Accountable Care Organisations and New Models of Care*

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*This document was made up of an extensive review of documents relating to the question of application of the ‘Accountable Care’ concept to England. Some documents have been summarised, some direct extracts have been taken to lead the reader to the most pertinent points. References are clearly given to the source document.
Lessons from the US to the UK

Contents

- Where to start – agree some fundamentals
- Characteristics of Successful Early ACOs
- Key points from The Advisory Board session for provider executives on service and system transformation
- Shortell Kings Fund paper key points - Lessons for England from the US
- Lessons from the states – Blue Cross Blue Shield Cal- attributes its success to four key strategies
- Address the challenges with ACO adoption head on
- Lessons from Partners HC – Tim Ferris
- McLellan and Darzi - Delivering accountable care for a population involves five key components
- Commonwealth Fund on Pioneer ACO model - A number of common features define success
- Commonwealth Fund – models of care for high cost, high need – issues pertinent to ACOs
Where to start
Agreement on some fundamentals & early decisions about

- Common and collective agreement on the problem we are trying to solve - cost, quality, population health
- Scope and scale - population size, all care vs elderly care?, health and social vs health, Geography. What's in / out provider wise. Interactions between services and providers clinically and organisationally. Dependencies between services (oncology needs path and radiol etc), dependencies around services needing equipment
- Extent and size of commissioning and provider budgets that people are prepared to see at risk??
- Is primary care in, where and how does primary care co commissioning fit
- What are the views and thoughts of providers? primary care, BDCT, Acute Trusts, Social Care provision – in or out? Specialised? Ambulances?
- Realism re time horizon to develop, implement and mature, timeframe for expectations re return on investments
- Who leads - commissioner / provider. GPs v hospitals (artificial question?)

What are the main service investments you need to make

- New service models – care coordination, palliative care, physical activity (prevent future, improve current – eg frailty and ageing)
- What infrastructure
- New premises
- What are the main partnerships you need to develop
- Institutional competencies
- Culture – what culture changes are needed. Management and clinical thinking. And Patient culture – down intensifying care – means shifting risk towards patients. How are we enabling this both culturally and with tools. Focus on behaviours
- Environment re-engineering – relationships between individuals and between institutions
- Are providers ready to take on risk management in the move away from fee for service / volume based care
- Do providers have the organisational tools, data and capability to take it on
Critical success factors – continually cited in the literature

- Culture – collaborative, transparent, progressive, performance driven
- Clinical leadership
- Legal and financial expertise
- Effective governance
- Effective primary care base to support care coordination
- Integrated and effective administrative and clinical IT infrastructure and operations

Characteristics of successful early ACOs

High level ACO concepts and characteristics that seemed to correlate with better results include

- Most successful ACOs are physician led
- Culture is important. Those experienced in care coordination, such as medical homes, seemed to have an advantage
- Transparency within the organization is valued
- The early adopters viewed the ACO model as a way to take control
- Good ACOs started with a strong primary care base
- Clinical champions are important, and every clinic should have one
- Strong administrative support allowed clinicians to focus solely on the patients
- They invested in tools that make it easier to work better
- Education in practice redesign was intentional and frequent, even daily. Meetings across different clinics facilitated proficiency in medical home concepts
- Beneficiary relations improved as care got better. Clinicians were happy; patients were happy.
- The ACOs became good at working with outside firms and other physician groups
- They also engaged various medical societies and other organizations
- A couple of final thoughts
  - Don’t try to do everything at once. It is important to prioritize
  - What works for one ACO may not work for others
Key points from the advisory board session for provider executives on service and system transformation

**Wherever you go- structure doesn't matter**
Org structure doesn't matter
Model of care does
Culture matters

**Sustainability of hospital model esp at pop of 350-400k**
Options are
Horizontal integration - across hospitals
Vertical integration - with community care and general practice

**Options for how we manage the ACO type of transition**
Whole population was seen as way to go by providers around the world

**Defining care integration**
wildly different definitions / inability to describe
Depends on whether a population or individual level construct
Notion has developed over many years and thus grown and developed 1980s was all about efficiency In 2015 - it's all about community care
Working definition - “All stakeholders work together, person centred approach, treat in lowest cost approp setting, and reduce need for treatment in a pop.”

