IMPLEMENTING HEALTH REFORM

Accountable Care Orgs Build On Medical Home Concept

One new concept to come out of the health reform debate is the Accountable Care Organization (ACO). The concept builds off the idea of the patient-centered medical home and calls for primary care physicians, specialists, and hospitals to band together to provide high-quality care for patients. Under the ACO concept, payments would be linked to quality, and ACO providers would have the opportunity to share in any savings realized through better, more cost-effective care. Under the Affordable Care Act, Medicare will launch a shared savings program in 2012 to test the concept.

Dr. Lori Heim, president of the American Academy of Family Physicians, explains how these ACOs might work and what might drive their popularity.

OB.GYN. News: The AAFP has spent a lot of time promoting the concept of the patient-centered medical home and the medical home neighborhood. Is an ACO the next logical step?

Dr. Heim: The ACO builds on the foundation of a medical home based in primary care. Both have the same goals for the patient: coordinated care that ensures a seamless transition from one service to another and one level of care to another.

The core of an ACO is effective primary care with a focus on prevention, early diagnosis, chronic disease management, and other services delivered through primary care practices. We believe that in order to be successful, ACOs will require a robust network of practices founded in primary care. They may involve other primary care practices, subspecialists, and in some cases hospitals. Envision the ACO as an expanding circle of health professionals with the patient and the patient's medical home in the center. The ACO concept requires that medical-home practices commit to performance improvement and publicly reported performance results. ACOs are a formalization of the medical home neighborhood, which is essential for a medical home to realize its full potential. Thus, an ACO may be the next logical step for physicians whose practices offer a mix of services; however, isolated rural practices will have more barriers to overcome to become members of an ACO.

OB.GYN. News: What are the advantages and disadvantages of an ACO?

Dr. Heim: ACOs will improve information flow and communication. They will offer payment incentives designed to produce high-quality, patient-centered, efficient care. The problem areas are in aligning the financial incentives in a way that provides the best value to the patient.

Cost savings to support an ACO will come largely from reductions in three areas: inappropriate hospital admissions and readmissions, diagnostic testing and imaging, and subspecialist expenses.

One of the greatest challenges to implementing an ACO is managing the conflicts associated with the internal distribution of funds. So, while we're likely to see improved referral patterns and communication that will provide seamless, high-quality health care, we also are likely to see tension as health communities move away from competition and toward cooperation and collaboration.

Physicians need to know their options for organizing into groups to create or become a part of an ACO.

DR. HEIM

OB.GYN. News: In the future, will all physicians be part of an ACO?

Dr. Heim: Because this concept is so new, it's hard to say. Decisions on organizing the delivery system will be local. We're going to see considerable experimentation with different structural models, different financing models, and different approaches to sharing payment or system savings among all providers. The medical home is important because its performance can be quantified and compensated relative to the value it brings to the entire system. The movement will likely begin in large and well-organized independent practice associations (IPAs), multispecialty groups, and integrated delivery systems. For efficiencies of scale, other physicians will first need to organize into groups that can assume performance risk (for quality and efficiency, not insurance risk) and contract with specialists, hospitals, and other providers to build out the ACO model that will be attractive to employers and insurers.

OB.GYN. News: What do physicians need to do now if they want to experiment with the ACO idea?

Dr. Heim: The first step is to become a high-performing practice by implementing medical procedures, protocols, and services, as well as quality improvement systems. The second step is to think about how physicians' practices fit into a larger health care community to provide comprehensive, integrated care. Physicians need to know their options for organizing into groups to create or become a part of an ACO. They need to understand their options for, and the implications of, contracting with or being employed by hospitals. ■

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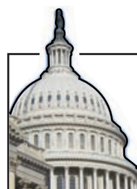

POLICY & PRACTICE

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Lawsuits Plague Ob.Gyns.

