Draft Summary of Accountable Care Domains and Best Practices

PBGH with minor Covered California edits 2017.12.07

Domain	Definition	Best Practice
1. Leadership, Governance, Organization and Experience	A system of population-based care coordinated across specialties and institutional boundaries sharing accountability for Triple Aim outcomes. The structure and culture of ACO management and governance, including ownership and range of population-based contracts in place. Role of contracting health plan as applicable.	• Leadership varies based on ownership but includes primary, specialty and hospital care accountability, quality management and care coordination director, with input from purchasers and consumers. • Decision-making processes are transparent to providers. • Culture supports innovation, rapid cycle quality improvement, information transparency, care redesign. • Demonstration of experience and aligned strategies across commercial and Medicare ACO and population-based payment programs. • ACO leverages community collaboratives to share best practices and lessons learned, support workforce development and obtain technical assistance. • Plan enhances ACO operations through infrastructure support, data sharing, payment and performance incentives, performance reporting and benchmarking, communication of best practices.
2. Member Identification and Engagement	Method to define the population attributed to an ACO (i.e., which members are "in" the ACO); process by which the ACO and its providers identifies and engages members based on their medical and psychosocial needs.	• ACO regularly incorporates data from the health plan to identify risk stratification of members who are accessing services from its providers. • ACO identifies (via electronic medical record or some other indicator) that a member is part of the ACO to assure that every provider touchpoint is utilized to engage the patient. • ACO uses multiple data sources (e.g., claims, authorizations, admissions and emergency department visits, provider referral) to identify and connect members to ACO resources and support.
3. Provider Engagement, Support and Feedback	Structure of network management (e.g., integrated multispecialty practice, independent practice association or foundation model) and contractual commitments to share data, engage in performance measurement and feedback and care management support.	Physicians, hospital and ancillary provider relationship includes: • Data sharing; • Performance measurement, feedback and benchmarking, including at the individual physician level; • Coordinated member engagement and patient handoffs; • Shared resources such as IT infrastructure, practice-based care coordinators and workforce development; • Care managers embedded in primary care practices and provide patient support through primary care or specialty referral to the ACO. • Collaborative learning/sharing of best practices; • Bi-directional support of care management processes.

Domain	Definition	Best Practice
4. Care Management and Population Health • Care Coordination • Medically Complex Patient Management • Behavioral Health Integration	Approach to patient risk identification, care coordination and member engagement in care management and support services, including integration of behavioral health services.	• All patients have a primary care provider who serves as the first point of contact, advocate and locus of coordination of care. • Primary care resources are sufficient to support data-driven, team-based accountability for their panel population. • Patients with chronic condition or behavioral health needs are proactively identified, tracked and engaged through patient-centered approaches. • Gaps in care are prioritized based on clinical significance and tailored to patient's readiness and health goals. • Patients are routinely screened for behavioral health needs. • Using a defined process and criteria, medically complex and at-risk patients are proactively identified and receive direct outreach and face-to-face contact, coordinated by or with the primary care physician. • Community resources are leveraged to address psychosocial needs and environmental barriers to self-care and health risk reduction. • Patient's caregiver is engaged in education and care coordination as needed
5. Quality Measurement and Improvement	Systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups (e.g., utilizing quality improvement models such as PDSA (Plan-Do-Study-Act), FADE (Focus, Analyze, Develop, Execute), DMAIC (Define, Measure, Analyze, Improve, Control), CQI (Continuous Quality Improvement), TQM (Total Quality Management)).	• ACOs and providers are accountable for a standardized and parsimonious set of high-value measures. • Measures that focus on clinical outcomes, patient experience, and total cost of care are prioritized over process measures. • A path towards measuring patient reported outcomes is defined and implemented. • A clear process of documentation is defined to measure patient report outcomes. • Measurement reporting is timely, transparent and succinct, and shared with payers, leadership, providers and consumers. • Real-time, actionable information is available to providers.
6. Network Management, Contracting and Financial Model	Structure of provider network (e.g., integrated multispecialty practice, independent practice association or foundation model) and partner hospital and ancillary providers and nature of	• The ACO is structured to provide comprehensive services with sufficient ambulatory, inpatient and ancillary services to optimize access and the site-of-care. • High performance specialty providers and preferred inpatient, outpatient surgical and ancillary providers are identified for referring providers. • ACO leverages alternative payment models to align incentives among providers.

Domain	Definition	Best Practice
	contractual commitments to share data, align financial incentives, engage in performance measurement and feedback, and coordinate care.	• Financial risk is tailored to organizational capacity and maturity, with a progression to two-sided financial risk with a portion of financial rewards and incentives passed through to individual physicians. • Hospitals participate in risk-sharing with aligned performance incentives.
7. Prescription Drug Management and Optimization	Appropriate and safe drug prescribing and administration, including evaluation of available choices and alternatives to optimize value.	• Formulary composition (if applicable) and polypharmacy is monitored. • High-value drugs are promoted. • Key quality, cost and utilization indicator reporting is available to prescribing providers, including specialists. • Prescription drug utilization and infusion is delivered at optimal site of care. • Payment reform ensures no physician compensation is dependent on or influenced by prescribing practices.
8. Health IT, Data Integration and Reporting	Health IT infrastructure and degree of data integration and exchange with providers.	• Support for both individual and population based views (registries) of clinical data. • Real-time clinical information capture and communication between treating providers. • Real-time reporting through electronic medical record and/or two-way participation in regional health information exchange (HIE). • Frequent (at least monthly; daily where feasible) data exchange with health plans, pharmacy benefit managers and relevant data suppliers. • Electronic medical record or clinical decision support system provides timely information at the point of care to help inform decisions about a patient's care, facilitate treatment decision support, and improve outcomes. • Data reporting categories include quality, cost and utilization metrics, using biometric and clinical lab values, medical claims and pharmacy information. • Analytics include risk stratification and predictive modeling – particularly high-cost high-need patients, gaps in care, adherence to evidence-based medicine and care pathways, provider-level utilization and cost variation. • Participation in community or other health information exchange networks reduces duplication of services, and supports portable clinical information and comparative effectiveness research.