Q&A Session for Partners in Health: How Physicians and Hospitals can be Accountable Together

**Q:** A key component of this reform is the use of a common IT vendor. Do you have any suggestions when currently the hospital and providers have different IT systems? Obviously, the expense and angst of eliminating one system is a challenge.

**From Jay Crosson:** It is correct, in my view, that an integrated clinical information system will be a key factor in ACO success. Yet, as the questioner states, this is an expensive proposition, and in some settings, hospitals are prevented by regulations from underwriting the independent physicians’ costs. A breakthrough may well occur when large firms, such as Google, Microsoft, IBM, etc. begin to market “virtual medical record” capabilities over the web, substantially lowering entry costs for providers.

**From Steve Shortell:** It helps greatly if there is a common vendor. It might be time to “bite the bullet” to make that happen. Otherwise, a lot of work will need to go into making the different systems sufficiently “compatible”. Perhaps some of the Federal Health IT technical assistance money could be used for this purpose.

**Q:** Where is the patient’s voice in this process? Is the rule making process sufficient for this level of engagement?

**From Jay Crosson:** In the end, patients will need to be an active part of the ACO-based redesign of the care system. Otherwise they will reject these changes.

**From Steve Shortell:** It is my understanding that the CMS patient grievance process will be maintained. Also the ACO quality metrics should include patient satisfaction and experience measures.

**From Stuart Guterman:** The patient is a crucial part of this arrangement. Aside from the fact that the health care delivery system exists to serve patients (a point that is all too often forgotten), the success of new organizational models like ACOs is critically dependent on the willingness of patients to engage with their providers in this model, and of course in the ability of the providers to meet their patients’ needs. Financial incentives can
be useful in providing rewards for providers based on patient experience with their care (as well as outcomes), and also in perhaps rewarding patients who are willing to ‘sign up’ with an ACO for their care. The voice of the patient also needs to be heard in the design and continuously in the implementation of new models of health care delivery, with direct participation by patient groups and solicitation of information on patients’ views of the appropriateness of their care as well as ‘objective’ measures.

Q: Will there be a Case Manager assigned to each patient under the ACO model?

From Jay Crosson: Case management and disease management processes are pretty fundamental capabilities of integrated care systems of today. The successful ones are those which are closely linked to the actual providers of care.

From Steve Shortell: This will be left up to the ACO. For example stage 3 severely ill Diabetics with multiple co-morbidities are like to have a case manager

Q: Isn't the current 3rd party mediated model of healthcare financing (whether government and/or private pay) at risk of implosion? Legions of physicians are opting out. Can these complex & open ended changes take root while simultaneously servicing demand.

From Steve Shortell: I don’t think so anytime in near future. Most physicians I know do not want to be directly in the insurance or “selling” business.

From Stuart Guterman: For the time being at least, our health care system involves not only the physician and the patient, but also one or more private or public third-party payers. The key to moving from the fragmented financing and delivery systems we have now to a more coordinated system in which the interests of the patient are appropriately represented is to align the financial incentives so that providers are rewarded for providing the appropriate and effective care that I believe they want to be able to provide, as well as for using health care resources efficiently. The payer has a role to play in this arrangement, as well as the provider and, most importantly, the patient.
Q: Do you think it's possible to re-align payment as you've described without mandated, multi-payor reform?

From Steve Shortell: Good question. In my view, will depend on how fast CMS can implement the new payment reforms and the degree of payer competition that will then take place in response to the new payment models.

From Stuart Guterman: Right now, I believe that the best way to proceed is to make sure that everyone understands the importance of working together to provide payment incentives that support the kind of care we’d like our health care system to provide us. That will require payers to work together (with providers and patients, as well as with each other) so that everyone’s not pulling in different directions. We have no choice but to try and accomplish this on a voluntary basis—if it doesn’t work out that way, we’ll have to investigate other options. I’d point out that the health reform law created an Independent Payment Advisory Board with a mandate to cut the growth of Medicare spending if it doesn’t slow down sufficiently—and they also can make recommendations that would apply more broadly as appropriate, although they don’t (yet) have the authority to implement those broader recommendations. If more stringent policies are needed, the mechanism for developing and applying those policies may be seen as already in place.

Q: Are you really going to know how these organizations are going to operate, until the new office, CMS and HHS come out with their rules?

From Jay Crosson: Good point. In addition, the current ACO model that CMS is creating is only the beginning of a long care system redesign process. It is hoped that the CMS Innovation Center will stimulate many other steps and models.

From Steve Shortell: We can get some idea from the experience of current ACO-like organizations but won’t really know a lot until the rules and regs come out.

From Stuart Guterman: There are some examples of ACOs already being developed in the private sector and in several states, including Vermont and New Hampshire. These initiatives will be tracked and their impacts analyzed as they unfold. But yes, tracking the progress and impact of health reform will be an important activity in the next few years.
**Q:** How can academic medical centers begin to participate? Will funds be available through Health Innovation Zones (per section 3021 – the CMS Innovation Center)?

**From Jay Crosson:** Academic medical centers have a keen interest in being part of evolving ACOs. One challenge for them will be developing a culture of “resource stewardship” consonant with the mission of ACOs.

**From Steve Shortell:** Yes. It is my understanding that funds will be available through the Health Innovation Zones. I know some Academic Medical Centers – Michigan, North Carolina – that are already forming ACO structures. Key issue will be forging the necessary new relationships with community-based primary care providers.

**From Stuart Guterman:** The section to which you refer does specifically mention Health Innovation Zones that involve Academic Health Centers, and the Innovation Center will be working with the relevant organizations to develop ACO-like models.

**Q:** Great stuff from all presenters; yet a grand canyon exists between theory & current practice. A homogeneous view of the market does not address the realities specific to: Medicare, Medicaid and commercial as distinctly different worlds.

**From Steve Shortell:** I agree. These will play out differently.

**From Stuart Guterman:** This is indeed a big challenge that we need to overcome.

**Q:** Absent a physician group practice culture the best intentioned ACOs can not succeed.

**From Steve Shortell:** I agree. This is one of the challenges to be addressed. The book [“Partners in Health”] provides some ideas and examples of how to do this.
From Stuart Guterman: It’s been argued that we can’t change the health care delivery system without changing the culture of health care organizations—and that we can’t change health care organizations without changing the financial incentives those organizations face. So it’s time to get started trying to do that.