An Accountable Care Organization Pilot: Lessons Learned
Overview

In 2008, an IPA (Hill Physicians Medical Group), a hospital system (Catholic Healthcare West, now Dignity Health) and a payer (Blue Shield of California) formed an innovative collaboration to build an Accountable Care Organization (ACO), with the goal of substantially reducing total healthcare spending and improving quality of care for California Public Employees’ Retirement System (CalPERS) employees and their dependents. CalPERS is the second largest healthcare purchaser in the nation, managing health benefits for nearly 1.3 million employees.

The catalysts for the pilot were rapidly escalating health costs and the desire to build a new model that aligned incentives among providers and payers, creating the foundation for continuous quality and cost improvements.

The ongoing pilot is being conducted among approximately 41,000 CalPERS members in Blue Shield NetValue™ and Access+ HMO® health plans assigned to Hill Physicians in Sacramento, El Dorado, and Placer counties, and access to four Dignity Health hospitals (Mercy General, Methodist, Folsom, and San Juan).

The pilot’s objectives are to create a new care delivery model that can bend the healthcare spending trend through re-aligned incentives among the health plan, medical group, and hospitals, with aggressive cost-saving initiatives designed to take substantial delivery cost out of the system, rather than merely shifting costs within the system.

The pilot also sought to achieve a first-year zero cost increase, versus historical annual growth of 8 percent to 12 percent each year. In 2010 the pilot achieved that goal, through more than $15.5 million in savings, including a 20 percent reduction in per-member-per-month costs for inpatient admissions. This is especially significant in light of the fact that the three pilot participants agreed to share the financial risk of the pilot.

But the focus was on more than savings, and the pilot has so far demonstrated that this collaborative approach has resulted in improved patient outcomes and better coordination of care across the continuum. When comparing the pilot population with other Northern California CalPERS members, the 2010 pilot results show:

• 15 percent reduction in inpatient readmissions within 30 days
• 15 percent reduction in inpatient days per 1,000 hospitalized pilot participants
• 50 percent reduction in inpatient stays per 1,000 of 20 or more days
• A half-day reduction in average patient length of stay

The pilot’s success is based on six strategies, contingent on firm and open cooperation among the three pilot participants:

• Population-specific utilization management through a coordinated operational infrastructure
• Elimination of unnecessary utilization and non-compliance through personalized population management
• Improved clinical and resource variation among physicians through quantitative analysis and targeted interventions
• Reduced pharmacy and utilization costs through targeted member outreach and drug purchasing and contracting strategies
• Rapid and efficient communication of patient medical information through IT integration
• Development of a comprehensive dashboard of leading and lagging measurements

The level of cooperation required an unprecedented sharing of cost and pricing information among organizations that typically play their cards very close to their chests when seated at the same table.

But once the walls came down, the results were “so simple, it’s embarrassing,” said one Blue Shield executive, while another said, “We have a unicorn. The status quo is over.”

The pilot participants are quick to caution that other ACOs aren’t guaranteed the same success. But they do believe they’ve developed a blueprint for others to follow, and are ready to share their “lessons learned.”

Leadership and governance structure

Health care today is a set of horizontal care delivery “silos” where organizations’ autonomous decision-making results in limited accountability of patient care across the healthcare continuum.

Lesson learned: Accountability must be built within the governance and organizational structure

The leadership and governance structure is one of the most critical aspects to the long-term stability and success of the pilot because it fosters financial and clinical accountability across the collaboration. A shared governance model – the Pilot Board – had executive leadership representatives from all three health organizations. This model inspired maximum
input from each team member, and ensured deadlocks were resolved in a timely and collaborative manner. In addition to the Pilot Board, a senior-level operational team – ACO Core Team consisting of clinical, financial, and operational leadership – provided day-to-day direction and decision making.

**Lesson learned: It’s not the type of organizations that defines the success of an ACO; it’s the leadership of the organizations**

The pilot placed an emphasis on the “accountable care” part of the ACO instead of focusing on the development of a third-party company – preferring instead to be virtually integrated across the current organizations. Members of the Pilot Board and the ACO Core Team were philosophically aligned in their commitment to their own organizations, to sustaining and improving the marketplace, to properly serving CalPERS’ members, and to the potential financial benefits. This alignment resulted in a consistent message to all people throughout all three organizations of the pilot’s strategic importance. They became effective advocates at guiding the principles that drove the innovation and transformations within. They provided succinct and dynamic direction on both strategic and tactical levels.

