

Case STUDY

 **Learning Systems**
for Accountable Care Organizations

Boulder Valley Care Network's Provider Engagement Strategy

This case study describes the strategy used by Boulder Valley Care Network (BVCN) to design a governance structure for its Accountable Care Organization (ACO) that promotes physician engagement. BVCN's experience can serve as a guide to ACOs that are attempting to work with physicians, particularly those in independent practice, who have concerns about partnering with a hospital-led ACO. BVCN also shows the benefits to the ACO of empowering physicians by placing them in key leadership roles. The strategy consists of two parts: (1) giving physicians a leadership role on the ACO board and committees, and (2) jointly negotiating participation and operating agreements by the two organizations partnering in the ACO: the hospital, Boulder Community Health (BCH), and the Boulder Valley Individual Practice Association (Boulder Valley IPA). BVCN found that this strategy helped it to build trust with physicians not employed by BCH and keep them engaged. The physician-led structure also improves care for beneficiaries by getting physicians involved in developing the ACO's clinical practice guidelines and targeting those guidelines to the needs of the beneficiary population they serve.

BACKGROUND

BVCN is a clinically integrated network (CIN) owned by BCH, a hospital in Boulder, Colorado, that serves patients located in urban, suburban, and rural areas. BVCN operates as a Shared Savings Program (SSP) Track 1 ACO that currently serves 9,500 aligned beneficiaries.

The CIN includes two collaborators, BCH and Boulder Valley IPA, which is a nonprofit IPA consisting of about 500 physicians and representing practices that range in size from one to about 20 clinicians. The BVCN ACO consists of 470 clinicians, 350 of whom are physicians. About one-third of BVCN's physicians are employed by the hospital and are

mainly primary care physicians (PCPs). The remaining two-thirds are independent. Most of them are specialists who represent about 40 different specialties. All of the BVCN ACO physicians are part of Boulder Valley IPA.

Specialists have a particularly important role in delivering care to beneficiaries in the Boulder Valley market. The population in the region is highly educated, affluent, and athletic, and many individuals are not aligned to PCPs. Beneficiaries often self-refer for their medical services. Some of the more common conditions that prompt beneficiaries to seek care from a specialist are hip and knee problems, skin cancer, mental health and substance abuse, and heart disease. For many specialties, there are

only one or two practices that serve the Boulder Valley market. For example, only one cardiology group, one independent oncology group, and four orthopedic surgery groups serve the region.

CHALLENGE: BUILDING TRUST BETWEEN HOSPITAL AND INDEPENDENT PRACTICE GROUPS

One of the key challenges in launching the ACO was getting buy-in from independent physician practices. These practices were concerned about ceding control to BCH for decisions related to negotiating with payers and other similar issues. For many clinicians, this concern came out of their negative experience with health maintenance organizations during the 1990s. “There were concerns from the IPA that if it was too heavy handed from BCH that [the ACO] would not be of value to the independent physicians,” said Ben Dzialo, executive director of BVCN. Moreover, for many specialists serving Boulder Valley, there was little incentive to participate in an ACO. Many of these clinicians were part of larger specialty practices with few or no competitors in the regional market, and they did well under traditional reimbursement structures. These clinicians also served beneficiaries who largely self-referred for their services.

More recent efforts to bring together BCH and independent physician practices has yielded mixed results, in part because these efforts relied on a loose organizational structure that did not win buy-in from either the organizations involved or the individual clinicians whom they represented. BVCN formed in 2009 under a memorandum of understanding (MOU) among clinicians and care delivery systems across Boulder Valley (see Figure 1 for a time-line for forming BVCN). The goal of the MOU was to help drive improvements in the quality of care and to reduce costs. However, Dzialo said that although the leadership of the MOU incarnation of BVCN did the best they could to succeed under that legal structure, the MOU was not able to provide strong incentives for the individual organizations to reduce spending, since doing so would also reduce their revenues. Additionally, BVCN in its original incarnation did not engage physicians to help spur quality improvements or increase efficiency. “The MOU was also an agreement at the organization level and didn’t require individual provider commitment. Many participants didn’t even know it existed, and so no change occurred,” said Dzialo.

