Levers of Successful ACOs

Part 4
Structure for Continuous Improvement

The prior reports in this series describe how high-performing accountable care organizations (ACOs) have achieved an organizational commitment to value, focused initial efforts on establishing proactive health management programs, and benefitted from organizational experience with managing risk and/or quality-based contracting. While these competencies provide a strong foundation to support an accountable care strategy, successful ACOs must build additional structures to drive continuous improvement year-over-year once the "low hanging fruit" has been harvested.

Operational infrastructure for performance improvement. Dedicated data, actuarial analytics, and performance improvement resources are crucial for ACOs looking to identify ongoing opportunities for improvement. They serve as key partners with clinical leadership in developing new workflows to address variation. ACOs employed various strategies to ensure new workflows were piloted and implemented effectively with support from both centralized and localized improvement support teams. Metric alignment across various ACO contracts was a common strategy to ensure provider focus on the most important metrics.

Tying performance to compensation and network contracts. ACOs are testing different approaches to direct performance-based physician payments, and most included quality performance as a component of employed physician compensation. Shared savings were distributed in a variety of ways to encourage continuous improvement, including gainsharing arrangements with affiliated providers, primary care incentive pools, and reinvestment in the accountable care infrastructure. ACOs also set performance criteria for affiliated post-acute care and specialty providers, and used incentives to direct referrals accordingly.

Participation in shared learning opportunities. Especially for early adopters, the ability to share notes and compare data with peer organizations helped ACOs to navigate uncertain waters, and to gain a better understanding of their own comparative performance. Where multiple ACOs were operating in a given market, the program provided a welcome impetus to collaborate on quality improvement best practices among otherwise competing entities.

As organizations reach later performance years in the ACO contract, it becomes more and more difficult to squeeze savings from a shrinking benchmark. However, high-performing ACOs are finding ways to build from early wins by encouraging staff and affiliated providers to continually identify and act upon opportunities for improvement. This final report describes further the structures for continuous improvement employed by ACOs that have been successful in achieving shared savings and high quality performance under a Medicare ACO program.[1]

Performance Improvement Infrastructure

When asked how the organization's operational infrastructure enables and supports quality

Key Strategies
- *Dedicate data/actuarial analysis and performance improvement resources to ACO efforts*
- *Streamline performance metrics across ACO contracts to maximize impact of interventions*
- *Integrate analytics, performance improvement, and clinical staff to design, pilot, and evaluate new workflows*

measurement, improvement, and reporting, high-performing ACOs first described the human resources dedicated to quality efforts. When asked which new staff contributed most to the success of the ACO, performance improvement and data analytics staff were mentioned second only to care management. In general, what differentiates these professionals from their care management counterparts is the internal, non-patient-facing focus. Whereas care management professionals are dedicated to improving quality and outcomes through patient outreach and care coordination, data analysts and performance improvement staff utilize the available data to track performance, identify opportunities for improvement, facilitate work flow changes, and provide support to clinicians.

Organizations hired quality improvement professionals with a variety of backgrounds, including registered nurses, registered health information administrators, medical technicians, and others with a quality improvement skillset. Data analytics staff were often recruited from payers for their claims analysis experience. Most of the hospital-led ACOs supported centralized performance improvement teams, often reserved for cross-business unit efforts and larger interventions, with additional performance improvement staff dedicated to specific business units. However, several ACOs mentioned making refinements to the organizational structure over time:

> *"When we first launched our quality coordinators, they were probably spending about 80 percent of their time collecting data, 20 percent on improvement. We needed to reverse that equation by getting cleaner data in the cost accounting system so they could spend 80 percent of their time doing the quality improvement activities that we trained them to do."*
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> **Executive, Integrated ACO**

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1   See Methodology section for detailed selection criteria for high-performing ACOs.

Recognizing the inherent need to coordinate quality programs with performance data, some ACOs reorganized their centralized departments accordingly, opting to shift analytics resources closer to front-line clinicians and care managers. For example, one hospital-led ACO decided to organizationally align quality analysis/reporting and care management under a single population umbrella, with both sides reporting directly to the CMO to maximize coordination and clinical oversight. Similarly, an integrated ACO paired the analytics resources with clinical leadership to assess workflow improvement opportunities:

> *"We've done a lot of that work to map workflows and make things easier for the clinician at the front end, and then we've built these 'hyper analytics' tools, to do the case finding and fallout finding. We've put together a whole team that oversees that and partners with the help of one of our medical directors."*
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> **Executive, Integrated ACO**

One ACO described engaging a cross-specialty committee structure including clinicians, nurses, analysts and performance improvement staff to redesign workflows and develop tactics, work-plans, and communications pathways. The performance improvement staff pilots the new workflow for additional refinement, and ultimately transitions management to the regular operations team, while continuing to provide assistance with tracking performance.

