National Business Group on Health®

ACO Journey Map SCORING GUIDE

INTRODUCTION

The ACO Journey Map is a tool to help employers assess an accountable care organization's (ACO) capabilities along a maturity path. It provides employers with a framework to prompt conversations with health plans and ACO providers, and to inform employer decision-making about an ACO strategy.

The following scoring guide contains instructions and detailed definitions of each competency in the ACO Journey Map.

COMPLETING THE ACO JOURNEY MAP

Employer and Health Plan

1. Identify markets where ACOs are available and where a significant number of employees access health care.

Health Plan and ACO Providers

2. Determine the ACO's maturity level (launching, developing, maturing) and status (not started, in process or complete) for each competency in the ACO Journey Map.
3. Fill in the appropriate circles.

Employer, Health Plan and ACO Providers

4. Meet to discuss the ACO's current and potential capabilities in combination with performance results (compiled separately).

Employer

5. Determine whether and how to pursue an ACO strategy.

Table of Contents

Disclaimer: The competencies outlined in the ACO Journey Map are not evaluation criteria. Instead, the purpose is to help an employer better understand an ACO's capabilities.

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Clinical Governance

⇒ Provider Responsibility	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Providers approve clinical and operational goals and plans** Physicians founding the ACO set initial goals and plans. They lead practice transformation and serve on the board and in ACO leadership roles. ACO clinical leaders jointly implement plans to meet initial contract goals with health plans for quality, health improvement, patient experience and cost.	**PCPs and specialists oversee quality and patient experience** A broad range of primary and specialty care clinicians in medical, pharmacy and behavioral health lead the ACO. Clinical leaders review and influence safety, quality and patient experience initiatives across the ACO network. ACO leaders implement plans to exceed health plan contract goals.	**Accountable for achieving sustained high performance** ACO leaders are accountable for setting and achieving top-decile national quality, safety and patient experience results across the ACO. ACO leaders accountable for exceeding health plan contract goals.
SCORING GUIDE	○ **Not Started:** ACO has no physicians in governance or leadership roles. ◐ **In Process:** ACO physicians are creating clinical and operational goals and plans for the ACO. ● **Complete:** ACO physicians are managing by using board-approved goals and plans.	◐ **In Process:** Board-approved plans in use. Recruiting more providers for leadership roles. Begin planning to beat health plan contract goals. ● **Complete:** Provider-led planning and leadership in place. Implemented plans meet and surpass goals.	◐ **In Process:** Provider-led planning and leadership in place, beginning to hold clinical leaders accountable for achieving and exceeding results. ● **Complete:** Planning, leadership and accountability produce sustained high performance.

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Network

⇒ Primary Care (PCP)	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Established primary care network** A core network of primary care physicians founds and launches the ACO. Other types of providers may also launch the ACO as members.	**Add high value PCPs** The clinical and financial performance of primary care physicians is evaluated. More high-value primary care physicians are added to fill access gaps.	**Optimize and refine network** Primary care physicians who meet or exceed performance goals are retained in the network. More such physicians may be recruited. Primary care providers unable to meet performance goals are not included in the ACO.
SCORING GUIDE	○ **Not Started:** ACO has not recruited primary care physicians. ◐ **In Process:** Primary care physicians are being recruited and are forming the ACO. ● **Complete:** Core group of primary care physicians has started to operate the ACO.	◐ **In Process:** Implementing performance evaluation of primary care physicians. ● **Complete:** Performance evaluation of primary care providers is a standard operating practice.	◐ **In Process:** Implementing practices to keep high performing primary care physicians and manage underperformers. ● **Complete:** Provider-led planning and leadership in place. Implemented plans meet and surpass goals.

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Network

⇒ Hospitals and Specialists

	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Established hospital and specialist network** A core network of specialists and hospitals is identified and recruited for the ACO network. Specialists and hospitals may – or may not – be members of the ACO.	**Add high-value hospitals and specialists** The clinical and financial performance of specialists and hospitals is evaluated. More high-value specialists and hospitals are added to fill access gaps.	**Optimize and refine network** Specialists and hospitals that meet or exceed performance goals are retained in the network. More such providers may be recruited. Specialists and hospitals unable to meet performance goals are not included in the ACO.
SCORING GUIDE	○ **Not Started:** ACO has not identified or recruited specialists and hospitals. ◐ **In Process:** Specialists and hospitals are being recruited for the ACO network. ● **Complete:** Core group of specialists and hospitals have started to participate in the ACO.	◐ **In Process:** Implementing performance evaluation of specialists and hospitals. ● **Complete:** Performance evaluation of specialist and hospitals is a standard practice.	◐ **In Process:** Implementing practices to keep high-performing specialist and hospitals and manage underperformers. ● **Complete:** Specialists and hospitals with demonstrated sustained high performance comprise the network.