**Working together across organisations – yes, who would disagree. But**
But what when there are elephants like too many organisations
Eg too many hospitals, too many fiefdoms that are independent Gen Practice?
Issues such as these will be important:-
Dealing with organisational relationships
Professional relationships
How many organisations should we sustain

**Policy context**
3 major drivers
1. Multimorbidity and demographic
2. Fragmented system (largely designed for health care needs 30 years ago)
3. Finances continually out of balance - financial model not fit for current HC needs. (How much spend on HC is too much - crowding out other social investments.)
Financial crisis has accelerated and multiplied in a short space of time

**Priorities of policy makers**
Access reforms, access faster, wait times Provider and payment reforms
After crisis - focus is more overtly on cost and financial system reform
Same issues across Europe and beyond. Not just a UK issue
Policy makers are following reform in other countries, and importing ideas from elsewhere faster and faster.
Being influenced by ideas coming from other systems - it’s ok - the fundamental demographic and epi issues are the same pretty much anywhere in the world.

Typology of reform across the world

1. Shifting risk to providers
Value based payment / payment reform
Risk based approach - ACO
Make providers more independent to facilitate the risk
Utilisation penalties
Increased competition - provider outsourcing

A number of strategies
Price signals Swiss TARMED payment model
Use and quality penalties
England - marginal tariff
Innovation incentive pools
Micro capital
Shared risk - two sided.
This is what can be counted and costed most readily - thus most focus here.

2. Shifting risk to the public
Co payments
Fat taxes etc
Public health - invest more
Self care and SDM
Cuts to local government - huge impact on patients (and providers)

3. Re-engineering the environment
Centralise / decentralise
Gatekeeping and thresholds
Access laws
New bodies

Lots of interest in alliance contracting
• But little by way of examples where it’s actually been implemented
• Legal opinion is that alliance contracts should be entered into with incredible care (Somerset / Symphony)
• Unwillingness to enter into risk based contracts for short term risk based contracts
Inevitably the policy environment will make this more difficult - future changes to payment systems, commissioner architecture, broader environment
• So we don’t invest in things with a long term ROI as we are on a short term leash

• Also – financially speaking – when Central Govt is busy cutting local govt (by a large sum) why would an NHS payer or provider enter into a long term binding contract with LA on this basis.

• People will be increasingly unwilling to as govt continues to cut LA funding

**Regulatory issues**

The regulatory system is for a provider not a system
The regulatory system is completely disconnected from cost (eg nursing numbers)

Pools of money to encourage providers to pool BCF Vanguard Germany - sickness funds set aside 1% of operating costs to invest in integrated care systems

**Before jumping in – know your data**

Macro economic data out to the long term - what’s the long term forecast for HC spend
Monitored year to year - key metrics, and then adjustments
Is there patient level costing - cost per patient month. Actuarial analysis.

**Devolution**

Policy makers are fickle
Devo is thus important as locally it might be argued that views and priorities of local pols are more stable than nationally
And can / will argue for stable policy envt nationally

**The issue of ACO and the USA model**

Poor starting point efficiency wise - thus easier to state large financial savings, especially if most of the cash savings are coming out of the hospital sector (which they are)
Helped and enabled by large injection of cash as a part of the ACA

**Issues around employment contract**

If moving towards salaried as a main form of contract for GP then this might (comparative to now) lead to large body of docs taking foot off pedal - as currently financially incentivised to work very hard.
So getting the incentives right for the docs employed needs to be right

**Population health management**

There isn’t a perfect blueprint
There isn’t a single model for success
There isn’t a one side fits all

**Avoidable admissions:-**

X% shouldn’t be there. We all know this. the value of x is hotly debated and depends on what you are counting
But they are - the lights are always on, there are (significant) cracks in the rest of the system. That’s why.
Six goals of population - the core attributes of pop management.
- Org commitment to pop h
- Robust care management
- Cohesive delivery system
- Sustained financial success
- Primary care core
- Well managed partnership network

All share a focus on risk management - The triangle
- High risk - trade high cost services for low cost management. Invest in care Mngt. Palliative care
- Middle tier - avoid unnecessary high acuity high cost spend. This is the critical group. This is the rising risk group. Multiple risk factors and multiple conditions. Most ROI here. Connecting with social care
- Low risk - keep well, minor ailment management. Self care etc

Index of options and interventions for all pop segments
- Pop health low risk / Prevn, access, self, etc
- Rising risk
- High risk - pop h management

The most successful have OVERTLY focused on risk factors, even to the expense of existing diseases.
And also focused on multiple risk management
In both high risk (case management and rising risk management) population

