Levers of Successful ACOs

INSIGHTS FROM THE HEALTH CARE TRANSFORMATION TASK FORCE

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Part 1
Identifying the Levers of Successful ACOs

Value-based payment models have proliferated over the past several years in an attempt to address the unsustainably high costs and variable outcomes of health care in the U.S., and to test innovative models to solve these particular challenges and promote high-quality, low-cost care. While there are several approaches to value-based payment, accountable care organizations (ACOs) have been the most popular vehicle for value-based payment model adoption to date, with over 923 ACOs covering approximately 32.4 million lives across the country.[1] ACOs can take a variety of forms, differing by provider configuration,[2] contracted payers, payment methods,[3] and more. While approaches to ACO implementation vary, the principles of population health management remain the same.

> *An ACO is a provider-led entity that agrees to assume financial responsibility for the cost and quality outcomes of a defined population.*

Now, several years into the accountable care movement, health care stakeholders are closely studying the structures and behaviors of existing ACOs to learn about the attributes of successful organizations. Understanding the levers of ACO success will be increasingly important for a number of reasons:

1. **Supporting vulnerable providers** – While all providers could benefit from the study of ACO success factors, the dissemination of successful strategies will be especially important for smaller, independent organizations without the capital to invest in custom, hands-on support. Moreover, these are the types of organizations who also cannot afford to get it wrong the first time. Their investments, and the order of those investments, are crucial, as is their configuration and the construct of their partnerships.

2. **Evaluating potential partners** – The transition to value requires health care stakeholders to seek new types of partnerships.[4] By better understanding the levers of ACO success, payers, purchasers, and providers will know how to accurately evaluate potential ACO partners.

3. **Influencing future ACO adoption** – The greatest driver of future ACO growth will be the success of existing ACOs, as fence-sitting providers will be swayed by participants' success or failure. This applies not only to new ACOs considering these arrangements for the first time, but also to those who are electing whether to renew ACO contracts or expand with additional payers, and those actively participating and looking for opportunities for improvement.

1 Muhlestein D, Sanders R, McClellan M, Growth of ACOs and Alternative Payment Models in 2017 (2017)

2 Leavitt Partners, A Taxonomy of Accountable Care Organizations (2014)

3 HCTTF, Accountable Care Financial Arrangements: Options and Considerations (2016)

4 Leavitt Partners, Defining High-Value Providers for ACO Partnerships

4. **Enabling the sustainable transition to a value-based health care economy** – There has been much debate around how to measure the success of early ACO programs.[5] While certain metrics can be used to evaluate financial and quality achievements, the actual impact of these initiatives is yet to be determined. It is important to remember that ACOs are not intended to be a short-term solution for savings. Instead, the ultimate goal of payment reform is to transform the way providers deliver care. Therefore, understanding long-term success factors will require deeper analysis into the delivery changes that lead to high-value outcomes.

Recognizing the importance of identifying and disseminating these success levers, the Health Care Transformation Task Force[6] (HCTTF) designed and conducted a nearly 12-month qualitative study analyzing the elements of ACO success. This report details that work, outlining research methods and describing key findings across a number of domains. The information contained in this paper represents the experiences of select ACOs, including HCTTF and non-HCTTF members, and is supported by additional evidence found in the current literature.

How to Use This Resource

The objective of this document and its subsequent reports is to move beyond high-level themes to provide a tactical guide for *understanding, prioritizing,* and *implementing* the levers of ACO success. While the principles in these reports should be broadly applicable across all ACO types, the application of these tactics will vary based on a number of factors including an organization's history, structure, governance, and market.

The HCTTF recommends that ACOs and other health care stakeholders leverage these resources to:

- Evaluate proficiency across key activities
- Educate organizations about the importance of these key activities
- Prioritize improvement efforts based on unique organizational needs

5 Song Z, Fisher ES. The ACO Experiment in Infancy—Looking Back and Looking Forward. JAMA. 2016;316(7):705-706. doi:10.1001/jama.2016.9958

6 The HCTTF is a consortium of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry— including patients/consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs. Our members aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

Methods

The Accountable Care Work Group set out to determine the factors that enable ACO success in ways that are scalable and applicable across the public and private sectors. To do this, the 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.

Project steps:

1. *Determine selection criteria*
2. *Develop interview guide*
3. *Conduct interviews*
4. *Code and analyze transcripts*
5. *Supplement with HCTTF member experience and literature review*

Defining "Success"

In order to determine which organizations should be interviewed for this research, the Work Group first established a definition for ACO "success." While the aim of this work was to identify levers that are scalable and applicable across public and private ACO contracts, the Accountable Care Work Group chose to focus on Medicare ACO activity as the foundation for interviewee selection and analysis. The standardized policies and transparency of CMS programs allowed for clearer identification and comparison of ACO success levers across organizations. With this decision to focus on Medicare activity for ACO subject selection, it was determined that the interviews would primarily focus on soliciting information related to managing Medicare beneficiaries, with the assumption that levers for success will change based on the population served and the relationship with the payer. However, while the criteria were intentionally Medicare-focused, the Work Group leveraged the Leavitt Partners ACO database to identify ACOs that met the initial criteria and had at least one commercial ACO contract so that commercial strategies could be included as an important, yet secondary, consideration.

It was determined that all interviewed ACOs must meet the following criteria:

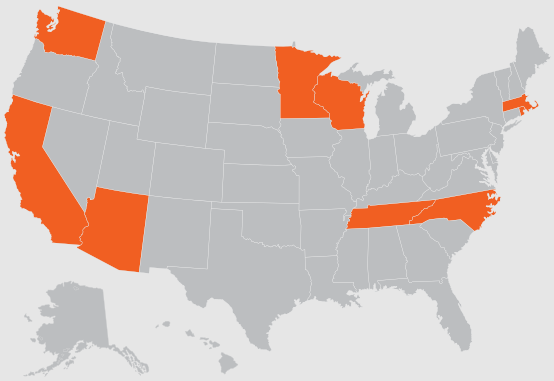
- Shared savings rate ≥2%
- Quality score ≥90%
- Below-average baseline[7]
- ≥5,000 ACO-covered lives
- More than one year under an accountable care contract
- At least one commercial ACO contract (in addition to a Medicare ACO contract)
- Diverse geographic representation (preferred)

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 then narrowed this list to 11 final ACOs in 8 states (Table 1).

7 ACOs with below-average baselines – or lower expected average expenditures – were considered more desirable to study based on the hypothesis that these ACOs began with less excess expenditures, and therefore, a shared savings rate ≥2% was even more meaningful.