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Care Model

⇒ Medical Home	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Implementing medical home** All primary care providers in the ACO and affiliated with it are implementing a medical home model consistent with state or federal advanced primary care programs and/or private accreditation. Efforts focus on high-risk patients.	**Established medical home, integrating behavioral health** All primary care providers work as medical homes. Expand services to moderate-risk people. Use protocols for care referrals and transitions among primary care, specialists, inpatient care, emergency care and other sites and providers. Integrating services to improve medical and behavioral health results.	**Optimize and complete** All primary care providers work as medical homes. Expand services to low-risk people. Use protocols for care referrals, coordination and transitions. Use integrated medical and behavioral health care service model. Quality improvement initiatives achieve improvements in medical home performance.
SCORING GUIDE	○ **Not Started:** ACO is not using medical homes or is only piloting them; not launched ACO-wide. ◐ **In Process:** Implementing medical homes across the primary care network. ● **Complete:** All primary care practices have completed medical home implementation for at least high-risk patients.	◐ **In Process:** Using medical homes for high-risk patients, implementing for moderate-risk patients. Implementing provider protocols. Testing behavioral health improvements. ● **Complete:** Using medical homes for high- and moderate-risk patients, coordinated care in practice with integrated medical and behavioral health models.	◐ **In Process:** Medical homes expanding to low-risk patients. Care is coordinated in integrated medical/behavioral model. ● **Complete:** Using medical homes to serve all risk levels with coordinated care. Integrated medical/behavioral health care standard. Achieve quality improvement across medical homes.

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Care Model

⇒ Risk Stratification	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**High-risk patients targeted** ACO targets high-risk patients in employer populations to proactively deliver additional health care and support services. High-risk patients are targeted based on health status and efficiency improvements in employer plans.	**Expanded to include moderate- risk consumers** ACO targets high- and moderate-risk patients in employer populations to proactively deliver additional health care and support services. Moderate-risk patients are targeted based on health status and efficiency improvements in employer plans.	**All consumers targeted** ACO targets high-, moderate- and low-risk patients in employer populations to proactively deliver additional services. Low-risk patients are targeted based on limited or infrequent needs, often for urgent, primary, preventive and wellness services.
SCORING GUIDE	○ **Not Started:** ACO is not using risk stratification or is only piloting that approach; it has not been launched ACO-wide. ◐ **In Process:** Implementing targeting for high-risk patients. ● **Complete:** Proactively targets high-risk patients.	◐ **In Process:** Proactively targets high-risk patients and implements proactive targeting for moderate-risk consumers. ● **Complete:** Proactively targets high- and moderate-risk consumers.	◐ **In Process:** Proactively targets high- and moderate- risk patients and implements proactive targeting for low-risk consumers. ● **Complete:** Proactively targets high-, moderate- and low-risk consumers.

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Care Model

⇒ Clinical Guidelines	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Established for high-risk patients** Use of guidelines and protocols focuses on high-risk patients. Independent implementation within primary care practices. Identify specialists and hospitals willing to adopt guidelines and protocols; implement as soon as possible. Support patients with utilization management requirements.	**EMR-based, expanded across conditions** Use of guidelines and protocols focuses on high and moderate risk patients across ACO providers. Use comparable guidelines and protocols in information systems across providers, including electronic medical record (EMR) workflow. Educate and evaluate all types of providers on guideline adherence. Support patients with utilization management requirements.	**Complete guidelines across ACO** Guidelines and protocols for high-, moderate- and low-risk people. Use standard guidelines and protocols in information systems, including EMR workflow. Internal process of deploying and updating guidelines to providers. Used to evaluate all types of providers for ACO participation. Support patients with utilization management requirements.
SCORING GUIDE	○ **Not Started:** ACO is not using guidelines or is only piloting them but not launched ACO-wide. ◐ **In Process:** Implementing guidelines for high-risk patients. ● **Complete:** Using guidelines for high-risk patients.	◐ **In Process:** Implementing comparable guidelines for high- and moderate-risk patients in EMRs and evaluating providers. ● **Complete:** Using comparable guidelines for high- and moderate-risk patients in EMRs and evaluating providers.	◐ **In Process:** Implementing comprehensive standard guidelines in EMRs and evaluating providers. ● **Complete:** Using comprehensive standard guidelines in EMRs and evaluating providers.

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Care Model

⇒ Quality	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Siloed quality efforts** As the ACO is forming, existing quality and safety programs used by each provider are operating independently and without coordination. These programs are assessed by the ACO. Identified shortcomings are resolved. Initial initiatives to improve outcomes for people in employer plans are implemented.	**Coordinated quality efforts** Continue monitoring and improving individual provider performance. Improve results by coordinating quality initiatives across ACO providers. Initial initiatives for people in employer plans are achieving positive results, and new initiatives are implemented.	**Continuous quality improvement** Improving quality at and across ACO providers is standard operating practice. Cross-provider activities led by the ACO, with participation by all providers. For employer plan populations, quality and safety performance are improving until reaching a sustained high level.
SCORING GUIDE	○ **Not Started:** ACO has not assessed participating provider quality evaluation and improvement initiatives. ◐ **In Process:** Assessing each participating provider's program. Identifying initiatives for employer plan population. ● **Complete:** Resolving any gaps in provider programs. Implementing initiatives for employer plan population.	◐ **In Process:** Improving provider performance. Implementing cross-provider initiatives and more employer plan initiatives. ● **Complete:** Improving provider performance. Fully implementing cross-provider initiatives. Employer results are improving; more initiatives added.	◐ **In Process:** Implementing standard process for improving quality at and across providers. Employer population results are improving. ● **Complete:** Improving quality at and across providers is standard. Employer population results continue to improve, reaching sustained high performance.

