



# Toward Accountable Care

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## HealthCare Partners: Building on a Foundation of Global Risk Management to Achieve Accountable Care

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**ABSTRACT:** HealthCare Partners, a medical group and independent practice association in Los Angeles, is one of the provider groups taking part in the Brookings–Dartmouth ACO Pilot Program to form accountable care organizations, which assume responsibility for improving patient care and lowering total costs and, in turn, share in the savings achieved. This case study explores: the characteristics of HealthCare Partners and its partner organizations, including the insurer Anthem, that are contributing to the development of the ACO; the rationale behind the decision to develop an ACO; the steps taken to implement the model; milestones achieved; and lessons learned. The keys to HealthCare Partners' success thus far include a strong primary care base, an emphasis on prevention and promotion, an integrated health information technology infrastructure, chronic care management and care coordination efforts, performance measurement and reporting, and experience with taking on risk.



### OVERVIEW

This case study examines the progress that HealthCare Partners, a Los Angeles–based medical group and independent practice association, has made in its efforts to become accountable for the quality and overall cost of care for its patient population. HealthCare Partners is one of the four provider groups participating in the Brookings–Dartmouth ACO Pilot Program that are profiled in the Commonwealth Fund case study series *Toward Accountable Care*.

Accountable care organizations (ACOs) have been proposed as a new delivery model to encourage clinicians, hospitals, and other health care organizations to work together to improve the quality of care and slow spending growth. The Affordable Care Act's ACO program is intended to promote better management and coordination of care for Medicare beneficiaries by enabling providers working in ACOs to share in any savings they achieve. However, there is

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**Exhibit 1. HealthCare Partners' ACO Milestones**

Q4 2009	Initiated ACO partnership with Anthem
Q2 2010	Selected to participate in Brookings–Dartmouth ACO Pilot Program
Q2 2010	Established ACO Steering Committee
Q1 2011	Initiated patient attribution
Q1 2011	Signed letter of agreement with Anthem

little evidence from the field on how organizations progress from traditional payment models toward the ACO model. To better understand this process, this case study documents HealthCare Partners' journey to develop an ACO.

HealthCare Partners is a medical group and independent practice association (IPA). The medical group employs approximately 700 primary care physicians (PCPs) and specialists in 50 medical offices. The affiliated IPA has over 1,000 PCPs and 1,400 specialists. HealthCare Partners has acquired extensive experience in taking on global financial risk. The organization is implementing a physician-led ACO, with Anthem as the payer, covering approximately 50,000 Anthem PPO members. HealthCare Partners was selected as a Medicare Pioneer ACO site in December 2011. (See announcement at: <http://www.hhs.gov/news/press/2011pres/12/20111219a.html>.)

The ACO will be integrated into HealthCare Partners' existing coordinated care model. HealthCare Partners and Anthem signed a binding letter of agreement approving a five-year ACO arrangement. The contract is being finalized and will likely stipulate a shared-savings model for the first year, link shared savings to ACO performance on quality metrics, and phase in a global capitation model over the course of the five-year agreement (Exhibit 1). Anthem is concurrently using the Episode Treatment Group and Brookings–Dartmouth attribution methodology to assign patients, but will introduce an ACO Preferred Provider Organization (PPO) health plan product in 2012 that employers and individuals can purchase. HealthCare Partners is working to determine

an effective governance board structure as well as a patient and physician engagement strategy.

There are several factors that appear to have contributed to the successful development of HealthCare Partners' ACO. These include: stable leadership, a strong primary care base, consistent emphasis on prevention and promotion, integrated health information technology infrastructure, use of effective care coordination and care management, performance measurement and reporting, extensive experience taking on risk, participation in the Brookings–Dartmouth ACO Pilot Program, and a solid payer–provider relationship (including active involvement in a joint implementation committee). In contrast, it has worked to overcome challenges associated with defining patient attribution, acquiring IPA physician support, and gaining PPO patient interest in selecting the HealthCare Partners–Anthem ACO product.

