April 2011

The Leap to Accountable Care Organizations

By Jim Molpus
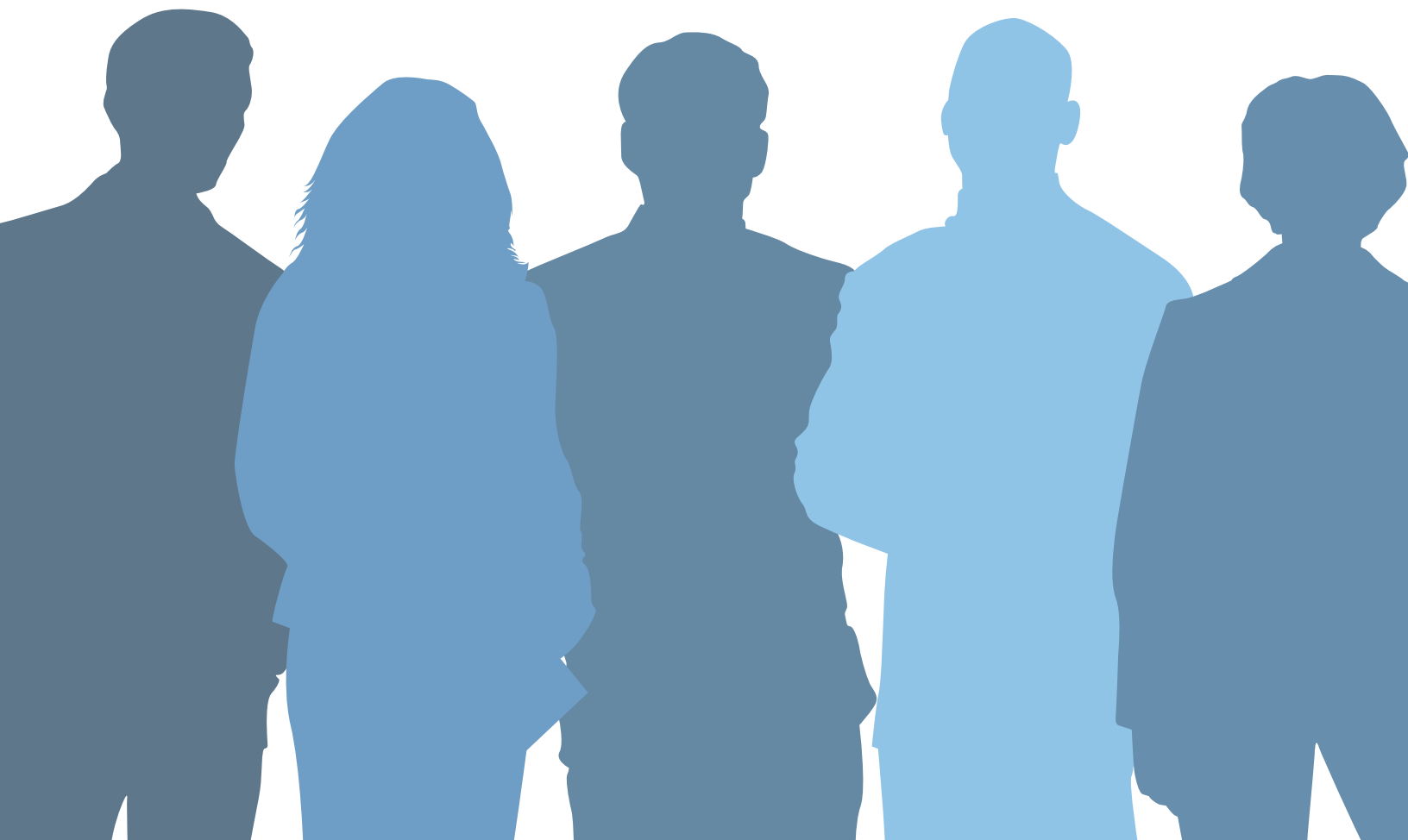
Foreword

REFORM AT THE LOCAL LEVEL

You've all probably heard the joke about ACOs and unicorns. You know, lots of people believe in them but no one's ever really seen one.