Table 1: Interviewed Organizations

ACO Name	Headquarters
Allina Health	MN
AnewCare Collaborative, LLC	TN
Atrius Health	MA
Arizona Connected Care, LLC	AZ
Aurora ACO	WI
Banner Health	AZ
CaroMont ACO	NC
Coastal Medical, Inc.	RI
ProHealth Solutions, LLC	WI
Providence Health & Services	WA
MemorialCare	CA



Primary Research and Analysis

Within each ACO, the HCTTF interviewed senior decisionmakers 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 (see Appendix). Interview transcripts were then coded to enable a thorough qualitative analysis.

The information below represents key findings from the analysis, outlining the common structures and strategies across some or all studied ACOs.

Findings

Throughout the course of these interviews, the HCTTF collected a large breadth of information regarding ACO structures and strategies. Although each organization had differing approaches and experiences achieving ACO success, common themes emerged. Following the qualitative analysis, the Task Force organized shared success levers into three major categories: **1) High-Value Culture, 2) Proactive Population Health Management, and 3) Structure for Continuous Improvement**. This paper briefly introduces the three categories, outlining their sub-topics and setting the stage for the subsequent in-depth reports which include aggregated findings, real-world examples, and recommended strategies.

Achieving a High-Value Culture

Perhaps the most elusive yet most important element for achieving long-term success is developing a culture conducive to value. Having a high-value culture means that all levels of the organization – particularly the leadership – demonstrate an internally-motivated commitment to excellent patient outcomes (quality) that are achieved at the lowest possible cost. This category represents the underlying current that drives all improvement efforts, by ensuring the ACO objectives are prioritized at every level of the organization.

As true with most other elements, approaches to developing and maintaining a strong culture will vary from organization to organization. Still, all studied ACOs have pursued similar channels for engaging individuals across the organization:

- Involvement by senior decisionmakers (i.e., governance bodies) in ACO operations
- Physician and community practice engagement
- Expanded clinical partnerships

Proactive Population Health Management

Unsurprisingly, common to all studied ACOs is a dedication to proactive population health management. Managing the health of a defined population across the continuum of care requires a complete paradigm shift for most providers, as well as the development of new systems and processes. While challenging to learn and implement, population health management is the cornerstone of all accountable care success. In addition to its foundational importance for accountable care, population health management and its various components were mentioned most frequently in the interviews, and were said to have the greatest impact on practice transformation.

While population health approaches can take many forms, most ACOs studied had developed analogous operational elements. Those fundamentals include:

- Systems for identifying high-risk patients
- General care management functions
- Specific disease management programs

Structure for Continuous Improvement

To be successful under any value-based payment model requires a strong supporting infrastructure, but this is especially true of ACOs. The nature of this care model, combined with the added complexity of multiple providers with disparate systems and multiple payers with different requirements, makes careful investments in infrastructure a principal strategic decision for organizations participating in ACOs. In combination with workforce resources, this is the backbone of all performance improvement. A successful ACO leverages its supporting structure to learn about its organization, its people, its performance, and its patients, and then uses that information to create feedback loops for continuous learning and system improvement. ACOs identified essential elements that support continuous improvement:

- Operational infrastructure for performance measurement
- Tying performance to compensation and network contracts
- Participation in shared learning opportunities

Conclusion

While the concept of payment and delivery reform is no longer novel in health care circles, the application of those reforms is still in its infancy. Providers across the country are pursuing a variety of payment models and partnership strategies, and all are in different stages of value-based readiness. Public and private pressures will continue to drive the movement toward value, but the ultimate sustainability of this transition will be determined by providers' willingness to share learnings, and the willingness of others to apply those lessons. Organizations like the Health Care Transformation Task Force and other learning networks support providers and the broader stakeholder community in navigating these changes by investigating and disseminating proven strategies. Just as individual ACOs must foster a high-value culture by promoting transparency and an attitude of continuous improvement, so must the health care system by sharing freely the levers of success.

Part 2
Achieving a High-Value Culture

When studying the success levers that allow accountable care organizations (ACOs) – as well as other providers engaged in payment and delivery transformation – to achieve high-value health care delivery, there is no better place to begin than culture. An organization's culture is a result of how governance bodies and leadership manage the organization in carrying out its mission. In health care, having a high-value culture means that all levels of the organization demonstrate an internally motivated commitment to excellent patient outcomes (quality) that are achieved at the lowest possible cost.[1] A high-value culture and ongoing dedication can be seen in more than an organization's mission, vision, and value statements – it is evident in the attitudes and priorities of senior leaders down to the most basic day-to-day operations.

Without a culture of high value, an ACO cannot truly commit to the continuous work of system transformation. However, while monumentally important, organizational culture can be ambiguous and therefore challenging to assess and improve. To help providers to understand and implement the cultural changes necessary to achieve high-value care, this report outlines four common behaviors among high-performing ACOs.

Pre-ACO activities and culture. While the specific approaches and payment details vary, most high performers have previous experience managing risk prior to forming or joining an ACO. This early adoption is a reflection of leadership's commitment to high-value health care and a culture that embraces change. Moreover, this history of risk assumption suggests that the ACOs' financial leadership is invested in the idea that outcomes-oriented payment is a viable business strategy.

Governance involvement in ACO operations. High-performing ACOs have the support and commitment of top-tier leadership and a governance structure that is conducive to fostering a high-value culture (e.g., encourages innovation and feedback).[2] Importantly, organizational leadership is committed to a culture of teamwork, collaboration, and adaptability in support of continuous learning as a core objective.[3]

Physician and community practice engagement. ACOs with a deep-seated high-value culture understand the importance of engaging clinicians and care teams to accomplish shared goals. To do this, ACO leaders invest in practice education and support services, as well as an aligned compensation structure that encourages continuous improvement, identifies and reduces waste, and rewards high-value care.[4] ACOs cannot succeed without truly engaged physicians who are committed to understanding their practice patterns and bringing these patterns into alignment with the goals of the ACO and evidence-based best practices, and serving as champions to help guide clinical peers.

1 Avedis Donabedian, Introduction to Quality Assurance in Health Care (2002)

2 Institute of Medicine, Core Principles & Values of Effective Team-Based Health Care (2012)

3 The Commonwealth Fund, Organizing the U.S. Health Care Delivery System for High Performance (2008)

4 Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century (2001)

Clinical partnerships. High-performing ACOs leverage the strengths of high-value partners to help manage the continuum of care. These ACOs are intentional and value-driven in their assessment of potential external provider partners, looking for organizations that are culturally like-minded.[5] Once selected, ACOs work collaboratively with partners to provide comprehensive, integrated, and coordinated care.

