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2012 National Quality Forum National Healthcare Improvement Award - SETMA Application
Demonstration of readiness to assume responsibilities

After reading the November, 2011, 695-page *Final Rule for Accountable Care Organizations (ACO)*, SETMA is prepared to move forward to participate in a physician-led ACO, which will be formed around an established Medical-Services-Organization (MSO) partner, an Independent Physician Association (IPA) and a Health Maintenance Organization (HMO). SETMA has worked closely and collaboratively with these organizations for sixteen years. Because most of patients covered by the HMO had not had insurance, and/or could not access care even when insured, it was important to SETMA for the HMO to succeed. The only way many of our patients could afford healthcare was through an HMO, most of which had come and gone in Southeast Texas; often leaving the most vulnerable patients without access to care. SETMA saw the HMO model of care as a solution to healthcare for these members of our community and our practice.

SETMA assumed medical leadership of the IPA in October 1997, with SETMA's CEO serving as the Medical Director. At that time, the IPA was losing $500,000 a month and the MSO, which was liable for the losses, was considering leaving the market. By eliminating waste, in ninety days, the IPA stopped losing money and in six months had monthly reserves. The process of eliminating waste included: rounding in the hospital on all covered patients every day; consulting with the attending physicians; insuring proper follow-up, and, establishing pre-authorization for major procedures and surgeries.

The high cost of care was not only the result of a high case mix index but also of utilization patterns in the medical community. How those problems were addressed is illustrated by a case study from October 27, 1997, the first day the new Medical Director made hospital rounds. A covered patient had been in the hospital for five days. After reviewing the chart, the Medical Director called the attending physician and asked why the patient was in the hospital. The attending responded, "Patient very sick (sic) and needs careful management." The Director asked, "Then why isn't there a history and physical, or a plan of care on the chart. And, why haven't you written a progress note since the patient was hospitalized and you haven't written an order in four days?" The attending said, "That is not true!" To which the Director rejoined, "I have the chart in my hand and I am at the hospital. It is true." The patient was discharged by the attending thirty minutes later.

Two other examples address waste and its elimination. Two surgeons had supported partial colectomy for a patient with chronic constipation. There was no other indication. The Medical Director denied the surgery. The surgeons appealed to the Federal Quality Improvement Organization

(QIO) for Texas. The QIO upheld the denial and everyone began to understand that unnecessary and dangerous surgeries and procedures were not going to be allowed. In another case, a patient was hospitalized with a "hot gallbladder." Surgery was going to be delayed for four days to allow the gallbladder to "cool off." Fortunately, the surgeon told the truth when he wrote in his progress note that he was going to be out of town playing golf. The patient's condition was normal except for a solitary gall bladder stone. The white blood cell count was normal; the patient had no temperature, no pain, no abdominal tenderness and no liver inflammation. The additional days in hospital were denied and the patient had surgery the same day. The quality of care began to increase and simultaneously the cost of care began to decrease. This has been successfully done for the past fourteen years in the patient population covered by the IPA. The CMS study done by RTI International, referenced earlier in this application, reflects the same performance by SETMA for fee-for-service Medicare beneficiaries.

Vision for the Value and Power of ACOs

In addition to medical management issues, there were other sources of waste in the care being delivered. One of SETMA's former partners was the Chairman of the Board of the above mentioned IPA. In November, 1997, two other SETMA partners told the Chairman that if the IPA was to be successful, laboratory services had to capitated. The Chairman correctly concluded, "If we do that, it will cost SETMA $50,000 a month," as SETMA operated a profitable reference laboratory. His two partners agreed with his assessment, but affirmed that the future of the IPA, MSO and PSO demanded this change, which was made under duress. SETMA lost income but the financial problems of the IPA and PSO improved. The long term affects of this change have been positive for SETMA, even though the short term outcome was costly. The transformation of healthcare into ACO's will affect other practices in the same way but the long term results will be equally good for them.

In 1997, SETMA began to engage other physicians, particularly specialists in dialogue about the future of healthcare. Because we had data on quality and cost through the MSO and the PSO, we were able to have these conversations based on facts. We knew the outcomes of patient care because we were caring for the same patients as the specialist, but now we also knew the cost of that care. We knew which specialists utilized more resources to provide the same services. Everyone did not want to be a part of the future we saw. One cardiology group wanted pre-authorization at every visit for laboratory test (to be done in their office), echocardiograms, EKGs, X-rays and other procedures. We declined and they resigned. Other cardiologists, equally excellent, agreed to work with us. Based on utilization and quality outcomes, they were able to qualify for incentive payments.