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Care Model

⇒ Care Coordination	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Through health plan or ACO** When launching, ACOs may rely on staff, technology, reports, registries and care coordination services from each health plan to expedite implementation, although some ACOs already have staff for these purposes. Typically start with care coordination by medical home-based care teams, at least for high-risk patients.	**Shifting to ACO** When ACOs serve multiple payers, they typically phase out support from individual health plans and use their own care teams, care coordinators, technology and other functions. Care coordination expands to include specialists and hospitals that join the ACO. Expands to include moderate-risk patients.	**ACO-driven** The ACO delivers its own cross-payer care coordination services. All participating providers use standard protocols, delivery models and information exchange. ACOs primarily exchange data and reports with health plans.
SCORING GUIDE	○ **Not Started:** ACO is not proactively coordinating care across providers or is only piloting this practice. It is not being done ACO-wide. ◐ **In Process:** Implementing care coordination across the primary care network, either the ACO's own network or through the health plan. ● **Complete:** All primary care practices use care coordination for at least complex patients.	◐ **In Process:** Replacing some health plan support services with ACO services. ● **Complete:** Some health plan support services have stopped. ACO is independently operating remaining care coordination services.	◐ **In Process:** Implementing independent cross-payer care coordination among all providers. ● **Complete:** Operating independent cross-payer care coordination among all providers.

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Care Model

⇒ Site of Care	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Adding low-cost sites of care** A core network of providers and suppliers in low-cost sites of care is identified and recruited. Such providers and suppliers may be members of the ACO or may be participants in the health plan's network that are not ACO members. Providers help patients meet benefit plan requirements and achieve savings opportunities using low-cost sites.	**Refer to efficient sites of care** The clinical and financial performance of providers and suppliers in low-cost sites of care are evaluated, and patients are referred. More such providers and suppliers are added to fill access gaps.	**Integrated into care model** Low-cost providers and product suppliers that meet or exceed performance goals are retained in the network and offered to patients. More such providers may be recruited. Providers and suppliers unable to meet performance goals are not included in the ACO.
SCORING GUIDE	○ **Not Started:** ACO has not identified or recruited low-cost site of care providers or suppliers.actice. It is not being done ACO-wide. ◐ **In Process:** Providers and suppliers in low-cost sites are being recruited for the ACO network. ● **Complete:** Core group of providers and suppliers in low-cost sites have started participating in the ACO.	◐ **In Process:** Implementing performance evaluation and referral practices for low-cost providers and suppliers. ● **Complete:** Performance evaluation and referrals for low-cost providers and suppliers is a standard practice.	◐ **In Process:** Implementing practices to keep providers and suppliers in low-cost sites and managing ● **Complete:** Providers and suppliers in low-cost sites with demonstrated sustained high performance comprise the network.

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Care Model

⇒ Medication	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Polypharmacy and reconciliations** Implement guidelines, protocols and pharmacist interventions to improve quality and reduce safety risks in ambulatory settings, starting with proper use by high-risk patients taking multiple medications	**Evidence-based use, adherence and efficiency** Guidelines and protocols focus on high- and moderate-risk patients across providers. Educate and evaluate providers and pharmacists. Expand pharmacist-provided interventions to moderate-risk patients to improve adherence and other outcomes. Support patients with utilization management requirements.	**Value-based, efficient across sites** Use standard guidelines and protocols for high-, moderate- and low-risk patients across providers. Evaluate providers and pharmacists for ACO participation. Improve and sustain high performance on medication-related clinical and financial results. Support patients with utilization management requirements.
SCORING GUIDE	○ **Not Started:** Not implementing new medication management initiatives or only piloting them. The initiatives have not launched ACO-wide. ◐ **In Process:** Implementing guidelines and pharmacist interventions for high-risk patients. ● **Complete:** Using guidelines and pharmacist interventions for high-risk patients.	◐ **In Process:** Implementing guidelines and interventions for high- and moderate-risk patients and evaluating providers. ● **Complete:** Using guidelines and interventions for high- and moderate-risk patients and evaluating providers.	◐ **In Process:** Implementing comprehensive standard guidelines and pharmacist interventions. ● **Complete:** Using comprehensive standard guidelines and pharmacist interventions.

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Consumer Experience

⇒ Access	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**24/7 access is available but inconsistent** Primary care providers are founding the ACO and implementing medical home models to expand access. Around-the-clock telephonic access to a care team member with access to patient information for a patient in need (not just a telephonic nurse line) is available inconsistently across primary care practices.	**Expanded 24/7 and same- day urgent access** All primary care providers work as medical homes with expanded access. Around-the-clock telephonic access to a care team member with access to patient information for a patient in need is standard. Same-day urgent care access is implemented, but practice capacity constraints may limit actual availability.	**Consistent 24/7 and urgent access** All primary care providers work as medical homes with expanded access. Around-the-clock telephonic access to a care team member with access to patient information for a patient in need is standard. Same-day urgent care access is implemented. Sufficient capacity is available to meet demand.
SCORING GUIDE	○ **Not Started:** ACO is not implementing access improvements or only piloting them. They have not launched ACO-wide. ◐ **In Process:** Implementing expanded access. ● **Complete:** Expanded access is inconsistently available.	◐ **In Process:** Implementing 24/7 access as standard. Implementing same-day urgent appointments. ● **Complete:** 24/7 access is standard. Same-day urgent appointment availability is inconsistent.	◐ **In Process:** 24/7 access is standard. Improving same-day urgent appointment availability. ● **Complete:** 24/7 access and same-day urgent appointments are standard.

