



Levers of Successful ACOs

Part 2 Achieving a High-Value Culture

When studying the success levers that allow accountable care organizations (ACOs) – as well as other providers engaged in payment and delivery transformation – to achieve high-value health care delivery, there is no better place to begin than culture. An organization’s culture is a result of how governance bodies and leadership manage the organization in carrying out its mission. In health care, having a high-value culture means that all levels of the organization demonstrate an internally motivated commitment to excellent patient outcomes (quality) that are achieved at the lowest possible cost.¹ A high-value culture and ongoing dedication can be seen in more than an organization’s mission, vision, and value statements – it is evident in the attitudes and priorities of senior leaders down to the most basic day-to-day operations.

Without a culture of high value, an ACO cannot truly commit to the continuous work of system transformation. However, while monumentally important, organizational culture can be ambiguous and therefore challenging to assess and improve. To help providers to understand and implement the cultural changes necessary to achieve high-value care, this report outlines four common behaviors among high-performing ACOs.

Pre-ACO activities and culture. While the specific approaches and payment details vary, most high performers have previous experience managing risk prior to forming or joining an ACO. This early adoption is a reflection of leadership’s commitment to high-value health care and a culture that embraces change. Moreover, this history of risk assumption suggests that the ACOs’ financial leadership is invested in the idea that outcomes-oriented payment is a viable business strategy.

Governance involvement in ACO operations. High-performing ACOs have the support and commitment of top-tier leadership and a governance structure that is conducive to fostering a high-value culture (e.g., encourages innovation and feedback).² Importantly, organizational leadership is committed to a culture of teamwork, collaboration, and adaptability in support of continuous learning as a core objective.³

1 Avedis Donabedian, *Introduction to Quality Assurance in Health Care* (2002)

2 Institute of Medicine, [Core Principles & Values of Effective Team-Based Health Care](#) (2012)

3 The Commonwealth Fund, [Organizing the U.S. Health Care Delivery System for High Performance](#) (2008)



Physician and community practice engagement. ACOs with a deep-seated high-value culture understand the importance of engaging clinicians and care teams to accomplish shared goals. To do this, ACO leaders invest in practice education and support services, as well as an aligned compensation structure that encourages continuous improvement, identifies and reduces waste, and rewards high-value care.⁴ ACOs cannot succeed without truly engaged physicians who are committed to understanding their practice patterns and bringing these patterns into alignment with the goals of the ACO and evidence-based best practices, and serving as champions to help guide clinical peers.

Clinical partnerships. High-performing ACOs leverage the strengths of high-value partners to help manage the continuum of care. These ACOs are intentional and value-driven in their assessment of potential external provider partners, looking for organizations that are culturally like-minded.⁵ Once selected, ACOs work collaboratively with partners to provide comprehensive, integrated, and coordinated care.

In this report, we describe further the clinical culture transformation for ACOs that have been successful in achieving shared savings and high quality performance under the Medicare ACO program.⁶

Pre-ACO Activities and Culture

Key Strategies

- *Cultural commitment at the board level to delivering high-quality, efficient care*
- *Manage risk and quality performance for commercial and public contracts, including Medicare Advantage, Medicaid managed care, and large purchasers*
- *Negotiate payment arrangements across multiple payers to support investment in infrastructure and care coordination*
- *Analyze expected financial and quality performance before selecting ACO track*
- *Pursue opportunities to learn and provide feedback to payer partners*

Most high-performing ACOs interviewed had managed risk and/or pay-for-performance programs within their commercial lines of business before joining the Medicare ACO program. Evaluations of the Medicare Shared Savings Program have shown that ACOs participating in the program longer were more likely to produce savings, and more likely to reduce spending by greater amounts.⁷ Pre-ACO value initiatives varied based on the payment arrangements made available in any given market; however, most executives interviewed expressed a belief that a large-scale transition away from fee-for-service payment was both imminent and desirable.

4 Institute of Medicine, [Crossing the Quality Chasm: A New Health System for the 21st Century](#) (2001)

5 Leavitt Partners, [Defining High-Value Providers for ACO Partnerships](#)

6 See Methodology section for detailed selection criteria for high-performing ACOs.

7 HHS Office of the Inspector General, [Medicare Program Shared Savings Accountable Care Organizations Have Shown Potential For Reducing Spending And Improving Quality](#)



“I would guess that most of the people who joined Pioneer [ACO] didn’t start from scratch. I would guess that they had similar cultures, whether or not they had some financial incentive for the performance.”

