

Medical Homes— The Path to an Accountable Care Organization?

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New Model of Care/PCMH



- A patient-centered medical home integrates patients as active participants in their own health and well-being.
- Patients are cared for by a personal physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology.
- These relationships offer patients comfort, convenience and optimal health throughout their lifetimes.



The TransforMED Patient-Centered Model A Medical Home for All



**A continuous relationship with a personal physician
coordinating care for both wellness and illness**

• Mindful clinician-patient communication:
trust, respect, shared decision-making

- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care

Access to Care and Information

- Health care for all
- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits

Practice-Based Services

- Comprehensive care for both acute & chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Care Management

- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies

Care Coordination

- Community-based resources
- Collaborative relationships
 - Emergency Room
 - Hospital care
 - Behavioral health care
 - Maternity care
 - Specialist care
 - Pharmacy
 - Physical Therapy
 - Case Management
- Care Transition

Practice-Based Care Team

- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

Practice Management

- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Health Information Technology

- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

Quality and Safety

- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

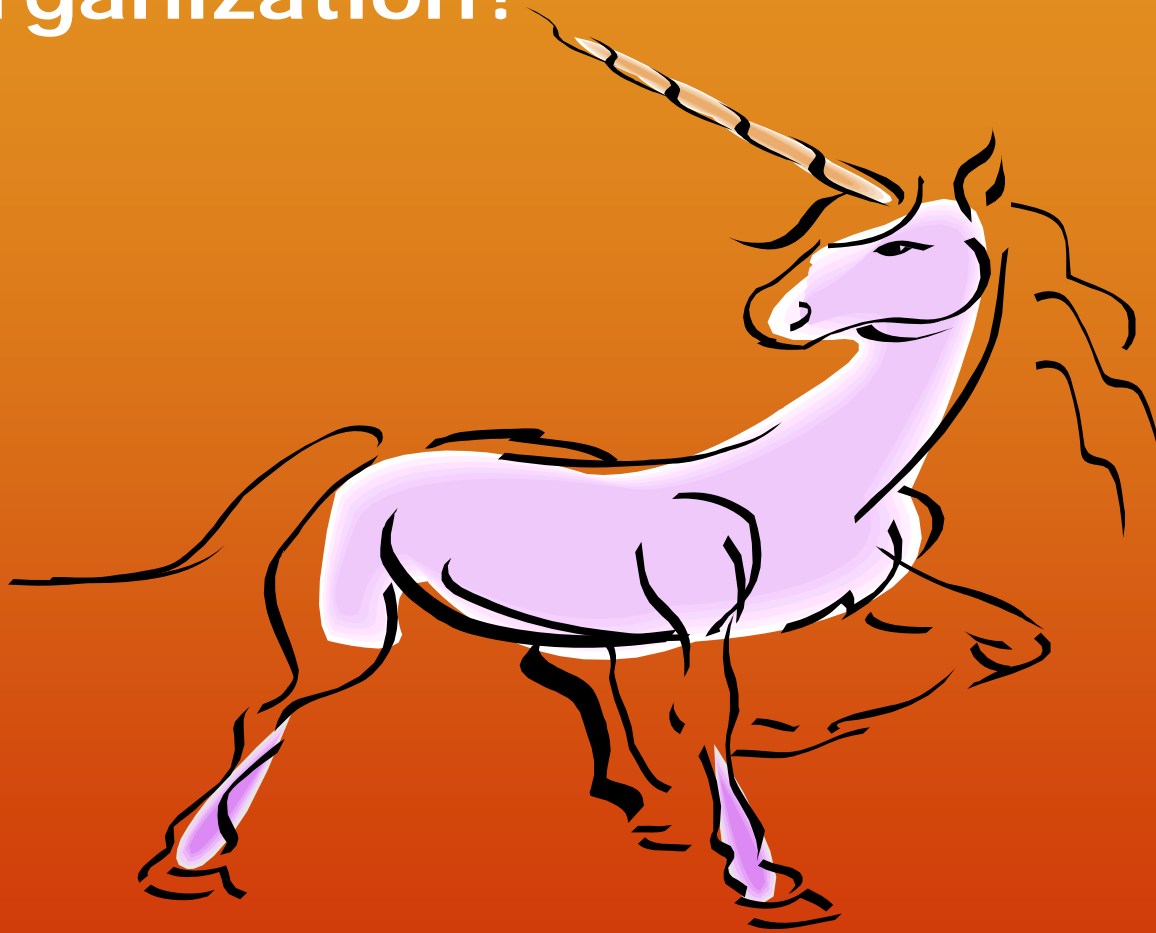
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PCMH Transformative Process

- Personal reflection and change on part of champions (physicians)
- Empowerment of team members to contribute, design and implement
- Hard work
- Time investment
- Systems level change
- Patient focus

What is an Accountable Care Organization?