In 2015, BCH and Boulder Valley IPA formed a steering committee to negotiate a reconstituted BVCN that would operate as a CIN and eventually as an MSSP ACO. To address the concerns of both the independent clinicians and BCH, BVCN established a governance structure for the ACO that allowed independent physicians to take a lead role in setting policy. By formally building in leadership roles for independent physicians and giving them a seat at the table from the outset of the ACO, BVCN was able to get their buy-in and their ongoing

Figure 1
Timeline for Forming BVCN ACO



engagement in the ACO’s work. The remainder of this case study describes not only the governance structure and its use in clinician engagement in more detail but also its success to date.

STRATEGY #1: PHYSICIANS LEAD THE ACO

To obtain buy-in from independent physicians, BVCN established a physician-led board that gave equal representation to BCH and Boulder Valley IPA. The steering committee that negotiated the creation of the BVCN CIN formed the 18-seat board in January 2017, and BCH and Boulder Valley IPA selected seven board members apiece. Five of the seven seats for each organization were reserved for physicians. The board also includes two community seats—one for a Medicare beneficiary and the other for a commercially insured individual—and two ex officio members, Dzialo and BVCN medical director Jason Cannell. Although BCH and Boulder Valley IPA propose their representatives to the board, the board ultimately votes

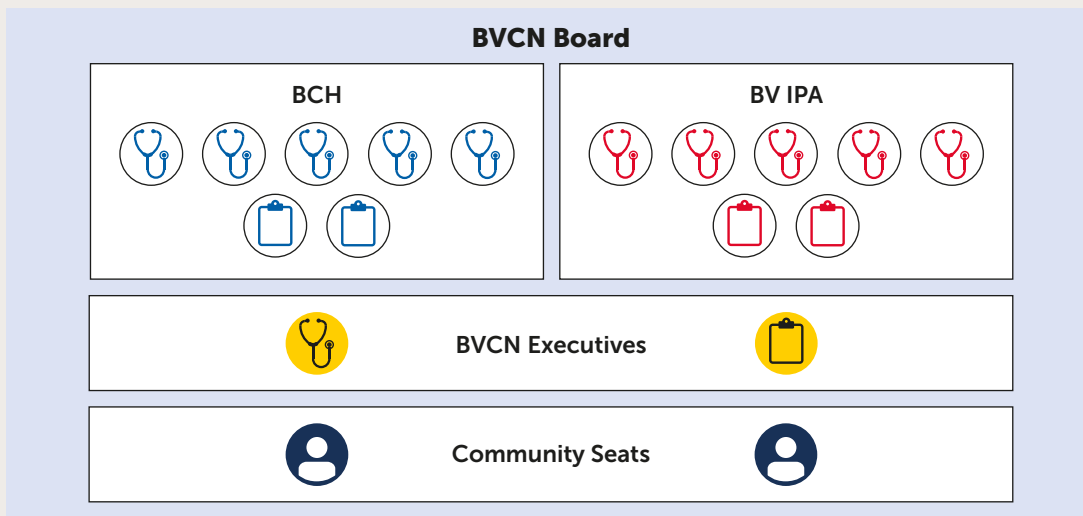
on whether to approve and seat all board members. Members serve three-year terms, and each member can serve a maximum of two terms. In addition to the board, BVCN formed three committees—the Finance and Contracting Committee, the Quality Improvement and Credentialing Committee, and the Data and Technology Committee—all of which are chaired by physicians who sit on the board. These three committees make policy recommendations to the board, which sets the course for the ACO as a whole (see Figure 2 for more detail on the composition of the BVCN ACO board and committees).

Dzialo said that BVCN designed its board and committees to ensure that physicians were guiding the work of the organization, which will ultimately improve care for the beneficiaries they serve. For example, the physician members of the board have been driving the development of evidence-based clinical guidelines for use across the ACO, and some of the guidelines address obstacles in delivering care to their patient populations. Dzialo noted that while some physicians