Nearly 70% of obstetricians and gynecologists have been sued during their careers, according to a survey by the American Medical Association. Ob.gyns. share the top of the most-sued-specialties list with general surgeons. About half of ob.gyns and general surgeons have been sued at least twice in their careers. Within the past 12 months, 9.5% of ob.gyns. have faced lawsuits. The AMA compiled the report from data in its 2007-2008 Physician Practice Information survey. "The findings in this report validate the need for national and state medical liability reform to rein in our out-of-control system where lawsuits are a matter of when, not if, for physicians," Dr. J. James Rohack, AMA immediate past president, said in a statement.

Med Students Want More Sex Ed

More than half of medical students completing an Internet survey said they had not received enough training on sexual issues to address their patients' sexual concerns clinically, a study in the journal Academic Medicine found. Despite this, four of five of the students said they felt comfortable dealing with their patients' sexuality issues. Students reporting limited sexual experience, being at risk for sexual problems, and feeling that they had not been trained adequately admitted more unease talking about sexual issues than other medical students did. The survey of U.S. and Canadian medical students included 1,343 women and 910 men.

Breast Information Mandated

Breast cancer patients in New York will soon be getting more information about their reconstruction options, thanks to a new law. Starting Jan. 1, 2011, hospitals throughout the state will be required to inform the women about the availability and insurance coverage of reconstructive surgery before they undergo a mastectomy, lymph node dissection, or lumpectomy. Since 1998, federal law has guaranteed universal coverage for reconstruction, but many women aren't aware of it or don't know where to get the procedure, according to Dr. Evan Garfein, a plastic and reconstructive surgeon in New York who pushed for the state's new law. Women who are poor, less educated, and in minority groups are disproportionately affected, he said in a statement. "Breast reconstruction has been repeatedly shown to improve the quality of life and overall well-being of women," Dr. Garfein said.

Panel to Shape Cancer Research

Late this month, a federal advisory panel will begin work on a research agenda to clarify environmental and genetic factors in breast cancer. The new Interagency Breast Cancer and Environmental Research Coordinating Committee will hold its first meeting on Sept. 30 and will begin to review all breast cancer research that is conducted or supported by federal agencies. The committee is to recommend ways to improve and expand research opportunities. The 19-member panel includes representatives of federal agencies, physicians, other health professionals, scientists, and patient advocates. "The broad range of expertise and insight of these individuals will ensure the federal research portfolio continues to advance our understanding of the critical links between our environment, our genes, and our health," Linda Birnbaum, Ph.D., director of the National Institute of Environmental Health Sciences and the National Toxicology Program, said in a statement.

$42 Million for HIV Prevention

The Centers for Disease Control and Prevention has awarded $42 million to 133 community-based organizations to fight HIV among at-risk populations, which include blacks, Hispanics, gay and bisexual men, and illicit-drug injectors. The organizations will receive an average $323,000 per year for 5 years to implement HIV-prevention programs, increase HIV testing, and promote knowledge of HIV status among individuals. The organizations will use small amounts of each grant to measure their effectiveness. According to the CDC, a local organization has community knowledge and perspective that enable it to reach people who might not otherwise get tested for HIV or access preventive services.

Part D Premiums Edge Up

Medicare beneficiaries can expect their monthly Part D prescription drug premiums to rise next year, but only by about $1, according to the Centers for Medicare and Medicaid Services. Officials at the agency estimated that the average monthly premium for standard Part D drug coverage will be $30, about $1 more than in 2010. By shopping around, beneficiaries may be able to find plans with lower premiums than they are paying now, CMS Administrator Donald Berwick said during a press conference to announce the new rates. He and other officials said premium rates will remain relatively steady in 2011 because minor cost increases for the Part D plans have been offset by increased use of generic drugs. Also starting in 2011, Medicare beneficiaries will be eligible for 50% discounts of if they spend enough on brand name prescriptions to reach the Part D coverage gap, or "doughnut hole."

—Mary Ellen Schneider