WHITE PAPER

Evaluating Health IT Tools to Unlock Actionable Data for Accountable Care Organizations

Introduction

Accountable care organizations (ACOs) have one goal: to improve patient outcomes and reduce unnecessary spending by delivering proactive, preventive, comprehensive care to their attributed populations.

In the ACO setting, primary care practices (PCPs) bear most of the responsibility for managing patients in a coordinated and cost-effective manner. PCPs aim to be the first port of call for patients with health concerns so they can identify the most appropriate way to address the individual's needs.

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In order to make the best possible decisions with the patient, PCPs require access to complete, accurate, and timely information about that individual's clinical history, healthcare utilization, and current risks. And they need to be able to take action with this information in a collaborative way.

While the vast majority of healthcare organizations have electronic health records (EHRs) and other health IT systems in place, few of these tools are designed for the specific needs of primary care providers in the ACO environment. PCPs, community health centers (CHCs) and other ACO participants should look for technology solutions that provide the following functionalities to help complete critical patient management tasks while meeting quality and financial goals.

Risk stratification and patient prioritization

ACOs are evaluated on how well they improve quality and reduce costs for a defined patient population. But they lack control over which patients are assigned to them. Some of these individuals, especially in the Medicare Pathways to Success program, are likely to have serious, long-term health concerns that may lead to expensive hospitalizations or emergency department events.

To manage complex patients and avoid unnecessary spending, PCPs must be able to identify these individuals, understand their risks and challenges, and visualize their healthcare utilization activities across the entire continuum of care.

PCPs should look for technology solutions that offer clear indicators of high-risk individuals and the ability to group, sort, and analyze patients by risk profile. The tool should allow care managers and other clinicians to generate lists of high priority patients in need of outreach activities, preventive care, or other routine services.

This will allow providers to focus on the patients who may benefit from enhanced management and maximize the impact of their limited resources.

Chronic care management and preventive care delivery

Approximately 6 in 10 American adults live with a chronic disease and around 4 in 10 have two or more ongoing conditions, according to the CDC. Avoiding exacerbation of common chronic concerns, such as heart disease, respiratory problems, diabetes, and chronic kidney disease, can improve quality of life and control costs.

PCPs in accountable care organizations have several strategies at their disposal to do this.

For example, Medicare Annual Wellness Visits (AWVs) are an important—and underutilized—opportunity to set shared health goals for the year ahead and close any gaps in preventive care.

Providers can use the patient prioritization features in their technology solutions to flag individuals in need of this annual service and add the AWV to an existing upcoming appointment, if possible.

PCPs should also look for health IT solutions that include pre-visit planning functions, such as a printable list of the patient's diagnoses and risks, recent specialist utilization, test results, and outstanding action items, to guide discussions in the clinic.

With the Aledade App's Daily Huddle, clinical staff can view patient care gaps, chronic conditions, specialist utilization, and recent hospital events so patients and providers stay on the same page. The Daily Huddle can be printed out or viewed on a mobile device to allow speedy access to valuable clinical information.

Transitional care management alerts

Hospitalizations and ED visits aren't entirely avoidable. Some patients do need acute care for their conditions. They also need follow-up after being discharged from the hospital.

Transitional care management (TCM) is a structured, time-sensitive approach to post-discharge care. TCM is designed to prevent 30-day readmissions by ensuring that patients understand their aftercare, have access to their medications, and know what to do if they experience additional symptoms or complications.

TCM is highly effective, but only if PCPs have near-real-time access to alerts about recent hospitalizations and discharges.

Accountable care health IT tools must be integrated into the surrounding community to incorporate admission, discharge, and transfer (ADT) data into their provider interfaces.

PCPs should look for solutions that include robust connections with local and regional health information exchange partners to be sure they are getting as much insight as possible into their patients' activities.

Support for appropriate clinical documentation and coding

Accurate clinical documentation and coding are critical to ACOs for several reasons.

Most importantly, complete and up-to-date documentation is the foundation of high-quality patient care. Clinicians simply must have full visibility into all of the patient's existing conditions and historical concerns if they are to make good decisions about treatment.

Second, because ACOs are judged on their improvement over a baseline, it's important for PCPs to have a very clear and accurate understanding of clinical severity and related spending patterns. Incomplete diagnoses or incorrect coding can skew quality and financial data in an unfavorable direction, leading to missed opportunities for the practice.

ACO participants should adopt value-based care applications that support appropriate documentation and complete coding. Tools that provide diagnosis suggestions within the workflow can help physicians accurately capture patient acuity and receive credit for the quality improvement work they are already performing.

Tools for COVID-19 response

The COVID-19 pandemic is affecting communities across the country, creating a variety of new challenges for primary care practices. While payers and regulators have adjusted the rules around ACOs in performance year 2020 due to the unpredictable impacts of the virus, PCPs are still dedicated to their fundamental mission of keeping patients as healthy as possible.

PCPs should be able to leverage their patient management tools to incorporate COVID-19 care into their existing care management and patient outreach initiatives. Applications that offer coronavirus-specific risk algorithms can flag patients who may be vulnerable to more severe outcomes from the virus and help prioritize conversations with those individuals.

Connecting with high-risk patients to provide education and information about care options could keep appropriate people safer and healthier at home, reducing risks for their families and communities.

Conclusion

Primary care practices participating in ACOs have to complete a variety of specialized tasks in order to meet their clinical and financial targets. To help them achieve these goals, their health IT applications must be designed specifically for the value-based care environment.

PCPs should carefully assess the features in value-based care applications to ensure the product offers easily accessible patient prioritization and management functions backed by robustly integrated data and sophisticated risk stratification algorithms. Physicians should also evaluate infrastructure requirements, ongoing technical support, and the availability of hands-on help when needed.

With the right tools and strategies in place, PCPs will be able to unlock the data required to engage in proactive, effective patient management while working toward their quality improvement and financial goals.

For more information about value-based care visit aledade.com.