Managed care traditionally has focused on serving relatively healthy patients, but the reality is that the top 20 percent of patients—those with advanced illnesses, those with multiple chronic conditions and those who are designated as at-risk—drive 70 percent of the cost, according to *CareFirst Book of Business 2010*, CareFirst Health Care Analytics. Accountable care and patient-centered medical homes are opportunities to provide this segment of the population with more services and to coordinate their care, which can result in improved outcomes and lower overall costs, according to experts.

Brian J. Silverstein, MD, senior vice president, CareFirst, BlueCross BlueShield, Baltimore, addressed this topic in San Francisco last October at the program.
“Accountable Care and Patient-Centered Medical Homes: Steps to Creating Value-Based Healthcare.”

The ACHE program, funded in part by the Fund for Innovation in Healthcare Leadership, was held in conjunction with the San Francisco Cluster. Silverstein led two panel discussions, one on accountable care and the other on patient-centered medical homes. Three experts participated on each panel.

Improving the health of a population and caring for the individual patient while also reducing per capita costs are three areas healthcare executives are trying to find answers for. Some experts believe accountable care organizations (ACOs) and patient-centered medical homes can be the solution.

“The questions for hospitals to ask are, ‘What is the right methodology, and where are we focusing our efforts?’” said Silverstein. “Where do I turn? Should I participate in a patient-centered medical home or an accountable care organization?”

Silverstein added that there is a great deal of confusion surrounding the topic, which can lead to “analysis paralysis,” where many organizations will then wait and see how this plays out. But instead…organizations [should] move to a state of action from a state of fear.”

No one model will work for every organization, but multiple models will eventually exist, said Silverstein. CareFirst, for instance, offers a patient-centered medical
Accountable Care and Patient-Centered Medical Homes

home program in which members are assigned to a primary care physician based on their two most recent years of claims data. Primary care physicians, in turn, form patient-centered medical home care panels, where they collaborate to provide care management plans for patients. The care plans serve as a patient-care road map.

“We want physicians to be accountable to other physicians,” said Silverstein. “We think that is the smartest solution for getting results.”

As an extra incentive for participating, physicians will be paid an additional 12 percent. “This is serious money for primary care physicians,” said Silverstein. Some 85 percent of primary care physicians in CareFirst’s market have signed up for the program, which began in 2011.

The program includes approximately 3,500 providers on 300 panels of varying sizes, mostly five to 15 physicians per panel. When physicians meet, patient information is reviewed so that each physician can see which patients need the most attention.

Silverstein said many in the healthcare field will resist the patient-centered medical home model because they fear change. “If they don’t want to change, they won’t,” he told the audience. “This is an emotional and cultural thing. But you as executives have to find out why there is a resistance to change and figure out how to overcome that resistance.”

The following are remarks from accountable care and patient-centered medical home experts who participated in their respective panel discussions following Silverstein’s presentation.

**Accountable Care**

**HealthCare Partners**

HealthCare Partners, Torrance, Calif., is participating in an ACO pilot project led by the Engelberg Center for Health Care Reform at the Brookings Institution and The Dartmouth Institute for Health Policy and Clinical Practice. The demonstration project expects to produce a successful model that will be replicable throughout the country.

“An ACO to me is promising but still unproven,” said William Chin, MD, executive medical director, HealthCare Partners, a medical group and independent physician association.

What is promising about an ACO, said Chin, is it provides the opportunity to reduce waste in healthcare. “When I talk about ACOs, I ask physicians, ‘Have you seen an inappropriate test ordered?’ They say ‘yes,’ and that it happens frequently. This is waste. Waste is a healthcare expenditure that does not improve clinical outcomes. Spending more does not mean better quality of care.”

Chin defined an ACO as consisting of three basic elements: being accountable for the service provided,
the clinical outcomes of care and the costs associated with delivering the entire continuum of care for the patient.

“All three legs have to be in place for an ACO to survive,” he said. He added that this kind of delivery system, in order to meet national healthcare goals, should be safe, timely, effective, efficient, equitable and patient centered.

