The Care Initiative

A look at how one medical group built its care coordination

By J. Kersten Kraft, M.D.

Long before the term accountable care organization (ACO) was coined, our organization was coordinating care among hundreds of independent physicians and a select group of hospitals. Our initiative started near the turning of the millennium, and it was driven as much by business needs as our desire to improve care quality.

Our organization, the Individual Practice Association Medical Group of Santa Clara County Inc. (SCCIPA), San Mateo, Calif., competes in a region dominated by a single managed care entity. Prior to the kickoff of our initiative, numerous independent physician practices existed in our area, yet little care coordination occurred. Duplicate tests, unnecessary hospital admissions and poor management of patients with chronic conditions were escalating costs within our network. Meanwhile, the region's dominant player was actively managing these issues and decreasing costs. We needed to change in order to survive. The concepts of care coordination provided us with the tools to attack rising costs and improve care quality, both of which are vital to attract new business from employers.

SCCIPA's care coordination model evolved over a number of years as we gradually built the infrastructure and processes to facilitate it. These included improving our contracting methods, developing new technology to exchange operational and clinical data, as well as structuring incentives and risk-sharing arrangements. It was an ambitious effort and took a great deal of work, but we started to see results, which made it all worthwhile. Duplicate laboratory and radiology tests decreased, hospitalization rates dropped, and patients with chronic conditions were tracked and carefully managed. Ultimately, physicians started earning bonuses for the savings we collectively achieved.

When the term ACO emerged around 2007,[1] it provided a concise name to the initiative we had been implementing for the previous several years. As the Department of Health and Human Services (HHS) embraced the ACO concept, it validated our approach. Currently, SCCIPA's ACO model is still evolving, especially in regard to recently released Centers for Medicaid and Medicare Services ACO guidelines. The following information details our approach and where we're headed.

The approach

SCCIPA's care coordination model was carefully presented to physicians as a way for them to better manage their practices. The physician network was already providing high-quality care, so we didn't want to create the perception that SCCIPA was telling them to practice "cook-book medicine." These were – and remain – independent physicians who enjoy their autonomy. What they lacked was a way to coordinate care among the hundreds of physicians in the network, and our model would provide them with the processes and technology to accomplish that. The physicians who saw value in the concept

[1] E.S. Fisher et al., "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," Health Affairs 26, no. 1 (2007): w44–w57 (published online 5 December 2006; 10.1377/hlthaff.26.1.w44).

became part of our network. Currently, our network has 280 primary care physicians and 550 specialists who provide care for more than 65,000 lives.

While presenting our approach to physicians, we had to overcome some long-held perceptions about managed care. Specifically, our care coordination effort focused extensively on referral authorizations and keeping patients in network to reduce costs. This placed limitations on where they could refer their patients, and that wasn't appealing to some physicians. To offset their concerns, we explained to them the cost savings that they could achieve by referring patients to authorized providers and facilities. These cost savings, in turn, could result in sizeable bonuses. That piqued their interest and won them over in most situations.

Of course, earning the bonuses meant that physicians would need to achieve specific objectives and report their data to SCCIPA. Objectives included identifying and tracking patients with chronic conditions, minimizing lengths of hospital stay, and much more. In an era of decreasing reimbursement, the bonuses were a powerful incentive to convince physicians that tracking the criteria was worth their efforts.

When the bonuses were paid out, the mindset of physicians was further changed. They realized the rewards of their efforts and started looking for ways to meet additional objectives to improve their earnings. In 2010, SCCIPA physicians achieved a savings of more than $3.5 million dollars, which was paid out to the physicians who met criteria to qualify for the bonus.

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Technology for care coordination

When SCCIPA started its care coordination initiative, we evaluated existing systems within the market to find a solution that could help us accomplish our goals. We didn't find exactly what we needed, so we developed our own authorization system to help us handle referrals. Starting out as a financial and administrative solution, it contained a configurable set of rules to manage the process. Referrals falling outside of the rules were reviewed by a medical director who approved or denied the request.

This system evolved to where referrals could contain clinical information to help make determinations. Further refinements have resulted in the technology being able to include a continuity of care document (CCD), which greatly expanded the solution's functionality. Today, the CCD includes patient condition and treatment histories, summarized pharmacy orders, and radiology and laboratory results. This information is uploaded into the system by physician practices – many of which have electronic medical record (EMR) solutions. Patient records are uploaded to the system, where they are scanned and read via optical character recognition. The electronic data populates the system, which is accessed from a Web-based secure interface.