**Lesson learned: Build in funding for project management oversight and resources**

To ensure the ACO achieved its goals, the pilot identified and implemented a set of diverse projects among the pilot participants. One challenge was that each organization had different project capabilities and approaches. To meet that challenge an ACO Project Management Office (PMO) centralized the coordination of the projects, including business case development, funding approval, risk management, outcome measurement, and program communication. The ACO PMO reported to the ACO Core Team and was accountable for the implementation of all projects. As part of the PMO, dedicated project management resources for all three organizations were funded and/or supplied to reach project milestones. These ACO project managers utilized a project management framework comprised of common standards, tools, practices, and methodologies.

As opportunities became projects, project teams consisting of an ACO project manager and subject-matter experts were brought together to develop the requirements and implement necessary changes throughout the three organizations. By capitalizing on each organization’s strengths and expertise, best practices were identified, created, and implemented. For example, the Patient Care Transition Team consisted of hospitalists, primary care physicians, inpatient nurses, inpatient case managers, outpatient case managers, and social workers from within the three organizations, who were directly responsible for patient discharge planning and follow-up care. These individuals also evaluated industry best practices and ultimately developed an integrated care transition model that ensured the smooth transfer of patients across all care delivery settings by engaging the patients and their caregivers.

**Lesson learned: Understanding and appreciation for culture and readiness for change**

It’s important not to underestimate the challenges of cultural and organizational differences. Conducting a cultural assessment allows each team member to understand the uniqueness of each organization. The key is to leverage the cultural strengths and neutralize the cultural differences of the organizations and various stakeholders. One valuable lesson was that individuals across the organizations learned to appreciate the internal challenges their peers encountered when driving change. Along the way, a sense of trust was established among all levels of the organizations, which resulted in more honest and effective communication that served to drive innovations and remove barriers.

When piloting ACOs, a readiness assessment must be performed to examine each team member’s current capabilities, strengths, and weaknesses. The readiness assessment evaluates the pilot participants’ readiness to succeed in an ACO based on a defined set of capabilities, including governance, leadership, culture, care management, quality management, information technology, and risk management.

As each organization’s capabilities are examined against the ACO-required capabilities, a gap analysis can define the strengths, weaknesses, opportunities, and overlap, to help ensure effective and efficient use of resources.

**Financial alignment**

Current payment models are fragmented across the continuum of care and do not support the common goals of care coordination and cost reduction. In many current payment models, IPAs are reimbursed on a capitated basis but individual physicians continue to be reimbursed on a fee-for-service (FFS). The FFS reimbursement model does not encourage the use of conservative treatment approaches or evidence-based medicine. Instead, it’s based on volume.
Lesson learned: Financial agreements must drive new partner-interaction models

Development of financial models in which risk is equitably shared between pilot participants both for profit and loss is a key component of achieving alignment. While there are many proposed models being experimented with, the models that will ultimately succeed will include risk that is meaningful, manageable, and truly shared (each team member participating in overall risk, not just that of their own historical venue).

The pilot participants believe ACO financial models must have a downside financial risk to encourage change. Financial incentives will not work without changes to the underlying infrastructure that improves care delivery. For example, hospitals can be capitated, but without some downside risk to physicians and the health plan, changes to clinical processes involving those pilot participants are more difficult to effect.

All the CalPERS ACO pilot participants agreed to take costs out of the system through improved utilization and include the target savings into future cost of healthcare trend, immediately incorporating the trend deflection into premium pricing. The pilot aligned the appropriate risk level based on an organization's ability to impact results; as a result, all pilot participants invested in reporting capabilities to measure the clinical outcomes and financial risks.

The essence of the arrangement was the interdependence between the healthcare providers and payer so that each organization had a vested interest in reducing costs – instead of the old model of shifting costs or maximizing fees. There were times when costs could be significantly reduced for one organization with a marginal impact to another organization. During these times, the Pilot Board came together to make a decision with the overarching goal of reducing total costs while providing high-quality care to members.

Clinical integration

Becoming an ACO means moving beyond the traditional, silo-production model of healthcare delivery toward a clinically integrated, disease-specific care delivery platform. As defined by the Federal Trade Commission in 1996 Statements of Antitrust Enforcement Policy in Health Care, clinical integration is “the implementation of an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.” The pilot strives to achieve clinical integration through continually evaluating and identifying clinical opportunities to align care across providers.

