

# Taking ACOs From the Think Tank to the Real World

*The ACO and Emerging Healthcare Delivery Coalition, a project of The American Journal of Managed Care, hosts meetings via WebEx, an online tool that combines elements of the conference call and PowerPoint. The sessions offer opportunities to hear case studies and ask “on the ground” questions, as new reimbursement models take shape.*

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No matter how good an idea is, taking it from theory to practice requires both a leap of faith and the willingness to ride out the unexpected. Risk-taking is a tall order in any enterprise, but it was especially true in healthcare about 4 years ago: Years of shrinking reimbursements from Medicare and Medicaid and rising costs had already squeezed stakeholders at every point in the chain of care.

Yet, with the 2010 Patient Protection and Affordable Care Act, the call for change had come: Fee-for-service reimbursement would be replaced over time with a system that rewarded value, not volume. The “accountable care organization,” or ACO, was on its way.

There’s much to be gained from sharing the journey with others, which is the concept behind the ACO and Emerging Healthcare Coalition, initiated by *The American Journal of Managed Care* in Spring 2014, with an inaugural meeting in Baltimore, Maryland, in May.<sup>1</sup> That meeting drew about 30 attendees; by midsummer, the Coalition had 70 members, and by late August the ranks passed the 100-member mark. A second gathering is planned for October 16-17, 2014, in Miami, Florida.<sup>2</sup>

What is drawing members to the Coalition? Among the benefits are the WebEx sessions: Held in between the in-person meetings, they have offered a perfect complement to the conferences in this time of rapid change. For healthcare professionals with few minutes to spare, these sessions are valuable educational tools that offer precisely 1 hour on case studies or emerging topics, with questions and answers that get to the heart of what new ACOs will be judged on in a year’s time. Participants have joined in from everywhere—their offices, other meetings, even aboard airplanes.

## For ACOs, Stakes Get Higher

CMS has 2 innovation programs. One is the Pioneers program, which began with 32 organizations experienced with value-based measurement, but now has 23 members.<sup>3</sup> The other initiative is the Medicare Shared Savings Program (MSSP).<sup>4</sup> Both programs ask ACOs to track how well they perform based on a set of quality

measures, which are a mix of healthcare outcomes, screenings, and measures of patient satisfaction. The set of 33 measures for the 2014 ACO performance year was released June 30, 2014.<sup>5</sup>

With payment riding on the performance, some ACOs have a financial incentive, perhaps for the first time, to reduce glycosylated hemoglobin (A1C) levels among high-risk patients, or, especially, to trim hospital readmission rates. The question becomes, how to do this? With the clock running on next year’s results, sharing ideas or asking questions can’t always wait for a study to be published. That’s where the WebEx sessions prove valuable: Presenters offer not only data but also practical suggestions, such as names of vendors or software platforms, which tell how they made change happen.

Given the learning curve involved, even ACOs that are generally performing well can fall short in MSSP, as Summit Medical Group learned last year. In the July WebEx session, Kimberley Kaufman, vice president for Value-Based Care, Summit Medical Group, outlined how her ACO today uses a series of tools to track high-risk patients after discharge from the hospital to avoid readmissions, which Medicare now tracks closely.

Using a metric that Summit calls LACED—for Length of stay, Acuity, Comorbidity, history of emergency department (ED) use, and Drugs prescribed—the ACO particularly targets patients on multiple medications or blood thinners, ensuring follow-up within 2 business days of discharge. At that time, visits with a primary care physician are scheduled for between 1 and 2 weeks of discharge.

## “Real Change Is Very Painful”

A theme runs across the presentations: Change is hard, even when all stakeholders know it must happen. At the July session, participants heard about this topic from Leonard Frommer, MD, executive medical director, Group Practice Forum, New York, NY, and assistant clinical professor, Department of Family Medicine, University of California at Los Angeles.

Frommer said among those slow to embrace the value-based

model are employers, who hold tremendous market power and could propel enormous change if they chose to exercise their clout. Frommer's research group engaged human resources executives from 10 large self-insured employers on accountable care issues, with the hope of persuading them to convert their payment models. All were intrigued by the concepts of value-based care, but at the end of the project, only 1 approached its third-party administrator about changing to a reimbursement model that rewarded providers based on value.

Many employers, even those that are self-insured, believe that they cannot change payment models because of insurers, when in fact that is not the case, Frommer said. As a result, employers typically limp from year to year, renewal to renewal, figuring out where they can shift costs to employees in higher copayments, or where they can find savings on the formulary.

"Real change is very painful," Frommer said. "There are derailers and obstacles and challenges everywhere you look."

Despite the awareness that the fee-for-service model rewards volume instead of value, when value-based care is implemented, "We bang head-on into the reasons why we have this chicken-and-egg conundrum for a lot of providers," he said. Providers are pouring resources into systems to provide value-based care, especially electronic health records, and many have not yet seen the "tipping point" at which those investments are paying for themselves.