Executive, Hospital-led ACO

Several organizations pointed to past involvement with managed care or risk-based arrangements as providing the experience necessary to effectively manage a shared savings program from both an administrative and clinical perspective. Two hospital-led ACOs were accountable for quality and total cost of care for large employer contracts before joining the Medicare ACO. Another organization built upon existing administrative structures for managing a risk-based physician hospital organization (PHO) with their community physicians, as well as a self-insured product for their own employees. Most organizations had some experience with Medicare and/or Medicaid managed care, and some ACOs had managed more advanced risk arrangements, including capitation, that require familiarity with the dynamics of benchmarking, risk adjustment, and quality measurement.

One physician-led ACO participated in commercial quality-based pay-for-performance programs before joining the Advanced Payment ACO (MSSP Track 1). The same ACO negotiated per-member per-month stipends with their commercial payers as part of a patient-centered medical home initiative to support expanded nurse care coordination. Blending together the Meaningful Use incentives, upfront payment of shared savings from Medicare, and commercial care management fees, the organization was able to spread financing across multiple sources to invest in the infrastructure needed to be successful. Several executives mentioned similar impetuses to pursue value-based models across multiple lines of business.

For early adopters, the decision to participate in a Medicare ACO program was often mission-driven and, to the extent possible, informed by data-driven projections. For example, one hospital-led ACO operating in a low-cost market analyzed its expected performance before opting for the upside-only MSSP track, recognizing that organizations with historically low expenditures are less likely to achieve shared savings under a national ACO benchmarking methodology.⁸ A few ACO executives, particularly those that joined the first Pioneer and MSSP cohorts, mentioned desirability of joining models at the earliest stage to be able to provide feedback and influence the program design before it fully matured, as well as providing an opportunity for the organization to learn and prepare for the future:

“When we entered [the ACO program], the organization was making a strategic decision, not because we thought we’d make a whole bunch of money in this, but partly to force ourselves to learn. And it looked like a relatively safe environment for us to develop some of the programs and skills and analytics [because] we had some pretty tight guardrails to protect us from savings and losses. We had always hoped that we’d use it as a learning platform and then be able to expand it across our whole geography...because we think the future is value-based payments.”

Executive, Hospital-led ACO

A smaller subset of ACOs shared a long pre-ACO history of improving quality by actively involving clinicians in the quality improvement work, transparently reporting metrics, and introducing coaching and decision support tools at the individual clinician level to supplement intrinsic motivation to achieve a high level of performance on quality. Two ACOs described well-established quality analytic structures which provided the organization with a clear picture of their relative quality performance on a regional and national level; confident in their ability to deliver a high-quality product, the Medicare ACO programs provided a welcome opportunity to be rewarded for quality and efficiency of care.

⁸ CMS has since modified the MSSP benchmarking methodology to incorporate regional adjustments.



Governance Involvement in ACO Operations

Key Strategies

- Consider aligning governance bodies for multiple ACO contracts
- Engage clinical/administrative dyad structures at the governance level
- Involve patients in practice redesign
- Identify the key, predictive indicators/metrics for success under the ACO contract

Each high-performing ACO described strong commitment and involvement from the highest echelons of leadership in the pursuit of accountable care and health care transformation, even where success under the shared savings model may put overall system revenue at risk. As one executive noted,

“To be perfectly honest, we track and report and talk about [the ACO performance] disproportionate to its impact on our whole organization’s bottom line. And that’s kind of a deliberate thing. It’s a big enough, important enough, unique enough thing that we used it as a way to get these conversations going across the organization so we could learn.”

Executive, Hospital-led ACO

Compliance requirements obligated participants to establish a governing board for the Medicare ACO with specified representation, but several interviewees noted a strategic decision to integrate the ACO’s governing body within a broader structure of governance across the organization. A centralized governance structure allowed for creation of common goals, alignment across various value contracts, and setting expectations at the senior leadership level to help drive an overall quality and efficiency strategy for the entire organization. One executive defined the organization’s governance style as “meta-leadership,” meaning the board placed an emphasis on aligning both clinical and operational leadership across all ACO contracts:

“We’ve got all these different contracted arrangements all with slightly different quality gates and metrics and financial arrangements and lengths of term, so many different variables... initially, actually, they were sort of like one person had this ACO, another person had that ACO. That actually doesn’t work because there are so many things that need to be overseen that really overlap. And if we’re going to have a system of care that looks at, for example, hospitalist coverage, we need to be able to work with those hospitalists regardless of which ACO we’re in.”

