CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Learning Systems
for Accountable Care Organizations

Operational Elements Toolkit

Introduction

Numerous Medicare accountable care organizations (ACOs) have achieved shared savings since 2012 by using a variety of strategies to improve population health and quality of care while limiting growth in healthcare costs. Each ACO is unique and has a different approach to providing value-based care; strategies developed by one ACO may not always be suited for another. In recognition of this, the Centers for Medicare & Medicaid Services (CMS) has developed a series of toolkits exploring common goals and approaches used by ACOs and related to care coordination, beneficiary engagement, provider engagement, and care transformation.

This fifth and final toolkit in the series presents a collection of fundamental strategies that Medicare ACOs use to deliver value-based care when beginning or refining operations. With these strategies, ACOs have established efficient and sustainable operations that support progress toward achieving their quality and financial goals. In exploring ACOs' development and implementation of elements to support operations, this toolkit examines how ACOs:

- Establish strategic partnerships to strengthen or expand the organization
- Understand beneficiary care needs and preferences
- Harness data to improve performance and support quality reporting

To produce this toolkit, the CMS ACO learning system conducted focus groups with representatives from 13 ACOs that participate in the Medicare Shared Savings Program and in the Next Generation ACO Model. The learning system offered ACOs an opportunity to participate in the focus groups if they had shared effective strategies fundamental to ACO operations during past learning system events; it also extended an open invitation to ACOs via newsletters for each

Overview of the CMS ACO Learning System and Toolkits

Since 2012, CMS has supported ACOs in their efforts to improve the delivery of care for their attributed patient populations through model-specific learning systems. These learning systems provide ACOs with a forum in which they can collaborate with and learn from one another. Across the model-specific learning systems, CMS has hosted over 250 virtual events and 75 in-person events on topics tailored to the needs and interests of current ACOs.

The five toolkits in the series serve as a resource that explore different aspects of how ACOs operate to provide value-based care. The toolkits bring together insights gathered during CMS-sponsored learning system events and through focus groups with the ACOs. Through these toolkits, CMS aims to educate the general public about strategies used by ACOs to provide value-based care while also describing actionable ideas to help current and prospective ACOs with operations.

Medicare ACO initiative.[1] During each focus group, the participants described their strategies for beginning or refining ACO operations. This toolkit is also based on the insights of approximately 30 ACOs that participated in other CMS-sponsored events, such as peer-to-peer learning webinars and case studies. For a list of the ACOs that contributed to this toolkit, please see page 16.

While many of the ACOs that contributed to this toolkit focused on strategies that yielded positive results, some ACOs candidly discussed strategies that were less successful than expected or for which results were not yet available. This toolkit includes lessons learned from ACOs' attempted interventions, along with snapshots that offer current and prospective ACOs a more complete picture of available options and possible implementation challenges.

[1] When considering which ACOs to include in the focus groups, we did not limit invitations strictly to ACOs that had consistently achieved shared savings. Doing so could have inadvertently excluded ACOs that were starting out in new, higher-risk programs or investing in infrastructure, thus creating situations in which they accepted short-term losses to position themselves for longer-term financial and quality successes.

Establishing Strategic Partnerships

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients.[2] When forming and joining Medicare ACO initiatives, provider participants establish strategic partnerships to strengthen or expand their operations to meet quality and cost goals. For example, ACOs form strategic partnerships between provider participants, including hospitals, individual primary care providers (PCPs) and specialists, and physician groups. These participants are eligible for shared savings and have an impact on attributed beneficiary lists, quality results, and financial outcomes. ACOs may also establish relationships with local organizations that serve as external partners, such as home health agencies, hospice or palliative care providers, and community-based organizations. These external partners are not eligible to receive shared savings but contribute to and benefit from ACO operations. In addition, ACOs may establish relationships with skilled nursing facilities (SNFs); ACOs' options for contractual relationships with SNFs may vary, in part based on model requirements and benefit enhancement opportunities.

To establish relationships with potential participants or external partners, ACOs begin with conversations about their value-based care strategy and the benefits of joining the ACO. As part of this process, many ACOs engage potential participants or partners in conversations to explore a culture match related to population health, and to communicate expectations for joining the ACO. Although this engagement to establish partnerships is essential to launch a new value-based care organization, ACOs also view it as an ongoing activity in response to shifting provider interests. Recognizing that each ACO has a unique structure and approach, this toolkit section explores ACOs' approaches to establishing strategic partnerships with both provider participants and external organizations by highlighting common themes and best practices that are generalizable to other organizations.

IDENTIFYING POTENTIAL PROVIDER PARTICIPANTS OR EXTERNAL PARTNERS

When identifying new provider participants or external partners to either form or join an existing ACO, ACO leaders look for providers and organizations with both a record of delivering high quality care and a stated interest in providing beneficiaries with coordinated care and promoting population health. ACOs emphasize that potential partners should enter the relationship with an interest in collaborating with ACO administrative and operational staff. Potential partners should also agree to contribute to developing new processes to improve health outcomes and deliver patient-centered care while reducing overall health costs. ACOs may identify new participants or external partners based on referral and utilization patterns, demonstrated gaps in the composition of their provider participant lists, or interest generated through word of mouth.

ACOs' review of referral and utilization patterns can include analyses of data related to volume and type of referrals and reviews of quality scores. Claims and referrals data help the ACO see which providers treat a substantial portion of attributed beneficiaries and in turn anticipate how these providers' decisions will impact ACO operations. ACOs have an incentive to involve these providers as participants or as external partners to support ACO operations and benefit from population health initiatives. For example, ACO leaders note that volume is particularly helpful when selecting preferred SNFs or SNF affiliates to engage as part of their post-acute care networks. ACOs may identify potential SNF partners based on analyses of quality data, including publicly available sources (such as the CMS Five-Star Quality Rating System on Care Compare[3]) and claims-based metrics (such as risk-adjusted average length of SNF stay, hospital and emergency department [ED] use after SNF discharge, and overall post-acute spending on beneficiaries who received SNF care).