This case study describes the progress that HealthCare Partners has made to become accountable for the overall quality and cost of care for its patient population. It focuses on identifying how HealthCare Partners embarked on its journey to 1) develop the internal capability to be accountable for the quality and cost of care of its patient population through an ACO, and 2) develop a contract with Anthem for this global quality/cost payment model. The case study outlines the key characteristics of the organization and its partners, its rationale for choosing to develop an ACO, steps taken to implement the model, and lessons

*We are big believers that population health is the only way to go. You can't take care of individual patients and expect to really improve their health and [the] well-being of the community. So we've always been of the belief that somebody has to manage the entire coordination of the patient and it might as well be us. So get the full capitation, global capitation for full risk across the entire spectrum of care, and then coordinate it and manage it.*

Robert Margolis, M.D., CEO,  
HealthCare Partners

### Study Methods

In late March and early April 2011, a team from The Dartmouth Institute for Health Policy and Clinical Practice conducted a five-day site visit to HealthCare Partners. Information was collected through in-person and telephone interviews with a diverse group of stakeholders. Site evaluators met with the leadership team as well as individuals overseeing areas that will directly affect the development of the ACO, namely:

- disease management;
- care management;
- clinical systems strategy (medical informatics);
- decision support (data warehouse and analytics);
- inpatient services and high-risk operations;
- regional high-risk operations;
- quality improvement; and
- ACO steering committees.

The site visit included focus groups with physicians and administrative staff at three HealthCare Partners medical group offices, including the Manhattan Beach Office, Sepulveda Office, and Montebello Office, which has an adjoining 12-hour urgent care center. Meetings were also observed, including a care management committee meeting between hospitalists and providers in the surrounding Montebello area. Slide presentations produced by HealthCare Partners, the ACO Provider Short Form Survey, and other literature provided additional information.

learned in overcoming challenges and facilitating early changes.

### HEALTHCARE PARTNERS: ORGANIZATIONAL CHARACTERISTICS

The emergence of HealthCare Partners dates to the mid-1970s, with the formation of two physician organizations: California Primary Physicians was founded in 1975 by Robert Margolis, M.D., HealthCare Partners' current CEO, and six other board-certified internists and emergency department physicians; and Huntingdon Medical was founded in 1980 by Bill Chin, M.D., now HealthCare Partners' executive medical director, and six other physicians. The two organizations joined forces in 1992 to create HealthCare Partners—a “Kaiser without walls,” according to Chin (Exhibit 2).

The organization has benefited from having stable leadership and board members throughout its development. HealthCare Partners believes the organization

has grown partly because of its visionary leaders, progressive culture, and commitment to achieving the organization's vision:

*HealthCare Partners will be the role model for integrated and coordinated care, leading the transformation of the national health care delivery system to assure quality, access, and affordable care for all.*

### Diversification Strategy

Over the years, HealthCare Partners has expanded its reach across state borders and service lines through a robust acquisition strategy. Mergers and acquisitions paved the way for the company to become the largest private medical group in California. With increasing longevity and growing prominence, HealthCare Partners also launched medical groups in Florida and Nevada, so that 40 percent of its business is now generated outside of California. The acquisition of medical groups in Florida and Nevada helped HealthCare

Partners attain several strategic goals, including geographic and payer diversification.

**Configuration in California**

HealthCare Partners has two structurally distinct service arms: a medical group and an independent practice association (IPA). Nearly 20 percent of the PCPs and specialists working within the HealthCare Partners service network are directly employed and salaried under the medical group (also known as the staff model). The medical group is composed of more than 50 medical offices and employs more than 200 primary care and 500 specialty physicians. The group contracts with most major HMOs and PPOs servicing the greater Los Angeles area. Approximately 45 percent of medical group patients are covered under managed care plans. Group model physicians have a direct relationship with the corporate company and, as such, are formally integrated into HealthCare Partners’ organizational structure. Concurrently, HealthCare Partners has managed care contracts with private independent groups via the IPA model. Roughly 1,000 PCPs and 1,400 specialists make up the IPA groups. These physicians see 55 percent of HealthCare Partners’ patients. Compared with the medical group, the IPA experienced faster growth in physician numbers over the past few years. Among the IPA and medical group physicians, 425 family practice physicians, 574 internal medicine physicians, 1,462 medical specialists, and 240 surgical specialists will be participating in the ACO.

**Regional Delivery of Health Services**

HealthCare Partners organizes health services delivery into regional business units—a structure underpinning the organization’s operations since its beginnings. “I believe that health care is a local product,” says Chin. “To try to run health care from a corporate office is a mistake. So we have different business units that are designed to meet the local needs of the community.” Accordingly, HealthCare Partners is split into six distinct regions encapsulating the medical group practices and IPA practices (Exhibit 3).