Most physicians and healthcare administrators I talk to say that they don't have a clear understanding of just what an ACO is. This HealthLeaders Media survey on accountable care organizations will hopefully provide further clarity to those of you who feel the same way. Others of you, who still doubt the reality of these organizations, will be convinced after reading this report that many organizations are actively developing very real organizations that will be able to or already can fully function as an ACO. Finally, many of the questions in this survey can be used to assess your own organization's readiness to move into the accountable care era and serve as a road map on how to do so.

Reforming our healthcare delivery system at the local level is really what ACOs are all about. Physicians and hospital systems must become more integrated. Healthcare must be delivered in a more patient-centered fashion. Quality gains must be continued and the escalating costs of care must be brought under control. As this survey points out, the perfect plan for accomplishing all these goals has not yet been designed, and perhaps one of the good things about the ambiguity surrounding ACOs is that there is still a lot of room in the model for good ideas.

Perhaps the most confusing aspect of ACOs is how the payment structures related to these organizations will function. CMS has finally released details about how its shared savings model will work. Commercial payers will likely follow suit, and many mechanisms for driving more accountable care through changes in the reimbursement system will eventually emerge. Building a more clinically integrated delivery system, however, can and should happen now instead of waiting until the last financial piece of the ACO puzzle is pressed into place.

So, whether you're far along in building an ACO or just starting to explore the concept of accountable care, this survey will help guide your activities. Building a better, more affordable, and sustainable healthcare system for our patients will not be easy, but remember, with great challenges come wonderful opportunities.

Ellis M. Knight, MD, MBA

Senior Vice President of Ambulatory Services, Palmetto Health

Executive Director, Palmetto Health Quality Collaborative, Columbia, SC

Lead Advisor for this Intelligence Report

Perspective

CHANGING THE WAY HEALTHCARE IS DELIVERED IS THE RIGHT THING TO DO. A successful healthcare organization is often defined not by quality

reports, but the patient experience. Happy and loyal patients are the key drivers for referrals, volume, and revenue, but they are not the only factors that allow your business to grow and thrive. And while patients may be at the heart of healthcare, when it comes to establishing a successful accountable care organization, it takes a comprehensive experience—satisfied physicians, a strong community connection, and robust referral network.

As they all begin to work cohesively together, a collaborative healthcare organization will emerge. In fact, according to the responses received in the survey conducted for this report, 82% of healthcare executives agree that personal health records need to be designed so that there is a combination of patient-entered information as well as data from back-end clinical systems, thus creating a collaborative health record for the patient.

Success or failure of an ACO will depend on an organization's ability to understand what stakeholders want, what they expect to be delivered, and how they want to receive or supply this information. Healthcare must place more emphasis on the use of digital communication mediums. Patients, physicians, and consumers have become dependent on the Internet and particularly on mobile devices. In fact, according to a recent IDC report, the move to mobile devices has already begun—the sale of smartphone devices outpaced traditional computers in 2010. And the adoption of mobile technology is projected to increase even more, at a rate of more than 55% this year.

The ACO question is not why to act, but when to implement and how to best reach consumers to meet their demands while leveraging existing investments, improving care coordination, reducing readmissions and making employees more efficient. Most healthcare executives surveyed for this report, 69%, have an online communications strategy to engage patients as part of ACO development. In the age of social media, user-generated content, and instant access to a variety of information sources and types, the collaborative nature of eHealth should be an integral part of a healthcare organization's ACO strategy.

As many CEOs that I've spoken with have said, and I agree, whether you choose to guide your organization to become an ACO or not, it's the right thing to do in order to improve the quality of care, increase patient satisfaction, reduce costs, and deliver an experience that engages and empowers patients, physicians, employees, and the community—inside and outside the doors of your organization.

