Better Healthcare Through Better ACO Patient Analytics

by Jim Anfield, Principal
Accountable Care Organizations (ACO) have become a major force in moving our country towards outcome based healthcare. This represents a shift from fee-for-service reimbursement to value-based reimbursement with a goal to improve patient care, promote continuity of care efficiency, and create health value for patients.

The generally accepted definition of an ACO is a group of health care providers, including doctors, hospitals, health plans and other health care constituents, organized to provide coordinated high-quality care to individual patients or populations of patients. **Frequently, the ACO will be a single health care system that has the ability to provide a full spectrum of health care services.** These healthcare services will include primary care, specialty care, hospital services, and ancillary services such as labs and radiology.

A core part of an ACO is the shared reimbursement model between a health insurance payer and the providers that make up the ACO. If an ACO makes demonstrated improvement against health outcome and financial goals, the payer will compensate the ACO with a provider financial bonus.

Therefore, the focus of the ACO is to provide continuity of patient care and to coordinate the patient care through the full spectrum of the health care within the ACO group. This means that all health care needs for patients are known within all of the ACO group members and information is shared that allows the ACO to effectively plan and build a care plan for the patient. The patients’ needs and their preferences are known, anticipated, and communicated to the right health professional at the right time. By creating this information flow within the ACO, this should increase the quality of care of the patients while making this care more efficient with much better outcomes for the patients and the respective patient populations.
Key Concepts for an ACO

Attribution

Attribution is the method and concept of defining patients or payer members who belong, or are attributed, to the ACO. Generally, a patient is attributed if their primary care doctor is part of the ACO and the primary care doctor has provided a base office visit or well care within the last year. The primary physician is deemed to have responsibility for that particular patient. It is this part of the care that additional healthcare needs are identified that can create additional continuity of care opportunities for the ACO.

Population Health Management

Population Health Management is the collection of patient data across all health data resources with the goal of aggregating this data into an analyzed, meaningful and actionable patient health care plan. Implementing this health care plan and strategies on behalf of the patient should result in enhanced clinical and financial outcomes. Population health can not only be focused on individual patients but also across groups that can include employer, disease states, high chronic care cases, or any other designated group.

Outmigration

Outmigration occurs when an ACO attributed patients seek or are referred to any healthcare provider outside of the ACO. Some outmigration is natural such as out-of-state care, lack of a specified specialist care, or after-hours care.
To effectively coordinate patient care with goals of best clinical outcomes and supreme patient experience as well as maximize the ACO financial results, the following key questions must be analyzed and understood:

- Who are the ACO attributed patients and what are their continuity of care needs?
- What is the outmigration rate for various patients or populations for attributed patients of the ACO?
- What is the lost revenue opportunity due to the attributed ACO patient outmigration?
- What is the increased cost of care coordination for ACO attributed patients from outside health care from non-ACO participants?
- What is the lost ACO health insurance payer incentive bonus due to outmigration and other performance gaps?
- What will be the net impact to patient satisfaction (HCAHP scores) by developing a seamless and coordinated patient health treatment experience?
- What will be the improvement of patient outcomes by having patients maximizing the use of the ACO healthcare services?
- Based upon the analyses, what action plans can be developed to mitigate outmigration and increase the ACO continuity of care?
Of course, effective answers to these questions and utilization of best practice ACO strategies requires that the ACO organizational data is readily available for data analytics. The ACO must leverage data and analysis across financial management, population health, and performance measurement. The key to success for an ACO is build a core capability to effectively consolidate, manage, and analyze all data to effectively manage and treat populations of attributed ACO patients. This will require that the ACO merge clinical (EMR), administrative, financial, health insurance claims, government sources, health information exchange (HIE), and even third party data sources into a unified data base creating a single source of truth for all patient data information.

Once all of the patient data is consolidated and normalized can the ACO begin the analytics and other analyses to maximize the value of the ACO on behalf of the patients as well as the members of the ACO. Advanced analytics, such as machine learning, can also be used to find deep hidden value not readily apparent by traditional analytical methodologies.
Once the analytics have been developed towards providing the questions posed above, specific actions plans should be in place to capture the patient health outcome and financial benefits. These ACO action plans could include:

- Ensure the proper ICD-10 coding and remediate any gaps in coding errors.
- Conduct outreach to the attributed ACO patients and conduct annual Annual Health Exams.
- Close any gaps in care found during the Annual Health Exams.
- Develop, implement, and enroll attributed ACO patients in appropriate chronic disease management programs.
- Develop tight integration in EMR and practice management systems that “push out or pop up” to the appropriate clinical care manager when healthcare needs for an ACO attributed patient are detected or identified.
- Build out ACO health information reporting, dashboards, and analytics to allow care managers to actively manage their patients from chronic care to post op to SNF.
About Aptitive

Aptitive is a data and analytics consulting firm with a focus on healthcare and insurance. Based upon our client’s existing business strategy, we develop data strategy/architecture and work within the cloud (e.g., Azure) or on premise to build out data infrastructure enabling Business Intelligence (BI), analytics, and also advanced analytics including machine learning, and AI.

About Jim Anfield

Jim is a principal at Aptitive in the healthcare and insurance practices focusing on helping his clients grow revenue, reduce cost, and deliver supreme customer experience by leveraging enterprise data and applying analytics.