ACO

A local health care organization and a related set of providers that can manage the continuum of care and be held accountable for the quality and cost of care delivered to a defined patient population.

Accountable care absolutely must be about improving and maintaining the health of a population of patients and not just controlling costs.

It must be about proactive and preventive care and not reactive care.

It must be about outcomes and not volume or processes.

It must be about leveraging the value of primary care and the elements of the Patient-Centered Medical Home."

Terry McGeeney, M.D., *The Patient-Centered Medical Home and the Accountable Care Organization*,
<http://transformed.com/CEORReports/PCMH-and-ACO.cfm>, (2010).

The Eight Essential Elements of a Successful ACO



How CMS defines ACO

- 1) Have a formal legal structure to receive and distribute shared savings
- 2) Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum)
- 3) Agree to participate in the program for not less than a 3-year period
- 4) Have sufficient information regarding participating ACO health care professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings.
- 5) Have a leadership and management structure that includes clinical and administrative systems
- 6) Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR), and (c) coordinate care
- 7) Demonstrate it meets patient-centeredness criteria, as determined by the Secretary.

Governance

- BOD must include some beneficiaries
- BOD must include representation from all ACO participants to make up at least 75%
- Considerable data reporting and access agreements with CMS
- All marketing materials to beneficiaries must be approved by CMS

Quality

- Patient care giver experience
- Care coordination
- Patient safety
- Preventative health
- At risk population/frail elderly health

Patient focus

- Patient survey/patient engagement process
- Process to evaluate health needs of population
- Process for coordination of care

Finances

- If savings of at least 2% are created, 50% of money above threshold is paid to ACO vs. 60% with risk for losses
- ACO is responsible for distributing savings
- Subject to 25% withhold of shared savings to offset possible future losses (may recoup at 3 yrs)
- Cost targets calculated on previous 3 yrs

Legal Considerations

- CMS and OIG guidance on waivers for Civil Monetary Penalty, anti-kickback and stark laws
- IRS guidance for tax-exempt entities
- FTC and DOJ: relevant market share held by ACO: less than 30% "safety zone", 30-50%: expedited, reduced likelihood of investigation review, over 50%: mandatory review process
- Focus on quality and service, not cost?

Sounds like a bigger PCMH.....

The five identified high-impact target areas for ACO initiatives are:

- Prevention and wellness;
- Chronic disease (75% of all U.S. health care spending, much of it preventable);
- Reduced hospitalizations;
- Care transitions (across our fragmented system); and
- Multi-specialty care coordination of complex patients.

PCMH and ACO Commonalities

PCMH

- Focus on patient safety
- Focus on care quality
- Focus on streamlined processes
- Patient-centered
- Team-based care
- Continuity of care

