Supercharge Your ACO: 6 Key Strategies for Top Value

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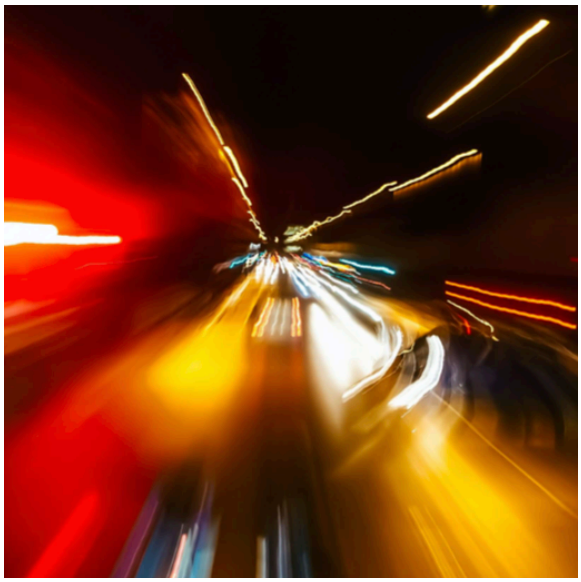

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Introduction

Act Now to Supercharge Your ACO

This is not a game. Your ACO faces a big challenge in achieving growth and prosperity. Corporate competition is capturing your turf. Well-financed corporate health care giants are taking the lead in value-based payment models, while traditional providers lag in progressing toward Risk.

Why should you care about corporate health care growth? Because they are taking your physicians and patients. Discouraged by systems reluctant to change, physicians have turned to these new models that promise better support, infrastructure, and tools to thrive. Corporate health care now employs more physicians than legacy hospitals and systems, and large scale players such as Amazon and CVS, along with equity-financed MSO/ACO-enablers like Aledade, are rapidly building networks of physicians across the country to participate in value-based payment models with global payments. Patients are also moving with them or seeking out corporate health care practices independently, finding conveniences, information, and a better attitude about costs.

These investments aren't side ventures. They vest practices in organizations and commit infrastructure, data, and support to their operations. They do what ACOs planned to do, but separately and under their own banner. Perhaps equally important, in a market-oriented culture they are champions of their own brands, which means that their visibility can also help them grow even more.

To remain relevant, MSSP ACOs must rapidly fire up strategies to compete, or forfeit physicians and patients to corporate health care. Traditional providers in ACO REACH are going toe-to-toe with corporate health care organizations that deploy advanced analytics to target services to patients.

ROJI's Powerful Strategies to Energize Results

Equipping your ACO with the tools for gaining strength has never been more important. Here you'll find essential strategies to generate significantly greater savings, better patient outcomes, and equitable services to all your patients. We answer these questions:

- How do you start putting together the infrastructure to generate analytics and drive efficient and better health care?
- What data is essential for success, without breaking your budget?
- What is the most cost-effective strategy for APP Reporting?
- How can you significantly ramp up savings from moderate to massive?
- How can you prove that your quality exceeds your competitors'?
- What steps should you take to keep physicians in your organization?
- How do you engage physicians in ACO performance initiatives?
- How can you identify patients' barriers to health status and help them overcome these obstacles?
- How can you keep and attract patients?
- What are the proven strategies for ACO sustainability and growth?
- How can your ACO best ensure the success of your stakeholder practices and referral sources?

Don't just sit and wait for your bottom line to tank. Act now to create the future health care system your patients need and deserve. Help your physicians' practices transition to value-based payment models before your ACO becomes obsolete. So, let's get started.

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Strategy 1A

Invest in Value Infrastructure: Amp Up Your Data Engine to Measure and Generate Value

Perhaps you started with no systems and little data, and you built technology piece by piece. You may have started with simple tools like spreadsheets and simple databases, using discharge reports or ER usage for population health outreach.

Or, you built a database with claims data, to identify patient risks and costs. Perhaps you were able to incorporate data from a stakeholder practice to test interventions.

Over the years you have probably migrated some initial tools to more sophisticated population health technology or developed analytical tools using more underlying data.

Despite this iterative development, most ACOs are still lacking the most important tool to really maximize savings and patient status: the patient-focused value-based technology to address the analyses and tasks essential to running Value-Based Payment Models.

An iterative approach is useful when you're learning and when there is time. But if you are still using piecemeal systems or systems that lack functionality, you cannot beat the competition that has built million-dollar systems to achieve greater results.

Functionalities in Value-Based Care Technology

Your value-based technology needs to cover all functionalities required for managing alternative payment models. This includes functionalities for analytics, operations, data-sharing, population health, and interventions. Here are the major capabilities of such a system:

- Data aggregation from multiple source systems, both internal and external;
- Ability to address variations in both costs and outcomes for every ACO patient;
- Prioritization of patients who need immediate interventions to change the course of care;
- Identification of major cost drivers, including advancements of clinical technology, specialty services, patient selection criteria, and stagnation in results for patients with chronic diseases;
- Predictive risk score for each patient's progression in their conditions and related high cost;
- Integration of all sources of data, including clinical and financial, to target interventions;
- Support for collaboration of an integrated clinical team for a treatment plan;
- Support for data-sharing with clinicians, and analytics aimed at clinicians;
- Episodes of care for comparisons of costs and outcomes, across both conditions and procedures, as well as population groups;
- Mechanism for patient engagement in a treatment plan, to report outcomes and provide feedback;
- Maintenance of patient health status over time, to reveal improving or worsening values, stagnation in care, and worsening of risk;
- Modeling of expenditures and projected costs against Value-Based Care models;
- Claims payment, when Rules are modified to allow internal negotiation of fees between ACOs and referral physicians (needed for commercial contracts and, in future, for Medicare);
- Distribution of risk and payments to internal ACO providers, depending on financial results (needed for global risk).

Five Priorities for Implementing Value-Base Care Technology

Let's assume that you have already invested in aggregating sources of clinical and financial data into a repository. First, let's examine what you need to manage the current environment. Your most immediate problem is identifying cost and helping to steer patient outcomes in a positive direction.

Your systems must aggregate the data and have analytics that tell you, by person, whether their clinical trajectory is on course or requires change. The data on what adjustments in the patient's plan are needed must be accessible at key decision points for every care team member, the patient, and the patient's support network. Those decision points occur when you can engage both the clinician and the patient and/or patient's support network. Clinical decisions are normally made iteratively over time in

response to new information—and not always at a visit when a clinician is reviewing an EHR record with the patient.

With the need for time- and team-variation in mind, your technology needs to have these key attributes:

1. Build technology to be person-centric, with capture of longitudinal transactional data from all systems (clinical, financial, administrative).

The system should also create major chronic conditions and procedures as Episodes of Care. Patient episodes will give you the major functionality needed to identify cost drivers as well as cost variations across both conditions and procedures. From there you will develop interventions on specific patients based on clinical and cost priorities.

