Toward Accountable Care Consortium

North Carolina Foundation for Advanced Health Programs

ACCOUNTABLE CARE GUIDE FOR COMMUNITY HEALTH PARTNERS

Preparing Community Health Partners for the Approaching Accountable Care Era

The Physicians Foundation
Empowering Physicians Improving Healthcare

Smith Anderson

North Carolina Medical Society
Leadership in Medicine

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County / Regional Medical Societies

Cleveland County Medical Society

Craven-Pamlico-Jones County Medical Society

Durham-Orange County Medical Society

Mecklenburg County Medical Society

Forsyth-Stokes-Davie County Medical Society

New Hanover-Pender County Medical Society

Pitt County Medical Society

Rutherford County Medical Society

Western Carolina Medical Society

Wake County Medical Society

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Specialty Societies

Carolinas Chapter, American Association of Clinical Endocrinology
North Carolina Academy of Family Physicians
North Carolina Chapter of the American College of Physicians
North Carolina College of Emergency Physicians
North Carolina Council on Child and Adolescent Psychiatry
North Carolina Dermatology Association
North Carolina Neurological Society
North Carolina Obstetrical and Gynecological Society
North Carolina Orthopaedic Association
North Carolina Pediatric Society
North Carolina Psychiatric Association
North Carolina Radiologic Society
North Carolina Society of Anesthesiologists
North Carolina Soc. of Asthma, Allergy & Clinical Immunology
North Carolina Society of Eye Physicians and Surgeons
North Carolina Society of Gastroenterology
North Carolina Society of Otolaryngology – Head and Neck Surgery
North Carolina Oncology Association
North Carolina Society of Pathologists
North Carolina Society of Plastic Surgeons
North Carolina Spine Society
North Carolina Urological Association

State Societies / Organizations

Community Care of North Carolina
Carolinas Center for Hospice and End of Life Care
North Carolina Academy of Physician Assistants
North Carolina Association of Local Health Directors
North Carolina Community Health Center Association
North Carolina Foundation for Advanced Health Programs
North Carolina Healthcare Quality Alliance
North Carolina Medical Group Managers
North Carolina Medical Society

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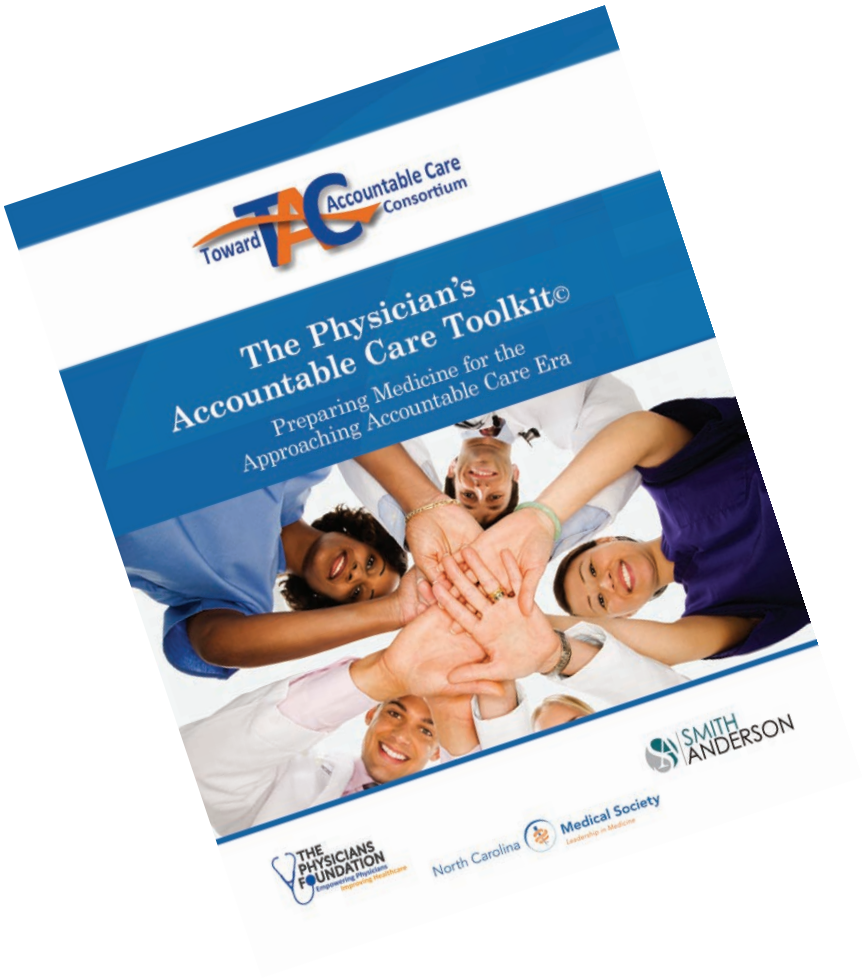
I. Introduction

A. Purpose of this Guide

The Physician's Accountable Care Toolkit© mentions physicians in its title and describes what it takes to create a successful ACO for every health care stakeholder, including community health partners. Because it is fundamental that an ACO be a win/win for all involved, it applies whether one is a primary care physician, specialist physician, hospital administrator, YMCA director or pastor. This *Accountable Care Guide for Community Health Partners*, on the other hand, spells out specific strategies for community health partners whether in a small town or large city. This guide is equally directed to community health leaders and the medical communities, as the most powerful ACO opportunities involve collaboration between the two. A basic understanding of ACO principles is necessary to fashion any successful ACO and being able to seize the advantages of wide use of community health resources.



B. Recap of The Physician's Accountable Care Toolkit©

1. What Is an ACO? – Former Administrator of the Centers for Medicare and Medicaid Services ("CMS") Mark McClellan, M.D., Ph.D. described an ACO as follows: "ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients." [1] Similarly, the National Committee for Quality Assurance ("NCQA") included the following definition in its draft ACO criteria: "Accountable Care Organizations (ACOs) are provider-based organizations that take responsibility for meeting the healthcare needs of a defined population with the goal of simultaneously improving health, improving patient experiences, and reducing per capita costs, … [T]here is emerging consensus that ACOs must include a group of physicians with a strong primary care base and sufficient other specialties to support the care needs of a defined population of patients. A well-run ACO should align the clinical and financial incentives of its providers…. ACOs also will need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance and organize providers around shared goals." [2] As this paper details, ACO experts state that advanced ACOs and all Medicaid ACOs need to include community health partners.

