Health Systems Take First Steps to Become ACOs

BY ALICIA AULT

FROM A CAPITOL HILL BRIEFING

WASHINGTON — A group of 19 health systems is taking the first steps toward becoming accountable care organizations, joining together to share best practices, coordinate care, and improve quality.

The health systems—which include Geisinger Health System, Baystate Health, and Bon Secours Health System—are all members of Premier Inc., a nonprofit health purchasing and quality improvement alliance. Premier will provide the expertise and databases necessary for the systems to build the accountable care organizations (ACOs).

According to Premier, members of the ACO Implementation Collaborative may be ready in 2012 to start contracting with the Centers for Medicare and Medicaid Services under the shared savings program mandated under the health reform law (Affordable Care Act). ACOs have been envisioned as the backbone of the new health care system, but they were not clearly defined in the law President Obama signed in March.

At the briefing, Sen. Max Baucus (D-Mont.), Rep. Earl Pomeroy (D-N.D.), and Rep. Charles Boustany (R-La.) praised the Premier effort, saying that it would help speed transformation of the health care system into one that values quality over quantity. Sen. Baucus said that the ACOs in the Premier alliance "put the new and innovative ideas in the health care reform law into practice to improve health care quality while reducing inefficient and wasteful spending." Rep. Boustany, who is a cardiovascular surgeon, added that the reform law did not go far enough to align incentives among health providers or to foster care coordination.

The Premier alliance will address some of these issues, he said, but it still is not clear if the ACO model can work in rural areas where there may be great distances between facilities and disparate missions from urban or suburban counterparts.

According to Premier president and CEO Susan S. DeVore, all members of the ACO collaborative will build the "critical components of accountable care," including a patient-centered foundation; medical homes that deliver primary care and wellness; incentives to reward coordination, efficiency, and productivity; tight integration among specialists, ancillary providers, and hospitals; reimbursement models that reward value over volume; and health information technology systems that can be used to coordinate care across networks.

The 19 systems already have some of these elements in place and can pursue accountability for a portion of their population, according to Premier. These hospitals and health systems have been participating in Premier's QUEST: High-Performing Hospitals collaborative. QUEST is a 3-year information and quality improvement sharing initiative involving 200 hospitals in 31 states. In the first year, hospitals reduced the cost of care by an average $343 per patient. The facilities delivered care according to evidence-based quality measures 86% of the time, according to Premier.

The ACO Implementation Collaborative aims to build on that success. The first step is to define value. According to Premier, the agreed-upon definition so far is to optimize patient outcomes, the patient care experience, and the total cost of care.

Dr. Nicholas Wolter, CEO of the Billings Clinic, which is part of the ACO collaborative, said although ACOs may seem to be a fad, much as managed care was in the early 1990s, more is known now about patient safety and delivering high-quality care. "In the ACO, patients are partners working with their care team to manage and improve their health. This is the real goal of health reform—the highest quality care at a more cost-effective price for patients and taxpayers." ■

To watch a video interview of Dr. Wolter, go to http://www.youtube.com/watch?v=2OzuMyovRss.

Members of the Premier Collaborative to Date

Aria Health, Philadelphia
AtlantiCare, Egg Harbor Township, N.J.
Baystate Health, Springfield, Mass.
Billings Clinic, Mont.
Bon Secours Health System Inc., Greenville, S.C., and Richmond, Va.
CaroMont Health, Gastonia, N.C.
Fairview Health Services, Minneapolis
Geisinger Health System, Danville, Pa.
Heartland Health, St. Joseph, Mo.
Methodist Medical Center of Illinois, Peoria
North Shore-LIJ Health System, Long Island, N.Y.
Presbyterian Healthcare Services, Albuquerque
Saint Francis Health System, Tulsa, Okla.
Southcoast Hospitals Group, Fall River, Mass.
SSM Health Care, St. Louis
Summa Health System, Akron, Ohio
Texas Health Resources, Arlington, Tex.
University Hospitals, Cleveland

ACGME Plans to Reduce Resident Duty Hours in First Year

BY ALICIA AULT

FROM THE NEW ENGLAND JOURNAL OF MEDICINE

The Accreditation Council for Graduate Medical Education has revisited its standards for resident duty hours and determined that some modifications should be made, mostly for first-year residents. All other residents should still be subject to an 80-hour work week and up to 24 hours of continuous duty, according to an article published online.

