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New Models of Care: New Opportunities

AND

Setting Reserves for Captives

PIAA

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ACO Development—Managing Evolving Physician Liability Risks

The risk mitigation strategies needed to work within the newer models of care can actually enhance financial performance—and that's a powerful combination. This alignment of safety and economics provides a strong incentive for physicians and hospitals to look for resources that will help them take risk management activity to the next level.

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The number of accountable care organizations (ACOs) is proliferating, in both the public and private sectors. According to a recent report, there are 428 ACOs in 49 states and the District of Columbia. This number includes more than 250 Medicare ACOs, with the latest group of 106 approved by the Centers for Medicare & Medicaid Services in January 2013. It is estimated that between 25 and 31 million Americans now receive their care through an "ACO." This does not include the numerous ACO-type arrangements being discussed by multiple payers in almost every market. Many are small and intentionally meant to be a first step in the process of learning how to "practice" in a different fashion. The shift from pay-for-volume to pay-for-value will not happen overnight, but it will (and already is) occur incrementally.

Physicians have been very active in forming ACOs, with physicians now leading more than 200 of them, followed by hospitals and health insurers. Specialty care providers and pharmacies have also been aggressive in the development of ACOs. Each of these models has a different approach to achieving savings, enhancing quality, and managing its patient population. However, all must refocus on balancing the need to reduce costs while maintaining excellence in outcomes and the all-important "patient experience." Many will use the patient-centered medical home with the corresponding medical neighborhood, while others will focus on the "principal care provider," who helps to coordinate care and receives additional compensation. Many will look for ways to engage the patient in a more effective way, as this is the fundamental principle of the ACO. The overlapping concept here is the need to better coordinate and manage the care and, importantly, to build in incentives to do so.

These new care delivery systems are (unintentionally) prompting a shift in what we call the "3Ws" of care. New pairings of providers are emerging, revising how we think of "who" is providing care. Today's patient may well be discharged from the hospital into the care of a nurse practitioner, who provides follow-up care, monitors recovery, tracks medication usage, and refers to needed specialists and therapies; the patient never has to see his family physician, relying, perhaps to a great extent, on telemonitoring.

Care settings are also evolving, changing the "*where*" of care delivery. Preventive and maintenance care is now routinely available in retail locations, and urgi-care centers are siphoning patients away from both emergency departments and primary care offices. Emergency departments may well be *admitting* patients to a different setting than a hospital. Similarly, at times, the emergency department may be *discharging* patients to a new setting to further stabilize the patient and for ongoing observation of his condition, before he returns to his home or a nursing home. Hospitals are adopting new ways of providing care and, perhaps in the future, will be assuming a different role.

Economics continues to play a greater role in the provision of care, and efforts to increase value and efficiency are also changing the "*what*" of care. The "Choosing Wisely" campaign, for example, is viewed by some as potentially redefining the standard of care, by identifying certain diagnostic and therapeutic modalities as unnecessary in certain circumstances. This campaign has great promise and should be monitored carefully. However, guidelines such as these, developed by professional medical organizations and formerly considered "suggestions" rather than "mandates," could come to be viewed as required care, and, if the guidelines are not followed, that could be deemed "evidence" of inappropriate care. At least one state, Georgia, has enacted legislative protection for providers, prohibiting care standards from being used as evidence of negligence, and federal legislation to accomplish this same objective has been introduced. This could be an important development, and we need to be prepared to fight some evidential legal battles along these lines.

New delivery models, combined with changes in the 3Ws, make transitions of care especially challenging. We have known for many years that some patients are discharged from the hospital with pending test results that the primary care provider may not know about. Discharge summaries, traditionally the vehicle for communicating information about a hospital stay, often fail to provide adequate information for a safe transition of care from the inpatient to the outpatient setting. Some studies have shown that only 12% to 33% of discharge sum-

maries were available to the primary care providers at the time of the first office visit. And, while the use of hospitalists and advanced-practice providers has been shown to increase efficiency and quality, it has also created a discontinuity between inpatient and outpatient settings and a fragmentation of care management. All of these transition-risk issues could intensify in an environment in which the system is put under greater stress, in terms of volume, and also in terms of pressures to create a more efficient process.

These changes are real, and they rely on technology, as well as a novel deployment of the personnel needed to make them happen. During the period of "transition" to new care models, we must concurrently evaluate and mitigate the risk to medical professional liability (MPL) claims. We can do this by focusing on reducing the number of adverse clinical outcomes (the root cause of claims).

One can map out where that potential lies and put in place a safety net to help reduce the probability that it will actually happen. We also need to strengthen our documentation systems, to capture important new topics such as patient engagement and responsibility—communication and patient experience. Electronic transition tools need to be deployed to prevent fragmentation of communication and documentation. Even our EMRs need to be a focus of our attention, and our EMR audit tools need to be used so as to maximize effective transitions and documentation.

Opportunities for MPL insurers

MPL insurers can help healthcare providers by becoming a platform and a resource center for this transformation. Consider some of the following tools and strategies that are being developed:

- New care pathways, by specialty, to articulate responsibility for ordering and follow-up on tests. These can fill the gap that results from incomplete discharge summaries or delays in receiving test results.
- Protocols specifying medication usage, direction, and follow-up. Medication coordination between primary care providers and specialists can avoid medication errors and improve outcomes.
- The second-generation supervisory strategy tool, which helps advanced practice providers, patient navigators, care coordinators, and other non-physician members of the care team to coordinate effectively. Making this work will require changes in policy and training.
- New patient-engagement tools assist providers in involving patients as active participants in their own care, making them full members of the care team. There should be concurrent documentation that this is happening.
- The new EMR risk audit tool can be used to improve documentation, enhance effective EMR use, and obviate "alert fatigue" and other "work-arounds."
- EMR capabilities should be evaluated to maximize inter-communication and to facilitate "neighborhood" collaboration.
- Patient portal protocols can be put in place to ensure appropriate usage, timely responses, and clarity of communication, and importantly, so that these portals are used as the risk-mitigation patient-engagement vehicle that they have the potential to become.

Economics of risk mitigation

The bottom line? One in four physicians is either in an ACO or plans to be in one in the coming year. That number will grow. So, quite soon, the majority of physicians will be involved in these new models of care and the risk associated with them. We need to get ahead of the wave of "transitional liability" that could come with it. MPL insurers have a vested interest in mitigating this risk, but they can now do so in a true "value-added" fashion for their physicians and hospitals.

The fact that the same risk mitigation strategies can enhance financial performance is a powerful combination. This alignment of safety and economics provides a strong incentive for physicians and hospitals to look for resources that will help them take this activity to the next level. For MPL insurers, this is an enormous opportunity: to provide unusual value during a time of great need. PIAA

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