

## How using care management guidelines can help accountable care organizations achieve success



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**While an accountable care organization (ACO) can take many forms, essentially it is a group of healthcare providers—primary care physicians, specialists, and hospitals—that have been incentivized with rewards (and/or penalties) to join forces and more efficiently and effectively deliver their services.**

In this new world, the consolidated entity, the ACO, bears the financial risk for care. This transfer of financial risk in the healthcare system to providers does not change the requirements for care management, but does make providers accountable for delivering care management services. Patients have always felt that their practitioners direct their care and provide the right amount of the right care at the right time. Now the ACO, a group of providers, is incentivized to provide that expected level of care to patients.

The exact structure of an ACO will vary, although there will be several core components.<sup>1</sup> Our focus here is on the role of evidence-based guidelines for care management, which hold enormous promise for assisting ACOs in achieving their two main objectives simultaneously: managing healthcare costs while preserving or improving quality.<sup>2</sup> This paper takes a somewhat narrow approach by using an illustrative example—in this case clinical referral guidelines—to showcase how guidelines interact with the accountable care concept. There are various other types of evidence-based guidelines that are applicable in the ACO model but in the interest of maintaining a reasonable length, this effort is focused on this one type of guideline.

### CLINICAL ACCOUNTABILITY AT THE HEART OF THE CONCEPT

At the heart of the ACO concept is the expectation that when groups of providers are collectively accountable for meeting cost and quality benchmarks, they will measure themselves against these targets and identify best practices. Implementation of best practices and ongoing measurement should lead to delivery of optimal healthcare.

This *systemization* of best practices aligns the objectives of an ACO—and many tenets of healthcare reform—with those of evidence-

based decision support tools: to assist in the pursuit of optimal healthcare. Effective evidence-based tools, including clinical guidelines, are designed to help remove variation from healthcare delivery. In addition to supporting high-quality care, they can help to reduce healthcare costs by encouraging the effective, efficient delivery of care, i.e., delivery that achieves desired patient care outcomes using an optimal level of resources.

### USING EVIDENCE-BASED GUIDELINES TO PROMOTE BEST PRACTICES

As Richard Kipp and Lisa Mattie described in a recent Milliman paper, the cost control opportunity for an ACO is a familiar one. Providers are being asked to share financial risk and, potentially, reap the rewards of a more efficient, higher-quality health system. In this effort, they must work collaboratively with other components of the system (payers and patients).<sup>3</sup>

The authors identify that one of the reasons for the failure of risk-sharing efforts in the 1990s was the lack of evidence-based clinical decision support tools. Evidence-based medicine can provide a road map to simultaneously achieve higher quality and more efficient care.<sup>4</sup> The attributes that define and make evidence-based guidelines useful to organizations providing, arranging, or paying for healthcare include:<sup>5</sup>

- A development and update methodology that is credible to healthcare providers because of its rigor and its inclusion of provider stakeholders
- A focus on actionable, measurable, and reportable content

1 Fitch, K., Murphy-Barron, C., & Mirkin, D. (July 27, 2010). Nuts and bolts of ACO financial and operational success: Calculating and managing to actuarial utilization targets. Milliman Healthcare Reform Briefing Paper. Retrieved Oct. 12, 2010, from [http://publications.milliman.com/publications/healthreform/pdfs/828\\_HDP.pdf](http://publications.milliman.com/publications/healthreform/pdfs/828_HDP.pdf).  
2 Blumen, Helen E. & Nemiccolo, Lynn D. (June 2009). The convergence of quality and efficiency and the role of information technology in healthcare reform. Milliman Research Report. Retrieved July 16, 2010, from <http://www.milliman.com/perspective/healthreform/pdfs/convergence-quality-efficiency-role-RR06-01-09.pdf>.  
3 Kipp, R. & Mattie, L. (July 2010). Controlling healthcare costs the old, new way. Milliman Healthcare Reform Briefing Paper. Retrieved Oct. 12, 2010, from <http://publications.milliman.com/publications/healthreform/pdfs/controlling-healthcare-cost-old-new.pdf>.  
4 Blumen & Nemiccolo, *ibid.*  
5 Fitch et al., *ibid.*