<b>Exhibit 2. Core Characteristics of HealthCare Partners</b>	
<b>Type:</b>	Medical Group/IPA
<b>Legal structure:</b>	Limited liability company (LLC)
<b>Location:</b>	Torrance, Los Angeles County, California
<b>Patients served annually:</b>	675,000 capitated commercial, Medicare Advantage and Medicaid patients
<b>Physicians, employed:</b>	200 primary care physicians and 500 specialists
<b>Physicians, affiliated:</b>	1,000 primary care physicians and 1,400 specialists
<b>Hospitals owned:</b>	None, 20 affiliated hospitals
<b>Electronic health record systems:</b>	Allscripts, Epic, and NextGen

Each regional business unit has two Regional Accountability Teams, with one team dedicated to supporting the IPA physicians and the other to the medical group. The teams include a medical director, regional vice president of operations, and regional vice president of care management. The Regional Accountability Teams have a significant role in ensuring alignment of goals and expectations between HealthCare Partners Corporate and the IPA sites. It also serves as a mechanism and filter through which HealthCare Partners can communicate changes to the broader IPA practices and through which IPA physicians can communicate their concerns to corporate leaders. Each regional team is held accountable for the collective performance of the physicians practicing in their business unit.

**Governance**

HealthCare Partners, LLC, is the parent company overseeing all of HealthCare Partners’ subsidiary holdings. It manages the administrative systems of its own staff-model medical group and provides central support services to its IPA network. The organization oversees operations of medical groups in California, Florida, and Nevada as well as The Camden Group, a national health care management and consulting firm.

**Exhibit 3. HealthCare Partners' Regional Business Units**

Region	Geographic area
1	Pasadena/San Gabriel Valley
2	Greater Los Angeles
3	South Bay
4	Long Beach
5	San Fernando and Santa Clara Valley
6	Talbert-Orange County

**Impact of Managed Care**

The emergence of managed care in the 1980s played a significant role in the evolution of HealthCare Partners. At that time, leaders made a decision to test whether HealthCare Partners had the capability to take on global financial risk. Subsequently, leaders invested considerable resources in developing HealthCare Partners' clinical expertise and health information technology (HIT) infrastructure to enable the organization to thrive and survive in a capitated environment. As described by some leaders, the decision to take on complete financial risk for managed care patients was one of the motivations for HealthCare Partners to employ physicians and ancillary providers.

Entering the managed care market led to business success. HealthCare Partners and its physician networks now serve over 1,000,000 patients in California, including more than 500,000 capitated commercial patients, 150,000 Medicare Advantage beneficiaries, and 25,000 capitated Medicaid patients. Early entry into managed care enabled the organization to build 25 years of experience managing global capitation contracts.

**Regulatory Environment**

HealthCare Partners is not required to obtain legal permission or licensure to provide managed care services in California. The organization legally provides managed care as a result of its business agreements with health plans regulated by the California Department

of Managed Health Care, which requires licensed health care plans to adhere to a number of consumer protection and public reporting requirements. Once HealthCare Partners establishes contractual relationships with licensed health care plans, these plans delegate a range of services to HealthCare Partners, including claims processing, utilization, and health services delivery. For doing this, HealthCare Partners receives a percentage of the capitated payments.

**ORIGINS OF ACCOUNTABLE CARE AT HEALTHCARE PARTNERS**

HealthCare Partners has made significant investments in administering comprehensive, patient-centered care by: 1) leveraging its existing infrastructure, 2) harnessing a culture committed to delivering accountable health care, and 3) developing internal capability to manage population health, quality, and costs. These investments aim to reduce unnecessary hospitalizations and excessive utilization, administer prevention and promotion programs, personalize treatment plans, and focus on the most costly and high-risk patients. Janelle Howe, director of disease management, said, "Every unscheduled hospitalization is a failure in how we coordinated care."

**Leveraging Existing Infrastructure**

HealthCare Partners began developing tools to coordinate care for patients with chronic conditions or multiple conditions in the 1980s (examples provided below).

Its leaders believe the ACO will better align payment incentives with the care delivery model for the PPO population. HealthCare Partners does not currently assume full risk for PPO patients. In order to transition to coordinating care for PPO patients, HealthCare Partners realized that the “finances have to match the expectations” (Tyler Jung, M.D., director of inpatient services and high-risk programs). The advent of ACOs helped HealthCare Partners identify a mechanism to incorporate PPO patients into the existing delivery structure.

### **Harnessing a Culture Committed to Accountable Care**

HealthCare Partners’ interest in becoming an ACO is driven in part by its commitment to delivering patient-centered, accountable care—embodied in its culture of ownership. Physicians cite teamwork, accountability, and taking ownership for patients as vital components in achieving consistently high performance on clinical quality and patient satisfaction metrics. HealthCare Partners engrains a strong culture of ownership by financially rewarding physicians who effectively and consistently coordinate the full spectrum of care delivered to their patients.

### **Developing Capabilities to Manage Population Health, Quality, and Costs**

HealthCare Partners has developed a robust system for managing population health, quality, and costs (Exhibit 4). Its approach has involved: 1) a robust HIT infrastructure; 2) care management tools, high-risk programs, and a hospitalist program; 3) performance measurement; and 4) development of performance improvement capacity.