Lesson learned: Care integration requires rethinking the care delivery processes

Integration of care requires streamlining the delivery processes, to coordinate patient care services across people, functions, activities, and operational units – to maximize the value of services delivery.

Clinical integration is not an easy task. As the pilot participants came together, it was apparent that clinical processes were fragmented, redundant, and sometimes conflicting – creating challenges for patients, providers, and payer.

Previously, each organization spent a significant amount of time and resources developing internal processes to support their individual patient care needs. Few of these met the ACO’s requirement to support clinical integration. To address this issue, a CalPERS-specific, multi-organizational and multi-disciplinary team was assembled to establish a baseline of current processes and develop new, integrated, innovative care processes. This open dialogue revealed an appreciation of the reasons why each organization performed processes in their own specific way. But because the old processes often created additional work for the pilot participants, fragmented care delivery, duplicated functions, and confused the patients, it was obvious a new, integrated approach was needed.

As a result of these interactions, horizontal and vertical approaches were employed to streamline and integrate care transition, disease management, and case management. (“Horizontal” refers to the coordination of activities at the same stage of delivery; “vertical” refers to the coordination of care at different stages.)

These new clinical processes focused on eliminating duplication, increasing coordination across the continuum, opening new communication channels, and tracking ACO operational performance metrics.

An example of this is the inpatient concurrent review process that was originally performed by all three organizations. The inpatient concurrent review process is part of utilization management in which health care is reviewed by nurses as it is provided. The nurses monitor the appropriateness of the care, the setting, and the progress of discharge plans – all directed at keeping costs down while maintaining effectiveness of care. Originally, the hospital performed the inpatient concurrent review process, the IPA staffed onsite concurrent review to track the status of each patient and provided discharge planning feedback to the hospital; and, in turn, the payers set up inpatient concurrent review processes that required the IPA to report back on a daily basis the discharge status of each patient. The bottom line was three different but duplicate processes creating friction among the pilot participants because the front-line clinical staff thought
the other organization was looking over their shoulder and telling them how to perform their job and care for the patient.

Through the pilot, several changes were made to the process to remove duplication, leverage resources, and improve discharge planning. The inpatient concurrent review process was modified to eliminate the duplicate oversight, with the hospital performing the concurrent review process as part of its inpatient utilization management processes.

The role of the IPA's onsite concurrent reviewer was expanded to assist with removing discharge road blocks (e.g., outpatient authorizations), patient follow-up appointment scheduling, and referrals to IPA case management. In addition, the IPA put in place an elective surgery pre-discharge planning process and daily clinical huddles to review each inpatient and proactively remove barriers.

To support the new processes and demonstrate results, new operational metrics and information technology solutions were implemented and reviewed on a weekly basis among all invested clinical stakeholders and pilot participants.

Lesson learned: Comprehensive care transition is crucial

A comprehensive Transition in Care (TIC) program is needed to ensure the coordination and continuity of care as patients transfer between different locations or different levels of care within the same location.

A major area of focus was reducing readmissions through proactively identifying high-risk patients, and improving discharge planning and outpatient follow-up/medication reconciliation. A review of the readmission rate, ER admissions, and 30-day-inpatient-to-ER rate illustrated the need for an integrated and coordinated care transition program.

In response, a best practice TIC model was adopted, leveraging resources and capabilities from all pilot participants. The TIC incorporated inpatient and outpatient interventions, including elective surgery pre-discharge planning, integrated discharge planning, high-risk case management, electronic information sharing, and physician variability reporting. The new TIC processes ensure the continuity of the patient’s care through standardized tools and communication channels, including patient follow-up appointment scheduling, medication reconciliation, patient “welcome home” calls and teach-back processes. The teach-back process requires the patient (or their surrogates) to verbally “teach back” information about proposed treatments, services, and procedures they’ve received during the inpatient discharge planning process.

To support continuous process improvement, a group of clinical stakeholders met monthly to review readmissions and discharge delays. The goal was to identify the root cause of the events and to refine the TIC process.

Population management

Population management includes prevention, disease management, and case management and is ultimately driven by clinical integration. The pilot targeted and impacted these areas through new integrated care delivery processes.