The 16-member ACGME task force that wrote the standards will review public comments and make any modifications considered necessary before July 2011, when the new standards will go into effect.

Wake Up Doctor gave the ACGME an 'F' for failing to comply with the IOM recommendation that continuous duty be restricted to 16 hours for all residents.

The original ACGME standards, established in 2003, have been the subject of much consternation in the medical community, with opinions differing over whether they have been too restrictive or too loose to properly protect patients and ensure a good quality of life for residents.

According to the latest report, written by Dr. Thomas J. Nasca, Dr. Susan H. Day, and Dr. E. Stephen Amis Jr. on behalf of the ACGME task force, the 2003 standards had the following three "problematic" elements, as identified by the educational community and the public:

► The limits on duty hours may have created a shift mentality among residents, which tends to conflict with the duty to serve patients.

► Many academic programs began focusing on meeting the duty hour restrictions, perhaps at the expense of education.

► The 80-hour work week, with up to 24 hours of continuous duty, was seen by many as compromising patient safety.

In 2008, the Institute of Medicine took a hard look at the ACGME standards and, among other things, recommended that no residents should exceed 16 hours of continuous duty.

The ACGME convened the task force to consider the IOM recommendations. One of the biggest challenges, according to the authors, was to reconcile the IOM's suggestion for an across-the-board restriction on duty hours with the continuing plea from academic programs that duty hours needed to be tailored to each specialty (N. Engl. J. Med. 2010 [doi:10.1056/NEJMsb1005800]).

For surgery, in particular, it would be difficult—and contrary to learning—to have a resident leave in the midst of a procedure because his or her duty hours had been reached.

The ACGME panel also had to weigh whether there was sufficient evidence to show that working more than 16 hours or up to 30 hours continuously led to more medical errors, as has been suggested by many critics of the duty hour standards.

According to the ACGME panel, the data thus far indicate only that first-year residents are more prone to mistakes as a result of sleep deprivation. Therefore, the task force urged a new paradigm for the first year of residency, whereby residents cannot be on duty for longer than 16 hours continuously and should have 10 hours off and 8 hours free of duty between their scheduled duty periods. First-year residents are not allowed to moonlight, and they must have direct, in-house, attending-level supervision.

All residents are allowed to work up to an additional 4 hours to facilitate patient handoffs—an area of concern for patient safety.

The panel decided not to tailor duty hours to specialties "because studies have not shown that the safety effect of current standards varies with specialty," said the authors.

The IOM had also criticized the ACGME for not properly enforcing the duty hours. The task force said that enforcement is an "inherent" challenge, partly because there are some 9,000 accredited programs.

However, the ACGME is now undertaking annual site visits and analyzing whether institutions can comply. Eventually, the organization will give each institution a report on its compliance status and recommendations for resolving problems. The reports will be made available to the public, said the authors.

Wake Up Doctor, a coalition of public interest and patient safety groups that has been pushing the ACGME to further restrict resident hours, said that the new standards don't go far enough. The group gave the ACGME an "F" for failing to comply with the IOM recommendation that continuous duty be restricted to 16 hours for all residents.

The coalition also gave a failing grade to the ACGME's plans for better monitoring compliance with the standards. However, the recommendation for greater supervision of first-year residents got higher marks.

The revised standards represent an important step, but "I think the acid test will be in the details," said Helen Haskell, founder and president of Mothers Against Medical Error, and a coalition member, in a statement. "We need to be sure that residents of all levels have sufficient backup and reasonable limits on their workloads." ■