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ORANGEPAPER

PREPARING FOR PRIMARY AND ACUTE CARE SYSTEMS: LEARNING FROM ACCOUNTABLE CARE ORGANISATIONS

INFORM

PRIMARY AND ACUTE CARE SYSTEMS: DELIVERING BETTER HEALTH OUTCOMES FOR THE POPULATION

The evidence from Accountable Care Organisations in the USA and integrated care in the UK.

One year ago, NHS Five Year Forward View (Oct 2014) called for local health economies to adopt new models of care centred on improving population health and well-being, and increasing the quality of treatment. In this paper, we share some learning, tools and experiences from the development of integrated care systems here in the UK and accountable care systems in the USA, which might help health and social care communities consider how they might move forward.

New operational relationships are emerging between the different professionals and providers involved in care delivery. The big prize is to refocus on the patient, improve health and well-being, improve outcomes from health and social care delivery, and provide a better experience of services whilst at the same time, containing cost growth and increasing value in the tax-funded system.

Primary and Acute Care Systems have been likened to Accountable Care Organisations (ACO) internationally.

Primary and Acute Care Systems:
Vertically integrated single organisations, which at their most radical would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget.
-Five Year Forward View

Accountable Care Organisations (ACOs):
Group of providers held jointly accountable for achieving a set of outcomes for a prospectively defined population over a period of time and for an agreed cost.
-McClellan et.al[1]

There are many great lessons to be learned from the early adopters of ACO models not least of which are:

- The central importance of the service user / patient as the real owner of their own health and health outcomes and the need to involve them at every level from policy to practice;
- The critical importance of sharing information between patient and professional and across care professionals at the point when treatment decisions are made;
- The need to rethink clinical governance and care protocols across the entire care pathway; and
- The massive operational and cultural transformation, which is required if the system is to become truly integrated from the perspective of the patient and refocused on prevention and early intervention.

This is not a "quick fix". If it was, it would already be normal practice across healthcare systems across the world. Implementing these models will be difficult. Investment and time is required if the valuable benefits are to be realised and return-on-investment is to be achieved. Early lessons from programmes such as the integrated care pioneer, integrated personal commissioning and new models of care programme, (England) and integration of health and social care (Scotland) bear this out.

1. McClellan, M., Kent, J., Beales, S.J., Cohen, S.I.A., Macdonnel, M., Thoumi, A., Abdulmalik, M., Darzi, A. (2014a), Accountable Care Around the World: A Framework to Guide Reform Strategies, Health Affairs, 33. n9. (2014): 1507-1515

In the USA, the design principles of ACOs as provider vehicles include:

- There is a mechanism for shared governance that provides all ACO participants (acute, community, primary, mental health and social care providers) with appropriate control over the ACO decision-making process.
- Provider reimbursement is tied to quality metrics and reductions in the total cost of care for an attributed population of patients.
- Five quality domains form the basis for determining, benchmarking, rewarding and improving ACO quality performance:

1. Patient Experience with Care
2. Care Coordination
3. Patient Safety
4. Preventive Health
5. At-Risk Population/Frail Elderly Health

However, ACOs have proven to be complex models that take time and technical expertise to implement. Results for ACOs have been mixed. Costs of organising and implementing the ACOs were higher than anticipated and care coordination via their clinically integrated network was problematic. Nevertheless, there is continued interest in the growth of ACOs, which is driven by a greater appreciation of placing the consumer at the centre of care delivery.

With the benefit of a learning curve from the USA experience in implementing such systems, we have identified the following challenges that health and care economies are facing in implementing an ACO model:

1. Patient and service user engagement

This seismic shift in the way that health and care is delivered is based on a hypothesis that by investing more in a public health initiative aimed at prevention and early intervention, including self-care, we will see significant reductions in relatively high-cost acute care, people living in better health for longer and experiencing seamless high quality services when they do need them.

