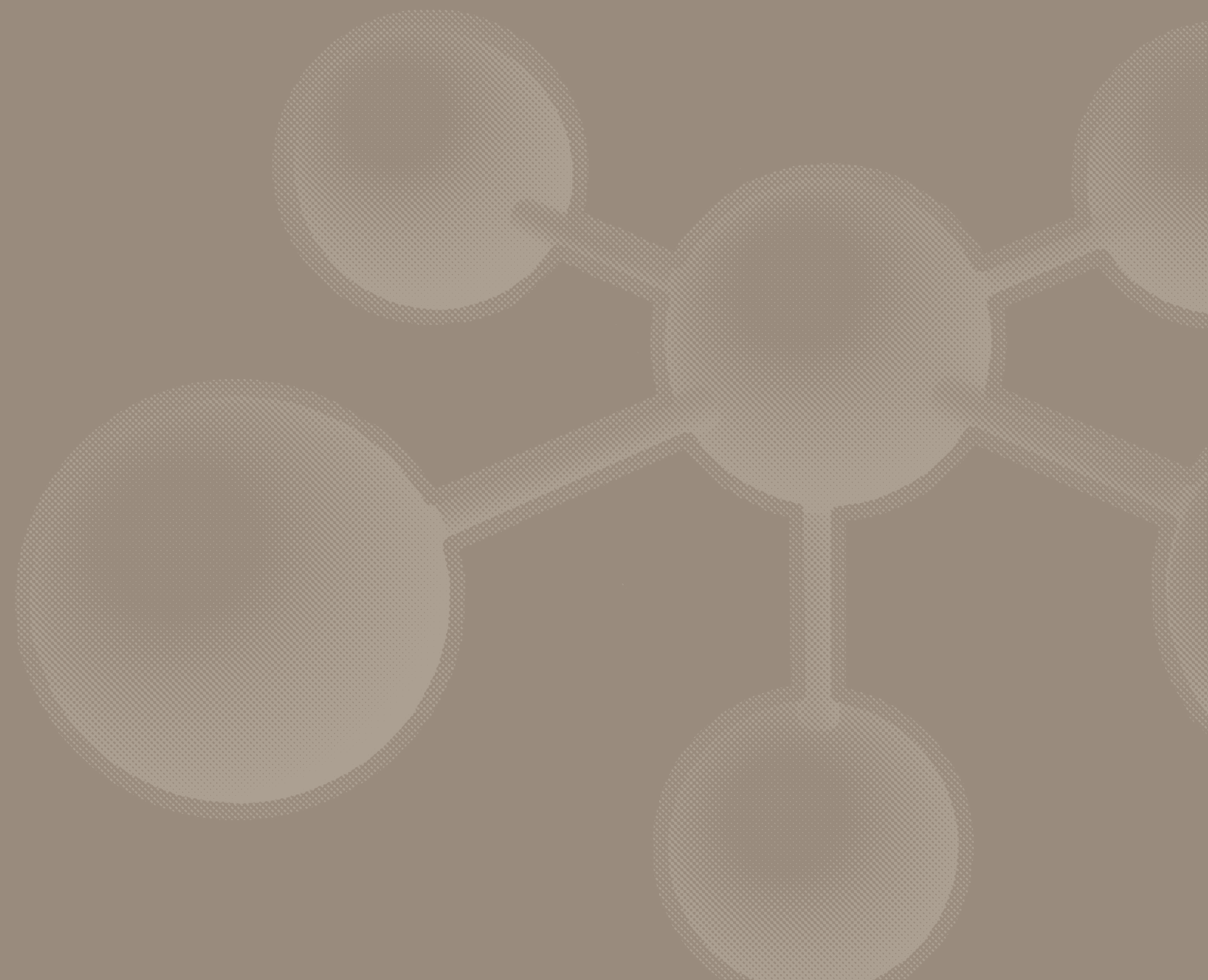


Valence[®]
Health

Corporate Headquarters
600 West Jackson Blvd., Suite 800
Chicago, IL 60661
t: 312-277-4801 f: 312-277-0330
www.valencehealth.com



The Cornerstones of Accountable Care

The Accountable Care Organization is emerging as an important care delivery and financing model to address the challenges of rising health care costs and fragmented care delivery. With health care reform offering new demonstration projects, and commercial health plans piloting a variety of opportunities, provider organizations around the country are considering whether to pursue becoming an Accountable Care Organization. As providers review ACO requirements, many are recognizing that the very process of developing an ACO addresses essential capabilities that providers must have to thrive in the post-healthcare reform environment. So the question appropriately shifts from “Should we be an ACO?” to simply “What should we do to be ready?”