Executive, Integrated ACO

Alignment at the governance level was often mirrored in the operational structure: centralized “population health” departments have been tasked with deploying population health management services and monitoring performance across the organization to minimize the burden for individual physician groups and departments to participate. Yet, not every high-performing ACO decided to fully align governance structures and operational services; some organizations opted to create a parallel structure to manage ACO compliance and performance apart from the fee-for-service lines of business, and reserved population health management resources for ACO-aligned beneficiaries. Additional



analysis about the decision to pursue parallel versus aligned operational structures is provided in a separate series of reports focused on a broader transformation to value.⁹

Dyad committee structures support integrated administrative and clinical operations

The board of the CaroMont ACO comprises physician representatives from each of the composite Tax ID Number (TIN) organizations, including a skilled nursing facility and hospice, in addition to the representatives required by CMS. The board’s committees employ a clinical/administrative dyad, in which physician representatives and operational executives work in concert to bring vetted proposals to the full board. For example, the ACO board may request that the Finance and Operations Committee review a contractual modification. That committee – representing the participating medical group providers (including hospitalists and multispecialty physician group practices) and appropriate financial leadership from the organization – would collectively review the proposal and make a recommendation for action by the board.

Health care organizations undertaking large-scale transformation of the overall financing and care delivery structure are often utilizing a dyad structure to implement the strategic objectives at the business unit level. It can be challenging to translate one-off strategies into an integral part of the daily workflow; employing the dyad structure and engaging physician leaders at the governance level ensures physician leadership in the initiative and support for organizational priorities.

Despite contrasting approaches to the overall organizational governance structure, nearly all high-performing ACOs emphasized the importance of physician participation on the ACO board, and in particular, involving both employed and community physicians as well as regional leaders impacted by the ACO strategy, where applicable. Some ACOs also expanded upon the requirement for Medicare beneficiary participation to engage consumers in unique ways:

“Initially, we had three Medicare beneficiaries on the ACO governing body, as was required, and they gave us interesting and valuable perspectives on their experiences as patients and so forth. But we sort of re-thought that, and we have just engaged about 25 patients across all payers to participate with us now on process redesign teams...So when they came in for the first meeting, what we said is this: what we used to do [to engage consumers] is like when you go to a restaurant and there’s a survey about what you think about the food. What we’re doing now is asking you to come in and help us design the menu, the décor, and the dining experience.”

Executive, Physician group-led ACO

Examples of recurring board meeting topics	Examples of topline priority measures
<ul style="list-style-type: none"> • Review priority quality measures • Review priority utilization measures • Highlight best practices • Share learnings from each department/region • Compare utilization by department/region 	<ul style="list-style-type: none"> • Hospital admissions • Readmissions • Emergency Department visits • Internal utilization • Outside specialty utilization

9 Health Care Transformation Task Force, [The Transformation to Value: A Leadership Guide](#)



ACO governing bodies serve a critical role in setting direction for high-performing ACOs, and identifying areas for improvement and investment. Most organizations reviewed data from multiple sources, including the EHR, internal claims data, and claims and quality reports provided by CMS to assess ongoing performance. Participants described similar processes to streamline and select priority metrics to ensure the board could focus on the most relevant indicators of success under the ACO model. However, participants also found themselves fighting the tendency to over-simplify:

“You’d like to tell people where there are just a few things that you need to do, but I take a little bit more holistic view and say, man, there’s a ton of stuff you have to get right to make this sustainable and effective.”

Executive, Physician group-led ACO

Physician and Clinical Practice Engagement

Key Strategies

- *Co-create project plans with front-line staff*
- *Devise sub-groups for the purposes of education and performance measurement*
- *Utilize physician advocates to convey ACO policies and requirements*
- *Establish a parsimonious set of actionable performance measures*

Consistent with the near-ubiquitous use of dyadic governance structures, successful organizations made clear that the ACO execution was not an administration-run effort. Administrative partnership with physicians and other clinical staff in planning was coupled with collaborative implementation strategies in the following areas:

- Building buy-in to the overall accountable care initiative
- Ensuring comprehension of specific ACO objectives
- Integrating practice improvement into regular work flow and tracking progress

Multiple ACOs used the word “co-creation” in describing the initial implementation process. One organization emphasized the breadth of staff included in project planning:

“There’s an inclusive and collaborative culture here that’s really crucial to getting buy-in.... If you’re going to get frontline people to change what they’re doing, it’s so much more helpful if from the very beginning they’re involved and telling you what would probably work best. And then, of course, they’re going to help design it. They’re going to then champion it. And so the order in which we have done things was significantly determined by what everybody in the offices wanted to do. And by everybody, I don’t just mean the doctors, but when we had convenings and brainstorming, we had receptionists and MAs and the pharmacists and the advanced practitioners and the nurse care managers as well as corporate folks to do that work.”

