Felecia Perkins’ medical problems sent her to the emergency room twice in one week, costing the 49-year-old Hampton diabetic time and money.

Then she found a solution that’s kept her out of the ER and in better health since: talking about her problems.

Perkins chats for five minutes to a half-hour a couple of times a week with her health coach --- a nurse who asks how she’s feeling, how her medication is working, and other questions. The answers are relayed to her doctor and to other medical professionals on her team so they can work together to best care for her. The frequent, if remote, contact serves her needs between office visits.

“She’ll call and ask if there are any concerns, how’s my pain, am I low on medication,” Perkins said of her coach. “You can get all the care you need, stay on top of things, and save time going to the doctor.”

Perkins is taking advantage of a growing health care option called an accountable care organization. It’s offered by her provider, Piedmont Healthcare, one of several top metro Atlanta health systems that have launched such a plan. In an attempt to lower costs, ACOs twist the traditional payment model by rewarding providers for value and efficiency, not for the volume of services they perform. ACOs emphasize primary care, preventive medicine and wellness, rather simply treating sickness.

For providers, the shift to a pay-for-performance system could result initially in lower revenue, but they could make it up by sharing in the expected savings.

Maintaining regular communication with patients like Perkins outside of the doctor’s office can head off more serious and costlier problems that can lead to hospital admission and treatment by specialists, advocates say. Physicians stress that the goal is to minimize avoidable hospital admissions, not withhold necessary care.

WellStar and Emory are among other local providers that have launched such organizations in recent years, while Grady is a partner in one. They go by different names and serve different groups, such as Medicare patients or the non-Medicare commercial market.

The development of ACOs got a boost when they were written into the Affordable Care Act, but the concept of outcome-based care is not new. However, it hasn’t taken hold yet. A recent study found that only about 10 percent of health-care spending by employer-sponsored plans was based on value instead of volume.

Providers have traditionally operated under a fee-for-service structure in which a provider’s reimbursement is based on the volume of services delivered. At the same time, providers are not directly compensated for potentially cost-saving services rendered outside of in-person treatment, including virtual care and the work of health coaches, dietitians, pharmacists and others.

“Providers have always been pursuing optimal outcomes, but the fee-for-service structure incentives volume without regard to outcomes, and does not compensate for non-face-to-face encounters that are the hallmark of
optimal population management," said Richard Gitomer, a primary care physician and chief quality officer of the Emory Clinically Integrated Network, Emory's version of an accountable care model.

Under ACOs, emergency room visits and hospital admissions and re-admissions are expected to decline as the amount of front-end care increases. That would lead to lower revenues.

"At the end of the day, there's less money going into the system," said William Custer, a health-care industry expert and associate professor at the J. Mack Robinson College of Business at Georgia State University. Providers who establish ACOs also face additional up-front costs that can come from an increase in staffing as well as improvements in information technology.

Providers can make up for that lost revenue and more, however, by sharing in the resulting savings. They earn bonuses for holding the line on costs if they also deliver quality care as measured according to a set of performance standards.

Now, explained James Sams, chief medical officer of Piedmont Healthcare's South Region, "We get paid to do things to patients." In the future, he said, pay will be for "improving patients' health and keeping them well."

One example of how that's being accomplished can be seen in the work done at a WellStar call center in Austell. There, 10 registered nurses work from 8:30 a.m. to 7:30 p.m., seven days a week, calling patients to check up on them.

They place 40,000 calls a month, trying to reach half of the system's ER patients and 80 percent of its in-patients within 48 hours. They ask patients how they're feeling, whether they're taking their medications, and whether they've scheduled a follow-up appointment, among other concerns.

Call center nurse Robin Ayres said many conversations she has with patients are routine and require no additional action. But she sometimes detects a problem during the course of talking, and that can lead her to offer advice to the patient and to relay the information to other medical professionals, including doctors for further follow-up.

The call center was originally set up about three years ago, primarily as a patient satisfaction service facility, and was staffed by non-nurse personnel. But, about a year ago, after it was determined that there were clinical needs that it could serve, the center was converted to its current use, and RNs were brought in to staff it.

"There are opportunities, particularly for those with chronic illnesses, to keep them from progressing to a more acute level of care," said Barbara Corey, senior vice president of managed care for WellStar.