2. This is Big, Different and Inevitable – If we stay on the current spending glide path, by 2035 health care costs in this country will be more than the total of all tax and other revenues collected in our country, and by 2080 taxpayer funded health care will equal all of our governmental revenues, meaning that everything else—defense, roads, education—must be funded by borrowing. The other options simply are unthinkable: tax increases, rationing care, or drastic reimbursement cuts. As a country, our health care costs are more than 50 percent more than in any other country, but we now are ranked 32nd in what we get for our investment. The Congressional Budget Office laid the groundwork for accountable care's "pay-for-value" underpinning when it reported that much of the blame for our runaway health care costs should be placed on our fee-for-service payment system where "providers have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists."

Besides fragmentation, duplication and "more is better" excess, there are significant unjustified variations in quality and costs of care for similar patient populations. Yet, when motivated providers collaborate to drive the highest quality outcomes and the lowest costs, they do. Wonderful things happen—the patient is happier, employers finally see a slackening of spiraling health care costs, physicians regain

[1] Mark McClellan, Director of the Engleberg Center for Health Care Reform at the Brookings Institution, *A National Strategy to Put Accountable Care Into Practice*, Health Affairs (May 2010), p. 983.

[2] National Committee for Quality Assurance, Accountable Care Organization (ACO) Draft 2011 Criteria, p. 3.

control of the physician-patient relationship and there is "found money" in savings from squeezing out waste to reward them for their efforts. Non-profit community health organizations get rewarded financially for their contributions to health and savings, solving funding problems.

Yes, reversing the way health care is paid for is big, and will require significant change. But, physician-led accountable care is the best way to fix health care and provide physicians financial and professional reward.

C. What Are the Essential Elements of a Successful ACO?

There are eight essential elements of any successful ACO. All eight are required. You cannot skip a step. **As early ACO success and failure reports confirm, by far, the most important element for ACO success is the creation of an interdependent culture of mutual accountability committed to higher quality at the lowest cost.**

1. Culture – Full collaboration and true partnering among hospitals, physicians, providers and community health resources will drive success. This must be coupled with buy-in to change habits to work in teams to drive value with a "win/win" population management philosophy. This is way, way out of physicians' hospital administrators' and community health's comfort zones. Physicians love independence, autonomy and often just want to see patients. Administrators have so far succeeded through strong leadership direction and infrastructure control. Community health resources are

unaccustomed to integrated care resting upon a technology platform. **"The most significant challenge of becoming accountable is not forming an organization, it is in forging one."** [3] Culture keys are: champions, governance and merit-incentives..

2. Primary Care Physicians – When reviewing Element 6 below, the core role of primary care becomes clear. Prevention, wellness, care transition and patient coordination management are the "low-hanging fruit" for ACO improvements, and savings and are all in primary care's sweet spot. Primary care is the only sub-specialty required in Medicare's ACO program. Sophisticated ACOs will thrive with hospitals, specialists and community health partners, but primary care, at least one-third of the total membership, always will be at the core.

3. Adequate Administrative Capabilities – ACO structural, operational and legal considerations are essential, but are relatively straightforward. Developing the interdependent culture and commitment to clinical transformation across the full continuum of care are more elusive and should receive most of the ACO leadership's attention. Ironically, because they are objective, readily measurable, and more familiar, structural, operational, legal and HIT issues often consume the bulk of planning time, leaving the subjective and "invisible" culture and care transformation issues behind.

4. Adequate Financial Incentives – "[I]f incentives are correctly aligned, organic innovations to solve other problems can and will engage…. Anticipated early versions of ACO payment incentives are likely to be directionally correct but unlikely to be sufficient to create the needed burning platform."[4] One rule of thumb may be found in antitrust law, where the behavior changing tipping point in health care is considered to be roughly 20 percent of total compensation. Fifty percent savings for ACOs not taking downside financial risk is a fairly common measure and viewed by most as adequate.

5. Health Information Technology and Data – Every successful ACO will run on a sound technology platform with meaningful, actionable data at the point of care, transferable across the continuum, and available in aggregate form to prioritize ACO initiatives, measure performance, and report to payers and health care regulators. In contrast to fee-for-service with its demands of physician time and lack of incentives to log and study data, ACO physicians clamor for such information. These HIT and data capabilities need not be prohibitively expensive nor mandate linking EMRs. Sometimes a "Chevy" will get you where you need to go just about as well as a "Cadillac."

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[3] Phillip L. Rowing, *Becoming Accountable*, HFMP Compendium Contemplating the ACO Opportunity, Appendix, p. 40 (Nov. 2010).

[4] Ann Robinow, Accountable Care News, *The Top 30 Obstacles to ACO Implementation*, (Dec. 2010).

6. Best Practices Across the Continuum of Care – The five identified high-impact target areas for ACO initiatives are:

- Prevention and wellness;
- Chronic disease (75 percent of all U.S. health care spending, much of it preventable);
- Reduced hospitalizations;
- Care transitions (across our fragmented system); and
- Multispecialty care coordination of complex patients.

"The best bet for achieving returns from integration is to prioritize initiatives specifically targeting waste and inefficiency caused by fragmentation in today's delivery system, unnecessary spending relating to substandard clinical coordination, aggravated with the complexity of navigating episodes of care, and unwanted variations in clinical outcomes driven by lack of adherence to best clinical practice." [5]

7. Patient Engagement – How can your compensation be based on outcomes when the patient is not "in the game?" Patient engagement and patient-centeredness are essentials to ACO success for this reason. The patient who has not self-referred to your office but should, is more important to population health management than the one who has. Two simple strategies often seen in successful ACOs are longer face-to-face initial visits with patients/families employing true communication skills and nurse coordinators who follow up with patients after they leave the facility or office. Technology is extending the virtual reach of these physicians and coordinators and are proving their "ROI," or return on investment, in the value-based payment era.

8. Scale-Sufficient Patient Population – There are certain front-end investments and ongoing fixed costs requiring a minimum scale of patient population to succeed. Medicare's ACO minimum threshold of 5,000 beneficiaries is a useful benchmark.

D. These Apply to Everyone

Because a successful ACO must be "win/win," with all stakeholders motivated to achieve their optimum value-added contributions to the enterprise, these principles transcend medical specialty, employment status, payer relationship or facility type. They apply to you whether you are a primary care physician, hospital CEO, community nonprofit or specialist physician. They are not mysterious; they are doable; culture dominates. It is the goal of *The Physician's Accountable Care Toolkit*© to serve as a roadmap for all readers to be able to unlock ACO success for their patients, themselves and their ACOs.

[5] *Toward Accountable Care*, The Advisory Board Company (2010).

II. Could Accountable Care Be A Good Thing For Community Health Partners?

In *The Physician's Accountable Care Toolkit*©, we learned what an ACO is, that it will not be going away and how to know if one stands to be successful. But what, specifically, will this mean for community health partners?

We recognize that there are various models for community health partners. As a result, the recommendations that follow may not be applicable to all organizations. The recommendations are merely a starting point and reflect strategies that may be modified and adapted based on variables such as geographic location, provider team make-up and breadth of service offerings.

