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From Clinical Integration to Accountable Care

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I. BACKGROUND

The American health care system has been unable to deliver high quality care consistently across populations[1] and to deliver value for the healthcare delivered.[2] The Patient Protection and Affordable Care Act of 2010 (PPACA) proposes several innovations that attempt to improve both the quality and affordability of health care services.[3] These innovations include bundling services for payment, encouraging the patient centered medical home, and increasing accountable care organizations (ACOs). ACOs, as well as these other innovations, require that physicians work together across specialties to improve the quality, safety, and cost-effectiveness of health services. There are four key challenges, however, to the widespread application of ACOs.[4] These challenges are: (1) the dominance of small physician practices, (2) the dominance of fee-for-service reimbursement, (3) the weaknesses of traditional hospital medical staff, and (4) acceptance by the commercial market.[5] This article briefly describes Advocate Physician Partners (APP), which demonstrates a model that has overcome these challenges and provides a basis for the development of an ACO. We believe this is a replicable model that can assist many providers in enhancing efficiency, delivering high quality care, and creating an ACO.

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1. INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 360 (Nat'l Acad. Press 2001); Elizabeth McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 NEW ENG. J. MED. 2635, 2635-45 (2003).

2. KAISER FAMILY FOUND. & EDUC. RESEARCH TRUST, EMPLOYER HEALTH BENEFITS 2007 ANNUAL SURVEY 19, ex. 1.1, *available at* http://www.kff.org/insurance/7672/upload/76723.pdf.

3. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3023, 124 Stat. 119 (2010) (to be codified in 42 U.S.C.).

4. Mark Shields et al., *A Model For Integrating Independent Physicians Into Accountable Care Organizations*, 30 HEALTH AFF. 161, 161 (2011).

5. *Id.* at 161-62.

II. FOUR CHALLENGES TO INTEGRATED AND ACCOUNTABLE CARE

The first challenge to attaining integrated care is that most physicians practice in small groups or solo practices.[6] These structures lack the capital or depth of management commonly associated with larger groups, many of which that have consistently delivered quality and cost effective outcomes. Second, fee-for-service reimbursement to physicians – the dominant mode of payment – encourages volume and does not pay for key tasks needed to provide high-quality cost-effective services.[7] Those tasks not reimbursed by fee-for-service payments include care management of complex cases; use of electronic tools, such as disease registries and quality reporting; and use of alternative patient encounters, such as electronic visits or scheduled telephone encounters.[8] Third, existing hospital medical staff structures makes it difficult to provide incentives to doctors for improved performance or to discipline them for poor cost-effectiveness, quality, or safety.[9] Finally, the commercial market will need to be involved in the support payment structures that facilitate ACOs since the reengineering of clinical practice and the cost of infrastructure must be spread across a large patient base, not just patients covered by governmental payers.[10] APP has demonstrated an ability to overcome these four challenges facing the successful development of ACOs.[11]

III. STRUCTURE TO OVERCOME CHALLENGES

APP offers policymakers a strong example of a health care system that could serve as one of the models for ACOs encouraged by the PPACA. APP is a joint venture between Advocate Health Care (Advocate), a not-for-profit, faith-based health system in northern and central Illinois, and has approximately 3800 physicians in Illinois. Advocate employs approximately 850 physicians in large multi-specialty groups throughout its 10 hospital campuses offering numerous services, including homecare.[12] Each hospital and its associated partnership physicians (employed and independent) have a local Physician Hospital Organization (PHO) board that leads the physicians towards quality, patient safety, and cost goals.[13] There are 2900 inde-

6. *Id.* at 161; *see* NAT'L COMM. FOR QUALITY ASSURANCE, SUPPORTING SMALL PRACTICES: LESSONS FOR HEALTH REFORM, *available at* http://www.ncqa.org/Portals/0/HEDISQM/CLAS/Briefing/Small_Practices_Report.pdf.

7. Shields et al., *supra* note 4, at 162.

8. *See id.* at 163.

9. *Id.* at 162.

10. *Id.* at 169.

11. *Id.*

12. *Id.* at 162.

