ACO Implementation Planning Guidance – September 2011

This ACO Implementation Planning Tool has three sections to guide your ACO's process for planning implementation. In the Excel workbook, these three sections are each contained in a separate tab.

1 **Overarching Goals**

Use this worksheet to document your ACO's overarching goals related to the three-part aims: Improve quality of care for individuals; improve health of populations; slow growth in total cost of care.

Tip: To develop these goals, consider what your current capacity and capabilities are and what the core ACO competencies would require.

2 **Short-term Action Steps** (2–4 weeks after the Accelerated Development Learning Session)

Use this worksheet to document your team's strategic priorities that will help you achieve your overarching goals. For each priority area, set doable action steps and assign one or more responsible persons or teams to accomplish those action steps to accelerate achievement in each Domain.

Tip: Add as many rows as you want to add action steps under each Domain, but keep the list realistic. Refine your list of action steps to those that can be completed within 2–4 weeks, and stick to that plan.

Tip: Copy this worksheet and use as a template for developing and documenting short-term action steps from month to month.

3 **Comprehensive ACO Plan**

After you return from the Accelerated Development Learning Session, use this worksheet to reflect on the implementation steps you learned about from the speakers, faculty, and other participants. This worksheet provides an opportunity to identify action steps, lead personnel, and time frames for each core competency.

Tip: Add or delete as many rows as you need to identify appropriate action steps. Refer to the Learning Module materials, and your own notes from the Day 2 worksheets, to synthesize the action steps that are most meaningful to your organization.

Tip: Save time by completing a cell by referencing any action steps that appear in cells in other tabs.

Three-part Aim		Overarching Goal for Your ACO
1. Improve quality of care for individuals	a.	
	b.	
	c.	
2. Improve population health	a.	
	b.	
	c	
3. Slow growth in total cost of care		
	a.	
	b.	
	c.	

Strategic Priorities		Short-term Action Steps	Lead Responsibility	Time Frame
Domain 1	Organizational goals, management, and governance			
Domain 2	Improving care delivery to increase quality and reduce costs			
Domain 3	Effective use of health information technology and data resources			
Domain 4	Ability to assume and manage financial risk			

Domain: Description	Compe-tency	Description	Action Step	Lead Responsibility	Time Frame	Relevant Learning Modules
1: Organizational goals, management, and governance	1.1	The ACO understands the local health care market, including competition and collaboration between providers, prevalent diseases, attributed populations of patients, and local health care cost drivers.	*e.g., 1) Evaluate internal data (hospital, group practice, etc.) OR 2) Contract with data vendor to provide population-level data on total cost of care, costs by type of service, quality, disease prevalence, and risk OR 3) Partner with health plan to obtain data analytics capacity*	*COO*	*4–6 weeks*	Module 1: Describing Your Population's Clinical and Risk Profile; Module 4: Risk Sharing, Incentives, and Start-Up/Capital Needs
	1.2	The ACO has conducted an ACO readiness assessment and identified strengths and weaknesses to be addressed during the ACO formation process.				
	1.3	Multiple stakeholders are involved in goal-setting.	*e.g., 1) Identify ACO provider partners and other key stakeholders and plan initial meeting to discuss ACO goals OR 2) Propose and discuss ACO-specific (and data-driven) three-part aims with ACO board*		*4 weeks*	
	1.4	The ACO has established an organizational structure for governance as well as relationships for coordinating care across multiple types of providers, sites of care, and payers.				
	1.5	Partnerships and contracting arrangements are in place for coordinating care across providers, sites of care, and payers.				
	1.6	The ACO has established a) an effective governance structure for governance and b) decision-making systems for clinical integration across provider organizations and for interactions with payers.				
	1.7	The ACO effectively manages change in organizational and clinical processes.	*e.g., ACO vision and goals are agreed upon by clinical leadership across ACO providers and communicated to all clinicians and administrators*			
	1.8	Physicians are actively involved in the ACO Board of Directors and are active in senior management and operational roles in the provider organizations forming the ACO.				

Domain: Description	Compe-tency	Description	Action Step	Lead Responsibility	Time Frame	Relevant Learning Modules
2: Improving care delivery to increase quality and reduce cost	2.1	The ACO has primary care providers with the capacity to manage populations and coordinate care across all ACO provider organizations.				Module 3: Connecting Providers and Managing High-Risk Beneficiaries; Module 2: Reshaping Care Delivery
	2.2	Delivery of specialty care is well coordinated with primary care.				
	2.3	Delivery of care is well coordinated across different settings of care and different provider organizations.				
	2.4	A systematic approach is in place for identifying patients at high risk for poor quality and high cost outcomes, such as those with multiple chronic diseases. Specialized care management is actively applied for high-risk patients.				
	2.5	ACO providers have a population-based care management orientation.				
	2.6	Adequate capacity is available in the ACO to deliver care, including inpatient, outpatient, post-acute, and behavioral health care.				
	2.7	Linkages have been established with community resources to promote ACO goals.				
	2.8	A systematic approach to care process improvement is applied by all ACO providers.				
	2.9	Evidence-based strategies to contain costs while maintaining or improving quality are systematically implemented by all ACO providers.	*e.g., 1) Evidence-based clinical decision support rules are used across ACO providers to ensure appropriate use of radiology; 2) case managers ensure medication reconciliation at discharge and follow up for all patients at risk of re-hospitalization*			
	2.10	Physicians, nurses, and other ACO providers are actively using EHR tools for clinical decision support for evidence-based practice.				