Executive, Physician group-led ACO



While population health initiatives were often driven by analytics to define target segments of the patient population and priority areas for improvement, high-performing ACOs relied heavily on clinical staff to review and refine implementation plans on the front-end. One ACO used multi-disciplinary teams – bringing together clinical leaders, operational and analytic resources, and project management – to co-create new project work plans and design pilots to inform the planned tactics and communication pathways, before ultimately tasking performance improvement staff to scale the polished implementation plan across various operational areas. Another organization designated highly engaged “ACO champions” from each practice to serve as informal leaders in the effort.

The participating ACOs utilized a variety of strategies to ensure clinicians understood and could act upon the ACO requirements, which varied based on ACO structure and physician employment model. A large, multi-regional ACO conducted regular town halls with each region to educate physicians and office managers about the contract parameters, while another required all new staff to attend an orientation session. Common training topics included quality measurement and reporting, care management programs, and utilization variation. A hospital-led ACO educated its community physicians on the importance of the Medicare wellness visit as a mechanism for getting patients in and completing annual quality metrics:

“It requires a very passionate on-the-ground team to keep people focusing on these things. And so we hire people specifically who have that passion and that vision to work on the accountable care services team.”

Executive, Hospital-led ACO

Most ACOs followed a similar model of breaking the ACO into subgroups for the purposes of assigning clinical leadership and measuring performance. One hospital-led ACO uses clinical subgroups to assign rewards based on overall contribution to earning shared savings, and deploys practice improvement teams to meet with poorer-performing primary care subgroups one-on-one and educate those practices using clinically actionable data.

Assigning subgroup leadership within a multi-regional ACO

For the non-employed physician group, Banner Health divided the market into about 10 regions and assigned regional chief medical officers that served as both a physician advocate as well as translator to other physicians within the region. The CMOs are practicing physicians trained to understand the ACO business, so they can quite literally “speak both languages.” It is standard practice for all Banner Health ACO communications to flow to the practices through the CMOs.

Considering the heavy burden of compliance and severe time constraints for most providers, high-performing ACOs took pains to prioritize only the most critical measures and present data to providers in the most meaningful way. One hospital-led ACO uses the total cost of care metric as the focal point for all improvement efforts, as it strikes a reasonable balance allowing for the overall system to remain competitive in the marketplace while the ACO operates under an independent budget. Another ACO with multiple operating regions created “six essentials” for all ACO practices to perform against, and generated minimum specifications for each region to meet; those practices failing to meet the minimum standard receive additional coaching and performance improvement support. And the timeliness of metrics matter; organizations expressed preference for metrics that could be refreshed on a weekly basis.



Yet, the process to refine critical measure sets is iterative, as one hospital-led ACO described:

“We’ve got good data out there, but we don’t think the physicians have necessarily been utilizing it. So our chief medical officer is going out and visiting with most of the primary care physicians. And we have a whole list of items that we want to work with them on and also get some feedback from them, and to make sure everyone understands that when we’re pushing them to do these quality checks and close those gaps, what the reasons and benefits are for everybody.”

Executive, Physician group-led ACO

Organizations also employed strategies to mitigate physician burn-out or “transformation fatigue”; one ACO established a voluntary physicians’ society to provide a forum for physicians to discuss best practices and barriers, and provide feedback to leadership. A physician-led ACO discussed the unique challenge posed by obligating physicians to increased workflow standardization and collective, transparent reporting on quality and cost performance within an organization that had previously encouraged autonomy with only a few centralized business services:

“I think we had a culture of quality. In fact – we’ve always been selective about the physicians who work here...But getting to the point of really having reliable data and believing it and getting to the point of sharing unblended data that is provider specific or office specific, sharing that broadly and really changing the culture to the point where all the providers and everybody in the offices feel that this is meaningful – that’s a journey that still continues.”

Executive, Physician-group led ACO

Clinical Partnerships

Key Strategies

- *Identify and engage high-performing post-acute and long-term care providers, including skilled nursing, home-health and hospice providers*
- *Embed nurse care managers within in-patient hospitals, emergency departments and skilled nursing to support transitions of care*
- *Integrate behavioral health with primary care to manage exacerbating co-morbidities*

Across the board, high-performing ACO executives found the most meaningful partnership with skilled nursing facilities (SNFs), because for most ACOs, post-acute care was determined to be driving the most prospective cost-savings under accountable care arrangements. ACOs also applied the available three-day SNF rule waiver, which permits ACOs to admit patients directly to a skilled nursing facility without an inpatient hospital stay, or prior to a full three-day hospital stay.¹⁰ The waiver allows for ACOs to create easier pathways for patients to be seen quickly by geriatricians in the SNF, and to simply avoid unnecessary inpatient stays where possible. Working with a “best in class” network of preferred independent SNF groups, one ACO found a way to convene the SNFs to be able to manage the three-day SNF waiver efficiently by providing performance reporting to the SNF on their length of stay, readmission

¹⁰ <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html>



rates, and quality metrics to improve standardization and reduce variation.

