

Accountable Care Organizations: The Key to Transforming Healthcare?

Talia Goldsmith, MHA Candidate 2011

Table of Contents

Objective	3
Introduction	3
Overview of ACOs as a Mandate and an Opportunity for Healthcare Organizations	4
Examples of Missions, Visions, Values and Goals for ACOs.....	6
Mission	6
Vision	7
Values	7
Goals.....	7
Key Internal and External Stakeholders for ACO.....	8
Key Attributes of the External Environment Relative to ACOs, and Most Significant Challenges in Implementing ACOs	10
External Drivers	11
Legislative and Political Changes:	11
Economic:	12
Social and Demographic Changes:	12
Technological Changes:	13
Internal Drivers	13
Lack of Direction and Infrastructure:.....	13
Bureaucracy and Resistance to Change:	14
Shortage of Primary Care Physicians:	15
Trends, Assumptions, Implications Analysis	15
Trends	15
Assumptions.....	16
Implications.....	17
SWOT Analysis	21
Strategic and Operational Issues Facing ACOs.....	21
Key Strategic Issues	22
Key Operational Issues	23
Alternative Strategies that Are Being Considered, and Strategies that Are Being Used to Develop ACOs	24
Conclusion.....	27
Bibliography	Error! Bookmark not defined.
Appendix.....	30

Objective

The US healthcare system is undergoing an epic transition that has the potential to transform the practice and delivery of healthcare services. Until recently, reimbursement models have offered minimal incentives for practitioners to improve quality and reduce cost, which has resulted in system fragmentation, duplication, and medical error. Today, the US government is pushing for reform in a strong effort to develop innovative solutions that address the unique challenges that afflict the healthcare system. Among the many initiatives is one that will play a key role in promoting high quality at a lower cost. *Accountable Care Organizations (ACOs)* are described as “provider groups that accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the groups’ clinicians.” ACOs are bringing broad appeal and hope for the future by improving the coordination and quality of care to patients while reducing the rate of increase in health care costs over time (Shortell, et al., 2010).

This research paper provides the reader with an overview of the accountable care model as both a strategic challenge and opportunity for healthcare organizations. Multiple factors that influence the development of ACOs will be described, including an organization’s directional strategies, the external healthcare environment, policy changes, new payment models, as well as different mechanisms that are critical to the success of implementation (such as common IT platforms and solid organizational infrastructures). Examples of alternative strategies that are being used to establish ACOs will be described and future implications of these changes will be examined.

Introduction

Accountable Care Organizations are considered a new model of care that will foster change by integrating physicians with other healthcare organizations and rewarding them for controlling costs and improving quality (Keckley and Hoffmann, 2010). Participating

organizations have a tremendous potential to transform care delivery by using a patient-centered approach where healthcare providers work collaboratively across the care continuum. The fact that physician integration and collaboration was not as heavily emphasized until now can be attributed to existing payment models (such as fee-for-service) that give doctors the incentive to produce more volume regardless of patient outcomes (Premier, 2010). “The current system, based on volume and intensity, does not disincentivize, but rather pays more for, overuse and fragmentation. Providers note that current payment systems undermine efforts to invest money and effort in delivery-system improvements that can sustainably reduce costs” (McClellan, et al., 2010). The methodology behind accountable care reimbursement is different than traditional payment models in that it changes the incentives to reflect better quality outcomes while containing cost. By working together with federal and state agencies, stakeholders across the healthcare continuum are diligently assessing systems-level approaches to building a sustainable approach that will improve quality and curb the growing healthcare tab.

In order to gain a better understanding of the full scope of accountable care organizations, this research paper is divided into different sections that incorporate several key topics. The paper begins by giving a broad overview of ACOs as a mandate and an opportunity for healthcare organizations. Directional strategies are described in the section that follows by breaking down components of an ACO’s mission, vision, values, and goals. The paper goes on to identify the internal and external stakeholders of ACOs, key attributes of the external environment, and most significant challenges in implementing ACOs. A Trends-Assumptions-Implications analysis is presented, followed by a SWOT analysis. To conclude, key strategic and operational issues that ACOs face are explained, and examples are given of alternative strategies that are being considered and currently implemented.

Overview of ACOs as a Mandate and an Opportunity for Healthcare Organizations

The Patient Protection and Affordable Care Act of 2010 is creating unique opportunities for healthcare organizations and leaders to redesign the current care delivery system to promote better value to healthcare spending (Purington, et al., 2011). Provisions of the reform law are stirring organizations to become active change agents by offering a series of incentive programs that must meet specific quality and performance measures. One such provision is the national voluntary program offered by the Centers for Medicare and Medicaid Services (CMS). The program, which will begin in January 2012, offers accountable care organizations an opportunity to participate in a “shared savings program.” “By focusing on the needs of patients and linking payment rewards to outcomes, this delivery system reform...will help improve the health of individuals and communities while lowering the cost of the system – up to an estimated \$960 million over three years in Medicare savings” (DHHS, 2011).

Even though ACOs are largely based on physician practices, they may take on many different forms. There are at least five different types of practice arrangements that fall under ACO consideration: Integrated delivery systems, multispecialty group practices, physician hospital organizations, independent practice associations, and virtual physician organizations (Shortell, et al., 2010). Regardless of ACO type, the opportunities lay in the shared approach to improving the coordination and quality of care for patients while reducing cost.

In order to be eligible to participate in CMS's voluntary program, healthcare organizations will need to meet specific criteria for developing an ACO, such as establishing structured governance and enrolling at least 5,000 Medicare beneficiaries to their network. Other requirements include the participation of primary care providers, the formation of a legal structure, and integrating clinical and administrative systems to support operations.