Some ACOs identify gaps in the composition of their provider lists, such as capabilities for addressing specific clinical or social needs, to target outreach to specific providers or external partners. For example, one ACO examines data from regional surveys to identify the top unmet health or social needs in the communities served and then determines what resources are available to address those needs. The ACO then collaborates with its parent organization to approach external organizations to partner

[2] For more information on ACOs, see the Centers for Medicare and Medicaid Services (CMS) "Accountable Care Organizations (ACOs)." Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO. Accessed March 12, 2021.

[3] As of December 1, 2020, the legacy Nursing Home Compare website is no longer available. Users are now directed to the new Care Compare website on Medicare.gov. There is no change in the information available about nursing homes or the methodology used to calculate ratings. For more information, visit https://www.medicare.gov/care-compare/. For more information on the CMS Five-Star Quality Rating System, see https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html.

on addressing identified needs. Another ACO opened a clinic in partnership with a local oncology group to improve access to care for beneficiaries by providing intravenous treatments in an outpatient setting. This relationship helped the ACO address a care gap and contributed to a lower cost of oncology care for beneficiaries.

Some ACOs find that providers and external organizations will proactively inquire about the possibility of joining the ACO to gain the benefits of participation or partnership, having heard about the opportunity from peers. ACOs note that these inquiries often signal a willingness to participate in improvement activities and a commitment to team-based care delivery; the new participants or partners quickly develop a collaborative rapport and establish a comfortable working relationship with current participants. This approach is more common among established ACOs, particularly those that offer clear supports for providers and a defined approach to allocating shared savings, which helps promote word-of-mouth referrals from current participants or partners. To further encourage proactive inquiries, ACOs may also ask current physician participants to introduce the ACO to a trusted, respected colleague or recommend an external partner to include in the ACO.

> "We get calls all the time, 'How do I get on the list?' A lot of it is meeting with them, identifying [problems], working together on that, that partnership. And really knowing that we have engagement helps garner that relationship."
>
> —ACO administrator

ATTRACTING NEW PROVIDER PARTICIPANTS OR EXTERNAL PARTNERS

After identifying potential participants or partners, ACOs begin a dialogue with them to discuss the benefits of a contractual relationship or partnership. The ACO leadership describes the supports available to providers, such as access to care coordination services, data analyses and related quality improvement coaching, and assistance with required quality data submissions for provider participants. These supports enable providers to deliver efficient and high quality care, which can lead to a steady volume of appropriate referrals, improved beneficiary access to needed treatment, and eligibility for participants to receive a portion of an ACO's potential shared savings.

When introducing the value-based care opportunity to prospective participants and external partners, ACOs describe how they can offer resources and support to enhance care coordination and deliver patient-centered care. For example, one ACO emphasized how its care coordination team conducts care plan meetings with SNFs for ACO-attributed beneficiaries and then supports SNF providers with discharge planning. Another ACO described how care managers place telephone calls to beneficiaries after inpatient discharge or ED visits to discuss follow-up care through the care transition. For providers who employ care managers within their care settings, ACOs may offer trainings to enhance the managers' skills and provide access to a population health management platform that supports data-informed decision making and improves care delivery.

ACOs also emphasize how participants and partners benefit from the ACOs' data management capabilities to quickly analyze claims or electronic health record (EHR) data to reveal patterns in care delivery. For example, some ACOs provide data feedback reports that highlight individual providers' performance on key measures, provide comparison data for peers, and allow providers to observe trends and changes over time. ACOs may couple these reports with hands-on guidance and coaching to support improvements for specific quality measures. For example, coaches may collaborate with providers to review data feedback reports and complete root cause analyses[4] to identify improvement opportunities. Coaches can then guide practices in conducting plan-do-study-act cycles[5] to support ongoing monitoring and refinement of their strategies. Multiple ACOs note that providers value these coaching services and view them as a reason to join an ACO.

[4] A root cause analysis is a tool used to identify the causes of a problem that occurred by tracing its origin and developing processes to prevent the problem from recurring. For more information on root cause analyses, see the Agency for Healthcare Research and Quality (AHRQ) "Root Cause Analysis." Available at: https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/root-cause-analysis. Accessed December 21, 2020.

[5] Plan-do-study-act (PDSA) cycles are tools to design, implement, reflect on, and modify an initiative. For more information on PDSA cycles, see the AHRQ "Worksheet for Plan-Do-Study-Act (PDSA) Cycle Planning." Available at: https://www.ahrq.gov/evidencenow/tools/pdsa-worksheet.html. Accessed December 21, 2020.

> We entice [potential partners] by really letting them know what we actually have available, both in terms of data [overall] and the data that can flow back [to them].
>
> —ACO administrator

With these data management capabilities, ACOs can efficiently submit required quality data on behalf of participants, which can also be used to satisfy Merit-based Incentive Payment System (MIPS) reporting.[6] ACOs emphasize their ability to streamline submission of quality data when engaging potential provider participants. In addition, ACOs may touch on MIPS reporting during regular monthly conversations between provider relations specialists who visit with physicians to keep this benefit at the forefront for busy providers, elicit information to inform quality data submissions at the ACO level, and facilitate continuous improvements to the MIPS reporting process.

DEFINING EXPECTATIONS FOR POTENTIAL PARTNERSHIPS

ACOs create written documents to define and communicate expectations for providers considering joining the ACO or organizations that may choose to become external partners. These written documents, such as care compacts or care agreements, provide terms and required activities to maintain participation, including how to collaborate with the ACO. Expectations in these agreements include providers' attendance at meetings, access to data or data systems, and participation in quality improvement activities to help meet established performance targets. A care compact could also be used to define specific expectations for timely patient-centered care delivery. For example, one ACO established an agreement with a specialty group requiring that referred patients be scheduled for a visit within one to seven business days of the referral, depending on the urgency of the clinical need. In exchange, ACO providers must be available during regular business hours if the specialty group requires clarification about the referral.