Domain: Description	Compe-tency	Description	Action Step	Lead Responsibility	Time Frame	Relevant Learning Modules
2: Improving care delivery to increase quality and reduce cost	2.11	Patient engagement and activation is a focus of all ACO providers.	*e.g., 1) Organize patient education materials on prevalent conditions and protocols to disseminate; 2) contract with vendor to deploy secure messaging capability across all primary care providers for consumers to communicate with the primary care providers and case managers*			Module 3: Connecting Providers and Managing High-Risk Beneficiaries; Module 2: Reshaping Care Delivery
	2.12	Decision making is shared between patients and providers.	*e.g., Disseminate shared decision-making aids across all primary care practices with guidance and education on how to use with targeted patient populations*			
	2.13	Medication reconciliation is commonly practiced by all ACO providers.				
3: Effective use of health information technology and data resources	3.1	The ACO has a comprehensive strategy for meaningful use of certified EHRs by all providers.	*e.g., Ask providers in network to report status on meeting meaningful use requirements for stage 1*			Module 1: Describing Your Population's Clinical and Risk Profile; Module 3: Connecting Providers and Managing High-Risk Beneficiaries; Module 2: Reshaping Care Delivery; Module 4: Risk Sharing, Incentives, and Startup/Capital Needs
	3.2	EHRs provide capability for clinical decision support.	*e.g., Ask HIT leads across providers in network about current CDS functionality and rules*			
	3.3	Registry functions are actively used to track the delivery of recommended care to patients.	*e.g., Determine if individual providers in ACO currently have registry functions and the needs for this capacity at an ACO level*			
	3.4	Health IT and information exchange provides effective support for medication reconciliation.				
	3.5	ACO providers actively use e-prescribing and related medication management functions in an EHR.				
	3.6	EHRs and Health Information Exchange support detailed quality measurement and performance reporting and feedback, including the ability to retrieve information about individual provider performance.				
	3.7	Clinical and financial data are regularly updated, integrated, and maintained across clinical partners and from multiple sources.	*e.g., Determine options to contract for data warehouse and identify data sources for clinical and claims data*			
	3.8	Information systems are in place to measure care process improvement, quality improvement, and costs of care.				
	3.9	Physicians and other clinical staff have access to actionable, up-to-date, and accurate clinical data at the time of office visits, as needed.				
	3.10	Financial data systems are sufficient for assessing and managing financial risk, and they are integrated with clinical data systems.				

Domain: Description	Compe-tency	Description	Action Step	Lead Responsibility	Time Frame	Relevant Learning Modules
4: Ability to assume and manage financial risk	4.1	The ACO has the capacity to a) identify financial risk options, b) assess the financial risk of patient populations, and c) determine critical mass of providers and patients needed to assume financial risk.	*e.g., 1) Financial analyses have been completed; 2) financial and actuarial resources have been identified and obtained*			Module 1: Describing Your Population's Clinical and Risk Profile; Module 4: Risk Sharing, Incentives, and Start-Up/Capital Needs
	4.2	Provider contracting methods are established to clarify accountability for patient care and to distribute the financial risk of patient populations.	*e.g., ACO has defined risk and incentive structures for participating providers*			
	4.3	Payment methods are considered and designed to share financial risks and rewards with ACO providers.	*e.g., 1) Alternative risk-sharing arrangements identified; 2) recommended arrangement adopted by ACO board; 3) sign-off obtained from all ACO partners*			
	4.4	The ACO has the ability to design, implement, distribute, and administer provider performance payment incentives.	*e.g., 1) Specific incentives for individual providers have been identified; 2) data requirements have been specified; 3) financial staff have been recruited and trained*			
	4.5	Partnerships are established with insurers and purchasers to share financial risks.	*e.g., Re-insurance strategy has been determined*			
	4.6	The ACO has adequate capital sources and resources to assume financial risk for patient populations.	*e.g., 1) First year investment and operating budget for ACO has been developed; 2) sources of operating capital have been obtained.*			
	4.7	Management and clinical capabilities are in place to understand and manage the costs of patient populations.	*e.g., 1) Methods of identifying high-risk patients have been identified; 2) provider-level reporting systems have been built and are in place*			
	4.8	The ACO has adequate internal financial planning and budgeting systems to assess the financial risk of patient populations and to manage financial risk.	*e.g., 1) ACO financial goals are reflected in operating plans and budgets of participating organizations; 2) monthly requirements have been defined; 3) data needed to track performance have been identified; 4) financial systems are in place*			