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Consumer Experience

⇒ Proactive Outreach	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Limited to high-risk patients** High-risk patients are proactively offered additional services.	**Expanded for moderate-risk patients** High- and moderate-risk patients are offered additional services proactively.	**Consistent outreach to all consumers** High-, moderate- and low-risk patients are offered additional services proactively.
SCORING GUIDE	○ **Not Started:** ACO is not proactively reaching out to patients or is only piloting the service. Outreach has not launched ACO-wide. ◐ **In Process:** Implementing proactive outreach for high-risk patients. ● **Complete:** Proactive outreach for high-risk patients.	◐ **In Process:** Proactive outreach for high-risk patients. Implementing proactive outreach for moderate-risk patients. ● **Complete:** Proactive outreach for high- and moderate-risk patients.	◐ **In Process:** Proactive outreach for high- and moderate-risk patients. Implementing proactive outreach for low-risk patients. ● **Complete:** Proactive outreach to all consumers.

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Consumer Experience

⇒ Satisfaction	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Measured for high-risk patients** High-risk patients are surveyed and evaluated.	**Improving for high- to moderate-risk patients** Surveying high- and moderate- risk patients. Demonstrated improvements in satisfaction among high- and moderate-risk patients.	**High satisfaction and consistent outreach to all consumers** Surveying all types of consumers, demonstrated high satisfaction. Concierge model improves service to consumers in ACOs.
SCORING GUIDE	○ **Not Started:** ACO is not measuring satisfaction or is only piloting it. This measure has not been done ACO-wide. ◐ **In Process:** Implementing satisfaction measurement for high-risk patients. ● **Complete:** Measuring satisfaction for high-risk patients.	◐ **In Process:** Measuring satisfaction for high- and moderate-risk patients. Implementing changes to improve results. ● **Complete:** Measuring satisfaction for high- and moderate-risk patients. Demonstrated improvements in results.	◐ **In Process:** Designing and implementing concierge model. ● **Complete:** Using concierge model.

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Consumer Experience

⇒ Portal	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Basic, includes records and messaging** View personal health information in each provider's EMR. May have download or transmit function. Secure two-way email-like messaging within portal for patient/provider communication included.	**Addition of care plans and content** Add patient access to care plans from primary care team. Related educational content available. Little or no integration across provider EMR patient portals.	**Comprehensive and mobile-enabled** Comprehensive portal includes single integrated personal health record, record transmission, scheduling, rich content and multiple provider communication channels. Key content and functions available on mobile devices. Evaluating self-service functions, social interactivity, integration with consumer health apps and products and other capabilities.
SCORING GUIDE	○ **Not Started:** Some providers do not have portals or are only piloting them but not launched ACO-wide. ◐ **In Process:** Implementing basic portal with records and messaging for all physician EMRs. ● **Complete:** All ACO members have access to basic portal with records and messaging for all physician EMRs.	◐ **In Process:** All ACO members have access to basic portal with records and messaging. Implementing care plan access and content. ● **Complete:** All ACO members have access to basic portal with records, messaging, care plan and content.	◐ **In Process:** Designing and implementing comprehensive portal. ● **Complete:** All ACO members have access to comprehensive patient portal.

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Technology & Analytics

⇒ Electronic Medical Record (EMR)	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Multiple and separate EMRs** At launch, multiple providers in the ACO have their own separate EMRs that exchange little or no patient-level data among themselves. Clinical guidelines and protocols not available in workflow.	**Limited data exchange between EMRs** ACO providers must implement active health information exchange capabilities. Notification of patient admissions, discharges and transfers from inpatient and emergency care is a high priority. Data exchanged on results of care patients received and care plans. Comparable clinical guidelines in each EMR's workflow.	**Complete EMR interoperability** Required patient data and information from all ACO providers available when needed by care team members in their workflow at the point-of-care and for analytics and stratification. EMR and population health tools integrated at the patient level and in provider workflows. Care plans based on standard clinical guidelines in provider workflow.
SCORING GUIDE	○ **Not Started:** Not all providers have EMRs. ◐ **In Process:** Providers without EMRs are implementing them. ● **Complete:** All providers have EMRs.	◐ **In Process:** All providers have EMRs. Implementing active exchange of high-priority data elements. Implementing clinical guidelines in workflow. ● **Complete:** All providers have EMRs with active data exchange of high-priority data and guidelines in their workflow.	◐ **In Process:** Implementing fully interoperable EMRs and related systems. ● **Complete:** Using fully interoperable EMRs and related systems.