Peter Kühn
CEO, MEDSEEK, Birmingham, AL

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Methodology

The Leap to Accountable Care Organizations study was conducted by the HealthLeaders Media Intelligence Unit. It is part of a monthly series of Thought Leadership studies. In February 2011, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. Respondents work in a variety of settings including hospitals, health systems, physician organizations, health plans/insurers, long-term care, and ancillary/allied providers. A total of 275 completed surveys are included in the analysis. The margin of error for a sample size of 275 is +/- 5.9 percentage points. A detailed report and analysis can be found online after April 18 at *www.healthleadersmedia.com/intelligence*.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

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About The HealthLeaders Media Intelligence Unit

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, printed publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

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Respondent Profile

Respondents represent titles from across the various functional areas including senior leaders, clinical leaders, operations leaders, financial leaders, and information leaders. Nearly one-half of the respondents have senior leader titles. They are from hospitals and health systems.

| Title

Base = 275

55%	20%	17%	5%	2%
Senior Leaders	Operations Leaders	Clinical Leaders	Financial Leaders	Information Leaders
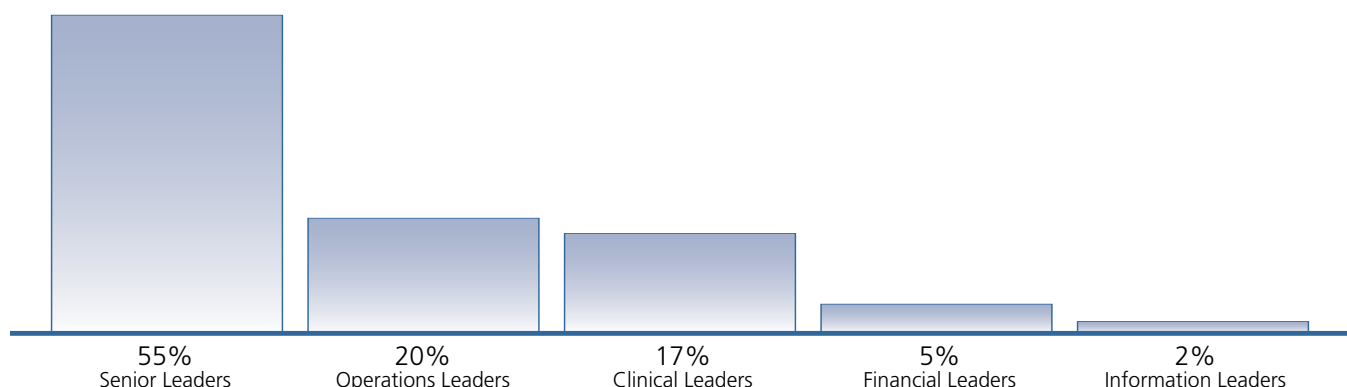
Senior Leaders | Chief Executive Officer, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical Leaders | Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD)

Operations Leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/Administration, Other VP

Finance Leaders | VP/Dir. Finance, HIM Director, Director of Case Management , Director of Revenue Cycle

Information Leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

| Place of Employment

Base = 275

Hospital	39%
Health system (IDN/IDS)	23%
Physician organization (MSO, IPA, PHO, Clinic)	21%
Health plan/insurer (IHMO/PPO/MCO/PBM)	7%
Long-term care/SNF	5%
Ancillary, Allied provider (Home health, Lab, Rehab, Postacute, etc.)	4%

| Number of Beds

Base = 107 (Hospitals)

1–50	17%
51–199	34%
200–499	36%
500–999	9%
1,000+	4%

| Number of Sites

Base = 63 (Health systems)

1–5	24%
6–20	30%
21–49	21%
50+	25%

ANALYSIS

Can Short-Term ACO Hopes Lead to Long-Term Solutions?

by Jim Molpus

Perhaps not since the HMO days has an acronym carried as much weight and hope as ACOs do for the reinvention of healthcare. Envisioned as a more refined and aligned version of its managed-care ancestor, accountable care organizations have been pushed by backers as a more elegant structure for financially rewarding the coordination of care, while critics argue that ACOs lack infrastructure and true integrative power that would make them revolutionary.