2. Support collaboration of care team members with shared data in episodes.

Eventually, this sharing must go beyond organizational boundaries and provide the mechanism for communication and input in the patient's outcomes and clinical interventions. Value-Based Care Technology is the starting point for driving change in clinical results as a result of data and insights from data. A big change in culture for clinicians, the beginning stages of Value-Based Care adoption will consist of building trust, learning, and using data.

To be comprehensive, you need to capture data from all venues of care—including, increasingly, the patient's home. Primary and specialty, primary and behavioral health provider, and primary and community social service organization or home care provider are just a few of the entities that will be involved with individual patients. Creating a plan that will involve multiple parties as well as the patient requires a common "system" in which each clinician (and the patient) can see outcomes and can contribute to the plan, subject to boundaries of the clinical team for each patient condition.

3. Provide the vehicle for patient engagement, patient-reported outcomes, patient self-management, and cost transparency.

Current systems are top-down and built for providers. Patients should be equal participants in new technology with a clear purpose of partnership. Along with many other changes to address health care consumer needs, the hierarchy of systems and their data must change.

The idea that provider data is superior and consumer data is suspect or of poorer quality prohibits you from seeing the full scope of your patients' health. In particular, lift prohibitions against inclusion of data from patient devices and patient-reported outcomes and include that data in the technology so that it can enhance information for members of the care team. Again, adding home environments and patient-directed responses should be planned but can be added at a later stage.

4. Incorporate both clinical and population health interventions.

Value-Based Care technology should measure health status improvement by positive changes in longitudinal outcomes and avoidance of low-value procedures, and by health equity measures. The tools

should ensure that findings loop back to views in all prominent technology—including but not limited to the EHR and population health—where data activates interventions for the care team and patient.

Cost data and goals can be included or not in interventions. Your care teams can probably achieve greater results if your path is clinical and patient-focused. You can prevent problems that cause patients to need higher resource care by helping them manage risks or improve their condition and age-risk management capabilities through data-driven population health programs tied to these risks.

In any event, costs will be always be measured as predictive and post-intervention, to determine the effect of the successful intervention.

5. Manage economics for provider episodes.

For ACOs embarking on a full Risk strategy that involves downstream payments, not only to primaries but also to outside providers, Value-Based Care Technology must have the functionality of claims payments, contract management, and population and network management that is tied to various insurance contracts. At-risk contracts are expected to grow 9 percent annually from 2020 to 2025.

This should be a priority because procedural episodes are likely to involve external specialists, so when permitted, there should be revenue-sharing with such practices if positive results from specialty projects accrue.

Even CMS is beginning to understand that until APMs such as ACOs can fully collaborate with specialty care through data sharing and reimbursement mechanisms, their ability to manage costs is limited, a perspective that we have frequently promoted as a means for ACOs to improve outcomes and better control costs. One of the advantages of the ACO Reach global payments options is that the payment mechanism facilitates collaboration with specialists, an advantage over the MSSP ACOs, which must rely on interest from the specialty group to generate engagement in collaborative sharing of data on outcomes and costs.

Today's current systems are still set up to support Fee-for-Service and cost distribution more than they are devised to redesign clinical care. But Value-Based Care requires us to rethink how to organize the fundamental systems we use to create effective, accessible care to patients. By integrating various functionalities in Value-Based Care technology, ACOs have the opportunity to not only target individual cost drivers and opportunities for patients through analytics, but also to enfold other providers, specialists, and their patients in a holistic technology to drive results.

Image: Michael Foursert

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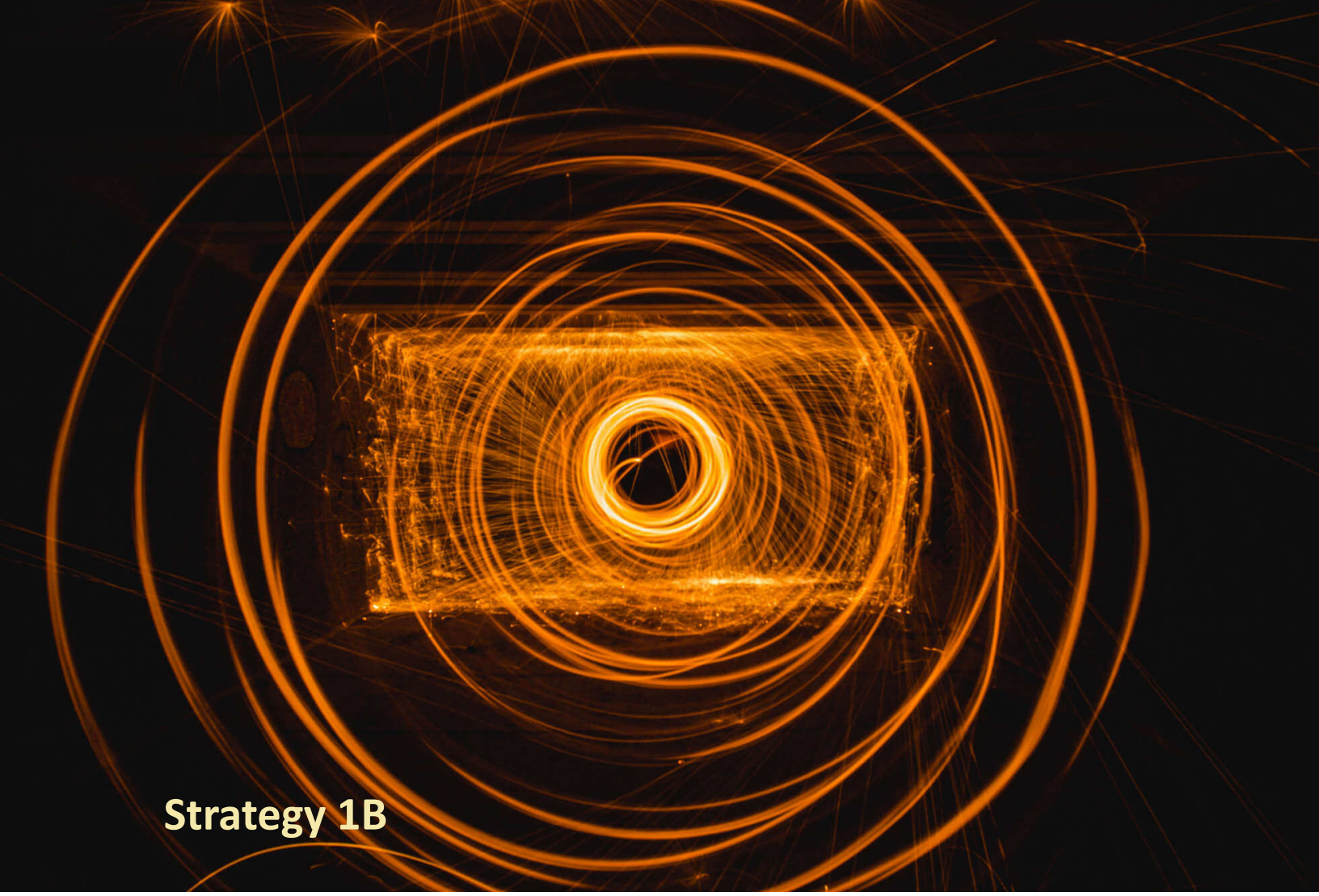

Invest in Value Infrastructure: Build Data Sufficiency to Drive Costs Down and Outcomes Up

ACOs have used "old school" data sources for many years to focus coordination of care activities. Perhaps your ACO has done the same, using reports such as admissions and ER discharges, post-acute admissions, visit history and missing labs to target patients for outreach. Similarly, your ACO might use Hierarchical Condition Categories (HCCs) to identify patients with higher risk factors for population health.