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Technology & Analytics

⇒ Predictive Analytics/ Registries	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Primary care registries only** As primary care providers start the ACO and begin implementing medical homes, initially focusing on high-risk patients, registries are created and managed for them to use.	**Primary and specialty care registries** As specialists and hospitals join the ACO network, registries are created for high- and moderate-risk patients to address primary, specialty and hospital care needs.	**Integrated registries** Integrated registries and population health management systems are used by all hospitals, physicians, care teams and ancillary providers in the ACO for better patient care at the point-of-care and for proactive outreach and services. All consumers are targeted.
SCORING GUIDE	○ **Not Started:** ACO is not using predictive analytics or registries or is only piloting them. They have not been launched ACO-wide. ◐ **In Process:** Implementing predictive analytics and registries in primary care for high-risk patients. ● **Complete:** Using predictive analytics and registries in primary care for high-risk patients.	◐ **In Process:** Implementing predictive analytics and registries in primary and specialty care for high- and moderate-risk patients. ● **Complete:** Using predictive analytics and registries in primary and specialty care for high- and moderate-risk patients.	◐ **In Process:** Implementing predictive analytics and registries for all providers and all consumers. ● **Complete:** Using predictive analytics and registries for all providers and all consumers.

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Technology & Analytics

⇒ Data Analytics	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Limited to EMR data** After data analytic systems are implemented but before private payer contracts are signed, ACOs have only primary care providers and their EMR data to rely on for opportunity and performance analysis.	**Multiple data sources to identify opportunities** Specialists and hospitals join ACO, systems are enhanced and more clinical and claims data generated. Broader and deeper analysis of opportunities and performance can be conducted. Start benchmarking with external sources and public reporting.	**Use comprehensive clinical/claims data** Continued system enhancements and the use of more provider and payer data sources over multiple years allow for extensive analysis of opportunities and performance. Benchmarking with external sources, along with public reporting, expands.
SCORING GUIDE	○ **Not Started:** ACO is not using data analytics or is only piloting its use; not yet not launched ACO-wide. ◐ **In Process:** Implementing data analytics with primary care EMR data. ● **Complete:** Using data analytics with primary care EMR data.	◐ **In Process:** Implementing enhancements to use clinical and claims data as new providers join and more payers contract with ACO. ● **Complete:** Using system enhancements and more clinical claims data. Start benchmarking.	◐ **In Process:** Implementing enhancements for more provider and payer data, multiyear analysis and benchmarking. ● **Complete:** Using system enhancements and more data. Conducting multiyear analysis and benchmarking.

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Finance Model

⇒ ACO Risk	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Gain-sharing tied to quality and cost** The ACO and health plan (and self-insured groups) share in savings if costs are below target (gain-sharing). [Learning Action Network Alternative Payment Model Category 3] If there is gain-sharing, the health plan and self-insured employers owe the ACO a cash payment. If ACO costs are above target, there is no "loss-sharing" in this one-sided model. Adjustments are made for achieving quality results.	**Gain- and loss-sharing tied to quality and cost** Works the same for gain-sharing, but if ACO costs are above target, a share of the "losses" is paid by the ACO to the health plan and self-insured groups. [Learning Action Network Alternative Payment Model Category 3] Adjustments are made for achieving quality results.	**At risk for total cost of care** This includes gain- and loss-sharing agreements that permit the largest upside and downside payments possible.[Learning Action Network Alternative Payment Model Categories 3 and 4] Full capitation or partial capitation for >75% of total costs included. All such agreements could also have quality, efficiency, patient satisfaction and other measures as payment gates or adjusters.
SCORING GUIDE	○ **Not Started:** ACO is not using risk-sharing or is only piloting it; this has not yet launched ACO-wide. ◐ **In Process:** Negotiating first gain-sharing only agreement with a health plan for employer group business. ● **Complete:** ACO has gain-sharing agreements only with one or more health plans for employer group business.	◐ **In Process:** Negotiating first gain- and loss-sharing agreement with a health plan for employer group business. ● **Complete:** ACO has gain- and loss-sharing agreements with one or more health plans for employer group business.	◐ **In Process:** Negotiating first full capitation or >75% partial capitation contract with a health plan for group business. ● **Complete:** ACO has full capitation or 75% partial capitation contract with one or more health plans for group business.

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Finance Model

⇒ Physician Incentives	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
COMPETENCIES	**Small incentive, limited ACO panel** Less than 10% of primary care physician pay at risk for a likely gain-sharing bonus with no loss-sharing risk.	**Increased incentive, expanded ACO panel, introduce downside risk** 10% to 25% of primary care physician pay at risk for a potential gain-sharing bonus or a pay reduction.	**Compensation with incentives tied to performance** More than 25% of primary care physician pay at risk for a potential gain-sharing bonus or a pay reduction. Risk of gains or losses on capitation agreements could be higher.
SCORING GUIDE	○ **Not Started:** ACO primary care physicians have no compensation incentive or is only piloting this; it has not yet not launched ACO-wide. ◐ **In Process:** Evaluating having less than 10% of total pay likely at risk. ● **Complete:** Physicians have less than 10% of total pay likely at risk.	◐ **In Process:** Evaluating having 10% to 25% of total pay likely at risk. ● **Complete:** Physicians have 10% to 25% of total pay at risk.	◐ **In Process:** Evaluating having more than 25% of total pay likely at risk. ● **Complete:** Physicians have more than 25% of total pay at risk.

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ACO Journey Map

The ACO Journey Map is a tool to help employers assess an accountable care organization's (ACO) competencies along a maturity path. It provides employers with a framework to prompt conversations with health plans and ACO providers, and to inform decision-making about an ACO strategy. For complete instructions and definitions of each competency, see the ACO Journey Map Scoring Guide.