What Healthcare Leaders Are Saying

"Our size ($300 million revenue) in a concentrated urban area suggests we will do better being a significant player in someone else's ACO."

—A leader whose organization is not planning to develop an ACO

"The only obstacle I see is adding the shared risk component to the physician side."

—Vice president of a physician organization

"I feel strongly these need to be physician led. The only motivation for a hospital to be involved is to protect their share of the money."

—Administrator of a physician organization

"Financial risk for hospitals is extremely high. There is much fixed cost that patient volume pays for. As volumes decrease, it will be difficult for a hospital to sustain its current financial position."

—CFO of a small health system

"Alignment only goes so far with docs when the bottom line is that they will likely make less money. Usually the government's promise of a carrot turns quickly to a stick only."

—Chief medical officer of a small health system

"There must be ongoing quality metrics in order to ensure that all ACOs are functioning properly."

—Chief compliance officer of a medium-size hospital

"We are in the preliminary phases of creating an ACO. It will be very difficult in the beginning, but will hopefully help to align physicians with hospitals."

—Board member of a small health system

Healthcare leaders appear resigned to the fact that some form of accountable care organization faces both providers and payers alike. Proposed guidelines for Medicare's Shared Savings ACO released recently have been met with as many questions as answers. What form ACOs will take is still a mostly open question, according to the ACO survey conducted for this HealthLeaders Media intelligence report.

In the survey, conducted prior to CMS's guidelines, 91% of leaders say their organization does not yet have an ACO—and the 9% that say they do have one make healthcare leaders wonder what definition of ACO they are using.

"I'd like to know what it looks like for that 9%," says Doug Hawthorne, CEO of Dallas-based Texas Health Resources. "We are certainly involved in the evolution of what an ACO might look like ... but I think the 91% are exactly where we are."

ANALYSIS (continued)

> "As a society, we have been much more inclined to place a higher value on procedures rather than coordination or the comprehensive care, managed model that we are all attempting to develop presently."
>
> **—James L. Holly, MD,**
> CEO of Southeast Texas Medical Associates in Beaumont

George Kyriacou, CEO of Hanover (PA) Hospital, agrees that calling yourself an ACO and actually being one is a matter of opinion. "I would bet that when you were to drill down into it—a definition of what is necessary and what they have in place—it would vary widely. It is a subjective assessment rather than a criteria-based response."

Still, 64% of those leaders surveyed say they expect to launch some sort of ACO in coming years, with a full 39% of those positive respondents saying they will launch an ACO either in 2011 or 2012; this suggests many organizations are still shooting for CMS' January 1, 2012 target for participation in the Medicare Shared Savings Program, the defining piece of the Medicare ACO model. Yet most of those planning to implement an ACO (52%) say they have no chosen date for implementation.

The data suggest an inherent conflict: a certain rush to gather the pieces for coordination, but a simultaneous acknowledgement that the fundamental work of an ACO requires a longer-term strategic view. James L. Holly, MD, CEO of Southeast Texas Medical Associates in Beaumont, says changing gears from one way of practicing medicine to another is not a quick shift.

"As a society, we have been much more inclined to place a higher value on procedures rather than coordination or the comprehensive care, managed model that we are all attempting to develop presently," Holly says. "It will be very hard to dismantle that mentality to where we have an equal

Does your organization's medical staff support an accountable care organization for your community?

45% I'm not sure

48% Yes

8% No
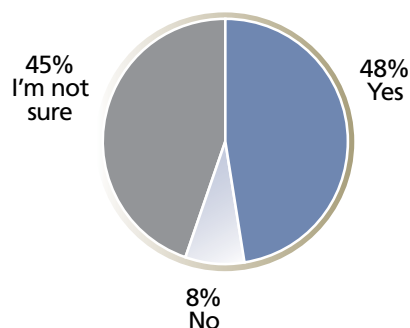
Base = 184
Multi Response
Among those who currently have/plan to implement ACOs

ANALYSIS (continued)

value placed on coordination and comprehensive care in the medical home model, which will have to be the foundation of a successful ACO."

