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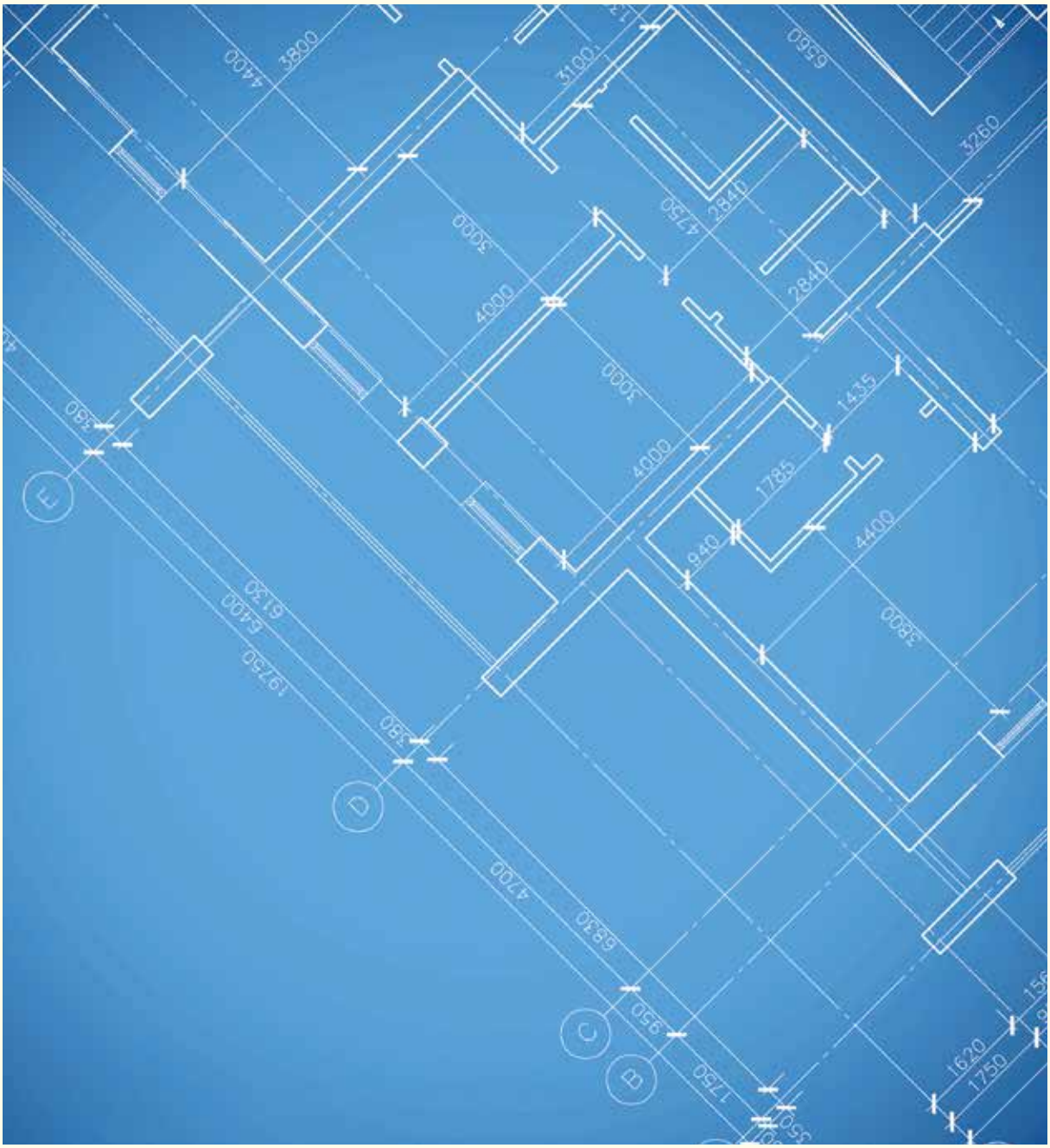
Developing a Blueprint for Accountable Care



Lawmakers, payers, and providers have touted accountable care as one of the most promising strategies to transform healthcare payment and delivery. Today, healthcare organizations around the country are putting the people, tools, and technology in place to take on greater responsibility for clinical and financial outcomes—and prepare for future competition based on value.