In this report, we describe further the clinical culture transformation for ACOs that have been successful in achieving shared savings and high quality performance under the Medicare ACO program.[6]

Pre-ACO Activities and Culture

Key Strategies

- *Cultural commitment at the board level to delivering high-quality, efficient care*
- *Manage risk and quality performance for commercial and public contracts, including Medicare Advantage, Medicaid managed care, and large purchasers*
- *Negotiate payment arrangements across multiple payers to support investment in infrastructure and care coordination*
- *Analyze expected financial and quality performance before selecting ACO track*
- *Pursue opportunities to learn and provide feedback to payer partners*

Most high-performing ACOs interviewed had managed risk and/or pay-for-performance programs within their commercial lines of business before joining the Medicare ACO program. Evaluations of the Medicare Shared Savings Program have shown that ACOs participating in the program longer were more likely to produce savings, and more likely to reduce spending by greater amounts.[7] Pre-ACO value initiatives varied based on the payment arrangements made available in any given market; however, most executives interviewed expressed a belief that a large-scale transition away from fee-for-service payment was both imminent and desirable.

> *"I would guess that most of the people who joined Pioneer [ACO] didn't start from scratch. I would guess that they had similar cultures, whether or not they had some financial incentive for the performance."*
>
> **Executive, Hospital-led ACO**

Several organizations pointed to past involvement with managed care or risk-based arrangements as providing the experience necessary to effectively manage a shared savings program from both an administrative and clinical perspective. Two hospital-led ACOs were accountable for quality and total cost of care for large employer contracts before joining the Medicare ACO. Another organization built

5 Leavitt Partners, Defining High-Value Providers for ACO Partnerships

6 Please see Methodology section for detailed criteria for high-performing ACOs

7 HHS Office of the Inspector General, Medicare Program Shared Savings Accountable Care Organizations Have Shown Potential For Reducing Spending And Improving Quality

upon existing administrative structures for managing a risk-based physician hospital organization (PHO) with their community physicians, as well as a self-insured product for their own employees. Most organizations had some experience with Medicare and/or Medicaid managed care, and some ACOs had managed more advanced risk arrangements, including capitation, that require familiarity with the dynamics of benchmarking, risk adjustment, and quality measurement.

One physician-led ACO participated in commercial quality-based pay-for-performance programs before joining the Advanced Payment ACO (MSSP Track 1). The same ACO negotiated per-member per-month stipends with their commercial payers as part of a patient-centered medical home initiative to support expanded nurse care coordination. Blending together the Meaningful Use incentives, upfront payment of shared savings from Medicare, and commercial care management fees, the organization was able to spread financing across multiple sources to invest in the infrastructure needed to be successful. Several executives mentioned similar impetuses to pursue value-based models across multiple lines of business.

For early adopters, the decision to participate in a Medicare ACO program was often mission-driven and, to the extent possible, informed by data-driven projections. For example, one hospital-led ACO operating in a low-cost market analyzed its expected performance before opting for the upside-only MSSP track, recognizing that organizations with historically low expenditures are less likely to achieve shared savings under a national ACO benchmarking methodology.[8] A few ACO executives, particularly those that joined the first Pioneer and MSSP cohorts, mentioned desirability of joining models at the earliest stage to be able to provide feedback and influence the program design before it fully matured, as well as providing an opportunity for the organization to learn and prepare for the future:

> *"When we entered [the ACO program], the organization was making a strategic decision, not because we thought we'd make a whole bunch of money in this, but partly to force ourselves to learn. And it looked like a relatively safe environment for us to develop some of the programs and skills and analytics [because] we had some pretty tight guardrails to protect us from savings and losses. We had always hoped that we'd use it as a learning platform and then be able to expand it across our whole geography…because we think the future is value-based payments."*
>
> **Executive, Hospital-led ACO**

A smaller subset of ACOs shared a long pre-ACO history of improving quality by actively involving clinicians in the quality improvement work, transparently reporting metrics, and introducing coaching and decision support tools at the individual clinician level to supplement intrinsic motivation to achieve a high level of performance on quality. Two ACOs described well-established quality analytic structures which provided the organization with a clear picture of their relative quality performance on a regional and national level; confident in their ability to deliver a high-quality product, the Medicare ACO programs provided a welcome opportunity to be rewarded for quality and efficiency of care.

8 CMS has since modified the MSSP benchmarking methodology to incorporate regional adjustments.

Governance Involvement in ACO Operations

Key Strategies

- *Consider aligning governance bodies for multiple ACO contracts*
- *Engage clinical/administrative dyad structures at the governance level*
- *Involve patients in practice redesign*
- *Identify the key, predictive indicators/metrics for success under the ACO contract*

Each high-performing ACO described strong commitment and involvement from the highest echelons of leadership in the pursuit of accountable care and health care transformation, even where success under the shared savings model may put overall system revenue at risk. As one executive noted,

> *"To be perfectly honest, we track and report and talk about [the ACO performance] disproportionate to its impact on our whole organization's bottom line. And that's kind of a deliberate thing. It's a big enough, important enough, unique enough thing that we used it as a way to get these conversations going across the organization so we could learn."*
>
> **Executive, Hospital-led ACO**

Compliance requirements obligated participants to establish a governing board for the Medicare ACO with specified representation, but several interviewees noted a strategic decision to integrate the ACO's governing body within a broader structure of governance across the organization. A centralized governance structure allowed for creation of common goals, alignment across various value contracts, and setting expectations at the senior leadership level to help drive an overall quality and efficiency strategy for the entire organization. One executive defined the organization's governance style as "meta-leadership," meaning the board placed an emphasis on aligning both clinical and operational leadership across all ACO contracts:

> *"We've got all these different contracted arrangements all with slightly different quality gates and metrics and financial arrangements and lengths of term, so many different variables… initially, actually, they were sort of like one person had this ACO, another person had that ACO. That actually doesn't work because there are so many things that need to be overseen that really overlap. And if we're going to have a system of care that looks at, for example, hospitalist coverage, we need to be able to work with those hospitalists regardless of which ACO we're in."*
>
> **Executive, Integrated ACO**

Alignment at the governance level was often mirrored in the operational structure: centralized "population health" departments have been tasked with deploying population health management services and monitoring performance across the organization to minimize the burden for individual physician groups and departments to participate. Yet, not every high-performing ACO decided to fully align governance structures and operational services; some organizations opted to create a parallel structure to manage ACO compliance and performance apart from the fee-for-service lines of business,

and reserved population health management resources for ACO-aligned beneficiaries. Additional analysis about the decision to pursue parallel versus aligned operational structures is provided in a separate series of reports focused on a broader transformation to value.[9]

Dyad committee structures support integrated administrative and clinical operations

The board of the CaroMont ACO comprises physician representatives from each of the composite Tax ID Number (TIN) organizations, including a skilled nursing facility and hospice, in addition to the representatives required by CMS. The board's committees employ a clinical/administrative dyad, in which physician representatives and operational executives work in concert to bring vetted proposals to the full board. For example, the ACO board may request that the Finance and Operations Committee review a contractual modification. That committee – representing the participating medical group providers (including hospitalists and multispecialty physician group practices) and appropriate financial leadership from the organization – would collectively review the proposal and make a recommendation for action by the board.