Hawthorne sees ACOs fitting into a long-term strategic vision for clinical integration at Texas Health Resources, with its 24 owned or operated hospitals and some 4,100 licensed beds.

"Our focus is ultimately that the ACO drives a value proposition similar to what [CMS Administrator] Don Berwick advanced through his IHI work with the triple aim: improved quality of care at lower costs with a better experience for those that you are serving," Hawthorne says. Any ACO development, he adds, will include an expansive view "both to the left and right of the hospital box" to include prevention, wellness, and primary care, as well as rehab and long-term care.
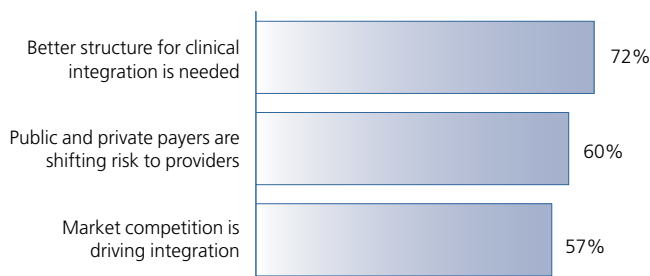
Ultimately the success or failure of the ACO concept will start with money: specifically, whether there is enough of it. Fully 81% of respondents rate as a high or very high barrier to success the lack of adequate funding for the ACO. Even beyond the bounds of what an ACO may look like under Medicare, any ACO that wants to share risk with commercial payers faces the task of negotiating a shared savings vision under a limited pie. Kyriacou says those discussions may ask for a leap that few payers are willing to make.

"There will be a significant amount of anger and stress as a result of those negotiations," Kyriacou says. "The natural tendency of those insurance companies will be to reduce expense as part of implementing these revised care delivery and payment structures."

> "Over the short term, relationships could become more stressed because there will be a tremendous amount of change."
>
> **—George Kyriacou,** CEO of Hanover (PA) Hospital

What are the top drivers for your organization to create an ACO?

Driver	Percentage
Better structure for clinical integration is needed	72%
Public and private payers are shifting risk to providers	60%
Market competition is driving integration	57%

Base = 184
Multi Response
Among those who currently have/plan to implement ACOs

ANALYSIS (continued)

A true collaboration would likely need to call for a year or two of revenue neutrality while hospitals work through the savings. But payers are more likely "to view this as a way to immediately start saving money," he notes.

The end point is still appealing, as 62% of respondents say that ACOs will improve healthcare quality. Even in the testy dynamic of hospital-physician relations, 43% say that an ACO has the potential of improving the relationship. Kyriacou agrees, but says the long-term gain may mean some short-term pain.

"Over the short term, relationships could become more stressed because there will be a tremendous amount of change," he says. "We will be looking at metrics of clinical performance on an individual doc. We are going to be looking at how much buy-in there is to evidence-based medicine. We are going to be looking at what does the hospital do versus the doctor versus the homecare agency, and saying where is it going to be more cost-effective compared to where it may have been done traditionally. All of those things cumulatively will add stress to the relationships."

One factor that all advisors contacted for this study agree on is that without a functioning electronic health record, no ACO can hope to succeed. The lack of EHR is rated by 63% of respondents as a 4 or 5 on a 5-point scale where 5 equals high on its potential to disrupt the development of an ACO. ACOs will need the EHR as well as other applications to be able to track and record outcomes in order to prove the value of the care provided, says Holly.

"It is much, much more than just an EMR. There will be significant fiduciary responsibility on the part of the ACO to convince Medicare that they are in fact achieving savings out of exemplary care, rather than what we used to call 'denial care' where you just didn't do things and showed up these savings," Holly says.