A. Pros

- Many community health care providers will find that the greatest positives of a well-organized ACO, such as improved communication and coordination of care among providers on behalf of and with patients, are already components of community health partner models.

- As with all providers who have been heroically battling a deeply fragmented system to provide cost-effective care, community health partners will find rewarding a model designed to truly gauge and value their contributions to health care, show respect for what they have been attempting to do and validate why they chose health care as a profession.

- Although change has risk, the risk of doing nothing is higher.

- A Compelling Case for Community Health Involvement – Community health entities are in a preferred position to impact the significant and largely avoidable chronic care costs in this country, to demonstrate "value" and thus be belatedly recognized and rewarded for their contributions.

    - Avoidable Costs – Preventing disease and promoting health target chronic disease. Physical inactivity, tobacco use and poor nutrition are the leading causes of chronic disease. The five most costly and preventable chronic conditions cost nearly $340-billion in 2010, 30 percent of total health spending. [6] The Milken Institute study predicted that investment in treatment and prevention of the most common chronic diseases could reduce health care costs by $218-billion per year and overall economic losses by $1.1-trillion. [7]

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[6] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey—Table of Total Expenses*, (2010).

[7] Milkin Institute, *An Unhealthy America: Economic Burden of Chronic Disease*, (2007).

- Community Health Programs Create Value – The Robert Wood Johnson Foundation reports that every dollar invested in community-based public health programs would return $5.60 in savings.[8] The profile of Medicaid beneficiaries makes them particularly good candidates for public health intervention and experience the largest gains in health status and savings.[9] ACO authority Harold D. Miller finds that inclusion of "public health and social services" are found in the most highly-developed and successful ACOs and recommends that all ACOs work to achieve this state.[10]

- Potential to Solve Funding Problems – The premise of performance-based reimbursement is to incentivize those who contribute to better health and lower costs. Community health organizations stand to generate substantial measured value and thus receive shared savings or other performance bonuses in proportion to those contributions. This suggests an annual funding stream to support and sustain these important organizations.

- The Core of the ACO's Mission: Population Health Management – As Dennis Weaver, M.D. commented, "At its most basic, population health management means actively working to keep your community healthy. When you think about it that way, it makes you wonder, 'Who or what is influencing the health of individuals in my community the most?' To date, population health strategy has focused mainly on the role health care providers themselves play as the main influencers of health outcomes. And health care providers are certainly important. But the reality is that we are not the only ones influencing the health status of the people we serve. … [Health] systems will need to engage with organizations that impact the health determinants in your community and influence individuals' behavior when they're between provider visits." [11]

- The sheer magnitude of avoidable costs coupled with the impact that would flow from the development of a community ACO strategy signal tremendous opportunity. We should have a sense of urgency to develop these solutions, given the rapidity of change.

- "Despite abundant evidence of certain clinical preventive services, many patients do not receive them. The reasons are numerous, including competing demands and limited reimbursement in primary care. A promising approach to enhancing the delivery of preventive services is for clinicians to coordinate, cooperate, and collaborate with external nonclinical organizations, such as local health departments and community-based organizations."[12]

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[8] http://healthyamericans.org/reports/prevention8.pdf.

[9] http://works.bepress.com/glen_mays/119/.

[10] Miller, Harold D., *How to Create Accountable Care Organizations*, p. 19, www.CHQPR.org, (Sept. 7, 2009).

[11] Weaver, M.D., D., *Who Really Influences a Population's Health? (Hint: It's Not Just Providers)*, The Advisory Board Company, Care Transformation Center Blog, http://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2014/07/sw-what-really-influences-population-health, (July 30, 2014).

[12] Agency for Healthcare Research and Quality, *Clinical Community Relationships Evaluation Roadmap*, v. (July 2013).

- **You Have a Seat at the Table. Take it!** There is a seat at the ACO table reserved for you, but they are not going to invite you to it - you must step forward and take it. Then show the ACO why it will be more successful by including you.

  - Medicare. The Medicare Shared Savings Program (MSSP) regulations state that, "In its plan to address the needs of its population, the ACO must describe how it intends to partner with community stakeholders to improve the health of its population."[13] The actual MSSP application requires a narrative describing "how your ACO partners with community stakeholders."[14] The Center for Medicare and Medicaid Services ("CMS") goes further in the commentary to the regulations in stating that, "a process for integrating community resources into the ACO is an important part of patient-centeredness" and specifically encourages that community health partners be on the governing body of an ACO by stating, "[w]e will finalize our proposal that ACOs describe how they will partner with community stakeholders as part of their application. ACOs that have stakeholder organizations serving on their governing body will be deemed to have satisfied this requirement." [15]

  - Medicaid. Medicaid programs around the country are moving to the ACO model. The strengths of community health partners match the needs of the Medicaid patient populations better than for most other populations (i.e., limited access to medical sites; gaps in health remedied best by community change, socio-economic factors, environmental issues, a population more disengaged from the medical system, and communication gaps.) The core role of community health partners in Medicaid ACOs, combined with the widespread emergence of Medicaid ACO programs, could be a real "game changer" for bringing community health resources into ACOs.

    The Center for Healthcare Strategies and the Nicholas Foundation published The New Jersey Medicaid Accountable Care Organization Business Planning Toolkit. Regarding the role of community partners, it states, "Establishing partnerships with stakeholders is an essential part of building a Medicaid ACO…ACO stakeholders can be categorized into three groups: (1) health care stakeholder; (2) community organization; and (3) other stakeholders (including consumer representation)…It is important that ACOs identify and collaborate with these key stakeholder groups, as each has an important role to play to enhance the ACOs ability to improve health care delivery in the community." The Toolkit specifically recommends that, "The ACO has a written community engagement plan. Community representatives are

[13] 42 CFR 425.112(b)(2)(iii)(A)

[14] Medicare Shared Savings Program 2015 Application, Sec. 11, Question 38.a/

[15] 76 Fed. Reg. 6789-67830 (November 2, 2011)

fully integrated into the ACO and have roles on the community advisory board. The board of directors has an active community stakeholder presence with some in a leadership role. Informal and formal mechanisms are in place, and the ACO has established processes that will help residents gain access to care and encourage active participation in their own health care plans." [16]

B. Cons

- Community health resources are working very hard and have run out of spare intellectual bandwidth to power these changes..

- You have seen this "next big thing" before and it didn't work out as advertised.

- Many of the needed health improvements—better diet, exercise, emotional support, etc.—often are difficult to achieve, take years to show savings, are difficult to measure and are hard to attribute.

- The interactions to create a linkage of clinician, patient and community resources are inherently complex. Further, these must all function in the broader socio-economic contexts, which differ by community.