An Accountable Care Organization is an integrated group of physicians and other providers organized together to assume responsibility for quality and efficiency of health care they deliver to a defined population. The Patient Protection and Affordable Care Act (PPACA) of 2010 established voluntary Medicare and Medicaid ACO demonstration projects by January 2012. Under those demonstration projects an ACO will be eligible for a percentage of savings they achieve if the ACO meets quality thresholds. PPACA also created the CMS Center for Innovation which is expected to fund additional projects with varying financing models including bundled payments and forms of capitation.

Currently there are more “unknowns” than “knowns” about the future of Accountable Care Organizations, including the exact payment mechanisms, the optimal structure, and whether, how, and how quickly other payers adopt accountable care models and move the concepts into the broader health care market. But it is clear that success under accountable care requires providers to transform both the organization and delivery of care, in ways that will benefit the successful provider system regardless of the ultimate form that Accountable Care Organizations may take.

1. Clinical Integration

Success as an ACO requires provider organizations to achieve a higher level of coordination and collaboration than typically exists today. Clinical Integration provides a bridge to build the capabilities and culture needed to create a viable Accountable Care Organization.

Clinically integrated provider organizations improve quality by coming together to collectively create standards of care, measure performance against those standards, provide tools to improve compliance, and work with physician members to educate and require compliance. Fully implemented, Clinical Integration comprises the organizational attributes necessary to catalyze the transformation of health care delivery to an ACO model, including governance structure, leadership, and comprehensive physician-hospital alignment.

Clinical Integration also has a specific legal meaning. To meet the Federal Trade Commission’s (“FTC”) definition of Clinical Integration, organizations must achieve efficiencies by monitoring and controlling quality, service, and costs; selectively choosing physician participants; employing evidence-based practice standards; and making a

significant investment of monetary or human capital in infrastructure, including information technology. Providers that become clinically integrated are permitted to jointly contract with payers, which can be a tangible value to physicians while building toward a viable ACO for the future.

As required to support an effective Clinical Integration program, governance structure and leaders who have the credibility and vision to lead transformational change are critical to moving a provider organization forward to becoming an ACO. Physician leaders must be able to articulate a vision of change and be champions for the adoption of evidence-based guidelines and performance measurement. Additionally, the organization must have a governance structure with the power to establish performance standards and require compliance of all physicians.

Questions to ask yourself today:

- Do we have engaged physician leaders with the vision and commitment to pursue clinical integration and accountable care?
- Do our physicians understand and can they envision bridging the gap between fee-for-service and population-based care delivery?
- Do we currently have a clinically or financially integrated network of providers, or will we have to form a new legal entity?
- Do we have the governance structures with status and credibility to make and enforce decisions about care management and providers’ ongoing participation in the network?

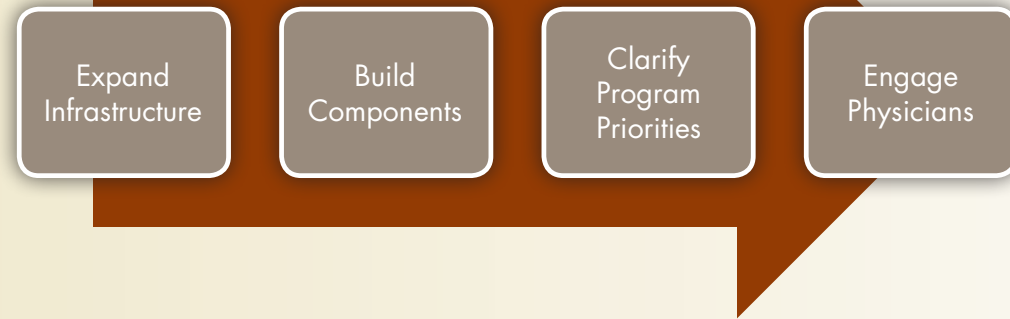
2. Care Coordination

Delivering value in health care can be summarized succinctly in the commonly quoted phrase: “*the Right Care in the Right Place at the Right Time, all of the Time*”. But that simple-sounding statement encompasses a broad shift from today’s typical care delivery model. Comprehensive Care Coordination is much larger than the old paradigms of utilization management or even traditional care management models. It encompasses a truly patient-centric vision, and requires change in multiple dimensions of the care delivery enterprise. Modifications will impact the practice patterns of providers as well requiring a new set of operational competencies, backed by sophisticated information management and human resources with new skill sets.