13. Shields et al., *supra* note 4, at 162.

pendent physicians in the partnership who typically are in solo or small (three physicians or less) single specialty group practices.[14] There are over 900 such small practices in APP.[15] The types of APP practices include: solo and group; single specialty and multi-specialty; and employed and independent.[16]

APP has two membership classes that have an equal number of governance votes: one for Advocate and one for the PHOs.[17] A majority of each class is required for a measure to pass.[18] Physicians elect the leaders of each local PHO who then send a delegate to APP's Board.[19] This ensures that independent physicians share in the PHOs' governance with Advocate. Furthermore, employed physicians occupy many of the Advocate governance seats in APP, thereby placing physicians in a super majority and hospital managers in the minority.[20] This creates a structure for both physicians and hospitals to work together to improve care with common quality and cost effectiveness goals.[21]

For over fifteen years APP has performed care management and managed care contracting.[22] Member physicians provide care for almost 1,000,000 patients in commercial health insurance programs, 230,000 in health maintenance organizations (HMO) plans and over 700,000 in fee-for-service plans.[23] Physicians and hospitals are collectively accountable for quality and cost during negotiations with payers because APP negotiates on behalf of both Advocate and physicians, and signs single signature contracts – contracts that APP executes and members of APP must accept.[24] Physicians must also meet strict membership requirements such as a threshold

14. *Id.*

15. *Id.*

16. *Id.* at 162.

17. *Id.* at 162. For more information about governance at Advocate, see *Physician Governance*, ADVOCATE HEALTH CARE, http://www.advocatehealth .com/body.cfm?id=1898 (last visited Apr. 25, 2011).

18. *Id.*

19. Shields et al., *supra* note 4, at 162.

20. *Id.* at 162-63.

21. *Id.*

22. *Id.*; *see also About Advocate Physician Partners*, ADVOCATE HEALTH CARE, http://www.advocatehealth.com/ body.cfm?id=1126 (last visited Apr. 11, 2011) (describing APP as a "care management and managed care contracting joint venture").

23. *Id.;* An HMO is "a health care system that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area, usually in return for a fixed, prepaid fee." *Frequently Asked Questions*, BLUECROSS BLUESHIELD ASS'N, http://www.bcbs.com/about/faq/ (last visited Apr. 25, 2011). For a discussion of fee-for-service plans, see *Fee-for-Service Health Coverage*, KIPLINGER, http://www.kiplinger.com/basics/archives/2003/11/fee.html (June 2010).

24. Shields et al., *supra* note 4, at 161, 163.

score on annual performance report cards and use key information technology.[25] This organizational structure establishes the framework for success. Without joint contracting, realizing true gains in quality enhancement and cost containment would be difficult.

IV. IMPORTANCE OF JOINT CONTRACTING

Joint contracting by the independent physicians with payors is critical to the success of APP for several reasons. First, since all APP physicians must participate in every signed contract, it assures a consistent network of physicians. This facilitates APP programs that integrate services across physicians and assures predictability of providers for patients. Second, it allows health insurance companies and APP, on behalf of its doctors, to agree to a common set of measures to be used by all physicians to improve quality, safety and cost-effectiveness. APP has successfully negotiated this same set of measures in all of its clinically integrated contracts, which greatly simplifies the reporting of outcomes by physicians and focuses the improvement effort by physicians and their staffs. Third, joint negotiations have allowed for the establishment of an incentive fund used by APP to overcome the limitations of fee-for-service reimbursement and reward practices that improve quality, safety, and cost-effectiveness. Fourth, joint negotiations have secured the support for the infrastructure used by APP to improve physician performance, such as information systems, registries, training programs, and academic pharmacy detailing. Finally, joint negotiations lead to a greater market recognition by the physicians than if each group entered into talks alone with the insurance company.

