white paper

COORDINATING CARE

Across the Healthcare Continuum

written by
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Introduction

Consumer-driven demands on healthcare coupled with the economic and political realities are resulting in a new definition of how best to provide healthcare in the United States. We also need to understand that there are multiple consumers to consider and that new delivery models are needed that can address the respective expectations and needs of these groups.

The complexity of the problems facing healthcare systems in meeting these evolving demands is a daunting challenge even for the most sophisticated and well-run organizations. Accountable Care Organizations (ACOs) or similar organizational risk-sharing relationships are rapidly emerging as a preferred approach for garnering the support of patients, providers and payers for optimizing care. For ACOs to be completely effective, the depth of preparation and fully understanding the complexities surrounding the diversity of care that ACOs need to address must be understood and incorporated into the organization's fabric for it to succeed.

Who is Today's Healthcare Consumer?

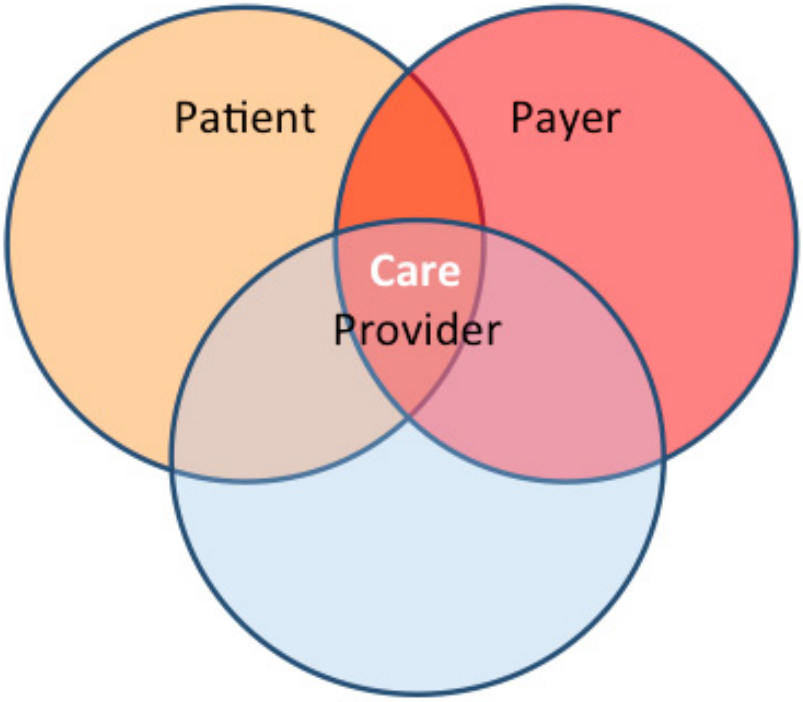
Healthcare delivery in the US is undergoing massive changes and while there is much discussion on how best to reach national goals, one thing is clear. Understanding the needs of the healthcare consumer and how best to successfully integrate comprehensive and real-time healthcare information for optimal care is an essential requirement. While hospitals are being looked to as the hub for both gathering and disseminating patient data, physician practices, testing facilities such as laboratories and radiology centers, pharmacies, and ancillary providers such as home care and medical equipment suppliers are all integrally involved in this.

Hospitals also realize that not only do they have a growing responsibility to both their patients and clinicians to serve as a hub for coordinating care, their inability to do this can have serious adverse impact on their financial bottom line. As Meaningful Use moves ahead into Stage 2 and beyond, those organizations that cannot clearly demonstrate they are meeting these expectations will see decreased reimbursement and will find themselves facing increasingly difficult contracting negotiations with all payers. Couple this with the growing trend for large companies to contract with preferred provider systems that meet the clinical, financial and operational objectives and the pressure is even greater for these provider organizations to maximize their adherence to contracted parameters.