Unresolved issues for all
- Managing workforce, current and future
- Boundaries - nurse / doc, AHP / doc, different types of doc, generalist / specialist, mental health
- Few in the hospital sector have deep understanding of GP - culture or contract
- Role of payers - v little discussion on this. Payers like to think they call tune, the reality is often rather different
- Contracts, payment models, making the £ work
- Social care - elephant
- Time horizons - for contracts and macro Econ (and political envt) - dictates the investments you might wish to make, the partnerships you invest in, the service models or infrastructure you invest in
- Culture - little to no discussion about culture.
- Shared decisions, self care or personalisation - no discussion
- Prevention - ditto
**Common features of new models**

Whether you do the USA version, Spain, NZ, Germany

Wherever you look the core features are the same

(yes of course some judgement needed about adjusting from country x to England as the underpinning structures will differ)

**Common features of success include**

- Big data - analytic / actuarial and clinical care. Linked data sets. Providers need this data – for whole pop. Payer role to facilitate, enable and help build the tools for both patients and populations. Where is the **air traffic control for population health?**

- Risk management across **all segments** of risk / population segments – however the slicing and dicing is done. Focus on average cost per patient month in each segment

- Culture and communication – **all examples given as “successful” attribute big chunk of their success to communication and active efforts to change culture**

- Changing the way providers are paid - **Movement towards a greater chunk of provider income being value based**

- Eventually movement to capitated budgets for populations. **This is about transfer of risk to provider. Are providers ready**

- Alignment of £ and non£ incentives – “incentives 2.0”

- Strategic role of payer – set system. Focusing minds on strategic change. Setting agenda. Danger that provider will seek to engineer the world in their own image Thus maintain business as usual

- Financial risk sharing contracts – two sided – if cost cheaper than benchmark agreed, provider gets to keep a % of the gain, if more expensive provider bears a % of the pain. The % can be negotiable
Shortell Kings Fund paper key points - Lessons for England from the US

NB I don’t think this is an exhaustive list and critically (for me) misses population health point!

From the range of evidence to date there are some key issues that require attention and may differentiate more successful ACOs from those that are less successful.

These are:
- Need to focus on the small proportion of people who account for a high proportion of use and cost through risk stratification
- Need to put in place case management and care co-ordination to support these people
- Need to support the development of integrated care through information sharing and investment in information technology
- Need to engage patients and to support them to play a bigger part in managing their health and well-being
- Four enablers of integrated care
  - Payment systems and incentives that are aligned behind the purpose of integrated care
  - Specific objectives related to the improvements in quality and outcomes that will support the partner organisations to work together to deliver these objectives
  - Networks and alliances between providers with the leadership and other capabilities needed to work effectively
  - Commissioners able to use their leverage to support the development of integrated care through innovations in payment systems and contracting

New support tools are required
Functional electronic health records that have the ability to exchange information across providers and include real-time information on patients, with the ability for patients to access and input into their medical record.

Data at the individual patient level needs to be aggregated so that patients most at risk of hospitalisation can be identified.

This allows multidisciplinary teams to intervene early to prevent a hospital admission.

Patient engagement
Much greater attention needs to be paid by ACOs to actively involve and engage patients and their families in their care.

This includes proactively contacting individuals to prevent disease in the first place, actively involving patients and their caregivers in setting care goals, sharing decision-making, and engaging in end-of-life and advanced serious illness care preferences.

Getting patient input into quality improvement efforts and care redesign is also important.
Cost and quality measures
Early evidence from ACO developments in the United States suggests a common set of cost and quality measures needs to be defined and set across the various contracts.

Lessons for England from the US
The need to focus on the small proportion of people who account for a high proportion of use and cost through risk stratification (NB – I don’t wholly agree with this!)
The need to put in place case management and care co-ordination to support these people.
The need to support the development of integrated care through information sharing and investment in information technology.
The need to engage patients and to support them to play a bigger part in managing their health and well-being.

Lessons from the states - BCBS attributes its success to four key strategies:

- **Changing how providers are paid.** Payers should offer financial incentives to doctors and hospitals; this way, providers are more inclined to focus on improving patient health. Payers need to work with providers to introduce this new payment method.

- **Giving providers data.** Providers may have some internal analytic tools, but they often need help building multi-payer systems. Payers are well-positioned to provide doctors with the tools they need to implement paying for value.

