Engelberg Center for Health Care Reform at Brookings

Adopting Accountable Care

An Implementation Guide for Physician Practices

EXECUTIVE SUMMARY
November 2014

A resource developed by the ACO Learning Network
www.acolearningnetwork.org

Executive Summary

Our nation's health care system continues to undergo significant transformation to address the quality and high cost of care. Accountable Care Organizations (ACOs) have become a substantial part of these efforts by realigning our current payment system to reward organizations that achieve high-value care. While the ACO concept continues to evolve, it can broadly be defined as: "a group of health care providers who accept shared accountability for the cost and quality of care delivered to a population of patients." **Physician-led** provider organizations are quickly becoming one of the biggest drivers of accountable care activity. Typically, these groups are not hospital affiliated and instead include one or more independent primary care physician groups or practice associations that have a large combined patient population. The physician members of these ACOs lean heavily toward primary care, but are increasingly including specialists. Unlike hospital-led ACOs which may offer primary care, specialty care, and acute care to their patients, many physician-led ACOs are limited to providing primary care, yet maintain responsibility for the total cost of each patient's care.

These physician-led ACOs can play an integral role in improving primary care and delivering high quality care coordination. Together these efforts have been effective in improving patient outcomes, reducing unnecessary hospitalizations and emergency room visits, and lowering costs. Successful population health management in these ACOs typically results in the provision of more primary care services (low cost care) and less acute care services (high cost care) in hospitals and other settings.

Because physician-led ACOs are often smaller organizations, they tend to be more flexible and nimble when it comes to adopting new practices and clinical transformation. However, these ACOs may have less advanced health IT systems, fewer resources and capital to invest in clinical and organizational transformation, and less experience with risk-based contracts.

Early results from the Medicare Shared Savings Program (MSSP) suggest that physician-led ACOs may actually have a leg up in terms of accountable care success. Out of the 49 MSSP participants that qualified for shared savings in their first performance year, a higher rate of physician-led ACOs earned shared savings compared to non-physician-led ACOs. While results are still being analyzed, these findings suggest that physician-led ACOs can play an important role in driving health care reform.

The purpose of this toolkit is to focus on the unique challenges and opportunities for physician-led ACOs. This work builds on the original **ACO Toolkit** developed by the **ACO Learning Network** in 2011 to help ACOs address technical, operational, and legal issues in ACO development and implementation. Likewise, the goal of this toolkit is to provide emerging physician-led ACOs with the knowledge and tools necessary to effectively address **four critical issues** in accountable care development and implementation: (1) identifying and managing high-risk patients; (2) developing high-value referral networks, (3) using event notifications, and (4) engaging patients.

This toolkit is a result of a collaborative effort by members of the **ACO Learning Network**. Members participated in twice-monthly conference calls and shared innovative ideas, technical challenges and lessons with each other. We also invited a number of guest experts to contribute their thoughts and ideas to inform the development of this resource. The toolkit includes examples and case studies to illustrate how various ACOs are approaching the implementation challenges they face in delivering high-value care. This executive summary provides key takeaways and recommendations from each chapter of the toolkit. While all lessons may not apply to all physician-led ACOs, they should serve as a guide or checklist of competencies that can prepare these organizations for success.

CHAPTER 1
Identifying and Managing High-Risk Patients

A cornerstone of successful accountable care is to identify patients who are not receiving optimal care, are overutilizing health resources, and as a result are contributing to excessive spending. By identifying those patients who are not currently well served by the health system and providing additional targeted resources (i.e., care coordination, social services, or care management), there is an opportunity to improve population health and achieve significant reductions in total spending. This chapter provides an overview of approaches to identify high-risk patients and strategies for implementing effective care management.

A. Identifying High-Risk Patients

1. **Define an intervention.** A key step is determining how you will intervene in the care of patients identified through a risk stratification process. If your goal is to perform intensive care management on the patients most likely to be admitted to the hospital for poorly managed chronic conditions, then analytics should be tailored to identify this population. If you hope to provide disease-specific telehealth, your identification process should be set up to flag these patients. This process can help determine the most promising care management tools for your ACO, and select the patients most likely to benefit.

2. **Use analytics tools that are most accessible.** If your population health vendor has set up an integrated predictive modeling platform that integrates all of your claims and EHR data, then use that tool. Look elsewhere if you don't have such a tool at your disposal or your vendor has over-promised and the integration is running behind schedule. Start with the data you have available and use a free risk-stratification method such as Hierarchical Condition Categories (HCC), Charlson, or the Chronic Condition Count. You can simplify efforts by creating a list of patients with multiple hospital admissions over the past six months.

3. **Combine your raw analytics with clinical intuition.** Providers have insights about their patients that cannot be ascertained by most analytic models. This includes gauging which patients do not show up for appointments, live alone, are unsteady on their feet, or have other psychosocial comorbidities. We recommend giving providers a list of patients generated electronically, and have them review the list based on their own knowledge of the patients.