Lesson learned: Create a standard ACO risk stratification process

The first step in creating a comprehensive population management solution is to define a standard risk-stratification process, to identify and mitigate the impact of at-risk populations with disease conditions. Before the pilot, three organizations (Blue Shield, Hill Physicians, and a Blue Shield disease management vendor) performed different risk stratification and predictive modeling processes, each using different data selection criteria, data, and systems. This caused each organization to identify different patients as being at highest risk. Inconsistent identification of high-risk members reduced the pilot participants’ ability to prevent repeat ER visits, admissions from ER, and inpatient re-admissions. It also left some high-risk members unidentified. An analysis of the top 1,000 high-risk members illustrated that between Blue Shield, Hill, and the DM vendor, there were significant differences in the methodology and results related to identification of high-risk members. This illustrated wide gaps in the completeness of risk stratification across the pilot participants.

New integrated risk stratification was implemented consolidating the three organizations’ risk scores, predictive costs, and enrollment status of members into one IT system and integrated process. The IT solution links the information to the Hill case management and disease management system, so case managers can now utilize common clinical information, risk scores, prospective/retrospective costs, and member care management information to target healthcare services to those members who will benefit most.

Lesson learned: Create an effective program for fragile, high-risk patients

ACOs need to create a comprehensive program focused on medically fragile and high-risk populations—a program that uses multiple outreach delivery channels and evidence based protocols.
An outcome of this new risk stratification process was the creation of a new case management program targeted at these patients with unique needs. When financially segmented, 10 percent of the patient population represents almost 70 percent of the total cost of healthcare for the defined population. Initially, Blue Shield, Hill Physicians, and Dignity Health had unique case management programs with different definitions of high-risk, different identification methods, and different entry and discharge criteria.

The team focused on developing a comprehensive program to provide end-to-end case management from outpatient services, inpatient services, and palliative care services for high-risk, medically fragile patients. The first step in developing the program was the development of standard cross-organization criteria to ensure consistent identification and selection of these patients. As patients were identified, new care-delivery processes were developed that included providing case management information to hospital case managers during acute care episodes, defining high-touch follow-up processes after an event, and implementing a physician home visit program.

**Lesson learned: Coordinate disease management programs across organizations**

Coordination of disease management programs across organizations is important to optimize resources and improve enrollment.

One challenge for the collaboration was multiple disease management programs and selection processes implemented by each organization. These programs were uncoordinated and targeted the same patient population, causing frustration for patients and the pilot participants. As part of the baseline process analysis, an integrated and coordinated referral process was implemented to maximize outreach efforts and standardize interventions as much as possible. The team used specific case-management outreach and focused on the top diseases, including chronic heart failure (CHF), coronary artery disease (CAD), diabetes, cancer, and hypertension, to increase overall enrollment.

For example, Blue Shield’s disease management vendor offered CHF disease management programs, Hill enrolled high-risk CHF patients into case management, and Dignity Health had another CHF disease management program. The teams evaluated the pros and cons of each program and developed enrollment standards based on the type of interventions and patient risk, to ensure each patient was enrolled in the best program for his or her individual care needs.

**Performance measurements**

A fundamental component of the ACO is the use of metrics to measure financial and quality performance. Ultimately, success will be measured by the ACO’s “triple aim” concept — health outcomes, patient experience and a cost/trend reduction. However, most potential ACOs do not yet have sufficiently complete data to produce a reasonable number of standardized, reliable, valid measures for comparison and benchmarking. Until meaningful, comparative performance reports are available, ACOs should first focus on measuring core capabilities critical to improving quality and reducing the cost of health care.

**Lesson learned: Performance metrics must be transparent**

Performance metrics must be transparent at all levels of the organizations to integrate accountability.

In the pilot, the organizations collectively developed and agreed to a set of macro- and micro-level metrics to mitigate future discussions of relevance. The goals of the metrics were to:

- Define the PMPM (financial) savings of a program, project, and specific service/procedures
- Validate that the implemented activities had a positive impact on the program (and see what drove the change)
- Understand trend deflections associated with specific services

Monthly macro-level financial and clinical performance metrics provide the Pilot Board with the current state of the ACO, allowing re-adjustment of strategies and resource allocations. Monthly micro-level metrics provide the ACO Core Team and its members with actionable clinical, utilization, and operational metrics to quickly identify trends. As a result of the reviews, the Pilot Board and the ACO Core Team identified areas of concern which were researched to identify the root-cause of the trends. As a response to the root cause trends, specific interventions were identified to continually modify or refine the day-to-day management of processes and resources.