In response to a question, Frommer said providers need to spread the word among employers: Harness your power to create change. In his own discussions with large employers, Frommer said, many do not recognize that because they pay for so much health insurance, they have the ability to create a value-based system. Having doctors talk directly to employers about this works best, Frommer said.

ACO Coalition co-chair Anthony Slomin, MD, CEO of Renown Health, Reno, Nevada, said that no single actor in the healthcare spectrum would make the difference alone. "Changing a belief system is a real tricky task," Slomin said. "We need leadership at all levels."

### Tracking Diabetes, Cardiovascular Health

This year, 8 of the 33 quality measures for ACOs focus on measures involving diabetes and cardiovascular health—including the "all-in-one" diabetes measure that includes control of blood pressure, A1C, and low-density lipoprotein, as well as tobacco cessation and daily aspirin use where indicated.<sup>5</sup>

It's no wonder, then, that both the July and August WebEx sessions spent time on how to identify high-risk patients and improve their health in these areas.

Summit's Kaufman shared how the ACO has made use of disease registries to keep track of patients with congestive heart failure or chronic obstructive pulmonary disorder. Care navigators cull registries first, then hand off patients who need to be checked to care

coordinators, who each get a list of 10 patients and a 2-week window to find them.

By following up with patients and getting them in for regular checkups, Summit has had success in lowering A1C rates for its highest risk diabetes patients, and had produced a total weight loss of 167 pounds among a group of 17 patients enrolled in a healthy lifestyles initiative.

Through WebEx, Kaufman shared a copy of a "scorecard" that Summit uses to evaluate individual practices, so each practice can see how it fares among others in the ACO. It was popular with the WebEx participants, and Kaufman said it's a hit with the ACO practices, too. This pointed to another emerging theme: setting up opportunities to let practices see how they compare with peers creates competition, and numbers start to improve.

In August, Coalition participants were introduced to the term "chief happiness officer" when they heard from Jeffrey Farber, MD, MBA, the chief medical officer at Mount Sinai Care LLC, in New York, who described how he meets the needs of a diverse group of 280 physicians in an ACO that formed in 2012 and expanded this year with the addition of the Beth Israel, St. Luke's, and Roosevelt practices.

The Mount Sinai Medical Center's Diabetes Alliance is a management collaboration of the Mount Sinai ACO and the Mount Sinai Health Network, designed to improve diabetes outcomes. As Farber explained, the Mount Sinai model makes use of care coordinators and certified diabetes educators (CDEs) not only to identify at-risk patients, but also to get them to change their behavior.

At its core, Mount Sinai's model involves transferring the relationship a doctor has built with a patient to a CDE who has more time to do the low-key follow-up and training in areas like nutrition, exercise, or social-service interventions that are preventing progress. Connecting the CDEs to patients is the job of 24 care coordinators, who have 500 care "encounters" with at-risk patients per week collectively. Patients receive customized treatment plans. As with Summit's effort, reducing unnecessary hospital admissions is a key goal. The approach is as much art as science. "Our care coordination model is nonclinical," Farber said. The care coordinators are social workers, not nurses. Their job is to target patients whose numbers or history show they need contact with a CDE, who have both clinical and motivational training. Farber described the approach as "a lot of high touch, not necessarily high tech."

In 2 of the basic clinical indicators of diabetes—A1C and cholesterol—patients of the clinics where the intervention has occurred started out with health measurements that were worse than New York City averages, and now these measurements surpass city averages. Blood pressure measurements in the clinics have improved, too. Almost half the targeted patients have lost weight—46%—and more patients who need to be self-monitoring are doing so, 78% compared with 66% before the intervention.

What makes it work? "The pre-implementation meeting [with



## ACO Coalition membership includes:

- ACO providers and leaders
- Payers
- IDNs
- GPOs
- Specialty and retail pharmacy
- National quality organizations



- PBM
- Pharmaceutical organizations
- Academia
- State associations
- Patient advocacy
- Health policy research

practices] is critical,” Farber told the group. Mount Sinai wants to be certain that primary care physicians understand the role of the CDE and embrace the care coordinator concept. After that, it helps when doctors see their patients’ health statistics improve.

### From Theory Into Practice

Former California HealthCare Foundation CEO Mark Smith, MD, had this to say about ACOs back in 2010: “The accountable care organization is like a unicorn, a fantastic creature that is vested with mythical powers. But no one has actually seen one.”<sup>6</sup>

The days of unicorns and the ACO as myth are long gone. But the learning curve for bending the cost curve and improving quality remains steep. That makes the ACO Coalition’s WebEx sessions an essential component of its mission: to bring together a diverse group of key stakeholders to work collaboratively, to build value, and to improve the quality and overall outcomes of patient care.

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