Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 167-169.

OP-ED

Are Physicians Ready for Accountable Care?

Matthew McNabney, MD

As health care in this country shifts toward delivery models that emphasize cost effectiveness and measurable quality, physicians must adapt to evolving expectations. In particular, they will need to possess the knowledge and skills to lead and contribute to accountable care organizations (or ACOs) [1, 2]. Many of these needed skills and practices are not specifically addressed in traditional undergraduate and postgraduate medical education. In this article, I will discuss a few competencies that are important for practitioners to develop in anticipation of a changing medical landscape.

A few existing models with similarities to ACOs have years of operational experience and can serve as important examples of techniques and best practices. The Program of All-Inclusive Care for the Elderly (PACE) [3] was developed in the early 1980s to provide comprehensive and cost-effective care for high-risk, frail older adults in a community-based model. Since 1980, PACE has expanded to 82 sites in 29 states and serves 24,000 older adults. All enrollees are under the care of a highly organized interdisciplinary team (IDT) with responsibility for all health care services and costs. Programs like PACE are fully integrated (outpatient, inpatient and long-term care services) and are responsible for all health care costs. Payments are capitated—per patient, rather than per intervention—and funding is primarily through Medicare and Medicaid, but enrollees not eligible for Medicaid can also pay with private funds. In every sense of the term, PACE programs are accountable for the health care needs of their patients. Because I am a medical director of a PACE program, I have had the opportunity to learn what practices and skills are most important for success in an integrated, cost-conscious, performance-driven program.

Be a Team Player

Consistent with federal regulations, PACE programs must maintain interdisciplinary teams as the primary mode of care provision. It is likely that ACOs, too, will establish IDTs specific to patient needs (and will monitor them to ensure best results). The members of typical IDTs in programs like PACE or ACOs include nurses, social workers, and transportation personnel as well as rehabilitation therapists. Sharing responsibility for assessment and treatment plans with nonphysician team members can be hard for physicians [4]. Although physicians have historically assumed leadership roles and *directed* care, most care situations are better served with a balanced interdisciplinary approach, in which input is freely exchanged and efficiently incorporated into plans of care. This is not easy, nor is it seen as feasible within many existing practice models. For this type of shared

decision making to be successful, clinical teams need common goals for patient care and a culture of respect in which input is continually encouraged. Taking notice of input and providing feedback (especially positive) is particularly effective in maximizing team performance.

Pay Attention to Costs

The degree of financial risk within the ACO structure depends on the specific payment model. For example, "shared savings" programs entail the least risk; provider organizations work to reduce costs to obtain a percentage of the money saved. In capitated models, provider organizations assume more risk because they receive a lump sum for each patient; if that patient's care exceeds the amount of the capitated payment, the organization loses money [1]. Physicians should be able to provide "high-value, cost-conscious care"; being able to do so has been recognized as a critical "core competency" in medical training [5]. For every test, treatment or consultation, I ask myself and others within our IDT, "Why is this being done, what do we plan to do with the result or effect, and how will that affect the patient? Does it have measurable value? Does that value justify the cost?" I have found that asking these questions routinely is sufficient to ensure that quality of care is not compromised while minimizing waste. For example, clinicians should routinely discuss with patients the likely outcome of a test and what next steps might be prompted by a positive result. As a result of these discussions, some patients will choose to forgo testing.

Let Patients Decide

Many decisions in medicine are driven by evidence-based guidelines that standardize care according to established recommendations derived from experts, and, in many respects, this has improved the quality of care. However, physicians must also practice patient-centered care, which is the intentional effort to include patients in medical decisions. Not only does this empower patients, it allows for appropriate deviations from standard practice driven by the individual's specific clinical scenario and preferences. This approach results in high-quality care that adheres less rigidly to recommendations *if* it is driven by patient wishes and perceived potential for benefit.

Acknowledge and Plan for Death

Patients do not typically enjoy talking about death, and doctors are often uncomfortable with these discussions as well. However, it is a central part of good medical care planning. In my experience, these discussions become easier and more natural as they become routine in patient-doctor conversation. Rather than discussing death as a medical defeat, physicians should describe these conversations as "insurance policies" for maintaining control of personal health decisions when decision making might not be possible. These discussions allow patients to clarify how they would prefer things to go at the end of life. This is analogous to addressing preventive care with patients, and physicians can prospectively serve their patients best by having thoughtful and clear discussions. Physicians who are able to serve patients through the end of life reap rewards associated with doing it well.

Conclusion

We are entering a new phase of medicine in this country. Physicians will work within models of care that are quite different from those prevalent 10 years ago. We will be expected to provide high-quality care that meets measurable standards, and we will be held accountable for outcomes. We will be paid less and less for how *much* we do, and more and more for how *well* we do. By engaging the four practices discussed above, it is likely that physicians will feel more prepared to care for patients effectively and enjoy their careers.

References

1. Berkowitz SA, Miller ED. Accountable care at Academic medical centers--lessons from Johns Hopkins. *N Eng J Med*. 2011;364(7):e12.
2. McClellan M, McKethan AN, Lewis JL, Roski J, Fisher ES. A national strategy to put accountable care into practice. *Health Aff (Millwood)*. 2010;29(5):982-990.
3. Eng C, Pedulla J, Eleazer GP, et al. Program of All-inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. *J Am Geriatr Soc*. 1997;45(2):223-232.
4. Grumbach K, Bodenheimer T. Can health care teams improve primary care practice? *JAMA*. 2004;291(10):1246-1251.
5. Weinberger SE. Providing high-value, cost-conscious care: a critical seventh general competency for physicians. *Ann Intern Med*. 2011;155(6):386-388.

Matthew McNabney, MD, is an associate professor of medicine at Johns Hopkins University in Baltimore, where he is medical director of the Program of All-Inclusive Care for the Elderly (PACE). He is also fellowship program director in the Division of Geriatric Medicine and Gerontology.

Related in VM

Ethics in Accountable Care Organizations, February 2013

The Physician as Hospital Employee, February 2013

Is the Standard of Care Always Worth the Cost? February 2013