ACOs: Implementing and Sustaining Value-Based Change

As seen in Health Intelligence Network.

Just as “Rome wasn’t built in a day,” neither is an efficient, sustainable, and physician-focused accountable care organization (ACO). Instead, expect to embrace a stair-step approach to making the necessary changes in your care delivery and administrative practices. Competency and capability development is always multi-dimensional, so consider these five steps as a benchmark for your organization’s critical thinking on ACO development.

Introduction

In California, we're now in what could be termed the "second generation" of commercial ACOs, given Blue Shield of California's first ACO with Dignity and Hill Physicians that was introduced five years ago. Since then, dozens of other ACOs have arisen in the state (California leads the nation in ACOs).

Many ACOs already have several years of direct experience (both positive and negative) with issues ranging across member attribution, risk identification, standing up new integrated and patient-centered care programs, and payer/provider data interoperability. Embedded in ACO programs are both old and new utilization management (UM), case management (CM), and disease management (DM) roles, and their related clinical and administrative processes.

As health economics dictate a shift from fee-for-service (FFS) to at-risk contracts, organizations—to realize the promise of value-based, accountable care—need to become more focused on measurable population health management improvements, including people, process, and technology enablement. Like any significant endeavor, the first major task is to establish and maintain clear goals.

Step 1: Reset Approach with Clear Goals

In care management, simpler is often better, especially if the same program can be used across numerous payer-specific ACOs. Some program capabilities are needed to address unique and specific line-of-business needs, yet other programs can work across multiple lines of business (e.g., commercial, Medicare, Medicaid). If several ACO contracts delegate medical management, health care delivery organizations have the opportunity to set up across-the-board quality and cost/utilization management programs deemed most appropriate to achieve steadily improving quality, resource/cost efficiency, and patient satisfaction improvements.

Your board and physician leadership need to be aligned with your long-term plan for reimbursement mix changes. Establish how you plan to grow your at-risk lives over your planning time horizon, being specific about percentage shifts in FFS and at-risk revenues. Given the increasing exposure to downside insurance risk in both shared risk and capitation contracts, this is obviously a difficult, yet essential, dialogue. For that reason, this value-based transformation needs to be led and championed by your CEO and CFO, as well as clinical leadership, in visible ways.

That's precisely the approach taken by Advocate Physician Partners, with 4,900 physicians and 12 hospitals in Chicago and Central Illinois. In 2011, Advocate became one of Illinois' first health systems to enter into an ACO agreement. Advocate's leadership broadcasted the initiative internally and ensured sufficient resources for its transformation. Today, Advocate is one of the nation's largest ACOs, with well over two-thirds of Advocate hospital revenue directly tied to value-based reimbursement.

To prevent inappropriate assumptions about the burden of illness in your attributed populations, get smart on the risk profile of each attributed population. Find the target populations for risk/care management, and match them to specific programs (e.g. prevention/wellness, chronic care management). Better-performing ACOs have high cost stratification in place for both a) common ETGs with high incidence rates, and b) uncommon ETGs with lower incidence rates. This risk identification technique allows them to proactively address care coordination needs for a more all-encompassing set of expensive chronic episodes.

These integrated care management efforts will require your clinical staff to potentially re-think and remodel their care approach, from a physician-only care delivery model to one involving team-based care across the medical, behavioral health, and social services continuum. It will also require empowerment of multiple members of a care team, as well as ensuring all roles are operating at the "top of their license" with clear delineation of who is coordinating what across a range of medical and non-medical services.

Step 2: Emphasize Financial and Organizational Goals

Be clear about the financial impact of the value-based ACO model and the individual contributions required of clinicians and administrative staff to reach sustained financial viability under these new reimbursement models. Also, be sure to align your financial incentives, such as individual physician bonus programs, with your new ACO financial contract structure.

