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ACO ASSESSMENT TOOLKIT

APPENDIX I. DISCUSSION GUIDE FOR EMPLOYER COALITIONS

JUNE 2017


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Appendix I. ACO Assessment Discussion Guide for Employer Coalitions

The following discussion guide was created by the Pacific Business Group on Health in collaboration with Anthem to support Provider Organization Process Reviews. The goals of the process reviews are to understand the structure of the organization and systems and operations for delivery of accountable care. Both the health plan and ACO perspective are important in understanding how well services are integrated and coordinated to support member needs across the continuum of health and providers.

Working with its employer members, a coalition may also elect to conduct a deeper dive that may include case reviews and audit of clinical processes.

Leadership, Governance, Organization and Experience

1. Describe the leadership and governance of the organization.
    a. Who is on the Board and what groups are represented by these individuals (primary care, specialists, leadership from key hospitals, other stakeholders, etc.)?
    b. How often does the Board (or Executive Committee) meet?
    c. How are decisions communicated to constituents?
    d. Does the Board include consumers and purchasers?
    e. Who owns the organization?
2. How is this group organized? Medical group, IPA, both?
    a. Do you have employed physicians?
    b. What is the mix of your employed vs. contracted doctors; PCPs? Specialists? Mental health providers?
    c. In the case of non-employed doctors, please indicate the proportion that are exclusively treating your patients. (Can you report this by PCP and specialists?)
3. What portion of market-share does this health plan represent in your total business?
    a. What proportion of the health plan's members are attributed to the ACO?
    b. What proportion of business is PPO business vs. HMO business?
    c. What proportion of this ACO patient population is treated by doctors on your HMO platform?
    d. In addition to the PPO platform that supports this ACO contract, do you also operate an HMO?
4. How many ACO or population-based contracts are held by the organization?
    a. Medicare Shared Savings Program participation or other Medicare pilot programs?
    b. Other commercial ACO contracts?
    c. Length of time and volume of membership?

Member Identification and Engagement

1. Please describe the initial intake process (please differentiate answers for medically complex patients vs. attributed patients)
    a. In person or via telephone?
    b. Is enrollment in this health plan's ACO opt in or opt out?
    c. Is "patient engagement" or "readiness to change" assessed during this or some other process?
    d. What is the frequency and nature of on-going member contact barring specific needs or issues (routine contact)?
2. What is the typical mode for patient communications? Which of the following methods does the group employ and for what purpose?
    a. Letters
    b. Phone calls
    c. Interactive Voice Response (IVR)
    d. Email
    e. Patient Portal
    f. Other
3. Does the ACO tailor communications based on the needs of the patient (i.e. high risk, mental health, socioeconomic factors)?
4. Does the patient have the ability to electronically view, download, and update personal medical information?
5. How does the ACO ensure timely access to care?
    a. Easy appointment scheduling with same-day availability based on acuity? How long does it take for a patient to obtain an appointment?
    b. Increased 24/7 patient, family and caregiver access (nurse advice line, after-hours call center, and/or telemedicine consultation) to providers who know the patient and have access to the patient's EHR?
    c. If the ACO offers a telemedicine option, please describe how it interfaces with the patient's PCP's record of care (i.e., how is it integrated with the patient's conventionally received care?)
    d. Do care coordinators receive next day notification about patient outreach?
6. How does the ACO provide information about patient rights and opportunities for redress/ recourse and second opinions?

7. What assessment tools are part of the enrollment process? (Psychosocial, depression, other behavioral health)?
    a. Are these repeated at periodic intervals?
8. Does the ACO support an infrastructure of "support" groups for special needs, e.g., cancer support, weight-loss support, etc.? Please describe.