Furthermore, ACOs will be required to report data on cost, quality and other measures, and use principles of evidence-based medicine, patient engagement, and patient-centeredness when providing care (Lieberman and Bertko, 2011). While these requirements apply to all ACOs that enroll in the program, it is important to note that the US government is giving organizations significant leverage in implementing the criteria. In other words, CMS accepts that a “one-size-fits-all” approach cannot be forced upon organizations, and, as such, as long as ACOs meet the stated guidelines and criteria they are free to make strategic and operational decisions based on what best supports their goals as an organization.

Examples of Missions, Visions, Values and Goals for ACOs

In order to succeed in today’s competitive healthcare environment, ACOs need to have a solid directional strategy that can guide them in making key organizational decisions. Maintaining a clear mission, vision, values, and goals is critically important to ensuring that organizations are headed in the right path towards future success. For ACOs this is especially important, given the number of players involved in sharing accountability for bringing healthcare value to large patient populations.

Mission

According to Swayne, et al., the mission of an organization “drives decision making because it is the organization’s reason for existing” (189). The mission statement of the New England Quality Care Alliance, a Tufts Medical Center-based ACO consisting of over 1,000 community and academic physicians, defines its mission as “a partnership of community and academic physicians dedicated to providing comprehensive, innovative, high-quality and affordable health care that brings value to its patients and the community, and expands the teaching and research mission of Tufts Medical Center” (NEQCA, 2011). Closely related is an organization’s vision statement, which will be described below.

Vision

A vision statement is just as important as a mission statement because it defines the organization's reason for existing, except it takes it a step further by providing a clear roadmap of where the organizations plans on heading in the future. "The vision provides hope for the future and values to tell everyone – employees, stakeholders, patients, and so on – how the organization will operate" (Swayne, et al., 189). MetroWest Medical Center, now part of NEQCA and a Tufts Medical Center affiliate, has a vision statement that clearly defines it's future direction: "MetroWest Medical Center will be the healthcare provider of choice for the region by placing the patient at the center of all decision making, offering exceptional service to patients, comprehensive and high quality clinical programs, a supportive work environment for employees, and an outstanding medical staff that represents a full range of specialties distinguished for clinical excellence" (mwmc.com).

Values

An organization's values are the "fundamental principles that organizations and people stand for – along with the mission and vision, they make an organization unique" (Swayne, et al., 189). Values are considered particularly noteworthy because they are what characterize the organization's behavior and that which is tightly embedded in an organization's culture. Some of the values that may be found in an ACO include: Patient-focused care, continuous improvement, supporting the good health of the community, teamwork, and innovation.

Goals

In order to effectively manage and deliver high quality care, healthcare organizations assign specific strategic goals that will help them achieve their mission and vision. "Strategic goals help to make the strategist's job feasible and help health care strategists to focus more effectively on those tasks that really make a difference with respect to organizational

success” (Swayne, et al., 189). NEQCA, for example, provides support to its network to reach its triple aim goal of “improve[ing] the health of a population of patients; improve[ing] the patient’s experience of care, including quality, access and reliability; and reduc[ing] the rate of growth of costs of care” (NEQCA, 2011). Generally speaking, ACOs strive to accomplish five distinct goals:

- 1) To lower the cost of providing care
- 2) To improve transparency and communication
- 3) To improve access to healthcare
- 4) To improve quality
- 5) To facilitate the coordination of care.

The following chart gives a more in-depth description of each of the five goals:

<i>Goal</i>	<i>Description</i>
<i>1) To Lower the Cost of Providing Care</i>	A main goal for ACOs is to reduce the overall cost of providing care through better coordination and physician integration. In order for cost savings to be realized two requirements have to be met: 1) Providers need to develop methods of consolidating services and reducing waste to ensure cost savings ...and... 2) Patients need to become actively engaged in shared decision making to maximize the potential for better outcomes
<i>2) To Improve Transparency & Communication</i>	The ACO model requires the sharing of patient information in order to achieve maximum efficiency and provide better care. Having a solid IT infrastructure in place for ACOs is a central element that will enable the flow of communication between caregivers and give them access to patient registries with important claims data in order to manage population health. Patient portals, social networking sites, as well as other innovative methods of virtual communication will boost communication and transparency among the different players.
<i>3) To Improve Access</i>	An important goal for ACOs is to improve access to lower cost settings by offering a full range of services as part of an integrated system. By doing so, hospital admissions will be reduced and consumers will have the freedom to access and choose from a variety of high-value providers at a lower cost.

<i>4) To Improve Quality</i>	One of the requirements for ACOs is to improve population health by meeting specific quality metrics. Better management of chronic diseases, improved healthcare outcomes, and disease prevention are all goals that will be achieved by improving the coordination of care.
<i>5) To Facilitate the Coordination of Care</i>	The ACO model includes case managers and other staff that can give patients direction in navigating the system. ACOs encourage innovative approaches to healthcare delivery that will ultimately enable patients to receive a comprehensive treatment plan that will maximize their health potential.

Key Internal and External Stakeholders for ACOs

Accountable care organizations have a long list of stakeholders, all of whom will be greatly affected by changes brought about by healthcare reform as its provisions continue to unfold. One of the biggest challenges will be to ensure that all stakeholders are incentivized to work together in a unified effort to transform the current system.

One of the external stakeholders is the federal government, which has a lot at stake, especially considering the amount of capital that is being poured into programs and initiatives that help support organizations meet their goals of improving quality and reducing cost. State and local agencies are another major external stakeholder because they help disseminate information from the federal to the state level while balancing state regulations and constrained budgets. Employers and consumers of healthcare can be considered external stakeholders because they are the recipients of care.

Some of the internal stakeholders include: Physicians, hospitals, healthcare executives, clinical and non-clinical staff, integrated delivery systems, pharmacies, labs, quality improvement organizations (such as NEQCA and the IHI), experts, consultants and partners who all work together to help drive the ACO initiative. Regulatory entities such as the Joint Commission and the Department of Public Health are internal contributors that set quality standards in accordance with regulatory requirements and address compliance

issues. Payors, in both the private and public sectors, are internal stakeholders because they align payments models so as to ensure that care is being delivered under reasonable and customary fee schedules.