- Community health tends to offer the most benefit to populations that may be uninsured, thus without an ACO payer opportunity.

III. The Recommended Approach For Developing Specialist Accountable Care Strategies

In the value-based reimbursement era, each type of medical or community care provider is rethinking its role. Some of the questions confronting each type of health care provider are: **What is our maximum value-adding contribution across an entire patient population? How can we generate quality and savings improvements for the ACO and thus maximize performance rewards for our specialty?** This rethinking is perhaps most dramatic regarding savings. The gain will not be from seeing a patient cheaper or quicker, but how to reduce costs for a patient population over a given period of time, often one to three years. Quality metrics exist to measure the quality of care rendered by one provider to one patient. But it is as fundamental as it is radically different, that accountable care strategic developments for any type of health care provider focus on excising avoidable waste across

[16] Center for Healthcare Strategies, Inc., The New Jersey Medicaid Accountable Care Organization Business Planning Toolkit, pp. 21-22 (June, 2013)

the continuum of care for the entire patient population. New coordination transition, education and engagement metrics will need to be developed and properly weighted by peer clinicians.

A hint of what any type of health care provider should prioritize is given by this list of the top five high-yield targets for ACOs:

- Wellness/prevention
- Chronic care management
- Reduced hospitalizations
- Care transitions
- Multi-specialty coordination of complex patients

***Particularly appropriate for community health partners**

From these potential initiatives, prioritize the ones that are likely to have the quickest and biggest results, proven metrics and community health care leaders willing to champion the effort. What is working elsewhere? This should reveal for any type of health care provider its potential prioritized list of value-add ACO initiatives.

Once this list is in hand, the last step is to marry them in a particular locale through a gap analysis to the areas of avoidable waste in that region. A health care provider can then make a compelling case that an area of the patient population's greatest need is matched with that health care provider's greatest strengths.

Any type of health care provider also can benefit from ACO negotiation and marketing tips, knowledge of how to ensure fair savings pool distribution, and what clinically valid metrics should be used to accurately measure their performance.

Ideally, this process should be led by a well-respected and diverse peer "accountable care workgroup" of a national or state professional society of that category of health care provider.

IV. The Process Followed For Creation Of This Accountable Care Guide For Community Health Partners

A. Process

- Potential initiatives underwent review by the Community Health Partners Accountable Care Workgroup, with the TAC Consortium and Initiative support team directed to perform more in-depth analysis of select possible target areas. These findings were further reviewed and revised by the Community Health Partners Accountable Care Workgroup and presented to the TAC Consortium and Initiative Physician Advisory Committee.

- Macro predictive cost savings estimates were made, but a refined financial predictive modeling analysis, though needed, is beyond the scope of this project. Likewise, while guidance on the nature and type of performance metric selection is provided, the actual full mapping of those metrics is beyond the scope of this project.

- The researchers and community health resource peer reviewers are comfortable that this represents a useful start in this important and rapidly evolving field. This Guide is a beginning, not an end, to the process.

B. Important Caveats

ACO Initiatives Necessarily a Sub-set of the Benefits of Community Health.

- Focus on ACO – type gains, not all possibilities. While acknowledging that the factors that have the greatest impact on health are outside of the medical system, an ACO strategy should not (initially) focus primarily on the main benefit of community health resources-preventing injury and illness in the first place by involving community environments. Community health partners are not yet routinely included in ACOs. At the beginning you need quick, measurable results, with the highest impact at the lowest cost. Many environmental and societal changes driven by community health care will have huge impacts, but for now they take too long, are hard to measure and are too dependent on outside variables (schools, government jobs).

- ACOs are starting to concentrate on the 10 percent of patients driving 70 percent of the costs. You should, too. The percentage of admissions and Emergency Department visits are coming from a very narrow group of patients who should be targeted. They tend to be overwhelmed, lack support mechanisms, lack transportation and need attention in their environment. This is a tremendous

opportunity for community health partners. Given the prioritized attention given to this targeted group by ACOs, this is also a great entry point to show value as a partner with an ACO.

- 2014 – 2015 Document. It currently is extremely difficult for the various "silos" in the medical field to coordinate, and almost unknown for community resources to be integrated. Strategies in this Guide address what is feasible in the next few years. Hopefully the benefits from fuller engagement will be allowed to take place down the road.

- Community health must be a part of a medical ACO. Once the benefits are appreciated, there is almost always an inevitable discussion around a community health-only ACO model. However, value-based care financial targets for a patient population will be assigned to the medical community, because that's where they arise. The historic costs for the patient populations are usually tied to the physicians who provide the majority of primary care for those patients. That said, there is every reason that community health partners should be viewed as essential to the success of an ACO as is primary care medicine. There also is every reason that community health partners should be the organizers of an ACO.

- This *Guide* is for physicians and administrators and community health partners. This *Guide* is intended not only to illuminate community health resources on opportunities in accountable care, but also the medical community on the benefits to them of strategic partnering in the new payment environment. "Working with partners outside the medical sector, through meaningful, ongoing relationships that go beyond resource referral will be central to the CCHH's (Community-Centered Health Home's) ability to participate in community-level change." [17]

V. Recommended Accountable Care Initiatives For Community Health Partners Providers

A. Awareness/Leadership/Urgency: Community Health Partners' Role in Guiding Change

Community health partners need to know what an ACO is, how to recognize one with a likelihood of success, and the professional opportunities and risks involved (the purposes of this *Accountable Care Guide for Community Health Partners*). A number of leaders need to get up to speed and be catalysts for this transformative change. These champions need to act with confidence, but also with a sense of urgency. This is mentioned as a strategy in and of itself because the biggest risk of failure of the accountable care movement and either collapse of Medicare and Medicaid or default to Draconian

[17] Cantor, J., Prevention Institute, Community Centered health Homes, p. 12 (Feb. 2011)

alternatives is lack of informed provider leadership. If you do not become involved, there is a good chance that the roles of community health partners will be missed and, like some early ACOs, you will not be involved at all in the shared savings pool distribution. Every successful ACO starts with a few champions. Why not have one be a community health partner? As Bert Coffer, M.D., said: "If you don't have a seat at the table, you are on the menu."

B. Before an ACO Develops New Resources, Look at What Community Resources Are Available

This is a two-sided strategy. First, the ACO needs to know what it needs. The strategies recommended in this Section V can help them see how continuing basic ACO strategies across the continuum to include community resources can be quite effective. Second, the community resources must be inventoried and linked to the ACO in time to prevent overlap and duplication. "To build and improve linkages across private and public health organizations within communities, it is important to identify gaps in needed health services and to fill those gaps by using the strengths and abilities of participating organizations." [18] Community Health Assessments are useful starting points to determine gaps in care. Given the historic fragmentation in health care, this obvious solution will probably prove difficult until pilots show how it can be done and accountable care's "we" incentives become more pronounced. There will be instant savings through avoided duplication and shared savings gains through improved population health.