### **Robust Health Information Technology Infrastructure**

HealthCare Partners is committed to developing a sophisticated HIT infrastructure that connects all stakeholders in the network: administrators, medical group and IPA providers, and patients. The organization’s vision for HIT states that by 2013, all data will be accessible any time of the day, anywhere in the world,

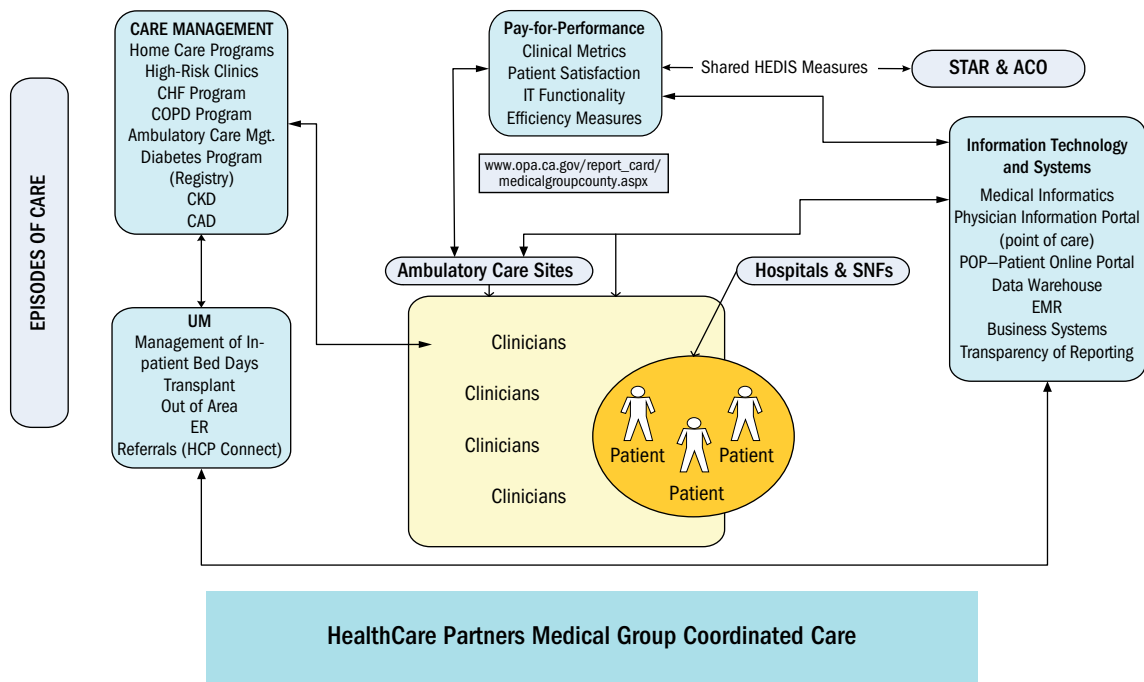
through any secure device or system, and by any appropriate user.

The medical group operates on a single technology platform that facilitates information exchange among physicians, while IPA physicians are not obligated to use either the Allscripts or Epic EHR systems and some are still using paper records. IPA physicians that do have EHR systems generally use NextGen. HealthCare Partners provides financial resources to IPA physicians who are willing to invest in the NextGen EHR to foster some level of interoperability among IPA physicians.

HealthCare Partners built a sophisticated internal data warehouse, dubbed the “single source of data truth,” that is capable of aggregating and harmonizing clinical, administrative, and financial data. Development of the data warehouse occurred over 10 years. The data warehouse pulls information from disparate EHRs and other sources (including patient portals) into a standardized format, giving HealthCare Partners a well-rounded view of its patients and enabling it to identify high-risk and high-cost patients.

HealthCare Partners’ HIT infrastructure and data warehouse serve as the foundation on which it can design care coordination tools and programs. These tools have been personalized for providers, management, and patients. Several physicians reported that these tools helped them understand their patients and develop care plans. The tools available to frontline physicians and management include:

- **Provider Information Portal (PIP).** The PIP is the primary tool that frontline physicians use to access comprehensive data on all of their patients. It is a Web-based system that is accessible to all medical group and IPA physicians. Performance metrics (Healthcare Effectiveness Data and Information Set, or HEDIS, measures) are captured in this system, enabling physicians to monitor their performance on predetermined care coordination and quality metrics. Results are aggregated for each regional business unit and by office site, and can be drilled down to

**Exhibit 4. HealthCare Partners' Care Coordination Model Available to Both Medical Group and IPA Physicians**

Source: HealthCare Partners, 2011.

each physician. Medical group physicians utilize the PIP frequently while there is lower utilization among IPA physicians.