4. **Take advantage of patient-reported data**. By asking patients to share personal information with their providers about their health care goals and disease-management challenges, a wealth of useful information can be obtained. ACOs can use established metrics such as the Patient Activation Measure (PAM), or they can create their own patient measures to track.

B. Care Management

1. **Invest in coordinated care transitions.** Creating a standardized workflow for smooth care transitions is essential to reducing hospital readmissions and can significantly reduce costs. Success of such a program will rely on the ability to receive notifications of patient discharges from hospitals and post-acute care facilities. Providers also benefit from a daily workflow that ensures patients are contacted within 1-2 days of discharge, medications are reconciled, referrals are tracked and patient education is completed.

2. **Use intensive care management thoughtfully.** Think carefully about how to select patients for intensive care management. Data show that such programs can have dramatic success, but they are also costly. Care managers are precious resources and must be deployed in such a way as to maximize their impact on the patients they manage. Choosing patients who already have strong support networks and dedicated caregivers may prevent you from realizing significant benefits from your intervention and from reaching the patients who need care management the most.

3. **Set up your care management to promote meaningful relationships.** Position your care managers such that they are able to develop relationships with the patients they are managing.

If their offices are embedded within a primary care practice, they can meet with patients during an already scheduled visit, and they can build strong relationships with primary care providers. If embedded care managers are not practical for your organization, consider having care managers conduct home visits, hospital visits or even post-acute facility visits. The stronger the bond between care manager and patient, the more likely the patient will be to contact the care manager when medical needs arise.

4. **Use information technology to promote care management success.** Very few electronic health record (EHR) systems are equipped to integrate care management. However, without IT integration, the hard work of a care manager may never result in meaningful impact. Consult with IT staff to develop a communication system that allows care managers to coordinate with other health providers including primary care, hospitalists, ED physicians, home health nurses, and others. If a patient is part of a care management program, this should be prominently displayed in the record to flag as a high-risk patient.

CHAPTER 2
Developing a High-Value Referral Network

Primary care services represent only 6 to 7 percent of total health care spending for any given patient, yet primary care physicians indirectly control or influence a much larger percentage of health care spending through decisions regarding referrals, diagnostic testing, home health care, and other ancillary health services. Physician-led ACOs will need to work beyond their own ACO to impact care throughout the care continuum, including specialty, inpatient, and post-acute care. This chapter describes strategies to improve relationships with clinical providers outside of your ACO.

1. Understand existing referral patterns. The first step in crafting a high-value referral network is to understand the current referral patterns of your ACO providers and how your ACO patients are utilizing resources. For example, do you know which providers outside of the ACO are caring for your ACO's patients? These data can be obtained through chart reviews, clinician surveys, claims analysis, or public use datasets. Once established, this information can inform more active management of referrals and improve care coordination.

2. Reduce unnecessary referrals. There is wide variation among primary care physicians regarding how often patients are referred to specialists. In a fee-for-service model there is no financial incentive to think twice before sending a patient to see a specialist for even minor medical issues. Sharing individual referral variation data with primary care physicians and establishing care protocols for common conditions can help reduce referrals for conditions that can be managed equally well by a primary care practice. Primary care physicians can also obtain the training to manage certain conditions that are often referred to specialists, including simple skin biopsies, diabetes or heart disease.

3. **Improve care coordination between primary care and specialists.** Inefficiencies in the health care system, such as lack of EHR interoperability, mean that a primary care physician often cannot receive information about a specialist referral unless the document is faxed. Similarly, specialists may not be aware of prior tests or diagnoses prior to the visit. As a result, many patients receive duplicate tests and other unnecessary services. Implementing the medical home neighbor model can help provide a framework for improved coordination of care and increased efficiency. Elements of this model include pre-consultation information exchange, co-management agreements, and shared expectations regarding communication between providers.

4. Avoid unnecessary facility fees. Medicare reimbursement rates for a screening colonoscopy or lumbar spine MRI are significantly higher in a hospital setting. Identifying imaging centers and endoscopy centers that are not affiliated with hospitals and do not charge a facility fee could facilitate significant cost savings.

5. Identify and partner with cost-effective specialists and other providers. While

challenging, identifying cost-effective providers can be achieved with the help of a robust analytics team who can gauge utilization and adherence to clinical guidelines by looking at claims data. If such analysis is beyond the capability of your practice, another option is to consult with primary care physicians. Finally, if your ACO has the potential to drive a significant amount of volume to preferred specialists, a preferred partnership may provide an incentive for the specialist to coordinate care, and to practice more cost-effectively without compromising quality of care.

6. Bring specialists into your ACO. A further strategy to control costs is to integrate specialists within your ACO and enable them to be accountable with you for the cost and quality of care. They will be able to participate in shared savings and may undertake stronger collaboration with primary care physicians. For high-demand specialists such as cardiology, psychiatry, dermatology and endocrinology, the specialist could be embedded within the primary care practice itself.