This joint contracting by APP on behalf of the 2900 independent physicians along with the 850 employed physicians is permitted under antitrust laws because APP is structured to deliver improvement in quality, patient safety, and cost-effectiveness.[26] Generally, antitrust law does not allow competitors to jointly negotiate unless there is either financial integration or clinical integration.[27] Under these laws, agreements among competitors affecting the prices they charge for their services are *per se* unlawful pursuant to Section 1 of the Sherman Act.[28] The Federal Trade Commission (FTC) historically permitted joint contracting between physician organizations if they were financially integrated, but not until 1996 did it allow clinical integration to render the same treatment. The FTC established guidelines that subject clinically integrated organizations to "rule of reason" treatment as

25. *Id.*
26. *Id.* at 162.
27. *Id.* at 164.
28. 15 U.S.C. § 1 (2010).

opposed to "per se" analysis.[29] *Per se* analysis is a presumption that certain agreements are conclusively presumed to be an unreasonable restraint on trade and thus, illegal.[30] This analysis is extremely difficult to rebut. By contrast, rule of reason analysis is a more in depth weighing of whether the agreement unreasonably restricts competition, and is easier to defend.[31]

Clinically and financially integrated programs, like APP, that sufficiently demonstrate an ability to create efficiencies will receive rule of reason treatment. First, HMO risk contracts demonstrate *financial integration* and APP has negotiated those types of contracts for the last fifteen years on behalf of the independent physicians.[32] Since 2004, however, APP has negotiated fee-for-service contracts (preferred provider contracts) on behalf of the independent and employed physicians using the model of *clinical integration* of its programs as the basis of negotiations.[33] Subsequently, APP received approval from the FTC to proceed with these types of programs and negotiations. APP used prior FTC decisions to guide its strategy and organizational structure.[34]

V. BENEFITS OF THE MODEL

In addition to overcoming the four challenges to integrate physicians, APP has demonstrated the ability to deliver progressively improved quality outcomes. It has done this by using a variety of strategies, which include incentive payments, formal collaborative educational programs for physicians and their staff using industry standard techniques, specific chronic disease clinics that support the practicing physician, online education for physicians and their staff, and electronic tools such as disease registries that help physicians track outcomes and recall patients needing key services.[35]

Furthermore, APP has demonstrated the ability to progressively increase the use of health information technology across its physician network. This began in 2004 with the requirement that all physician offices have high speed internet.[36] High speed internet allowed physicians to have rapid

29. *See* FEDERAL TRADE COMM'N & DEP'T OF JUSTICE, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (Aug. 1996), reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,153, http://www.ftc.gov/reports/hlth3s.htm [hereinafter POLICY STATEMENTS].

30. United States v. Socony-Vacuum, 310 U.S. 150, 229 n.59 (1940).

31. Broad. Music, Inc. v. Columbia Broad. Sys., Inc., 441 U.S. 1 (1979); NCAA v. Bd. of Regents of Univ. of Okla., 468 U.S. 85 (1984); Texaco v. Dagher, 547 U.S. 1 (2006).

32. Shields et al., *supra* note 4, at 162.

33. *Id.* at 165.

34. *Id.* at 164.

35. *Id.* at 163.

36. ADVOCATE PHYSICIAN PARTNERS, THE 2010 VALUE REPORT 29 (2010), *available at* http://www.advocatehealth.com/documents/app/final_1640_Value%20Report%202010.pdf [hereinafter VALUE REPORT].

access to results for diagnostic studies, laboratory tests, and hospital discharge information. APP's use of technology progressed to include web-based disease registries, which allow tracking of patients with chronic conditions in a physician's practice and recalling of these patients when appropriate.[37] APP also utilizes web-based learning programs for both physicians and staff which are designed to accelerate the quality and safety outcomes of the program.[38] Additional tools allow physicians to access all of their filled prescriptions with prompts and reminders to identify opportunities for generic substitution.

