Acclivity HEALTH

Issue Brief

Accountable Care Organizations

Roadmap For ACO Success

The Path Forward Requires Insight and Foresight

As the CMS Innovation Center moves into its second decade, CMS will focus on getting all Medicare Fee for Service beneficiaries into an accountable care relationship with providers by 2030. Will you be ready?

CMS has set their goal to transform the healthcare system into one where providers can:

- **Put people at the center of their own care, letting them select their own primary care providers**
- **Ensure health equity by giving underserved beneficiaries increased access to accountable, value-based care**
- **Reduce fragmentation and costs**
- **Holistically assess patient needs, considering patients' preferences, values, and circumstances**
- **Coordinate care within a broader total cost-of-care system**
- **Make medical records and facilities accessible after hours**

If you're managing an ACO or are a care manager in this changing environment, the path to financial and performance success may not be easy. However, the rewards can be great, with improved access to high quality care for all Medicare and Medicaid beneficiaries and higher shared savings for your ACO.

Going forward, your challenge is to maximize the efficiency and effectiveness of your limited staffing resources. You'll need to monitor and manage the continuously changing metrics for your value-based care contracts and identify new opportunities for success.

To meet the new goals CMS has set to provide health equity across the country, your ACO will need actionable insights and care management workflows that enhance revenue and support effective outreach programs. The right tools will help you:

1. Understand the nature of your patient populations
2. Predict prospective utilization before it occurs
3. Deliver care to patients entering high-utilization periods
4. Ensure seriously ill patients receive the right care at right time in right setting
5. Track patterns of behavior to identify where your ACO differs from the norm and identify potential abuses in utilization of services, treatments, or medications

The following pages outline the steps you can take and strategies you can utilize to transform your ACO from one that is getting by today to one that will truly thrive through the changing requirements of CMS.

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1 Understand Your Patient Population

To ensure health equity, you need a way to identify your patient population and monitor the social determinants that affect the health of the patients you cover. There are tools you can use to understand your population, which include Area Deprivation Index scores that rank neighborhoods by socioeconomic disadvantage, the National Equity Atlas that has community ratings based on racial and economic equity, and County Health Rankings. If you are investigating analytics and workflows to help you manage your ACO, look for a solution that integrates at least one of these ratings into its platform.

Once you have a clear understanding of your population, you'll need a way to manage the preventive care requirements of your value-based care contracts automatically, such as Annual Wellness Visits and recommended screenings, to ensure patients don't fall through the cracks. You'll also want to identify the best patients to follow with your limited resources.

You should be able to view all the chronically and seriously ill patients in your patient population based on the probability of Total High Cost, Probability of Inpatient Hospitalizations, and/or number of chronic conditions for chronic care management. These patients will require closer follow up to manage their care and prevent or reduce acute care utilization, unnecessary specialist visits and medication adherence to achieve their health goals.

Any care management solution you invest in should include comprehensive data on your patients' entire medical journeys, including all providers visited, diagnoses, chronic conditions, procedures, hospitalizations, medication adherence, and paid amounts. It should also help you identify shifts in the composition of your patient populations.

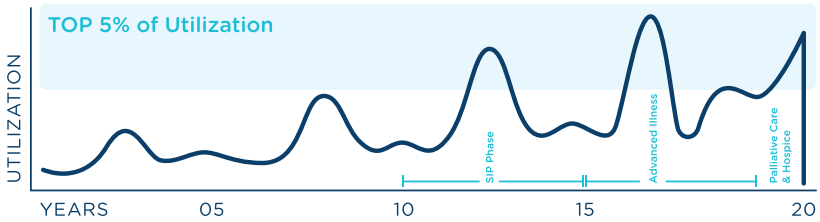
2 Predict Prospective Utilization Before It Occurs

Patients do not steadily progress from "normal" utilization levels to high-utilization levels and stay there. People have health care episodes that may require the support of oncologists, cardiologists, orthopedists, and other chronic illness specialists for a set period. These episodes show up as spikes in utilization that may last six to nine months while someone goes through a major medical procedure and then "regresses to mean" as the patient's utilization level drops back to a more "normal" level.

Once a patient returns to that lower level of utilization, your organization can fall back to "close monitoring" with frequent primary care visits. The chart below outlines a typical high-risk long-term utilization pattern and should be the kind of report you can create for each patient in your population to help your providers manage care efficiently.

Typical Pattern of High-Risk Long-Term Utilization

Variable Care Management Model



3 Deliver Care To Patients Who Require The Most Care

To date, most ACOs have struggled to meet quality and cost metrics because they have focused on past utilization and spending. However, to improve future performance, it's critical to know what's happening now.

Care management services must be dynamic, focusing on the continuously evolving cohort of patients that are entering or transitioning through a period of high utilization. By focusing resources on those patients who are entering a high-utilization episode, you can reduce stress on the patient, maintain high levels of care coordination, and mitigate the costs of each high-utilization episode.

When you develop a strategy to identify the high-risk pool of patients in or about to enter a high-utilization period and closely monitor these patients for utilization behaviors, medication adherence, and socio-economic factors adversely impacting their health care, you maximize the efficiency and effectiveness of your limited care management resources.

4 Ensure seriously ill patients receive the right care at the right time in the right setting

Too often clinicians only have access to the health data they collect themselves. They don't know when other providers have seen their patients, what treatments and medications they've been prescribed, whether patients are complying with their prescribed treatments, how many trips they've taken to the ED, or even whether they've been hospitalized.

Your ACO can help your providers coordinate care by aggregating comprehensive patient data that goes beyond their EHR systems and then using insights from that data to build collaborating opportunities with referral partners with similar goals and aligned incentives. This can include medical specialists as well as continuing care providers, such as SNFs, home care organizations, and palliative medicine and hospice organizations. This process can be automated with technology that enables patient data to be shared for timely and seamless transitions.

State-of-the art analytics platforms are available that provide insights into cost and utilization risk, medication compliance, mortality risk, and psychosocial issues that are hard for humans to recognize and quantify remotely. Obtaining and sharing Palliative Performance Scale and mortality risk scores with the providers in your ACO, along with the conditions that affect each patient's rating, can help improve their confidence when making a home health, palliative, or hospice referral. Additionally, offering connected care referral mechanisms to your providers can facilitate the addition of palliative and social service resources to a patient's care team.

Getting patients the right care at the right time in the right setting is key to meeting Value-Based Care quality and utilization metrics.

5

Track Patterns Of Provider And Facility Behavior

Like patients, providers and facilities can and do suffer from adverse behaviors. You should have a way to determine how members in your ACO perform compared to established norms. For example, you should be able to do a performance analysis that integrates all relevant data from patient profiles through all the medical and pharmaceutical claims that compares cost and utilization metrics for the same quarter of two consecutive years to determine performance trends on a year-over-year. When you compare your performance to that of all other ACOs, you can see if or where your ACO deviates from the norm. In the event of deviation, you should be able to drill down to determine potential abuses in performance or spending.

Risk-adjusted utilization metrics can be established to objectively monitor both facilities and specialties to identify those who present adverse behaviors as well as those who deliver beneficial behaviors. With this level of insight, you can implement changes, improve financial performance, and enhance the quality of care your beneficiaries receive.

Get On The Path To ACO Success

Start Your Transformation Today

With staff shortages, overburdened providers, and ever-changing contract metrics, you can't maintain the status quo and expect to succeed financially. Now is the time to start maximizing your efficiencies and make the changes you need to ensure the patients you serve get the care they need, when and where they need it.

For more about how we can help you find success as an ACO, please contact us at info@acclivityhealth.com or call 904 562 1368.

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