Stakeholder reaction to recent changes around ACOs has been mixed. Amy MacNulty, Lecturer in Healthcare Administration at Suffolk University and President of MacNulty Consulting, LLC, a healthcare management consulting firm that provides strategy and planning services to healthcare organizations, explains that stakeholders have been exhibiting "...a range of reactions depending on how ready they are [for change]. For PCPs who have been in risk contracts (such as in large physician groups), they probably have experience with risk contracts so they are much more ready to do this. For solo physicians who do not have the infrastructure support and information systems, it is much more difficult. The hospitals are...very concerned and worried about what this will mean because [ACOs are]...designed for the lowest cost setting with the highest health. The academic medical centers are worried and community hospitals are much better positioned in the sense that they are a lower-cost setting. Steward Health Care System, [a community-based accountable care organization], for instance, is positioning itself as a low cost, high value provider. Their response is 'we can deliver the same outcome at a lower cost within the community.' You have competitive strategies from hospitals as to how they are going to respond to these kinds of incentives. Employer stakeholders are positive in that anything that reduces cost for them is a good thing given improved outcomes." Many of the reactions described can be directly attributed to changes that are taking place as a result of external environmental forces.

Key Attributes of the External Environment Relative to ACOs, and Most Significant Challenges in Implementing ACOs

The external environment is directly affecting the way the healthcare industry operates and, as a result, how ACOs are emerging. Today's healthcare organizations are

investing more time and money in “collecting and organizing information about the world in which they operate” so they can gain a competitive advantage and build strategies to anticipate and respond to significant shifts in the environment. “Organizations that fail to anticipate change, ignore external forces, or resist change will find themselves out of touch with the needs of the market, especially because of antiquated technologies, ineffective delivery systems, and outmoded management. Institutions that anticipate and recognize significant external forces and modify their strategies and operations accordingly will prosper” (Swayne, et al., 36-37). In order to succeed in today’s competitive market, ACOs will have to balance ongoing economic, political, social/demographic, technological and competitive environmental challenges by effectively executing operational and directional strategies.

The following section describes the key external and internal drivers and challenges that are shaping today’s healthcare environment and ACOs. The external drivers and challenges are separated into four categories: 1) Legislative and political, 2) economic, 3) social and demographic, and 4) technological. The internal drivers and challenges include those that are specific to ACOs. They are separated into three categories: 1) Lack of direction and infrastructure, 2) bureaucracy and resistance to change, and 3) physician shortage.

External Drivers and Challenges:

1) Legislative and Political:

Policy changes and healthcare reform are driving the change effort by creating incentives and building a regulatory foundation for improving quality. This is occurring while funding for Medicare and Medicaid continues to be cut, as well as federal sponsorship for other public programs. The US government is putting forth initiatives to reduce escalating healthcare costs and as a result, is shifting more accountability towards corporate governance. Furthermore, we see more regulation centered around patient privacy and

confidentiality thanks to the widespread use of electronic medical records and sharing of PHI.

2) Economic:

The current economic environment is presenting considerable challenges to healthcare organizations that are already facing cuts in payor reimbursement and limited financial resources. Substantial investment in both time and money are required to establish an ACO's infrastructure. Those organizations that already have a solid health information technology (HIT) foundation may find it easier to facilitate integration. Other organizations that are not as advanced are facing financial constraints and may not be eligible to receive grant funding. Perhaps most troubling is that many organizations that are already participating in pilot programs have not indicated achieving a positive return on investments related to improvement activities (Lake, et al., 2011). Many fear that economic and market rewards may not materialize for a long time. On the consumer end, employers are no longer able to bear the burden of paying for high insurance premiums. To make matters worse, the current unemployment rate is resulting in the loss of employee-sponsored healthcare benefits.

3) Social and Demographic:

Individuals are living longer while the largest segment of the population, the Baby Boomers, is expected to reach 53.7 million by the year 2020. This will result in high healthcare utilization and incidences of chronic diseases. Studies suggest that seven out of ten deaths among Americans each year are from chronic diseases with heart disease, cancer, and stroke accounting for approximately 50% of all deaths (CDC, 2010). The need for chronic disease management and preventative measures given these facts cannot be understated.

4) Technological:

Improvements in science and technology continue to develop to meet the demand for high quality while driving up healthcare costs. Widespread use of health information technology support systems is anticipated, including the “automation of basic business processes, clinical information interfaces, data analysis, and telehealth” (Swayne, et al., 38). Technology will play a fundamental role in enabling ACOs to better manage their operations and achieve organizational goals by facilitating the transfer of information.

Internal Drivers and Challenges:

1) Lack of Direction and Infrastructure:

In order to avoid a reoccurrence of the HMO backlash, the US government is taking cautious steps in ensuring that consumers continue to have the freedom to see providers of their choosing, even outside an ACO. Understanding that ACOs come in all shapes and sizes, CMS is giving ACOs considerable leverage by allowing them to implement organizational strategies that they best deem fit. Unfortunately, this can leave providers directionless and confused. Dr. Emil Yagudin, a Primary Care Physician from Framingham, MA, who recently joined NEQCA through the MetroWest Accountable Health Care Organization, explains that no clear direction has been given to him as of yet. “They keep talking, but nothing is happening so far. ‘Don’t expect a recipe from us, it’s all a process and we will all learn from each other how to work as a team,’ they say. I worry about that because nothing is clear to me. They tell us we have to work better, so we say, okay, what do we have to do? And then they say, ‘we can’t tell you what you have to do.’ They don’t give you any clear answers.”