Living in Two Worlds

Hospital and health system leaders face an enormous challenge as they move toward accountable care: They must maintain adequate revenue to keep their doors open while investing in the infrastructure to build their value proposition. "For the next 10 years, we need to be comfortable living in both the fee-for-service and accountable care worlds," says Nance McClure, COO, HealthPartners, a Bloomington, Minn.-based health system with its own insurance plan. "Obviously, we need the margin to reinvest, but we also have to moderate price as a way to position ourselves in the total-cost-of-care market and attract patients who are more price sensitive."

HealthPartners has adopted the Institute for Healthcare Improvement's Triple Aim as its guiding vision and is testing a number of value-based payment models with its own health plan and other payers in the market. "We want to redesign care to be consistent with the Triple Aim at the macro level, rather than having pockets of ACO strategies," McClure says.

Failure to fully commit to accountable care may be why many organizations have stumbled in their early ACO efforts, says Stephen Rosenthal, senior vice president of population health management, Montefiore Health System, Bronx, N.Y. While three-fourths of Medicare ACOs failed to earn shared-savings bonuses in 2014, Montefiore had another successful year in the Pioneer ACO program, generating more than $13 million in savings. "This isn't just a project for us," says Rosenthal. "We've been doing population health management for 20 years. When the Pioneer program came along, it provided an opportunity to scale up and take care of the Medicare fee-for-service population, which has not had the benefit of population health management before."

Still, most healthcare organizations do not have Montefiore's experience with taking on risk to manage a patient population. This has led to some innovative approaches, including ACO collaborations between competitive health systems. For example, in 2010, Methodist Health System, Omaha, Neb., partnered with Nebraska Medicine, also of Omaha, to create the Nebraska Health Network. Early on, the ACO's focus was managing the care of the health systems' 18,000 employees. However, it has expanded its scope, and to date it has signed contracts for more than 50,000 lives. Lee J. Handke, Nebraska Health Network's CEO, says the ACO's steady growth has helped it stay focused during a time when healthcare leaders face multiple priorities. "There's a danger in trying to change everything at once," Handke says. "You need to build momentum over time."

Making the transition from fee-for-service to value requires an intentional commitment and a focused strategy. Whether an organization is looking to launch a population health program, participate in an ACO, pilot new payment models, or forge community partnerships, effectively pursuing an accountable care strategy requires a robust plan. With this in mind, this HFMA Educational Report, sponsored by 3M Health Information Systems, focuses on the key areas that should comprise any accountable care road map.

Acquiring and Aggregating Data

Those at the forefront of accountable care recognize that good clinical and financial data underpin any value-based care effort. Claims data in particular can be essential to these types of arrangements. Until recently, however, payers have been reluctant to share claims data with providers, but that attitude may be changing, says David G. Carmouche, MD, former executive vice president for external operations and chief medical officer at Blue Cross Blue Shield of Louisiana, based in Baton Rouge. "If health plans are going to rely on providers to manage patients in a guaranteed-issue world where there is less underwriting, they have to give them the tools and information to enable their success," Carmouche says. "Health plans are able to do that when they are not revealing contracted prices with providers. They can

summarize and blind data or use analytics vendors that cleanse data sets so they are still useful." Some payers have gone to the next level and created Web portals that generate reports on key provider opportunities.

A number of provider organizations are making timely, accurate claims data part of their negotiations with payers. "One of our mantras when exploring partnerships of all shapes and sizes is 'no data, no deal,'" says William "Rick" Ludwig, MD, chief medical officer, Providence-Swedish Health Alliance, Seattle, a Medicare ACO that also contracts with commercial insurers and employers. For example, the ACO executed a complex agreement with the Boeing Co. to access members' historical claims data through its health plan's third-party administrator, Blue Cross Blue Shield of Illinois. "The information allows us to better understand our member population and their health history, which can help shape our care management strategy, as well as financial projections," Ludwig says. "While valuable, claims data are far from perfect. Sometimes they can paint an incomplete picture, and often there is a lag in getting information. In many cases, data are one to three months old before reaching providers."