- **Promoting healthy living.** To help consumers stay active, it’s important to provide wellness incentives that include educational tools that make healthcare quality and cost transparent. Blues companies use enhanced network and benefit designs that encourage consumers to make more informed choices about which provider they choose.

- **Emphasizing savings.** Be mindful of costly services that don’t add value - duplicative testing; fraud, waste and abuse, and rising pharmaceutical costs that threaten patient access to new drugs.

Address the challenges with ACO adoption head on

**Leadership**

**Physician leadership**
Hospital administrators have to balance physician autonomy and the need for some guidance and standardization under quality improvement initiatives.

**Cultural changes**
A culture of continuous quality improvement will be paramount to ACO efforts
Incentives should avoid pitting departments or categories of providers against each other.

**Clinical integration**
Hospitals have made significant investments in clinical integration, adding an extra layer of sophistication to participation in ACO contracts.
Operational

Shared savings distributions
Administrators have to decide how and when these revenue sources should be distributed. Difficulty stems from assessments leadership is forced to make regarding who is responsible for generating what savings and to what degree they should be rewarded.

Physician alignment
Attribution models based on the provision of primary care services and quality measures have raised the profile and demand for primary care physicians. Hospitals have acquired physician practices in some markets whereas in other markets, hospitals have focused on finding or building competent physician group partners that can self-manage.

Lessons and early priorities

- **ALL in org got to be a part** - Top to bottom / Communicate
- **Governance model**
- **Financial model and payment mechanisms**
- **Frontline led investments to reduce costs**
- **Science and knowledge base** - Evaluate everything!
- **Continual measurement across large pops** - Evaluate everything
  - Even if not publicly reported **Move to registry type based outcome based care** – builds cultural expectation that all systems are a part of this.

McLellan and Darzi - Delivering accountable care for a population involves five key components:

1. A specified population for which providers are jointly accountable.
2. Target outcomes for the population – outcomes that matter to individuals.
3. Metrics and learning, to monitor performance on outcomes and to learn from variation.
4. Payments and incentives aligned with the target outcomes.
5. Co-ordinated delivery, across a range of providers, of the care necessary for achieving the desired outcomes

Characteristics of successful accountable care systems

1. Take a broader perspective than illness.
2. Start to pay for outcomes
3. Create a favorable environment for organizations to collaborate
4. Encourage inter-operable data systems.
5. Value-based payments reforms
6. Clinical-integration reforms,
7. Data-transparency reforms

Functional components

Population
Prospectively identified. Capturing all people who meet the criteria
Intersections and co-morbidities recognized
Populations prioritized on potential value
Based on a holistic view of spend across providers

Outcomes
Outcomes that matter to people and clinicians
Balanced across prevention and cure
Comparable with other provider networks
Aligned with global best practice
Differentiated on the basis of patient risk and co-morbidities

Metrics and learning
Metrics proven as leading indicators for outcomes
Monitoring is validated, real-time, transparent
Monitoring integrated into clinical work flow
Results made public to allow comparisons
Closed learning loop based on variations and feedback
monthly, high level dashboard of key financial and utilization metrics and other information needed to manage WHOLE population – not just the high risk
Payments and incentives
Payments capitated (year-of-life)
Payers and providers share risk and savings
Differential payments based on outcomes
Incentives at all levels for success
Complemented by professional rivalry on outcomes
(Much to learn from Commonwealth Fund Incentives 2.0)

Co-ordinated delivery
Formal agreements amongst providers
Facilitated by data sharing and access
Clinicians empowered to adjust interventions
Ensuring full use of all team members
Focus on prevention, community, and self-care where possible

Commonwealth Fund on Pioneer ACO model
A number of common features define success. For example the Commonwealth fund profiles of pioneer ACOs

Key features of all
• High degree of clinical integration and sophistication with health information technology and informatics, which are needed to identify high-risk patients and create workflows that enable providers to efficiently meet patient needs.
• Population segmentation, risk prediction, and performance improvement techniques to proactively develop individualized care plans and automatically generate and distribute prioritized lists about gaps in care
• Population risk management is the norm – this applies to both individual high volume care pathways and to “high risk” patients, and it also applies to corporate competencies
• A strong payer–provider relationship (including a joint ACO implementation committee), a focus on performance measurement and reporting, an expanding health information technology infrastructure, and an integrated system that facilitates communication and collaboration across the continuum of care
• Long term development of infrastructure for population health care – requires time AWAY from direct clinical care
• Single electronic record – across all providers
• Performance improvement – clinical and financial
Key bit is the Lessons learned from the summary report