CMS guidelines require ACOs to meet specific performance and quality measures. In order for organizations to meet such requirements, they will need a means to accurately track and measure performance. Therefore, the importance of having a solid infrastructure to support these goals cannot be underestimated. According to Amy MacNulty, the

significant investments in infrastructure that hospitals, physicians, and care providers will have to make in terms of their information systems, care management across settings, and patient education and support to help them transition into this new model is estimated to cost an average of \$2-3 million dollars.

Establishing, tracking, and attaining meaningful measures proves to be another notable challenge. According to pilot demonstrations, “organizations developing patient registries often noted that the registries are only as good as the data contained in them. Thus, if the data fed into the registries are inaccurate, the registries are inaccurate and not useful for population management or obtaining performance bonuses” (Lake, et al., 2011).

2) Bureaucracy and Resistance to Change:

The ACO model may require a complete restructuring of operations. Pilot demonstrations acknowledge that one significant challenge is staff and physician resistance to change. There are other challenges, as well. Training and recruiting staff who have the appropriate skills to transform an organization is no easy feat. Complex organizations that employ physicians on a contractual basis or other nonexclusive ways may face even more challenges in making sure that everyone is on board with the necessary changes. “The redesign of care to improve quality and efficiency is often a difficult and uncertain journey, requiring resources and expertise beyond most physician practices and hospitals” (Davis and Schoenbaum, 2010). Organizations need to ensure that the right resources are in place to support organizational transformation.

Implementing the necessary changes that will support the ACO infrastructure can create significant disruptions to operations. As an example, the implementation of electronic medical records requires changes in the office workflow patterns and staff responsibility thereby affecting productivity (Lake, et al., 2011). Furthermore, bureaucracy in large and complex organization can become a barrier to quick implementation and necessary changes.

3) Shortage of Primary Care Physicians:

The ACO model emphasizes the need for a strong primary care foundation, however, one major challenge is the shortage in primary care physicians. According to the Health Resources and Services Administration, in 2009 there were 6,204 Primary Care “Health Professional Shortage Areas” with 65 million people living in them. According to HRSA, more than 16,000 providers would be needed to meet their need for primary care providers (HRSA, 2010). Primary care practices, under ACO guidelines, would have to partake in the responsibility for providing, coordinating, and integrating care across the health care continuum. However, the act does not provide “direct incentives to other providers to work collaboratively with primary care providers in achieving these goals and optimizing health outcomes” (Rittenhouse, et al., 2009).

In order to identify how ACOs may be affected in the future by the many challenges noted above, it is important to conduct a Trends-Assumptions-Implications analysis that examines specific healthcare trends in more detail, develops assumptions about the future trajectory of these trends, and determines the possible implications of the projected trends.

Trends, Assumptions, Implications Analysis

Trends:

As previously explained, recent policy changes are creating new challenges for healthcare organizations to operate more efficiently using fewer resources. Healthcare reform is not only expanding coverage, but also pushing for better coordination of care and quality improvement across healthcare settings. As such, organizations are rethinking investment choices and implementing informed decisions when considering competitive business strategies. Since capital access under the stagnant economy is making it difficult for healthcare organizations that lack profitability to secure funding for expanding services that support demand, many organizations are choosing to capture additional market share and

competitive advantage by merging and building integrated systems (Smith & Ricci, 2011). The need for highly integrated systems is becoming evident as population trends signal an increase in utilization within the coming years.

As the Baby Boomer population ages, more and more of them will have multiple chronic illnesses that increase demand for patient services. In order to meet the demand and adapt to the new environment, successful healthcare organizations are placing providers in selected service lines “to improve payer mix, develop a primary care network that will position the organization to become the ACO in its market [or even to offer direct contracting to local employers and Medicare], and to recruit specialists [such as cardiology, oncology, orthopedic spine] who can move high margin procedural volumes to the hospital” (Kittredge, 2010). Central to these changes are the technological developments that are allowing for the virtual transfer of information. Significant investments are being made in medical technology in response to local competition and the need for more standardized, high quality care.

Assumptions:

The healthcare market will continue to adapt to environmental changes especially as the provisions of healthcare reform are enacted. New business models that focus on quality improvement will emerge as organizations struggle to operate under increasing financial pressures. As organizations evolve, a prime focus on client satisfaction and customer service will “increasingly determine the success of health care organizations in a competitive market” (Shi & Singh, 2008). Cost pressures will continue to afflict healthcare organizations and lead them to seek competitive strategies such as mergers and alliances as a means of balancing costs and increasing market share. “Further consolidation will be seen within the healthcare industry [and] healthcare corporations will continue to expand into segments that have less regulation and into business outside of the traditional health care industry”

(38). Environmental factors will continue to shape the healthcare industry and, as a result, organizations will have to adapt accordingly in order to maintain a competitive advantage in the market.

Evidence-based medicine will continue to shape the practice of medicine while developments in science and technology will pave the way for new treatment options, advanced (non-invasive) procedures, better medications, and new vaccinations. Clinical evidence and proven best practices will help standardize the care being delivered to individuals with chronic conditions and specific disease states. ACOs will play a key role in achieving higher quality at lower cost by better coordination and innovative payment methods that provide systematic approaches to providing care at the population level.

These changes will cause a market shift that will transfer the risk from payers to providers and, as such, will hold them accountable for the cost and quality being delivered to their respective populations (See Figure 1 in Appendix). Alternative quality contracts (AQC)s provide a good example of this transfer of risk. AQC)s are global payment models that offer substantial performance incentive payments to participating physicians (BCBS, 2010). As use of AQC)s becomes more widespread, physicians will play a principal role in meeting quality and cost targets.

