Establishing the Basis for Accountable Care Organization Success

Care management is the key to Accountable Care Organization (ACO) success, but many healthcare organizations overlook the most fundamental factor in care coordination…an advanced system of primary care! ACO models involve many varied elements of care management, but without advanced primary care at the center of these systems, success can be disjointed. There are many misconceptions surrounding the advanced primary care model of care, which builds on the patient-centered medical model of healthcare. However, these newer primary care models serve as a foundation for ACO performance improvement, which clearly tie medical home strategies to financial success. Establishing advanced primary care as the focus of development is the key toward transforming care and meeting the ACO goals of improving quality and reducing costs.

Care Management Models for Success

Primary Care and the Future of Family Medicine 2.0 provides current information on effective care management

models. As our current healthcare model continues to change, the emphasis on primary care has shifted to a more coordinated approach to care management. This collaboration centers around the primary care model as the hub for value-based care, where the team approach to patient services is emphasized to create a patient-centered, self-monitored model of care.

This patient-centered model revolves around a team of primary care providers who work together with specialists to manage population health and improve patient outcomes. Each team is led by a primary care physician who coordinates patient care and services. This collaboration improves clinical outcomes and patient satisfaction, and reduces both errors and costs overall. The Primary Care model of care management is the future of ACO success and the backbone of healthcare reform.

Patient-Centered Medical Home

At the heart of this foundation is the Patient-Centered Medical Home (PCMH). The Patient-Centered Primary Care Collaborative (PCPCC) definition of the PCMH is described as:

A model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions. It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff. Above all, the medical home is not a final destination instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs.

It is apparent that with proper implementation, the medical home approach to healthcare meets the ACO goals for care management. This cohesive collaboration of care providers and care teams in a comprehensive, patient-centered setting is the future of the primary care model and the basis for quality care implementation.

The Agency for Healthcare Research and Quality (AHRQ) agrees that the benefits of the PCMH hold promise for the future of healthcare improvement in America. The AHRQ exposes the PCMH as a "model" and not a "place" where primary care functions as the core of care management and delivery.

Coordination and Communication

The model of advanced primary care is developed by a team of people led by a core physician to provide comprehensive care, in-office and beyond, through advanced coordination and communication efforts. Providers who prove they can coordinate care among various providers in a patient-centered model achieve the highest level

of recognition from the National Committee for Quality Assurance (NCQA). This recognition increases value-based incentive program rates and is directly associated with improvements in patient health and outcomes.

PCMHs, ACOs, annual physicals for Medicare enrollees, and incentives for employer wellness programs all require a strong foundation in primary care. The advanced primary care model focuses on coordination and communication to manage patient care by improving access to, and use of, the specialty and alternative health services on which patients rely. This cooperative model clearly ties in to ACO performance by improving patient satisfaction, quality of care, and affordability.

Transforming Care Delivery

Transforming care delivery is the key to improving ACO success and increasing value-based payments, and it all starts with a foundation in primary care. Many healthcare organizations have successfully transformed their models of care to advance primary care delivery. Others have attempted to implement elements of the PCMH model of care, lacking focus on overall program management, design elements, and execution strategies. Achieving transformative change is difficult and requires complete commitment on the part of the physicians, care team, and healthcare organization leadership.

