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Accountable Care NEWS

How Origami is Like Managing an ACO

New surveys find that population health is not growing at the rate many expected it to – and some respondents say only 10% of revenues comes through risk-based agreements. ACOs across the country are facing the challenge, but many hesitate to take on more risk because they don't feel ready.

by Pranam Ben

Recently, I was helping my daughter learn origami, the ancient Japanese art of paper folding. As we were folding little bits of paper, I became frustrated that my designs were falling apart, or just didn't look right. Not knowing why I was struggling, I did some Google searches about origami and learned about Robert J. Lang PhD, an American physicist who is also considered the finest origami artist in the United States. A quote from Dr. Lang stuck with me: "Almost all innovation happens by making connections between fields that other people don't realize."

Lang consults with carmakers, manufacturers and other companies about design, but his theories could also teach a lot to Accountable Care Organizations. After all, helping patient populations achieve better outcomes is about using data to find connections that are not obvious. By finding those connections, making predictions and acting on them, we can help ACOs achieve the Triple Aim of improving experience and care quality, improving outcomes and reducing costs; in other words, the goals of value-based care.

Finding unseen connections, unsurprisingly, is not simple. ACOs need to establish operational strategies that leverage automation and create insight-driven clinician workflows that enable efficient responses when trends are identified. Making these connections easily actionable is just as important as discovering them.

Becoming a Clinically Intelligent Network

ACOs belong to a class of healthcare organizations that includes large health systems, academic medical centers, multi-disciplinary physician groups and other large institutions: clinically integrated networks. Some of these organizations were early advocates for the free flow of data across their enterprises, knowing it was essential for safe, effective care and for identifying population health trends – even before the Medicare Shared Savings Program existed. Now that nearly every hospital has an electronic health record system, the vast majority of CINs are pursuing similar population health management goals. While they may be integrated, many CINs are still not able to accurately identify trends, determine the causes, make predictions and take action.

The CINs that are now forming connections and making insight-driven interventions are what I like to call "clinically intelligent networks." They are using analytics and automated workflows to more efficiently and effectively manage patient populations. Transitioning to a clinically intelligent network involves answering four key questions for every patient and population:

[1] What happened? All CINs are continually capturing data from around the enterprise. They are most interested, however, in the data concerning patients with multiple chronic conditions, any of which could land them in the emergency room or admitted to the hospital. Capturing and sharing this historical data amongst providers is the first step in becoming an intelligent network, but discovering the underlying causes needs to follow.

[2] Why did that happen? In origami terms, historical clinical data is the paper, and advanced analytics technology available today is how we start to make the connections that are unseen by the naked eye. Clinical data, however, is just the foundation. We also need demographic, environmental, lifestyle and many other data points to accurately determine why patient population health trends are deteriorating or improving.

[3] What will happen? What it is even more challenging, even for higher-performing ACOs and clinically integrated networks, is making predictions about patients' health and behaviors. These are the most difficult connections to see, but, again, advanced technology powered by machine learning capabilities is helping. At a rapid pace, artificial intelligence programming within population health management platforms is helping ACOs make more accurate predictions about the likelihood of an ER visit or admission, care plan adherence and usage of preferred network providers.

[4] What should I do? Just as quickly as predictions are formed, AI alerts physicians, care managers and other providers about opportunities to intervene – even for patients who perhaps are not even considered high risk or at risk. These AI-generated notifications can also prompt automated outreach activities, such as text messages, to help patients stay on track with their care plans. Automated outreach can also help patients overcome social determinant of health-related obstacles, such as transportation or in-home caregiver support gaps. Frontline clinician workflows can be aligned with the AI functionality, so they can concentrate on the most challenging patients and help them achieve better outcomes.

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Visualizing results

Clinically intelligent network transitions are happening now all around the country. By utilizing advanced population health management technology, organizations are finally visualizing these unseen connections. ACOs and other CINs are able to predict emergency department utilization per 1,000 patients on a quarterly and yearly basis with a variance of only 3%. Likewise, ACOs are predicting patient admissions on a weekly, monthly and quarterly basis with similar accuracy and are forming monthly, quarterly and yearly spending forecasts with only a 0.25% variance.

AI and similar analytics technology is helping ACOs adjust patient behaviors, too. Managing referral networks and enhancing automated communications with patients is helping ACOs reduce utilization of non-preferred providers by 3% and save 15% on referral care costs. This improved oversight directly impacts their MSSP incentive or value-based payment. They are receiving real-time insight and notifications into outstanding and unusual diagnoses and medications, which helps care managers discover care gaps and reduce wasted care.

Seeing populations in new ways

Just as Dr. Lang encourages us to approach a simple piece of paper with a new mindset, I encourage ACOs to approach care with an equally new perspective. It is easy to become bogged down in daily patient care needs, of which there are many. But it is equally important to anticipate care needs that are not yet obvious. Technology can help, but it is this new mindset of looking toward the future and taking action now that will help all organizations transition from mere integration to true intelligence.

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