We therefore need to redefine who the real healthcare consumers are. Patients are always healthcare consumers but in today's evolving healthcare system, that definition is too restrictive. Clinicians (doctors, nurses, therapists and technicians, etc.) are as much a consumer as are patients and as a group they are also extremely influential in determining where their patients/clients go to receive care. Many hospitals and healthcare systems now are recognizing that they must meet provider expectations for data, clinical services and both administrative and technical support if they want their loyalty to remain intact.

The third consumer is the payer. Not only does this include the insurer, but also employers as well as state and federal agencies involved in underwriting the cost of care. In fact, they can be considered the fundamental consumer because the type of care a patient can receive is most often determined by what the payer will allow. In Figure 1, the intersection of the respective interests of the 3 principal consumer categories is rapidly determining what can be considered as the Care continuum.

Today's Healthcare Consumers



The 3 different Healthcare Consumers. What we define as "Care" is effectively the intersection of what the each of these groups expects healthcare to provide

ACOs as an Emerging Solution

Accountable Care Organizations (ACOs) are emerging as the provider entity most aligned with coordinating care across the Healthcare Continuum. Since this concept was first introduced in 2006 by Elliot Fisher MD, the Director of the Center for Health Policy Research at Dartmouth Medical School, the concept has grown in popularity and acceptance both by providers and consumers[1]. The core fundamentals for ACOs are:

- Primary care Provider-led organizations are collectively accountable for quality and total per capita costs across the full continuum of care for all their patients
- Payments linked to quality improvements that also reduce overall costs
- Care is measured by increasingly more sophisticated performance measurement, to support improvement and provide confidence that savings are achieved through improvements in care

With the emphasis across the continuum of care clearly on quality and cost containment, the importance of making certain every provider involved in is seamlessly linked professionally and technologically to the health system is a fundamental requirement for these organizations. This assures that the entire care team has access to the entirety of the information and resources needed to make the right decision at the right time for the right reason.

While hospitals are well acquainted with JCAHO, CMS and other quality surveys, new regulations and measures such as HCAHPS satisfaction scores are placing increasing financial pressures to maintain and demonstrate that optimal care is

being provided. Other, more onerous, factors such as the Affordable Care Act (ACA) penalizes hospitals for Medicare patients readmitted within 30 days for conditions such as heart failure, psychoses, vascular surgery, COPD and pneumonia with the list of new diagnoses expanding annually. Commercial payers are also looking to adjust payments when there are higher than anticipated readmission rates for contracted patients so it becomes an operational and financial imperative for hospitals to take an active role in coordinating care once the patient is back in the community setting. In terms of lost reimbursement, the literature cites cost of a congestive heart failure readmission approached $19,000 and for pneumonia nearly $16,000[2]. For just one case per month of each deemed an unnecessary readmission, the hospital could face an annual loss of reimbursement of $400,000.

An ACO Clinical Scenario

ACOs are being seen as an answer for addressing this myriad of issues facing hospitals and providers. Using the following clinical scenario we can better understand how an integrated ACO model can be effective in optimizing care and cost containment.

Susan B. is a 57-year-old working mother of 3 who has a history of Type II diabetes, hypertension, and the early stages of Congestive Heart Disease. Her primary care physician is a member of large multispecialty group affiliated with an ACO. While Susan is a conscientious patient, her most recent examination showed her blood pressure has been increasing, she has had increasing difficulty in completing certain activities due to shortness of breath and fatigue, and her glucose levels as well as her Hemoglobin A1c are becoming higher than her doctor would like to see.

One day at work, Susan feels dizzy and has increasing tightness in her chest. Her colleagues call 911 and she is transported to the local hospital by emergency responders. Fortunately for Susan, her doctor and the local hospital are part of an ACO that addresses clinical, operational, and informational needs for both patients and providers.

During transport, the emergency responders can see the totality of Susan's medical information from her doctor's office on the web-enabled laptop. They access her medications, lab results and current diagnoses since Susan cannot provide needed answers to all questions. In addition, there are a number of questions they want to ask her physician. The ACO provides the responders with information on how to reach Susan's physician and they send a text message regarding her low blood sugar. Within moments they receive a reply from her doctor including recommendations on how best to manage this problem. The first responders also send this information to the Emergency Department so that all the care team has the same, up to the minute information.