> "Our focus is ultimately that the ACO drives a value proposition similar to what [CMS Administrator] Don Berwick advanced through his IHI work with the triple aim: improved quality of care at lower costs with a better experience for those that you are serving."
>
> **—Doug Hawthorne,**
> CEO of Dallas-based
> Texas Health Resources

ANALYSIS (continued)

Hanover Hospital is investing $12 million in a communitywide EMR project to link the 106-bed community hospital with the city's physicians, Kyriacou says. Even with roughly half of the costs covered under federal stimulus funds, the EMR project is a big investment that he hopes will pay off in care coordination, either under an ACO or other payment models based on proving value. "Some communities look at the EMR as a solution. We view it as a necessary baseline tool, but not the solution," Kyriacou says. "It is how we use it and are able to actually manage the care using that tool that will really be the proof."
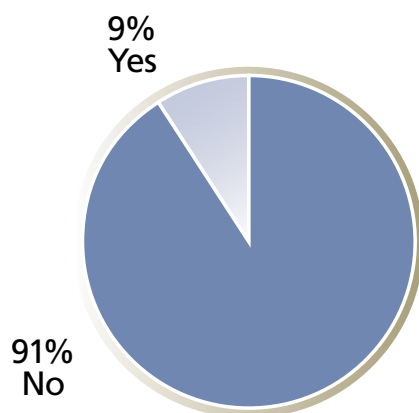
Jim Molpus is strategic relationships director for HealthLeaders Media.

Survey Results

FIGURE 1 | Status of ACOs

Q | Does your organization have an accountable care organization now?
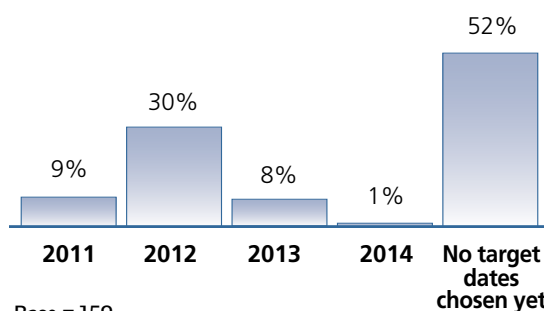
9%
Yes

91%
No

Base = 275

FIGURE 2 | Future Plans for ACOs

Q | Is your organization planning to implement an ACO structure in the future?

36%
No

64%
Yes
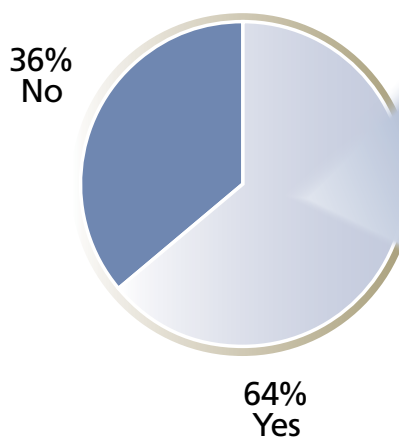
Base = 250

Q | When will your ACO be operational?

2011	2012	2013	2014	No target dates chosen yet
9%	30%	8%	1%	52%

Base = 159

Survey Results (continued)

FIGURE 3 | Medical Staff Support for ACO

Q | Does your organization's medical staff support an accountable care organization for your community?

45%
I'm not
sure

48%
Yes

8%
No
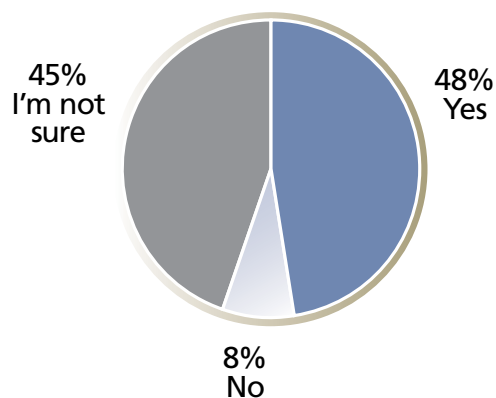
Base = 184
Among those who currently have/plan to implement ACOs

FIGURE 4 | Components of ACO Implementation

Q | Which of the following do you plan to implement as part of your ACO?