Now is the time for you to invest in real data. Here's why you need that now, and how to do it.

Three Ways that Data Creates ACO Opportunities

You can't intelligently manage Risk without being able to predict and control total patient care costs. That means moving your data sources from retrospective, easily found data to comprehensive data that can be used to estimate future costs by patient.

You have three major objectives for impacting aggregate patient care costs through data:

- **Systematically identify patients with chronic conditions who are in decline or progressing to advanced disease.** These are the patients who will impact your future bottom line as their health erodes. Clinical data from the EHR creates the opportunity for you to target clinical and social service interventions based on key indicators and potentially to improve the course of their lives and cost trajectory.

- **Identify cost drivers in specialty care by comparing results of patient episodes from individual procedures or specialty conditions.** By examining different specialty providers, surgical approaches and other components of procedures, you can identify variations as well as notable observations and outcomes. Share these results with specialty providers to evaluate and improve, engaging them in your ACO goals.

- **Involve clinicians in improvements by providing meaningful and relevant data for their patients.** These should include point-of-care tools for considering specific interventions for patients at the time of the visit.

Five Data Sources and Their Value for Value-Based Payment Models

So, which data sources should you tap? First, understand that if you are to achieve any of the above, you will need to integrate data from these sources into a patient-centric database. Why? Because at the heart of each objective is a set of actions to examine or act upon for each patient. Whether population health, clinical change in treatment, or examination of variations in care for patients with the same condition—each intervention or improvement is based on findings from patient-level data. You must layer the data from each of the five sources into patient histories, outcomes, and costs.

1. EHR Data

Your ACO has probably considered Claims data from CMS as the nucleus of your ACO data empire. Nope. While Claims data is valuable for revealing most patient care costs and utilization, you need EHR data to provide the foundation of clinical information necessary for analyzing costs and outcomes, and certainly for targeting interventions.

Unless you are a single group ACO supported by a common EHR, the concept of aggregating data from multiple EHRs may be new. With APP reporting on the horizon in 2025, many groups are just starting to understand the dimensions of EHR data-driven opportunities.

These are just a few of the essential data types that the EHR offers to meet the three objectives for thriving under Risk, none of which are available through Claims alone:

- Lab and other test values for conditions, enabling you to stage patient risks;
- Prescribed drugs and history of prescriptions;
- All diagnoses, not just those billed during the year;
- Trend of critical lab values such as A1C, blood pressure;
- Other patient history that can explain poor outcomes or events.

2. Claims Data

Claims data contributes to your patient information in three important ways. First, it adds data about your patients, including conditions or procedures and some clinical status indicators of which you may have been unaware. This information should be blended into your patient's data history.

Second, it provides information on other providers giving services to your patients. Knowing providers outside your network should enable you to better evaluate your referral sources and help cultivate your specialty referral strategy. Your specialty relationships could include data sharing or involvement of the specialty group in your ACO initiatives.

Finally, claims data reveals essential cost of care and utilization information that can be analyzed by patient episodes to identify variations and cost drivers.

3. Patient-reported Outcomes and Devices

Many patients are now collecting information through wearable devices, and this data is rarely flowing into EHRs. Whether captured through portals or devices, patient-origin data both supports patients' efforts to document and improve their health status and also incorporates vital feedback into the clinical data. Why depend on survey data or limit your patient contributions to feedback on services, when you could benefit from rich lifestyle data or incorporate clinical values into your repository? Patient-reported data can also provide valuable information on the patient's level of engagement in treatment, or how effective the treatment is.

Despite the value, however, there's a hitch. Clinicians and organizations are often opposed to such data being directly ingested by the EHR. If that is the case, ACOs should instead consider how to incorporate this data into the ACO patient-centric repository.

4. Social Determinants of Health (SDOH)

If you have patients who are unable to access good care, it will cost you more. Whether you are pursuing ACO REACH or not, your ACO should care about improving health equity because it will improve your economics under risk as well as provide better patient care. Many ACOs are enthusiastic about improving health equity, yet distressed about the staffing and process required to collect SDOH data and still struggling, as a result.

In the long term, the use of standardized tools and Z codes may improve the incorporation of SDOH data in EHRs, but input from provider offices will be required for an ACO to reap the rewards of good SDOH data. ACOs have a legitimate leadership role in this area because the value-based agreements negotiated by ACOs incorporate health equity requirements. As such, your ACO may consider working with community organizations or creating better strategies for collection of SDOH data going forward.

In the meantime, ACOs can use the other sources of data they are aggregating to target patients for examination of SDOH issues. For example, condition episodes such as diabetes should identify patients with stagnant, poor outcomes and no change in medication. This and other indicators signify that investigation is necessary to determine affordability or other issues contributing to the patient's situation. Targeting patients for identifying SDOH issues will lessen the data collection burden on everyone, while providing a path forward for your ACO to address the most critical and obvious cases.

5. Specialty Provider Data

As discussed, significant sources of specialty care make an important contribution to ACO patients, and all efforts to formalize the relationship between the specialty providers and your ACO's mission is key. One aspect of this relationship must center on data sharing.

There are several options for this if the specialty practice is not ACO-participating, all of which require good faith negotiations for the benefit of each party. First, the specialty practice can provide EHR data to your ACO, which can be ACO-limited (only with technical capability). Second, your ACO could also arrange for its data vendor to aggregate and separately categorize ACO patients and provide analytics to the ACO and practice alike. This would provide the full benefit of episode-based cost analysis to the specialty practice while also providing detail on ACO patients to your ACO. Finally, the specialty practice could independently aggregate and furnish the data to your ACO.

Tip: Ensure the Value of Your Data for ACO Interventions

Data value is not defined only by specific sources, but by attributes. There are key markers in the data that you can use to predict patient costs or risk, identify failures of treatment or patient engagement issues, or health equity. These three are essential elements of your data build:

- **Time.** Many organizations will approach data aggregation by limiting the time or data values at the onset, in the mistaken idea that this makes it simpler. Clinical values over time are the most important marker of successful or failed treatment and patient adherence. Likewise, data over more time is much more significant than less time, because you can track conditions, outcomes, and events for patients over a longer period. Data should be aggregated for the maximum period of time, at least two years, and all diagnostic and lab values should be collected, not limited by venue or certain periods.