**Lesson learned: The right financial and clinical benchmarks are required**

Industry-accepted and mutually agreed-upon financial and clinical benchmarks are required.

We discovered that each organization utilized its own internal and external benchmarking tools to identify
various outliers and areas of opportunity. As data is consolidated, standard ACO tools must be used to measure performance nationally and regionally. In the pilot, the ACO used industry-accepted benchmarks for the “well-managed” population in Sacramento to identify inpatient and outpatient outliers. Diagnosis-related groups (DRGs) outside the average length of stay (ALOS) or admissions per 1,000 for the well-managed population benchmarks were evaluated from multiple perspectives: physician outliers, hospital variations, clinical variations, technical advances, regulation changes, and member variations – to identify specific interventions for improving results. For example, since hysterectomies fell outside the ALOS and admissions per 1,000 benchmark, the team identified targeted interventions, including physician measurement, alternative care settings, conservation treatment options, and member shared decision-making services to reduce admissions and days – ultimately reducing costs.

Information technology

Information technology is a key enabler for the ACO – the ability to integrate systems and aggregate data across multiple organizations will lead to higher-quality, effective, and efficient patient care. To be successful, the ACO requires the ability to share clinical, financial, and administrative information across all pilot participants.

Lesson learned: Adoption of EHR with evidence-based protocols is important

The use of electronic health records (EHRs) is a critical factor in the success of an ACO. The EHR systems need to capture the necessary patient data, support care-related transactions, and provide the care team with clinical decision support based on evidence-based protocols. A challenge throughout the healthcare industry is the lack of adoption of EHRs by physicians and the lack of EHRs’ inter-operability. This challenge is exacerbated by the fact that these systems must provide the right information at the right time, in the right form, and be supported by an infrastructure that ensures privacy and security.

Lesson learned: Real-time data sharing is required to drive clinical integration

To address these challenges, the pilot participants created multiple channels for physicians and care providers to obtain clinical information – including an EHR system, physician portal, and a hospital portal. Underlying these solutions was the initiative by Hill and Dignity Health to implement an exchange of data between pilot participants to support the real-time sharing of information to both the inpatient and outpatient physicians and care providers, including real-time notification of ER visits, discharge summary to the primary care physician and case manager, and case management information to inpatient case managers.

Lesson learned: A standard data repository is needed

A standard data repository is necessary to allow for consistent and standardized clinical, utilization, and financial reporting. Data is the most important ACO technology asset, especially data that is turned into “actionable” information to support changes in population management and clinical processes. An IT infrastructure that tracks, monitors, and analyzes clinical, utilization, and financial data is fundamental to the development of an ACO. Currently, each organization maintains a separate data repository and unique business intelligence tools. Blue Shield is working on a long-term strategy to develop a comprehensive ACO data repository that will be available to all pilot participants. This solution is important as it provides a single source of information to support ongoing patient care, and financial, quality, and utilization measurements.

Physician engagement and measurement

Lesson learned: Engagement of the physician community is key to success

Physician engagement is essential in the development of an ACO. Physicians that can act as trusted change leaders need to be identified early and selected carefully. The pilot engaged physician leadership in various aspects, including care delivery redesign, clinical programs, and physician measurements. These leaders were involved in every aspect of the clinical initiatives, and ultimately educated the larger provider community on the changes. In specific instances, these physician leaders piloted new care delivery models (e.g., palliative care) to provide feedback on improvements.

Another function of physician leadership was their involvement with the design and review of physician performance reporting. This engagement ensured physician challenges to the results were reviewed and validated by their peers. As physicians who did not meet the care standards were identified, specialty chiefs delivered the message to those physicians requiring interventions for improvement. Peer-to-peer feedback was the key to effecting long-term change in practice patterns.
Conclusion

The ACO pilot achieved its objective by employing a unified approach to quality through integrating processes, quality metrics and data, clinical best practices, member outreach, and physician engagement. Supporting this model is a financial arrangement that ensures the health plan, medical group, and hospital system share in the savings. But the focus was on more than just savings; this unified approach to quality has resulted in improved patient outcomes through better coordination of care across the continuum.

The ACO pilot with CalPERS is still in place and continues to achieve results. It demonstrates that a new care delivery model can bend the healthcare trend with aggressive initiatives that take costs out of the care delivery system, rather than merely shifting costs within the system.

Working with top doctors and hospitals, Blue Shield has created several other ACOs throughout California, and will continue to seek opportunities for new collaborations in the years to come.