ACOs offer support and access to resources to help participants or partners meet predefined expectations, which sustains relationships over time. For example, ACO quality improvement experts meet with providers, either one on one or in small groups, to discuss progress toward meeting targets and consider opportunities for further quality improvements. Multiple ACOs describe convening group meetings of post-acute care providers to consider recent care delivery data and determine which performance improvement strategies will help to achieve quality goals. Providers and practice staff note their appreciation for the ACOs' work in tracking performance and supporting implementation of new approaches.

> There's expectations of what excellence looks like, but it's not just 'Oh, we expect you to be excellent.' It's 'We expect you to be excellent, but we're going to work with you to help you on that.
>
> —ACO administrator

ENSURING A CULTURE MATCH WITH PARTICIPANTS OR PARTNERS

Before welcoming new participants or external partners, many ACOs assess a "culture match" to determine cohesion between the ACO's overall population health strategy and the provider's ability to operate successfully in a value-based care environment. ACOs seek participants and partnering organizations that can demonstrate an openness to contributing to improvement processes and interest in collaborating with the broader care team to provide patient-centered care. To ensure a match, a parent company or management services organization that operates multiple ACOs with varying levels of risk might adopt a phased approach, such as inviting providers to join a one-sided risk model to confirm the culture match, and then encouraging transition to a model with downside risk.

Although ACOs emphasize the importance of ensuring a culture match when beginning operations, they note that

[6] Eligible clinicians participating in an ACO that in turn is participating in an Advanced Alternative Payment Model (APM) model or payment track may also qualify as a Qualifying APM Participant (QP) and be exempt from the requirement to report under MIPS, in addition to receiving an APM incentive payment. For more information on MIPS APMs, see the CMS "MIPS Alternative Payment Models." Available at: https://qpp.cms.gov/apms/mips-apms. Accessed March 10, 2021.

this effort remains a continuing activity to sustain external partnerships and maintain participating providers' mindset for population health. For this ongoing effort, ACOs look to establish buy-in and engagement with staff across all levels of the provider group or partnering organization. In particular, ACOs have found success when providers help lead care improvement efforts, rather than relying solely on messaging about initiatives from the ACO's administrative leadership. By including providers in the organizational decision-making process and empowering them to lead improvement efforts, ACOs proactively reinforce the shared vision.

> We have found that we've had a lot more success when the providers are helping to lead the change, and it's not coming from just administration. They're the ones at the frontline, they understand what's working, what's not working, [and] what can be improved.
>
> —ACO administrator

Strategies for Establishing Strategic Partnerships

- Identify potential provider participants or external partners to join the ACO based on referral and utilization patterns, demonstrated gaps in the composition of provider lists, or in response to interest generated through word of mouth.
- Communicate the benefits of the ACO to potential partners, such as access to additional care coordination resources, availability of data analyses and related quality improvement coaching, and assistance with required quality data submissions.
- Create written documentation, such as care compacts or agreements, to establish terms and required activities for maintaining participation in the ACO, and offer supports to help participants or partners meet these expectations.

Understanding Beneficiaries' Care Needs and Preferences

ACOs looking to begin or refine operations implement strategies to gather insight into the health needs and preferences of their attributed beneficiary populations as a key element in delivering high quality, person-centered care. ACO leaders use these insights into beneficiaries' physical and emotional health to better support providers in delivering care that addresses their patients' clinical and social needs, expressed values, and identified health risks. In addition, with a clearer understanding of beneficiary health needs, ACOs can identify opportunities to adjust existing processes and develop targeted new initiatives to improve outcomes and lower spending.

Two fundamental strategies that ACOs use to assess beneficiaries' health needs are annual wellness visits (AWVs) and advance care planning (ACP). Although each of these efforts provides unique insights to inform patient-centered care, some ACOs encourage providers to combine the two services into a single care experience. Whether completed separately or in combination, AWVs and ACP serve as structured mechanisms for meaningful conversations between providers and beneficiaries to help drive higher-value care.

ANNUAL WELLNESS VISITS

ACOs use AWVs to enhance the beneficiary care experience, improve performance on key quality measures, and reduce overall costs of care.[7] ACOs report that AWVs facilitate person-centered care by strengthening the bond between beneficiaries and their providers. In addition, ACOs may use insights derived from AWVs to support providers in adjusting their service offerings to more effectively deliver the care that beneficiaries need.

ACOs design their AWV initiatives to help participating providers and their support staff conduct these visits for all attributed beneficiaries on an annual basis. ACOs develop communication strategies to highlight the beneficial impact of AWVs on care delivery and provide tools to encourage processes that may increase the efficiency and effectiveness of the visits. To spur consistent use of AWVs, ACOs offer providers with relevant training opportunities and access to resources, support with beneficiary engagement, and insight into improvement opportunities through data analyses.

> "We started our annual wellness program a number of years ago…we knew that it was a good opportunity to get the beneficiary in front of us to close care gaps, to work on disease management, and just overall engage them in their health care."
>
> —ACO administrator

AWV Overview

An AWV is an annual preventive service that is reimbursed by fee-for-service (FFS) Medicare. Core visit components include such things as health risk assessments, preventive screenings, and a review of current providers and medications. During the visit, ACO clinicians provide "personalized prevention plan services," in which the clinicians and beneficiaries work together to outline a preventive care plan—including targeted screenings—to cover the next 5–10 years. The AWV creates an opportunity for the beneficiary to engage with ACO providers in a multifaceted discussion around health status, opportunities, and risks.

Additional details regarding AWV visit components and policy may be found in Chapter 15 of the Medicare Benefit Policy Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf. Additional details on AWV implementation and billing may be found in the Medicare Learning Network: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html.

For one ACO's approach to maximize the effectiveness of AWVs, see the case study on Bellin Health: https://innovation.cms.gov/files/x/aco-casestudy-bellin.pdf.