Health care organizations undertaking large-scale transformation of the overall financing and care delivery structure are often utilizing a dyad structure to implement the strategic objectives at the business unit level. It can be challenging to translate one-off strategies into an integral part of the daily workflow; employing the dyad structure and engaging physician leaders at the governance level ensures physician leadership in the initiative and support for organizational priorities.

Despite contrasting approaches to the overall organizational governance structure, nearly all high-performing ACOs emphasized the importance of physician participation on the ACO board, and in particular, involving both employed and community physicians as well as regional leaders impacted by the ACO strategy, where applicable. Some ACOs also expanded upon the requirement for Medicare beneficiary participation to engage consumers in unique ways:

> *"Initially, we had three Medicare beneficiaries on the ACO governing body, as was required, and they gave us interesting and valuable perspectives on their experiences as patients and so forth. But we sort of re-thought that, and we have just engaged about 25 patients across all payers to participate with us now on process redesign teams…So when they came in for the first meeting, what we said is this: what we used to do [to engage consumers] is like when you go to a restaurant and there's a survey about what you think about the food. What we're doing now is asking you to come in and help us design the menu, the décor, and the dining experience."*
>
> **Executive, Physician group-led ACO**

Examples of recurring board meeting topics	Examples of topline priority measures
• Review priority quality measures • Review priority utilization measures • Highlight best practices • Share learnings from each department/region • Compare utilization by department/region	• Hospital admissions • Readmissions • Emergency Department visits • Internal utilization • Outside specialty utilization

9 Health Care Transformation Task Force, The Transformation to Value: A Leadership Guide

ACO governing bodies serve a critical role in setting direction for high-performing ACOs, and identifying areas for improvement and investment. Most organizations reviewed data from multiple sources, including the EHR, internal claims data, and claims and quality reports provided by CMS to assess ongoing performance. Participants described similar processes to streamline and select priority metrics to ensure the board could focus on the most relevant indicators of success under the ACO model. However, participants also found themselves fighting the tendency to over-simplify:

> *"You'd like to tell people where there are just a few things that you need to do, but I take a little bit more holistic view and say, man, there's a ton of stuff you have to get right to make this sustainable and effective."*
>
> **Executive, Physician group-led ACO**

Physician and Clinical Practice Engagement

Key Strategies

- *Co-create project plans with front-line staff*
- *Devise sub-groups for the purposes of education and performance measurement*
- *Utilize physician advocates to convey ACO policies and requirements*
- *Establish a parsimonious set of actionable performance measures*

Consistent with the near-ubiquitous use of dyadic governance structures, successful organizations made clear that the ACO execution was not an administration-run effort. Administrative partnership with physicians and other clinical staff in planning was coupled with collaborative implementation strategies in the following areas:

- Building buy-in to the overall accountable care initiative
- Ensuring comprehension of specific ACO objectives
- Integrating practice improvement into regular work flow and tracking progress

Multiple ACOs used the word "co-creation" in describing the initial implementation process. One organization emphasized the breadth of staff included in project planning:

> *"There's an inclusive and collaborative culture here that's really crucial to getting buy-in…. If you're going to get frontline people to change what they're doing, it's so much more helpful if from the very beginning they're involved and telling you what would probably work best. And then, of course, they're going to help design it. They're going to then champion it. And so the order in which we have done things was significantly determined by what everybody in the offices wanted to do. And by everybody, I don't just mean the doctors, but when we had convenings and brainstorming, we had receptionists and MAs and the pharmacists and the advanced practitioners and the nurse care managers as well as corporate folks to do that work."*
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> **Executive, Physician group-led ACO**

While population health initiatives were often driven by analytics to define target segments of the patient population and priority areas for improvement, high-performing ACOs relied heavily on clinical staff to review and refine implementation plans on the front-end. One ACO used multi-disciplinary teams – bringing together clinical leaders, operational and analytic resources, and project management – to co-create new project work plans and design pilots to inform the planned tactics and communication pathways, before ultimately tasking performance improvement staff to scale the polished implementation plan across various operational areas. Another organization designated highly engaged "ACO champions" from each practice to serve as informal leaders in the effort.

The participating ACOs utilized a variety of strategies to ensure clinicians understood and could act upon the ACO requirements, which varied based on ACO structure and physician employment model. A larger, multi-regional ACO conducted regular town halls with each region to educate physicians and office managers about the contract parameters, while another required all new staff to attend an orientation session. Common training topics included quality measurement and reporting, care management programs, and utilization variation. A hospital-led ACO educated its community physicians on the importance of the Medicare wellness visit as a mechanism for getting patients in and completing annual quality metrics:

> *"It requires a very passionate on-the-ground team to keep people focusing on these things. And so we hire people specifically who have that passion and that vision to work on the accountable care services team."*
>
> **Executive, Hospital-led ACO**

Most ACOs followed a similar model of breaking the ACO into subgroups for the purposes of assigning clinical leadership and measuring performance. One hospital-led ACO uses clinical subgroups to assign rewards based on overall contribution to earning shared savings, and deploys practice improvement teams to meet with poorer-performing primary care subgroups one-on-one and educate those practices using clinically actionable data.

Assigning subgroup leadership within a multi-regional ACO

For the non-employed physician group, Banner Health divided the market into about 10 regions and assigned regional chief medical officers that served as both a physician advocate as well as translator to other physicians within the region. The CMOs are practicing physicians trained to understand the ACO business, so they can quite literally "speak both languages." It is standard practice for all Banner Health ACO communications to flow to the practices through the CMOs.

Considering the heavy burden of compliance and severe time constraints for most providers, high-performing ACOs took pains to prioritize only the most critical measures and present data to providers in the most meaningful way. One hospital-led ACO uses the total cost of care metric as the focal point for all improvement efforts, as it strikes a reasonable balance allowing for the overall system to remain competitive in the marketplace while the ACO operates under an independent budget. Another ACO with multiple operating regions created "six essentials" for all ACO practices to perform against, and generated minimum specifications for each region to meet; those practices failing to meet the minimum standard receive additional coaching and performance improvement support. And the timeliness of metrics matter; organizations expressed preference for metrics that could be refreshed on a weekly basis.