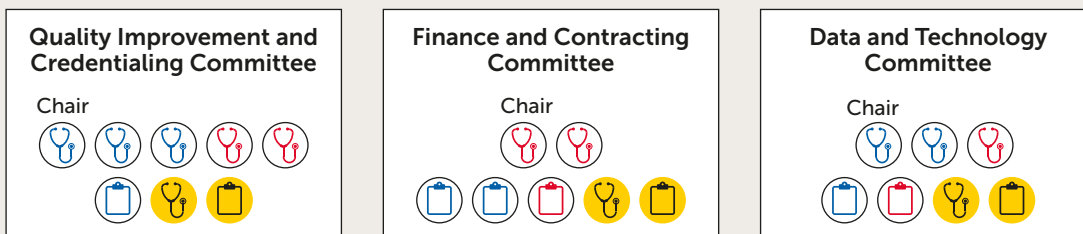
within BVCN are skeptical about using externally generated practice guidelines or quality measures, they feel more confident about adopting guidelines by physicians tailored to treat the patients they serve within their community. “Through our physician-led approach, our participants build the clinical practice guidelines for each other so that they focus on improvements to the pain points that they see for their patients on a daily basis,” said Dzialo. “This ensures that what we create is applicable to the needs of our population.”

BVCN found one of the key strategies to making sure that physicians truly guide the work of the ACO is to appoint physicians to serve as the chairs of both the board and the committees. Dzialo said that if an ACO appointed someone with a business or an accounting background to chair the finance committee, physicians serving on the board might defer conversation and decision-making to the individual with an administrative background because the physicians are less familiar with accounting principles. Appointing physician chairs

Figure 2
Composition of BVCN Board and Committees



BVCN has three standing committees whose membership includes both board members and non-members. Each committee chair is a physician and board member.



BVCN: Boulder Valley Care Network **BCH:** Boulder Community Hospital **BV IPA:** Boulder Valley Individual Practice Association

👤 Physician 📁 Administrator 👤 Community Member

to the board and the committees reduces the risk that staff other than physicians will steer the meetings. “We don’t want the committees to have token physician representation,” said Dzialo. “The physician chairs are the ones facilitating the meeting, and if the physician chair doesn’t get what’s going on, they get to slow down the meeting.” This committee structure ensures that the physicians understand the topics of discussion and the clinical-practice implications of committee decision-making, which in turn sustains physician engagement in the organization.

STRATEGY #2: JOINTLY NEGOTIATED AGREEMENTS GIVE INDEPENDENT PHYSICIANS A VOICE FROM DAY ONE

The BVCN board created the participation and operating agreements for the ACO, and the equal representation on the board from BCH and Boulder Valley IPA helped to facilitate negotiations. This balance ultimately helped win buy-in on the final agreements from the IPA members, including the specialists who are crucial to the ACO’s success. Although the primary focus of the agreements is the CIN, the CIN operating agreements also include the ACO governing rules, under which BVCN may include or exclude members of the CIN from the ACO.

Having the Boulder Valley IPA board members involved in negotiating the agreements allowed the board to ensure that the agreements addressed the concerns of independent clinicians that are associated with ceding control of key decisions to the hospital. For example, BCH felt BVCN would only be sustainable if BVCN had single signature authority for the whole network, meaning that BVCN can include all network practices in any contract it negotiates with payers. Although independent practices were hesitant about granting BVCN single signature authority, Boulder Valley IPA’s board members agreed to grant it because their representation on the board will ensure that the authority is not used to the detriment of physician practices.¹ The IPA also successfully negotiated language in the BVCN agreements that made sure that member practices would retain ownership of certain intellectual property generated by the practices, such as clinical practice guidelines, in the event that BCH was ever acquired by a larger health system.

Dzialo said that joint negotiation led to a longer development process for the agreements but ultimately produced agreements that had strong support from the independent clinicians. According to Dzialo, the parent company of many CINs drafts the participation and operating agreement and then forms the board. BVCN took the opposite approach; it put the board in place before negotiating the agreement. “It took a lot of time to create the operating agreement. However, it made physician recruitment a lot easier,” said Dzialo.

“We didn’t sign anything until both sides [BCH and Boulder Valley IPA] agreed upon what was in the language. This [process] took way longer than if we had out-of-the-boxed it, but it was a necessary step for trust reasons.”

—Ben Dzialo, BVCN Executive Director

Boulder Valley IPA’s involvement in the negotiations also helped to assure other independent clinicians that the agreements were a good deal for physicians. “The IPA’s CEO had a leg to stand on when the participants or potential participants would go to him asking questions, [such as] ‘Is this a land grab? Is this acquisition in disguise by BCH?’” said Dzialo.