C. Implement a "Facilitated Consumerism" Strategy

Health care consumerism is considered to be the process of engaging patient populations with information and incentives to change behaviors and improve health care purchasing decisions, regardless of health plan design.[19] As part of the consumerism megatrend in our society, it is predicted that health care information and incentives will overtake paternalism and control as the main instruments of health policy. Payers (and self-funded or insured employers) are employing focused attention to encourage enrollees regardless of their disease status to influence lifestyle choices outside of the traditional medical system. This "facilitated consumerism" can be an opportunity to encourage individuals to access community health resources within an ACO. Individuals need not only know what community resources are available, but need to be incentivized, be offered choices, and have transparent information on costs, benefits and access. The health and wellness options cannot be overly burdensome. A core premise of consumerism is that the more a consumer shares in the costs, the more they will seek ways to minimize health care spending, including by improving their health.

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[18] Buncombe Co. Health Dept., *Local Public Health Potential Role with ACOs & Research on Clinical Community Connections*, p. 2, (March 2014).

[19] Bachmarm, R., *Making Health Care Consumerism Work in 2013 and Beyond*, The Institute for Healthcare Consumerism, http://www.theihcc.com/en/commnities/health_care_consumerism/making-health-care-consmerism-work-in-2013-and-be-hg3u4986.html (2012).

An ACO facilitated consumerism strategy could provide patient population information regarding available community health partner resources, transparent information, and various incentives to motivate their use to promote health, wellness and safety. Providers, including particularly patient navigators in the ACO, should be aware of the resources and the community health partner linkage plan.

D. Community-Based Prevention – Health Care Not Sick Care

The goal is to improve community health and avoid patients having to access clinical care altogether or at least the high-cost complex and acute care elements. These involve deep societal and educational determinants—ranging from having healthy foods accessible, having access to physical exercise, providing family support, providing transportation to building character. The prevention efforts should be basic initially, such as a single initiative like blood pressure. It possibly should proceed in tiers: Tier 1 – diet and exercise; Tier 2 – self-screening and managing chronic disease. "The U.S. Administration for Community Living has supported the translation of Stanford University's Chronic Disease Self-Management Program to over 140,000 participants through community-based organizations." [20]

While we think of community health resources as creating a healthier environment or more self-aware citizens, they also can extend the reach of medical care and screening:

"Based on input from the expert panel, these services could potentially be provided in non-clinical settings and are candidates for delivery through a clinical-community relationship:

- Alcohol misuse screening and counseling;
- Breastfeeding counseling;
- Healthy diet counseling for adults with known risk factors for cardiovascular and diet-related chronic disease;
- Obesity screening and counseling for children;
- Tobacco use counseling and interventions for non-pregnant adults; and
- Tobacco use counseling for obesity.

In addition, the literature review specifically assessed evidence on counseling to promote physical activity as an aspect of screening and counseling for obesity." [21]

[20] *Id.*, p. 3.

[21] Agency for Healthcare Research and Quality, *Clinical-Community Relationships Evaluation Roadmap*, Appendix B.1, (July 2013).

Similarly, as mentioned, ACOs are targeting the 10 percent of patients who drive 70 percent of the costs and are becoming aware of just how much of their ability to affect improvement lies outside of the medical system. These patients often are overwhelmed, lack a support system, lack transportation, and lack self-management skills. This offers up a major value-add core for community health in an area of high priority for ACOs. This could serve as a good entry point to an ACO.

Specific examples of community partnerships:

- An urban ACO serving a large city works with a local public health authority to identify geographic pockets of patients with diabetes. The ACO focuses on improved diabetes management in the clinical setting while linking to community resources for patients requesting exercise and physical activity options. Public health can lead a campaign to improve access to fresh fruits and vegetables and change policies related to menu labeling.

- An ACO serving a number of suburban communities identifies high use of the emergency department from alcohol-related issues in young adults as a focus for improvement. Working with the public health authority, local schools and substance abuse agencies, the collaboration creates a safe rides program and develops policies to monitor underage liquor sales.

- An ACO serving a large rural population has trouble providing enough access to elders for immunizations. Using evidence-based best practices, communitywide access to immunizations is provided by working with the public health authority and local pharmacies. Communication strategies that link pharmacies and public health to the ACO are developed, along with an immunization registry for public health population level surveillance. The financial "return on investment" or ROI to the ACO is positive because of the prevention benefits relative to increased immunizations and coordination costs. Though shared savings distribution policies of this ACO are not known, under the merit-based approach we recommend, the community resources involved should receive distributions in proportion to their savings contributions.

  - *Achieving Population Health in Accountable Care Organizations* by Karen Hacker, MD, MPH, Deborah Klein Walker, EdD, American Journal of Public Health, 2013; 103(7):1 163-1167. [22]

- In Buncombe County, North Carolina, a joint Community Health Assessment/Community Health Need Assessment has driven the development of a community health improvement plan based on the priorities that came from the assessment. A Collective Impact approach

[22] Buncombe Co. Health Dept., *Local Public Health Potential Role with ACOs and Research on Clinical Community Relations*, p. 3, (March 2014)

influenced the process as well as the structure of plan development, including shared goals, agreed-upon evidence-based strategies and shared measures. The local health department continues to serve as the backbone organization to facilitate this community health improvement process, which includes over 70 community organizations, the local hospitals and members of the medical community. A specific example of clinical-community connections within that process is a diabetes pilot, aimed at consistent messaging across clinical practice and community partners, an agreed-upon referral process to community support efforts, shared measures and evaluation efforts and two-way communication. This pilot involves four family practices and three community-based programs that provide diabetes prevention and self-management programs. This effort potentially could support the ACO that is being developed in the region.