- Clinical Viewer.** The Clinical Viewer is embedded within the PIP and is used at the point of care. It allows users to generate a complete medical history on any HealthCare Partners patient. Providers use it to track patients' movement through HealthCare Partners' system, as well as their medications, allergies, lab and diagnostic results, procedures, vital signs, immunizations, and referrals. Providers also use the Clinical Viewer to produce Patient Intervention Reports, which provide a list of outstanding action items pertaining to each patient. Physicians in the medical group have unlimited access to the viewer, and IPA physicians have access to the laboratory and referral functions.
- Clinical Dashboard.** The Clinical Dashboard is also embedded within the PIP and is used by the management team to document physician performance. The dashboard reports on physicians'

achievement of quality metrics by using composite scores.

- Clinical decision-support platform.** This platform is in development as part of HealthCare Partners' broader efforts to manage high-risk and high-cost patients at the point of care. Through this platform, HealthCare Partners plans on systematizing clinical guidelines and rules to help guide patient referrals. Physicians are given a score indicating whether their referrals align with the guidelines. The goal is to work with physicians whose scores are outliers.
- Predictive modeling system.** Predictive modeling aims to identify high-risk and high-cost patients using information such as risk adjustment factor scores to better predict future patient costs. The goal is to enroll seriously ill patients and high utilizers in care coordination programs. HealthCare Partners is in the early stages of developing this system, which will be used by both the management team and providers.

In addition to creating and refining a suite of IT tools for frontline use, HealthCare Partners spent considerable time developing tools for end users (e.g., managers, medical group site leaders, regional directors, and patients). For example, the Resource Center collects, aggregates, and further standardizes the information from the tools discussed above for management use. It provides automated, comprehensive reports on HealthCare Partners' financial, quality, and operational performance. HealthCare Partners created a patient portal, similar to a personal health record, to give patients access to their medical records.

Brett Meyers, director of clinical systems strategy, emphasized the importance of HIT in understanding the needs of patients. “[If we could] use these tools to identify as best we can the patients that are most at risk, and then match them with the providers that are the most efficient and have the best outcomes,” he said, “that would be the Holy Grail.”

### **Capability to Care for a Population**

HealthCare Partners has a comprehensive population health management strategy to proactively address the needs of high-risk patients and those with chronic and complex conditions. The three main care management programs include: 1) disease management and case management, 2) complex care management, and 3) high-risk programs. Patients with multiple comorbidities may be enrolled in a combination of these programs.

***Disease management and case management programs.*** About 5 percent of HealthCare Partners patients are responsible for more than 55 percent of hospital utilization. HealthCare Partners has developed in-house disease management programs tailored for patients seeking treatment for the costliest diseases, including heart failure, diabetes, coronary artery disease, chronic obstructive pulmonary disease, and asthma. Those eligible to participate in the disease management programs are identified through utilization patterns, disease registries, or referrals. When an individual is enrolled in disease-specific management programs, they are paired with a nurse care manager who contacts them regularly to monitor their

conditions for one year post-discharge from the hospital and are given expedited access to clinical staff. For example, patients engaged in the heart failure disease management program are assigned to a care team, which could include a cardiologist who is involved in high-level patient management, a nurse practitioner who is responsible for managing patients' symptoms, a care manager who conducts follow-up visits and disease education, and a care coordinator who monitors patients' stability on a monthly basis. Each disease management program has a physician champion charged with identifying and supporting the use of clinical best practices.

### ***Complex care management programs.***

HealthCare Partners designed a Complex Care Management Program to provide high-risk patients with long-term, personalized care. Multidisciplinary care teams work with patients diagnosed with diabetes, chronic obstructive pulmonary disease, heart failure, chronic kidney disease, depression, dementia, cancer, and organ transplant to: 1) facilitate coordinated care and communication among multiple providers, 2) promote shared-decision making, 3) encourage treatment adherence, 4) prevent unnecessary hospitalizations, and 5) empower patients to manage their conditions.

***High-risk programs.*** HealthCare Partners designed three other programs to help high-risk patients avoid unnecessary hospitalizations. At five Comprehensive Care Centers, multidisciplinary teams work closely with patients to stabilize them and provide comprehensive care management. Patient visits average 45 minutes, instead of the usual 15-minute consultations. Since the launch of the centers, there has been a reduction in hospitalizations and increased cost savings to the system. HealthCare Partners also created an end-stage renal disease program to help such patients follow preventive care and maintenance regimens in order to reduce the likelihood of hospital admission. Finally, clinicians and nurse practitioners make home visits to the most at-risk, frail seniors. This approach to tracking patients care and identifying those with special needs will carry over to the ACO.