4. Build partnerships with long-term and post-acute care facilities. Long-term and post-acute care (LTPAC) facilities are significant drivers of health care spending. Yet, many physician-led outpatient provider groups have felt they do not control the LTPAC care their patients receive. However opportunities now exist for ACOs to form partnerships with these facilities to reduce hospital readmissions and ensure that transitions are better coordinated with primary care providers.

CHAPTER 3
Using Event Notifications

Since most physician-led ACOs operate independently of hospital systems, usually with separate health IT platforms, they must implement additional IT solutions to receive notice of acute events involving their patients. Real-time notification of patient events, such as emergency room visits or hospital admissions, can allow ACO staff to implement prompt follow-up and appropriate interventions, thus minimizing further complications. This chapter describes basic

strategies and highlights examples of ACOs that are using technology to improve care coordination.

1. **Get your data house in order.** An advantage for many physician-led ACOs is having ready access to clinical data. Ensuring that you are making meaningful use of existing EHRs will provide the necessary foundation from which you can pull key elements of population health. Fundamental information about patient problems, medications, tests, demographics and vital signs are the building blocks from which all other data feeds can expand. Creating master patient indexes with care team relationships defined is also necessary.

2. **Leverage existing relationships.** Take advantage of state-wide or regional health information exchange (HIE) capabilities where they exist. However, if sufficient HIE infrastructure does not exist, an ACO can begin working with local hospitals and long-term and post-acute care (LTPAC) facilities to get notification data, such as ADT feeds. Many ACOs already have strong relationships with hospitals and LTPAC providers based on their historical admitting, rounding, teaching and collaboration. For many physician-led ACOs, one or two hospitals may constitute a majority of the acute events for their attributed patients. Building care management processes and protocols can lay groundwork for more comprehensive event notification management in the future.

3. **Build notification processes into the existing clinical workflow.** Utilizing existing workflows can ensure that the right ACO staff member gets to the right patient in the most efficient manner. Successful workflows will allow clinical staff the opportunity to act in real time as patients experience acute events.

4. **Utilize decision support rules.** The application of decision support rules helps direct notifications to the right person in your organization and can automate some of the initial decision-making. Rules can ensure that care managers and providers receive the most important notifications in real time while less urgent alerts can be batched and sent daily.

5. **Ensure that notification alerts lead to clinical intervention.** Receipt of an event notification should trigger an intervention or response. Examples include scheduling an appointment, arranging transportation or setting up a home visit. The event notification system should bring to the provider all the information needed to effectively carry out such an intervention. Ideally, the ACO will set up protocols outlining who will receive the notification, what possible actions they should perform, and how to deal with special circumstances.

CHAPTER 4
Engaging Patients

Patient engagement within an ACO occurs at many levels. First, there is patient engagement in self-management of their current health status and caring for any medical conditions. Second, is the engagement of patients and their families in partnership with their providers and other professionals within the ACO. Ultimately, patients, families, and community members must be engaged and aligned with the overall practices and goals of the health organization and the ACO. In this chapter we discuss approaches to strengthening ACO engagement with patients, families, and their communities.

1. **Invest in outreach methods that reach all patients, not just the complex.** The shared savings model typically incentivizes a significant amount of energy and resources for the most complex patients. However, ACOs should not ignore the large numbers of patients who require little to no care management and are generally in good health. Building a connection with these patients can improve patient satisfaction and increase retention while using health care resources wisely.

2. **Determine each patient's preferred method of communication.** Understanding how patients want to receive information (i.e., phone, mail, email, text) is the first step in ensuring that important messages can be delivered in a timely and user-friendly mode in both directions.

3. **Schedule beneficiaries for a Medicare wellness visit.** These billable visits are without cost to patients and allow the ACO to collect health risk assessment information from patients that can allow them to receive more targeted care. In addition, the visit can help the ACO meet quality measures on prevention, medication usage and management of specific chronic diseases. The Medicare wellness visit also has the side benefit of providing the ACO with a billable visit that is reimbursed by Medicare.

4. **Connect with patients while they are hospitalized or in a skilled nursing facility.** Even though primary treatment decisions for these patients are made by a hospitalist or SNF physician, patients want to hear from their primary care practice when they are inpatients. A brief phone call or drop-in visit can reassure patients that their provider is engaged and aware of their medical condition. At the same time, these check-ins can also help to facilitate transitional care support and avoid unnecessary hospital costs.

5. **Work collaboratively with patients to achieve their care goals:** Patient engagement that builds an environment of participatory medicine provides an opportunity to foster partnership between patients, families and clinicians. Providers can use tools such as shared decision-making, patient-activation measures, and behavioral science techniques to increase patient engagement in their own health goals.

6. **Get patients involved in ACO decision-making.** Allow patients an opportunity to have their voices heard through participation in quality improvement initiatives, focus groups, and patient advisory councils. Be sure to provide patients multiple channels for voicing their opinions, with comment boxes in the clinic, and an email inbox devoted specifically to patient and family concerns.