[7] For an example of research on ACOs' use of AWVs, see Beckman, A.L., A.Z. Becerra, A. Marcus, C.A. DuBard, K. Lynch, E. Maxson, F. Mostashari, et al. "Medicare Annual Wellness Visit Association with Healthcare Quality and Costs." *American Journal of Managed Care*, vol. 25, no. 3, March 2019. Available at https://www.ajmc.com/view/medicare-annual-wellness-visit-association-with-healthcare-quality-and-costs. Accessed January 5, 2021.

Supporting ACO providers' use of AWVs

While PCPs are aware of AWVs as an established visit type, ACOs note that PCPs may question the value of AWVs or raise concerns about how to accommodate the workload associated with delivering these visits annually. To that end, ACOs develop initiatives to convey the value of AWVs and streamline the process of completing visits. ACO initiatives often include three elements: (1) training opportunities to describe how AWVs increase understanding of beneficiaries' care needs and highlight operational best practices, (2) suggested workflows to streamline the process of completing an AWV and maximize its value to beneficiaries, and (3) resources and tools to support seamless implementation of suggested workflows.

Offering educational sessions on AWVs. Many ACOs offer multimodal training and educational opportunities to describe the value of AWVs and suggest possible operational efficiencies for provider participants. For example, ACOs may leverage standing group practice meetings or committee forums as an efficient mechanism to engage a wide variety of providers and their support staff. Some ACOs conduct virtual or in-person training sessions that feature presentations by ACO leadership or peer-to-peer sharing on effective approaches (see ACO Snapshot 1 for one example).

In these education sessions, ACOs often begin with a clear description of how AWVs can meaningfully improve beneficiaries' quality of care. ACOs may cite publicly available research or leverage their own data, if available, to highlight the benefits of AWV completion. For example, ACOs share data analyses exploring the relationship between AWV completion rates and improved performance on quality measures. ACOs also describe how information gathered from AWVs can feed into improved clinical documentation and help the care team develop increased awareness of beneficiaries' health needs, which in turn supports their efforts to deliver patient-centered care.

ACOs also use training sessions as an opportunity to highlight the potential financial benefits associated with AWVs. ACOs describe how providers can seek FFS Medicare payment for the AWV and provide information on relevant coding. Some ACOs also share insights on how data from AWVs may inform risk assessments, including Hierarchical Condition Category (HCC) and

ACO Snapshot 1: Providers' Peer-to-Peer Sharing on AWVs

Objective: Increase provider engagement in the ACO's initiative to expand beneficiary access to AWVs.

Tactic: Host a peer-to-peer sharing event to discuss approaches to integrating AWVs into care delivery.

Strategy: A Next Generation ACO reviewed data on the number of beneficiaries receiving AWVs and identified an opportunity to address underutilization. Believing that AWV-related messaging would be most effective coming from those performing the visits, the ACO hosted a networking event to encourage peer-to-peer sharing among providers. It designed the event to highlight concrete approaches to operationalize AWVs for more beneficiaries. The event also highlighted the value of AWVs to the patient experience, provider care delivery, and ACO results.

The ACO identified PCPs and practice managers from select practices to speak at the event about their respective practices' approaches to conducting these visits. The presenters described their practices' strategies to make the appointments as meaningful and convenient as possible for beneficiaries, including combining an AWV into an existing appointment rather than requiring stand-alone appointments. The presenters also described their practices' operational approaches, emphasizing opportunities for increased process efficiency and reduced burden on administrative staff. One presenter—a PCP—also noted how his practice used AWVs to support the identification of beneficiaries in need of targeted care management strategies.

In addition to hearing from practice representatives, event attendees received informational materials from the ACO that highlighted AWVs' relationship with quality measures and potential effects on patient satisfaction and ACO financial performance. The materials also included descriptions of billing codes for AWVs and other preventive services.

The event attendees' feedback emphasized appreciation for both clinical and administrative perspectives as well as for the informational materials.

Risk Adjustment Factor (RAF) scores. ACOs reinforce the insights from these training sessions by including information about AWVs in existing newsletters or email blasts to participating providers.

Developing AWV workflows. Recognizing that providers may struggle to fit additional AWVs into their schedules, ACOs pair training and educational opportunities with suggested workflows to streamline the process of completing the visits. ACOs encourage providers to customize workflows to the individual needs of their medical group or patient population. These optional workflows depict carefully sequenced steps that leverage both clinical and administrative staff. Some ACOs suggest that providers engage registered nurses or advance practice providers in conducting the AWV. This approach enables frontline staff to operate at the top of their licenses, creates additional opportunity for in-depth conversations with beneficiaries, and reduces provider burden. Other ACOs encourage a team-based approach, in which medical assistants and clerical staff support pre-visit planning—including phone outreach to help prepare the beneficiary for the visit—before the PCP conducts the AWV. One ACO's workflow incorporates a pre-appointment checklist for beneficiaries to help them gather and organize information that supports more meaningful discussion during the AWV, including types of medication taken and any other providers currently supporting their care.

Providing written and electronic support tools. To preempt common operational questions and challenges, ACOs develop written and electronic tools for provider use. ACOs produce frequently asked questions (FAQ) documents, visual displays of workflow processes, and AWV manuals or toolkits to support providers in implementing workflows. To provide real-time reminders that support clinicians in walking through the clinical and social health risk screenings within an AWV, some ACOs lean on their EHRs: ACOs may either consolidate assessment tools into a single AWV template or program sequential, automated prompts for each AWV screening question. ACOs have also programmed flags in the EHRs to indicate a need for follow-up or referrals when a beneficiary screens positive on certain assessments.

Engaging beneficiaries in AWVs

ACOs' initiatives consider how to help providers when engaging beneficiaries in the AWV by capitalizing on opportunities to emphasize how the visit improves beneficiaries' overall health care experience. ACOs note that some beneficiaries are unaware of the opportunity to participate in AWVs, whereas other beneficiaries may be aware of the AWV but do not recognize the value in repeating it annually. To support providers and their staff in communicating the value of AWVs to beneficiaries, some ACOs develop pamphlets or brochures that they encourage providers to share with beneficiaries by mail, distribute at "Welcome to Medicare" visits, or make available in practice waiting rooms. These materials describe the elements of the AWV and how the visit enables providers to better understand a beneficiary's health care needs and support their continued well-being.