Regardless of the kind of data on which a value-focused organization relies, it should take a well-considered approach to how to use and communicate the information. Following are a few strategies to keep in mind.

Create an infrastructure to support data analytics. Nebraska Health Network uses a third-party analytics tool to identify opportunities from claims data and measure progress toward the entity's goals. The ACO also plans to build an enterprise data warehouse to merge clinical, claims, lab, and pharmacy data to get a more complete picture of the populations it manages. "Our two sponsoring systems use different electronic health records, and we have several other EHRs within our independent clinics, so merging the data is not overly straightforward," says Handke. "But it can be done, and it must be done, to drive forward the value proposition to our customer."

The ACO recently hired a new vice president of operations, who has experience working with analytics tools in the financial and insurance industries. Part of this executive's new role will be building a larger team of analysts and IT experts to support the ACO's strategy.

Work with what you have. One of the biggest mistakes that healthcare leaders make is waiting for "perfect" data before taking action, says HealthPartners' McClure. "You need to start moving forward with data that are good enough. Look for key themes on one population. For example, you can identify opportunities to improve back pain and mental health outcomes across your whole population by analyzing a subset of the patient base." Once you test new strategies on a smaller subset, you can apply best practices and lessons learned to a larger group.

Do not overwhelm providers with too much data. In the case of data, more information is not necessarily better. Organizations should commit to delivering essential information to the people who need it in a timely manner. Montefiore, for instance, creates simple dashboards that allow providers to quickly see trends in their patient populations. "Physicians don't have time to wade through data on their 1,000 patients," says Rosenthal. "But if we can show them the 15 diabetes patients with critical changes in their health status, we can focus clinician attention, ultimately improving the quality of patient care and generating savings."

Marry data with real-world assessments. Data analysis is only the first step in effective care management. Organizations must go beyond the data and consider the patient's life situation and other external factors. "When a delivery system is involved in care management, it must be engaged in dealing with its population's social challenges as well," Rosenthal says. "You can have three individuals who are the same sex and same age, and who have the same clinical diagnosis and blood work, yet they can have three different life circumstances that require a different intervention. You wouldn't identify those circumstances until you actually do an assessment of the individual to understand what his or her life challenges are, such as poor housing or lack of transportation."

Partner with payers on data-driven care management. Historically, payers have been more successful at leveraging data to drive outcomes. Providers should consider reaching out to their larger payers to join forces in this area. For

example, while at BCBS of Louisiana, one of Carmouche's key goals was engaging the state's 2,100 primary care doctors—most of whom were small-group, independent practitioners—in care management. "We saw an opportunity to leverage our 70 percent market share and make a strategic investment to allow practices to function as population health managers but remain independent," he says. The voluntary program, Quality Blue Primary Care, provided physicians with a no-cost patient registry tool that pulled approximately 100 data elements (such as patient lab reports, blood pressure stats, and other quality metrics) from each practice's EHR. The tool also included data on preventive services and wellness screens from BCBS of Louisiana's claims feed, as well as pharmacy data from pharmacy benefit managers. "Providers were able to see most of the care their patients had received over the past three years in one spot," Carmouche says. The health plan also assigned care managers who would proactively review the care registry and follow up with high-cost patients who had not been in to see the physician. "The practices loved that because we were helping them see more of the right patients," he says.

Reducing Variation

Until the past decade or so, physicians have relied primarily on their own training and experience to guide treatment. With the advent of evidence-based guidelines, many healthcare organizations began to measure their own performance against established standards in an effort to improve quality and reduce unnecessary costs. Now, ACOs are using the same approach to show medical groups how they perform against one another, says Ludwig of Providence-Swedish Health Alliance. For example, his ACO shows medical groups how they compare based on referral patterns, care protocol adherence, and utilization of high-cost imaging.