Yet, the process to refine critical measure sets is iterative, as one hospital-led ACO described:

> *"We've got good data out there, but we don't think the physicians have necessarily been utilizing it. So our chief medical officer is going out and visiting with most of the primary care physicians. And we have a whole list of items that we want to work with them on and also get some feedback from them, and to make sure everyone understands that when we're pushing them to do these quality checks and close those gaps, what the reasons and benefits are for everybody."*
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> **Executive, Physician group-led ACO**

Organizations also employed strategies to mitigate physician burn-out or "transformation fatigue"; one ACO established a voluntary physicians' society to provide a forum for physicians to discuss best practices and barriers, and provide feedback to leadership. A physician-led ACO discussed the unique challenge posed by obligating physicians to increased workflow standardization and collective, transparent reporting on quality and cost performance within an organization that had previously encouraged autonomy with only a few centralized business services:

> *"I think we had a culture of quality. In fact – we've always been selective about the physicians who work here…But getting to the point of really having reliable data and believing it and getting to the point of sharing unblended data that is provider specific or office specific, sharing that broadly and really changing the culture to the point where all the providers and everybody in the offices feel that this is meaningful – that's a journey that still continues."*
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> **Executive, Physician-group led ACO**

Clinical Partnerships

Key Strategies

- *Identify and engage high-performing post-acute and long-term care providers, including skilled nursing, home-health and hospice providers*
- *Embed nurse care managers within in-patient hospitals, emergency departments and skilled nursing to support transitions of care*
- *Integrate behavioral health with primary care to manage exacerbating co-morbidities*

Across the board, high-performing ACO executives found the most meaningful partnership with skilled nursing facilities (SNFs), because for most ACOs, post-acute care was determined to be driving the most prospective cost-savings under accountable care arrangements. ACOs also applied the available three-day SNF rule waiver, which permits ACOs to admit patients directly to a skilled nursing facility without an inpatient hospital stay, or prior to a full three-day hospital stay.[10] The waiver allows for ACOs to create easier pathways for patients to be seen quickly by geriatricians in the SNF, and to simply avoid unnecessary inpatient stays where possible. Working with a "best in class" network of preferred

10 https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html

independent SNF groups, one ACO found a way to convene the SNFs to be able to manage the three-day SNF waiver efficiently by providing performance reporting to the SNF on their length of stay, readmission rates, and quality metrics to improve standardization and reduce variation.

> *"We were able to tighten the number of SNFs that we contract with. We looked at all of them and their performance, and said 'you're in, you're out' based on criteria. I think that skilled nursing facilities are waking up, especially in our neck of the woods, and they want to partner with us. And you can certainly see in our data those [SNFs] that pay attention and those that don't; those that are actually willing to partner with us to develop a plan of care in the first week and to help educate their staff."*
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> **Executive, Integrated ACO**

Several ACOs built staffed nurse care manager teams to manage the transitions of care for patients upon discharge or direct referral to SNF in order to avoid readmissions, some tasking care managers in the inpatient hospital, emergency department, or provider practices, while other organizations asked ACO providers and care managers to round directly in the nursing homes. Affiliation with home health and hospice agencies was also key to finding innovative ways to bring care in the home as well as lengthening hospice length of stay and getting palliative care involved early, and encouraging better collaboration with the physicians. One physician-led ACO created a multidisciplinary team led by a nurse practitioner that does home visits for about three hundred of the sickest patients. Another organization partnered the home health provider with the ACO's chronic disease educator to train patients to support self-management.

ACOs found patients presenting with a secondary behavioral health diagnosis are three times costlier than ACO patients without such diagnosis; therefore, another key clinical partnership was creating linkages with behavioral health providers. However, there was no dominant integration strategy present among the high-performing ACOs interviewed. Both a physician-led and hospital-led ACO had piloted co-location of behavioral health providers in primary care offices, but found that referrals were too haphazard and the behavioral health providers were not touching the right patients. The physician-led ACO evolved its approach to integrate behavioral health providers within the disease management teams, so that services were preferentially directed to the costliest chronic disease patients.

Conclusion

While successful ACOs often benefitted from deep expertise and organizational commitment to high-quality care, the path to value can be long and challenging. Culture change within an organization does not happen overnight. The common theme across all the strategies employed to achieve a high value culture was building strong partnerships. In the new world of accountable care, historic silos must be broken down and old structures for clinical and administrative coordination must be reconsidered, and a new business model needs to take root. ACOs are addressing these challenges by identifying high-value partners, creating tighter organizational alignment, and involving clinicians and patients in designing a sustainable value-based system.

Part 3
Proactive Population Health Management

For successful accountable care organizations (ACOs), population health management is the cornerstone of delivering high-quality care while lowering total costs. To be cost-effective requires developing systems and processes that identify patients for proactive intervention, building the internal staffing capacity and clinical partnerships to appropriately manage patients, and adequately integrating new programs within the existing patient care workflow. While the population health management programs can take many titles and positions with the organization, the ACOs in our study described common operational elements to their approach.

> *"A lot of what we've built has been built very specifically to do population health management, I think that's the difference. I was a primary care physician in the community for 20 years, and it was the old reactive model: there's 30 patients on my schedule today, and those are the people I'm going to work with…nothing like this proactive, population-based approach."*
>
> **Executive, Physician group-led ACO**

System for identifying high-risk patients. The crux of population health management for successful ACOs is to proactively identify patients with high clinical risk, and refer those patients to the appropriate intervention. In most cases, "high clinical risk" was defined by patients' likelihood of hospitalization. ACOs placed importance on developing a standard risk model to stratify patients through claims and active emergency department utilization data (e.g., ADT feeds) in order to be pragmatic in matching the highest-need patients with highest value care management resources.

General care management functions. ACOs described multidisciplinary teams comprised of nurses, social workers, and pharmacists that serve general care management functions, but also non-licensed staff to address the nonmedical needs of ACO patients. Most ACOs mentioned utilizing the electronic health record (EHR) system to flag ACO patients for clinically-meaningful preventive care, and communicating with providers about patients at highest risk of hospitalization. Provider systems varied in the approach to integrating care management staff across the care continuum.

Specific disease management programs. Successful ACOs have also implemented care management programs specific to patients with certain chronic illnesses or disease states. These more targeted interventions focus on supporting patient self-management to prevent ED visits and hospitalizations for certain diagnoses such as heart failure, COPD, and diabetes. Where care management programs overlap, ACOs instituted huddles or weekly case reviews to discuss individual patients that may have multiple teams involved in their management.