- Gaining buy-in from providers and building systems for performance reporting and feedback appear essential for fostering an environment of accountability
- Internally managed reporting systems and feedback mechanisms that have been accepted by providers as a credible way of identifying opportunities for improvement
- Explicit cost-reduction targets – meaningful to the frontline, whether set by federal or state governments or self-imposed based on market conditions. These targets helped them identify and prioritize programs that could lead to reductions in costs or improvements in quality
- Dominant purchaser (CalPERS) that structured its benefit offerings to encourage cost-consciousness in its beneficiaries when they chose among competing health plan offerings
- Price-sensitive consumers and the market competition they fostered led the ACO partners to realize mutual benefit by acting together like a virtually integrated delivery system
- (Of note, there is something here around being open honest and transparent with citizens about cost of care - and some, though a little equivocal, evidence this does have a bearing on how people think about their health care use. Maybe especially alongside shared decision making)

Challenges

- Key is difficulty of changing patient and provider behaviour
- Sites that have produced early results had an infrastructure for robust data analytics to monitor performance and identify opportunities for improvement
- The method used to determine whether ACOs qualify for shared savings presents another challenge for ACOs that need to invest in staff and technology to manage care
- Some of the ACO’s expenses (e.g., for case managers who oversee the care of patients with chronic and complex conditions) may recur each year, while Medicare’s savings expectations will increase over time to ensure total spending for ACO patients continues to decrease relative to fee-for-service spending. This is a critical point. There is a constant need for the infrastructure - some of which is clinical some of which is administrative. But there is a constant need for more and more savings
- Developing a portfolio of initiatives that take aim at several challenging problems (e.g., care coordination, patient engagement) because discrete quality improvement programs will not achieve the returns needed to qualify for shared savings or other payment incentives
Lessons for the NHS
Allow time to build the relationships and cultures that enable GPs and specialists to work together to improve care. Overcoming historical divisions between general practitioners and specialists in England will not happen quickly, and sustained effort will be needed to nurture collaborative clinical practice and team working.

Payment systems also need to be aligned behind new care models. The United States is moving away from fee for service reimbursement for physicians and activity based funding for hospitals towards systems that reward improvement in the quality of care, such as capitated budgets, bundled payments, and pay for performance.

Information Technology, and especially the electronic patient care record, is a powerful enabler of integrated care.

Success Requirements
Effectively engage physicians
Six factors that appear to differentiate the higher performing ACOs from the others.
Size or Scale of the Organization.
Recent Medicare legislation requires only 5,000 enrollees to be in the shared savings program, however many are much larger than this particularly on the commercial side. The Dartmouth-Berkeley National Survey of Accountable Care Organizations (NSACO) has identified some ACOs with upwards of 100,000 enrollees or more, bringing to light the consideration of economies of scale in an organization. The more people an organization has under the risk-bearing contracts, the greater the incentive for the organization to invest in infrastructure support such as Electronic Health Records (EHRs) and patient activation and engagement training for providers.

Care management capabilities
Physician organizations need to fundamentally redesign how care is provided. This includes greater use of pre-visit planning, development of care transition programs, and increased use of nurse practitioners, physician assistants, and community health workers.

Electronic health record functionality
Electronic Health Record Functionality, with the key word being functionality. Most health care practices now utilize EHRs, but the ability to use EHRs for all of their functionality is variable and limited. The benefits of increased EHR functionality are visible in some ACOs through the use of patient portals and the ability to communicate with other providers that are a part of the ACO.
**Effective partnerships**

Within ACOs, the health of an entire population is being managed, placing greater emphasis on the management of post-acute care. The development of relationships between hospitals and skilled nursing facilities, home-health care agencies, and rehabilitation centers requires new partnerships with a common vision and aligned financial incentives. The ACOs that have been more successful are those that are developing such relationships.

**Patient and family engagement**

While patients can go anywhere for their care, the ACO is still accountable for their treatment and the costs incurred, so there is an incentive for the ACO to make specific efforts to engage patients in their own care management and keep them within the umbrella of the ACO. This is particularly important for the management of chronic illness, which requires the involvement of patients and their families to avoid preventable hospital admissions and re-admissions and emergency department visits. There is much to be learned about how best to engage patients and families in their care.