SUCCESS OF GOVERNANCE STRATEGIES IN ENGAGING CLINICIANS

BVCN’s leadership team has used the governance structure described above to more fully engage existing ACO participants and encourage skeptical practices to sign on. Dzialo and Cannell lead the ACO’s clinician engagement efforts, which include meetings with existing and prospective participants. Dzialo said that when they meet with new practices, they use the governance structure to address the practices’ concerns around ceding control to BCH. “[The practices] say, ‘Oh, this is Big Brother coming in and telling me how to practice.’ And [we’re] able to say, well, actually, BCH does have representation, but this is a collaboration, this is physician led, this is actually your peers making the decisions about what is and is not acceptable. So it’s not a big hospital telling you what to do,” said Dzialo. “And having that comfort level is quite helpful for us when we reach out to these small practices.” Dzialo said that BVCN’s message to smaller practices is that the ACO gives them the ability to access the larger administrative resources of BCH and the ACO without having to sacrifice their independence.

For some prospective BVCN members, the offer of a position on the board or on one of the committees has convinced them that BVCN would be responsive to the needs of their practice and to independent practices more broadly. For example, BVCN persuaded a large orthopedic practice to sign on in part by offering its CEO a seat on the Finance and Contracting Committee. One of the CEO’s concerns about joining the ACO was BVCN’s single signature authority. Granting the CEO a leadership role that is structured around the ACO’s finance and contracting reassured her that the ACO would not misuse that authority.

Visible representation on the board and committees from independent physicians with stature in the Boulder Valley region has also served as a strong signal to prospective participants that the ACO would be a worthwhile arrangement for their practices. Dzialo said independent clinicians see these respected peers in

¹At present BVCN does not participate in single signature contracts. BVCN is using its shared savings contracts to develop the infrastructure to allow them to enter single signature contracts in the future

leadership roles in the ACO, and they know that these leaders would not sign onto an organization that harmed their practice. These high-profile board members also act as channels through which ACO participants can raise their concerns by reaching out to the board members directly.

In addition to helping recruit new practices, the physician-led structure of BVCN also helps to keep existing participants engaged. The physicians on the board and committees have a personal commitment to making sure the ACO is working well. Dzialo points out that a leadership team composed of representatives from the different practices helps to create a sense of ownership, and the success of BVCN becomes a reflection of the practices and physicians, so they “have skin in the game.”

“That’s the strongest message we have, that your colleagues are the ones who are driving strategy, are the ones driving operations, are the ones doing what is asked of you. And that goes a long way, especially when we find ourselves in situations where there are a lot of skeptics.”

—Jason Cannell, BVCN Medical Director

That sense of ownership by physicians has a positive impact on the ACO’s approach to improving quality of care. For example, Dzialo noted that physician leaders have been pushing the ACO to review its relatively low performance on the SSP diabetes composite performance measure. Dzialo said from a business perspective, there is little incentive to focus on this measure because it is being retired in 2019, and it requires PCPs and ophthalmologists to share clinical data, which can be costly and technologically challenging. But Dzialo said that the physicians on the board have directed the ACO to examine its performance

on this measure to make sure that it is providing high quality care to their beneficiaries. More broadly, BVCN’s physician leaders strengthen the ACO as a whole by recruiting new practices and helping to sustain the involvement of existing members.

NEXT STEPS

BVCN has benefitted from its cultivation of physician leadership, and will continue to build on these relationships in the larger community. Looking ahead, BVCN plans to strengthen the connections between the members of the board and the ACO practices. Each member of the board will take on the role of a champion, serving as the liaison to the board for a specific subset of participants. The goal is to build on the board members’ existing ties to their physician peers and create a more formal structure for having participants interact with the board.

Although BVCN continues to recruit new practices, its efforts have slowed and become more focused relative to its first year in the SSP model. In 2019, BVCN is focused on recruiting some specialties that, though key to the care of Medicare beneficiaries, are not currently represented in the ACO, such as anesthesiology, psychiatry, nephrology, and emergency medicine. BVCN also continues to recruit new PCP practices.

ABOUT THE ACO LEARNING SYSTEMS PROJECT

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