Managing limited care management resources is not without its own unique set of challenges. ACOs discussed ongoing efforts to refine the population health management infrastructure to be able to more accurately identify the highest-need patients, and reengineer the team structure to touch those patients with more frequency. Perhaps most importantly, ACOs are struggling with the ability to quantify the return on investment (ROI) from care management programs, considering the myriad intersecting factors at play.

In this chapter, we describe further the population health management methods employed by ACOs.[1]

System for Identifying High-Risk Patients

Key Strategies

- *Establish and utilize standard risk models based on claims and clinical data*
- *Regularly test and refine the risk model for maximum risk predictability*
- *Integrate real-time data sources where possible (e.g., ADT feeds)*
- *Make the risk score actionable for clinicians and case managers using decision support tools*

High-performing ACOs have developed methods for segmenting patient panels and prioritizing high-risk patients for care management programs. Some organizations have developed care management programs that are available to all patients, while others instead reserve those programs for patients in value-based contracts. Whether implemented broadly or limited to ACO-aligned patients, calibrating the system to ensure maximum impact of care management programs for the ACO population is crucial in a world of limited resources for non-billable services.

> *"Our clinicians understand that we're trying to move to the future. But we still have to be pragmatic in the meantime. And we can't afford to do everything for everybody...We're pushing as hard as we can so that this will be available for more people, but if they help us by letting us segment that service, it makes it easier for us to prove that it works and justify and sell it to other payers."*
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> **Executive, Hospital-led ACO**

The ACOs we interviewed described a variety of front-end tools used to stratify patients and segment the target population, including home-grown analytic models, EHR modules, and standalone population health management software. Use of payer claims data to establish a risk score and consequent triggers for program assignment was most common. Only one ACO in our sample relied on physician referrals alone to assign patients to care management programs, allowing for primary care and specialty providers that serve a subset of patients as de facto primary care (e.g., cardiology, endocrinology, oncology) to make the referrals.

Yet, organizations that allowed for or depended on physician referral to care management emphasized the importance of using standard risk models to segment the population and match intensity of the care management programs with prospective patient risk:

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

"We learned over time that we had to be smart about using standard risk models to identify the patients most in need. And we had to be smart about not filling up the resource with patients other than the ones who needed it the most. And that means that while we let clinicians refer to it on their own, whether they're ACO patients or not, the bulk of these team members' time is spent on the patients that we select, where we need the most help to manage their care."

Executive, Hospital-led ACO

For example, one ACO utilized the Johns Hopkins ACG® System[2] – which calculates relative patient risk scores based on claims data and clinical data from the EMR – and built out additional decision rules to generate a high-risk patient list. The process initially required the ACO to engage in manual chart reviews to determine the validity of various decision rules.

Regardless of the exact analytic model, the real pressure test for ACOs has been making the risk score actionable, and that means ensuring its visibility – and meaningfulness – to clinicians, care managers, and discharge specialists.

"I think it's a mistake to think that if you get the right software package that you're going to be able to do population health management."

Executive, Physician group-led ACO

One ACO organizes patients into four categories, from least to most intensive:

1. *~35% of patients receive wellness/preventive care prompts, e.g., preventive screenings, vaccination outreach.*
2. *~40% of patients receive early disease management in response to early symptoms of chronic disease.*
3. *~20% of patients are more frequent ED and hospital utilizers. These patients are assigned to patient navigators to assist in discharge planning and complex case management to manage chronic illnesses.*
4. *The remainder of patients receive hospice or palliative care for late-stage illnesses.*

Claims data lacks a critical benefit when it comes to proactive population health management: timeliness. And for patients that fall into category 3 (above), preventing unnecessary hospitalizations requires real-time intervention when patients hit the emergency department. Keeping track of patients' interactions with the hospital has particular relevance for provider-led ACOs, especially when those patients seek care outside the ACO's network. Successful ACOs have IT systems in place to alert care management staff when ACO patients are registered in an ED or admitted to a hospital through ADT (admission, discharge, transfer) feeds.

One ACO mentioned utilizing PatientPing, a platform that pushes ADT notifications back to the practice when their attributed patients are seen at any hospital in the region. Another ACO implemented real-time visual cues within the EHR to prompt rapid intervention:

"We utilized technology to flag patients. We don't say to the patient, you're a frequent flier. But we used communication amongst the ambulatory case managers, the transitional case managers, and the ED case managers and social workers that cover the ED to let them know, hey, Susie Smith's back in the ED. Can you go intervene?"

Executive, Hospital-led ACO

2 Additional tools and/or products mentioned: Truven Health Analytics care management suite, AthenaHealth patient roster tool, and Epic Health Planet readmissions risk score module.

Building the right predictive model for care management

Atrius Health, a physician group-led ACO, determined that the second largest opportunity for savings – after post-acute care – was preventing hospitalizations in the first place. To do this, the organization built an analytic model to proactively identify patients with high clinical risk. The model assigns a score for all adult patients over age 65 for likeliness of hospitalization in the next six months, which is used three ways:

1. A **multidisciplinary care team** reviews the high-risk patient list on a regular basis ensure a comprehensive plan of care is in place.
2. A **case management team** conducts outreach and assesses patient appropriateness for enrollment in case management.
3. High-risk patients are provided **enhanced access** to point-of-care services (e.g., invited for same-day, face-to-face appointment or home visit rather than telephonic care management)

Several executives mentioned integrating tools into the EMR to make it easy for frontline staff to direct patients to care management and other programs available to ACO patients, such as highlighting insurance type in the patient header to alert clinicians that the patients may be eligible for "unique benefits," (e.g., a waiver from the otherwise required 3-day hospital stay to qualify for SNF care). Some ACOs expanded view-only access to patients' clinical data to support population management.

Segmenting and identifying the targeted patient population for care management is just the first step in delivering effective population health management, as discussed further below.

General Care Management Functions

Key Strategies

- *Redefine the care management role and recruit/retrain staff to meet the new objectives of accountable care*
- *Use a combination of centralized and embedded services to make most efficient use of face-to-face patient time, and regularly evaluate the right balance of services*
- *Embed care managers in the emergency department, skilled nursing facility, and on inpatient rounds and care team huddles to support patient education and transitions of care*

When asked what care delivery changes had most meaningfully and directly contributed to the success of the ACO, the executives of high-performing ACOs almost universally described the importance of care managers. In this section, the term "care manager" is used as an umbrella term encompassing care coordinators, navigators, and health coaches; for most ACOs interviewed, this work was performed by registered nurses, while some ACOs used clinical social workers. Care management was often rendered as part of a multispecialty team, and in some cases, multiple care managers were assigned to the same patient. The professional licensure, titles, and organizational structures for care management were

varied, yet the ACOs described similar processes for integrating new staff and mechanisms to better care for patients with chronic disease and complex needs.