Implications:

The herd-like tendencies of the healthcare industry to become part of the latest trend have historically resulted in unintended consequences. Take, for instance, the efforts to contain cost in the 1990s, which resulted in the HMO backlash. In this same respect, it is questionable whether enough details are being considered from a systems-level perspective to enable such a large-scale transformation to happen so quickly. As healthcare organizations race to form integrated systems through hospital mergers and physician practice acquisitions, many smaller individual group practices will become at risk for being

left behind. Dr. Yagudin explains, “the problem is I cannot survive on my own. I don’t have a choice and I have to do my best and follow what the others are doing.” Another unintended consequence of organizational expansion and competitive strategies is the increasing leverage integrated systems will have with insurance companies when negotiating rates which, in turn, could drive up cost.

Another major implication is the increasing responsibility physicians will bear for patient health outcomes even if beneficiaries choose to consult providers outside the ACO. On the beneficiary side, if patients are unaware that they have been assigned to a physician group that is part of an ACO, he/she “may not be able to become full partners in managing their care” (Inglehart, 2010). In past pilot demonstrations such as the Medicare PGP in 2005, even though the physician group met 29 of its 32 quality goals and generated Medicare \$38.7 million in savings, the groups were not faced with financial penalty if they missed their targets. Given this fact, it is difficult to establish whether a similar initiative on a national level will build strong enough incentives to be able to alter physician behavior (Iglehart, 2010).

Samantha Henderson, Research Associate at the Institute for Healthcare Improvement, explains that aligning payment models is proving to be a major challenge for ACOs: “There are tiered risk levels; the more advanced integrated systems can go on the most advanced path. For those who are waiting in the waters then there is no penalties at first if they fail. The problem is how do you get both private and public insurances to coordinate payment methods. It’s really confusing. Change is going to be tough for those hospitals and clinicians where the model since they entered the profession has been to grow, grow, grow.... if people cut your process then you compensate by adding volume. Because the business model is changing people are frightened that they won’t be able to do this

anymore. My fear is that organizations are more focused on the finances rather than changing the process for the sake of better quality.”

On the policy side, stakeholders need to be aware that transformational change will take substantial time and effort to achieve. This fact is made clear by Marian Johnson, Research Associate at the Institute for Healthcare Improvement who is working on initiatives that support ACO development. She observed, “I think there is a huge potential for this to fail and a lot of it is political and it really depends on which way Congress may shift. If people actually are serious about trying to repeal health reform then this would be part of their target....I think that many people see ACOs as another acronym for HMO. The next few years will be interesting because there will be some big winners and some big losers and I’m not sure how it’s all going to play out. I think that the younger generation of doctors is much more amenable to working in teams and as part of a system. That, in and of itself, is making these partnerships a little more seamless but that’s going to be a slow change. What we’re dreaming of seeing will most likely not take place until 50 years from now.”

Even though research has demonstrated that large, integrated networks have been effective in achieving cost savings and quality outcomes, there is little evidence that defines “the relative effectiveness of particular organizational structures or types of provider composition, such as the specific specialty mix of providers or the extent or types of affiliations with hospitals or other facilities” (Lake, et. al., 2011). Learning from successful organizations in how their approach worked will prove critically important for future learning purposes. Legal implications also have to be considered as ACOs “could run afoul of antitrust and anti-fraud laws, which try to limit market power that drives up prices and stifles competition.” A major concern is that ACOs in rural markets could grow so large and powerful that they would employ “the majority of providers in a region” (Gold, 2011).

The many significant implications have to be assessed in order to minimize the potential for failure.

Before adopting the ACO model, healthcare organizations have to consider many strategic alternatives. As indicated in the previous sections, organizations must take into consideration the many internal and external factors that currently influence the healthcare environment. In this same respect, it is important to consider future implications to these changes and how they may affect the organization's strategic posture. In order to evaluate the likelihood that an ACO can meet its potential goals, it is important to conduct a SWOT analysis to identify key factors that may influence the organization's directional strategies. The following chart depicts key strengths, weaknesses, opportunities and threats when considering ACOs in today's healthcare context. The analysis is not specific to any particular organization; rather, it provides a general example of the strategic method used that could be applied when considering the ACO model.

SWOT Analysis

<u>Strengths</u> • Support from the government • Physician integration and collaboration/Better coordination of care • Increased patient-centered approach • Flexibility in forming ACOs • Shared decision making • Evidence-based clinical outcomes • “Strength in numbers” (i.e. shared responsibility) • Consolidation of organizational resources • Payment model that emphasizes improved quality & efficiency	<u>Weaknesses</u> • Insufficient time to develop needed infrastructure to support ACOs • Insufficient/lack of technological infrastructure • Additional administrative burdens/disruption to operations • High cost and time commitment of developing an ACO • Requires the involvement and commitment of all healthcare stakeholders
<u>Opportunities</u> • Shared savings and significant incentive potential for physicians • Community/population benefits as a result of better coordination of care • Potential to significantly reduce medical error & waste • Reduction in cost and improved quality standards • Increasing market share opportunities through expansion of scope strategies (vertical integration, product development, etc), and market entry strategies (mergers, alliances, acquisitions)	<u>Threats</u> • Risk of treating patients with unpreventable conditions and outcomes • Ensuring patient adherence and accountability • Policy and legislative restrictions • Provider financial risk • No guarantee of immediate ROI • Increased competition based on large group market power • Shared responsibility • Lack of regulatory clarity surrounding legal and antitrust issues

Strategic and Operational Issues Facing ACOs

According to Peter Senge, author of *The Fifth Discipline: The Art & Practice of the Learning Organization*, systems thinking is needed in today’s environment more than ever because of the increasing amounts of complexities that exist in our world. Senge describes that for the first time in history, “humankind has the capacity to create far more information than anyone can absorb, to foster far greater interdependency than anyone can manage, and

to accelerate change far faster than anyone’s ability to keep pace” (Senge, 1990). Today’s healthcare environment is changing at such a rapid pace that it is becoming increasingly important for healthcare professionals to engage in systems thinking. Problems in the healthcare system (such as medical error) are a consequence of failing system approaches. Knowing where to connect the dots will enable leaders to assess potential gaps and risks.