Physicians can be a driving force in adopting best practice and reducing variation. An effective method for bringing physicians together and encouraging collaboration is to create physician-led committees. "The group practices that we put into our Boeing network never really talked to each other before, but we created an infrastructure through the ACO, so these groups are getting together for the first time," Ludwig says. "Not only are they looking at each other's data, but they are able to share best practices." They do this through a formal committee structure. "The committee infrastructure is critical, particularly when you have groups outside your own employed group in the network. You have to engage them and get them excited about the work," he says.

Each month, Ludwig leads a model of care committee where the medical groups discuss key initiatives like improving care transitions. As a result of the committee's efforts, the ACO developed a residential care team composed of physicians and nurse practitioners who visit ACO patients in skilled nursing facilities. The ACO has also reduced the 30-day all-cause readmission rate for patients in the skilled nursing facilities from 13.3 percent to 7.5 percent and shaved nine days off the average length of stay from 29 days to 20 days.

Nebraska Health Network also uses physician-led committees to engage providers in reducing practice variation and improving quality. It currently has 13 care redesign workgroups on topics like primary care, emergency department utilization, and oncology. Their purpose is to review best practices and determine which evidence-based guidelines should be issued to the network. "As part of our clinical integration strategy, we will actually measure compliance with those guidelines," Handke says.

Demonstrating Value

To be successful with risk-based payment models, healthcare organizations need to consistently demonstrate that they can be good partners with various stakeholders and deliver value, namely high-quality care that keeps costs in check. To that end, organizations can consider the following strategies.

Think like a payer. Health systems tend to focus on government-mandated quality metrics and patient satisfaction, but from a payer finance perspective, these endpoints do not add a lot of value, says Carmouche, the former BCBS of Louisiana executive. "Payers want to see things like a decrease in avoidable ED utilization, as well as a decrease in avoidable admissions and readmissions," he says. "At the end of the day, health plans are really looking for the total cost of care to go down, not just the rate of increase to slow over historical terms."

Nebraska Health Network's Handke, who spent 13 years with Blue Cross and Blue Shield of Nebraska, says his health plan experience helps him have the value conversation with payers. "We are actively engaging medical directors on the insurance side and HR leaders on the employer side to jointly define what measures and information are most important to them, and we are currently developing reports to reflect those attributes," Handke says. "We know employers and insurers want to understand how their population is segmented by risk, what we are doing as a system to care for those patients, and how we perform on quality measures and cost metrics. In the end, the reports should hold us accountable to deliver on our promises."

Have a "compass." Organizations must do more than give lip service to delivering value: They should establish guiding principles for the work. Consider Nebraska Health Network, which is resting its value strategy squarely on the healthcare consumer. "Everything we do must be adding value to the end customer," Handke says. "This means focusing on better outcomes, a more customer-friendly experience, and lower overall costs." To stay attuned to the right goals, Nebraska Health Network outlined several guiding principles for its work:

- Create a clinically integrated network of providers
- Become experts in population health management
- Build the IT infrastructure to make data-driven decisions and measure outcomes
- Engage consumers in new ways, such as telemedicine
- Develop products that leverage the ACO's value

Be open to payer-driven approaches. Many payers are experimenting with different payment models, finding that some are more successful than others. At BCBS of Louisiana, Carmouche developed six care-savings agreements with providers (including hospitals and a large multispecialty group). In designing the agreements, the health plan reviewed two years of per-member-per-month costs for an attributed group of primary care patients and projected future costs using year-over-year trend assumptions. With that information, it created a set of cost targets that would trigger a shared-savings opportunity back to the practice. "We had monthly operations meetings with providers, and we were working with many hospitals that had no formal resources in care management or process improvement," Carmouche says. At the time Carmouche left the health plan, the ACO partners still had not generated shared savings, although most of the deals were in their first years.

Other programs, however, have been more successful. Carmouche created another program that gave providers with BCBS patients who had at least one chronic disease a $10 per-month per-patient care management fee. For patients with two or more chronic diseases, BCBS paid $15 a month per patient. Over the next two years, that payment would scale up or down depending on how well the physician managed these BCBS patients. Physicians in the top one-third of performers would see their care management fee rise 150 percent over two years, while the bottom 20 percent would see their fee decrease by 25 percent. Today, 700 physicians responsible for 200,000 BCBS patients are participating in the program, which led to double-digit increases in key quality metrics. After the first year, the program also led to a total-cost-of-care savings, which is currently being validated by a third party.