Many ACOs referred to workflow redesign activities as "gap closure," which was typically driven by performance on ACO quality measures, and used performance improvement staff to provide one-on-one education to provider subgroups on key ACO metrics. For example, one hospital-led ACO deployed a "gap closure team" to help physicians make sense of the EMR data and facilitate improvements:

> *"It's the gap closure work where we provide physician-level performance data on the measure. And this gap closure group says, 'How can we help you in your practice to make changes? What can we do to help support you?' That's been just super important for us across all the measures that we monitor as an organization, but in particular for [the Medicare ACO]."*
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> **Executive, Hospital-led ACO**

Most high-performing ACOs added dedicated teams of data analysts, or supplemented prior departments with new full-time resources for the ACOs, to provide close to real-time assessment of expected performance under the ACO contract. As mentioned in prior reports, these ACOs have developed proficiency with managing financial risk and reporting on quality measures; several ACOs described teams of data analysts tasked with projecting monthly financial forecasts using CMS monthly claims files, as well as dedicated quality measurement reporting teams.

> *"You have to be able to invest in actuarial analyses and tools that take the rows and rows and rows of data [from CMS] – which otherwise mean nothing – and massage it and put it into something that makes sense. We take the various files that are coming from CMS and create a monthly financial forecast, so we have a pretty good idea each month of where our actual dollar amount is trending at all times."*
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> **Executive, Integrated ACO**

Successful ACOs commonly use priority metric sets to both report cost, quality, and utilization performance to leadership at an aggregate level, and to incentivize behavior change at the individual clinician level. Many participants sought to align metrics across multiple contracts, and to create weekly or monthly dashboards of metrics with the greatest impact on patient outcomes and quality/cost

performance under ACO contracts. To provide a sense of the magnitude, one ACO estimated having to report a total of 300 quality metrics across all lines of business; in response, the organization created a health care intelligence team to support quality monitoring, reporting, and provider education. A physician-led ACO employs a "measure steward" (trained MD-PhD) to help prioritize metrics by potential impact on patient outcomes according to the literature.

Performance forecasts and retrospective analysis in turn fuels the organization's efforts to improve workflows and make improvements stick. There was a large emphasis among interviewees on educating and incentivizing providers (both employed and affiliated) to improve coding and quality reporting, due to the relative importance of accurate risk adjustment and quality measurement under ACO contracts.

> "We need a certain set of standards and workflows for us to be able to report effectively on quality and cost performance. The clinicians have to put certain information in specified, mineable data fields in the EMR, and that just is what it is. Otherwise, we can't collect it."
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> **Executive, Physician-led ACO**

Health information data sources and technology to support continuous improvement

High-performing ACOs have invested in various technology platforms to collect, manage, and analyze data for the purposes of reporting, tracking, and improving performance under the ACO requirements. The two primary data sources – submitted/adjudicated claims, and clinical data from the electronic health record – when analyzed together provide insight into the overall performance at a patient and clinician level. However, these sources have their own set of drawbacks when it comes to data timeliness and completeness. For that reason, ACOs described different use cases and technology platforms using each data source for continuous improvement.

Claims data	Clinical data (EHRs)
• Financial performance trending • Utilization variation analysis • Patient risk stratification • Peer comparison (using statewide all-payer data or national multi-payer data)	• Quality measure dashboard • ACO eligibility portal • Clinical decision support tools • Patient rosters and disease registries • EHR interfaces to share clinical records and ADT notifications

Greater transparency on provider-level performance and utilization variation presented the most common tool for encouraging continuous improvement and behavior change. One physician-led ACO even tracked which providers were looking at their own quality scorecard to identify targets for more high-touch provider education. An integrated ACO developed a homegrown application that shows providers claims- and clinical-based measures on their panel of aligned beneficiaries, and stressed proper documentation as one tactic to improve performance:

> "It's not that doctors weren't doing some of these functions, like depression screenings, they just weren't putting it in the medical record. We did an intervention on that a couple years ago, and that also helped get our scores up."
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> **Executive, Integrated ACO**

Tying Performance to Compensation and Network Contracts

Key Strategies

- *Incorporate key quality and utilization metrics into compensation plans for employed physicians*
- *Establish separate funding pools to incentivize primary care process changes*
- *Develop network criteria for affiliated post-acute care providers and specialist referrals*

One of the fundamental challenges to continuous improvement under an accountable care arrangement is the underlying payment structure, which remains grounded in fee-for-service. To the extent that providers are still paid based on volume, there remains a financial incentive to drive that volume. This issue is further compounded by the lag time for paid shared savings or recouped losses for ACO performance.