The accountable care model challenges organizational leaders to consider strategic options that drive progress in their organization while maintaining a systems thinking approach. Operational issues also need to be considered to identify potential challenges and effective methods of implementation. The following chart demonstrates the interdependency (“systems” approach) between the mission, vision, values and goals, and key strategic and operational issues facing ACOs (See Figure 2 in Appendix). The five strategic domains were drawn from the American Medical Association’s *Strategic Issues Forecast 2015*, which identifies “long-term strategic issues affecting hospitals and health systems in the 2011 to 2015 horizon” (AMA, 2010). Below is a breakdown, in question form, of the strategic and operational issues that fall under each domain.

Key Strategic Issues:

Care Coordination:	• How do we recruit primary care physicians and expand organizational capacity? • What role will technology play in designing the systems necessary to effectively coordinate care and improve quality? • What will be the role of the hospital in the ACO care model? • What role will ACOs play in addressing end of life care?
---------------------------	--

Quality Improvement:	• How do we define and develop quality metrics that are realistic and attainable? What should the metrics be? • How do we develop meaningful incentives that promote continuous quality improvement and physician collaboration? What should the incentives be? • What role will ACOs play in improving the quality of care?
-----------------------------	--

Efficiency:	• How can ACOs utilize performance improvement methods to reduce variability with limited resources, lower reimbursements, and increased system utilization? • What role will HIT play in improving efficiency? • What role can the government play in developing better efficiency metrics to guide ACOs as they meet their goals?
New Payment Models:	• What types of payment models best create incentives for physicians to improve quality and efficiency? • What is the role of public and private payors in creating better value and promoting population health?
Bending the Cost Curve:	• How do we ensure that quality is not jeopardized at the expense of lower cost? • How can evidence-based medicine be used in conjunction with cost effectiveness research to create more value?
Key Operational Issues:	
Care Coordination:	• How can we provide better coordination of care between acute care settings and ambulatory care settings to reduce hospital readmission rates? • How can we improve practice standards to emphasize prevention and disease management? • How can IT support systems be used to share information with out-of-network physicians? • How can we best keep the patient informed? • How can we incentivize patients to stay in-network?
Quality Improvement:	• How can we promote continuous quality improvement within the care setting? • How can we help patients become more actively engaged in shared decision-making? • How can we meet quality metrics? • How can we meet consumer expectations?
Efficiency:	• How can we change operations to ensure maximum efficiency and productivity? • In what areas can we eliminate waste and streamline processes?

New Payment Models:

- How can we improve contracts with payors to reflect high performance and quality?
 - How can we improve contracts with suppliers?
 - What is the best way for ACOs to implement payment models?
-

Bending the Cost Curve:

- How can we restructure hospital services to maintain financial viability (assuming reduction in admissions)?
- How can we use a systems approach to lowering costs across ACO settings?
-

Alternative Strategies that Are Being Considered, and Strategies that Are Being Used to Develop ACOs

Some of the strategies being used to develop ACOs include multifaceted approaches that can be examined on both a macro and micro level. According to Swayne, et al., “strategies selected by organizations should address external issues, draw on competitive advantages or fix competitive disadvantages, keep the organization within the parameters of the mission and values, move the organization toward the vision, and make progress toward achieving one or more of the organization’s strategic goals” (198). This is the case for many healthcare organizations that are trying to align long-term strategic goals while balancing the changing healthcare environment.

Market dynamics and healthcare reform are forcing executives to reevaluate their organization’s directional strategies by reformulating their vision for the future. As one healthcare executive notes, “with all the changes swirling around us we needed a more long-range strategic planning process. So we developed a 10-year strategic vision statement that takes the disjointed, uncoordinated, inefficient and far too risky system that we’ve got now and transforms it over that 10-year period to hopefully a system that’s going to be remedying all those sort of problems” (Molpus, 2011). Many are developing alternatives that consider different adaptive, market entry, competitive, and implementation strategies. However, before moving towards accountable care, organizations must recognize their

internal (strengths and weaknesses) and external environment (opportunities and threats), determine what resources are available to them, assess potential barriers and risks, and evaluate the implications to all alternatives. Moving towards accountable care is somewhat like “the diffusion of any innovation” where early adopters are able to move quickly given their experience and infrastructure. Late adopters are those that base their move on a strategic initiative as a result of external environment factors that force them to identify where the gaps lay and where they are in terms of infrastructure. More importantly, they realize what it will take for them to get to where they need to be.

The strategic posture of an organization, as mentioned previously, is another element that needs to be considered when analyzing strategic alternatives for ACOs because “the ACO has to serve to transform an organization into a totally different delivery model over the next several years. If we don’t... [achieve]... the two broad objectives for the future —improving quality and driving efficiency—then there’s really no purpose in going through all the struggle and pain” (Molpus, 2011). In order to succeed in this market, an ACO’s strategic posture has to match that of a *prospector*, which searches for new market opportunities, engages in experimentation and innovation, and creates change in the service area, or an *analyzer*, which balances stability and change, maintains stable operations in some areas, but also searches for new opportunities and engages in market innovation (Swayne, et al., 230).

Prospectors and analyzers may consider directional strategies such as expansion of scope through vertical integration by “increasing the comprehensiveness and continuity of care, while simultaneously controlling the channel of demand for health care services” (Swayne, et al., 206). One such strategy is currently being executed by Tufts Medical Center. The Floating Hospital for Children extends to other locations throughout Massachusetts and provides pediatric services including dermatology, orthopedics, and cardiology. Expanding their scope of services to different locations such as Chelmsford, Woburn, and Framingham

increases the hospital's market share and competitive advantage thereby making it an effective strategy.