In order to achieve this, people need to be encouraged to take an active role in maintaining their good health and well-being through shared decision-making and communication about self-management, medications and lifestyle changes. In the USA, many wellness and health promotion activities are patient-driven and can be key components in programmes to prevent and treat active disease and manage chronic conditions.

Historically, health and care providers have not been particularly successful in engaging people in their own care, and patients have not always shown much interest in these responsibilities. The move towards personalisation (personal health and personal care budgets) and introduction of the Care Act (2014) is changing this. Mobilising people to participate as partners in the delivery of accountable care will be new territory for most health and care delivery organisations. Careful choices and priority setting will be required to ensure that investments in user engagement are consistent and can be leveraged to promote accountable care.

2. Who is accountable?

By definition, an ACO is comprised of three elements:

- Accountable: Those who are accountable for the cost and quality of care for a whole population will be incentivised to improve care. Accountability refers to both clinical and financial accountability.
- Care: An ACO delivers, rather than commissions care.
- Organisation: Accountable providers come together in a formal organisation structure to build an appropriate leadership team and governance structures.

Currently, the NHS system consists of commissioners who do not deliver services and providers who struggle to understand how they can share clinical and financial risks with other providers, be it through a legal structure,

contractual mechanism or other arrangements. There is little incentive, legally or structurally, for an organisation to move towards adopting the status of an Accountable Care Organisation. Thus, a true ACO can only be created when providers work together under strong leadership that accepts accountability.[2] This needs to be embedded through robust governance structures.

Over the last year, the local government devolution agenda in England has presented some potential new options for health and care systems to deliver integrated care. As part of this movement, new governance structures and mechanisms are being developed, bringing together health and local government commissioners and provider networks.[3]

3. New ways of contracting with and reimbursing providers

Over the past three years, the Department of Health has supported pioneers to consider new ways of contracting and Monitor has stated that their long-term aim is to develop a payment system that supports delivery of good quality care for patients in a sustainable way.[4] All of these initiatives indicate that the current contracting approach will not enable more integrated, population-focused health and care delivered for better outcomes. Traditional tariff-based structure does not align financial incentives appropriately between commissioner and providers, or between providers, to deliver the integration of services that patients need or secure improvements in outcomes.

The goal of ACOs should be to develop payment systems that reward improved performance. To accomplish this goal, there are a wide variety of shared risk models that could be employed. Year of care and capitation are examples of risk sharing arrangements. The chosen methods should aid the ACO in changing clinical behaviour and delivery of care.

For all typical ACO cost-sharing methodologies, a spending benchmark should be established as a baseline using historical data. In the Centers for Medicare and Medicaid Services (CMS) Shared Savings program, if an ACO can maintain or improve quality at less cost than the benchmark, it receives a portion of the savings.

4. Integrating Health Information Technology

Integrated care requires the provider to deliver patient care that is responsive to immediate circumstances. Access to information about the patients is required for care coordination, which is at the core of accountable care capabilities. Information governance emerged early as a challenge for integrated care pioneers.[5] The requirements of the Health and Social Care Act (2012) have left health and care systems with a number of very practical challenges in sharing information across providers, especially between the NHS and local government.

Assuming that the information governance challenges can be overcome, health and care systems are then faced with an array of technology options, which may represent a significant investment and therefore risk to decision-makers. The USA experience has shown that making the right decision here has a significant impact on ACO success. Health and care partners developing a Primary and Acute Care System (PACS) model should consider:

- Understand what you have today and how it can be optimised and integrated;
- Be clear about what you need the system to do *(care coordination and/or support management decision-making)*
- Availability of resources for investment *(technology, supporting infrastructure and people)*;
- Technological innovation moves faster than procurement systems so buy for agility; and
- Broaden the decision-making process using initiatives such as the Local Digital Roadmap[6] to guide decision-making.