Given beneficiaries' competing health care priorities, as well as potential logistical challenges and time constraints associated with travel, ACOs encourage providers to implement scheduling approaches that ease beneficiary burden. Some ACOs encourage providers to focus on preventive care, which can encompass ACP and discussions with the care coordination team, within AWVs. Other ACOs suggest that providers' schedulers reach out to beneficiaries who already have existing acute care appointments to add an AWV on the same day. In recent years, ACOs have pivoted to conducting AWVs as telehealth appointments.

To support providers in identifying beneficiaries for targeted AWV outreach, ACOs deploy electronic tools. Some ACOs use EHR flags to indicate when a beneficiary is due for an AWV. Alternatively, ACOs may provide "care gap lists" to practices based on EHR records and claims data, which list each beneficiary and the date of their most recent AWV (see page 14 for more information on care gap lists).

Leveraging data to increase visibility

ACOs track AWV completions over time and share these results with providers to collaboratively identify improvement opportunities. Using claims or EHR data, some ACOs include AWV completion metrics on practice-specific scorecards and physician dashboards. Other ACOs circulate ACO-wide and practice-specific data in regular reports or discuss the insights from these data in standing monthly or quarterly meetings. A few ACOs incentivize AWVs by tying visit completion to performance-based incentives or calculations determining the distribution of shared savings.

ADVANCE CARE PLANNING

ACOs encourage providers to engage beneficiaries in ACP to inform the delivery of compassionate, respectful, and patient-centered care. ACP conversations create opportunities for providers to identify approaches to care delivery that are aligned with patients' wishes and preferences. In some cases, ACP may also minimize costs by avoiding undesired intensive treatments at the end of life.[8]

ACOs design their initiatives to support providers in conducting meaningful, high-value, and timely ACP conversations. ACOs promote adoption of ACP by (1) normalizing the conversation, (2) sharing actionable resources and tools, and (3) supporting beneficiary engagement. While ACP initiatives may be used to improve communications with all attributed beneficiaries, some ACOs focus their initiatives on high-need populations to yield the most value for their efforts, such as targeting beneficiaries enrolled in complex care management programs.

ACP Overview

ACP comprises education and structured conversations with patients around their health care wishes and care options and encourages patients to proactively consider their likely functional trajectory following an intervention or treatment. These conversations may focus on an individual's anticipated decline due to an existing condition or consider broader hypothetical scenarios, such as catastrophic accidents. ACP may include concrete documentation, such as advance directives. CMS provides reimbursement for ACP as an optional component of the AWV or as a separate Medicare Part B medically necessary service.

For a general overview of ACP in Medicare FFS, see https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/advancecareplanning.pdf. For additional details on reimbursement for ACP as an optional component of AWV, see Chapter 15 of the Medicare Benefit Policy Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.

Addressing ACP challenges

ACOs note that ACP initiatives require providers to embrace a mindset that proactively plans for beneficiaries' functional decline. ACOs report that some providers express discomfort with ACP or indicate they typically conduct ACP only with terminally ill patients. To support and encourage providers to conduct ACP with a broader set of patients, ACO-wide communications convey the idea that ACP can occur in ambulatory settings. For example, ACOs may encourage PCPs to initiate ACP in the context of preventive care, such as during an AWV. ACOs also work to socialize the idea that ACP can occur throughout a beneficiary's lifespan and well in advance of an individual experiencing serious or advanced illness. Recognizing the need to normalize ACP and increase employees' comfort with and knowledge of its concepts, one ACO pushed its employees to complete their own ACP, thus ensuring that the process and its potential value was at the forefront for everyone who interacted with beneficiaries.

Supporting providers' ACP efforts

As ACOs work to encourage use of ACP in ambulatory settings, their initiatives center around supporting providers. ACOs note that providers recognize how ACP creates an opportunity to engage beneficiaries in planning for health care needs and goals but express a lack of experience or discomfort in conducting such discussions. To increase provider comfort when conducting these conversations and promote widespread engagement in ACP efforts, ACOs disseminate structured ACP tools, offer actionable training, and provide ongoing support.

Disseminating structured tools. To support a consistent and high quality approach to ACP, ACOs disseminate structured conversational tools. These tools, which generally include sample prompts and questions for beneficiaries, serve as a base from which providers can begin their patient conversations. The tools also give providers options for sensitive yet clear language that can help them to navigate these potentially emotionally charged conversations. Given the plethora of ACP tools available, ACOs generally opt to use or adapt an existing tool in lieu of designing their own (see box "Tools to Support ACP" for examples).

For one ACO's approach to ACP, see the case study on Integra Community Care Network: https://innovation.cms.gov/files/x/aco-casestudy-integra.pdf.

[8] For an example of research on the effects of ACP on cost, see Klingler, C., J. in der Schmitten, and G. Marckmann. "Does Facilitated Advance Care Planning Reduce the Costs of Care Near the End of Life? Systematic Review and Ethical Considerations." *Palliative Medicine*, vol. 30, no. 5, 2016, pp. 423–433. Available at https://doi.org/10.1177/0269216315601346. Accessed January 5, 2021.

Tools to Support ACP

A number of organizations have developed tools to support meaningful ACP. Publicly available resources and programs supporting ACP include the following:

- Five Wishes, a program from Aging with Dignity
- Tool Kit for Health Care Advance Planning, a resource from the American Bar Association
- End-of-Life Decisions, published by National Hospice and Palliative Care Organization
- The Conversation Project, by the Institute for Healthcare Improvement

For a more comprehensive overview of publicly available tools to support ACP, organizations can reference the 2014 "Decision Aids for Advance Care Planning" technical brief[9] published by the Agency for Healthcare Research and Quality. This brief addresses ACP in the general adult population, as well as targeted ACP for individuals with serious or advanced illness.

