contractor needs, and manage sequencing of deployment to still meet meaningful use on time.

CMIO: Bridge the communications gap between I.T. and physicians, and provide guidance on the realities of clinical practice as I.T. systems are selected and deployed.

CNO: Drive nursing adoption of relevant I.T. systems in partnership with the chief nursing information officer, and identify nurses who can serve as department leaders and physician trainers.

Source: The Advisory Board Company, presented at HIMSS11 in Orlando

ments already are overwhelmed with meaningful use, ICD-10, HIPAA 5010 and forthcoming enhanced privacy/security mandates, and that's got to be considered, Garets says. "In our history, we have never had this much on our plate."

Defining an ACO

So what, exactly, is an accountable care organization? A formal definition in the health reform law would have been nice, but it wasn't supplied.

The law dances around as it explains Medicare's ACO, which is referred to as a "shared savings program." It says that HHS shall establish a program "that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under the program, providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service through an accountable care organization. ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2)."

Under the law, a Medicare ACO "shall be willing to become accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to it."

Absent a concrete, uniform definition, stakeholders are creating their own. An ACO "is the formalization of a model for health care delivery that moves at least some of the responsibility for the cost of health care to providers and has a series of organizational and legal structures to en-

able you to care for patients in different ways," says Wilson at Norton Healthcare. "It's focused around building newer methods of delivering care while cutting costs and improving care. ACO is the big roof under which a patient-centered medical home can sit. It is the overarching structure."

Christopher Manion, M.D., medical director at Community Health Network of Central Florida, a physician-hospital organization of which Parrish Medical Center is a member, provides his own definition: "In short, an ACO will be a community-based group of primary care and specialty health care providers, hospitals and related services including home care, hospices, pharmacies and laboratories that will treat patients almost as a single cohesive entity, sharing information with each other as well as with the patient.

"Typically, these ACOs will be led by a hospital or health system with the resources to marshal and manage these stakeholders into an effective clinical force. In a system where information is shared, the patient is part of the process and all parties are focused on reducing costs while improving functional outcomes, we have the opportunity to change the current system often described as 'sick care' into a true 'health' care environment with a focus on preventive care."

An accountable care organization, according to Margaret O'Kane, president at the National Committee for Quality Assurance (NCQA), an accreditation firm in Washington, is "an organization that tries to provide seamless care with the right quality at an affordable cost." ACOs, she adds, will operate at a broader level of care coordination than medical homes by working with providers under contract and financially

incentivized to provide a high level of coordination across the continuum of care.

And one more definition, from Barbara Gray, R.N., vice president of the accountable care collaborative at Premier Inc.: “ACOs are a group of providers willing and able to take responsibility for improving the health status, efficiency and care experience of a defined population. Patients also will be accountable for improving their health.”

In essence, ACOs to some degree are a return to capitated payment, primarily under the bundled payments model. But while the shared savings model isn’t capitated, Wilson of Norton Healthcare sees capitation as the future for ACOs. “At some point, you won’t be able to extract more savings from your organization.”

And the point of full or partial capitation being the ACO model will come in five to 10 years, he believes.

Asked if capitation is coming back, NCQA’s O’Kane has a quick answer: “I hope so, it works.” In five years, ACOs will look attractive to more and more providers and there will be a number of success stories to nudge others toward the model, O’Kane predicts—if all goes well. “A lot of things have to break the right way, the rules have to be written the right way and consumers have to be supportive,” she says. “If 20 percent of the population is in an ACO in five years, I would call that a raging success.”

Don’t expect domination

Still, O’Kane doesn’t see ACOs as a dominant model in health care even after 10 years “because there are so many obstacles. There’s no single answer for health care, there will be multiple answers.”

One reason Norton Healthcare started building an ACO with Humana was because Norton would rather structure the ACO its way than have another way later imposed on the organization. But another pressing reason for the ACO was that while there may be multiple answers for health reform, the reality is that insurer reimbursements will only continue to fall and Norton believes Medicaid-level payments will become the norm. That means providers have to get a lot more efficient.

The tens of millions of patients newly insured under Medicaid that could come into the nation’s health system under reform may only be the start, says Norton CMO Steve Heilman. “There’s a thought and fear in the industry that private insurance bought through state insurance exchanges will be paid at Medicaid levels,” he notes.

Core Technology Needs for ACOs

Financial Infrastructure: Validate budget goals based on beneficiary population, track performance payments received and administer chosen payment methodology (such as shared savings) to participating providers.

Reporting Infrastructure: Monthly performance reports, population management trends such as disease and case management, and utilization and practice variation reports.

Performance Management: Disease-specific dashboards, comparison of actual results to benchmark data and performance targets, and adherence to evidence-based medicine.

Data Aggregation: Aggregation and sharing of administrative and clinical data from disparate sources, and shared disease registry accessible and enriched by all participants.

Clinical Data Exchange: Hospital shares detailed procedure information and discharge plan with a patient’s primary care physician, and physician shares outpatient care history with the admitting hospital.

Role-Base Security: Access to aggregate cost and quality trends by governance and project teams, secure repository for shared aggregate and detailed data, and sharing of patient-specific clinical data between responsible caregivers.