**Measurement standardization and transparency**

Measurement Standardization and Transparency is needed for both external involving public reporting of quality measures and for internal continuous quality improvement efforts. Any one of the six factors alone are unlikely to make much difference. Rather, it is all of these factors used in combination with each other that creates a platform for the successful implementation and growth of Accountable Care Organizations.

**Emerging market characteristics**

As indicated in Table 1, enrollment in ACOs in California is projected to grow significantly over the next two years, by approximately 48 percent, moving California towards the Berkeley Forum overall vision of managing population health with a high value health care system (Berkeley Healthcare Forum ACO Brief). The market characteristics examined in the current report include the concentration of the provider market, hospitals, and medical groups.

It is well-known in California that there have been a number of horizontal hospital mergers and an increase in the size of hospital systems, as well as medical groups. We looked across the state at the market concentration by county for hospitals and medical groups using the Herfindahl-Hirschman Index (HHI), which looks at the concentration ratio of particular providers in given markets.

Through this analysis we found a negative association between the location and the growth of ACOs and the concentration of the market. The more concentrated a market is, the less likely it is that an ACO will form there; this was true for both hospitals and medical groups.
We also discovered a positive correlation between the location of Health Maintenance Organizations (HMOs) and the location and growth of ACOs in these areas. One possible reason for this is that in these regions there is increased knowledge of how to do risk-based contracts and how to manage the covered lives, meaning the infrastructure is already present for a managed care organization. Another possible reason for the formation of ACOs in areas where more HMOs are present is that this is a competitive response to Kaiser Permanente, and one way to compete with Kaiser is to set up an ACO. These market trends will continue to be monitored over time.

**Ongoing challenges**

There are several ongoing challenges to creating more integrated systems of care such as those represented by ACOs. Not the least among these is that creating integrated systems of care is difficult work requiring considerable resource investments (the cost of integration) in increasing EHR functionality, workflow redesign, and developing partnerships with others.

Also, in recent years the less integrated Preferred Provider Organizations (PPO) have gained market share at the expense of HMOs. Efforts are now being made to create at least “virtual” ACOs among these provider groups. The state is also hampered by lack of an All Payer Claims Database (APCD) making it difficult to assess comparative performance, which can serve as a stimulus for ongoing improvement. Serving the state’s large Medi-Cal population, which involves addressing issues of health literacy, is an added challenge.

There is also the longer term question of whether there is sufficient clinical and managerial leadership to “stay the course” as further demands are placed on the system. But, as expressed by Tom Williams, immediate past president of the Integrated Healthcare Association and vice president of accountable care operations and strategy at Stanford Health Care: “California is fortunate to have many integrated health care delivery systems at various stages of development. The advancement of these systems into Accountable Care Organizations and partnerships should be viewed as an important and very positive innovation in payment and health care delivery.”

**The bottom line is that California’s ACOs are helping to move the state toward achieving the vision of having 60 percent of the population receiving care in integrated systems by 2022, and at the same time reducing the percentage of the state’s health care expenditures paid through fee-for-service arrangements from 78 percent today to 50 percent by 2022.**
Commonwealth Fund – models of care for high cost, high need – issues pertinent to ACOs

challenges associated with ACO adoption and required organisational & operational capabilities needed to succeed

It is widely believed that ACOs need to have a series of operational capabilities in order to succeed:

1. Strong leadership and governance that will support a clear mission, alignment across ACO provider participants, provider accountability for quality and cost, and resolution of internal disputes;
2. Partnership between physicians and hospitals, for a team-based approach to care whether the hospitals fall within the ACO or are contracted externally;
3. A foundation of effective primary care practice operating as Patient-Centered Medical Homes;
4. Affordability and efficiency in patient meeting evidence-based standards;
5. Meaningful use of health information technology that supports the integrated and actionable data required to inform care management in ongoing retrospective population analysis and monitoring of fiscal and clinical performance;
6. Risk assessment of the population for which the ACO is responsible; and,
7. Operational capacity to contract with health plans and providers and align incentives for costs and quality, to receive and distribute funds across ACO participants, and potentially if delegated by health plans, to administer quality assurance, provider credentialing, and handling of patient complaints.