## **Hospitalist Program**

HealthCare Partners helped pioneer the hospitalist movement 30 years ago. Its hospitalist program promotes evidence-based care in hospital and nursing home settings, building on the close partnerships it has with some 25 hospitals in Los Angeles and Orange County. HealthCare Partners hospitalists are employed directly by the system; they have admitting privileges, provide clinical services to hospitalized patients, and facilitate patient handoffs between hospital and medical group/affiliated physicians. For example, hospitalists complete daily census reports to notify primary care providers when their patients are admitted and provide updates on their progress. Similar to medical group physicians, hospitalists work toward and are motivated to reduce hospital costs, excessive length of stay, readmissions, and unnecessary medication utilization.

The Care Management Committee Meeting between hospitalists and primary care providers in the Montebello Office demonstrates how hospitalists facilitate coordinated care. These weekly meetings include hospitalists, skilled nursing facility physicians, and primary care providers engaged in open discussion about their patients. Hospitalists work with the primary care providers to develop treatment plans for patients who are hospitalized or have been recently discharged. Physicians take into account their patients' clinical and psychosocial status, such as the ability of their family to care for them at home.

## **Pay-for-Performance**

HealthCare Partners instituted a Primary Care Physician Compensation Program to appropriately compensate and reward medical group primary care physicians for their performance in providing high-quality care and service, increasing revenue streams, and growing HealthCare Partners' patient base. Physicians' performance results are measured based on managed care panel size, fee-for-service charges, and quality measures (Exhibit 5).

The IPA physicians' compensation differs from that for physicians in the medical group since they are not directly employed by HealthCare Partners.

Furthermore, the Regional Accountability Teams have leeway in determining how the IPA physicians are incentivized. In cooperation with HealthCare Partners Corporate, the teams generally incorporate financial incentives (e.g., bonus payments) into IPA physicians' contracts.

## **Quality and Performance Improvement Capability**

The organization explores ways to refine and pilot-test care delivery initiatives at the practice level before scaling up to additional sites. Individual medical group practices can nominate areas for improvement initiatives. IPA physicians are encouraged to participate in practice redesign efforts, for example to improve patient flow in ambulatory care settings.

HealthCare Partners routinely fields surveys of patient experience in all six regional business units, with a goal to have 100 completed surveys per primary care physician each year. Findings are shared with the physicians and medical groups, and individuals and practices are recognized and rewarded for achieving high levels of patient satisfaction. HealthCare Partners believes such efforts help to ensure that physicians are aligned with the goal of delivering accountable care. For example, based on patients' feedback, the organization is working to increase the hours of operation at certain office sites.

## **MOVING FORWARD WITH ACCOUNTABLE CARE**

Before launching into an ACO contract, HealthCare Partners engaged in preliminary activities, including: 1) selection of a payer-partner; 2) selection and participation in the Brookings–Dartmouth ACO Pilot Program; and 3) engagement in national health policy dialogue on ACOs.

## **Establishing the Payer–Provider Partnership**

HealthCare Partners and Anthem established an ACO partnership in the latter part of 2009. In March 2010, the two parties put out a press release announcing the ACO partnership. HealthCare Partners' leaders believed Anthem was the most logical partner with which to develop an ACO since it is a dominant