ACO executives drew a distinction between the role of care management professionals and more traditional case management; whereas case management generally anticipates case resolution, with a set start and end date, care management requires more dedicated and ongoing relationships with patients, family, caregivers – and physician practices that may be resistant to change.

The unique skillset demanded by effective care management required ACOs to rethink their hiring, recruitment, and training programs. One ACO described the process of completely overhauling the case manager job description, recognizing that successful hospital case manager skills do not necessarily translate to population health management. Another ACO used standardized behavioral tests to match staff with the right organizational roles, resulting in lower staff turnover in comparison to industry peers. A hospital-led organization takes personal commitment to transformation into account when screening and recruiting new hires:

> *"Folks were brought on because they have passion for transforming healthcare. The accountable care services team is focused on how we bring the organization along with one foot in fee-for-service and another foot in value-based contracting, and so we hire people specifically who have that passion, and that vision."*
>
> **Executive, Hospital-led ACO**

Building multispecialty care teams to address complex patients

Allina Health launched a team-based care management approach to support the ACO, comprised of a registered nurse, pharmacist, social worker, and care guide (bachelor-trained health coach). ACO-aligned patients are assigned to a care team based on complexity; the care team will step in to manage transitions of care and coordinate between primary and specialty care upon admission to the hospital, and for a 90-day follow-up period. The intent upon patient assignment to a care team is to eventually graduate the patient back to standard primary care.

The high-performing providers described significant investment in both human resources and infrastructure to support care management, with one physician group-led ACO estimating 150 new staff positions were created to support an ACO of about 600 total employees:

> *"What we have today is so much more extensive than what we started with. Our analytics capabilities are so much deeper today, and we have so many more people. Pharmacy techs, a quality assistant team, a centralized transitions of care team, analytics...We didn't have them before. Now we have disease management teams for diabetes, heart failure, COPD, and we've had to expand our IT team. And that's not the whole list."*
>
> **Executive, Physician group-led ACO**

So how have ACOs deployed new staff – or redesigned positions – to both meet ACO patient needs and realize return on investment? First, ACOs differentiated between general care management functions and those tailored to meet the needs of individuals with specific conditions, which is discussed more in the following section. Second, each organization established a configuration of centralized and/or

embedded staff; the exact balance of centralized versus embedded support, and the respective scopes of work, underwent many iterations.

For example, one physician group-led ACO described how the organization adapted the original scope of work for practice-embedded nurse care managers by transitioning a set of functions to a centralized team:

> *"One of the things we learned is that the offices were feeling pretty heavily burdened [after transitioning to PCMH]. Then you start layering all this other ACO stuff on top of them and they're overwhelmed. And the way that we solved that was by taking some of these functions and centralizing them. Transitions of care is a good example, because our nurse care managers who were embedded in the practices were telling us they're spending half their day making transitions of care phone calls. And so when we centralized that, it unburdened them."*
>
> **Executive, Physician group-led ACO**

The ACO additionally implemented a centralized Medicare annual wellness visit team and prescription refill program, critical care management functions that could be delivered telephonically that were otherwise dominating the clinic-based care managers' limited time. Conversely, another physician group-led ACO moved telephonic health coaches back into the clinics:

> *"The health coaches [RNs] work with the individual and the families telephonically primarily…Now what we've done is we've placed them in the different clinics, so if their patients do come in, they can spend more time with them. I think that's been more effective."*
>
> **Executive, Physician group-led**

Within this ACO, the health coaches are assigned to "rising risk" patients to address social determinants of health and teach lifestyle modifications, serving in complement to the hospital-embedded nurse care managers. Embedded care managers also work closely with clinicians when patients show up in the hospital. An integrated ACO described the general structure for daily team huddles, which support more real-time management:

> *"We have been doing daily huddles on any ACO patient admitted to the hospital. All the case managers jump in. We now know who's in the hospital. We run down them. Why are they there? What's going on? What's the plan?"*
>
> **Executive, Integrated ACO**

On the opposite end of a hospital stay, one physician group-led ACO has implemented a more reactive huddle method to prevent potential readmissions. For one hour per week, the team in each practice gets together with the care managers to review any hospital discharges from the past week and confirm that any patients at high-risk for readmission are connected to care.

Finally, most high-performing ACOs had dedicated resources to supporting transitions of care, including navigating patients to the right post-acute care setting or wellness program, tracking patients at risk for readmission to the hospital, and educating families and caregivers to make informed, shared decisions. ACOs have embedded care management staff in the emergency department, hospital, and/or skilled nursing facilities, with the goal of making sure patients are cared for in the most clinically appropriate setting to meet their needs:

"There's a lot of people likely to default to skilled nursing facilities [following a hospital stay]. So we worked with our case managers, saying that's not the best place to send patients…Nurse practitioner rounding models also make sure those patients are reviewed and navigated, and a project in ortho called the 'Wizard of Oz.' Because there's no place like home."

Executive, Integrated ACO

Chronic Disease Management Programs

Under the auspices of population health management, high-performing ACOs operate programs to actively engage patients with specific diagnoses that correlate with higher overall spending, and those with higher variation in cost and quality outcomes. The most frequently mentioned disease management programs addressed the following chronic conditions:

- Diabetes
- Chronic Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disorder (COPD)
- Chronic Kidney Failure

Most interviewed ACOs created patient rosters and registries for targeted conditions, building upon the systems and platforms described above that were utilized to identify high-risk patients. One ACO created registries using EHR data dedicated to identifying and closing care gaps (e.g., diabetic patients due for a visit), but shared those patient rosters externally so clinics without access to the same EHR would still be able to review the outreach lists. Some ACOs delegated chronic disease management to specific teams for each disease state; one organization used the targeted conditions to prioritize patients for general care management:

"It's really focused around that multidisciplinary case review. So the rosters or the lists or the registries of patients that go to the teams, if those patients have CHF or COPD, they bump up to the top of the list."

Executive, Physician group-led ACO

The disease management programs generally comprise two pillars: first, implementing evidence-based standard treatment protocols for patients with chronic disease. A physician group-led ACO developed an algorithm on the likely protocol for certain diseases, which providers reference as a checklist to guide the patient interview process. A health system-led ACO convenes groups of employed physicians to establish care protocols by consensus for the priority conditions, with clear outcomes data supporting consensus-based approach.