"When you finish a performance period, it might be six or nine months before you really have the final reconciliation of cost performance. The lag times are a real challenge. You got to start spending on day one of performance year one knowing that it's going to be 21 months before you get paid. And that's if you hit it out of the park in your first year and actually create shared savings."

Executive, Physician-group led ACO

To address the inherently contradictory financial incentives of a value model built on a fee-for-service chassis, high-performing ACOs have tested various performance-based incentives at the group or individual level. For example, a majority of the high-performing ACOs did not directly incentivize employed physicians for performance on specific contracts, yet half the ACOs interviewed described compensation arrangements for employed clinicians that incorporated provider-level incentives for quality measures, utilization metrics, and/or other "board objectives." On the other hand, most interviewees relied heavily on specific performance-based contracting for affiliated providers.

Sharing in success: shared savings distribution strategy

One physician group-led ACO varied greatly from the general pattern for employed provider compensation:

"When we've made shared savings distributions for the last two years, we've included every employee of the company, right down to the receptionist and medical assistants. They got about a week's pay each time…It's so easy to say, 'We're all in this together' when we have new work to do, but if it's true when we have new work to do, it should be true when we've had success and profitability. And so we've included them."

The same ACO is testing a new physician compensation model that also incorporates patient experience survey results, citizenship (e.g., ACO meeting participation), and openness to new patients along with quality and cost performance at the subgroup level.

High-performing ACOs were much more likely to incorporate specific process and outcome metrics as a component of primary care physician (PCP) group contracts. For example, one integrated ACO pools any shared savings payments earned from the Medicare and commercial contracts to fund a PCP incentive program:

> *"The cumulative shared savings is what goes back out to the doctors. However, our performance in all contracts has not been consistent, and so we moved it into a PCP incentive program rather than a shared savings payout. That way, we can simply use that money to be very specific in changing behaviors."*
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> **Executive, Integrated ACO**

Tying PCP group performance incentives to specified behavior changes (e.g., accurate coding) was a common theme for many ACOs. One hospital-led ACO used shared savings distributions to drive primary care referrals to high-quality, low-cost specialists. Primary care groups that embrace the process are seeing their work pay off in the form of bonus checks to the practice, with the expectation that the shared savings will be reinvested to sustain the accountable care structure.

> **Streamlining key performance metrics to drive continuous improvement**
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> An integrated ACO uses a **care management impact score** to provide a single index of effectiveness across the organization's myriad quality initiatives. The algorithm produces a score on a 4.0 grade point average scale using national or state benchmark data. Performance in the top decile on a given benchmarked metric (e.g., readmission rates) is analogous to an "A" grade, top quartile grades earn a "B," and so on. The organizational score can be further analyzed at the individual business unit and metric level, and the granular scores are made broadly available to ACO staff and used frequently in communications about organizational performance. The interviewee noted that physicians "don't like getting anything less than a 4.0," which drives healthy competition amongst clinicians to earn the highest grades on care management.

Beyond direct compensation and contractual arrangements, high-performing ACOs have also leveraged network arrangements to incentivize continuous improvement among affiliated providers. For provider group-led ACOs, hospital partnership and strategic alignment is key to success, while curating a high-performing network of independent post-acute providers is critical for any type of ACO. Interviewees described various methods and measures for filtering out "low value" post-acute care providers from the referral network, which encouraged those preferred providers to maintain or improve value, and those carved out of the network to pay more attention to performance criteria. Multiple ACOs employed a preferred provider network of specialists.

High-performing ACOs have established structures to reward network affiliated providers for continuous improvement through a combination of financial, educational, and transparency mechanisms. One ACO began by educating the neighborhood physician line on the importance of the annual wellness visit:

> *"We started really educating the community physicians on the importance of the annual wellness visit (AWV), and demonstrated how you could address a lot of the ACO quality metrics inside that AWV and not make it into something that was unmanageable. We saw a huge jump in fall prevention and our screening metrics."*
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> **Executive, Integrated ACO**

Other ACOs relied on a combination of education and contract modifications to encourage continuous improvement among network providers.