E. Link Community Care to Medical Care – Connect Organic Support to Medical Support

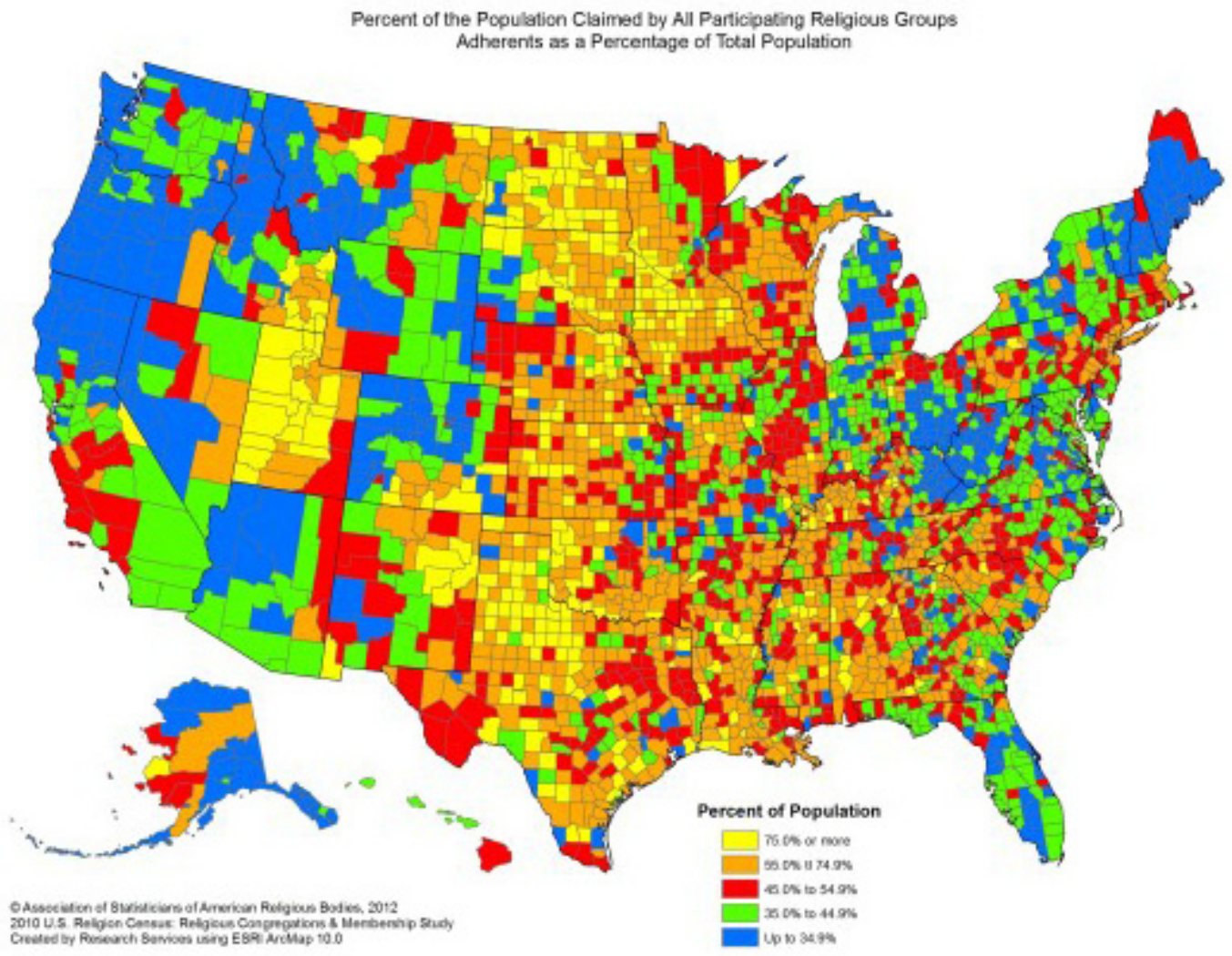
The economic alignment inherent in value-based payment will sustain the linkage given the significant value-adding benefits of the combination, but how do we get this started? Successful pilots would provide concrete proof of the efficacy of this linkage, historically impaired by the fee-for-service reimbursement model. Stakeholder meetings, presentations of the win/win scenarios set forth in this *Guide* backed by predictive financial modeling to show return on investment and other communication streamlining are recommended. In some communities, it has been shown that public health can be a connector and catalyst. Public health contributes specific value through health assessment to establish gaps in care, priority setting and strategic direction. One aid might be a care coordinator who knows all the assets. Community leadership is essential. Use the trust in the faith community to link patient, doctor and the community's resources. One workgroup member said, "If someone has to quarterback this, it must come from the community." Use hospitals' community health assessments as platforms for connectivity.

F. Link to Patients

Community health partners can provide unique contributions regarding patient access and engagement. Transportation, trust, entry point to the care system in a clinical care "desert" and providing family support and child care are part of health care. ACOs can share demographic and health status data to identify regional "hotspots"—those areas where health care dollars are "hemorrhaging" said one Workgroup member. Community resources can then be effectively targeted. In Greensboro, North Carolina, Cone Health noticed over 200 children from one ZIP code admitted to the emergency room with asthma-related symptoms. Common triggers for these children were preventable exposure to

lead paint, dust mites, roach infestation, cigarette smoke, animal hair and household chemicals. Cone Health identified these patients on its community wide electronic information system, thus connecting community resources to patients in a targeted way.

- The Underappreciated Potential of the Faith Community. As the map illustrates, as compared to the 1,128 Federally Qualified Community Health Centers, 1,200 United Way agencies and 80,000 schools, there are around 350,000 congregations in the U.S. with one-half partnering in some way with the community. Congregations are anchor supports especially in poor neighborhoods and rural areas. The shift to value-based health care payment not only stands to provide economic returns to community partnerships, but also to forge better linkage to these untapped resources to improve health, seen as the faith community.



CEO of Cornerstone health Care, an ACO based in High Point, NC, Grace Terrell, M.D. noted that "the medical and financial model embedded in fee-for-service is physician-centric, hospital-centric, and undervalues the roles and potential contributions of the wider community network in which patients actually live their lives. How can we integrate the official world of traditional health care services with the unofficial safety net that is where patients live their lives as real people, members of churches, who are connected to 'shut-ins' who may need health care services?"

VI. We've Got Some Great ACO Contributions - Now What?

As noted, there are some clear strategies for community health partners for improving health and reducing overall costs for commonly occurring disorders, which are ideal for accountable care's emphasis on collaboration and value-based reimbursement. But how does a community health partner find the right ACO partner, mesh these initiatives into programming, and be rewarded fairly?

A. Pick the Right ACO(s)

As detailed in the companion white paper, *The Physician's Accountable Care Toolkit©,* there are eight elements essential for every successful ACO. They are agnostic as to who or what owns or hosts the ACO, but they must all be present.

Culture will usually be the tell-tale indicator on whether any ACO has a chance for success.

- Physician-Led – Longstanding habits of individualism and competition among physician groups will have to transform to a culture of cooperation and collaboration. Physicians have not led complex change, are resistant to capital risk and worry that fewer tests and procedures will lower incomes.

- Hospital-Led – Hospitals need to shift focus from the current business model of providing acute inpatient care and address head-on the operational impact of decreased admissions. Hospitals need to adopt a partnering culture with physicians and depart from a command and control approach encouraged by the bureaucratic fee-for-service system.

