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Improved Transitions through Accountable Care Organizations

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Accomplishing successful transitions of care is a complex feat that requires coordination among many different players. Of the models that exist today, the Accountable Care Organization (ACO) is among the most useful in effecting successful transitions of care. For this reason, the recently enacted health care reform legislation places emphasis on implementing the ACO model.

Accountable Care Organizations

An ACO is a local health care organization and a related set of providers – at minimum, primary care physicians (PCPs), specialists, and hospitals – that are held accountable for the cost and quality of the care delivered to a defined population.

The goal of the ACO is to deliver coordinated, efficient care. In addition to a bundled payment for providing care to a population, ACOs generally receive a financial bonus for achieving specific quality and cost targets. In some cases, ACOs that fail to achieve targets are subject to a financial penalty.

In order to meet the requirements for this type of incentive system, an ACO must be able to: care for patients across the continuum of care in different institutional settings; engage in prospective budgeting and planning for resource requirements; and support comprehensive, valid, and reliable measurement of its performance.

These goals, along with their structural and financial qualities, motivate ACOs to develop systems that promote efficient, effective transitions between stages of health and care settings.

ACOs and Health Care Reform

The Patient Protection and Affordable Care Act (PPACA) of 2010 encourages the creation of ACOs. By means of a shared savings program (to be established January 1, 2012), the Act allows providers organized as ACOs to share in the cost savings they achieve for Medicare. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries; have adequate participation of PCPs; and to define and implement processes to promote evidence-based medicine, report on quality and costs, and coordinate care.

The Centers for Medicare and Medicaid Services has outlined the preliminary requirements for Medicare ACOs,[1] which include: a formal legal structure to receive and distribute shared savings; a sufficient number of PCPs for the assigned beneficiaries; a minimum of 5000 assigned beneficiaries; an agreement to participate for no less than 3 years; documented information regarding participating health professionals to support beneficiary assignment; a leadership and management structure that includes clinical and administrative systems; defined processes that promote evidence-based medicine, report data for quality and cost measures, and coordinate care; and a demonstrated model of patient-centeredness.

Evolution of the PACE Program: A Model ACO

The Program of All-inclusive Care for the Elderly (PACE) is already established as an ACO that utilizes the pillar of transitions of care (ie, includes an electronic medical record [EMR], medication management, caregiver support, and physician follow-up). The PACE model of care can be traced back to the early 1970s, when a public health dentist along with community leaders created a community-based system of care to meet the needs of immigrant populations in San Francisco. In 1990, Medicare and Medicaid issued waivers to several sites as demonstration

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programs, and the Balanced Budget Act of 1997 established PACE both as a permanent part of the Medicare program and an option under state Medicaid programs. Existing PACE demonstration programs became permanent PACE providers by 2003.

Although these programs typically care for fewer than 5000 assigned beneficiaries, PACE is an ACO with a proven track record. PACE has demonstrated very positive outcomes for an especially frail population of older adults in 3 specific areas[2]:

- *Health Care Utilization.* PACE enrollment led to sustained lower levels of hospitalizations and long-term nursing home (NH) admissions and sustained increases in ambulatory visits.

- *Health and Functioning.* PACE enrollees had higher levels of self-reported health and physical functioning in the short term; generally these decreased over the follow-up period. Enrollees lived in the community more days per year and experienced decreased mortality.

- *Satisfaction and Quality of Life.* Over the duration of the evaluation, PACE enrollees were more likely to report regular attendance at social functions (at least once per week), satisfaction with care, and a better quality of life. These satisfaction and quality-of-life effects gradually declined as the length of enrollment in the program increased.

The PACE model[3] is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. PACE serves individuals aged 55 or older who are: certified by their states as needing NH care, able to live safely in the community at the time of enrollment, and live in a PACE service area. One important distinction is that older adults cared for by PACE are considered to be active "participants" in the PACE program rather than "members" or "patients." Although eligibility for NH level of care must be certified for enrollment, only 7% of PACE participants actually reside in a NH. If a PACE enrollee does need NH care, the PACE program pays for it and continues to coordinate the enrollee's care.

Seniors' health care costs are typically paid by Medicare and Medicaid programs or out-of-pocket, making access to comprehensive (ie, preventive, primary, acute, and long-term) care difficult or impossible. Because they are designed to deliver a comprehensive set of services focused on health and well-being, and because of their ability to combine dollars from different funding streams, PACE programs can offer seniors who would otherwise be relegated to NHs the option of continuing to live in the community.