Market development is another strategy that is being used by organizations to “achieve greater volume, through geographic (service area) expansion or by targeting new market segments within the present geographic area” (Swayne, et al., 2006). Franciscan Alliance/St. Franciscan Hospital and Health Centers is implementing a market development strategy by operating 13 hospitals in four distinct markets: Indianapolis, Lafayette and Northwest Indiana and the south side of Chicago. By assessing potential for accountable care, such as care management programs and IT infrastructure, Franciscan Alliance is able to focus on services that meet specific market segments. “We’re also focusing on getting our arms around the post-acute continuum.... And we see chronic disease management and integrating with post acute providers as very important going forward” (Molpus, 2011).

Some organizations are using market entry strategies to develop ACOs. Monarch Healthcare, for instance, is using a cooperation strategy. By partnering with other hospitals in the form of a strategic alliance, organizations can “achieve some long-term strategic purpose not possible by any single organization” (Swayne, et. al., 223). Monarch has relationships with over 20 hospitals. This strategy improves their relationship by translating the work to improve quality and cost. “We’re working to educate our physicians and hospital partners about what an ACO is, and how to engage with us to succeed together. So our initiatives as an ACO are a continuation, really an expansion of some of the principles that we’ve already started” (Molpus, 2011). Children’s Hospital Boston and other academic medical centers around the Boston area are all pursuing similar strategies.

On the micro, or organizational, level, ACOs are looking at physician leaders to help drive initiatives. Physician champions are those respected insiders who help “sell” the project within organizations and prove to be particularly important in ensuring that

physicians and other clinicians are on board. In addition, clinical staff, such as nurses and medical assistants, are being encouraged to take on new responsibilities by initiating programs. Giving staff specific responsibilities and ownership of projects increases accountability and makes them feel as key contributors in the change process.

Organizations are becoming more transparent by opening lines of communication to engage staff and, as such, mitigating some of the fear that staff may have about changes that are taking place. “Commitment to transparency also facilitate[s] support among clinical and nonclinical staff because they underst[and] the programs’ goals and steps needed to achieve these goals” (Lake, et al., 2011). Organizations are finding ways to encourage physician participation by enhancing incentives. For instance, some healthcare service vendors, such as Quest Laboratories, are offering stipends to participating physician practices to assist in purchasing computer hardware and software in order to expand the EHR platform. Infrastructure support is also being given to smaller practices that have fewer internal resources to support improvement activities. This is the case with Middlesex Family Practice, PC, which has been receiving technical assistance including on-site support from NEQCA and MetroWest Medical Center representatives. Regardless of the strategic alternative being sought by the organization, there is one more key element that is critical to the transformation towards the accountable care model. Having a strong leadership team to guide the change initiative is central to achieving long-term organizational success.

Conclusion

This research paper seeks to inform the reader about the various facets that characterize accountable care organizations within the context of today’s changing healthcare environment. The paper provides an overview of ACOs and examples of directional and alternative strategies that are being used, and it acknowledges key attributes and challenges as they relate to the internal and external environment. Key stakeholders are

identified and a SWOT analysis is presented to demonstrate key strengths, weaknesses, opportunities, and threats. Finally, key strategic and operational issues are described and a Trends-Assumptions-Implications analysis is presented to highlight fundamental future challenges.

I believe that accountable care organizations hold a promising potential to transform the US healthcare delivery system by better coordinating care and utilizing valuable resources (such as HIT) to support the transfer of information across the care continuum. If done effectively, ACOs will benefit by substantial cost savings through the consolidation of resources and streamlining of processes. For consumers, these changes will result in better quality, reduction of medical error and waste in the system, and improved management of population health. While many challenges lie ahead, one thing is certain: The ACO model is effectively challenging healthcare leaders and organizations to shift the focus from providing *care* to promoting *health*.

Figure 1: ACO will cause a market shift where providers will bear increased burden of risk

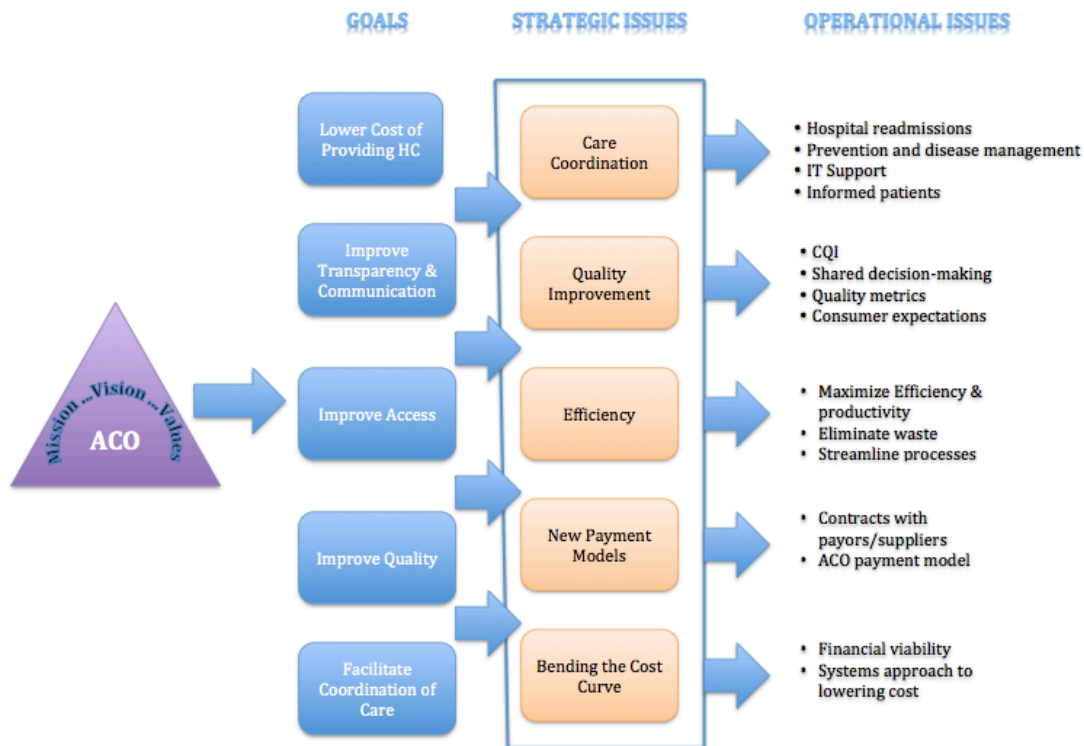
MARKET SHIFT AND HOW IT AFFECTS REIMBURSEMENT

The market shift requires hospital networks to master cost management with a focus on outcomes for higher reimbursement



Source: Molpus, 2011

Figure 2: ACO Systems-level Approach to Key Strategic and Operational Issues



Bibliography

American Medical Association. *Strategic Issues Forecast 2015*. November 2010.