- **Clinical Events.** Condition-related events like exacerbations, hypoglycemia or other clinical diagnoses, and disease progressions are also important markers for predicting patient crises. Claims data only offers a retroactive view of utilization and lacks the predictive clinical elements for future risk. These data types are essential to view patient risk profiles and establish improvement plans that involve clinicians, as well as outreach to potential social services.

- **Provider and Patient Actions.** The previous two data types will reveal patients who are succeeding or at risk. The next task is to examine both provider and patient actions. These

include prescribed medications, specialty referrals, patient self-management programs, patient outreach or education, behavioral health or social services, and so on. Populations of patients who have not improved over time, yet for whom no changes are made, can be referred for clinician review. Likewise, patient actions such as poor visit timeliness, missed visits, and no visits are important indicators for ACO action.

Building ACO data prowess will take time and funding, but will be required to sustain your ACO's revenues as you transition to Risk. The cost of aggregation is lowest and the data value highest using a holistic data-gathering approach, rather than measure-specific or single purpose. With Claims for Medicare patients already available, additional data sources can be added and enhanced over time.

ACO reluctance to adopt data aggregation has occurred for various reasons—cost, history, lack of value in data, provider pushback. Now is the time to get smart about data. Equity-backed providers have already invested in the technology needed to address costs. To manage Risk and compete for providers and patients, ACOs emerging from legacy provider groups must do the same.

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Strategy 2

Mitigate Costs With 3 Person-Focused Tactics

Consider this: If you are really going for top health care Value, you must dramatically reduce total patient health care costs by *lowering the average cost of care per patient*.

Think that sounds obvious? Then you're missing the nuances of "cost of care per patient" and will have difficulty identifying the levers for change. Until recently, most providers understood "cost of care" to mean what it cost your organization to provide services. Now the frame of reference has shifted. But providers' enthusiasm wavers for these changes, because they affect the bottom line and are harder to do. To achieve top health care Value, providers need to make a quantifiable impact on the cost of health care to *consumers and payers*.

You must beware of how Fee-for-Service changes your perspective on costs, since risk-based reimbursement represents an extremely small part of current revenues. Taken together, Fee-for-Service

and an organization-centric approach to lowering costs hamper your ability to act in the interests of Value instead of short-run advantages for your organization.

Cost Mitigations Won't Harm Your Organization

Of all the actions to improve Value, cost initiatives have been the most problematic for providers. How you react to the opening statement gives clues to how you might broaden your perspective to more effectively address cost of care per patient:

- If you're concerned that lowering the average cost of care would lower revenues, understand that you're responding to what would occur under Fee-for-Service reimbursement, and not necessarily under Value-Based Care Reimbursement, such as global payments.
- If you assume that lowering cost of care per patient means denying care, you're responding to historical practices like prior authorization or discouraging patients from seeking services (also harming you and/or patient)—not to data-driven approaches to achieving efficiency.
- If you interpret your total patient health care costs as total claims but believe you have no control over them, you have yet to marshal your organizational resources to really engage in cost reduction.
- If the statement seems completely obvious but not very compelling, then you are underestimating the energy involved to lower cost of care.

Historical Cost Efforts Have Focused on Low Hanging Fruit

Most likely, your ACO has tried several approaches to mitigating cost. One common ACO approach involves identifying and reducing service utilization by service venue. Perhaps your ACO has reduced use of sub-acute facilities after hospital stays. Or maybe you've used patient outreach following emergency room visits or hospital admissions to try to correct course going forward. Another common approach: trying to direct services to certain settings to limit care delivered in more expensive ones.

While these types of cost mitigation efforts can produce one-time savings by instituting policies around appropriate referral settings, they only have a marginal impact. Nor will they influence future costs of individual patients.

Constraining Long Term Costs Requires a Data-Driven, Clinical Focus on Outcomes Improvement

If you want to substantively reduce patient care costs, here is your only serious option: Focus on the clinical care process, from diagnostics through treatment, to identify variances and causes. Only by addressing both clinical decisions and patient responses can you effect meaningful change.

Your path to cost improvement requires improving patient health status, focusing on those who are most vulnerable to higher costs as a result of poor health. Your goals are consistent with your medical mission:

to stem progression to more expensive disease, control conditions, avoid admissions or events like exacerbations, and prevent complications. Data is essential to this process. With data, you can identify and intervene with patients before the risks turn into costs. Without it, you're chasing events that have already occurred.

Three Inflection Points for Interventions

To improve both care and costs successfully, focus your initiatives on these three inflection points, where risks to patients' outcomes and costs are increasing.

1. Address specialty care costs.

Specialty medical care accounts for 40-60 percent of your total costs. Depending on how providers participate in your ACO, you can access specialty care data through your own EHR data or work with referral groups to share data and conduct improvement initiatives. As global payments gain predominance, commercial payers and Medicare will begin to enable negotiated rates between ACOs and non-participating specialists. In fact, CMS is already considering this. Both ACOs and outside specialists stand to gain by protected data-sharing to lower cost of care under risk-based reimbursement.

How do you assess specialty medical care? Start by examining cost variation in procedures and high-cost medical diagnoses. Cost variation analysis represents costs and outcomes associated with each patient case of similar characteristics, with variations due to clinician decisions or patient preferences and circumstances.

You can unlock this capability by creating episodes of care to compare patients with the same condition or procedure to identify common cost drivers and patient issues. The point of this analysis is to engage clinicians in a process of review, feedback, development of interventions for patients, and to begin a discussion of appropriate clinical guidelines. For procedures, this case discussion may lead to collaboration among primaries and specialists on clinical pathways. Some interventions are appropriate for immediate population health outreach or referrals.

Analysis of variations are essential in the following types of cases:

> **A. Diagnostic and surgical procedures.** Episodes bundle pre-procedure, procedure, and related follow-up services for each patient in time-delineated blocks. Your clinicians should be involved in the approval of episode criteria as well as the analysis of results. What do episode comparisons reveal through cost variation analysis? Just some of the discoveries include:
>
> Patient selection issues, including selection of patients for routine surgeries despite pre-existing serious clinical conditions;
>
> - Cases involving multiple procedures performed by different clinicians;
> - Cases involving trauma;
> - Use of different approaches, e.g. open or laparoscopic;

- Use of different anesthesia agents;
- Different venues of service;
- Complications and post-surgical infections, and repeat surgeries;
- Mortality.

B. Specialty medical conditions and medical treatment in oncology, kidney care, and other higher cost conditions. Medicare cost measures are frequently focused on specialty conditions but bundle disparate conditions for cost benchmarking, which makes them inappropriate for clinically-focused cost variation. However, your ACO can use the Medicare cost measures to create more discrete patient episodes by condition or treatment, which can help you better approach clinicians to evaluate variations and target interventions to improve outcomes in the patient population. You can also work with these specialty practices on Medicare's specialty care payment models, if available, and develop optimal clinical pathways that can be used to help both primaries and specialists collaborate on care at various disease stages.