### Exhibit 5. HealthCare Partners' Physician Compensation Program

Component	Description	Weighting
<b>Patient satisfaction</b>	<p>A random patient satisfaction sample is taken from a physician's encounter activity. Patient satisfaction is measured using the results of two questions:</p> <ol style="list-style-type: none"> <li>1. "Overall how satisfied are you with the doctor/clinician?" The percentage of respondents who indicated "completely satisfied" is included in the measures.</li> <li>2. "Would you recommend the doctor/clinician to your family or friends?" The percentage of respondents who indicated "definitely yes" is included in the measure.</li> </ol>	<p>Based on the clinician's individual patient satisfaction score, a clinician will be awarded 0 to 4 points based on the following formula:</p> <ol style="list-style-type: none"> <li>1. Maximum of 2 points based on <math>2 \text{ points} * ((\% \text{ patient satisfaction with clinician}) - 50\%) / 25\% = \text{awarded points}</math></li> <li>2. Maximum of 2 points based on <math>2 \text{ points} * ((\% \text{ recommended clinician}) - 70\%) / 20\% = \text{awarded points}</math></li> </ol>
<b>Quality outcomes</b>	<p>Selected quality measures will be calculated on a physician level (rather than group level) and include all of the individual physician's patients (not just the health plans who participate in the program). During each calculation, the most recent year's year-end clinician data will be used. Quality measures for internal medicine/family practice include:</p> <ol style="list-style-type: none"> <li>1. Adults with acute bronchitis</li> <li>2. Breast cancer screening</li> <li>3. Chlamydia screening</li> <li>4. Colorectal cancer screening</li> <li>5. Diabetes care, HbA1c control &lt;7</li> <li>6. Diabetes care, LDL&lt;100</li> <li>7. Nephropathy screening</li> <li>8. Appropriate medications for asthma</li> </ol>	<p>Up to eight points are available under:</p> <ol style="list-style-type: none"> <li>1. Adults with acute bronchitis: clinician will be awarded 0 to 1 points based on the formula: <math>1 \text{ points} * ((\% \text{ acute bronchitis score}) - 40\%) / 40\% = \text{awarded points}</math></li> <li>2. Breast cancer screening: clinician will be awarded 0 to 1 points based on the formula: <math>1 \text{ points} * ((\% \text{ breast cancer screening score}) - 73\%) / 10\% = \text{awarded points}</math></li> <li>3. Chlamydia screening: clinician will be awarded 0 to 1 points based on the formula: <math>1 \text{ points} * ((\% \text{ chlamydia screening score}) - 63\%) / 10\% = \text{awarded points}</math></li> <li>4. Colorectal cancer screening: clinician will be awarded 0 to 1 points based on the formula: <math>1 \text{ points} * ((\% \text{ colorectal cancer screening score}) - 60\%) / 10\% = \text{awarded points}</math></li> <li>5. Diabetes care, HbA1c control &lt;7: clinician will be awarded 0 to 1 points based on the formula: <math>1 \text{ points} * ((\% \text{ diabetes care - HbA1c &lt;7 score}) - 60\%) / 10\% = \text{awarded points}</math></li> <li>6. Diabetes care, LDL&lt;100: clinician will be awarded 0 to 1 points based on the formula: <math>1 \text{ points} * ((\% \text{ diabetes care - LDL &lt;100}) - 56\%) / 10\% = \text{awarded points}</math></li> <li>7. Nephropathy screening: clinician will be awarded 0 to 1 points based on the formula: <math>1 \text{ points} * ((\% \text{ nephropathy screening score}) - 85\%) / 10\% = \text{awarded points}</math></li> <li>8. Appropriate medications for asthma: clinician will be awarded 0 to 1 points based on the formula: <math>1 \text{ points} * ((\% \text{ appropriate medications for asthma}) - 87\%) / 10\% = \text{awarded points}</math></li> </ol>
<p>The total points for patient satisfaction and quality elements will be added. Managed care panel size adjusted for continuity and fee-for-service charges; a senior panel morbidity credit also is factored into the compensation formula. Based on the total number of patient satisfaction and quality points, a per-paneled patient dollar value is assigned to each physician's panel to create the compensation for the primary care physician. The compensation is <i>not</i> based on the number of patients seen.</p>		

insurer in Los Angeles. The strength of the partnership between HealthCare Partners and Anthem has played a key role in moving the ACO forward.

### **Participation in the Brookings–Dartmouth ACO Pilot Program**

Participation in the Brookings–Dartmouth ACO Pilot Program gave HealthCare Partners a head start in implementing an ACO for a commercial PPO population and potentially implementing an ACO for the fee-for-service Medicare population. The goal of the pilot program is to support early and successful adoption of the ACO model, and to provide technical support and direction to advance the ACO model. As the only pilot site with a dual medical group and IPA structure, HealthCare Partners hopes the ACO model will propel it to the position of lead provider for both PPO and HMO patients in the greater Los Angeles area.

### **Involvement in National and State Health Policy**

HealthCare Partners engaged in the national movement to develop new and effective payment models and delivery systems prior to the passage of the Affordable Care Act. The organization contributed to the national policy discourse on ACOs and supported early adoption of the ACO model. Additionally, HealthCare Partners' CEO, Robert Margolis, M.D., chairs the National Committee for Quality Assurance's (NCQA) ACO Task Force, which is developing a set of accreditation standards for emerging ACOs. The task force released draft criteria in October 2010 for public comment. Margolis noted that in addition to following the NCQA criteria, organizations pursuing ACO implementation should focus on developing consumer protection guidelines, a legal structure, aligned incentives, a feedback loop to practitioners, and adequate patient satisfaction metrics. These are the main areas that HealthCare Partners sought to address early in the ACO implementation process.