2. See Welbourn, D., Inman, L., Mallender, J. (2014), Accountable Care Organisations can properly manage commissioning risks, HSJ
3. Greater Manchester Health and Social Care Devolution booklet. http://gmhealthandsocialcaredevo.org.uk/wp-content/uploads/2015/09/GM-Devolution-September-2015-Booklet.pdf
4. http://www.england.nhs.uk/resources/pay-syst/ntps/ ; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445731/LPE_Capitation.pdf
5. Case study – Information governance and Southend's s251 application. www.local.gov
6. The Forward View into Action: Paper-free at the Point of Care – Preparing to Develop Local Digital Roadmaps. September 2015

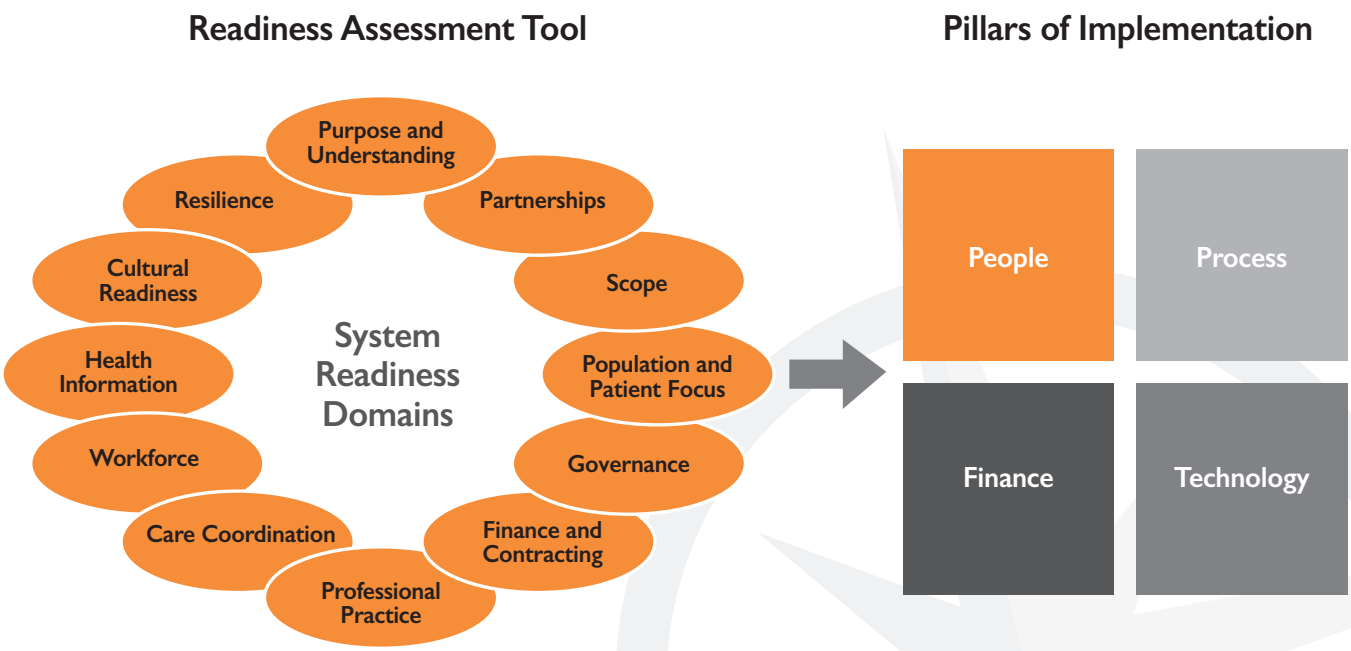
TRANSFORM

BUILDING AN EVIDENCE-BASED TRANSFORMED MODEL OF HEALTH AND CARE

There are a number of different models of care emerging in England following the principles of accountable care organisations. Relatively few at this point are single legal entities. Many are made up of networks of providers (and occasionally commissioners), which have come together in a governed network. For the remainder of this paper, we will refer to Accountable Care Networks (ACNs) in acknowledgement of the plurality of models that are being pursued in England, some of which include commissioners.

