The focus of health care reform has moved from increased access to health insurance to concern about gaps in quality, rising costs, and a delivery system model that some think is designed to augment rather than solve these problems. Public and private sector efforts to encourage greater accountability for quality and cost were evolving prior to the new health care reform legislation, but focus on the concept of Accountable Care Organizations (ACO) has accelerated due to language in the reform legislation that authorizes Medicare to contract directly with ACOs. This interest is driven by growing consensus that meaningful delivery system reform will need to be built around local accountability across a coordinated continuum of care that engages multiple health care professionals and institutions in the consistent provision of high quality care. Such accountability must allow flexibility to accommodate the diverse practice types and organizational structures upon which the U.S. health care system is already built so that strategies to improve care can reflect local health system conditions. There is also recognition that the current payment system built around volume and intensity must give way to one that promotes value and encourages collaboration and offers greater transparency to consumers.

The ACO concept has evolved as a model through which integration and accountability can be achieved while building on existing relationships and community networks. Observation of the delivery of health care in communities pointed to the fact that physicians continue to have strong affiliations to one or a small number of hospitals, and their patients tend to receive most of their care within the network of those institutions and their affiliated physicians. Building on these informal networks to create organized systems that could be held accountable for providing high quality care to their already established patient population might make more sense, and be more likely to succeed, than attempting to create new, fully integrated systems of care. Rewarding these informal networks for improved performance on cost and quality parameters should encourage further improvement and evolution toward more tightly organized systems of care.

Since the original discussions of ACOs occurred, the focus has expanded from systems built around hospital affiliations to models built by large, multi-specialty physician groups and independent practice associations, which offer a model for small practices to share resources and increase influence in their local delivery system. A recent article in Health Affairs offers five examples of existing delivery system models that could evolve into ACOs: integrated delivery systems such as Kaiser Permanente and the Giesinger Health System; multi-specialty group practices such as the Cleveland Clinic or Mayo Clinic; physician-hospital organizations like Advocate Health in Chicago; IPAs; virtual physician organizations, examples of which include the Grand Junction, Colorado, health care community and the North Dakota Cooperative Network.

Effective no later than January 2012, the new health care reform legislation establishes a Medicare shared savings program for ACOs as a permanent option under Medicare. Each eligible ACO is required to have a formal legal structure that permits it to receive and distribute shared savings payments and to meet quality and reporting standards that will be developed by the Secretary of HHS. In order to participate, an ACO must agree to a minimum 3 year contract and serve an assigned Medicare population of at least 5,000 patients. Although the Secretary of HHS is empowered to define additional eligible groups, some of the groups identified in the legislation as eligible to participate as a Medicare ACO include group practices, IPAs or other networks of individual practitioners, and hospitals that employ health
Shared savings based on benchmark targets that would be divided among participating providers in a manner determined by each ACO.

- Evolution to greater integration and accountability that would begin with no downside risk of the ACO sharing in financial losses if patient care costs were greater than expected. There was some discussion of a “tiered” approach which would reflect the level of capacity and experience an organization had, setting liberal spending targets initially under the shared savings approach for newly formed organizations while offering the opportunity for highly integrated systems to bear increased financial risk immediately.

Experience with similar features tested in a five year Medicare Physician Group Practice demonstration project permitted ten group practices to achieve bonus payments by meeting quality standards and reduced costs. Data from the first three years of this demonstration showed very mixed results with some groups qualifying for bonuses while others had patient costs that grew faster than those for comparable Medicare beneficiaries. Expanding the concept beyond the Medicare population is also under discussion. Providers may be more likely to respond to incentives if a larger percentage of their patients were participating in the same model and payers were using uniform performance and quality standards. Whether physicians, hospitals and other health care providers will see the possibility of shared savings as sufficient motivation to change care patterns in a way that might reduce the services they provide, with no clear experience of upside potential, remains to be seen. The challenges of acquiring and implementing data systems and organizational structures necessary for successful ACO performance, and requisite startup capital, may also create barriers or at least result in delays in the evolution of coordinated systems of care.

Physicians interested in learning more about ACO formation may want to visit the ACO Learning Network sponsored by the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice at www.xteam.brookings.edu/bdacoln/Pages/home.aspx.
"Marketing and Growing Your Practice—Part II"

Presented by

Marcia Brauchler, MPH

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- Developing a comprehensive marketing campaign: creating a plan from budget to implementation
- Looking at a “menu” of marketing opportunities to select what works for you and your practice
- Reviewing “tangible” marketing efforts, like print advertising, practice brochures and website development
- Reviewing “intangible” marketing efforts, like establishing physician referrals and patient satisfaction
- Social media expert, Eric Elkin, will discuss what is best for you: Twitter, Facebook, LinkedIn?

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The Ugly Face of Facebook for Physicians

Online communication using tools like Facebook can make communications with family and friends easy and instantaneous. The perception of privacy, however, may be false. It might be tantalizing to use this tool for your practice, but qualities that make Facebook simple to use can create issues for medical practices. Before either creating a Facebook page or connecting your personal profile to your practice, consider the following:

- Assume all your comments on the Internet are public, permanent, and discoverable in litigation. If only one word of your communications is case related, all of it is discoverable.
- Avoid discussing medical or financial information on Facebook. Remember that content on Facebook belongs to Facebook—and the final use of that information is not under your control.
- Prevent the unintended use of your comments, links, and thoughts. Facebook uses programs that actively link any postings, profile information, and links to external sites. These links and their activity may not be obvious, or in some cases detectable. Privacy settings are tricky with social media sites, and change rapidly.
- Remember that discussions inside Facebook among friends are visible to others.
- Avoid giving advice on social media sites.
- Avoid “friending” patients, unless they were your offline non-patient friends before Facebook. Consider drawing a bright line between your personal and professional life and avoid postings and links which may not reflect favorably on your profession.
- Guard your reputation with relentless intensity. Tools that enable our ever-easier communication can capture events and behavior which may not reflect well in a different context—such as the courtroom.

Understanding the growing risks of and mounting penalties for breaches of patient data and financial records, The Doctors Company created and added CyberGuard℠, free for its member physicians. The new coverage protects physicians when they are on social media sites like Facebook for defense of a privacy breach. For more information, please visit www.thedoctors.com/cyberguard.

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UPDATES

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An excerpt from the
Denver Medical Bulletin
May 27, 1911

Gentlemen—In our efforts to bring the profession closer together and thereby become a more potent factor in bringing about needed reforms, it seems to me that we ought to make mention of the noble and tireless fight which Senator Dr. Sharpley and his colleagues made in that direction during the session of the recently adjourned legislature. The City and State Medical Societies ought to take official action commending them and expressing to them our appreciation of the service which they rendered in our behalf. Let us not forget to reward merit. G. L. Monson
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