

## **Accountable Care: How Are You Helping Your Organization Prepare? September, 2011**

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*LESLIE: I have been holding back on having a discussion in our column on accountable care organizations (ACOs) because of other health care priorities such as the HITECH Act, ICD-10-CM/PCS transition and sweeping changes in cancer registry, just to name a few. But it's time now to turn our attention to ACOs and the HIM role.*

*PATTY: There is a lot of change and perhaps ACOs will be the most transformative in terms of healthcare reform and how we practice HIM.*

*LESLIE: Health information will need to be a core competency of ACOs, according to Don Berwick, MD, MPP, and administrator of the Center for Medicare and Medicaid Services (CMS). In a New England Journal of Medicine article he wrote, "Information management -- Making sure patients and all healthcare providers have the right information at point of care -- will be a core competency of ACOs."*

*PATTY: This is a big statement by the CMS administrator. It drives home the importance of managing health information to improve healthcare outcomes as well as costs. Credentialed HIM professionals are prepared academically and through career experience to ensure that an organization's health information is accurate, timely, protected and accessible to those with a need to know.*

*LESLIE: I recall when Dr. Blumenthal, the former head of the Office of the National Coordinator for Health IT (ONC), referred to information as the "lifeblood of medicine." I think it's critical that our country's leaders are creating urgency around health information and the importance of data being reliable and available when it's needed.*

*PATTY: And in turn, it's equally critical that HIM professionals tap into this urgency and leverage their training and unique health information body of knowledge to transform how their organization uses information and equally important that consumers experience a different kind of healthcare because of effective and efficient use of health information.*

*LESLIE: What a great opportunity for HIM professionals to demonstrate their health information knowledge -- and to build on the rich history of transformative health information practices developed and implemented by those credentialed professionals that preceded the current HIM workforce.*

*PATTY: How true. HIM professionals have a long history applying their expertise to achieve organizational success on key health care reform initiatives. Reforms such as the implementation of JCAHO's medical record standards and subsequently information management standards, implementation of grouping systems such as DRGs, followed by variations through the years including MS-DRGs and APR-DRGs, implementation of prospective payment systems and managed care, quality reporting requirements, transition from paper*

*records to horribly complex hybrid records to electronic records and more recent mandates to ensure patient information privacy and security and meaningful use of electronic records. These are just a few highlights of healthcare reform initiatives that required HIM knowledge and experience during the past 50 years.*

*LESLIE: These are all very important milestones in the evolution of the practice of managing health information, but what is coming now -- the implementation of ACOs and completing the transition to electronic health records is potentially the most intensive and challenging change of all.*

*PATTY: How so Leslie?*

*LESLIE: The way we think about the "record" needs to change. The "record" as it is structured today, whether it is electronic or paper or a combination of both, is designed to support a single episode of care. This design therefore perpetuates a fragmented or silo view of a patient's health information. Our payment systems and decades of organizing medical records in episodes is holding us back from thinking about organizing healthcare data and documentation as a continuum of healthcare treatment instead of an episode of treatment. ACOs will push HIM practice toward its renaissance, forcing us to rethink not only how data and documentation should be organized, but how to leverage data in such a way that it truly improves patient care, inspires patient engagement and reduces burgeoning health care costs.*

*PATTY: I have been so immersed in our conversation I realize we never fully defined the concept of an ACO nor how it's different than its managed care predecessors.*

*LESLIE: Good point! Let's step back and do that briefly now. First let's look at the CMS definition of an ACO: An ACO is a an entity comprised of hospitals, primary care and specialty physicians, networks of individual physician practices, or suppliers involved in patient care who work together to coordinate the care for a minimum of 5,000 Medicare fee-for-service beneficiaries who are assigned to it.*

*I think it's important to understand that there are three aims as communicated by Dr. Berwick:*

- 1. "Better care for individuals"*
- 2. "Better care for populations"*
- 3. "Slower growth in costs through improvements in care"*

*PATTY: These aims seem pretty general to me Leslie.*

*LESLIE: The broad aims are simply stated, but how to achieve better care for individuals or populations for example lies in the 65 "proposed measures for ACO quality performance standards." In addition, it's proposed by CMS that ACOs use a shared savings and loss model. This model is detailed in the Medicare Shared Savings/ACO noticed of proposed rulemaking.*

*PATTY: The proposed rule anticipates that 75 to 150 ACOs will apply and be accepted in the initial roll out of ACOs.*

*LESLIE: What is your understanding on how ACOs are different from HMOs and managed care programs of the past?*

*PATTY: I understand there are a few differences. First off, the number of Medicare beneficiaries will be smaller. HMOs, for example, had hundreds of thousands enrollees where an ACO can have as few as 5,000 Medicare*

*beneficiaries. Incentives also appear to be more aligned in the ACO model. Financial incentives are based on predetermined measures and targets and on a shared revenue model.*

*LESLIE: I think prior managed care models did not have the benefit of today's environment where it is more commonplace for hospitals to have relationships with physician groups, thus removing some of the conflicts common under other traditional managed models.*

*PATTY: There are other differences too, including different payment options and the advancement of technology, which didn't exist under prior managed care models.*

*LESLIE: Financial and clinical data can more readily be shared among providers and we didn't have the tools to aggregate data for population health analysis as we do today.*

*PATTY: Well it all remains to be seen but I know organizations are beginning to organize themselves differently in preparation for early participation in adopting the ACO concept. The final rule is yet to be published and no doubt CMS is trying to sort through the significant amount of feedback it received on the proposed rule.*

*LESLIE: As we await for the final rule, now is a good time to read up on ACOs and engage in discussions with colleagues, in particular in envisioning HIM practice in an environment where the management of health information is squarely focused on the patient, the patient is engaged in shared decision making about their treatment options and the "record" is no longer episodic but longitudinal in design.*

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