HOW TO SCORE: ○ Not Started ◐ In Process ● Complete

ACO Name: EXAMPLE OF COMPLETED FORM

COMPETENCY EXPECTATIONS	LAUNCHING 1-3 YEARS	DEVELOPING 2-5 YEARS	HIGH PERFORMING 4-8 YEARS
Clinical Governance			
⇒Provider Responsibility	○ Providers approve clinical and operational goals and plans	◐ PCPs and specialists oversee quality and patient experience	○ Accountable for achieving sustained high performance
Network			
⇒Primary Care (PCP)	○ Established	◐ Add high-value PCPs	○ Optimized and refine network
⇒Hospitals and Specialists	● Identified and recruit	○ Add high-value hospitals and specialists	○ Optimized and refine network
Care Model			
⇒Medical Home	○ Implementing	◐ Established, integrating behavioral health	○ Optimized and complete
⇒Risk Stratification	○ High-risk patients targeted	◐ Expanded to include moderate-risk patients	○ All consumers targeted
⇒Clinical Guidelines	○ Established for high-risk patients	● EMR-based, expanded use across conditions	○ Complete guidelines across ACO
⇒Quality	○ Siloed quality efforts	◐ Coordinated quality efforts	○ Continuous quality improvement
⇒Care Coordination	● Through health plan or ACO	○ Shifting to ACO	○ ACO-driven
⇒Site of Care	○ Adding low-cost sites of care	◐ Refer to efficient sites of care	○ Integrated into care model
⇒Medication	○ Polypharmacy and reconciliations	◐ Evidence-based use, adherence and efficiency	○ Value-based, efficient across sites
Consumer Experience			
⇒Access	○ 24/7 access	○ Expanded 24/7 and same-day urgent access	○ Consistent 24/7 and urgent access
⇒Proactive Outreach	○ Limited to high-risk patients	○ Expanded for moderate-risk patients	○ Consistent outreach to all consumers
⇒Satisfaction	○ Measured for high-risk patients	◐ Improving for high- to moderate-risk patients	○ Concierge model for all consumers
⇒Portal	○ Basic, includes records and messaging	◐ Addition of care plans and content	○ Comprehensive and mobile-enabled
Technology & Analytics			
⇒Electronic Medical Record (EMR)	○ Multiple and separate EMRs	◐ Limited data exchange between EMRs	○ Complete EMR interoperability
⇒Predictive Analytics/Registries	○ Primary care registries only	● Primary and specialty care registries	○ Integrated registries
⇒Data Analytics	● Limited to EMR data	○ Multiple data sources to identify opportunities	○ Use comprehensive clinical/claims data
Finance Model			
⇒ACO Risk	● Gain-sharing tied to quality and cost	○ Gain- and loss-sharing tied to quality and cost	○ At risk for total cost of care
⇒Physician Incentives	◐ Small incentive, limited ACO panel	○ Increased incentive, expanded ACO panel, introduce downside risk	○ Compensation with incentives tied to performance

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COMPETENCY	DEFINITION	RATIONALE FOR INCLUSION
Clinical Governance		
⇒**Provider Responsibility**	• ACOs are owned and operated by different configurations of providers who are members and share in governance, investments and financial risk. • Other providers may be preferred referral destinations even though they are not ACO members (e.g., hospitals). • Over time, participation in ACO leadership by a broad range of providers, including the types of providers serving people in employer-sponsored plans (e.g., OB/GYN, is important.). • Physician leadership and oversight spans a broad range of areas, including quality, safety, practice guidelines, provider participation, performance evaluation, utilization management, care coordination, reporting, patient rights and experience, technology and financial arrangements.	ACOs must be actively governed to succeed, primarily led by physicians and other clinicians. Accountability for planning and performance rests with the ACO board and leaders.
Network		
⇒**Primary Care (PCP)**	• Primary care providers deliver clinical services to people with low-, moderate- and high-risk health status. They also refer patients to specialists and other providers within their ACO. • ACOs need enough primary care providers to meet access needs. • Primary care providers build and lead care teams in medical homes and across ACO networks. They also use other methods to improve results. • The quality and efficiency of the care delivered by primary care-led teams affects many aspects of ACO performance and patient satisfaction.	Primary care providers deliver care to patients and implement population health improvement and efficiency initiatives. Sufficient patient access to high-performing primary care physicians is needed.
⇒**Hospitals and Specialists**	• The ACO's specialist and hospital network should include high performers committed to improving based on results. • The performance of all hospitals and specialists must be evaluated and managed. • Participating specialists and hospitals must meet expectations for care coordination, referral management, clinical guidelines, admission notifications, data sharing, utilization management, patient access, reporting, governance and other areas. • Some ACOs have only physician members and do not have a hospital member. Not all specialists and hospitals used by the ACO are members of the ACO.	Specialists and hospitals drive a large portion of total costs. Their active support of the ACO's goals is critical. Sufficient patient access to high-performing specialists and hospitals is needed.