2. Identify patients at critical clinical junctures or clinical events to identify patients who are moving to a higher risk status and may trigger higher future costs.

You can filter patient episodes to examine specific events by diagnosis that reveal clinical decline or events and examine patients with decline of multiple outcomes or specific outcome criteria. Examples include:

- Complications or exacerbations of an existing condition, such as hypoglycemia, metastatic disease, kidney failure;
- One or more new serious diagnosis;
- Decline in multiple outcome levels or severe worsening of one major outcome.

These analyses will flag patients who may need specialty referral, population health programs, or outreach for health equity determination.

3. Zero in on patients with persistent poor control in chronic conditions.

Patients with poorest control levels or repeated exacerbations in their conditions represent cohorts with highest risk. Their failure to improve may involve either clinician or patient issues, or both. Perhaps the therapy is not working, and the clinician has not adjusted course because the patient has not been in, or your system lacks the ability to flag a patient for review based on outcomes. Or perhaps the patient is not adherent for either personal preferences, or because there are financial or social obstacles to following the course of treatment. Regardless of cause, this cohort of patients is likely to progress further in disease and experience exacerbations or events that trigger higher cost. As a result, they represent a high priority group for population health and clinician reviews as well as an opportunity for interventions that will positively affect both outcomes and cost performance.

Potential Interventions Are the Starting Point for Further Analysis

Even with data, identifying potential interventions still requires further review. Your first step is a clinical review of the patient's status. But take care! With all cost strategies, your ACO should not put physicians on the defensive by using patient status as a back-end scoring device for clinicians. Strive for support and collaboration. Even when the data points to clinical decision-making as the cause of a higher episode cost, there are many other possible explanations.

Likewise, it's a mistake to assume that patients who have had no change in medication regimen were failed by physicians. The lack of treatment changes may highlight a health equity issue; perhaps the patient is unable to afford a preferred medication. Episodes of care present cases which illuminate multiple avenues to explore—health equity, personal preferences, circumstances, or conditions which prohibit change.

In sum, to significantly lower costs, you need both patient-centric and systemic interventions, guided by data insights—but directed by clinicians and other stakeholders, including patients, families, and communities.

Image: John Cameron

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Strategy 3

Target Interventions with Data Tools for Improving Outcomes

Since the inception of ACOs, quality reporting to CMS has served as the "test" of ACO quality by CMS and ACOs alike. If you subscribe to that idea, however, you are missing real opportunities to impact patient health by improving outcomes.

Quality measures, whether collected and reported via the CMS cost interface or Advanced Performance Pathway (APP) reporting, judge you based on how your population meets the level of quality defined by the measure. But that comparison is based on only the most recent single value in a handful of outcomes. If you are using the CMS cost interface, then only a few hundred patients are even measured by that metric. Does this system really assess your ACO's ability to improve health care status? Hardly. Quality reporting data is not actionable for significant intervention efforts.

Poor outcomes lead to cost overruns and progression of disease to higher cost levels. Without data-driven approaches that identify worsening outcome trends for individual patients (See Strategy 3, Cost Mitigation), your ACO is handcuffed and cannot avoid declines in health status, costing you more money.

Now is the time to change that and supercharge your performance. Here's how:

Create a System to Align Your Data for Action

Your first step is to deploy a system for action in both costs and outcomes. Focus on creating actionable data for specific improvements, including clinical interventions, patient interviews and motivational counseling, and social services. Once you've aligned your data, programmed algorithms will highlight patients needing interventions. A data vendor with the ability to create episodes of care will enable you to integrate EHR data, claims, and other sources to successfully identify patients needing action, based on criteria, across a spectrum of conditions. Episodes are critical to reduce cost variation, as noted in our discussion of cost mitigation.

With episodes, you can target specific interventions to patients based on an optimal clinical care plan for their condition(s). You can create paths in your system to determine whether population health staff work with the patient first, or whether clinician review is warranted, depending on the intervention. Finally, with EHR links, you can ensure that clinicians see any intervention suggestion for the patient at point of care, enhancing the ability to discuss it with the patient during a visit.

Look at Outcome Values Over Time for Opportunities to Improve

To make change, you must know where to intervene. Start by pulling in all data that reveals outcomes, costs, and transactions for each individual patient, within primary chronic conditions or specialized area of concern.

Episodes of care are a complex instrument that you can use for your unit of analysis and comparison between patients, providers, and locations. To be useful for defining interventions and making comparisons, each episode must have clinical integrity, with discrete clinical diagnoses that relate to one central medical condition, and outcome measures that are accepted patient status indicators. While each episode of care is designed differently, you should be able to compare patient episodes to evaluate cost variation, differing outcomes, and identify interventions that should be used to improve patient status.

Each patient episode embeds an underlying standard of care, a clinical pathway or treatment plan that includes evidence-based interventions. For example, a heart failure episode may embed the gold standard of heart failure medication in the standard of care. For patients who are not on these medications and are experiencing worsening conditions, the system's episode will identify them for clinician review. For patients whose outcomes are poor, the absence of expected clinical actions reveals opportunities for. In this respect, episodes of care enhance EHR clinical decision support with an extra layer that reveals patient cases who are missing expected therapies.

Know Where Your Interventions Will Be Focused

After defining your clinical and cost improvement priorities, your ACO should decide on the scope of interventions to adopt and how they will be conducted. Be wary of limiting your opportunities by

choosing one intervention for a major condition. Because interventions are generally performed on a population and patient basis, it makes more sense to bucket applicable interventions for patients, saving time and staff.

You are likely to have a variety of intervention types:

- Clinical review for potential changes in treatment;
- Programs your ACO will organize for patients, such as Self-Management;
- Population health for outreach to patients for interviews, appointments;
- Community referrals;
- Specialty or other therapy referrals.

If you decide on interventions in advance, you will be able to organize the details and the process for implementation, engaging your clinicians in the process.

Prioritize Patients by Risk and Opportunity

Your ACO might begin with high-volume metabolic conditions to identify patients by highest need in each clinical condition. Perhaps you choose to start with diabetes, obesity, and hypertension, which would result in two episodes (diabetes and hypertension) and a variety of outcomes for each condition, including obesity and blood pressure for both episodes. Examine a variety of significant, related outcomes for each condition, because clinical action often involves affecting multiple conditions with medications or other therapies.

Your analysis should answer questions that the data should be able to reveal. For example:

- Are outcomes worsening or improving, and over what duration?
- What treatments have been tried, such as prescribed medications, nutritional services, patient self-management, therapies specific to the condition, specialty referral?
- Does patient history reflect any other issues that may affect outcomes, such as SDOH or other unrelated conditions?
- Are there specific limitations that might disqualify any potential intervention?

