



FROM THE PRESIDENT

Florida Academy of Family Physicians “Preparing Family Physicians for an ACO Environment”

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The Florida Academy of Family Physicians leadership is working diligently to secure information that will be of value to you, your practice, and patients as health reforms steer us toward an Accountable Care Organizational model.

To that end, the federal government released the latest statistics on health care expenditures on January 5, 2011. The latest information reflects a \$2.49 trillion dollar spend in 2009 making healthcare a record 17.6% of the U.S. economy. Federal spending on Medicaid rose nearly 22% in 2009. Of course this pre-dates President Obama's landmark health care reform initiatives, the effects of which have yet to be realized.

Embedded in that legislation is a host of initiatives, not the least of which is the Accountable Care Organization or ACO. These organizations will be charged with increasingly taking on population health management and slowing the growth in health care spending while simultaneously improving the care delivered.

It should be no surprise to Family Physicians that moving care upstream to include better preventive care and better chronic disease management should decrease the total cost of care for a population of patients. Continuity of care with access to care in the lowest cost environment is a foundational component of Family Medicine. The Patient Centered Medical Home is a good example of how we are industrializing these fundamental principles of care.

The Patient Centered Medical Home in combination with acute and post acute resources can begin to manage the clinical and, ultimately, the financial risk of a population; this is the essence of the accountable care organization. Do we have the technical infrastructure to manage patients in a proactive manner that translates to better outcomes at a lower total cost of care? Do we have the data aggregation capabilities and analytics to do this effectively? The FAFP Foundation's Diabetes Master Clinician Program is one such initiative.

Accountable care organizations will be expected to do this in exponential ways. Of course, to meaningfully manage patients' care between office visits and between hospitalizations or other such episodes of care, will require resources. It

means compensating our physicians for taking the time and effort to manage that care better. Hence, a new payer-provider relationship will be necessary to accomplish this task of population health accountability.

The ACO will likely slow inflationary health care expenditures and, in many ways, will do so at the expense of acute care facilities. Stated differently, if primary and secondary prevention and chronic disease management were each maximized for a given population of patients, the hospitalization rates would be expected to decrease and with that, hospital margins. Accountable Care Organizations will, at a minimum, consist of primary care physicians, specialists and hospitals. Compensation would come to the ACO and would be distributed based upon criteria as set forth by the ACO. Logically this distribution would reward high quality, efficient processes that are delivered at the lowest cost alternative.

The ACO model is, however, not without controversy. Does every physician have to be employed by the ACO? Does it require a single platform EMR? How will this be different than the PHO movement of the 1980s?

First, on the matter of employment, the definitive answer is no. To be an ACO does not in and of itself require employment. However, for independent physicians to participate in a collective bargaining or joint contracting program is to invoke legal constraints around antitrust issues. Fortunately, case law and published “indicia of clinical integration” serve as road maps as to how to create a Clinically Integrated Network, or CIN, that both allows independent physicians the legal ability to act as one while simultaneously holding those physicians to a high standard of clinical integration for the purposes of delivering better care at lower costs. Independent physicians will either need to work within these legally appropriate clinically integrated networks or they will need to be employees.

Seeing this writing on the wall is one of the reasons the FAFP facilitated the publication of our earlier document entitled the “FAFP Hospital Affiliation White Paper” (available for download at www.FAFP.org). It is a roadmap to assist FAFP members with how to either affiliate or become employed based upon their own circumstances and career objectives. On the matter of technology, again the answer to a single platform is largely no. While having a group of physicians and hospitals on a common technology platform is ideal, the reality is that this is difficult to accomplish, particularly in a short time period. For-

tunately, interoperability standards will make the connecting of disparate systems easier with time. In the meantime, registry systems, HIE vendors and compression of the office EMR market are all contributing to the creation of ACOs.

The costs associated with integrating these systems is one of the limiting factors to why physicians alone will likely not be successful developing large scale sustainable ACOs. However, hospital and health systems may provide capital resources to assist with this work. Finally the core question of what is or will be different about ACOs compared to the PHOs of yesterday? It is a core question that needs to be considered carefully.

First and foremost, PHOs were driven by the insurance industry. As such, it placed physicians in the unpopular position of gatekeeper instead of patient advocate. It focused on utilization and not on clinical outcomes. ACOs, however, should be physician led and should in fact be based upon clinical outcomes. This coupled with the fact that we have better systems today from which to measure and share those outcomes are key attributes that make change likely. Consumer expectations are higher, reporting is increasingly transparent, and the percentage of GDP on health care are all compelling arguments as to why it is different today than it was then.

So while the Patient Protection and Affordable Care Act establishes a voluntary program of ACO development for Medicare participants, many believe the commercial industry will follow suite. So clinical integration and accountable care organizations are likely to become household terms and, as such, the FAFP and AAFP will work to assist our membership in both understanding the various initiatives as well as in making sound decisions as to how to potentially proceed.

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