Clinical pathways — 80%

Care coordinators and/or nurse navigators — 74%

Medical home — 70%

Base = 184
Multi Response
Among those who currently have/plan to implement ACOs

Survey Results (continued)

FIGURE 5 | Top ACO Drivers

Q | What are the top drivers for your organization to create an ACO?

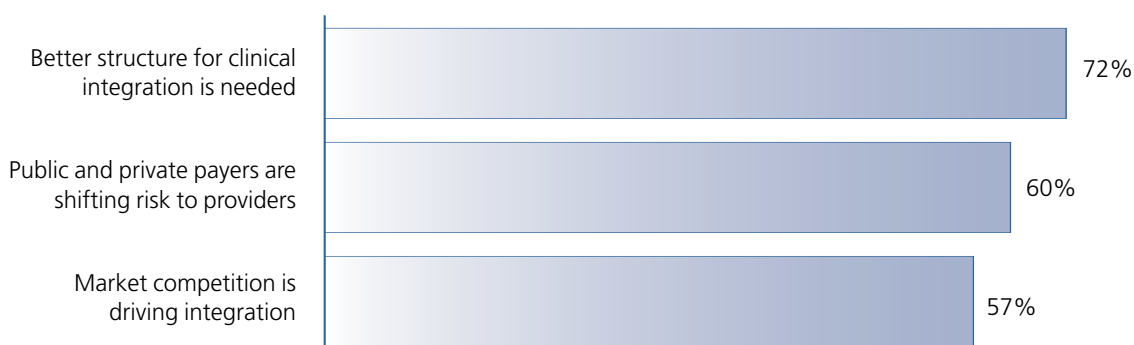|	
Better structure for clinical integration is needed	72%
Public and private payers are shifting risk to providers	60%
Market competition is driving integration	57%

Base = 184
Multi Response
Among those who currently have/plan to implement ACOs

FIGURE 6 | ACO Barriers to Success

Q | Rate these potential barriers to accountable care organizations' success based on their potential to disrupt development.

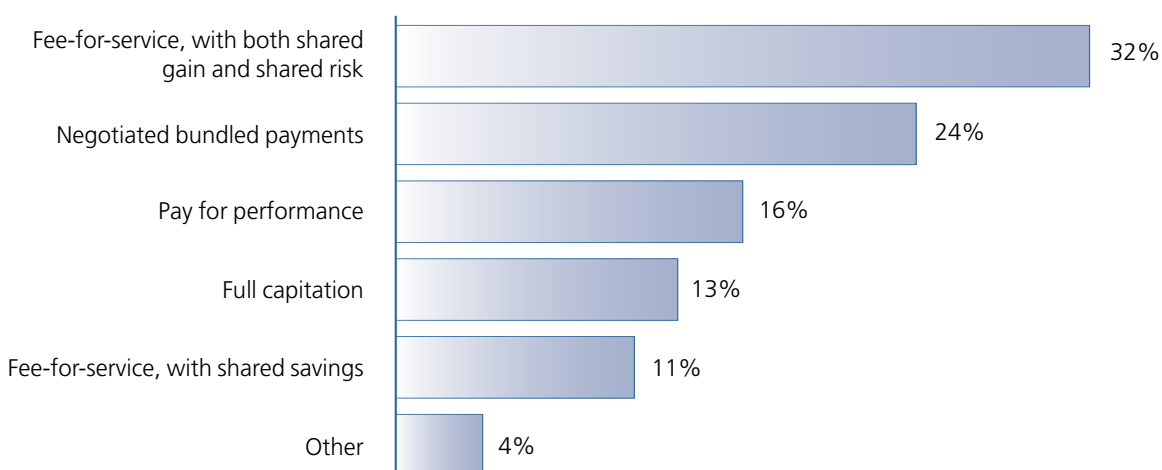|	High (5)	(4)	(3)	(2)	Low (1)
The financial risk of inadequate payment rates	43%	38%	15%	4%	1%
Lack of common EMR/IT system	34%	29%	20%	13%	4%
Physician resistance	26%	35%	24%	11%	4%
Lack of uniform healthcare quality and/or cost data	26%	37%	25%	9%	2%
The administrative costs of running the ACO	25%	36%	28%	8%	3%
Shortage of primary care physicians	24%	27%	26%	17%	6%
Lack of ongoing legislative momentum in support of ACOs	17%	35%	34%	12%	2%
Federal laws that restrict physician self-referral and kickbacks	16%	33%	30%	15%	7%
Payer resistance to new payment structures	13%	20%	37%	21%	9%
Patient resistance	6%	14%	31%	31%	18%