Quarterly report cards on physician performance are also available electronically. APP facilitated electronic prescribing by providing links to physician billing systems and training physicians and staff on the tool and office reengineering to most effectively use it.[39] It accelerated the use of electronic tools in the hospital by educating its physicians and providing incentives for use.[40] These tools included computerized physician order entry and use of the electronic intensive care unit.[41] Finally, the use of electronic data interchange (EDI) for the submission of bills to managed care organizations was accelerated through education and incentives.[42] This rate of adoption, which is higher than the general market, led to significant savings for managed care organizations.[43]

Although APP is now deploying a fully integrated electronic health record, it is worth noting that APP's initiatives began without a widespread implementation of electronic health records. APP piloted a full electronic health record in 2009 and began a rollout of an integrated health record in the summer of 2010.[44] It is expected that the system will have 1000 independent physicians in this integrated system by mid-2012. The 850 employed physicians had initial access to an integrated electronic health record, which has been progressively rolled out across this group since 2006. By the end of 2010, 650 of the 850 physicians had a fully deployed electronic health record.[45]

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37. *Id.* at 11, 14.
38. *Id.* at 15.
39. *Id.*; Shields et al., *supra* note 4, at 166.
40. VALUE REPORT, *supra* note 36, at 14.
41. *Id.* at 14-15.
42. *Id.* at 14.
43. Shields et al., *supra* note 4, at 168.
44. VALUE REPORT, *supra* note 36, at 15.
45. NAT'L INSTS. OF HEALTH, ELECTRONIC HEALTH RECORDS OVERVIEW 1 (2006) ("The Electronic Health Record (EHR) is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The HER automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete

Of all the electronic tools deployed by APP, the disease registries have been deemed to be the most powerful tool during the first seven years of APP. These registries will be fully integrated with the electronic health record so that data can be transmitted directly from the record to the registry.[46] Many prompts and reminders have been built into the electronic health record during its installation to assist physicians and their staff in achieving the goals of APP's program.

VI. SELECTING PRIORITIES FOR A PROGRAM OF CLINICAL INTEGRATION

Improving the cost-effectiveness of services has been a focus of APP since the beginning. For the purposes of the program, value can be thought of as quality plus service divided by cost.[47] APP evaluates initiatives before selection to ensure that they increase this value equation. Particular attention is paid to initiatives that help reduce indirect medical costs as well as direct medical costs. Key indirect medical costs are absenteeism and presenteeism since they have a major impact on productivity for an employer.[48] Absenteeism is the rate of lost days at work for an employee.[49] Presenteeism is the rate of reduced productivity that occurs when an employee is present at work but is not fully productive.[50] An example of an initiative in the APP program that reduces both absenteeism and presenteeism is the screening and treatment for depression.[51] Another APP high impact initiative that reduces direct medical costs and improves value has been the increase of generic pharmaceuticals when clinically appropriate. APP has had a prescription rate of generic pharmaceuticals that is four to six percent higher than the general market. This translates into over $20 million per

record of a clinical patient encounter, as well as supporting other care-related activities directly or indirectly via interface-including evidence-based decision support, quality management and outcomes reporting").

46. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, REGISTRIES FOR EVALUATING PATIENT OUTCOMES: A USER'S GUIDE NO. 07-EHC001-1, at 1 (R.E. Gliklich & N.A. Dreyer, eds. 2007) ("[A] patient registry is an organized system that uses observation study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition or exposure. . .to describe the natural history of a disease, to determine the clinical effectiveness or cost effectiveness or health care products and services, to measure or monitor safety and harm and/or to measure the quality of care").

47. PETER DUCHESSI, CRAFTING CUSTOMER VALUE: THE ART AND SCIENCE 85 (2002).

48. Paul Hemp, *Presenteeism: At Work-But Out of It*, HARVARD BUS. REV. AT LARGE 1 (Oct. 2004), *available at* http://www.ihpm.org/pdf/HBR%20Presenteeism.pdf (Presenteeism is defined as expenses, estimates based on employees' salaries, are the dollars lost to illness-related reductions in productivity).

49. BUREAU OF NAT'L AFFAIRS, Q. REP., CHAPTER 13: ABSENTEEISM (2006). (The BNA quarterly report defined absenteeism as those absences that are unplanned and cause disruption in workflow or productivity).

50. Hemp, *supra* note 48, at 1.

51. VALUE REPORT, *supra* note 36.

year in savings for employers, managed care organizations, and patients.[52] Although these examples are representative of APP's successful outcomes, utilization of transparency with identification of benefits to stakeholders are critical factors for clinical integration to obtain market acceptance.