In this process, authorizations were not used to limit care but to manage its quality which resulted in decreased cost of care, with patient safety and health, and national standards as the guiding principles of decision making. Over the past sixteen years, denial rates for authorizations have been less than one percent, but even with that, patterns of care changed. Patients began to understand that the coordination and authorization processes added a layer of safety to their health care, particularly when they saw their friends and/or family members have negative results in following through on care we recommended that they not have. An example was a 94-year-old who wanted coronary by-pass surgery because he could not walk and play a round of golf. We told him that his life-expectancy was greater without surgery than with, and that all he had to do in order to control his angina was use a golf cart. He left the HMO, had the by-pass surgery, and died on the operating table.

In addition to building a multi-specialty clinic, SETMA built relationships with other providers who answered consults in a timely fashion and who opted for cost-effect, efficient care. They did not always default to expensive technology which added no value to the patient's care. SETMA developed a philosophy which supports the premise: ***Excellence and Expensive are not Synonyms***. These relationships have sustained a successful IPA for sixteen years. The same management, infrastructure, relationships, quality, and cost controls will be utilized to build a successful ACO.

Managed Care, Medical Home, ACO

An ACO is a logical extension both of our experience in Medicare Advantage and our functioning as a medical home which provides the patient-centric, coordination functions needed for success in the new model of care. SETMA's experiences, innovations and philosophy of practice enabled us to succeed in managed care and in medical home, both of which are the foundation from which success in an ACO will flow. Except in the case of existing staff-model HMOs and/or functioning IPAs, the infrastructure costs of forming and sustaining an ACO may be much higher than most people think. And, that cost is going to be incurred without any guarantee of recovery. As a result, we recommend that those who wish to pursue the formation of an ACO, partner with those who have an significant existing infrastructure, therefore avoiding the need for duplication.

If an organization is starting to become an ACO *de novo*, SETMA would judge it as being virtually impossible. The foundation required for success, in addition to a sixteen-year history of practicing in an accountable-care environment, in making tough decisions for the good of the group, and in building the tools for success, are:

1. A robust EHR with disease management and screening and preventive care tools in place and functioning.
2. The additional IT requirement of a secure web portal through which to communicate with patients and to engage them in their own care is essential.
3. An HIE which promotes the continuity of care through effective communication and sharing of patient-care information.
4. Experience with global risk for healthcare such as was gained by managed care in general and Medicare Advantage and its predecessors in particular.
5. Experience with quality metrics in tracking, auditing and analyzing data through which to design quality improvement initiatives, after finding leverage points for improvement.
6. The integration of data aggregation over a large network of providers, facilities and practice types. SETMA has this capacity internally and the MSO and HMO partner add to that capacity.
7. Proved ability to provide high quality, low cost care which is valued by patients. This has been proved by our success with HMO patients and by RTI International's cost, coordination and quality analysis of Medicare Fee-for-Service experience at SETMA for 2007, 2008, 2009 and 2010.
8. Experience with patient-centric care in a coordinated setting and with Patient-Centered Medical Home functionalities.
9. Administrative, financial and coordination capabilities which include risk stratification, care management and direction, referral mapping, case management, etc.

10. A willingness on the part of healthcare providers to build a future for their patients and for themselves which in the short run will cost them but which in the long run will benefit all who participate.

Revenue-Sharing Model

The highest probability of ACO success is in an integrated delivery network such as staff-model HMOs or IPAs such as the one in which SETMA participates. These organizations already have an electronic infrastructure, which can be adapted to the accountability and accounting functions needed for success in an ACO. In the same way, non-staff model HMOs with strong relationships with IPAs may also provide an increased probability of success. When the staff model has an ownership interest in hospitals, the potential for success is enhanced significantly. The principle reason for the higher potential of success in these instances is that they already have a model for the sharing of revenue and the participants have already accepted the details of that revenue-sharing model.

When the participants in an ACO do not have an integrated financial relationship, it will be very difficult to hold the group together once the division of profits begins to take place. The USA health care system has placed high value on facility and procedure services and has placed little value on comprehensive and coordinated care. There is nothing structurally within the ACO model which addresses that dichotomy in anything but a *Laissez-faire* manner. The division of the financial benefits of the ACO may be its Achilles heel.

Finding a venue which equitably shares revenue, valuing elements of care which are pivotal to ACO success but which have traditionally been undervalued, or unvalued is critical. SETMA, our IPA, MSO and HMO have a revenue-sharing model which will operate seamlessly but separately in the ACO setting. The model respects all members of the healthcare value equation including CMS. The revenue-sharing model is based on measurable quality metrics, participation in care coordination and in patient satisfaction survey results.