To promote widespread adoption and consistent use of selected conversation tools, ACOs note developing workflows to support implementation. These workflows support integration of selected tools into existing care processes. Some ACOs leverage their EHRs to formalize their workflows and support a consistent approach to ACP conversations (for one example, see ACO Snapshot 2).

Delivering relevant and actionable training. ACOs use ACP trainings to share messaging with providers about the importance and benefits of ACP to both the provider and the beneficiary. During these trainings, ACOs stress how insights gathered during ACP can improve clinical documentation and support the provider in delivering patient-centered care. ACOs also note the possibility of Medicare FFS reimbursement for ACP and use trainings to share guidance on proper billing.

To ensure that the information shared in ACP trainings is actionable and relevant, ACOs consider the information needs of their providers. Trainings may be built around

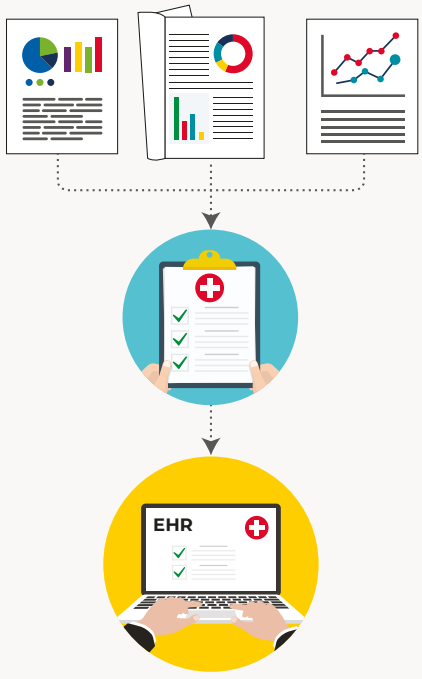
ACO Snapshot 2: Deploying a Standardized Tool to Support ACP Conversations

Objective: Encourage a consistent approach to ACP conversations for beneficiaries enrolled in complex care management.

Tactic: Develop a standardized and structured conversation tool that leverages the EHR.

Strategy: A Next Generation ACO considered improvement opportunities related to ACP and refined its approach to both conducting and documenting goals-of-care conversations. To target high-need beneficiaries, the ACO focused its ACP initiative on its existing complex care management program. The ACO medical director and senior director of population health services collaborated to provide the program's team members with standard guidelines and processes for goals-of-care conversations that could be used with a diverse set of beneficiaries. For example, the ACO used publicly available materials to design a tool comprising sample conversation prompts to begin the goals-of-care discussion. The tool also included realistic examples of how these conversations might proceed, including possible responses from beneficiaries. After nurse care managers piloted the tool, the ACO incorporated it into its program enrollment process to expand use to more beneficiaries.

To promote widespread adoption of the tool and simplify the documentation process for goals-of-care conversations, the ACO asked its information technology department to build the tool into the EHR. When a beneficiary enrolls in the complex care management program, the nurse care manager accesses the tool in the EHR to support the goals-of-care conversation and document the beneficiary's responses in specialized fields. Other providers with access to the EHR, whether in an outpatient or hospital setting, can review this information about beneficiaries' wishes when engaging them in decisions about their care.



[9] Butler, M., E. Ratner, E. McCreedy, N. Shippee, and R.L. Kane. "Decision Aids for Advance Care Planning." Technical Brief No. 16. AHRQ Publication No. 14-EHC039-EF. Rockville, MD: Agency for Healthcare Research and Quality, July 2014. Available at https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/advanced-care-decision-aids_technical-brief.pdf. Accessed January 5, 2021.

structured ACP tools promoted by an ACO. Alternatively, trainings may address ACP in the more general context of geriatric or palliative care.

To maximize the reach of their training efforts and ensure accessibility, ACOs leverage a variety of strategies to disseminate educational materials. For example, ACOs provide synchronous trainings, disseminate asynchronous audio and video trainings, and build ACP education into standing meeting series and newsletters. Some ACOs also produce recorded training sessions, podcasts, and short videos that providers can access at their convenience.

To allow clinical staff an opportunity to engage with colleagues in developing their ACP conversational style, ACOs prioritize interactive trainings. Such trainings generally include role playing and case studies, which give participating staff the opportunity to engage with ACP tools in real time and receive feedback on their approaches. Depending on the ACO, these trainings may be conducted by members of the palliative care team, geriatricians, or experts from care management.

Providing ongoing ACP support. Recognizing that ACP may require significant emotional investment, ACOs emphasize the value of mentorship for providers conducting these conversations. Some ACOs make peer-to-peer support available to providers by connecting them to ACP experts across the organization, such as representatives from palliative care services, care management, or social work. These champions serve a dual function: amplifying the ACO's ACP messaging and serving as an ongoing resource for clinicians seeking support with difficult beneficiary conversations.

> "The care management staff need [ACP] champions who will be there when they need to talk through a difficult conversation that didn't go as they planned. Provide ongoing support . . . you can't just do one training session and walk away."
>
> —ACO administrator

Engaging beneficiaries in ACP

ACOs promote flexible implementation approaches for providers engaging in ACP to respectfully meet beneficiaries' needs and encourage ACP conversations in a variety of care settings. Some ACOs may encourage providers to integrate ACP into existing care structures—for instance, by integrating ACP discussions into AWV workflows. Other ACOs suggest that providers share relevant ACP documentation with beneficiaries during a scheduled visit and encourage them to complete the forms at their leisure. Some ACOs emphasize that ACP conversations can happen in any medium, such as within a telehealth visit, at the provider's and beneficiary's mutual convenience.

To support communication between beneficiaries and their providers, some ACOs suggest that providers transparently document beneficiaries' care wishes in real time using their EHRs or other standardized electronic templates. To provide beneficiaries with a portable summary for easy reference, ACOs encourage providers to share a copy of this documentation with the beneficiary when they leave the visit.