- Community-Led – As noted earlier, while there must be a primary care medical component for an ACO, there is no reason the community cannot champion the creation of one. In fact, if the precepts of this guide are followed, this approach stands to be very successful. There is a higher likelihood of strategic value-adding involvement of community health and a better chance of closing the gap between community health and medical care. Notwithstanding, from a culture change perspective, it will probably be better to partner from the beginning with the medical community to gain mutual trust and buy-in.

Strategic Note: A member of the Community Health Partners Accountable Care Workgroup who is a rural health leader in state government emphasized the tremendous opportunity presented by community health serving as conveners, bringing together the disparate elements involved in a community's health care, including local, state and federal government.

Remember, even if a community health partner performs perfectly, he/she still will fail if the rest of the ACO is flawed.

The eight elements will determine the attractiveness of the ACO regardless of whether it is part of a hospital system, under the roof of a large multi-specialty clinic, or a network of small practices. However, each model has its nuances and presents different strengths and weaknesses. Available ACO options will, of course, be different in metropolitan and rural settings. The presence or absence of community health associate providers affects ACO partnering options.

B. You Have Picked a Winning ACO, Now Have the ACO Want to Pick You

1. Build Relationships – community health partners should be engaged with all the medical specialties and the local health care delivery system. This is a first step to team-building and readiness to partner.

2. The Planning Process – cBy now, it should be clear that if all stakeholders knew the synergies possible for linking in an ACO the medical community with community health resources, the planning process would be a breeze. However, the still dominant fee for service environment has encouraged fragmentation and separation. It financially penalizes collaboration. So, this exciting teaming, obvious to you now, likely will be very foreign in communities where these ACOs need to be developed. How do you bring people to the table in the right way?

The New Jersey Medicaid Accountable Care Organization Business Planning Toolkit recommends a three step process:

- "Identify – Health care, community and other stakeholders with interests in the designated area.

Strategic Note: Prior to any convening of stakeholders, inventory existing medical, community, political and other resources.

- Engage – Stakeholders, through discussions with ACO representatives, integrating their interest in ACO structure and missions and envisioning a role for them in the ACO Leadership.

Strategic Note: While being open to creative ideas, be prepared before meeting with the stakeholders. If possible, collect and study community health assessments and use this Guide to craft preliminary win/win ACO strategies for better health. This is a good time to show the benefit of community resources, such as assessments created by health departments.

- Collaborate – With stakeholders after the ACO is formed to build an effective ACO structure the community can embrace through formal and informal means." [23]

3. Have a Compelling Story – As noted, the skill sets of community health partners, are ideally suited for ACOs. Utilizing them in an ACO is a "no-brainer." We have heard of the "elevator pitch" for startups, whereby the entrepreneur can tell a convincing reason to invest in her company in the length of the time it takes to ride an elevator. Community health partners have a great story and should reduce it to one or two pages. These initiatives are simple "plug and play" add-ons to the ACO's existing activities, are synergistic, and will help the ACO meet quality and savings goals.

Strategic Note: Start simple. Start with your one best initiative, and then expand later.

4. Primary Care Is the Client – In the new era, success will depend on the patient-centered medical home and neighborhood. Though primary care in some cases has lost its decision-making authority to health systems, payers, and large clinics, at the end of the day, primary care will be your client.

VII. What Are The Relevant Metrics?

A. The Basic Categories and Sources

You will need baseline data, of course, to create the comparison point on quality, efficiency and patient satisfaction "before" the ACO took over so you can compare it to what happened "after." Hopefully, some of this data also will be useful to determine local gaps in care to help you pinpoint initiatives to pursue. Broadly, the measures chosen will need to cover quality, efficiency and patient satisfaction. An ACO may choose to match clinical initiatives and metrics (e.g. prevention of readmissions for heart

[23] Center for Healthcare Strategies, Inc., The New Jersey Medicaid Accountable Care Organization Planning Toolkit, p. 24 (June, 2013)

failure and the readmission rate for heart failure) but early metrics could be more general. The Joint Commission National Quality Core Measures, the National Institutes of Health, the CDC, the National Quality Forum and ACOG are recommended sources for nationally validated metrics. The AMA-convened Physician Consortium for Performance Improvement® and your own specialty society are other important sources of validated evidence based measures. Thinking of ACO common interests will be helpful in decisions about metrics for your specialty. For example, in addition to metrics specific to a community health associate, think about those which are also important to the ACO (e.g., the MSSP quality measures, utilization or cost saving indicators), your hospital partner (Joint Commission measures) and payers.

B. Examples of Measures That Serve Multiple Interests In the ACO

- Preventive services measures such as influenza and pneumonia vaccination, tobacco cessation counseling.
- Ambulatory sensitive admissions for CHF and for COPD.
- Acute care indicators such as aspirin for acute MI.
- Patient safety and care transition activities such as medication reconciliation, patient receipt of transition records, and fall risk assessment.
- Utilization and financial measures such as percent revisits to emergency department (ED), pm/pm for ED care,

  imaging rates (CT, MRI).
- ED utilization rates.
- ED-to-hospital admission rates.

C. Metrics to Measure Community Health Partner Performance:

At this infancy of involvement of community health resources in ACOs, there is not a developed body of metrics to measure performance. Metrics are essential to measure which community health partners are performing the tasks assigned in the initiatives selected by the ACO and the achievement of their hoped for outcomes. The Community Health Partners Accountable Care Workgroup suggests that priority attention be given at a national level to the development of these crucial measures.

VIII. How Do I Ensure That The Savings Pool Distribution Is Fair?

As mentioned in the *Toolkit*, some of the savings pool distributions should be used to maintain the ACO infrastructure, to "prime the pump" as it were. As much as possible should go to incentivize providers, facilities and community health partners for the extra management time, practice pattern changes, patient follow-up and effort to create those savings. **To create maximum motivation and trust, the proportion of distributions should be in proportion to the relative contributions to the pool for all involved, including community health partners.** Community health partners would commit, through a contract with the ACO, to following the ACO's initiative involving them in exchange for a fair portion of the savings pool. The more incentive, the greater the odds of increasing the size of the savings pool going forward.

Strategic Note: Some ACOs may choose to use a portion of their shared savings to partially compensate hospitals and specialists who are seeing revenue reductions due to changes in practice patterns (which is not offset by increase in market share and overhead reductions). Some ACOs will distribute savings to capital investors. We caution that such tactics will slow the transformational changes needed, sap motivation and ultimately challenge the competitive viability of the ACO altogether.

The TAC Consortium and Initiative has overseen the development of a merit-based shared savings pool distribution methodology for use with multi-specialty ACO initiatives. The Guide can be found here: http://www.tac-consortium.org/wp-content/uploads/2013/09/Shared-Savings-Guide_091013_revised_reduced-file.pdf.