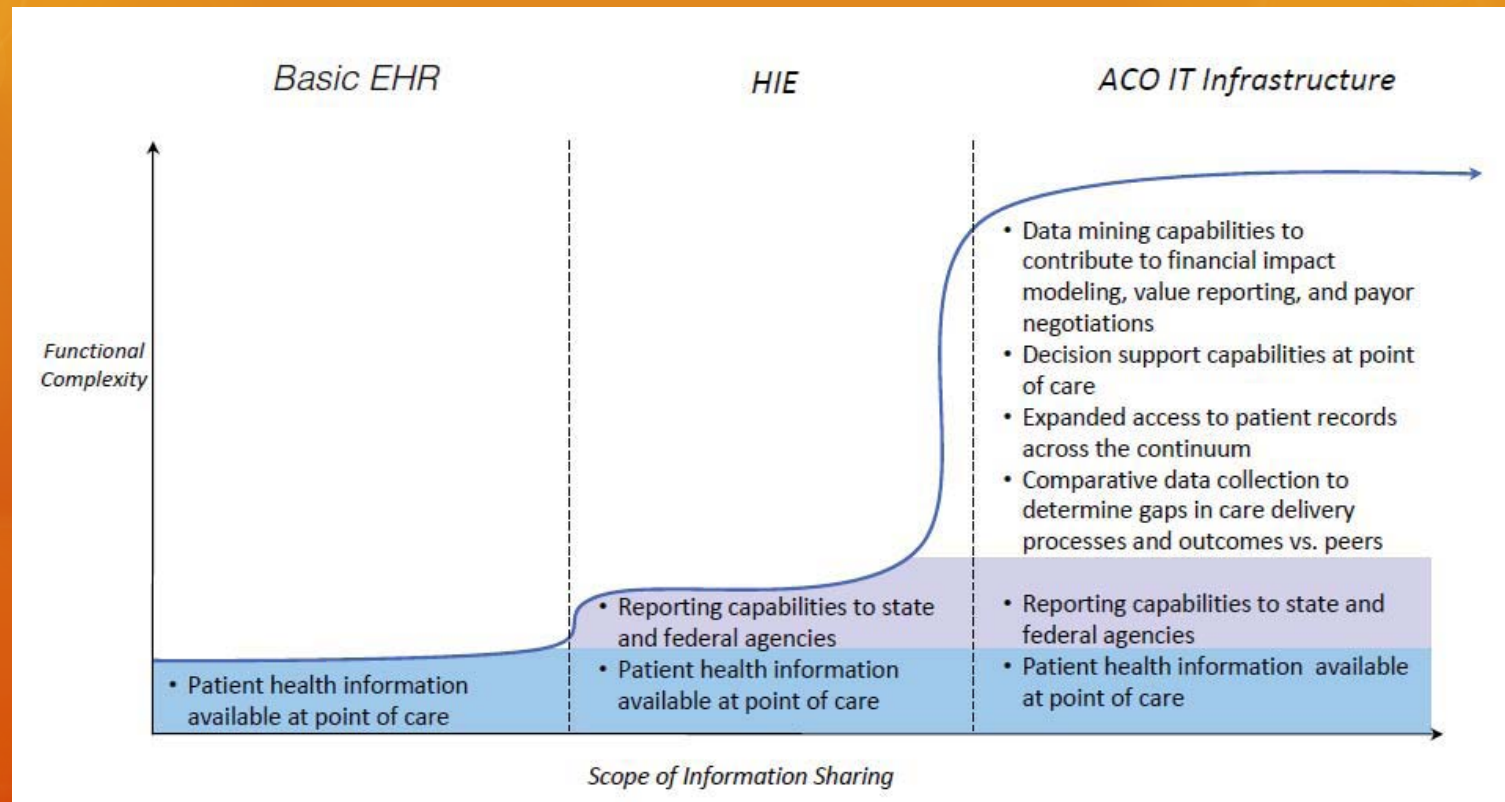
ACO

- Should focus on safety (hand-offs)
- Focus on care quality
- Process requirements and reporting of such
- 8 criteria for patient-centeredness
- Integration of care across providers and sites

What will Primary Care Practices Need to do to form ACOs?

- Obtain complete and timely information about their patients
- Develop technology support for managing populations
- Cultivate adequate resources for patient education and self-management
- Ensure a culture of teamwork
- Coordinate relationships with other members of the healthcare system, includes communication
- Develop ability to measure and report on quality of care
- Learn skills for infrastructure and financial modeling change
- Commit to improving value as a top priority

IT Infrastructure



PCMH and ACO Differences

PCMH

- Practice level
- One practice
- Patient centered
- Physician lead

- Time investment required
- Focus on process change
- Precedent/guidelines
- ?Unclear financial risk

ACO

- Community level
- Multiple healthcare providers
- ?Patient centered
- Non-physician led
- Unclear legal guidance
- Size/capital requirements
- Focus on driving outcomes
- Few precedents/?guidelines
- True financial risk

The US Healthcare System: Present and Future

- Fee for service today
- Silo delivery mentality
- Form
- Individual
- Volume
- Treadmill



- Fee for value tomorrow
- Collaborative delivery
- Function
- Population
- Results
- Satisfaction

References

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Thank you

Questions?

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