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COMPETENCY	DEFINITION	RATIONALE FOR INCLUSION
Care Model		
⇒**Medical Home**	• The medical home care team provides, arranges and coordinates services to meet the physical and mental health needs of patients, including prevention, primary care, specialty care, behavioral health, medication, inpatient care and other services. • Team-based care is practiced. Can include physicians, nurses, coaches, pharmacists, dieticians, care coordinators, social workers and behavioral health staff. Use co-located staff and/or centralized shared staff. • Patients and their families are guided through care planning, shared decision- making, treatment adherence and care delivery. • Medical homes offer shorter urgent care waiting times, enhanced hours, 24/7 access to a care team member and phone, email and other contact channels.	ACOs need a strong primary care foundation. People get high-quality primary and preventive care in medical homes. Care teams also help people get high-quality, efficient care across the ACO.
⇒**Risk Stratification**	• ACOs use many methods to target people for proactive outreach and services based on clinical and financial risk levels. • In some ACOs, only specific, targeted risk groups are offered certain additional services. • Stratification should reflect population health and savings opportunities typically found in employer plans, including medical, pharmacy and behavioral health services. • A small percentage of people are at high risk of costly uncoordinated care. They are often targeted first for the most intensive support. • Many people have moderate and low health risks and costs. They can benefit from targeted, proactive outreach and services that are tailored to their health needs and ROI. • All types of people can benefit from additional health care and support services.	People with unmet health needs can benefit from additional services delivered by ACOs. ACOs must find, engage and help people across the risk spectrum.
⇒**Clinical Guidelines**	• Clinical leaders implement guidelines and protocols to: – Reduce inappropriate variation, unsafe care, overuse, misuse and low-value care, while increasing high-value care. – Help patients make informed decisions. – Use for decision support in electronic medical record system workflow. – Use in risk stratification, registries, gap in care closure, care coordination, transition management, site-of-care guidelines and patient education and portals. – Allow clinicians to evaluate performance and make information publicly available. • Providers help patients comply with health plan and pharmacy benefit administration for coverage, medical necessity, utilization management, site of care, medication use and other areas.	Evidence-based clinical guidelines are used to improve quality and help patients make decisions. Guidelines do not replace benefit administration responsibilities by health plans, providers and patients.

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COMPETENCY	DEFINITION	RATIONALE FOR INCLUSION
Care Model *Continued*		
⇒**Quality**	• All physicians, hospitals and other providers in the ACO are individually accountable for delivering safe, appropriate, high-quality care that is coordinated across providers. • As ACOs mature, ACO clinical leaders can: – Implement methods for helping people get high-quality care and care for themselves. – Set high standards for all providers, monitor outcomes and improve results. – Use internal and external sources of quality and safety reporting to evaluate providers. – Incorporate patient input. – Reduce problems in quality, safety and care coordination that occur across and among providers. – Remove providers with unsatisfactory results from the ACO. – Publicly release quality and safety results.	ACO providers can improve service delivery, quality, safety, personal health status and cost efficiency.
⇒**Care Coordination**	• Primary care doctors, specialists and hospitals in an ACO use standard protocols for scheduling, information exchange, accountability transfers and other functions. • Medical home care teams proactively coordinate referrals, tests, therapies, procedures and admissions and discharges from inpatient and emergency care. Sometimes, specialists lead care coordination. • Proactive services are targeted at people with complex needs using multiple providers. • Care team members schedule appointments, transfer information, track patient progress, update care plans, follow up with patients, resolve problems patients encounter and refer patients to additional services. • Services are delivered by care team members, staff co-located at practices and/or staff in shared centralized units.	Care coordination helps patients get high-quality care from the right types of providers in a timely, safe and efficient way.
⇒**Site of Care**	• ACO refers patients to clinically appropriate providers and suppliers in the lowest-cost sites of care. • Examples include independent and/or office-based: urgent care, ambulatory surgery, radiology, lab, pharmacy, equipment, dialysis, infusion therapy and deliveries. • ACO includes such providers as members or preferred referral destinations aligned with health plan networks. • ACO evaluates the performance of such providers in their network. • Providers help patients comply with health plan and pharmacy benefit administration requirements, including using low-cost sites of care; lowering out-of-pocket costs; complying with formularies and utilization management and accessing centers of excellence.	Many sites of care, products and providers offer services at the same or higher quality and at lower total cost than alternatives. ACOs help people obtain the best benefits possible from low-cost providers meeting quality standards and providing the most appropriate care for the patient.

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COMPETENCY	DEFINITION	RATIONALE FOR INCLUSION
Care Model *Continued*		
⇒**Medication**	• Collaborative efforts among physicians, pharmacists and other care team members can improve appropriate medication use. • Guidelines and protocols for medication therapy can improve outcomes, reduce unsafe prescribing and polypharmacy and support appropriate use of generics. • Pharmacist-provided patient education, therapy management, medication reconciliation and appropriateness reviews help providers and patients. • Pharmacists, as care team members sometimes co-located in practices, can help patients improve adherence. • Providers help patients comply with pharmacy benefit administration for coverage, dispensing, formulary use, generic use, utilization management, specialty medication benefits and other areas.	Medication therapy using evidence-based prescribing and treatment adherence support can help many people. Prescribing guidelines do not replace benefit administration responsibilities by health plans, providers and patients.
Consumer Experience		
⇒**Access**	• 24/7 access to a care team member with patient information and based on patient need. • Shorter same-day appointment waiting times for urgent needs. • Enhanced in-person hours (e.g., extended hours) periodically. • Contact channels to communicate with care teams through phone, secure email and other means.	Better access to primary care can improve patient satisfaction and utilization.
⇒**Proactive Outreach**	• People with complex needs using multiple providers are typically proactively contacted first, followed by people with moderate and low risks who are expected to need help. • Common reasons people are contacted are for discharge follow-up, referrals, scheduling, care plan updates, care gap closure, medication reviews, education, coaching or preventive care reminders. • Contact can come from anyone on the primary or specialty care team, hospitals and other providers. Staff working directly for the ACO may also contact people. Staff may be co-located at practices or in centralized units. • People are typically contacted by phone, secure messaging or mail. • Success requires two-way communication by patients, which they do not always want.	People benefit from proactive outreach to help them get care, change behavior and make informed decisions.