One aspect of an ACO can be a hospitalist program, said Chin, which can substantially improve care and reduce costs.

A good hospitalist can divert one-third of ER physician recommendations, reducing admittance rates in the ER, said Chin. Within 48 hours of a patient being discharged, there is communication between the hospitalist and primary care physician to ensure all follow-up information is being carried through. “This improves transitions of care,” he said.

Reductions in lengths of stay, resource utilization, admission rates and re-admission rates have been experienced, he said.

Changes coming, said Edmondson, include the following:

• Keeping groups of people healthy instead of treating them when they get sick
• Offering care at sites convenient to patients rather than at centralized facilities
• Customizing care for each patient in place of treating all patients the same
• Being responsible for the needs of all people (community) instead of for those who seek services (market share)

An important question that healthcare executives will need to answer, said Edmondson, is what will it take to set up an ACO? Most hospitals don’t have a lot of the infrastructure needed or the capital to invest, he said.

“Hospitals face a real question about what their role is going to be,” he said. “We are the highest cost piece of the healthcare system. As healthcare executives, do we stay on the periphery and wait and watch or do we act? Healthcare will change, costs are too high and customers aren’t happy. Do we lead change and get out in front of it or not? We want to lead change.”

“Waste is a healthcare expenditure that does not improve clinical outcomes. Spending more does not mean better quality of care.”

—William Chin, MD
HealthCare Partners
Southwest General Health Center
An organization that is leading change is Southwest General Health Center, Akron, Ohio.

“I’m finding it’s about accountable care, not about the organization,” said Thomas A. Selden, FACHE, president and CEO.

Selden described Southwest General as a high-quality, low-cost provider that owns about 15 percent of its market. He said a different healthcare delivery model is needed that is accountable for value, but as a small player in its market the organization isn’t building an ACO but is planning on participating in at least one.

“It’s not about merging with big players but about ‘co-opetition’—cooperating with our competitors,” said Selden. “We will compete against them, but where we don’t need to compete against them we won’t, which will save us money.”

In July 2011, Southwest General formed a community health collaborative with two other hospital systems of similar size to Southwest General. “We are working on shared services like supply chain cost reductions in which we pool our resources on supplies,” he said.

But the boldest of the collaborative’s initiatives is the formation of a physician contracting organization, which includes more than 400 physicians and a plan to eventually have as

The Fund for Innovation in Healthcare Leadership

The program “Accountable Care and Patient-Centered Medical Homes: Steps to Creating Value-Based Healthcare” was funded in part by the Fund for Innovation in Healthcare Leadership, a philanthropic initiative of the Foundation of the American College of Healthcare Executives (ACHE).

An article on the first of two Fund programs for 2011, “Ethical Challenges and Responsibilities of Leaders,” which was held in August at the New York Cluster, appeared in the January/February issue of Healthcare Executive. For 2012, “The Ethics of Mission and Margin” will be held May 23 in conjunction with the San Antonio, Texas, Cluster, and “Leadership Issues in Palliative and End-of-Life Care” will be held with the Atlanta Cluster on Sept. 11.

The Fund was established in 2006 to bring innovation to the forefront of healthcare leadership by developing and enhancing its focus on future healthcare leaders, ethics in healthcare management and healthcare management innovations. In its commitment to developing future leaders, the Fund has also provided scholarships for the Foundation of ACHE’s Senior Executive and Executive Programs. Since the Fund’s inception, more than 1,400 generous donors have made contributions. This support has enabled the Fund to strengthen the field of healthcare leadership by providing educational opportunities on important trends and issues.

For more information on the Fund, including ways to contribute, please visit ache.org/Innovation or contact Laura J. Wilkinson, CAE, vice president, Development, at (312) 424-9305 or lwilkinson@ache.org.

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many as 700. Selden said this would be another alternative to commercial payors or ACOs to deliver high-quality, low-cost care.