Changing practice patterns is a broad mission. To drill down to the kind of change required means focusing on how to translate evidence based medicine principles into actionable best practice delivery goals that can be applied in day-to-day practice. It means reducing variation and increasing reliability in patient care through understanding and compliance with current evidence based guidelines. It also means establishing the processes and teamwork to ensure appropriate and complete hand-offs between providers throughout the course of patient care episodes.



CARE COORDINATION DECISIONS



Moving forward successfully requires the organization's careful review and consideration of several key Care Coordination choice points. Included among the decisions to be made are:

- What infrastructure do we need to build at the practice sites and in the organization?
- What is our best approach for developing these program components, both now and in the future?
- What are our specific goals, priorities and timing objectives with this endeavor ...
 - Clinical, market, business, financial?
 - Immediate, near term, long term?
- How, and who, will most effectively engage and align the physicians, and lead the practice pattern change initiatives?

In this process it is crucial to effectively address the choice, timing, and pace of interventions in order to ensure timely outcomes while balancing both competing resource constraints and the capacity and fortitude to embrace and implement change.

Another critical component of new development is engaging and empowering the patient. Areas of emphasis will likely include: motivational strategies, effective adult education models, development and implementation of self care modules (with appropriate and timely professional oversight and intervention), and implementation of shared decision-making techniques. The goal is obvious: engaged, interested, informed and motivated patients partnering with their caregivers in achieving optimal clinical outcomes. The challenges extend beyond the patient – to the practice and physicians to develop, implement, and embrace the tools and strategies to truly integrate these approaches.

Successful organizations will also have a new set of operational competencies. They will have the staff and information resources to study, understand and improve processes. Essential is the ability to measure current performance and identify variances, providing that information to care providers at the right time and in an actionable format. They will also need more effective communication between physicians, other clinicians, and care coordination staff and new training in skills to intervene and effect change in practice patterns.

Ultimately, of course, the organization will also need the leadership, governance structure, and alignment vehicles in place to influence physician practice and, as needed, require participation in clinical quality initiatives and practice patterns aligned with established guidelines and standards. This may imply modification of existing governance and/or behavior norms. In some cases the development of a new entity or organizational structure may be required to create the environment which will be needed to move forward effectively, constructively and successfully in delivering the clinical value proposition embedded in accountable care models.

Questions to ask yourself today:

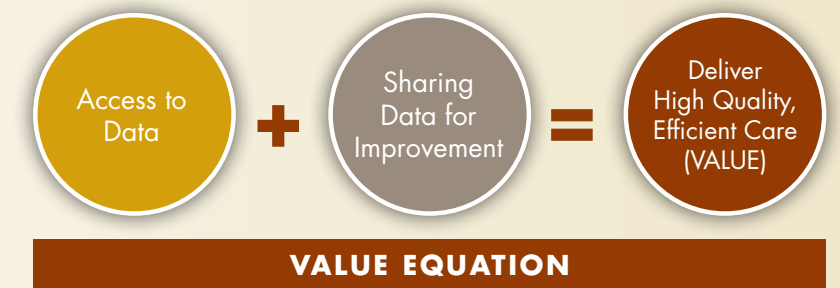
- How do we measure performance? Do we have tools and data to measure and identify variances?
- Do our providers embrace and practice according to evidence-based guidelines?
- Do we have the resources and staff to identify gaps in care, track and engage patients, and coordinate their care?
- Do we have the leverage (and leadership) to engage physicians and ensure alignment with clinical quality/value objectives?
- Do we have the care coordination resources to engage patients, conduct outreach, measure feedback, and improve the patient experience?
- Do we have scope or affiliations to facilitate integrated care delivery across the continuum?
- Are systems and incentives designed and aligned to deliver the desired outcomes?
- And if not, do we have or can we develop plans, strategies and resources to address these areas effectively and timely?

3. Information Technology

All of the changes required to become an Accountable Care Organization require health care information to be collected, managed and shared in a far more efficient and timely manner than is true in most health care systems today. It is potentially more useful to focus on functions and data needs, rather than specific system or model for providing and exchanging data.