A. Transparency of Results

The results of the APP program have been described each year in a summary entitled the Value Report, which is distributed to employers, insurance companies, and other key constituencies and is available online to the public.[53] This transparency is a critical part of the program for two reasons. First, physicians and hospitals are aware of this public reporting, which helps accelerate performance.[54] Furthermore, it allows APP to tell its story directly to employers and the general public without having that performance translated by insurance companies.[55]

B. Benefits for Stake Holders

The APP clinical integration program, which began in 2004, needed to provide benefits to key participants in the health care market in order to be successful.[56] APP had to offer benefits to hospitals, physicians, insurance companies, employers, and patients. There are several benefits from the clinical integration program for hospitals, including a business relationship with physicians to achieve joint outcomes.[57] The joint outcomes include improved cost-effectiveness for hospitals and improved patient safety.[58] In addition, the program can enhance physician loyalty to the institution.[59]

Likewise, there are several benefits of the program for physicians. These include: better alignment with hospitals, marketplace recognition, incentive payments for services not covered by fee-for-service compensation, rewards for clinical excellence, and an interface with multiple insurance compa-

52. Shields et al., *supra* note 4, at 168.

53. VALUE REPORT, *supra* note 36, at 9, tbl. 1.

54. *See, e.g.*, ANN LENNARSON GREER, EMBRACING ACCOUNTABILITY: PHYSICIAN LEADERSHIP, PUBLIC REPORTING, AND TEAMWORK IN THE WISCONSIN COLLABORATIVE ON QUALITY 14 (Commonwealth Fund 2008).

55. Merrill Goozner, *Quality, Economy, Transparency: A New Healthcare Code*, FISCAL TIMES, May 10, 2010, *available at* http://www.thefiscaltimes.com/Columns/2010/05/10/How-A-Wisconsin-Program-Can-Save-Americas-Health-Care-System.aspx.

56. *Health Care System "In Pursuit of Excellence" Case Example* (Oct. 2008), AM. HOSP. ASS'N, http://www.aha.org/aha/member-center/constituency-sections/Health-Care-Systems/advocatecase.html.

57. *Id.*

58. *Id.*

59. Shields et al., *supra* note 4, at 165.

nies.[60]

Finally, there are multiple advantages to the marketplace, which comprises patients, insurance companies, and employers. These advantages include: providers focusing on outcomes and enhanced value, demonstration of efficiencies of care delivery, a stable and cohesive network of providers that is focused on improved outcomes, transparency of results, and leadership by physicians of a reengineered health system.[61]

C. Critical Success Factors for Clinical Integration

There are a number of factors that have been critical to the success of the clinical integration program. First, physician leadership has been essential. Although APP is a joint venture between hospitals and physicians, physicians have spearheaded the program design and implementation.[62] Again, negotiations with insurance companies have insisted on a common set of metrics and thresholds for success.[63] This has allowed APP and the physicians to focus on a single set of metrics with a single reporting system, which has helped drive results. Although physicians acknowledge that efforts such as care management and patient follow-up are important, they are not reimbursed for these services by the fee-for-service system.[64] Thus, payment to physicians for improving clinical performance and for services not compensated by fee-for-service payments has countered this traditional disincentive and led to improved outcomes.[65] Additionally, infrastructure support has been critical for the success of the program. This infrastructure has included tools such as web-based disease registries, formal educational programs for physicians and staff, coaching physicians on the use of health care information technology, and outreach efforts to patients to increase adherence to key processes.[66] At the same time, much effort is needed to optimize the expenditures for infrastructure since these funds take away from potential incentive payments to physician practices. Finally, the alignment between hospitals and physicians has helped accelerate change both for inpatient care as well as outpatient care.[67] Hospitals bring considerable information technology, management expertise and capital that otherwise would not be available to physician groups and the program helps to better engage physicians.[68]

60. *Id.* at 164.
61. *Id.* at 164-65, 169.
62. *Id.* at 162, 164.
63. *Id.* at 164.
64. *Id.* at 163.
65. *See* Shields et al., *supra* note 4, at 163-64.
66. *Id.* at 164, 166, 169.
67. *Id.* at 166, 169.
68. *Id.* at 162, 164, 169.