Upon arrival at the hospital, the Emergency Room team has already seen Susan's medical information from her physician's EMR system. Susan is evaluated without the need for duplicative diagnostic tests already done by her physician, initial treatment is started and she is admitted for Congestive Heart Failure and Diabetes. Susan quickly improves and on day 2 is scheduled to be discharged to home. Through the ACO, the hospitalist has been in ongoing communication with Susan's primary care physician and together they develop a post-discharge plan for her. This involves Home Care nursing follow-up through an agency that also participates in the ACO to facilitate patient care and management.

On the 2nd home-care visit, the nurse notes that Susan's ankles appear swollen, she is somewhat short of breath and she has a non-productive cough as well as breath sounds indicative of heart failure. Prior to the ACO, the homecare nurse would have called 911 to have Susan brought back to the hospital for an evaluation, which most likely would have resulted

in a non-reimbursed admission. Instead, she immediately contacts Susan's primary physician. Since Susan is not in any acute distress, the physician orders a diuretic to be given immediately and asks the nurse to remain with Susan to observe her response to treatment.

Susan improves quickly and her physician and visiting nurse agree that Susan does not need to return to the hospital. Her doctor modifies the treatment protocol and also changes Susan's office follow-up appointment to the next day. The doctor, nurse, and Susan are all linked through the ACO's appointment system and this information is immediately available to Susan.

This scenario typifies how an ACO that integrates hospitals, physicians, community providers and support services can provide the right care at the right place based upon the right information that is available in the right format using the right tool. It also exemplifies how a well organized ACO not only improves clinical outcomes, it also reduces costs, optimizes the use of available hospital and community resources and respects the expectations of the patient and the various providers who were involved in caring for Susan. Of course the 3rd customer, the payer, is equally satisfied because the services provided were oriented to the specific needs of the patient at that particular moment in her care.

In fact, no provider is immune to the consequences of unjustified patient care management. ACOs, by the fact they are financially responsible for all care provided to their patients quickly discover that repeated tests, unnecessary diagnostic procedures, and referrals for clinical assessments that could have been avoided can have severe and sometimes catastrophic outcomes for the organization.

Preparing for Success

In order for the ACO model described above to work at this level of efficiency, a vast amount of preparatory work is essential to achieve success. Most hospitals and systems simply do not have the resources nor expertise that are needed to go from concept through to implementation and many that have done this on their own have met with significant, costly and time-consuming delay and ultimately failure. Because of this, they frequently turn companies with a proven record of success such as Divurgent to guide them through the process.

Amongst the elements Divurgent recognizes as key success factors are:

- **Provider and Services Alignment:** In the past, this viewed only physicians as providers, but now forward thinking systems need to look at ancillary community services as well. Does the scope of services therefore meet the patient consumer needs? Are we addressing not only the needs of the today's community but are we also planning for future? These and similar questions need to be asked early in the ACO development if it is grow and prosper.
- **Improving Process and Cost Efficiencies:** While many organizations are constantly striving to improve their internal processes, ACOS demand that global processes need to be evaluated. Questions that explore cause and effect must be evaluated both within the parent organization as well as the impact on the entire system.
- **Quality Must Come First:** ACOs are a business model and this implies that the more business (i.e. more patients) you have, the more successful you will be. In fact, the quality of services must be the first priority of any successful ACO if the model is going to attract and build new business.

- **Technology is at the Core of a Successful ACO:** Not only must ACOs be able to electronically follow the care for their enrollees, progressive ACOs are looking at ways using technology to provide the right information to the right people at the right time for the right reason using the right format. In the scenario, we saw the value and impact of using technology not only during the hospitalization, but as an effective tool for avoiding a subsequent admission that was successfully managed by the community care provider network. This is, in fact, an extension of the "5 Rights" that HIMSS has defined as the foundation for effective care and optimizing clinical decision support[3].
- **Optimizing Payment:** Optimal care justifies optimal compensation both to the ACOs from the payer and to the respective providers from the ACO. This means that the ACO has the responsibility to track care, track outcomes and track the value this has not only for the patient and the providers, but also for the payers. Clearly, when the ACO can demonstrate these operational and clinical gains, this should be recognized as justification for higher payments to providers as well as to the ACO by the payers.