On a conceptual level, health information technology must support delivery of clinical value: higher quality, effective and efficient patient care. Providers need the right information to make timely, individual patient decisions at the point of care, based on current, comprehensive information and patient history.

The exchange of relevant patient data requires the capability to integrate/aggregate data from multiple community sources (e.g., hospitals, physician offices, labs) and store this data in a central data repository. Having access to credible and current data is critical to encouraging physician participation, as well as supporting performance monitoring at the provider, practice, and network levels.



The information technology platform must include:

- Timely clinical information that can be accessed by multiple providers across the care team
- Clinical decision support based on evidence based guidelines agreed upon by the organization
- Measures of compliance with guidelines and quality outcomes at the provider, practice, and network level
- Physician performance benchmarking

As an ACO, the organization must also have the capability to calculate and redistribute payments to providers out of shared savings or other incentive pools, and possibly the transactional capability to distribute capitation payments.

Questions to ask yourself today:

- Do we have baseline data to measure physician performance?
- How will we obtain physician practice level data? How will we expand or create those datasets?
- How will we provide timely, actionable information to providers to support clinical decision making?

4. Financial Management

To succeed, ACOs will need tools and data to support a new level of financial modeling. They will have to establish actuarial cost and utilization targets for a defined population and then apply care coordination resources to achieve those targets. This process of benchmarking and managing toward targets requires a high level of understanding and coordination between the financial and clinical teams.

Provider organizations will need to develop financial and managerial expertise as they model various forms of at-risk payment associated with accountable care models including shared savings models, bundled payments, and partial and full risk capitation. They will also need to strengthen or put in place the cost accounting and data collection systems needed to manage under those payment models.

It will also be critical to factor plans into managed care contracting strategy early. Provider organizations that are pursuing Clinical Integration and developing strong accountable care capabilities should approach payers early and engage them in understanding the value of the clinical and operational improvements the organization is making, in order to gauge their support and gain their investment in your programs.

Questions to ask yourself today:

DO WE HAVE

- Experience with risk and/or pay-for-performance programs? With bundled payments and episode payment?
- Data to estimate performance under alternative payment arrangements?
- Actuarial support to validate targets?
- Financial stability to weather new risk/financial arrangements?

What should we do to be ready?

The most important advice is to start now to assess your position and determine how to move further toward a sustainable accountable care model.

The first stage is Integration – building the culture and capabilities of a clinically integrated organization. Key steps in this phase are to analyze the physician panel and referral patterns; understand drivers of hospital cost and utilization as well as ancillary services cost and utilization; and ensure the leadership, governance structure, and alignment vehicles are in place to influence physician practice and, as needed, require alignment and compliance with standards.



The next phase is Delivery System Improvement – building the vital infrastructure to enable effective care coordination and fully integrated care delivery. An essential step at this stage is the acquisition of information system capabilities to measure performance and deliver actionable information to the provider for timely and effective decision support.

Finally, moving to true accountability requires financial, operational sophistication to monitor outcomes, manage risk and costs, and deliver optimal outcomes across a population.

The Accountable Care Organization model holds enormous promise as an integrated care delivery and financing model; but the future of ACO is far from certain. What is clear is that provider organizations that develop the capabilities and culture necessary for success in an accountable care environment will have the attributes required to deliver on the clinical value proposition -- the tools to thrive in the post-healthcare reform environment.

Valence Health

Valence Health delivers patient-centered, data-driven solutions so providers can achieve optimal reward for quality care.

- **Clinical Integration** – integration of providers across delivery settings to enable comprehensive patient care through intelligence
- **Management Services** – full suite of medical, financial, analytic, and call center services for the effective utilization of health care dollars
- **Focused Consulting** – highly experienced healthcare executives provide customized guidance and implementation to ensure sustainable success
- **ACO Expertise** – strategy, implementation and operations expertise for the fastest, most effective path to accountable care

Founded in March 1996, Chicago-based Valence Health offers providers organizations such as IPAs, PHOs and health systems, a wide selection of products and services designed to improve the quality of care delivery and achieve clinical excellence to be successful in today's evolving healthcare environment.

www.valencehealth.com

For more information, please contact Elizabeth Simpkin, Vice President, Consulting Services at 312.277.6340 or esimpkin@valencehealth.com