Tension in the ACO Model

One of the principle means of ACOs creating financial savings will be in the using of lower levels of care, i.e., outpatient rather than inpatient services. If hospitals are partners in the ACO, they will recognize that the increased savings often result from decreased utilization of their services. In their own defense, hospitals will increase their competition with ambulatory-care providers, both by owning medical practices and by opening their own ambulatory-care centers. The perverse result could be not only increasing competition, which in this unique case might drive up cost, but also make appropriate and beneficial collaboration between hospitals and independent healthcare providers more difficult. Increasing cost savings at the expense of the hospital could also create the situation where essential and expensive care could be limited due to increasing financial pressure on the hospitals.

SETMA believes that this perverse effect can be avoided by dialogue between the ambulatory providers and the hospital. Each must recognize and respect the role of the other. With ambulatory care providers working with hospitals to improve lengths of stay and thus the effective return on DRGs; to decrease preventable readmissions; to prevent redundant and expensive care, a true collaboration between inpatient and outpatient care can be achieved. This partnership between hospital and healthcare provider can go a long way to avoiding the perverse effect of conflicting interests.

The ACO model in which SETMA will participate does not engage the hospital as a partner. The hospital is not asked to participate in the risk and is paid standard DRGs for their services. The hospitals interests are addressed through excellence of care with excellent and timely documentation of all reasons for admission and co-morbidities, with the utilization of hospital services for important ambulatory services where possible and appropriate. This is why, SETMA has been a good partner with hospitals with whom they have not shared risk but which hospitals have valued SETMA's participation on their staff.

Avoiding the Hazard of Involuntary Enrollment

Patients who understand the benefits of restricted-access healthcare (managed care) have already elected to join Medicare Advantage programs. One trade-off is that for agreeing to see only certain healthcare providers, the patient receives increased benefits and reduced cost. This methodology has increased access to healthcare for many. Others, either because of excellent insurance, or personal resources, have rejected that model of care, even though it can be demonstrated that Medicare Advantage is providing improved care. To involuntarily enroll those who have previously rejected a "managed care" model creates an ethical dilemma.

SETMA will transparently notify all whose care is to be managed in an ACO. The ACO will enroll only those who give prior consent to do so. As with patient-centered medical home, the best solution for the future of healthcare is engaging the patient as a partner in preserving their health with improved quality by cost savings. This process begins with the methods of patient enrollment (engagement). Patients recruited for participation in an ACO must be engaged actively in learning how to access care efficiently and at the appropriate level. Being patient-centric; this care will also be patient driven.

In an age where most patients have more confidence and trust in technology – procedures, tests, etc. – than they do in a personal relationship with a healthcare provider, it may seem that the principle way to decrease the cost of care is to ration care by structurally decreasing access to care.

However, in an environment where healthcare providers are functioning as a team with the patient as part of the team, the best way to change the healthcare-cost curve is to restore patient trust in their healthcare providers, where the provider's counsel is sought before a test is ordered. This is the reason why any ACO which has the potential for success must be built upon healthcare providers who not only have the designation but who are also actually functioning in a patient-centered medical home. ***It is only with compassionate, comprehensive, coordinated and collaborative care that the relationship with provider and patient can recreate the trust bond which supersedes technology in the healthcare-decision-making equation.*** In that trusting relationship, wise decisions can be made about watchful waiting, appropriate end-of-life care and a balance between life expectancy with and without expensive but unhelpful care.

Recently, Mark Bertolini, Chairman, CEO & President of AETNA said, "Convenience is the new word for quality." The statement on its face seems an oversimplification. However, as SETMA became a PC-MH, we came to see that "Coordination" translates into:

1. Convenience for the patient, which,
2. Results in increased patient satisfaction, which contributes to,
3. The patient having confidence that the healthcare provider cares personally which,
4. Increases the trust the patient has in the provider, all of which,
5. Increases compliance (adherence) in obtaining healthcare services recommended which,
6. Promotes cost savings in travel, time and expense of care which,
7. Results in patient safety and quality of care with cost savings.

It was only through this analysis that we accepted "convenience" as a worthy goal of quality care as opposed to it only being a means of "humoring" patients. This fulfilled SETMA's goal of ceasing to be the constable, attempting to impose healthcare on our patients; and, to our functionally becoming the consultant, the collaborator, the colleague to our patients, empowering them to achieve the health they have determined to have.

In addition to continuing to function in the Medicare Advantage practice model – 25% of our patients have chosen to get their healthcare through this method – and in addition to continuing to transform our practice into a patient-centered medical home – all of our patients are treated in a coordinated fashion -- SETMA is ready to and will participate in an ACO. We expect this to add one more dimension to our growing into a full-fledged, 21st-century multi-specialty practice.