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COMPETENCY	DEFINITION	RATIONALE FOR INCLUSION
Consumer Experience *Continued*		
⇒**Satisfaction**	• Patient experience and satisfaction with care can be measured and improved by ACOs and their participating providers. ACOs can receive input from: – Annual surveys and direct patient input is obtained and evaluated, leading to improvement in policies, practices and results. – Family members. – Multiple available tools and methods. • Related areas of health literacy, education, engagement, activation and loyalty can also be measured and improved. • A concierge model offers dedicated staff at the ACO and/or participating providers to help consumers access care, get information and resolve problems about how the ACO operates and how to reach its providers.	People satisfied with their care experience are more likely to engage with care teams to manage and improve their health.
⇒**Portal**	• High-quality user interfaces, integrated personal health records, record transmission, self-service functions, scheduling, rich content, social interactivity, integration with consumer health apps and products and multiple secure provider communication channels are emerging very slowly. • Initially, consumer portals are from the EMRs used by each provider, with little or no data exchange.	Access to information, transactions and messaging through portals is appealing to many consumers.
Technology & Analytics		
⇒**Electronic Medical Record (EMR)**	• Inpatient and ambulatory EMRs are among the technology competencies needed by ACOs and their providers. Options include: – Predictive analytics, registries, data analytics and patient portals. – Additional systems for admission/discharge notification, clinical guidelines, care planning and coordination. • EMRs are clinical documentation and ordering systems. • Physicians also use workflow features in EMRs to make consumers aware of guidelines to support care delivery protocols and decision-making. • Separate EMRs are typically used by each different provider group. Sometimes, all physicians in a health system use one EMR. • Implementing data exchange and interoperability among EMRs requires collaboration, investment and time.	All providers and patients need electronic medical record systems to collect, store and use clinical information.

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COMPETENCY	DEFINITION	RATIONALE FOR INCLUSION
Technology & Analytics *Continued*		
⇒**Predictive Analytics/Registries**	• Predictive analytics tools collect clinical data from EMRs; claims data from medical, behavioral, lab and pharmacy benefits and from other sources for the purpose of applying algorithms that stratify patients based on predicted risk of future health events. • Registries of patients for the ACO to proactively support are prioritized based on risk stratification, physician referral, diagnosis, admission/discharge/transfer alerts, gaps in care, risk of readmission, use of high-cost services, use of costly drugs and other criteria. • Alerts for point-of-care patient-level actions are sent to EMRs and care team workflows. • Work lists of proactive outreach services for care teams, care coordinators, utilization managers, pharmacists and others are created and managed.	Predictive analytics and registries are used to find and help people who are expected to need more care.
⇒**Data Analytics**	• Data analytics systems collect clinical data from EMRs; claims data from medical, behavioral, lab and pharmacy benefits and from other sources for the purpose of applying algorithms that identify and measure population-level trends and opportunities. • Sophisticated reporting is performed for individual provider performance evaluation, ACO-level results for contracted outcomes, performance for specific populations (e.g., by payer), public reporting and other results.	Population- and provider-level data analysis identifies opportunities and measures results.
Finance Model		
⇒**ACO Risk**	• Most contracts use existing fee-for-service payment methods. In addition, each health plan uses its own contract terms with ACOs. In general, there are two components: – *Total Cost of Care:* Achieve a total cost of care that increases at a lower rate than the market trend and/or achieves a targeted per member per month (PMPM) total cost of care compared to market. Total cost includes medical and, sometimes, pharmacy and behavioral. – *Quality and Other Outcomes:* Achieve improvements in quality, efficiency, patient satisfaction and other measures that are then used to determine whether the ACO is eligible to receive shared savings in full or in part. • Population-level full or partial prepaid capitation is a possible alternative. These options are more feasible as ACOs mature, show success and gain financing.	The potential for rewards and losses creates incentives for provider investments and behavior change.

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COMPETENCY	DEFINITION	RATIONALE FOR INCLUSION
Finance Model *Continued*		
⇒**Physician Incentives**	• For employed physicians, the incentive to try to earn a bonus and risk a pay cut is the percentage of pay at risk (e.g., 20%) times the likely percent of at-risk pay that could be gained or lost (e.g., likely between -20% and +20%). The example yields +/- 4% of total pay at risk. • For independent physicians billing fee-for-service, the size of the incentive needed to earn a bonus and risk a pay cut depends on the impact on net compensation, which is based on the percentage of total net pay in at-risk contracts (e.g., 40%) and the likely percent of at-risk net pay that could be gained or lost (e.g., likely between -20% and +20%). The example yields a likely +/-8% impact on the physician's total net pay. [Note: in some cases, because the gain or loss is on total claims, not net pay, the risk is much higher.]	The potential for rewards and losses in physician pay creates incentives for investments and behavior change.