How to Compare Results Across Providers and Groups

While targeting interventions is an ideal mechanism for improving patient outcomes, be wary of using the mechanism as a tool to assess clinician quality. While analyzing cost variation will reveal different practices among physicians, comparing episodes on outcome issues is much more difficult. There are several reasons why condition episode data must be carefully evaluated and is not always appropriate for comparing quality of providers. For example, there may be higher numbers of patients with poor control concentrated with specific providers. There are a variety of reasons why this occurs:

- preference or subspecialty of the clinician(s);
- assignment of new patients by the practice to particular clinicians;
- dedication of a practice to serving more difficult patients;
- scheduling of highest need patients to see or have case management by nurse practitioners;
- participation of the practice in resident training;
- selection of the patients based on physician criteria, such as race;
- actual difference in clinician practices.

The improvement process you adopt should organize the data to facilitate clinician improvement of outcomes, by presenting possibilities for intervention and creating the support needed for navigating the clinical, health equity, and patient reasons why the patient is not improving.

Chipping Away at Quality Versus Supercharging Your Improvements

ACO history is replete with the adoption of single improvement programs, grant-funded initiatives that are time- and resource-restricted, limited population health, and use of intuitive rather than evidence-based programs. With the proper infrastructure and data aggregation, you don't need to take a one-by-one approach to improving patient outcomes and costs. You can reap significant savings and health improvements by using your data, not staff, for the heavy lifting of identifying opportunities, and use the technology to facilitate information sharing and focus by clinicians and population health staff.

Change is the point of your competitors' investment in systems. However, you already have access to online technology that you can use to take action now.

Image: Ricardo Arce

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Strategy 4

Jumpstart ACO Health Equity with Data and Collaboration

ACO REACH is Medicare's response to blending several key values in its most advanced payment model to date. In addition to traditional ACO quality and cost values, ACO REACH also includes population-based payments (including global payments), rather than Fee-for-Service, and promotes health equity as a central goal. If your ACO is an ACO REACH participant, one of your first requirements is to establish a health equity plan. The financial stakes are higher in ACO REACH; not only are payments risk-based, but also the costs of identifying and addressing health equities are uncertain.

As you prepare to implement the most challenging alternative payment model (APM) in the ACO spectrum, you must figure out how to get the data that will help you develop and implement that plan. It's a herculian task. Your first challenge is how to quantify health equity and identify patients who are vulnerable because of racial bias, poverty, food or housing insecurity, and job or transportation issues. There are options for how to tackle this. But unless you can efficiently identify patients at higher risk because of unmet needs, your second challenge is that you may face cost overruns and still fail to adequately improve health equity in your patient population.

Even if you are a traditional ACO MSSP, understand that resolving health equity, even if not currently defined by your payment model, is also in your future. That's because as you transition into Risk, vulnerable patients are where you will find opportunities for improving outcomes and savings.

Here’s the dilemma for all ACOs: Social Determinants of Health (SDOH) data remains insufficient to identify the individual circumstances that influence patients' health and ability to access care. And, there is lack of consensus on how to get that data. The bottom line: your ACO must innovate to develop your own template for health equity, by cultivating both available data and data-gathering methods while you plan long term solutions.

Let's address the fastest and most effective way to get started now.

The Challenge of Collecting Social Determinants of Health (SDOH) Data

Obtaining SDOH data is the first step toward helping patients in need to get better health care by identifying circumstances that prevent them from accessing services or quality care. In any effort to measure health equity, including CMS initiatives, using SDOH is a specific point of CMS guidance. This is based on the assumption that all patients are screened on SDOH. However, the question remains: Is it feasible to conquer the SDOH data hurdle in the short-term?

SDOH defines an individual’s circumstances, such as poverty or homelessness, that affect their ability to access care or treatments. The data is currently classified by ICD-10 "Z codes," a set of 10 categories of 70 separate psychological, family, living environment and economic circumstances that can affect health status and/or access to quality care. Theoretically, SDOH provides the measurement construct for identifying the precise triggers for inequity and points to solutions.

SDOH is intended to identify patients who are marginalized in one of two ways: those without access to any care, and those facing obstacles in the care process itself. Capturing SDOH is an enormous undertaking and is not a short-term project. The notion that every patient will consent to being questioning about personal vulnerabilities by their medical providers is idealistic. Lack of trust, feelings of embarassment or shame, and the level of staff interview expertise—all affect the process. Whether most, if not all, patients are able to participate in the process is also a hurdle; while some practices deploy patient-reported tools, individuals with literacy issues will be underreported.

In short, building SDOH data to help identify health equity issues is often unrealistic in the near term. In fact, there is very slow gain on SDOH data collection, with paltry results, at best. Practices on the front line of patient care say that they do not have the capacity to interview and collect SDOH data on patients. Even for those who try to do so, recent information indicates that key variables for patients are often missed.

As a data aggregator, we find that provider organizations' ability to capture SDOH data is still highly variable and, overall, insufficient to support usage of a full SDOH-data collection model as a basis for health equity.

Three Ways to Jumpstart Your ACO Health Equity with Data That's Already Available

Without adequate SDOH data, do ACOs lack the tools to address health equity? Absolutely not! Your ACO can access a wealth of data to jumpstart your health equity process. This approach significantly conserves resources while providing you with patients who are likely to need attention. Here's how:

1. Use geographic, income, race and coverage data to reveal patients with potential access issues.

Your ACO collects address and coverage data that is the basis for billing. Assuming you are aggregating data from all practices for analytics, quality, and other purposes—and you already need to do that--you can identify patients by various criteria as an initial proxy for patients with SDOH circumstances. Medicaid is one place to begin segmenting your list to identify those who are dual-eligible for Medicare and Medicaid, as income is the first eligibility requirement. For both criteria, your goal should simply be to produce a smaller patient list for targeting data collection, to make your job more manageable.

You must ensure that your efforts to target people who are disadvantaged does not turn into a strategy to avoid their selecting your ACO. Fee-for-Service reimbursement often leads providers to create anti-selection strategies. With the higher value placed on health equity, however, you can potentially disqualify your ACO by using such strategies. Moreover, your ability to demonstrate that you can effectively work to improve outcomes for patients who are vulnerable is an essential part of your success criteria as an ACO. In addition to being the ethical path, it will also make a significant contribution to cost improvements for CMS criteria if these patients are in your ACO.

2. Work with community organizations to identify patients' insecurities in vulnerable geographies by ZIP code.

Let's start with the assumption that physician practices lack the capacity and capability to elicit patient responses about circumstances, even if this is not always the case. Trust is a huge issue if patients have experienced poor access or bias. Alternatively, community organizations are well situated and already working in areas of financial and social vulnerability. Collaborating with them to interview patients in your ACO and their communities can be a powerful strategy. This will reinforce your referral relationships in the community and begin to furnish some SDOH data for your organization. By working effectively with existing organizations that also have connections to resolve the identified issues, you can have a real positive impact on patient circumstances and their health status. Deploy resources you would use internally to support, instead, sustainable outposts in the community and maximize your efforts.

3. Curate your EHR data to identify patients by criteria indicating gaps, poor outcomes, treatment issues, and utilization.