Provider Engagement, Support and Feedback

1. Is there PCP or PCP office partnership with care coordinators for intake?
2. How does the ACO document and/or systematically check that recommended referrals have been acted upon?
3. Does the ACO alert specific PCP providers that a specific patient has been attributed to him/her?
    a. If so, is there a feedback loop to gather information from the PCP about the patient, to communicate back to care coordinator (and likewise back to the physician again as appropriate) on a regular basis as updated information is received from health plans? Please describe.
4. Are there non-physician clinicians notified of the patient's attribution and clinical status?
    a. What is the professional delineation of your non-physician practitioners? How many of each of the following specialties do you have on staff and generally speaking, how many patients can they manage at one time?
        i. Social workers?
        ii. Diabetes educators?
        iii. Nurse Practitioners?
        iv. Other?
5. Is there a "team" approach? Please describe what the team looks like and how they operate.
6. Is the chart or EMR marked for easy identification of attributed patients by all who access it?
7. Does the medical group have a process and system that supports clinician (e.g., physician, etc.) referral of patients into care coordination who may not be automatically attributed?
8. Does the treating clinician receive feedback about the patient's engagement in the recommended care management protocol?
9. Do ACO physicians get referral support, i.e., information informing them about high value providers to whom they should refer?

Care Management and Population Health

- Care Coordination
- Medically Complex Patient Management
- Behavioral Health Integration

1. Does the ACO risk stratify each member based on severity of illness(s) and intensity of services? Please describe.
2. Do care coordinators (or PCPs) routinely capture data on:
    a. Smoking status?
    b. BMI?
    c. Lifestyle, e.g. exercise, alcohol use?
    d. Important social determinants, e.g. domestic violence risk or family stress?
        i. Does the ACO have any partnerships with community organizations and social services agencies (e.g., housing, food assistance, transportation)?
3. How is care coordinated between primary care and mental/behavioral health professionals?
    a. What is the referral process for patients at risk for depression?
    b. Are clinical records exchanged between medical and mental/behavioral health providers?
    c. Is there an integrated care plan for primary care and mental/behavioral health?
    d. Recognizing that there might be a mental health carve-out plan, does the referral process consider the patient's benefit design and impact of using network or non-participating providers?
4. What is the group doing different now with regard to care coordination than prior to the ACO contract with the health plan?
5. Do the patients enrolled in this health plan's ACO have care management or care coordination that is different from other health plans' ACO members? Please describe. (Note: the point of this question is to assess how the group administers varying ACO contracts across plans).
6. What are the staffing ratios for care coordinators to attributed patients?
7. Are care coordinators embedded within primary care practice sites, centralized, or both?
8. Do the ACO care coordinators conduct home visits?
9. Does the ACO staff conduct daily or weekly care coordination huddles to risk-stratify/tier

case load and discuss cases? Please describe.

   a. Are shared decisionmaking techniques included in clinician training and is its use promoted?
   b. Are motivational interviewing techniques included in clinician training and is its use promoted?
   c. Is there ongoing training?
   d. What ongoing monitoring exists to assure quality improvement around these proven techniques?
   e. Are there any carve-outs (behavioral health, cancer, end-stage renal disease, etc.)?
      i. If so, does the ACO coordinate with a warm handoff to assure that there is someone to take care of the patient on the other end?

10. Please describe the role the care coordinators play in transitions of care? (This includes to specialists, ER, Hospital, SNF, Rehabilitation, Outpatient treatments and services, Home Health, DME, and Behavioral Health) Or does the ACO have systematic processes around smooth transitions that do not involve care coordinators?

    a. What services are provided to patients deemed at high-risk for readmission?

Quality Measurement and Improvement

1. Please describe the monitoring system and metrics the ACO uses to provide information about:

   a. Number of patients outreached and enrolled
   b. Utilization metrics
   c. Clinical and quality metrics (can you provide a list of the quality metrics you routinely evaluate?)
   d. Patient engagement
   e. Patient experience (patient satisfaction)? Patient Assessment Survey (PAS)? Other?
   f. Patient Reported Outcomes Measures?
   g. Patient total cost of care?