The second pillar of chronic disease management is promoting effective patient self-management. One example of patient engagement was relayed by a physician group-led ACO which had implemented a stoplight modality to assess and react to disease management that was easily translatable across clinicians, care managers, and patients; in the patient record, green denotes well-managed disease with limited need for follow-up, whereas patients "in the red" require immediate treatment. The program is overseen by a chronic disease educator who additionally offers educational programs multiple times per month in various clinics to engage patients and caregivers directly and to ensure they understand their role in the care plan.

Educating patients to support self-management

A well-crafted and well-intentioned patient education webpage is only useful if patients visit the site. Banner Health addressed the issue of low website traffic in a unique way; the organization partnered with a branch of the local newspaper to create a magazine for the offices that is very community-centric, with local physician and community-member interviews interspersed with stories related to the ACO quality metrics, such as fall prevention, diabetes management, and shared decision making. But to what does the organization attribute increased traffic to the patient education page? Including a crossword puzzle in the magazine, with answers only available on the website.

Managing multiple care management programs and functions – including continuous, rapid-cycle evaluation and refinement of the approach – prompted many high-performing ACOs to restructure operations accordingly. For larger health systems, this often took the form of newly instituted (or reconstituted) departments and leadership tasked with aligning care management activities across all ACO contracts.

> *"We have a population health division, with an EVP of pop health. We have a VP of care management. And so that's really the focus: how do we align and make sure that we're paying attention to all the needs of all the populations we serve."*
>
> **Executive, Hospital-led ACO**

One physician-led ACO assigns a lead care manager to coordinate the patients' care plan in those instances where a single patient is referred to multiple programs:

> *"For any given patient, they need to have one nurse care manager who's on point. Now, that might be their practice embedded high-risk nurse care manager, or it might be the nurse care manager in the COPD program, or it might be the nurse care manager in the at-home program. We actually have an established hierarchy, that if you are going to be treated under any of those programs, your nurse care manager will be determined based on the hierarchy."*
>
> **Executive, Physician group-led ACO**

Team huddles were another common approach for effectively managing the care managers. Overlap huddles provide the opportunity for multiple teams to discuss a single patient and to develop care plans that fully consider all aspects of their care.

Conclusion

High-performing ACOs have launched extensive population health management infrastructure to address cost and quality variation and opportunities for improvement, resulting in successful performance under the Medicare ACO programs. However, the organizations in this cohort expressed a number of similar ongoing challenges, with the top concern being inability to accurately quantify the return on investment of care management programs. There was a shared opinion among high-performing ACOs that organizations need to spend to save; investment in the care management model must start on day one of the contract, while savings – if achieved – will not be paid out for nearly two years. This concern was punctuated by financial reality: if the organization does not achieve savings, the longevity of maintaining ACO overhead costs will come into question. ACOs are addressing these challenges by continuing to improve upon care management models and to provide patients with high-quality, high-value care while transitioning to a sustainable value-based system.

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]

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

Performance Improvement Infrastructure

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*

When asked how the organization's operational infrastructure enables and supports quality 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."*
>
> **Executive, Integrated ACO**

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."

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]."

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."

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."*
>
> **Executive, Physician-led ACO**

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."*
>
> **Executive, Integrated 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

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."*
>
> **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

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."*
>
> **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.

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.

Appendix

Methodology

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.

Acknowledgments

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.

4 The HCTTF is a consortium of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry— including patients/consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs.
Our organizations aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

5 ACOs with below-average baselines – or lower expected average expenditures – were considered more desirable to study based on the hypothesis that these ACOs began with less excess expenditures, and therefore, a shared savings rate ≥2% was even more meaningful.

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Interview Questions

1. **Brief History and ACO Overview**
   a. Tell me about the history of the ACO: When and why did the ACO come together?
      - ACO provider configuration (e.g., physician- or hospital-led; risk-bearing participants versus strategic affiliations versus referral network)
      - ACO contract details (e.g., payer, payment model, number of covered lives, start/end dates)
      - Date of first ACO contract
      - Percentage of total revenue under value-based payment
      - Geographical areas served (e.g., region, urban versus rural, etc.)

2. **Governance and Operations**
   a. What elements or activities related to the ACO's governance and operational structure have contributed to its success?
   b. Where does ACO leadership fit within the organization?
   c. In what ways are you measuring/tracking ACO success at the governance level? How have you changed your operation metrics to reflect your value-driven strategy?
   d. To what extent are patients and patient representatives involved in governance?

3. **Financial Structure**
   a. How has the ACO's financial structure enabled its success? For example, what specific activities related to financial readiness (e.g., financial systems, contracting, risk assessment and management, etc.) have most noticeably contributed to the ACO's success?
   b. Have you established systems for tracking utilization, revenues, and costs?
   c. We'd like to understand the financial incentives for participating providers. Do you offer performance-based earning opportunities? What incentive structures exist for contracted and/or employed providers?
   d. In addition to the ACO's internal financial structures, what external factors, if any, led to the ACO's financial success?

4. **Quality**
   a. How does your operational infrastructure enable and support quality measurement, improvement, and reporting (e.g., staff, HIT, protocols, etc.)?
   b. In what ways have you incorporated ACO quality measures into your providers' workflow?
   c. What changes have been made to instill a culture of ongoing quality improvement across the organization?

5. **Clinical Transformation**
   a. What are the top three care delivery changes that have most meaningfully and directly contributed to the success of the ACO? What evidence do you have to support this?
   b. What are your strategies for identifying and managing vulnerable populations?

c. How are you managing chronic disease differently for your ACO population than before? Any new diseases/care management programs?
d. How do you facilitate smooth and effective transitions of care?
e. Any new work with post-acute care, behavioral health, and/or pharmacy integration?
f. What do patients experience in your ACO that they would not experience otherwise?
g. How are you evaluating your progress toward clinical transformation? To what extent do you incorporate patient experience or feedback in those evaluations?

6. Data and IT Infrastructure

a. What HIT investments have proven to be most beneficial and why (e.g., clinical data integration/ interoperability, improved decision support, telehealth capabilities, creation of rosters or other outreach tools)?
b. What data sets do you have access to (e.g., claims, EHR, patient experience, patient self-reported outcomes, health risk assessments, ADT feeds)?
c. How do you operationalize that data across the organization, differently than you did before, or differently for this population? How often and what type of data are shared with providers to support them in population health management?

7. Workforce Development

a. What strategies for engaging, re-orienting, and supporting ACO clinicians and other staff have been most beneficial?
b. What strategies for hiring, training, and deploying new staff contributed to the ACO's success, if any?

8. Strategic Partnerships

a. Have partnerships contributed to the success of the ACO? If yes, what partner(s) have been most influential? How/why did you choose them?

9. Lessons Learned

a. What have been the top 3 challenges/barriers to your success? If you could start again, knowing what you know now, what would you do differently?