# Sample Scenario: Building an Accountable Care Organization

*The following scenario illustrates the kinds of issues candidates of the Master of Health Care Delivery Science program can prepare to address and lead to resolution. Information in this case considers the experiences of health care organizations and is intended to reflect issues many U.S. hospitals face.*

## The Opportunity:

- **The total cost of the U.S. health care system now consumes 17 percent of its gross domestic product**, a proportion significantly higher than that of any other developed nation and almost twice the median of these countries. In the U.S., hospital stays and physician charges account for two-thirds of health care spending.
- In addition to high cost, the **U.S. health care system suffers from quality lapses and wide variation in access**.[i]
- The **Accountable Care Organization** (ACO) model has emerged as a leading proposal for addressing these three problems of cost, quality, and access.[ii]

The ACO model, which began as a theoretical construct in discussions between The Dartmouth Institute (TDI) and the Brookings Institution, now has five pilot sites across the U.S. and legislative and financial support in the Health Care and Education Reconciliation Act of 2010. As of January 1, 2012, the Centers for Medicare & Medicaid Services (CMS) has been authorized to experiment with payment reform, focusing on institutions that (1) are willing to be accountable for the quality of care and cost of services for the Medicare beneficiaries assigned, (2) have a defined process to promote evidence-based medicine, (3) can report on quality and cost metrics, and (4) have in place a formal legal structure to distribute savings.[iii] Of course, the presupposition in this model is that health care institutions have the capability to deliver high quality at lower cost so there are savings to be shared.

The following describes the initiatives of a 600-bed, tertiary-care urban hospital seeking to align its organizational and payment structures to optimize the outcomes of its patient population while reducing operational inefficiencies and waste. Responding to recent health care reform legislation, the hospital embarked on development of an ACO.

## Analyzing the Issue:

The hospital's senior leadership identified several clinical and administrative leaders to spearhead an evaluation and planning process to initiate an ACO. Over a four-month period, the team conducted a preliminary assessment that entailed data analysis, best-practice research, discussions with key stakeholders, and design of an initial implementation strategy.

*Data Analysis:* Using the hospital's in-house data, the team identified wide variation of treatment patterns among providers in a range of diagnoses and services, including heart disease, orthopedic procedures, cancer treatments, and end-of-life care. This research also uncovered evidence of duplication of tests and paperwork, unclear or poorly communicated treatment plans, and patient safety concerns associated with discontinuous care. The team's findings suggested a number of opportunities to improve how their health care operations are structured.

*Best-Practice Research:* The team studied ACO demonstration projects to identify potential strategies appropriate to the hospital's environment. It also researched supportive models and programs, such as patient-centered medical home pilots and health-IT meaningful use payments.

*Stakeholder Assessment:* The team began conversations with commercial and public payers to determine respective interests. Team members discussed infrastructure required to develop alternative payment methodologies and frameworks for collaboration. In addition, the team identified key physician and executive leaders across the care continuum to engage in the process.

*Implementation Strategy:* After the team completed the initial evaluation, it developed a roadmap to guide the hospital's effort. This strategy included

- primary goals, major initiatives, a timeline, and key milestones for the project;
- creation of work groups to focus on key areas of the implementation, such as development of clinical/performance metrics, identification of the appropriate service area, data exchange, and communications;
- a strategy for engagement with clinical and administrative leaders in the regional health system, followed by collaboration with commercial and public payers.

## Action Plan:

With input and support from the hospital's executive leadership, the team began implementation of the strategy. Over the next 12 months, the team engaged senior clinical and administrative leadership, established dedicated work groups, held a series of educational sessions, worked with the state's largest employers, and furthered discussions with payers. During this period, they initiated

- an appraisal of the population of patients to be served;
- a process to identify the appropriate service area and network required to provide quality care for the resident population;
- a business-case analysis to quantify the likely costs, benefits, and trade-offs of various approaches;
- planning sessions with the state's two largest employers to define interests and outline a strategy for negotiations with insurance companies;
- pilot efforts to reorient care delivery away from clinical programs defined by academic medical specialties toward multidisciplinary clinical programs organized around patient health conditions;
- assessment of the hospital's and community's existing health information technology capabilities and the requirements necessary to enable information sharing and proactive patient management;
- adjustment of the strategic planning and annual budget process to help guide the organization while it is undergoing significant change;
- development of methods and metrics to assess patient outcomes and monitor the health status of the local community, including the cost of the care provided to patients;
- creation of an integrated physician network to coordinate patient care between primary care and specialty physicians across inpatient and outpatient settings.