For providers working together to deliver a contract for a whole population, it requires changes at the strategic, managerial and operational level. Providers in the CMS Shared Savings Program are rewarded to improve operational efficiency and improve outcomes. They face significant risks if they are unable to deliver the operational transformation required at the pace determined by the contract. Understanding the readiness of the system for this transformation and identifying areas of risk is a critical component in managing a successful transformation.

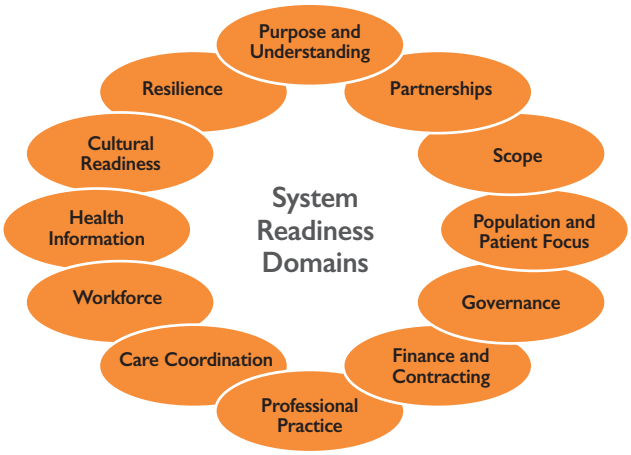
Figure 1: Tools to assist development of ACNs



ASSESSING THE SYSTEM'S READINESS FOR ACCOUNTABLE INTEGRATED CARE DELIVERY

There is no blueprint for becoming an ACN. Each health and care provider will have a different history, context and operating model, which will help to determine the steps that need to be taken and timescales required to move towards becoming an ACN. Various readiness assessment tools have been employed by some of the key advisors in the USA, where they have been subject to considerable practical testing[7] to help answer 'Where are we now?' A synthesis of these tools, and practical application in the English health system over the last 12 months, has resulted in a tool, which uses key domains that can be used at different points in time to track the progress being made to full successful implementation.[8]

Figure 2: System readiness domains



Collectively, the 12 domains reflect the full breadth of considerations over which the potential ACN should be able to demonstrate the competence, capacity and capability required to deliver the triple aim of all healthcare transformation—high quality outcomes, excellent patient experience and increased value for the taxpayer. This includes having a joint understanding of the aim, vision and values, including having a robust governance system; an identified target population with active and involved patients; joint planning and development of end-to-end procedures; widespread adoption of evidence-informed clinical pathways; use of comprehensive quality and performance metrics; use of improvement science to drive better outcomes and value; deep analytical capability with links between clinical and financial data; agreed plans for gain-sharing as well as risk-sharing; trust between various arms of the partnership; and robust systems for planning and management.

Our experience shows that organisations and networks of organisations working towards new models of care vary in their profile against each of these domains at any given point in time. Using the assessment helps a system identify its current capability, whilst providing a framework for production and implementation of developmental plans. These plans fall under the four broad pillars of people, process, finance and technology.

PILLARS OF IMPLEMENTATION:

1. People

The move towards becoming an ACN usually requires several changes at organisation and governance levels. This may include changes to organisation structure, legal structure or governance model. For example, a low score on the 'Purpose and understanding' domain under the readiness tool may indicate that the providers do not yet have a shared purpose reflected in a governance model that recognises clearly who has authority to make what decisions and how accountability will be held. Our use of the tool has helped health and care system leaders translate this risk assessment into an implementation strategy, which has included launching an ACN organisational structure by chartering a leadership steering committee with

7. See for example American Institute for Research – Bundled Payment for Care Improvement: Readiness self-assessment, American Medical Group Association –ACO readiness assessment, Health Dimensions Group – Health care reform readiness assessment, etc.