Perceptions of PACE may vary widely from one stakeholder to another. Public awareness is often limited to PACE vans that provide transportation for participants. Policy makers may understand PACE as a program that integrates Medicare and long-term care funding in a way that saves taxpayer dollars while providing more effective care. PACE participants and their family members might focus on the PACE Center as the central part of the program. In reality, it is the combination of clinical and support service components that results in care and services tailored to the individual needs of each PACE participant.

Interdisciplinary Team Approach

PACE care planning is the process by which each participant's Interdisciplinary Team (IDT) holistically assesses his or her medical, functional, psychosocial, and cognitive needs, and develops a single, comprehensive plan of care to address those identified needs. The IDT members who conduct the extensive discipline-specific assessments collectively discuss the participant's identified needs and design and monitor the individualized care plan. The care plan delineates problems, interventions, and measurable outcomes to improve, maintain, recover, or reset a participant's baseline health status and preferences for health care.

When a care plan is properly executed, the assessments and care planning flow together in a seamless, ongoing process that:

- Takes into account each participant as a human being with unique characteristics, needs, and documented preferences;

- Anticipates potential problems by identifying individual risks and determining how these risks can be minimized to foster the participant's highest feasible level of well-being;

- Develops and implements a plan of care that integrates discipline-specific assessments and allows for coordinated and continuous evaluation of the efficacy of care; and

- Comprehensively reevaluates the participant's status at prescribed intervals as well as at episodic reassessments prompted by changes in the participant's health status. Note: Significant changes in health status compel a timely reassessment that cannot be deferred to a prescribed interval such as semiannual or annual reassessments.

Role of Technology

Within PACE's approach, the key elements that support transitions of care include an EMR, medication management, caregiver support, and physician follow-up. In addition to utilizing a complete EMR that increases the level of communication and permits analysis of clinical

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practices, PACE programs commonly employ technologies such as home monitoring and sensors. These provide additional oversight and warn of potential issues before significant problems develop.

Given the high number of medications prescribed for this population, assuring that participants take the right medication correctly is critical. To address medication reconciliation, many PACE programs arrange for their home care nurses to visit with participants immediately upon discharge from a facility to assure that they understand and have access to discharge medications. As part of the process, home care nurses also remove medications that are no longer prescribed.

Technology also is used for medication management. At-home dispensing devices, placed at the bedside, prompt participants to take their medications at the appropriate time and notify the care team of any issues electronically in real time. The devices are especially helpful in managing "as needed" medications, which may otherwise be overused as a result of participant cognitive issues.

Caregiver Support

Because caregivers are critical to enabling older adults to remain in their homes, caregiver support is a major focus of PACE. The program features hands-on caregiver education, timely caregiver support, and extensive nonmedical caregiver assistance, which includes home aides, respite care, and home improvements.

Physician Follow-Up

An unmet opportunity identified with regard to transitions of care is assuring timely physician follow-up. PACE programs provide transportation, which often presents a barrier to making a physician appointment. Most PACE programs go further by actually setting the appointment, conveying information to the physician, and providing an escort to assure that the physician's advice to the participant is followed at the conclusion of a visit.

The foregoing components have resulted in improved care transitions for PACE participants. Perhaps the most impressive improvement has been in transitioning long-term NH residents back to the community. In early 2010, the Commonwealth of Pennsylvania established a long-term NH transition program wherein individuals who had been in the NH for more than 90 days were assisted back to the community.[4] This program has not only resulted in $250 per day cost savings for the State, it also has improved the quality of life for these older adults who receive the support necessary to live in their own apartments.

ACO Role in Improving Care Transitions

Clearly, ACO models similar to PACE can deliver improved care transitions. To promote ACOs, the correct financial incentives and resources to develop interdisciplinary care teams and technological support systems must be put in place. In addition, certain components of ACOs, such as the Medical Home, can be applied in the fee-for-service market to improve care transitions. Beyond the immediate benefit for participants, it is likely that ACOs will produce a Hawthorne-like effect in other health care delivery systems which, in turn, will improve transitions for non-ACO participants.

At this critical time when health care reform is focused on improving quality while reducing costs, ACOs can serve as the foundation for improving care transitions – a critical element in bettering outcomes.

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