A number of questions remain regarding ACO formation and operation. A few of the most critical include:

1. How will physicians, hospitals and other providers clinically, operationally and financially integrate?
2. How many providers will seek to become ACOs given the high bar for quality reporting set by the proposed rule for the Medicare Shared Savings Program ACOs?
3. How will legal and regulatory barriers, such as anti-trust, anti-kickback and health insurer reserve requirements be addressed with ACOs?
4. How will providers share risk and savings within and outside of the ACO?
5. How will transparency on performance and payment

Table 4. Challenges Associated with ACO Adoption

<table>
<thead>
<tr>
<th>Category</th>
<th>Common Challenges</th>
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</thead>
<tbody>
<tr>
<td>Leadership</td>
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<td>• Incentives should avoid pitting departments or categories of providers against each other</td>
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<td></td>
<td>• Proper and sufficient investment will signal a commitment to transition</td>
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<tr>
<td>Cultural Changes</td>
<td>• Hospitals have made significant investments in clinical integration, adding an extra layer of sophistication to participation in ACO contracts</td>
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<td>Shared Savings Distributions</td>
<td>• Attribution models based on the provision of primary care services and quality measures have raised the profit and demand for primary care physicians</td>
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<td>• Hospitals have acquired physician practices in some markets whereas in other markets hospitals have focused on finding or building competent physician group partners that can self-manage</td>
</tr>
<tr>
<td>Physician Alignment</td>
<td>• Payers not currently participating in value-based contracting nonetheless are benefiting from care delivery improvement efforts (the “spillover effect”)</td>
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<td></td>
<td>• Improvements are not being rewarded, and all savings are accruing to the payer</td>
</tr>
<tr>
<td>Funder Mix</td>
<td>• Resisting strategy is to move as much business as possible into value-based contracts</td>
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(Endnotes)

1. Ref needed
### New Models of Care & Accountable Care Organisations – Lessons from elsewhere translated to England

#### Exhibit 2: Key Capabilities for Population Health Management: Examples from Study Sites

<table>
<thead>
<tr>
<th>Capabilities</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Care redesign to improve the delivery and coordination of care</td>
<td>Behavioral health service delivery is being integrated across three counties and enhanced through collaboration of services, improved transitional care for patients with chronic conditions, mental health programs, and care management of administrative processes (Health Share). A smartphone hospital discharge practice was established to connect inpatient and outpatient care, manage acute follow-up primary care appointments, enhance patient education, and create stronger links between skilled nursing facilities and in-home management services (Uni-Dignity-Blue Shield). Millennial positions were employed to increase timely access to care. Medical assistants were assigned to help physicians meet patients’ care needs, and nurses staffing a 24-hour call line were provided with access to electronic records and care protocols to help route patients to appropriate sites of care (Parkfield).</td>
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<tr>
<td>Care management of patients with complex, costly needs</td>
<td>Health resilience specialists engage, mentor, and help meet medical and nonmedical needs of high-risk patients in a grant-funded, proof-of-concept program (Health Share). An integrated referral process is used to ensure that patients in need of case management services (e.g., for heart failure, diabetes, cancer) receive them from the most appropriate providers in the ACO (e.g., medical, pharmacy, and behavioral health) (Uni-Dignity-Blue Shield). Virtual care teams made up of pharmacists, social workers, and case managers help primary care physicians manage the clinical and psychosocial needs of primary care patients with chronic conditions. Physicians are deployed to Sacramento’s skilled nursing facilities to monitor patients and intervene when necessary to avoid admissions (Uni-Dignity-Blue Shield). Nurses embedded in primary care sites coordinate care and provide individualized care management to patients at risk of hospitalization; nurses receive electronic alerts when patients visit an ED or are hospitalized. Patients with some chronic conditions are referred to specialized case management programs (Parkfield).</td>
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<tr>
<td>Patient/family engagement and activation</td>
<td>A community advisory council is tasked with performing community health assessment and developing a health improvement plan to guide care transformation (Health Share). A patient activation measure tool to assess patients’ self-management capacities and determine appropriate support levels to achieve treatment goals (Parkfield).</td>
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<tr>
<td>Integrated data and analytics</td>
<td>Medical group monitors physician performance and provides coaching when there are signs of unnecessary use of services or inappropriate specialty referrals. High-cost patients in need of care management are identified using professional, pharmacy, and hospital claims data (Uni-Dignity-Blue Shield). Risk identification data from Medscape are combined with in-house data (e.g., billed charges, number of specialists seen, medications prescribed, gender, and age) to predict patients in need of care management (Parkfield).</td>
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*Note:* ACO = accountable care organisation; ED = emergency department. Source: Authors analysis.