The Many Roadblocks of Creating an ACO

April 5, 2013 by Gabriel Perna

On the surface, it’s obvious why many providers would go down the path of becoming an accountable care organization (ACO). The end result can leave you in a much better place clinically and financially, and overall in-tune with innovative models of reimbursement.

In a study from last year, researchers at the Dartmouth Institute for Health Policy and Clinical Practice found that programs which resemble ACOs have in the past saved as much as $532 per Medicare dual-eligible beneficiary while reducing readmissions by a significant margin. Meanwhile, other ACO-related studies, including one on health payer Cigna’s various initiatives in this area, have also shown positive results from both a clinical and cost-reduction standpoint.

Yet successfully mining this opportunity is a tremendous achievement, the path of becoming an ACO and changing the organizational structure is fraught with numerous challenges that can derail any organization. Those who have been on the front lines of this journey say it is an ongoing process, one that involves numerous obstacles from both the cultural and IT standpoints.

Banner Health

Taking that first step, in itself, may be a challenge. For Banner Health, a Phoenix-based acute-care healthcare system with 23 hospitals and healthcare facilities across multiple states, acknowledging the rising costs of delivering care in a pay-for-volume model and regulatory pressures from the Centers for Medicare & Medicaid Services (CMS) quality improvement initiatives was reason enough.

As a result, Banner Health leaders created the Banner Health Network (BHN), expressly designed to take on accountable care organization (ACO) development both through the Medicare Shared Savings Program (MSSP) for ACOs, and via collaborative contracting with health plans in Arizona. In the months since starting down this path, BHN has already begun to reap the rewards of this commitment. As Tricia Nguyen, M.D., BHN CMO tells it, taking on accountability meant a significant reduction in hospitals admissions, complications from patients being admitted to the hospital, and a positive impact on its bottom line.

Naturally, Nguyen says, getting there hasn’t been an easy ride for the organization, which first partnered with Blue Care Blue Shield of Arizona to be half-owners of BHN’s Medicare Advantage patients and then with Aetna (Hartford, Ct.) to implement the IT necessary for this kind of collaboration to work. The technology, she says, is needed to aggregate disparate data sources, such as electronic health record (EHR) systems and medical claims.
“We wanted to create a longitudinal, 360-view and understanding of the patient and members that we are accountable for, so we can apply analytics and identify the population by disease, such as diabetics, asthmatics, etc. Then we can categorize them, by low, moderate, or high risk, so we can focus our resources and interventions to those with the highest need,” Nguyen says.

Through Aetna, BHN has been able to bring these data sources together, create disease registries, and use analytics for population health on one platform. But this in itself was a challenge, Nguyen says. “The biggest challenges from an IT perspective were ensuring everyone was on an EHR and adopting the disease registries,” she notes.

**Culture Problems**

These IT challenges speak to a larger obstacle that BHN and many other organizations face when trying to create an ACO. As Nguyen says, they had to work towards changing the culture, which includes the physicians, the patients, and the administration. Even those IT challenges mentioned above, investing in the technology stacks, getting physicians to adopt, relate back to the larger cultural shift.

Changing the mindset of the practitioners was a tough sell, Nguyen says. “Moving them from volume to value, from a sickness model to a proactive, wellness model – that means they have to practice medicine very differently,” she says. “Instead of having patients call us for an appointment, they needed to figure out how we can reach out to patients and invite them to be evaluated to identify issues that need to be mitigated.”

Nguyen, who is a physician herself, says having physician leadership has helped. The ACO’s board is comprised of 80-90 percent physicians. Had that not been the case, she says that many of the physicians would have perceived this entire endeavor as “business as usual.” In addition, BHN has kept open an active, two-way dialogue with the physicians, to keep in the loop. Communication is extremely important, she says. Physicians are encouraged to provide feedback. She says one thing that helped spur participation is money.

“Once we starting paying them for the time spent at these [engagement] meetings to learn, that became an intrinsic motivation factor. Now they are internalizing it. Now we’re seeing intrinsic motivation from the physicians to help lead the change. They’re now coming up with ideas on what they can do differently,” Nguyen says.

It’s not just the physicians who have been hit with a bit of culture shock. Getting patients to change their habits and be more accountable with their healthcare has also been a challenge, Nguyen says. Getting the providers on board first was primary, but patients will be next. BHN will try to build public awareness of the ACO through direct conversations and newsletters. Through its commercial payer partners, she says, it will also look to provide incentives for the patients.

**Brevard Physicians Network**

For the leaders at Brevard Physicians Network, a Melbourne, Fl.-based independent practice association (IPA) with more than 300 physicians, physician buy-in presented a similar challenge. Brenda Radke, CEO of Brevard, says she had to let physicians within the organization arrive at their own conclusion because it would give her a much higher rate of compliance, she says. It didn’t happen overnight.

“It took me three years to get them to see that ‘she’s not bluffing, we are evolving, healthcare is changing,’” Radke says.
Brevard implemented a population health, analytics platform from Medecision (Wayne, Pa.) which allows it to integrate claims data sources. Like BHN, Brevard has required its physicians to adopt an EMR, and it is in the process of connecting that clinical data with the payer data. The idea is to give a quick, snapshot of how the physician is performing in quality measures, while providing a comprehensive, real-time record of the patient.

According to Radke, part of the challenge is convincing it the office staff to buy-in. “They’re the ones who are driving the bus,” she says, adding that the organization is trying to find ways to incentivize and inspire the staff, since they’re reaching out to patients and managing their cases. “That’s always going to be a challenge.”

Another challenge, Radke says, is centered on creating an understanding with nearby hospitals and health networks. She says Brevard has been reaching out to these organizations and trying to form partnerships.

The Square Root of N

“Go for the low hanging fruit,” is what Nguyen would tell others who are dealing with these cultural issues. What this means, she says, is go for the people who are ready, willing, and capable of making those changes and buying into value-based healthcare. She says if you can get a group of champions on board, it will create a snowball effect.

“To make meaningful change, the formula that I’ve learned is the square root of N,” explains Nguyen. “So if you have a group of 100 that you want to change, the square root of that 100 is 10. You need to change 10 people, then they become your champions and disseminate. They can demonstrate the outcomes, then once that’s done, you can invite others in.”