Engage employers. These companies can be willing and eager participants in ACO models. "Employers are benefiting from provider networks beginning to assume more care management capabilities and quality management services," Montefiore's Rosenthal says. Many large employers, including Montefiore, have moved to a self-insured model in which they use the insurance company for its provider network and administrative capabilities but are largely self-funded. Montefiore has entered a unique shared-savings program with the United Healthcare Workers East Union 1199SEIC. Other ACOs, like Providence-Swedish Health Alliance, are contracting directly with employers.

Team up with the competition to meet gaps in care. In some areas, organizations are looking to their peers for assistance in delivering value and closing care gaps. "In one part of the Twin Cities, we chose to partner because we had primary care clinics but not a hospital," says McClure with HealthPartners. In 2010, HealthPartners formed the Northwest Metro Alliance with Allina Health. Today, it serves more than 300,000 people who receive care at five Allina Health clinics, four HealthPartners clinics, Allina's Mercy Hospital, and

affiliated specialists. The Northwest Metro Alliance, which has been called a "learning lab" for ACOs, has achieved some significant results to date:

- 11 percent decrease in 30-day, all-cause readmissions from 2013 to 2014, which avoided an estimated $1.3 million in unnecessary hospitalizations at one hospital
- Medical cost increases that were 31 percent lower than the average for Twin Cities patients with private insurance
- 2 percent reduction in medical costs for Medicaid patients, which resulted in $7 million in savings from 2013 to 2014

Improving Cost of Care

One of the most challenging aspects of developing an accountable care strategy is quantifying cost and ensuring patients receive care in the locations that deliver the highest quality at the lowest cost. "For many healthcare organizations, this may be new measurement territory," says HealthPartners' McClure. "However, healthcare organizations are making strides in identifying and improving the total cost of care—a significant metric in the march toward accountability."

In simple terms, McClure defines the total cost of care as price plus use across an attributed population, risk-adjusted to account for severity. "It is not just what you provide but where attributed patients get care outside the system as well, so you need claims data from a major payer in your market to do that," she says. "If you want to understand how what you do affects the premium down the road, the total-cost-of-care view is the most holistic way to look at that.

"Our total cost index allows us to get a relative view of total care cost compared with others in our market. It also lets us drill down and understand where there is variation, which gives us opportunity to improve," McClure says.

To fully appreciate costs of care, organizations may want to turn to technology. For example, Nebraska Health Network plans to implement a comprehensive cost-accounting system. "It is on our road map," Handke says. "We need to be able to look at the total resources of our system and identify areas of highest quality and lowest cost so we can build centers of excellence within the system."

Providence-Swedish Health Alliance also plans to implement a permanent cost-accounting system. In the interim, ACO leaders use a proxy system that helps them understand costs across the network.

Enabling Sustainability

Healthcare leaders say one of the greatest challenges ahead is sustaining their accountable care efforts so they may realize the return on their investment. To deliver the greatest value over time, organizations are employing several approaches.

Gain sustainability through scale. Today, Montefiore manages 400,000 lives, with plans to expand to 1 million lives by 2018. "Managing a population of 5,000 lives is often as costly as managing 1 million, relative to the proportion of the population," Montefiore's Rosenthal says. "With 1 million lives, we will have $8 billion in medical expenses and premiums, and a 1 percent margin allows for a certain amount of sustainability." Montefiore also has set a goal to move to a fully capitated model. "Once we achieve that, we will have greater flexibility in providing the right services at the right time for the right benefit," Rosenthal says.

Compensate physicians for their work. "If providers live in a world based purely on relative value units, there is little chance that they will prioritize many of the activities that are needed for ACO success," the former BCBS of Louisiana executive Carmouche says. "Health systems that can influence provider compensation through employee contracts or revenue sharing in a clinically integrated network will have an advantage, and the dollars need to be meaningful enough for physicians to pay attention."