VII. TRANSITION FROM CLINICAL INTEGRATION PROGRAM TO ACCOUNTABLE CARE ORGANIZATION

The APP clinical integration program has laid the groundwork for further innovations that are available to both the commercial market and government programs. These innovations include bundled payments, prevention of readmissions, and accountable care organizations.[69] In fact, APP has entered into a contract effective January 1, 2011 with Blue Cross Blue Shield of Illinois, the largest carrier in the state, that is a shared savings contract structured similar to what is expected to emerge from the federal government for ACOs.[70]

A. Shared Savings Contract

As stated above, APP's contract with Blue Cross Blue Shield is a shared savings contract.[71] As a result of this arrangement, APP will share in savings generated by a rate of increase in health care costs that is slower than the rate of increase across the comparable market in Illinois, when both are calculated on a risk-adjusted basis.[72] All costs in the provision of care are included in the contract including those associated with inpatient, outpatient, diagnostic testing, skilled nursing facility, home care, and pharmaceutical costs.

B. Contract Duration Increased To Enable Reengineering of Care

The typical two-year contract that has been used between Blue Cross and APP in the past has been extended to a three-year contract in recognition of the significant infrastructure and time that will be required to reengineer the way care is provided in order achieve the desired savings.[73] The types of necessary changes which will occur include training of providers, develop-

69. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3023, 124 Stat. 119 (2010) (to be codified in 42 U.S.C.) (describing the national pilot program on payment bundling).

70. *See id.* § 3025 (explaining the provisions of the hospital readmissions reduction program).

71. Shields et al., *supra* note 4, at 169 (describing APP's contract with Blue Cross Blue Shield); *see also id.* at 164 (describing shared savings from ACOs).

72. *Trends in Health Care Costs and Spending*, KAISER FAM. FOUND., 1 (Mar. 2009), http://www.kff.org/insurance/upload/7692_02.pdf; Slowing the rate of increase in health care costs is a priority for many providers because of the dramatic increase in these costs in recent years. Spending on health care in the United States increased from 7.2% of the gross domestic product (GDP) in 1970 to 17.6% of the GDP in 2009, and is expected to continue to rise.

73. *Advocate Health Care, Blue Cross and Blue Shield of Illinois Sign Agreement Focusing on Improving Quality Bending the Health Care Cost Curve*, BLUE CROSS BLUE SHIELD OF ILLINOIS (Oct. 6, 2010), *available at* http://www.bcbsil.com/company_info /newsroom/news/advocate_announcement.html.

ment of new internal APP incentives, new information technology tools, dedicated case management staff, and reengineering of inpatient care.[74] For example, Advocate will employ over 70 full-time nurses dedicated to primary physician practices to perform care management on the high risk patients in the program. They will be supported with computerized care management software that monitors patient progress according to guidelines and is available to all providers across the continuum of care. In addition, ten practice coaches will be deployed across the physician network to help physicians interpret performance data in order to improve their practice patterns and the patterns of the consultants they use.

C. Attributed Patients

The calculation of savings and the measurement of quality and safety outcomes will be performed on attributed patients – patients receiving care within the APP network two or more times over a two year period.[75] The attribution technique is essential for the success of this type of program since it is built on the standard preferred provider contract which allows patients to change providers at any time.[76] This is prospective, allowing APP to identify patients in the program and to reach out to the patients on behalf of the treating physicians to encourage participation in programs that enhance patient outcomes. These include services for chronic disease, as well as prevention services.