8. For more details, see www.optimitymatrix.com/healthcare

shared accountability across the partners. Probably more importantly though, the biggest changes are not structural but behavioural. ACNs require clinical and non-clinical staff and patients to behave in very different ways. Coordinating care across pathways and a network of providers means a different skill set and sometimes the development of completely new roles. We are starting to see the emergence of new care navigator roles.[9]

2. Process

Clinical and operational processes do not cross organisational boundaries today. ACNs need to redesign processes and pathways by starting with the patient or service user as the locus rather than institutional requirements that have historically siloed processes. Learning processes which support continuous improvement and promote the use of evidence-based practice that is shared across traditional boundaries is also an important process that must be built in early on. All of this only happens if the work on the people pillar is aligned to develop and reinforce the use of these processes and systems, and the benefits and impacts have been identified and are consistently measured. The feedback loop is a key component of successful ACN implementation with real-time feedback on measures that matter to patients. The 'Clinical practice' domain of the Readiness Assessment tool looks at whether there are agreed evidence-informed pathways across the continuum of care for a specific cohort of the population (e.g. frail elderly). A low score would indicate that there is inconsistent use of evidence-based pathways across the network or gaps in the pathway, which highlights where implementation could focus.

3. Finance

In recognition of the time and investment required to develop an ACN, they usually have contracts over multiple years. These contracts move from having a small proportion of reimbursement based on outcomes (probably process outcomes for the first year or two) to having much larger proportions based on outcomes. There will be gains but also risks that need to be shared and managed by the ACN so they need to have worked out how this will work in a way that incentivises the whole system appropriately whilst minimising perverse incentives. The readiness assessment looks at a systems current contracting and reimbursement arrangements, performance monitoring and management and market management to assess what changes to systems and processes as well as working practices and competencies would be needed to move to population-based capitation if that is the direction of travel.

4. Technology

All successful examples of implementing integrated care through ACN-style contracts identify that the Health Information Technology (HIT) capability is fundamental to the ability to improve coordination, achieve better outcomes and manage the gain-sharing and contracting arrangements. The readiness assessment tool provides a framework for the health and care system to explore the strengths and weaknesses of their infrastructure and identify where there are opportunities for immediate integration as well as requirement for longer-term investment.

OUTPERFORM

HOW WE HAVE HELPED HEALTH AND CARE SYSTEMS SUCCEED IN DELIVERING THIS TRANSFORMATION

Leveraging the Readiness Tool and Pillars of Implementation described previously, Optimity Advisors has assisted health and care systems that are developing new models of care to focus their attention and efforts on key requirements needed to build a successful, integrated model of care delivery. The tools aggregate best practice guidelines and enable whole systems to focus on core building blocks that include near-term financial incentives and long-term operational transformation. Below we describe two case studies. The first is a UK health and care system that has been developing their new model of care since early 2015. The second is a USA ACO, which was part of the first wave of ACOs in 2011.