Conclusion

At the current level of expenditure growth, projections consider the cost of healthcare expenditures to be unsustainable.[4] Factors that come into play include the growing Baby Boomer segment, the uninsured percentage of Americans is continuing to grow, and CMS estimates show that by 2019, healthcare costs in the US can easily top $4.6 trillion[5].

Other countries spend far less than the US with have documentable better care[6]. ACOs are an answer to the challenge to show that we can again be a world leader in providing high quality cost effective care. We must, however, begin the process now and also invest wisely in preparing these organizations to address the needs of the patients, providers and payers who are, in fact, the ultimate customers of any ACO.

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About the Authors

Jeffrey Goldstein MD, MS, FACHE is a senior consultant of Clinical Transformation at Divurgent. Dr. Goldstein is a recognized leader in healthcare spanning over two decades guiding a variety of hospitals worldwide to reach their clinical, operational and financial goals.

His career includes serving as Medical Director, hospital CIO and COO, and primary consultant to hospitals, health care systems and government regulatory agencies. Dr. Goldstein has served on numerous regional and national committees for addressing issues to improve America's health by bringing together providers, payers and consumers that resulted in practical and viable solutions for improving clinical outcomes, patient safety and organizational efficiencies..

Dr. Goldstein received his medical degree from CETEC University School of Medicine and completed his Residency training in Family Practice at SUNY Stony Brook – Glen Cove Hospital. He also holds advanced degrees in Electrical and Biomedical Engineering from SUNY Buffalo and the University of Connecticut. He is a Fellow of the American College of Healthcare Executives where he was the national chairperson for the college's Physician Special Interest Group as well as serving on the NJ Regent's Advisory Council and also a member of the American College of Physician Executives.

Mary Staley-Sirois, MBA, PT, CPHIMSS is Principal of Clinical Transformation at Divurgent. Ms. Sirois has nearly 20 years of healthcare operational and strategic planning experience across a wide spectrum of providers and academic environments. As a physical therapist by clinical background, she has worked with large and small healthcare systems on the planning necessary for clinical transformation as a result of an EHR deployment, organization governance and change management, medical and clinical staff collaboration on best practice and evidence-based processes, regulatory compliance readiness and issue resolution, organizational budget development and related benefits realization projection, and detailed project planning. Ms. Sirois' work is focused on leveraging the skills and team of the healthcare organization in the deployment of strategic initiatives - from product development, to operational management, to transformation of clinical process and practice, to EHR adoption. Ms. Sirois is well-published on HIPAA compliance and is a public speaker in healthcare operations and regulatory compliance. In addition to her work in the healthcare provider market, Ms. Sirois works closely with international organizations for the development of operational and educational programs to improve healthcare in developing countries.

COMPANY OVERVIEW

Divurgent is not the typical healthcare consulting firm. As a nationally recognized company, we strive to be different, to think outside of the box for innovative healthcare solutions. Our goal is simple. To transform healthcare to our clients and the communities they serve.

Focused on the business of hospitals, health systems and affiliated providers, Divurgent believes successful outcomes are derived from powerful partnerships.

Recognizing the unique culture that every organization offers, we leverage the depth of our experienced consulting team to create customized solutions that best meet our client's goals. Utilizing best practices and methodologies we help improve our client's operational effectiveness, financial performance and quality of patient care.

Our Commitment

Divurgent is dedicated to helping our clients improve their operational effectiveness, financial performance and quality of patient care. Through thought leadership, providing value for our services and delivering innovative solutions , we are committed to improving the quality and safety of healthcare delivery for our clients and the communities they serve.

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