Strategies for Gathering Insight into Beneficiaries' Health Care Needs

- Offer multimodal training and educational opportunities to providers that clearly articulate the value of AWVs and ACP to the beneficiary and provider.
- Pair AWV training opportunities with distribution of suggested workflows and structured tools to support providers seeking to streamline their processes.
- Disseminate structured ACP conversational tools to support providers in their efforts to navigate difficult conversations and deliver respectful, high quality, and patient-centered ACP.
- Encourage providers to adopt approaches for AWVs and ACP that minimize beneficiary burden—for instance, by combining AWVs and ACP into a single visit or offering telehealth opportunities.

Harnessing Data to Improve Performance and Support Quality Reporting

Data management to support performance improvement and quality reporting is a fundamental element of ACO operations. ACOs use data from multiple sources to analyze patterns in care delivery, design and implement improvement strategies, and collect quality measures data to submit to CMS. To support these efforts, ACOs assess which sources are the most accessible, complete, and accurate. These data come from disparate, heterogeneous data sources, such as claims from different payers or clinical data from multiple EHRs. Many ACOs employ staff to manage the data or procure external vendor support to integrate these diverse sources within a centralized, standardized platform, such as a data warehouse. With a consolidated data repository, ACOs are well positioned to leverage these data to produce analyses that support their leadership with decision-making and operational improvements. ACOs also rely on these data to generate resources—such as dashboards or care gap lists—that engage participating providers in ACO strategies and promote quality improvement initiatives. Additionally, centralizing and standardizing data allow ACOs to automate the process of reporting quality measures.

SELECTING DATA SOURCES TO SUPPORT QUALITY IMPROVEMENT EFFORTS

ACOs develop their data strategies in part based on which data sources are readily available for use and updated on a timely basis, with many ACOs relying heavily on claims and EHR data. Claims provide insights into the volume and types of services delivered to attributed beneficiaries, and the resulting health care spending. EHR data include more detailed clinical information, including health status, diagnostic results, and treatment dosage. ACOs may supplement information from claims and EHRs with other data sources, such as admission, discharge, and transfer (ADT) system data; immunization records; risk assessment data; and data on social determinants of health (SDOH).

ACOs track service utilization through monthly Claim and Claim Line Feed (CCLF) files from CMS. The monthly CCLF files include claims for Parts A, B, and D for beneficiaries attributed to the ACO who have not opted out of data sharing. ACOs participating in multiple value-based care contracts may combine CCLF files with similar claims files to more fully track both the utilization of services and spending.

EHR data allow ACOs to examine changes in their beneficiaries' health status over time, which enables them to identify opportunities for improvement and assess the potential impact of care delivery reform efforts. ACOs also rely on EHR data to meet quality measure reporting requirements. ACOs offer trainings for administrators at clinical sites to ensure they understand documentation requirements for each measure, the quality measure parameters (for example, the numerator and denominator), and how to enter the data necessary to receive credit for each measure.

ACOs supplement claims and EHR data with other sources that help them coordinate care and gain a more complete picture of beneficiaries' health. For example, ADT system data allow ACOs to track their beneficiaries' movement into and out of hospitals, EDs, and other facilities, supporting their efforts to coordinate care. Some state and local governments provide ACOs with access to data from health information exchanges and immunization records. ACOs may also collect data on their beneficiaries related to SDOH, which may enable them to reach out to those beneficiaries with unmet social needs. ACOs also can use data on patient-reported outcomes to identify priority areas for improvement.

AGGREGATING AND STANDARDIZING DATA SOURCES

Although ACOs have access to a diverse range of data sources that provide rich detail on their patients, ACOs note that employing these data effectively requires aggregating them into a usable reporting format. Some ACOs address this challenge by combining data in a data warehouse and conducting analyses to identify care gaps, track downstream changes in beneficiaries' health following receipt of services, and report quality measures. Data warehouses enable ACOs to link a beneficiary's claims, clinical data from EHRs, and other records (such as immunization records and ADT

For one ACO's approach to develop a data management system, see the case study on Nebraska Health Network: https://innovation.cms.gov/media/document/aco-casestudy-nebraskahealthnetwork.

data), turning a potentially unwieldy amount of data into a powerful tool for understanding their beneficiaries' care. In addition to aggregation, another key goal in setting up a data warehouse is to standardize data across different sources. For example, some ACOs describe needing to map common variables with different names across EHRs or various payers' claims.

To pull EHR data from individual provider groups into a data warehouse, ACOs often require those groups to allow remote access. In return, ACOs offer to use their access to pull the data necessary for quality measure submission, which reduces providers' reporting burden. One ACO estimated that by relying on remote access to entities' EHRs, it was able to automate about 75 percent of the quality measure reporting process (largely on the provider side), eliminating the need for provider groups to pull the data themselves and transmit the data to the ACO. Some ACOs make remote access a requirement for providers to join the ACO. One ACO found that practices allowing remote access had higher quality scores compared to those that did not, which persuaded the ACO's board and quality committee to add a requirement that all primary care practices joining the ACO going forward must allow remote access.

> "Remote access has been so crucial, and we were able to demonstrate that the quality scores for those practices where we have remote access was actually light years better than the ones where we did not."
>
> —ACO administrator

Given the challenges of standardizing data from multiple EHRs, some ACOs encourage all participating providers to adopt a single EHR platform, which substantially lowers the burden of quality measure analysis and reporting. By using just one EHR platform, ACOs are capable of automating reporting processes and running mid-year reports to promote improvement efforts. One ACO experienced the challenge of reporting quality measures from more than 20 different EHR platforms across the organization and began offering a subsidy to practices that shifted to its preferred platform—noting, however, that progress has been slow. Another ACO is embarking on a four-year process to bring all its employed medical groups onto a single EHR platform, rolling out the initiative in stages across its different geographic regions.