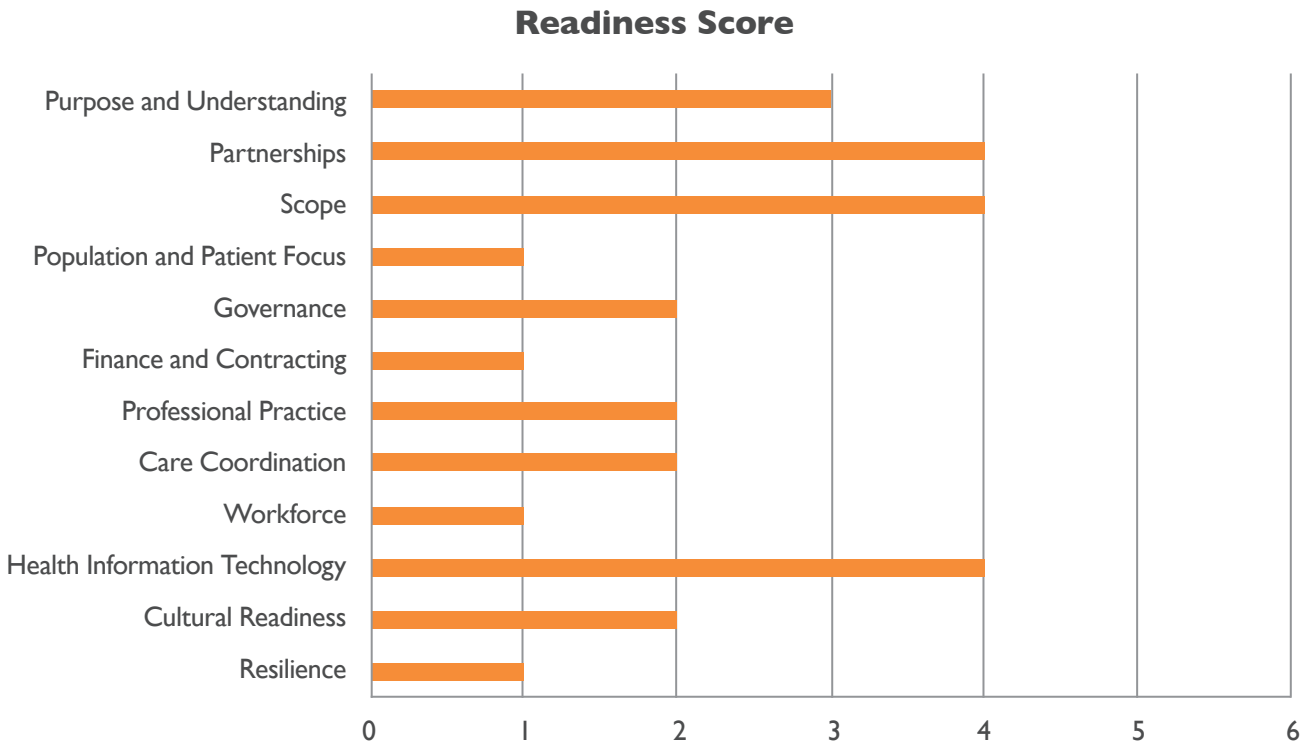
9. Safer passage: how care navigators help improve mental health services. Health Service Journal, March 2012

Case Study 1: Readiness Assessment for New Models of Care

Client: A health and care economy serving an urban population of a quarter of a million people has an ambition to expand out the scope of their Adult Integrated Care Programme to deliver a whole system model of care population health and well-being outcomes, stronger more resilient communities that experience better health and care services, and better value for money. This would require a step change in leadership, pace and implementation.

Problem statement: The leaders of the health and care system (commissioners and providers) wanted to understand how well the existing integration programmes were delivering and what this might mean for building out the whole system model of care. They also wanted to understand what the priorities for operational transformation in the immediate future should be.

Our solution: Using our readiness assessment tool over four months, Optimity conducted a series of monthly workshops with the leadership group, over 40 in-depth one-on-one interviews with a range of stakeholders from across the system, participated in a number of business meetings and reviewed documents from across the system, including programme documents. What emerged from this process was a readiness rating profile, which summarised the current capability against that required for the "perfect" system. This was then used to prioritise those areas, which needed further discussion and development and was built in to the implementation plan.



The way forward: The findings from the review formed the basis of a complete refresh of the Adult Integrated Cere programme. The governance model was redesigned to ensure that all of the partners were involved in making timely decisions. The operating model for the programme delivery was also redesigned to harness the collective intelligence of a much wider group of staff from across the system, and a refreshed and reprioritised implementation plan that was owned by the delivery teams and informed by the readiness assessment is now being delivered with clear metrics and reporting.