D. Regular Performance Measurement and Incentives

It is anticipated that there will be at least quarterly measurements of cost performance with interim payments made to APP for any shared savings earned.[77] There will be an annual reconciliation of the quarterly payments.[78] In addition, regular measurement of quality and safety outcomes will be performed, and penalties will be imposed for any deterioration in performance.[79]

E. Key Elements of Success for Shared Savings Contract

For a shared savings contract to be successful, there will have to be reengineering of the full care continuum. Preventive services will need to be enhanced. Outpatient care for chronic diseases and access to primary care will need to be re-tooled to avoid emergency room use and avoidable hospital admissions. Hospital care must be revamped to optimize length of

74. *Id.*
75. Shields et al., *supra* note 4, at 162.
76. BLUE CROSS BLUE SHIELD OF ILLINOIS, *supra* note 73.
77. VALUE REPORT, *supra* note 36, at 6.
78. *Id.*
79. *Id.*

stay and improve safety. And, transitions from the hospital to home or nursing home or home nursing will need to be redesigned to avoid needless readmissions to the hospital. APP, while working in all of these areas, however, will focus on the key elements of success for the early years of this shared savings program.

These key elements include: (1) a reduction in unnecessary hospital use, (2) increased access to primary care, and (3) the use of backfill tactics.[80] Since such a large portion of the health care dollar is spent on hospital care and significant opportunities have been identified both nationally and locally to optimize use of the hospital, the reduction of unnecessary hospital use is a key initial focus of this shared savings program. Providers can minimize unnecessary utilization through avoidance of readmissions, utilization of optimal outpatient care and reduction in length of stay as compared to national benchmarks. Additionally, an increase in access to primary care is viewed as a key strategy to reduce emergency room use, to optimize the management of chronic disease, and to provide appropriate diagnostic evaluations. The appropriate use of pharmaceuticals is another cornerstone tactic.[81] The use of appropriate generic prescriptions as well as the evidence-based use of expensive biologic formulations will be implemented as part of this program.[82] Also, APP will need to continue to enhance prior programs to improve quality, patient safety and patient experience in order to document the value of the clinical integration program. Finally, "backfill" of hospital beds is needed to maintain hospital viability. Since fewer hospital bed days will be needed per 1000 patients if the program is successful, APP, with its hospital partners, will encourage physicians to use Advocate hospitals for a larger portion of their practice and to encourage more physicians to join APP.

F. Mechanisms to Pursue Elements for Success

Additional tactics in the initial phase of this shared savings program have been selected to achieve the key elements of success. Models from patient centered medical home literature have been evaluated to select those strategies that have the greatest return on investment. Mechanisms to improve primary care access include electronic visits, group visits, open access techniques, and use of advanced practice nurses.[83] Patient communication and

80. Jeff Goldsmith, *Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers*, 30 HEALTH AFF. 32, 38 (2011).

81. VALUE REPORT, *supra* note 36, at 33 (discussing computerized physician order entry systems).

82. *Id.* at 18.

83. *An E-Visit Primer*, AM. MED. ASS'N (Nov. 13, 2006), http://www.ama-assn.org/amednews/2006/11/13/ edsa1113.htm; AGENCY FOR HEALTHCARE RESEARCH & QUALITY, *Group Primary Care Visits Improve Outcomes for Patients with Chronic Condi-*

outreach will be essential to increase the selection of APP providers by patients. Tactics to improve ambulatory care outcomes, such as the use of dedicated care managers, chronic disease clinics, and clinical protocols will be expanded.[84] Improvement of inpatient care through greater use of hospitalists and physician centric case managers will be utilized.[85] Additionally, transition care managers, medication reconciliation, and prompt office visits after discharge which have successfully reduced readmission rates in many cases will be used more extensively .[86]

Protocols, implemented with the assistance of care managers in emergency rooms, could help deflect hospital admissions to more appropriate settings, such as home care or skilled nursing facilities. This could optimize the use of such post-acute settings.[87] Furthermore, programs that use advanced practice nurses and dedicated physicians to perform rounds at skilled nursing facilities will be developed. Since all of the cost calculations are risk adjusted for the shared savings contract, emphasis will be placed on instructing providers to record appropriate diagnostic codes.[88] Lastly, analytic tools that provide rapid feedback to providers will be added to the traditional clinical integration reporting tools used by APP.