2. Does the ACO use measures that differ from the measures required by the health plan?
3. Do different health plans require different measures from the ACO?
4. What measures does the plan routinely report to the ACO, and with what frequency? Does the ACO use this information for quality improvement?

5. What change(s) have been most impactful in the ACO improving quality of care or reducing total cost of care (i.e. most impactful at increasing value)?
6. How does your operational infrastructure enable and support quality improvement?
    a. What methods are used in structuring quality improvement activities (e.g., Lean, Total Quality Management, Plan-Do-Study-Act, etc.)
    b. What training does the ACO provide to care coordinators and other members of the care team? How are new staff integrated? Are staff recertified on an annual basis or other frequency?
    c. In what ways do you support or train physician office staff in modifying workflow to improve patient experience, care coordination and data capture for quality measurement?
    d. How do you instil a culture of ongoing quality improvement throughout the organization?

Network Management, Contracting and Financial Model

1. Recognizing that the ACO enrollment is PPO-based, what efforts does the organization undertake to steer members to:
    a. Higher-performing specialists?
    b. Hospitals?
2. What is the primary hospital for ACO patient referrals?
3. How do you communicate that hospital preference to your ACO doctors?
4. Does the ACO partner with the health plan to determine expected costs, cost savings, cost thresholds?
5. Does any portion of the health plan's added payments to the group filter to the specific treating PCP?
    a. If so, how is that determination made?
6. What is the financial arrangement between the group and the ACO hospital? Any shared risk?

Prescription Drug Management and Optimization

1. Is a patient-specific drug review and reconciliation routinely performed on ACO patients?
    a. Does the ACO consider the drug benefit of the enrollee when making prescription decisions, e.g. with regard to step therapy? Plan formularies? How is this operationalized?
    b. Does the ACO consider the drug benefit of the enrollee when making prescription decisions, e.g. with regard to step therapy? Plan formularies? How is this operationalized?
    c. Does the ACO routinely consider the site of administration for drugs like Remicade to avoid hospital-based, unnecessarily expensive administrations?
    d. Does the ACO interface with care managers provided by PBMs in cases of specialty prescriptions?
2. What incentive exists for prescribing doctors to consider lower tier drugs when prescribing?
    a. Do prescribing physicians receive benchmark reports informing them about their practice patterns as compared to other physicians with regard to drugs? With regard to diagnostics?

Health IT, Data Integration and Reporting, including Data Support from the Health Plan

1. What is the health information strategy for patient information and for performance measurement?
2. What is the EMR and/or CM Software system used to support clinical care and care coordination?
3. Do the care coordinators access the same system as other treating clinicians?
4. Does the ACO have access to patient EHR data?
    a. For all providers?
    b. If not for all providers, for what percentage of providers?

   c. Is the access to all EHR data, or just specific measures?

5. What information do you get from the health plan to support patient identification? With what frequency?
6. Does the information from the health plan alert the ACO about:
   a. High-risk individuals (chronic +2 or some other definition?)
   b. Attributed individuals? I.e., does the ACO get "advance" notification of attributed patients (non-medically complex) or at the end of the measurement period?
   c. How often is the high-risk patient information refreshed with health plan data?
7. Does the ACO integrate information about patients with the data supplied by the health plans to better understand the specific clinical profile of attributed patients? Please describe.
8. What role does pharmacy data play in the ACO's identification/stratification of patients?
   a. How timely is the pharmacy data that the ACO receives?
9. Is the ACO notified by the health plan when there is an Emergency Department or Hospital admission or readmission?
   a. What is the timeframe relative to the occurrence?
   b. Is this notification for all health plan ACO patients?
      i. Those identified as high risk only?
      ii. All patients from the health plan in general?
10. What are the strengths and weaknesses of the data the ACO receives, i.e., what data set(s) are most useful?
11. Does the ACO support telemedicine or virtual visits? Does the ACO support secure email communications? Please describe.

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