As second-generation ACOs gain steam, we see them getting smarter on their end-to-end risk/care management models. Rather than relying on industry vendors to co-architect their HIT vision, many ACOs will build up internal HIT knowledge and secure objective, third-party input on enterprise-wide HIT strategies. These strategies will address both overall enterprise needs, as well as narrow, unique line of business needs. The objective of this effort should be to align senior staff on a multi-year, holistic vision of the organization and its operations. It can also pay for itself by identifying technology rationalization opportunities (often latent or un-identified by existing staff who could be wedded to a particular solution/vendor because of convenience or other subjective criteria).

Step 3: Involve People and Roles

Aligning the roles of patient care delivery staff to support an ACO model is as much a cultural shift as an operational one. First, the combined clinical and administrative staff need to be educated on management expectations for how their departments and individual roles might change (e.g., in a team-based care model). The new goals and focus of population health and patient-centered care are not trivial. The dual focus on both quality and cost/resource efficiency can be a difficult transition. Providing real examples and proof points can be instructive, such as those that show how reduced utilization through use of evidenced-based medicine guidelines (and joint physician/patient decision-making) can benefit the patient, curb medical cost inflation, and lead to higher patient satisfaction.

As you examine roles in your organization in a new ACO world, realize there may be duplicative roles across both your organization and others, particularly payer medical management and inpatient case management. For instance, creative collaboration with a payer could help rationalize UM, CM, and DM roles in both organizations, while simultaneously improving program enrollment/adoption and member/patient experience.

Remind staff that moving along the ACO "change curve" will require a series of stair-steps, with changes happening incrementally across many areas inside and outside the organization. The goal of management is to orchestrate these changes in such ways that quality, cost, and patient satisfaction improvements can be readily seen as "waypoints" toward the desired future state of the enterprise.

Step 4: Create and Maintain Sustainable Processes

Process orientation and management is becoming a more valuable competency in most ACOs. Starting with the process of identifying the right group of patients for care coordination is a good initial step. If you don't have the patient "risk score" data you need in-house, collaborate with your payers; they're likely rich with the information you need to make informed decisions about areas of focus. Staff your care coordination needs accordingly, using conservative case load benchmarks in the early going, so that staff case managers/care coordinators are not initially overwhelmed by productivity expectations. Work intelligently to determine the location of care coordination roles—those that should be situated centrally (e.g., in a managed services organization) and those situated with clinical/administrative staff at physician offices.

Being process-oriented means being "performance tracking"-oriented. Develop measurement capability so that leaders can be informed by dashboards that tell them the health of the processes along with results (e.g. quality and utilization; "planned versus actual" performance reports). Appreciate how the care management programs will need tuning for unique attributes of local markets. For example, the largest opportunity for improved chronic care management in one California county may be youth asthma hospitalization rates, while in another county the opportunity may be adult obesity.

Measure your results and continuously modify and improve your processes. And inform and engage your physicians continuously in the change management process, so that they can effectively "champion" the improvements.

Step 5: Connect with the Right Technology

One area of potential long-term financial gain is making better use of your existing technologies, or replacing them with simpler, cheaper, and more effective technologies. You may already have latent potential for technological efficiencies in your current technology portfolio. Over the past few years your organization may have purchased a veritable hodgepodge of niche technologies. But are they all working together, as needed, to your utmost advantage? Might a narrower set of existing and new solutions be far better than, say, six disparate systems?

Also, remember that as your ACO moves down the path of accepting more financial risk, the need to enhance IT systems will increase, so that people and processes supporting “risk management” can be sufficiently supported.

Whatever actions you take regarding your technology, in an ACO world it is essential that technology is placed within the natural workflow of your clinical staff. If your clinicians and staff are taking a lot of extra time training and re-training themselves to use a particular technology, they’ll be relieved if you provide them with a less time-consuming, superior solution in one or a few, easy-to-use software applications.

Be sure your technologies meet multi-payer needs, (Commercial, Medicare, and Medicaid), as a simpler technological footprint has speed and cost-to-market benefits that typically result in improved overall operations. This will likely yield improved patient service and quality, and also provide the benefit of higher staff satisfaction with their work environment.