Tactics to expand market share for Advocate hospitals are needed since success of other improvement mechanisms will actually lead to reduction of hospital use, and thus reimbursement, for a given population.[89] These include better communication with patients and physicians, as well as development of performance incentives for physicians. As such, promotion to

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tions, http://www.innovations.ahrq.gov/content.aspx?id=1890# (last updated Dec. 22, 2010); AGENCY FOR HEALTHCARE RESEARCH & QUALITY, *Open Access Scheduling for Routine and Urgent Appointments*, http://www.cahps.ahrq.gov/qiguide/content/interventions/OpenAccessScheduling.aspx (last visited Apr. 25, 2011); Thomas Bodenheimer & Rachel Berry-Millett, *Follow the Money—Controlling Expenditures by Improving Care for Patients Needing Costly Services,* 361 NEW ENG. J. MED. 1521, 1521 (2009).

84. H. Carl Palmer et al., *The Effect of a Hospitalist Service with Nurse Discharge Planner on Patient Care in an Academic Teaching Hospital*, 111 AM. J. MED. 627, 631 (2001); Susan Jaques, *Using A Physician-aligned Case Management Model to Influence Hospital Length of Stay and Payer Denials.* 7 LIPPINCOTT'S CASE MGMT. 113, 119 (2002).

85. VALUE REPORT, *supra* note 36, at 18; *see also* Maria T. Currier & Morris H. Miller, *Medicare Payment Reform: Accelerating the Transformation of the U.S. Healthcare Delivery System and Need for New Strategic Provider Alliances*, 22 HEALTH LAWYER 30, 33, 35 (2010).

86. VALUE REPORT, *supra* note 36, at 3 (letter from APP President, Lee Sacks, M.D.).

87. Allan H. Goroll, MD, et al., *Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care*, 22 J. GEN. INTERNAL MED. 410, 410 (2007), *available at* http://www.springerlink.com /content/x864841076775u6p/.

88. Karen Davis, PhD, et al., *A 2020 Vision of Patient-Centered Primary Care*, 20 J. GEN. INTERNAL MED. 953, 954 (2005), *available at* http://onlinelibrary.wiley.com/doi/10.1111/j.1525-1497.2005.0178.x/pdf.

89. *See, e.g.,* ARTEMIS MARCH, THE BUSINESS CASE FOR CLINICAL PATHWAYS AND OUTCOMES MANAGEMENT: A CASE STUDY OF CHILDREN'S HOSPITAL AND HEALTH CENTER OF SAN DIEGO 30 (Commonwealth Fund 2003).

patients that highlight the advantages to them of the coordination among care managers in the inpatient, outpatient, home care settings, and with the primary care settings will be implemented.[90] Physicians will be educated on the opportunities in a shared savings program to be rewarded for delivering value to patients instead of the traditional rewards for volume only. If APP can be first to market with a shared savings program, physicians will realize these benefits can be derived at Advocate and will move more of their practice to Advocate. In this new structure, value for patients- better quality, safety and cost-effectiveness will be the key determinant of financial and programmatic success. APP's clinical integration program has established credibility with physicians and the market and the additional tools described will make an ACO program even more attractive to physicians, patients, employers, and insurance companies.

VIII. CONCLUSION

Advocate and APP are well positioned to take on the commercial and governmental contracts represented by an ACO. Past experience in a clinical integration program provides a foundation for teamwork between physicians from multiple specialties and a hospital working to improve quality, patient safety, and cost-effectiveness. The Advocate and Blue Cross Blue Shield contract serves as a prototype of a commercial ACO. Furthermore, it fits with Advocate's long-term strategy to provide lifelong relationships with patients to meet their health care needs, regardless of setting. To succeed, Advocate and APP must outperform the market competition. The program must perform better by reducing readmissions, avoiding unnecessary admissions and emergency room visits, expanding primary care access, and enhancing quality and patient safety. We believe that the mechanisms described above will enable attainment of these elements of success.

90. Molly Merrill, *The Camden Group Names Top 10 Healthcare Trends in 2011*, HEALTHCARE FINANCE NEWS (Jan. 11, 2011), http://www.healthcarefinancenews.com/news/camden-group-names-top-10-healthcare-trends-2011.