

7 Essential Components for a Successful ACO

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Jullian (Bo) Bobbitt, Jr., JD

Are you ready to establish an Accountable Care Organization (ACO)? Your answer probably depends on how successful you have been at creating a fully integrated health care system.

Five ACO (Accountable Care Organization) initiatives will produce the biggest and quickest bang for your buck.

Health Care Analytics

Data and reports are simply information. It's the ability to analyze this information that allows for enhanced decision making and subsequent actions. Our analytics give you the ability to look at your data, its context and what factors are driving health care costs.

By understanding these cost drivers, advanced analytics provides the decision support to develop and implement strategies for improving clinical effectiveness, coordinating care, reducing financial risk and improving the financial sustainability of your ACO.

Care Coordination of Complex Patients

If an ACO has a medical home component, it functions as the organizational center for care coordination. The patient is given to a managing physician who ensures there is a proper care plan. Care coordination programs organize and synchronize services including pharmacy, specialists, home health, physical therapy and case management.

Along with these five components, a primary care physician is fundamental for ACO success. Through a shared savings compensation program, physicians are offered incentives for those who follow best practices and produce the savings. Aside from having the tools and colleagues to positively influence countless patients, significant financial rewards are an important and advantage.

Care Transitions

The principle of the medical home concept is to coordinate care by aiding patients in navigating through the medical structure that usually included fragmented segments. Care transitions' capability to coordinate patient care will be a valuable element in ACO success.

Chronic Disease Management

According to Internal Medicine News, 75 percent of all health care spending is used on patients with chronic diseases, and is an even greater percentage for Medicare patients. Forbes Insights reports that, in 2005, an average patient with a chronic disease cost \$7,000 annually, \$15,000 with two diseases and \$32,000 with three. These diseases are complex, tougher to reverse and uses more specialists, thus care coordination by primary physicians is key.

Predictive Modeling by eQHealth

Predictive modeling is essential to identifying high risk patients. With this information, the ACO can stratify and prioritize patient populations, allowing patients to be categorized by illness, their severity and identify any gaps in care.

A predictive modeling tool can take an ACOs utilization data and identify patients whose health, functional ability and use of health services suggest they are good candidates for care management programs. The result is better health for the patient and reduced costs for your ACO.

Prevention and Wellness

The health care climate is shifting from payment for volume under fee for service to payment for value under accountable care. There is a cost-saving benefit to keeping people healthy. With this shift, effective prevention and wellness will be tied to a strong economic payback. Primary care physicians will now be paid to take extra time with patients, do more follow-ups, create medical homes and encourage healthy lifestyles.

Reduced Hospitalizations

Self-caused chronic diseases may cause avoidable readmissions; lack of proper prevention or care coordination can cause others. Establishing a doctor-patient relationship will help the patient avoid using the emergency room as a default plan.