Participation in Shared Learning Opportunities

Beyond investment in internal structures for performance improvement, another common strategy among high-performing ACOs was participation in shared learning opportunities with external organizations. The interviewees valued two main sources of external learning: regional peers, and national industry consortiums.

Some regions with multiple operating ACOs have established a voluntary learning collaborative for best practice sharing and addressing common challenges. Over half the sample group attributed some success to participation in a regional collaborative, and perhaps unsurprisingly, some interviewees pointed to other ACOs within the sample as generous partners in shared learning among the early model adopter cohort. In one highly competitive market with a dense concentration of ACOs, the local ACO collaborative encouraged organizations to work together in ways that had not happened previously, including sharing data on utilization and quality to support regional benchmark comparison.

Wisconsin Collaborative for Healthcare Quality

As a voluntary collaboration between health care providers, payers, and other health care stakeholders in the state, the Wisconsin Collaborative for Health Care builds consensus around key cost and quality metrics for public reporting.[2] Wisconsin-based ACOs in the study cohort pointed to the consortium as an important driver of transparency around both quality improvement best practices, as well as benchmark data. The group also collectively works to develop practice protocols and eliminate practice variation statewide.

Interviewees participated in national consortiums for easy access to content expertise, and sought consulting resources and publications for data analysis and implementation guides.3 ACOs moving into more advanced risk models noted less relevance for organizations with a singular model focus as their organization matured. Early Medicare ACO adopters also participated in learning systems facilitated by CMS, and found CMS was receptive and made modifications to address issues reported by the early adopters.

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2   http://www.wchq.org/index.php

3   Interviewees mentioned the Premier Health Care Alliance, National Association of Accountable Care Organizations, the Accountable Care Learning Collaborative at Western Governors University, and the HCTTF Accountable Care Work Group

Conclusion

The Medicare ACO methodology pressures participants to continually improve against historical performance to remain successful, and high-performing ACOs have taken steps to inculcate continuous improvement structures to build upon earlier performance. However, many challenges remain. Commonly referenced barriers included misalignment among different ACO contracts, and finding the right metrics to focus on for the biggest impact. More technical idiosyncrasies were also raised as potential obstacles for long-term success, such as the intrinsic disincentive to choose low-cost providers to participate in the ACO due to the benchmarking methodology favoring historically higher-cost providers with (theoretically) more excess utilization. Historically low-cost providers and ACOs operating in lower cost regions, therefore, find it increasingly more challenging to produce year-over-year savings. ACOs are addressing these challenges by piloting, refining, and sharing lessons learned from implementing continuous improvement structures.

Methodology and Acknowledgements

Recognizing the importance of identifying and disseminating levers of success among high-performing ACOs, the Health Care Transformation Task Force[4] (HCTTF) designed and conducted a nearly 12-month qualitative study analyzing the elements of ACO success. To do this, the Accountable Care Work Group conducted a multi-step project which included, among other things, a series of in-depth interviews with leaders of successful ACOs to investigate the common structures and strategies that enable success.

It was determined that all interviewed ACOs must meet the following criteria:
- Shared savings rate ≥2%
- Quality score ≥90%
- Below-average baseline[5]
- ≥5,000 ACO-covered lives
- More than one year under accountable care contract
- At least one commercial ACO contract (in addition to a Medicare ACO contract)
- Diverse geographic representation (preferred)

Using the PY 2015 Medicare ACO performance results and the Leavitt Partners ACO database, 21 Medicare Shared Savings Program (MSSP) and Pioneer ACOs were identified as meeting the criteria. The Work Group conducted interviews with 11 of the 21 ACOs, corresponding to over 10 hours of interviews. Within each ACO, the HCTTF interviewed senior decision-makers involved in designing and implementing accountable care-related activities across the ACO. To standardize the areas investigated, all ACOs were interviewed using the same interview guide. Interview transcripts were then coded to enable a thorough qualitative analysis. All quotes in this report draw from these interviews and written transcripts.

This is a product of the Health Care Transformation Task Force under the leadership of the Accountable Care Work Group. The Accountable Care Work Group is comprised of Task Force members and other organizations dedicated to improving the design and implementation of the ACO model in public and private payer programs. The Work Group addresses both internal operational challenges as well as public policy issues that challenge transformation efforts for health care organizations.