## Challenges:

Establishing an ACO is a considerable undertaking. Its aims and requirements fundamentally challenge the fee-for-service structure and culture within which the majority of health care organizations operate.

In crafting the hospital's strategy for implementation, team leaders encountered divergent priorities and incentives among partnering entities, resistance among providers and administrators, varying degrees of data quality, and competing demands for resources. These challenges prompted the team to evolve its approach and focus considerable attention on

- making the benefits to the patient experience a focal point of discussions;
- engaging physician and administrative leadership across the care continuum;
- crafting and articulating a clear, compelling, and consistent message of the project's goals;
- where possible, aligning efforts with existing strategic objectives, including recent patient-centered medical home initiatives, regulatory compliance, and quality improvement programs;
- enlisting expertise in metric creation and strengthening data collection efforts.

Combined with the visible support of and regular communications with the hospital's executives, the team's data-driven approach, leadership, and change management skills enabled it to adapt effectively and move the project forward.

## Results:

Twelve months into the implementation plan, the institution was seeing progress.

- The hospital had completed a series of models to capture variation in care delivery patterns among its providers and established processes to learn from that data. Changes were under way to link cost information to the decision-making apparatus and better track the financial impact of changes in care delivery.
- Discussions with the state's top employers produced a unified approach on key areas of negotiation with payers.
- The hospital and the region's largest payer agreed on an alternative reimbursement methodology to support transition to a population- and outcomes-based payment model.
- The hospital's leadership has engaged in system-wide discussions to ensure easy access and a continuum of care for the multicounty service area. Leadership envisions a confederation of primary care networks, critical access hospitals, and visiting nurses at one end of the care spectrum and skilled nursing homes and hospice care facilities at the other end. Discussions are under way to develop these relationships.
- The metrics work group developed an initial measure set to gauge clinical outcomes.

## Next Steps:

As the provider network begins to coalesce, the team envisions several steps needed to actualize the ACO vision, including the following:

- Creation of a data analysis capability to document verifiable, nationally recognized quality and cost metrics across the network;
- A more robust health information technology infrastructure, with capabilities of linking patient demographic, clinical, and financial information across multiple care delivery sites;
- Continued collaboration with the state's largest employers;

- Further discussions with payers about the opportunity for a shared savings model while the system rightsizes its care network around the population's needs;
- Establishment of a formal legal structure and process for measuring the financial impact of changes in the delivery of care and distributing the savings.

## Additional Benefits:

The team forged important new pathways for communications across the institutions involved and with external constituencies in the care delivery continuum. Further, the project was able to achieve early successes with quality and cost outcomes, which underscored the importance of patient care decision making based on rigorous evaluation of comparative data. The team plans to build on this experience to highlight essentials of an adaptive learning organization and extend that experience into the budget and strategic planning processes of the institution and the related ACO network.

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[i] Berwick, D.M., T.W. Nolan, J. Whittington. The Triple Aim: Care, Health, and Cost. *Health Affairs*. 2008;27(3):759–69.

[ii] Crosson, F.J., L.A. Tollen (eds). *Partners in Health: How Physicians and Hospitals Can Be Accountable Together*. San Francisco: Jossey-Bass, 2010.

[iii] Hastings, D.A. The Timeline for Accountable Care: The Rollout of the Payment and Delivery Reform Provisions in the Patient Protection and Affordable Care Act and the Implications for Accountable Care Organizations. *BNA's Health Law Reporter*. 25 March 2010. http://www.ebglaw.com/files/38833_BNA%20Article%20-%20The%20Timeline%20for%20Accountable%20Care%20(3-25-10).pdf Accessed October 29, 2010.