Physicians have widely embraced the solution, and in many situations it has proved quite helpful. For example, a physician in an emergency department was recently presented with an unconscious SCCIPA patient. Not knowing her condition, he accessed her CCD via the online system and discovered a medication order that could potentially cause her to lose consciousness. Armed with that information, he was able to make informed decisions about her treatment and avoid expensive tests. The physician determined the patient did not require an overnight stay and she recovered.

The technology is available for physicians to use with their SCCIPA patients, which typically makes up about a third of a practice's patient base. The improved access to clinical information has resulted in many practices requesting to use the solution for their non-SCCIPA patients, although that is not currently supported.

What started as an authorization management system has undergone a clinical integration process. Our technology now supports the exchange of clinical and operational data. Based on the combined clinical and administrative data, coupled with the care management rules engine, patients can be triaged into the case man-

agement workflow for added services and care transition support. The stream of information allows the care team to easily communicate and collaborate.

Results

SCCIPA's care coordination efforts have resulted in several notable accomplishments. For example, duplicate tests have been greatly reduced due to the availability of patient information within the CCD. Additionally, ancillary service providers, such as reference laboratories and radiology imaging centers, are placed on capitated contracts. These providers receive a fixed payment to cover a patient's testing needs, which encourages the elimination of duplicative testing. In 2010, SCCIPA identified that 71 duplicate computed tomography (CT) scans were prevented as a result of this practice, a savings of nearly $100,000.

Another benefit that SCCIPA has realized is reduced hospital admissions and reduced lengths of stay. SCCIPA contracts with a team of hospitalists to monitor and manage patients during hospital visits. The hospitalists are financially incentivized to reduce admissions when possible and closely monitor patients to reduce lengths of stay when admitted. In 2010, SCCIPA prevented 128 hospital admissions through the use of its contracted hospitalists, resulting in a savings of approximately $1.6 million.

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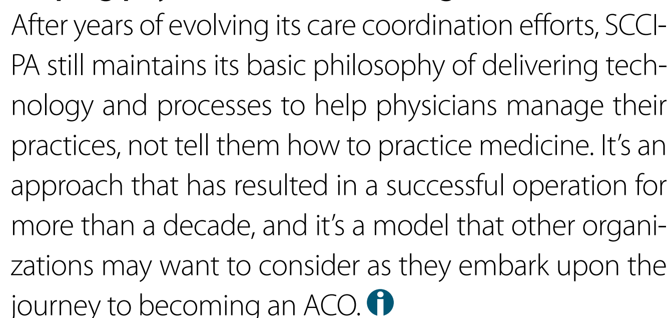
Other successes include improvements in managing patients with chronic conditions to reduce costs. Physicians are incentivized to identify and monitor patients with chronic conditions. Bonuses are based on improving the health of populations with chronic conditions, reporting on health status and ensuring that tests and treatments adhere to evidence-based medicine guidelines.

Future enhancements

Knowing the requirements contained in recently released ACO guidelines, SCCIPA is planning to further evolve its technology system to facilitate even greater levels of quality measurement. Currently, pharmacy order and fulfillment information is imported into the system from claims data. This information is uploaded into the system twice a month. SCCIPA is now working to have providers and pharmacy benefit management companies upload this data in near real-time to improve the information quality and help prevent adverse drug events. This enhancement is scheduled for deployment in mid-2011.

Additionally, to extend the value of its solution, SCCIPA plans to provide patients with secure online access to their information by the end of 2011. Once logged into the system, patients will be able to view lab test results, medication data, as well as radiology and pathology reports. Eventually, SCCIPA plans to deploy an interactive online feature allowing patients to securely discuss their conditions and questions with a nurse practitioner, request appointments and share self-management and wellness information through the patient portal.

As a result of its success, the care coordination platform is now available commercially – and used by organizations throughout California – through a vendor, Health Access Solutions. SCCIPA works closely managing the product in cooperation with this company so that other provider groups may have access to the software.



Helping physicians, not hindering them

After years of evolving its care coordination efforts, SCCIPA still maintains its basic philosophy of delivering technology and processes to help physicians manage their practices, not tell them how to practice medicine. It's an approach that has resulted in a successful operation for more than a decade, and it's a model that other organizations may want to consider as they embark upon the journey to becoming an ACO.

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