IX. Protect Your Interests: Negotiation Tips

A. Negotiating with ACOs

Community health partners may be asked to sign ACO participation agreements with an ACO. Although every stakeholder who follows this Guide will bring much to the table and is in position to negotiate a reasonable contract, these are very specialized arrangements and it is recommended that you retain legal counsel knowledgeable in negotiating these types of agreements. Community health partners should be particularly mindful of the following areas:

- Investment – Any ACO upfront cost obligations?

- Ongoing Risk – What happens if the ACO takes on medical cost risk and does not meet targets? Are you proportionately responsible?

- Distribution of Savings – It should be distributed in proportion to contribution to savings, after expenses, but will savings go to investors, owners, to cover lost hospital or providers' revenues relative to fee for service?

- Data – Who collects it? Is the severity adjusted? Are the metrics clinically valid for your specialty?

- Corrective Action – Your continued participation is tied to performance. ACO contracts will have "teeth." Review the fairness and peer review aspects of the contract.

- Exclusivity – Are you contractually bound to just one ACO? (Distinguish from extra-contractual restrictions of a payer, including CMS.)

- Support – ACOs are team-based systems that should provide you every reasonable tool and human support to help you optimize your performance and patient care. These should be spelled out. The Physician's Accountable Care Toolkit© is specific about what types of support you should seek from your ACO.

B. Negotiating with Private Payers

The bulk of this Guide promotes your reimbursement optimization by: (1) designing high value initiatives; (2) earning participation in a well-designed ACO by making the value case; and (3) protecting your interests by negotiating a merit-based shared savings distribution. However, both the ACO in its negotiations with commercial payers, and you, as its member depending on the results, need to know the agreement's hotspots.

- Prepare Before You Negotiate – A well-negotiated shared savings agreement merely creates the framework for providers to succeed. There must be a team committed to the shared savings principles who share a common culture of trust and willingness to be flexible and welcome changes. It also is important to know who are your accountable care partners. Your facility or practice group could be doing a great job, but the endeavor will fail if others do not provide the necessary quality and efficiency. You must match the strengths of your accountable care organization with any gaps in care for your target patient population and determine whether the predicted return on infrastructure investment will be positive. [24]

[24] Portions reprinted with permission from The Advisory Board Company©.

- Know Your Patient Population – The arrangement could start with one population and eventually expand. Since the premise of determining savings depends on comparing actual costs with the anticipated unmanaged costs of a defined population, it is crucial to know exactly who is in the patient pool to determine baseline historical spending.

- Understand How Patients Are Assigned – The predominant shared savings model, the Medicare Shared Savings Program (MSSP), "attributes" patients to an ACO's primary care physicians based on where they receive a plurality of primary care services. Medicare patients have freedom of choice, so in some areas, there is problematic patient leakage that makes care management and financial forecasting difficult. While this may become the default assignment standard, it is preferable in agreements with private payers to have the patient assigned to the network and reflect this on a patient's enrollment card. It is important to determine how long patients must be enrolled before their performance measurements should occur.

- Identify Any Service Carve-Outs – Most arrangements cover the full range of services, which makes savings calculations much easier. However, sometimes pharmacy, mental health, organ transplants, dental, pediatric, out-of-area, emergency, catastrophic or untrackable services are carved out. It is possible that a specialty or type of service not provided within a network may be excluded.

- Strive to Achieve More Than Cost Savings – The goals and performance metrics are to uphold the Centers for Medicare and Medicaid Services' ("CMS") Centers for Medicare and Medicaid Services "Triple Aim" Vision—improved population health, enhanced patient satisfaction, and decreased cost. Only if the hurdles of the first two are met are you eligible for shared savings.

- Think Beyond Performance Metrics – Performing well on payers' list of metrics is the way to maximize reimbursement; however, it is not sufficient just to "teach the test". In order to succeed, an ACO needs to have the right infrastructure investments in place to deliver better quality and lower cost care for populations of patients. This includes investments in care management for engaging patients inside and outside of the health system, and information technology for tracking gaps in care and clinical outcomes over time. Metric selection should align with hospital initiatives to successfully redesign the delivery of care for patients and families. It also is prudent to standardize metrics across payers to the extent possible.

- Pin Down How Savings Are Determined – Although the concept is simple—the ACO gets a share of savings if it is able to do a good job at managing costs of the attributed population; carefully reviewing how savings will be determined is essential. For example, shared savings contracts may

include downside risk to the provider if cost targets are not met, and it's important to consider your organization's appetite for financial risk before entering into such an agreement. It also is recommended not to focus solely on year-over-year performance. Accountable care is a marathon, not a sprint, and requires a dedicated commitment from leadership to transform into an effective population manager.

- Obtain Payer Support – Increasingly, payers are providing resources and support to fledgling ACOs to help achieve the goal of higher value care. Consider negotiating for such things as the following:

    - Data – Seek supplementary claims and other health and financial data. Payers sometimes offer database access, reporting tools, and utilization, cost and other reports. ACOs cannot effectively assess where the waste is or how they are doing without access to this type of information.

    - Help with Patient-Centered Medical Homes ("PCMHs") – Payers often assist providers in establishing accredited PCMHs and provide enhanced fee-for-service or performance payments to support practice transformation.

    - Payer-supplied care coordination training.

    - Participation rights to roundtables and forums.

- Other Contract Considerations – A shared savings negotiation checklist should also include consideration of the following:

    - Flexibility for the ACO to localize the most appropriate value-adding programs;

    - Description of duties of payer and providers;

    - Description of the association of shared savings with fee-for-service payments;

    - Benefit design and co-pays to facilitate achieving your care management goals; and

    - Marketing and steerage—will your organization be in a "narrow network?"

X. Conclusion

America's health care system will soon become unaffordable absent major change. The accountable care movement holds promise to address runaway costs and thus must be taken quite seriously. There are opportunities for professional and financial reward for the informed community health partner. Put another way, the risks of passivity are just too great. All the alternatives are unacceptable to a caregiver-led system of providing the highest quality at the lowest cost. Community health partners have skills and experience that position them to lead in the success of ACOs, but this is not yet widely recognized within the medical community. Grace Terrell, MD puts it plainly: "Community partnerships MATTER MORE THAN PRACTICALLY ANYTHING in the world of value-based care." To make sure a fair and sustainable ACO model becomes reality, it is important for community health partners to step up with like-minded providers to lead in this potentially career-changing transformation.

This *Guide* is intended to illustrate the significant opportunities for community health partners in accountable care, to assist them in avoiding the pitfalls, and to help them develop accountable care strategies in different settings. For further information, contact the TAC Consortium and Initiative lead liaison, Melanie Phelps, at either mphelps@ncmedsoc.org or 919-833-3836.

ACKNOWLEDGMENT

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