“We were able to tighten the number of SNFs that we contract with. We looked at all of them and their performance, and said ‘you’re in, you’re out’ based on criteria. I think that skilled nursing facilities are waking up, especially in our neck of the woods, and they want to partner with us. And you can certainly see in our data those [SNFs] that pay attention and those that don’t; those that are actually willing to partner with us to develop a plan of care in the first week and to help educate their staff.”

Executive, Integrated ACO

Several ACOs built staffed nurse care manager teams to manage the transitions of care for patients upon discharge or direct referral to SNF in order to avoid readmissions, some tasking care managers in the inpatient hospital, emergency department, or provider practices, while other organizations asked ACO providers and care managers to round directly in the nursing homes. Affiliation with home health and hospice agencies was also key to finding innovative ways to bring care in the home as well as lengthening hospice length of stay and getting palliative care involved early, and encouraging better collaboration with the physicians. One physician-led ACO created a multidisciplinary team led by a nurse practitioner that does home visits for about three hundred of the sickest patients. Another organization partnered the home health provider with the ACO’s chronic disease educator to train patients to support self-management.

ACOs found patients presenting with a secondary behavioral health diagnosis are three times costlier than ACO patients without such diagnosis; therefore, another key clinical partnership was creating linkages with behavioral health providers. However, there was no dominant integration strategy present among the high-performing ACOs interviewed. Both a physician-led and hospital-led ACO had piloted co-location of behavioral health providers in primary care offices, but found that referrals were too haphazard and the behavioral health providers were not touching the right patients. The physician-led ACO evolved its approach to integrate behavioral health providers within the disease management teams, so that services were preferentially directed to the costliest chronic disease patients.

Conclusion

While successful ACOs often benefitted from deep expertise and organizational commitment to high-quality care, the path to value can be long and challenging. Culture change within an organization does not happen overnight. The common theme across all the strategies employed to achieve a high value culture was building strong partnerships. In the new world of accountable care, historic silos must be broken down and old structures for clinical and administrative coordination must be reconsidered, and a new business model needs to take root. ACOs are addressing these challenges by identifying high-value partners, creating tighter organizational alignment, and involving clinicians and patients in designing a sustainable value-based system.



Methodology and Acknowledgements

Recognizing the importance of identifying and disseminating levers of success among high-performing ACOs, the Health Care Transformation Task Force¹¹ (HCTTF) designed and conducted a nearly 12-month qualitative study analyzing the elements of ACO success. To do this, the Accountable Care Work Group conducted a multi-step project which included, among other things, a series of in-depth interviews with leaders of successful ACOs to investigate the common structures and strategies that enable success.

It was determined that all interviewed ACOs must meet the following criteria:

- Shared savings rate $\geq 2\%$
- Quality score $\geq 90\%$
- Below-average baseline¹²
- $\geq 5,000$ ACO-covered lives
- More than one year under accountable care contract
- At least one commercial ACO contract (in addition to a Medicare ACO contract)
- Diverse geographic representation (preferred)

Using the PY 2015 Medicare ACO performance results and the Leavitt Partners ACO database, 21 Medicare Shared Savings Program (MSSP) and Pioneer ACOs were identified as meeting the criteria. The Work Group conducted interviews with 11 of the 21 ACOs, corresponding to over 10 hours of interviews. Within each ACO, the HCTTF interviewed senior decision-makers involved in designing and implementing accountable care-related activities across the ACO. To standardize the areas investigated, all ACOs were interviewed using the same interview guide. Interview transcripts were then coded to enable a thorough qualitative analysis. All quotes in this report draw from these interviews and written transcripts.

This is a product of the Health Care Transformation Task Force under the leadership of the Accountable Care Work Group. The Accountable Care Work Group is comprised of Task Force members and other organizations dedicated to improving the design and implementation of the ACO model in public and private payer programs. The Work Group addresses both internal operational challenges as well as public policy issues that challenge transformation efforts for health care organizations.

11 The HCTTF is a consortium of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry— including patients/ consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs.

Our organizations aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

12 ACOs with below-average baselines – or lower expected average expenditures – were considered more desirable to study based on the hypothesis that these ACOs began with less excess expenditures, and therefore, a shared savings rate $\geq 2\%$ was even more meaningful.