The Foundation of an Accountable Care Organization

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The Foundation of an Accountable Care Organization

Establishing an Accountable Care Organization (ACO) is currently the perceived end game in health care. Recent legislation is propelling this movement, yet there is no clear answer on how to begin building a successful ACO given the complexities of our current health care system. At its core, there must be three components: primary care physicians, specialists and at least one hospital system, combined to share financial and clinical responsibility for the quality of care delivered in the communities they serve. However, this organization cannot exist without a proper foundation that defines the relationship of these three components based on solid financial and operational information. Building this foundation for an ACO is a step-by-step journey and it begins with a hospital-physician alignment strategy that will enable health care organizations to quickly adapt to this new delivery model.

ACO Simply Defined

The key attributes of an ACO are:

**Comprehensive coordination**
All care is coordinated for a particular patient episode of care according to well-established clinical best practice standards for designated episodes of care, coordinated between all ACO parties engaged in the care giving process. Information sharing, formalized physician relationships and clinical compliance (action, time and measurement) are the critical building blocks of comprehensive coordination.

**Measurement**
All decisions and actions are defined and continue to be defined based upon additional demographic and episodic care metrics to refine a series of clinical protocols.

**Cost, quality, time and outcome dimension**
These are the primary dimensions that will gauge the effectiveness of an ACO. All ACO actions will be evaluated on ability to reduce cost and create better, measurable outcomes. Time and action are the only two driving forces that a medical provider has to affect outcomes. Today, much of health care delivery is a compilation of disparate parts. In an ACO model, the objective is to develop health care “systems” that are singularly focused on being oriented to consistently delivering care that is well coordinated, applying proven clinical protocols, and is both optimally time and cost efficient for patients. This change in operating philosophy is a daunting task and should not be taken lightly.

Creating an ACO requires doctors and hospitals to work closely together clinically and financially. Not all ACOs have to look exactly the same. However, the end result should be similar: creating an integrated health care organization that is responsible for delivering the best possible quality outcome - which typically translates into the most cost efficient outcome as well. The road to an ACO may never truly be complete as more information, such as demographics, is added to the process to better refine the time and procedure dimensions that affect the cost, quality and outcome measurements. For example, do you perform knee rehabilitation on a 70-year-old patient before and after a knee replacement surgery? Would you do the same for a 40-year-old athletic person as well? These are the refinements to a clinical care model that will take time to resolve and build upon over time.
Hospital-Physician Alignment as the Foundation of an ACO

Many hospitals and physicians are attempting to define the end of the journey versus defining what roads should be taken to achieve the shortest and most effective route to an ACO over time. For certain, the relationship between a hospital, its affiliated physicians and future physician needs will have to be defined, refined and optimized to serve as the foundation of an ACO. An ACO cannot exist without formalizing and reinforcing the symbiotic relationship between physicians and hospitals. There are too many legal, operational, financial and emotional barriers to achieving success in building an ACO without formal, exclusive relationships. Here are the phases associated with effective hospital-physician alignment:

**Inventory:** Most organizations must take the time to evaluate the existing relationships between hospitals and physicians. Many of these relationships have been neglected without clinical, financial or market review. This process will require true introspection of these relationships to determine what can be done to move them forward or terminate them.

**Optimize:** All physician relationships have an overarching clinical quality theme underscored by an efficient and effective financial and operational management theme. While healthcare cost accounting is generally rare, all operational processes, staffing, revenue cycle, patient satisfaction and centralized business office functions will require an intense assessment and overhaul. This phase should initiate the building of a trusting relationship between the hospital and physician group based upon consistency, transparency and speed in execution. It is critical to define the operating model with clear-cut information and assessment data. The physician should be enabled to affect the financial aspects of the practice without impact to the clinical side of the practice. Financial analysis and optimization should be first as the data is transparent and recommendations can be clearly outlined. Clinical data is much more complex and should be reviewed incrementally once the financial side of the equation has been in the optimization process for at least six months.

**Aggregation:** The local market will provide the hospital and physician with a clear sense of what services and volumes will be needed. If you are an orthopedic practice in Colorado, the seasonality of your practice will be acutely visible in May of each year. If you are a family practice physician or hospital operating in an economically disadvantaged area, then your payer mix and service needs may be focused in a very narrow fashion. Each organization should evaluate the market, demographic and needs of the community to prioritize the formal relationships between medical providers. Once the planning is complete, then specific providers and services should be itemized to determine the necessary relationship structure from employment to clinical affiliation to co-management of service line strategies. This phase is very prescriptive and will require multi-level communications plan within the physician community.

**Valuation:** The valuation phase is the culmination of the financial information for all providers within a marketplace whereby reimbursement is accumulated for a certain procedure from all participants. In other words, what is the total reimbursement for a certain disease state and procedure class? While this phase is financial in nature, it provides a basis for the initiation of clinical, cost and outcome analysis. This process should be incremental as there are many variables in this analysis. Efforts should be focused upon the “Top 10s”. The top ten hierarchies should be based upon diagnosis, procedures, providers and then dollars. It’s important to resist the drive to get too far ahead of this information exchange.
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ACO: As previously defined, an ACO provides comprehensive coordination of healthcare delivery services from inpatient, outpatient, ancillary and prescriptions with measurements along the dimensions of cost, procedure, quality, time and ultimately outcomes. The building block of the hospital-physician relationships will be the single most important aspect of achieving some level of an ACO. Whether an ACO is an entity that takes insurance risk or not, the ACO provides a systematic delivery of care within a marketplace and is dependent on solid hospital-physician relationships.

Summary

While establishing an ACO may be the end game in health care, it is more of a journey than an end result. The alignment or relationship between hospitals and physicians is the critical foundation of this journey and without establishing processes for all physician organization activities over time, the ACO will never meet its simplest objectives. While financial drivers and analysis have historically taken a back seat to clinical analysis, the financial analysis is much easier to define and develop incremental information value today. Clinical data is much more fragmented and complex to decipher than current best practices for clinical care. The market will demand much more clinical effectiveness data in the future. The only way to achieve or meet these market demands will be a strategic, prescriptive and transparent hospital-physician alignment model.

About John R. Thomas

J.R. Thomas has been with MedSynergies, Inc. since its inception in 1996, when he began as senior vice president and managing director of development. While at MedSynergies, Mr. Thomas has held positions such as senior vice president and chief financial officer, and has been a member of the board of directors since 1999.

Prior to joining MedSynergies, Mr. Thomas was the vice president of the newly formed HealthCare Finance Group for Bank One. He was also the assistant vice president for Texas Commerce Bank, where he focused on hospitals, emerging healthcare markets, core finance and revenue.

Mr. Thomas is a national speaker on topics such as revenue cycle management, billing and collections processes and capitalization, raising funds, bank debt, turnaround and high/low debt revenue.

Mr. Thomas received his Master of Business Administration, with honors, from the University of Texas Graduate School of Business. While at the University of Texas, he focused on finance and management and was selected as the Sword Scholar and received the Dean’s Academic Award. Mr. Thomas received his Bachelor of Arts from the University of Arkansas.

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