Your aggregated, patient-centric data is a second source to identify patients with issues such as persistently poor outcomes over time, poor visit profiles, missing health data, and problematic admissions or emergency room use. The data must be developed into patient episodes, by conditions and other criteria, to examine their trended values (such as hemoglobin A1C) and to find patients who

are not improving, who have frequent instances of utilization or exacerbation, or who have poor visit profiles for their conditions.

From this point, you can further analyze the data to dive into such areas as lack of treatment or medication change (indicative of financial hardship for pharmaceuticals), lack of patient self-management programs or referrals to nutritional resources (possible patient transportation or employment-related obstacles) for further patient identification by the practice or your community contacts. Episodes of care are the best way of comparing patient outcomes and costs to reveal equity, outcomes and cost differences for each condition or set of circumstances. Your clinical data is a bedrock of patient histories that can, if creatively examined, reveal patients who have unaddressed issues. If those patients are not getting what they need to improve, the reasons are often outside the health care system.

Waiting for all-patient SDOH data is not ever going to be the "easy" way to establish the foundation for tackling health equity. Creativity and collaboration are your key tools. Data plus community are your ACO's resources to make the best use of those tools. Look beyond the health care system in a sincere quest to improve patient health, and your ACO can jumpstart the process to achieve equitable health care for all.

Image: Martin Adams

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Strategy 5

Implement 3 Clinician-Directed Initiatives to Keep Physician Practices Onboard

With physicians joining corporate health, merging with equity-based practices and ACO-enablers, the pool of physicians for traditional ACOs is shrinking. With adoption of risk-based reimbursement or global payments, even hospital-based ACOs will face changing economics, with the threat of lower margins and stagnating investments in physicians.

Why Are Physicians Choosing Acquisition and Employment in Corporate Health?

Physicians are not pawns in the acquisition process. They are voting with their feet, influenced by benefits that health care giants and venture-capital funded organizations are offering. These organizations are offering serious benefits to physicians:

- **Financial stability and growth.** Access to financial administration and payer contracts (including risk-based reimbursement) through venture capital-backed MSOs provides an avenue for revenue stabilization and growth. Practices that suffered financially during the pandemic may be

particularly focused on gaining more access to new patients, supported by investments in telecommunications.

- **Data, analytics, and technology.** Most private companies have a strong technology orientation, coupled with a desire to share results data with physicians that has been less common in hospital-based practices and unavailable when practices are small and self-funded.
- **Support.** Investment in extenders, as well as support staff, frees physicians to perform clinical functions.
- **Autonomy in clinical decision-making.** Physicians are saying that they have more clinical autonomy in corporate settings than they do in hospital-based practices.

Three Broad Strategies for Your ACO to Keep Physicians

To stem the erosion of your physician base, your ACO must ensure physicians that you will provide financial security, support for practice transformation and transitions to Value-Based Care, and data infrastructure for success under value-based reimbursement. These three essential strategies will help them to move onto more solid ground:

1. In implementing your infrastructure and data sufficiency efforts, put emphasis on information-sharing and ACO-connecting applications that provide specific project support for physician participation.

We have already addressed the need for infrastructure and data, and the urgency of creating this foundation immediately. ACOs, traditional practices, and hospitals face a dilemma for creating Value-Based Care Technology—lack of experience in Value-Based Care itself, as well as lack of process for collecting and processing data from practices' EHRs. Your success will most likely improve by using a vendor experienced in these areas, including quality reporting to CMS. [link to RoJi difference?] YES The use of a vendor will be faster and cheaper than adopting a common system, which is often a multi-year planning and implementation process. As your capacity for analytics grows, however, you may eventually want to consider a common system so that you can integrate changes faster between various technologies.

A second issue to address is how you can use technology to support physicians in ACO programs. You will need applications that make it easy for practices to digest patient episodes, respond to cost and outcome data, and participate in more expanded clinical teams, inclusive of population health. And, it must be simple, seamless, and careful not to burn your clinicians' time to participate.

Consider these strategies for informing, involving, but not overwhelming your clinicians. We have addressed several cost and outcomes initiatives that involve clinicians, and it is critical that these are streamlined and, when feasible, begin with samples of data with the opportunity to dig deeper.
For example:

- When providing information on cost variation of procedures, share samples of relevant patient episodes, rather than all episodes, that show representative issues. Clearly articulate any questions and provide a response mechanism for feedback.

- For targeting interventions, provide data at point of care for required clinician review, and create a mechanism for physicians to delegate the review to other clinical staff who are named in the system as the accountable contact.

- Invest in applications that allow physicians to easily communicate within integrated clinical teams so that your Value initiatives can track decisions and support movement forward.

- Your investments should also extend to other technologies—a common telehealth system, wearable device reporting (e.g. continuous glucose monitoring), and patient-reported outcomes.

2. Involve physicians in costs.

Physicians universally report that cost data is not shared with them, and they don't know how to address costs with patients. With patients demanding cost transparency, that has to change. Physicians need to understand costs using episodes of care, have access to their own data, and be able to use ACO materials or applications to provide estimated costs to patients.

Your programs to help physicians are best if they are physician-directed and formulated, and implemented by trusted staff. To begin this process, involve physicians in comparative analytics of their own patients and all referred services through patient episodes that are clinically defined—only possible once the data supports both claims and providers' own data.

They, more than administrative staff, are aware of what their patients need to change their own risks, and these physicians must be more involved in crafting solutions for their patients. Administrators who process complaints from physicians about their workload too often misinterpret the message from physicians. They aren't asking to be removed from patient care; they are asking for either the time to do what they need, or someone to catch the ball and carry out the whole intervention.

3. Advance toward value-based reimbursement with linked compensation and benefits for physicians.

If you and your practices are still rewarding only volume of services and have not yet established a compensation mechanism for Value, you can't fully realize the potential of your steps toward change. It doesn't matter whether your reimbursement is still on Fee-for-Service or not; you can still construct a pool of money to align with your cost goals. Unless physician compensation is financially aligned with your goals, it will be more difficult to get attention from practices and physicians.

To do this, you obviously need to create the necessary pool of money, which can be done if you are processing ACO claims under global payments. As your ACO proceeds down the basic tracks of ACO Pathways, you will need a risk structure, in any case, to accommodate the ACO when value-based

reimbursement becomes the norm, to protect yourself from overruns. PHOs and IPAs have performed this function for years, but some ACOs have not.

With your participating practices or stakeholder organizations, your top imperative is to ensure that physicians have the time as well as the rewards to review data-driven tools, their results, and participate in outcomes and cost initiatives.

The idea that providers themselves can still be on the forefront of controlling costs is a compelling vision. But to realize that vision, you need the tools for success. Without physician volume and leadership, your ACO cannot survive. And your physicians need much more support to stay afloat.

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Strategy 6

Boost Your ACO's Future by Igniting These Consumer Strategies

If you see patients as captive assets, think again. Take a closer look at your ACO claims data. Chances are, your patients are not loyal and are splitting their health care dollars with other competitive providers. But that's not all. A large percentage of consumers are now self-directing their health care, using wearable devices, alternative therapies, and choosing where to go based on what they need. If your your patients' health care is fragmented, that's a big problem for you. Why?