Source: MedAnalytics Inc.

Norton and Humana initially started the three-year ACO pilot with their own employees and dependents that received care during the last two years from Norton-employed physicians. Simultaneously, the delivery system began implementing clinical changes. These included ramping up preventive care for all patients, looking for inappropriate diagnostic imaging procedures, and improving care coordination and disease management for patients with certain chronic illnesses. The ACO is tracking Norton and Humana employees and dependents to see how clinical changes affect the cost and quality of care.

In February, the delivery system and payer were waiting on the initial set of data reports for the first six months of the ACO pilot. “Generally speaking, this whole process has taken longer than any of us thought it would,” says Norton’s Wilson, owing in part to lengthy negotiations over data use agreements: For instance, if a patient leaves employment at Norton, sees a different physician outside the network or dies, “do we keep that data?” Heilman asks.

Another data issue: Norton has never had payer data—such as medications ordered, filled and picked up—sent to the organization before. Any data on patients treated by non-Norton providers must be “blinded” so the delivery system doesn’t see other providers’ ED charges, payments and other proprietary information.

Norton started the ACO with a strong inpatient EHR and a good cost/accounting system, and it is building a strong statistical group

in informatics to track quality. “We have a five-year history of quality reporting on our Web site,” Wilson says.

The delivery system has purchased the Amalga data integration, aggregation and analytics platform from Microsoft Corp. to build a data warehouse that can aggregate inpatient, ambulatory and cost/accounting data. To boost the information technology capabilities of community physicians, Norton plans toward the end of 2011 to start offering ambulatory software from Epic Systems Corp. to affiliated practices.

On their own, Parrish Medical Center and its Community Health Network of Central Florida are developing an accountable care organization.

At some point, the ACO will be opened to community employers, but initially the hospital and health network will be the pilot project, with ACO membership limited to employees. “Nobody really knows how to run an ACO, so this will help us refine our methods,” says Manion, the health network’s medical director. “This will teach us to manage a sizable population—our employees.”

Selling a concept

Parrish Medical Center is self-insured, facing annual double-digit cost increases and lacking the data warehouse and analytics capabilities to pinpoint ways to reduce costs and improve population health status. That’s one big reason for forming the ACO; the other reason is to gain the experience needed to more effectively sell the concept to other organizations when the time comes to expand.

When approaching other employers in the region about joining the ACO, "We want to be able to truthfully say that not only do we have the experience and needed skills, we have enough confidence in it that we started it with ourselves," adds Chris McAlpine, senior vice president at Parrish Medical Center. The hospital has been preparing for an

ACO-type program for several years—it would rather be ahead of the curve instead of gearing up when ACO reimbursements become real. "It's well-known that medical thinking doesn't change on a dime," McAlpine says. "We're being proactive."

Parrish Medical established a clinic for

employees and dependents in May 2009 with services and medications free to those enrolled in the self-funded health plan. That makes getting care much easier, takes away incentives to not fill medications or get them elsewhere, and improves population health.

In 2010, the clinic had 2,000 encounters and dispensed more than 2,500 medications. While final 2010 financial results aren't yet known, "it appears that the clinic concept has contributed to lowering the overall cost and helping the plan finish the 2009 year under budget," Manion says. Over time, the clinic will evolve into a patient-centered medical home, which is a cornerstone of an ACO, Manion says.

For years, health insurers have analyzed claims to drill down on how providers are giving care and the cost of managing specific populations. Now, Cigna Corp., which administers Parrish Medical Center's self-funded health plan, is sharing Parrish's aggregate claims data and the hospital is investing in data warehouse and analytics technology from MDI, Jacksonville, Fla.

Among early revelations is an 11 percent annual increase in cancer diagnoses. "This has been known by payers but now we know it too," Manion says. Knowing population health threats enables the organization to focus prevention and disease management programs among specific populations. ■

Registries a Key ACO Component

Each day, staff members at Advocate Physician Partners, the physician/hospital organization of Advocate Health Care serving the Chicago region, can run reports on patients scheduled for appointments the following day.

The reports check multiple registries—such as pharmacy, laboratory, electronic health record, oncology, chronic disease and preventive care—to identify gaps in care that physicians can address during the upcoming office visits.

Registries are relatively inexpensive, critical I.T. components under the emerging accountable care organization care model, said Lee Sacks, CMO at Advocate Health Care and CEO of the PHO. Speaking in February at HIMSS11, he advised attendees to invest in registries—and don't wait until adoption of electronic health records as registries provide valuable services even without an EHR.

Registries are part of Advocate's Clinical Integration initiative that started in

2004 and today supports registries and a data warehouse. A Web-based commercial registry is populated with data from various registries.

Advocate is preparing to participate in an accountable care organization with Blue Cross of Illinois and is looking at additional investments to support comprehensive coordination of patient care—starting with primary care physicians—across the continuum of care.

For instance, the organization will hire more than 70 care managers—many of whom will work with small physician practices—to help chronically ill patients improve their health status. Low-hanging fruit that care managers will focus on—avoidable admissions, readmissions and inappropriate emergency department visits—should help bend the health care cost curve. More use of nurse practitioners and physician assistants can enable primary care practices to see more patients, Sacks said.



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