- Integration with automated systems to support practitioner and staff workflow (i.e., to promote systemization)
- ACOs may use clinical guidelines to help evaluate the medical necessity of requested (or, retrospectively, rendered) services—the previously mentioned internal review of utilization and quality. Reviewed services typically include:
  - Appropriateness of select ambulatory and inpatient elective surgery, advanced imaging modalities, and specialty drugs
  - Appropriateness of one- to three-day inpatient stays for medical conditions
  - Inpatient continued stay review to manage length of stay and to help prevent medically unnecessary readmissions
  - Concurrent review of rehabilitation and skilled nursing facility stays, or home care services, to manage services and to help reduce readmissions
  - Appropriateness of referrals to specialists

It is expected that there will be a variety of ways that healthcare providers will organize themselves into ACOs. And within ACOs themselves, there is likely to be considerable variation with respect to which services are directly provided and which are arranged. Such organizational variation will likely determine how evidence-based clinical guidelines are implemented, and indeed, which ones will be adopted as standards of practice.

#### USING EVIDENCE-BASED GUIDELINES TO PROMOTE COMMUNICATION

In addition to internal review of utilization and quality, evidence-based guidelines can provide a basis for communication between providers, and between providers and patients about care. These parties need a way to talk about care that is planned, in progress, or has occurred. This is the essence of the collaboration in the ACO concept. When the provider organization consists of a consolidation of individuals and organizations, communication among the providers themselves is essential to ensure delivery of the right care by the right provider.

The importance of this communication has been codified by accreditation standards. In mid-October 2010, the National Committee for Quality Assurance (NCQA) released draft standards for the accreditation of ACOs. One category is named “Care Coordination and Transitions.” This category recognizes the promise of communication among the entities in an ACO to simultaneously improve care in the three domains of quality, cost, and patient experience.

The only standard proposed for this category states: “The organization can facilitate timely information exchange between primary care, specialty care and hospitals for care coordination and

transitions.” Documentation of information in referral systems may be one component of this communication.

#### CASE IN POINT: REFERRALS FROM PRIMARY CARE TO SPECIALTY CARE

For illustration purposes, we will focus on referrals from primary care to specialty care to demonstrate the kind of collaboration, efficiency, and quality focus that evidence-based medicine can bring to an ACO. As noted earlier, other guidelines—for example those controlling hospital admission—are quite applicable as well.

It is a key care transition that occurs frequently. In 2005, 59.5% of office visits were made to primary care practitioners, 20.8% to surgical specialists, and the remaining 19.7% to medical specialists.<sup>6</sup> Although it is unknown how many of the office visits to specialists require formal *referrals*, in the post-healthcare reform world, an ACO could be responsible for managing referrals for the 40% of office visits that are visits to specialists.

Evidence-based medicine can supply the content of referral guidelines so that primary care practitioners can be prompted to ensure their patients will be cared for at the most appropriate level and by the most appropriate practitioner. An important function of a referral system is to ensure that patients receive needed specialty care when their care needs exceed that which can be provided in the primary care setting. Additionally, to ensure continuity of care, the referral system also must include communication from primary care to specialty care regarding the needs of the patient and reciprocal communication from specialty care back to primary care as to the results of consultation and treatment.

ACOs will likely base adjudication of specialty referrals on:

- **Patient eligibility:** Patient enrollment with the payor or participation in the ACO
- **Network or ACO status of the referred-to specialist:** Provider contract with the payor or participation in the ACO
- **Benefits language:** Whether the requested specialty services are covered by the patient's insurance contract
- **Medical necessity:** Whether the requested specialty services are considered clinically appropriate and needed for the diagnosis or treatment of the condition. Reviews for referral services have several dimensions that can include:
  - *Type of services:* Is the referral for an evaluation of an acute condition or for ongoing management of a chronic condition?
  - *Number of services:* Is the referral for a one-time visit or for a number of visits?
  - *Length of time that referral is valid:* Is the referral for a visit that must be scheduled and completed in a brief period of time or for services that will span a longer time frame?