Case Study 2: Implementation Plan for ACO

Client: A USA-based partnership between a private payer, hospital and physician network recognised the need to evolve their care delivery and financial operating models and get ahead of the current market shift towards accountable care.

Problem Statement: The client was challenged by varying degrees of understanding ACO operations and a legacy culture, which did not support a move towards a truly integrated care delivery model.

Our solution: Optimity assessed business and clinical competencies of the hospital and physician network seeking to transition to an Accountable Care Organisational (ACO) model. As part of the assessment, Optimity assessed and developed recommendations around the organisation, process (clinical and operations), technology and financial areas, providing opportunities for the hospital and physician system to evolve into a quality- and cost-based integrated care delivery model. In their first year as an ACO, the client has been rated as one of the top performing ACOs in the USA with significant savings and improvements in quality. Example recommendations and core competencies identified as part of the assessment are provided below although we have translated these into terms that are more meaningful in the UK health and care system:

Figure 4: ACO core competencies

PEOPLE	PROCESS	TECHNOLOGY	FINANCE

• Patient centred behaviours
• Communication and activation
• Governance
• Operating model
• Workforce
• Recruitment
  • New roles to bridge traditional boundaries
  • Culture and behaviour change
  • Performance monitoring
  • Training/Development
	• Population risk analysis
	• System-wide quality reporting
	• System-wide contract management
	• Payment and reimbursement
	• Compliance and risk management
	• Incentivising value added services
	• Focused goals:
	  • Admission avoidance
	  • Readmission reduction
	• Single point of access
	• Joint assessment, planning and care coordination
	• Managing service utilisation—right care, right place
	• Health & wellness programmes
	• Clinical protocols
	• Extended primary care services
		• Health Information Technology
		  • Virtual Care Records
		  • Integrated data reporting systems
		• Advanced care management systems
		  • Care planning
		  • Decision support
		• Risk stratification
		• Predictive modeling
		• Workflow / Automated triggers
		• Patient Accessibility (Portals)
		  • Health and care record
		  • Self-care and self-management
		  • Supplementary health communications
			• Cost Reporting
			• Population risk reporting
			• Gains sharing / Revenue model
			• Capital budget planning
			• Pay-for-Performance modeling
			• Competitive cost benchmarking

Table 1: Example recommendations

PEOPLE	
Challenges: Legacy providers do not buy into the ACO culture. Consumers are not aware of appropriate utilisation.	**Recommendations:** All provider groups in the ACO are represented in leadership/executive committee with shared accountability. Consumers are empowered and incentivised to be "accountable" for appropriate services.
PROCESS	
Challenges: Historical referral patterns do not align with ACO financial, delivery and reporting objectives.	**Recommendations:** Incentive model must account for geographic variability and demographic risk. Care Delivery model must "integrate" services from Health & Wellness to Disease/Case Management.
TECHNOLOGY	
Challenges: Current system capabilities are not able to integrate data from disparate sources. Patient clinical and financial data are not integrated to support holistic reporting and enterprise operations.	**Recommendations:** Data strategy and information sharing is owned by all participants. Enterprise reporting addresses individual & population and financial & clinical data.

ABOUT OPTIMITY ADVISORS

Optimity Advisors is a rapidly growing, multi-industry strategy, operations and information technology advisory firm with multiple locations throughout the United States, United Kingdom and Europe. We specialise in the critical set of services that sit between high-level strategy and delivery and execution. We provide a strategic outlook through proven methodology, knowledge and instinct, helping to craft an actionable future vision that aligns with your long-term goals and objectives. We bring an end-to-end industry understanding to help you rise above the day-to-day, focus on the opportunities ahead and align your organisation for success.

CONTACT

Dr. Niamh Lennox-Chhugani,
NHS and Local Government Lead
niamh.lennox-chhugani@optimityadvisors.com
+44 (0)20 7553 4841

www.OptimityAdvisors.com

Washington, DC | Brussels | London | Los Angeles | New York | Zurich