You can't coordinate your patients' care if they are going elsewhere. By the time you know about those experiences through claims data, however, it's months later and too late to act.

If your patient accessed another provider because they couldn't access your services, or your patient preferred someone else, you have a relationship issue that is now harder to fix. You've created a path to someone else because you were not the easy option.

Your patients' costs outside your network are harder to control. Providers outside your system don't have access to your patient's data and aren't aligned with your improvement strategies. But these additional costs will be part of your total patient care costs.

Lack of consumer appeal will cost you growth of new patients and increase your providers' frustration, giving them an incentive to leave your ACO.

Value-Based Care Is About Consumerism, and ACOs Have a Role to Play

If you've blamed network leakage on Medicare's policy of free choice of provider, you are missing the fact that one primary goal of Value-Based Care is to ensure that consumers have access to care and better patient experiences.

Providers have been extremely slow to adopt consumer-directed strategies, especially key initiatives that address consumers' two big issues: better information to make decisions about their health, and cost information.

ACOs have not perceived it as their role to further consumer initiatives, leaving that terrain to their providers. But failure to meet consumer needs thwarts their ability to compete with organizations that are directly appealing to consumers based on benefits offered—compared with treatment they receive from traditional health systems.

Powerful ACO Strategies to Inspire Consumer Trust

We've advised many ways that health care systems and ACOs can attract and engage consumers, and help consumers to better manage their health with better information.

Simply put, here's where your power lies: Use your ACO leverage with your provider organizations and with payers to address consumers' most urgent needs:

- Avenues to access health care when they need it;
- Cost transparency to manage their budgets;
- Information to make wise choices.

Fix the Front Door to Health Care

Your front door is how both consumers and existing patients get to you when they need health care. Your providers may have their own websites plus a call-center or call desk. But that's just the start. Your front door sets consumer expectations from the get-go, from how easy it is to find parking and access the building, to whether your receptionist or intake person is helpful and welcoming; from comfort of the waiting area to length of time spent there, and so on.

You need to know how each of your providers' front doors appears to consumers, either welcoming or annoying. Will your providers be willing to talk to you about their operations? Here's why they should:

Your payer agreements create the patient volume that gives you legitimacy to collaborate with them. They would not be in your ACO if they did not need your participation in their business.

Your big fix-it list for the front door includes:

- **Provide information on how to access urgent health needs as well as emergency needs.** Sending established patients through a call-center to try to reach their doctor is a huge front door gaff. Patients, understandably, resent slogging through a call center and waiting for a call-back that may not happen. You should work with your providers to establish clear methods of getting care when patients need it, and not redirect them to other avenues. If you want your patients to go to urgent care for any urgent visit (and there is a shared electronic medical record), tell them! The problem arises when there is no communication to your patients about where to get urgent care (or emergency care, and the difference between the two), and your patients are struggling to be seen.

- **Arrange access points to urgent care.** If you have no urgent care facilities that can be used by your patients throughout their geographic area, you will need to determine your access points for urgent care and implement them. Don't assume that telemedicine will be enough, although it can help triage patients. Engage urgent care facilities, on-call staff, and contractual arrangements.

- **Create online scheduling.** Your competitors have facilitated online scheduling for both new and existing providers. You will need to accept this as a consumer reality, providing choices for new patients.

How to get Value right? Show first and foremost that you respect consumers and your patients by making sure they can reach you when they need to. That tells them everything they want to know about whether they must navigate their own care or that you are there to help them navigate your environment. It tells them that you will take their concerns seriously, that you value them as customers.

Your competitors are eagerly marketing their immediate capability for scheduling visits. Don't lose your patients or raise their costs by encouraging them to test the alternatives.

Provide Consumer-Friendly Cost Information

Your ACO providers may be among the many who still have not met requirements for providing cost transparency to patients. But your ACO cannot afford to ignore this hot-button issue.

Get involved to ensure that your participating providers create a system that not only meets federal requirements, but also gives consumers what they need to manage their costs. Collaborate, if possible, on how data and verbal information is presented, and on the system for accessing this information. Your participation will give you valuable insight into potential cost mitigation efforts. More importantly, you'll gain an understanding of the intricacy of clinical decisions and related costs that aggregate to total patient costs.

After working to facilitate your providers, your ACO should then create a system that enhances patient cost views with episodes of care. Why? Because it will also help patients to understand costs within the context of full treatment, rather than as individual, isolated components.

Strategy 2 in this eBook involves cost mitigation by creating patient episodes of care for procedures and conditions. What patients really want to know, if they are confronting a major decision, is their total payout, not the price of individual phases or components that they typically won't even consider as part of the whole, such as imaging, anesthesia, facility costs, services of assistant surgeons, and so on. Helping patients understand the building blocks of total cost is a missing, essential element to achieve cost transparency. Without that understanding, people fight over the cost of a single component or feel hoodwinked.

Even if patients receive a detailed list of care costs, your ability to explain the whole picture contributes to patient trust. Develop cost ranges for procedures or medical treatment to enhance more specific price transparency documents without conflicting in detail. This will prove useful for patients who are in the early stage of their decision process, trying to understand the scope and direction of the treatment plan.

Facilitate Patient Choices with Clinical Information

Consumers who are trying to assess treatment regimens are often suspicious that health care providers won't give them the full scoop. Some believe that provider advice is tainted by financial gain. Others don't understand the clinical issues and question the motives, background, and urgency.

Lack of trust emanates directly from insufficient information on clinical harms or benefits. While most physicians or clinical settings are time-pressed, the reality is that the information is not readily available to physicians to provide to consumers. And while clinicians often scoff at patients googling data that is off base, your ACO needs to recognize that lack of access to treatment information is frustrating for consumers—and address it.

Consumers are not at fault for being unable to make complex clinical decisions (and adhere to advice) if they don't understand the underlying reasons. They are stymied by health literacy at a clinical level, paywalls on research journals, limited time in appointments with their providers, and not wanting to aggravate their clinical team with questions.

Enable your ACO's physicians to help their patients by providing essential information in key clinical treatment areas. There are many resources now available to help patients be educated virtually, understand procedures and treatments, and validate their concerns. Whether the patient's treatment is for a life-long chronic condition or an issue of shorter duration, ACOs can play a valuable role in helping patients get access to the best information, both for making choices and adhering to treatments.

Fostering a shared decision approach with informed patients will also be key to cost control. Patients want to know: What if I don't do what you are suggesting? What will happen? Their ability to understand

the consequences of delayed or non-treatment in terms of life choices and costs requires significant time and effort, a major endeavor for both patients and providers that significantly affects outcomes.

Accountable care should mean that both physicians and patients are working from shared knowledge, preventing rather than retrospectively treating clinical conditions. Helping consumers access that knowledge and learn to make an informed decision is one of the most important strategies your ACO can undertake.

Image: Greg Rakozy

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Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.