Base = 275

Survey Results (continued)

FIGURE 7 | Impact of ACOs

Q | What impact will accountable care organizations have on each of the following?

	Improve	Stay the same	Deteriorate
Healthcare quality	62%	31%	7%
Healthcare costs	45%	33%	21%
Hospital-physician relations	43%	32%	24%
Payer-provider relations	24%	42%	33%

Base = 275

FIGURE 8 | Payment Structure for ACOs

Q | Which payment structure do you think will work best for accountable care organizations?

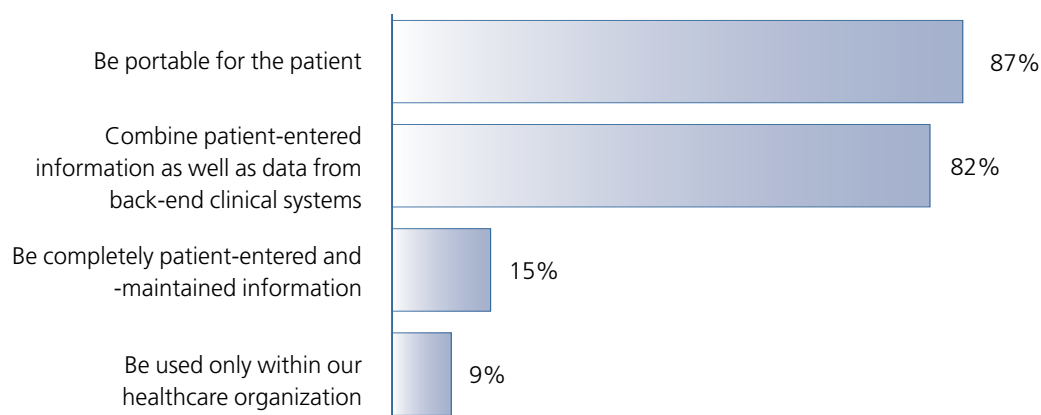| Payment structure	Percentage
Fee-for-service, with both shared gain and shared risk	32%
Negotiated bundled payments	24%
Pay for performance	16%
Full capitation	13%
Fee-for-service, with shared savings	11%
Other	4%

Base = 184
Among those who currently have/plan to implement ACOs

Survey Results (continued)

| FIGURE 9 | Personal Health Records |

Q | A personal health record should:

Be portable for the patient	87%
Combine patient-entered information as well as data from back-end clinical systems	82%
Be completely patient-entered and -maintained information	15%
Be used only within our healthcare organization	9%

Base = 184
Multi Response
Among those who currently have/plan to implement ACOs

| FIGURE 10 | Online Communications Strategy for ACO Development |

Q | What is your strategy for using online communications to engage patients as part of your ACO development?

	Percent
Update our existing website to assist and attract new patients	59%
Provide patients with an online experience that includes information from hospitals, physician practices, and other services	58%
Retain existing patients by offering a patient portal for interactive services such as appointment scheduling and access to medical records	58%
Use social media and networking sites such as Twitter and Facebook	39%
Use customer relationship management software for targeted marketing campaigns	28%
We do not yet have a strategy in place	31%

Base = 184
Multi Response
Among those who currently have/plan to implement ACOs