Show, do not tell. "You can't just tell medical groups that they need to reduce costs and improve quality—you have to show them what to do," says Ludwig, who created a list of five "musts" for groups participating in the Providence-Swedish Health Alliance. The list includes the following actions:

Follow a protocol for care transitions. Providence-Swedish Health Alliance provides all medical groups in its network with a checklist for managing recently discharged patients.

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ADDRESSING PROVIDER FAQs

James Lawson, vice president, Populations and Payment Solutions, 3M Health Information Systems, answers common questions from provider organizations.

Q How can my health system begin to "think more like a payer"?

Payers care about cost containment, quality, and access to care. Healthcare providers should demonstrate how efficiently they meet these metrics. One way is to target waste—avoidable or unnecessary care—such as preventable readmissions, complications, ED visits, and high-cost imaging services.

More and more, payers measure quality by results, not by adherence to clinical guidelines or care processes. Providers need to become as familiar with clinical and financial outcome measures (such as DRGs and risk-adjusted readmissions) as they are with traditional activity measures (such as relative value units)—to the point of replacing them in financial models.

Q Should the focus be on becoming the low-cost provider?

No. Simply reducing the price of services is unlikely to result in higher quality. The focus should be to increase the value of care—high patient outcomes and better experience for the cost.

Rather than low cost, look at the total cost of care (TCC)—all of a patients' care across the spectrum from hospital stay to discharge to follow-up—as opposed to the unit price of a service. Some high-cost services, in the end, decrease TCC by improving the patient's health and avoiding extensive care.

TCC emphasizes caring for the entire person in a comprehensive way, addressing all health concerns, not one isolated disease. It can lead to discussion about socioeconomic factors and lifestyle choices that influence total cost. This might not happen with narrower metrics.

Q How do you avoid overwhelming clinicians with too much data?

First, make sure that clinicians can access data within their daily workflow with an easy-to-use interface. Second, reduce alerts and reports to only the information that requires attention. Show them the elements of care they can affect and those that are used to evaluate and compensate them. Third, explain what the data mean and what should be done with them. The data are simply a mechanism to allow all parties to collaborate in a way they haven't historically.

The ideal in value-based contracts is to help physicians succeed. Share the data, provide frequent updates, and let them monitor their progress. With the emphasis on analyzing data, it can be easy to forget the importance of helping clinicians use it effectively.

Source: 3M Health Information Systems

After piloting the checklist, one of the ACO's partner hospitals reduced all-cause readmissions from 11 percent to 5.8 percent during the past 12 to 18 months.

Focus on reducing inpatient admissions. In one region, the ACO is testing dedicated phone lines in the emergency departments (EDs) that allow ED staff to request next-day appointments in the clinics rather than admitting a patient to the hospital.

Manage frequent ED utilizers. Through a weekly care management call, the ACO provides medical groups with information on high utilizers and suggestions for outreach.

Reduce unnecessary imaging. One of the medical groups in the Providence-Swedish Health Alliance developed a clinical decision support tool in the EHR for physicians ordering high-cost imaging tests, such as a computed tomography scan. The tool helped the group save $2 million in unnecessary tests and has since been shared with other groups in the ACO's network.

Engage physicians in generic prescribing and managing high-cost specialty drugs. Providence-Swedish Health Alliance hosts a monthly pharmacy utilization committee where medical groups get together with pharmacists to share best practices.

Move beyond the mistrust. Carmouche believes that collaboration between providers, payers, and lawmakers is vital for the success of accountable care. "Providers need to reframe those historical relationships because there are many opportunities for collaboration on value," he says. "If we can do it in Louisiana, it can be done anywhere."

In the end, a robust accountable care effort depends on engaged leadership that consistently communicate their commitment. If a CEO is ready to move toward value, but the CFO and COO remain focused on maximizing revenue, then the organization will not be able to move forward. "The degree to which the C-suite does not send mixed signals is critical," Carmouche says. "Otherwise, there is an ambivalence that permeates the health system and undermines these efforts. You have to pay attention to revenue in the short run, but there is no doubt that in most markets, future success will be based on value."