Accountable Care Organizations, Where do Urgent Care Centers Fit?

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Under the Affordable Care Act, the Centers for Medicare and Medicaid Services will pioneer a number of new projects which affect the delivery of healthcare in the United States.

Among these projects, the most ambitious is the proliferation of the Accountable Care Organizations (ACOs). Other initiatives include pay-for-performance (P4P) and quality improvement agendas proffered by organizations responsible for accreditation, all focusing on clinical delivery pathways or "care paths."

The Problem

The genesis of the term "ACOs" can be traced to Elliot Fisher, MD, MPH, who heads up the Atlas Project at the Dartmouth Medical Schools. Dr. Fisher and his team determined that there is a wide range of cost and quality across the country, and that higher cost does not necessarily mean better quality.

For example, in 2006, in New York State, the average Medicare spending per enrollee was $9,564, compared with $6,122 in Oregon and $8,304 nationally.

Moreover, an analysis by Price Waterhouse Coopers' Health Research Institute determined that out of the $2.5 trillion spent on healthcare, $1.2 trillion could be eliminated or significantly reduced by the adoption of clinical delivery pathways, operational controls, and behavior modification as it relates to obesity, smoking, alcohol abuse, and non-adherence to prescribed treatment regimens.

Current Model vs. the Proposed Future

In our existing fee-for-service model, doctors and hospitals get paid more by ordering more services and, generally speaking, admitting more patients. Under the ACO model, hospitals and doctors would be paid based upon their ability to hold down costs of Medicare beneficiaries.

In essence, pay would be based on improving care, not driving it. If ACOs fail to meet cost and quality standards, they would receive a lower payment from Medicare.

The outcome of this model is to force providers and health systems into becoming integrated models á la Mayo Clinic and Kaiser, both of which were early pioneers in this model.

The challenge, of course, is cobbling together a group of primary and specialty physicians along with a hospital system to share risk (and rewards) under the ACO model.

The Challenges

This all looks great on paper, but as you can imagine, there are significant challenges in the execution. The delivery of quality care for serious illnesses requires the longitudinal coordination of services among multiple providers and institutions. Handoffs between these entities account for much of the quality gap and cost inflation.

For example, it is very common to have a patient who was just discharged after a surgical procedure performed in another facility present in the ED or an outpatient setting with a post-op issue. Or, like a patient of mine yesterday who had a complete outpatient work-up done in one state (including MRIs and neurosurgical evaluation) show up in our emergency department (on Sunday when his PCP and outpatient imaging centers were closed) requesting a second opinion and complaining of issues requiring an immediate duplication of his tests in order to determine the seriousness of his emergent complaints.

Under our current reality, most physicians in the United States still practice in small groups; therefore, integrating the large number of "unaffiliated" providers across the healthcare continuum is a daunting task. Moreover, given the diminishing numbers of primary care providers, who is going

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to act as gatekeeper and coordinator responsible for the longitudinal delivery of care within the advanced medical home concept?

Physician practice has long been characterized by a high degree of professional independence and a culture of individual responsibility. Team-based medical education remains a concept of the future. This is further reinforced by current professional malpractice liability programs and our current payment mechanism, which focuses on price control of individual services yet continues to reward high-technology procedures, as well as those providers who own their facilities or increase their volume of services.

The outcome has been an increase in direct competition between physicians and hospitals and the growing unwillingness of community-based specialty physicians to take emergency department calls without a stipend.

Finally, the lack of primary care physicians who follow their patients into the hospital has led to the need for full-time hospital-based physicians.

These obstacles and many others will lead to significant friction in the adoption of the sweeping changes proposed by Medicare.

Unscheduled Care and Associated Costs

In the aforementioned Price Waterhouse study, $14 billion of the $1.2 trillion spent on avoidable care was for unnecessary emergency department visits.

As everyone reading this article is aware, our industry exists for four reasons:

1. Inability of patients to see a primary care provider (if they have one) on-demand. Primary care providers spend the majority of their time coordinating care and performing scheduled health screenings of their patients.
2. The overcrowding and high cost of emergency departments. ED visits across the country continue to rise. Interestingly, insured patients account for the greatest portion of that growth.
3. The consumer-centric demands of the populace. No one feels comfortable anymore waiting to see if they get better. "Tincture of time" is a phrase from a bygone era.

   I recently saw a patient in the ED who complained of having a sore throat for 30 minutes. Since she had been waiting 45 minutes to see me, I asked her if she developed her sore throat while waiting in the lobby. Her response: "Yes." I did not ask any other follow-up questions since I was afraid to learn anything else.
4. The medical illiteracy of much of the population. Earlier this week, I took care of a "family plan" in the ED. Both parents and two kids. The children "felt warm" per Mom and were bundled up so much that only their nose and mouth were visible (I practice in Phoenix and it was 75° degrees outside). The father's complaint: "I noticed some hair on my pillow and I may be going bald." The mother weighed at least 350 pounds and complained of knee pain.

   You get the point; "the fix" has to include either the ability to move low-acuity patients to a lower cost setting once they walk through the ED doors or a massive educational effort directed towards patients who are using the system inappropriately.

"Should the urgent care industry position itself differently, knowing that a sea change is just around the corner?"

My analysis of the government's proposal is that it does little, if anything, to cogently address these issues. Thus, urgent care has a significant role in the future provision of care, particularly as it relates to the non-emergent, unscheduled delivery of healthcare.

In the recent past, retail clinics were seen as a mechanism to stem the tide of the rapidly escalating costs associated with on-demand care. Unfortunately, these clinics, given their size constraints, overhead, and slow revenue growth, have been unable to meet the high expectations of the healthcare industry and are currently evaluating alternative options within the care continuum (chronic disease management, for example). In fact, in 2010 alone, 106 retail clinics closed their doors. Even MinuteClinic has yet to break even and according to Tom Ryan, CEO of MinuteClinic parent company CVS Caremark, will not do so until mid-2012.

Therefore, given the above, my question to you is: Should the urgent care industry position itself differently, knowing that a sea change in healthcare delivery and payment mechanisms is just around the corner? Or, have we as an industry been moving toward this eventuality for years and now, finally, the rest of the healthcare industry is catching up?

My take is that more consolidation in our industry is just around the corner as consolidators look to improve margins through operating efficiencies and economies of scale. Also, many of the smaller operators will find it increasingly difficult to survive in this environment and slowly get their margins squeezed even tighter. The good news is that we are an industry of innovators and if the past foreshadows the future, to paraphrase Gloria Gaynor, *we will survive.* ■