USING DATA TO IMPROVE QUALITY AND CLOSE GAPS IN CARE

Using an aggregated and standardized data repository, ACOs can rapidly and efficiently calculate metrics that improve the quality of patient care. By tracking utilization, spending, and outcomes in visual displays of key metrics—such as scorecards or dashboards—participating providers can see trends in their own performance and in relation to their peers. They also can create care gap lists, which identify attributed beneficiaries who have not received recommended services.

> "Fundamentally, we have more data than we ever have had before, and the value comes when we turn that data into knowledge."
>
> —ACO administrator

Scorecards allow ACOs to show providers how they compare to their peers on key quality metrics and to incentivize improvements. ACOs may generate scorecards for clinically integrated networks, employed medical groups, specific practice locations, hospitals, or individual physicians. The scorecards include metrics on use and cost, allowing providers to see how they contribute to the ACO's shared savings. Moreover, the scorecards can display those metrics along with comparisons to practices or providers within the same region (for example, county) or throughout the ACO, which creates an incentive to improve quality.

Care gap lists allow clinicians and administrators to identify patients with demonstrated gaps in their care and take steps to close them. Examples of the care gaps identified by ACOs include patients diagnosed with chronic conditions who have not had recent appointments or those due for needed services (especially those included in quality metrics, such as depression screenings, mammograms, or colonoscopies). ACOs can then pull care gap lists into dashboards, which offer electronic platforms for providers that create interactive displays of key metrics and other data. Care gap lists may also track services delivered to a provider's beneficiaries by other providers (for example, by showing that patients have received

mammograms or colonoscopies from other providers), allowing providers to focus on addressing remaining gaps in care. Physicians and nurses may review the dashboards at each visit and use the information to prioritize delivering services that close gaps. Additionally, practice managers can review gap lists and proactively reach out to beneficiaries to schedule visits for addressing care gaps. ACOs can also use care gap lists to target beneficiaries in coordinated campaigns to close those gaps. For example, one ACO used abstracted data from EHRs to create the contact list for a phone campaign to increase influenza vaccination rates.

> "We think about how the data tells us a story: the 'what,' the 'so what,' and the 'now what.'"
>
> —ACO administrator

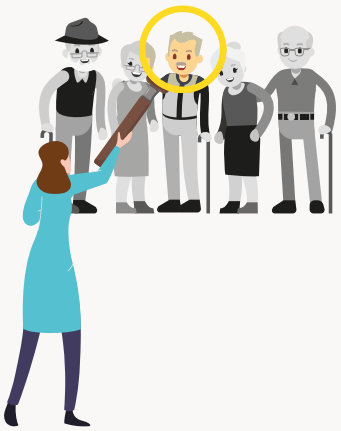
USING DATA TO CONDUCT EXPLORATORY ANALYSES

ACOs can conduct exploratory analyses that inform quality improvement strategies. Using these analyses, they can identify drivers of expenditures, such as inpatient admissions, readmissions, ED visits, ambulance services, and use of long-term nursing facilities. ACOs can use the findings of these analyses to develop high-impact, low-cost opportunities to reduce expenditures. For example, an ACO may use claims data to identify beneficiaries with the highest expenditures for a particular service, and then review their EHR to obtain context for their high utilization and assess opportunities for meeting their needs more efficiently (see ACO Snapshot 3 for more information).

Multiple ACOs noted using data to address SDOH and promote equity by identifying disparities in care not apparent when considering their entire patient populations. Some ACOs collect data on SDOH and race/ethnicity from beneficiaries through patient portals accessed before a visit. These data allow the ACOs to highlight opportunities to address gaps in care and improve quality for particular patient subpopulations.

> "We weren't really telling the whole story. Now that we're focusing on breaking some of those measures down by race and ethnicity, that certainly tells us a very different story of what's actually happening and helps us to prioritize where we go next.
>
> —ACO administrator

ACO Snapshot 3: Using Data to Focus Attention on Beneficiaries with the Greatest Need



Objective: Identify beneficiaries with high utilization and connect them to available services.

Tactic: Analyze claims and EHR data to identify beneficiaries with high utilization so that care coordinators can develop targeted strategies that address patients' care needs.

Strategy: A Next Generation ACO relies on claims and EHR data to identify beneficiaries with particularly high utilization and enlists care coordinators to investigate potential drivers of their care patterns. In the first step in this process, the ACO's data analytics team aggregates claims data for services—such as ambulance transport, SNF use, and home health use—to create a series of easily digestible and service-specific Excel documents that enable care coordinators to begin their data review. A member of the data analytics team and a care coordinator review the data together to identify beneficiaries for whom the ACO might address needs more efficiently. The care coordinator then looks at EHR data for these beneficiaries to gain additional context that may identify potential causes for the high utilization.

For example, for ambulance services, the Excel file contains one tab displaying data on the highest utilizers of ambulance services across the ACO and other tabs showing the highest utilizers by individual provider. In one instance, the ACO identified 25 beneficiaries who each had at least $45,000 in ambulance services over the course of a calendar year and began reviewing EHR data to learn more about their care needs. The care coordinator found that the beneficiary with the highest utilization had end-stage renal disease and relied on ambulances for transportation to dialysis services. In this case, the care coordinator provided information obtained from the EHR to a licensed clinical social worker, who reached out to the beneficiary and explored the beneficiary's challenges in accessing conventional transportation. The social worker then worked to connect the beneficiary to a less costly, more sustainable transportation option for traveling to receive dialysis.

Strategies for Harnessing Data to Improve Quality and Streamline Quality Reporting

- Aggregate and standardize data from claims, EHRs, ADT system data, immunization records, risk assessment data, and data on SDOH by using a data warehouse.
- Use claims, EHR, and other data sources to create dashboards and care gap lists that allow providers to track their performance on quality metrics and identify opportunities to close those gaps.
- Obtain remote access to practices' and providers' EHRs to streamline collecting the data necessary for quality measure reporting.

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