6 Cherry, D.K., Woodwell, D.A., & Rechtsteiner, E.A. (2007). National ambulatory medical care survey: 2005 summary. Advance data from Vital and Health statistics; no. 387. Hyattsville, Maryland: National Center for Health Statistics.

- *Associated services included with the referral:* Does the referral include diagnostic services such as an electrocardiogram with a cardiology referral or obstetrical ultrasounds with an obstetrics referral?

Evidence-based guidelines can provide direction on all of these questions related to medical necessity reviews for referral services. Other guidelines can help inform accountable care in other ways.

As an illustration, here are some reasons for referral from a primary care practitioner to an ear, nose, and throat (ENT) specialist (otolaryngologist) for sinusitis (sinus infections):

- Sinusitis unresponsive to antibiotic therapy
- Complicated sinusitis, such as sinusitis accompanied by:
  - Severe headache
  - Facial swelling
  - Altered mental status
- Sinusitis in a patient with an anatomic abnormality, such as:
  - Nasal polyps
  - Nasal septal deviation

These recommendations are based on articles published in medical journals that have been consolidated into an evidence-based referral guideline.<sup>7,8,9</sup> This evidence-based guideline can provide a basis for ACO communications and discussion with the various parts of their organizations about appropriate or inappropriate specialist referrals. ACOs can build upon this base and provide information to their participating physicians and facilities about the length of time that the referral would be valid (e.g., 30, 60, or 90 days), the number of visits that would be included (e.g., an initial visit followed by one, two, or more follow-ups), and associated tests or procedures that should be authorized along with the specialist practitioner referral (e.g., sinus imaging study, sinus irrigation, laboratory examination of sinus drainage). The clinical communication between primary care and specialty care can be documented within the system used to implement the referral guideline.

7 Wilson, J.F. (2010). Acute sinusitis. *Annals of Internal Medicine* 153(5): ITC31. DOI: 10.1059/0003-4819-153-5-201009070-01003.

8 Rosenfeld, R.M., et al. (2007). Clinical practice guideline: adult sinusitis. *Otolaryngology Head and Neck Surgery* 137(3 Suppl): S1-S31. DOI: 10.1016/j.otohns.2007.06.726.

9 American Academy of Allergy Asthma & Immunology (2009). How the allergist/immunologist can help: Consultation and referral guidelines citing the evidence. Retrieved Sept. 23, 2009, from <http://www.aaaai.org/professionals/resources/rgce/professionals.asp>.

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## USING EVIDENCE-BASED GUIDELINES TO DISTRIBUTE FUNDS

When the ACO receives a global payment for care, guidelines may be able to assist with payment allocation among providers of care—using the example above, primary care, otolaryngologist (ear, nose, and throat specialist), imaging facility, and laboratory. For example, if a guideline calls for ancillary tests, this information can be used as a basis for who should share in payments and at what percentage.

In addition, ACOs may choose to allocate payment based on providers meeting or exceeding benchmarks for adherence to evidence-based guidelines.

## CONCLUSIONS

New operational and reimbursement healthcare models, such as ACOs, will lead to increased utility of existing or enhanced tools—one of those being evidence-based guidelines. Serving as a communication base, evidence-based guidelines can assist ACOs in improving the quality and efficiency of the care they deliver. One can imagine many layers of communications built upon the hub of evidence-based guidelines, including service authorizations; case management documentation of patient goals, activities, and accomplishments; inpatient utilization management, and transition of care activities. With evidence-based guidelines as the base upon which all these activities and information sits, ACOs will step down the path to success.

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