Amy MacNulty. Suffolk University Lecturer in Healthcare Administration. Phone interview. April 20, 2011.

Berwick, Donald (31 March 2011). Launching Accountable Care Organizations — The Proposed Rule for the Medicare Shared Savings Program. *New England Journal of Medicine*. 10.1056/NEJMp1103602.

Blue Cross Blue Shield of Massachusetts (May 2010). *The Alternative Quality Contract*. Accessed on 26 April 2011 from: <http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf>

Centers for Disease Control and Prevention (7 July 2010). *Chronic Diseases are the Leading Causes of Death and Disability in the U.S.* Accessed on 26 April 2011 from: <http://www.cdc.gov/chronicdisease/overview/index.htm>

Davis, K. and Schoenbaum, S. *Toward High-Performance Accountable Care: Promise and Pitfalls*, The Commonwealth Fund Blog, September 2010.

DHHS. Centers for Medicare & Medicaid Services Office of the Inspector General. 42 CFR Part 425. Volume 76 No. 67. 7 April 2011. Accessed on 9 April 2011 from: <http://edocket.access.gpo.gov/2011/pdf/2011-7880.pdf>

DHHS. Centers for Medicare & Medicaid Services. *Medicare Shared Savings Program: a new proposal to foster better, patient-centered care*. 31 March 2011. Accessed on 14 April 2011 from: <http://healthreform.kff.org/Document-Finder/CMS-ACO-Fact-Sheet-for-Consumers.aspx>

Emil Yagudin, MD. Middlesex Family Practice, P.C. Framingham, Massachusetts. Personal interview. April 15, 2011.

Gold, Jenny (18 January 2011). *Accountable Care Organizations, Explained*. NPR. Accessed on 9 April 2011 from: <http://www.npr.org/2011/04/01/132937232/accountable-care-organizations-explained>

Health Resources and Services Administration (HRSA) 28 May 2011. Accessed on 13 April 2011 from: <http://bhpr.hrsa.gov/shortage/>

Iglehart, John (20 January 2011). Assessing an ACO Prototype — Medicare's Physician Group Practice Demonstration. *New England Journal of Medicine*. 364:198-200

Keckley, P., Hoffmann, M. *Accountable Care Organizations: A new model for sustainable innovation*. Deloitte, 2010. Accessed on 9 April 2011 from: http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_AccountableCareOrganizations_070610.pdf

Kittredge, Frank (16 November 2010). *An Overview of Healthcare Trends*. HKS. Accessed on 18 April 2011 from: <http://www.hkssmarthealthcare.com/?p=575>

Lake, T., Stewart, K., Ginsburg, P. Lessons from the Field: Making Accountable Care Organizations Real. *National Institute for Healthcare Reform*. Research Brief: Number 2, January 2011.

Lieberman, S., Bertko, J. Building Regulatory And Operational Flexibility Into Accountable Care Organizations And 'Shared Savings.' *Health Affairs*. January 2011. 30:1.

Marian Johnson. Institute for Healthcare Improvement. Phone interview. April 19, 2011.

MetroWest Medical Center. *Mission and Vision Statement*. Accessed on 15 April 2011 from: <http://www.mwmc.com/about-mwmc/mission-statement.aspx>

Miller, Harold (November 2009). *Creating Accountable Care Organizations in Massachusetts*. Massachusetts Hospital Association.

Molpus, Jim (January 2011). The Bridge to Accountable Care Organizations. *HealthLeaders* Media In Collaboration with PWC.

New England Quality Care Alliance. *Mission Statement*. Accessed on 16 April 2011 from: <http://www.neqca.org/AboutUs/Mission>

Premier, Inc. 2010. Retrieved on 9 April 2011 from: <http://www.premierinc.com/advisorlive/Presentations/aco-white-paper.pdf>

Purington, K., Gauthier, A., Patel, S. and Miller, C. *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations*, The Commonwealth Fund and the National Academy for State Health Policy, Feb. 2011.

Rittenhouse, D., Shortell, S., Fisher, E. *New England Journal of Medicine*. 2009; 361:2301-230.

Samantha Henderson. Institute for Healthcare Improvement. Phone interview. April 19, 2011.

Senge, Peter M. *The Fifth Discipline: The Art & Practice of The Learning Organization*. Currency Doubleday, New York, 1990.

Shi, L., Singh, D. *Delivering Health Care in America: A Systems Approach*. Jones and Bartlett Publishers, Inc. Sudbury, MA. 2008.

Shortell, S., Casalino, L., Fisher, E. How The Center For Medicare And Medicaid Innovation Should Test Accountable Care Organizations. *Health Affairs*. July 2010. 29:7.

Smith, D., Ricci, C., Healthcare Trends – 2011. *Healthcare Leadership White Paper*. 2011. Accessed on 14 April 2011 from: <http://www.besmith.com/Repository/6/Document/2011%20Trends%20whitepaper WEB.pdf>

Swayne, L., Duncan, J., Ginter, P. *Strategic Management of Health Care Organizations, Sixth Edition*. Jossey-Bass, A Wiley Imprint, 2008.