**Patient-Centered Medical Homes**

*Catholic Health Partners*

Catholic Health Partners, Cincinnati, is the largest health system in Ohio.

Ken Bertka, MD, vice president, physician clinical integration, said a patient-centered medical home is a high performing primary care medical practice managing the health of a defined practice population. The following are some National Committee for Quality Assurance patient-centered medical homes recognition “must do” criteria for a successful patient-centered medical home, according to Bertka:

**Enhance access during office hours**
- Provide same-day appointments based on the needs of patients
- Offer timely clinical advice by phone or secure electronic means when the office is closed

**Use data to identify and manage populations**
- Identify the top three chronic conditions. These can vary, but diabetes is often at the top of the list for primary care physicians caring for adults
- Generate a list of patients not recently seen

**Plan and manage care**
- Conduct pre-visit preparation
- Provide patients and families with individual care plans, including treatment goals, which are reviewed at each relevant visit

**Support self-care processes**
- Provide educational resources for more than 50 percent of patients/families
- Develop and document self-management plans with more than 50 percent of patients/families

**Track referrals and follow up**
- Give the consultant the clinical reason for referral and pertinent clinical information
- Track status of consultant reports: overdue reports tracking

**Measure and improve performance**
- Set goals and act to improve performance on preventive care measures, chronic or acute clinical care measures, utilization measures affecting healthcare cost and/or performance data for vulnerable populations
- Set goals and act to improve performance on patient/family surveys and/or feedback from vulnerable groups

*BlueCross BlueShield of Michigan*

BlueCross BlueShield (BCBS) of Michigan works with

“Healthcare will change, costs are too high and customers aren’t happy. Do we lead change and get out in front of it or not?”

—Bob Edmondson
Azul Health Group
patient-centered medical homes throughout the state. “This is doable stuff,” said T. Jann Caison-Sorey, MD, senior medical director, PPO and Care Management, BCBS of Michigan. “But it will not be easy.”

When BCBS of Michigan reviewed its client data a few years ago, executives were surprised at the amount of variation in care and the opportunities for improvement. Some physicians expressed concern that variation existed because their patients were different, sicker or weren’t following doctor’s orders. To lessen the variation, “we worked toward changing the physician mindset” to one of greater accountability for physician interventions and patient outcomes, said Caison-Sorey.

Patient-centered medical homes can succeed when patients are shown they are as much a part of the care equation as the physician, said Caison-Sorey. “Patients don’t see themselves as stakeholders, explaining that their physicians will take care of them.” Changing this belief will require educating patients, she said. “We can’t change this paradigm alone. Significant improvement requires partnerships among patients, doctors and health plans.”

She said pharmacists will also need to be included in the patient-centered medical home equation. “We need to have pharmacy on board. We need to have them regularly looking at first-filled for chronic conditions and adherent rates. How often do they get filled? Are patients coming back for medication refills on a timely basis?”

**TransforMED**

TransforMED, Leawood, Kan., is an affiliate of the American Academy of Family Physicians. Terry McGeeney, MD, president and CEO, TransforMED, said there are four success factors of a patient-centered medical home:

1. **Leadership**: “Cultivate leaders within your organization and physician practices.”

2. **Change management**: “Many physicians don’t like change. They don’t like variation. You have to manage this aggressively.”

3. **Teamwork**: “This is not intuitive for physicians. They are trained to be captains of their ship. You have to teach them to function as a team, get them to understand to do things by protocol and use best practices.”

4. **Communication**: “Executives have to do a better job of providing tools to physicians to strengthen their communication skills.”

McGeeney added that some physicians don’t understand the patient-centered medical home concept—they believe their practice is a patient-centered medical home.

Interestingly, though, McGeeney said some experienced physicians have been the most receptive to patient-centered medical homes, “because it’s important to them that the value of primary care survives.”

*John M. Buell is a writer with Healthcare Executive.*

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—Thomas A. Selden, FACHE
Southwest General Health Center