### **Exhibit 6. Core Characteristics of the ACO**

<b>Payer-partner:</b> Anthem
<b>Legal entity:</b> Entity within existing parent organization (LLC)
<b>Oversight of ACO formation:</b> HCP-Monarch-Anthem Steering Committee with topic-specific subcommittees
<b>Payment model:</b> Shared savings, no risk in Year 1; transition to risk-bearing
<b>Patient attribution model:</b> Anthem ETG (Episode Treatment Group) Method and Brookings–Dartmouth Method
<b>ACO patient population:</b> 50,000 Anthem PPO patients
<b>ACO physician population:</b> 1,000 PCPs; 1,700 specialists

### **CREATING THE INFRASTRUCTURE TO BECOME ACCOUNTABLE FOR CARE**

In 2010, HealthCare Partners and Anthem began working together to develop the contract and infrastructure needed to establish an ACO (Exhibit 6). The ACO will be used as a mechanism to incorporate fully insured Anthem PPO patients into HealthCare Partners' risk-based care model. Over the years, HealthCare Partners has successfully built strong relationships with managed care entities, but this is the first time it is actively working to provide coordinated care for a specified PPO population. Anthem officially delegated health services delivery to HealthCare Partners for its ACO population in the Los Angeles region in the third quarter of 2011. HealthCare Partners plans to expand the ACO to the Medicare population in 2012. Key components relevant to the ACO's infrastructure include: the ACO steering committee and its structure, governance and leadership, and terms of contract; payment model; patient attribution; benefit design; patient engagement and notification; and physician engagement.

### **ACO Steering Committee Structure**

HealthCare Partners has internal and external steering committees to oversee the ACO implementation. Each member of the internal committee leads the development of a specific area relevant to the ACO. Additionally, HealthCare Partners jointly established

an external ACO steering committee involving Anthem and Monarch HealthCare, which is also building an ACO with Anthem in Orange County.<sup>1</sup> Anthem, however, has a separate contract with each provider organization. The joint steering committee is organized into nine focus areas, with Anthem, Monarch, and HealthCare Partners participating across all dimensions (Exhibit 7). The committee facilitates collaboration, sharing of best practices, and timely troubleshooting when problems arise and enables key individuals from all three organizations to stay informed of each other’s progress.

**Structure of the ACO**

The ACO is based on a single-payer (Anthem) and single-provider (HealthCare Partners) structure. It will be physician-led and include providers in both the medical group model and IPA. HealthCare Partners is actively exploring relationships with different hospitals in their service area for the ACO. To address some hospitals’ concerns about losing profit margin if they enter into an ACO agreement, HealthCare Partners is focused on developing an effective communication strategy.

The ACO will be integrated into HealthCare Partners’ current service delivery model, and the organization’s care coordination and disease management programs, hospitalist initiative, pay-for-performance programs, and IT tools will be available. HealthCare Partners believes its existing structure will enable the ACO to produce the anticipated quality improvements and cost savings.

**Governance and Leadership**

It is expected that the ACO leadership will come from HealthCare Partners existing leadership structure. It also is highly likely that the members of the ACO steering committee will participate in the governance board. The precise terms of participation, including patients and frontline physicians’ roles, have not been

<sup>1</sup> A case study of Monarch HealthCare’s development of an ACO is available at <http://www.commonwealthfund.org/Publications/Case-Studies/2012/Jan/Monarch-Health-Care.aspx>.

<b>Exhibit 7. Subcommittees of the HealthCare Partners–Anthem–Monarch ACO Steering Committee</b>
• Attribution
• Clinical operations
• Contracting / Framework
• Cost of care
• HIT / System operations
• Marketing / Sales / Communications
• Medical management delegation
• Performance metrics
• Product development / Benefit design

finalized. To date, HealthCare Partners is using patient focus groups, marketing research, and questionnaires to understand the needs and expectations of its ACO patients.

**Terms of Contract**

HealthCare Partners entered into a five-year ACO agreement with Anthem by signing a letter of agreement on March 29, 2011. This binding agreement was shaped into a comprehensive contract in the third quarter of 2011. The contract will be renewed every year, shaped by the ACO’s performance in the previous years. Medical management, which consists of utilization management, case management, and disease management, was delegated from Anthem to HealthCare Partners in the third quarter of 2011.

**Payment Model**

HealthCare Partners and Anthem are negotiating the level of risk that the organizations will take over the five-year agreement. HealthCare Partners will not assume downside risk in the first year. Instead, the ACO will include a medical management fee to HealthCare Partners and distribute shared savings between Anthem and HealthCare Partners. How the shared savings will be distributed is still under discussion, but HealthCare Partners plans to include both the medical group and IPA physicians. HealthCare Partners also indicated that shared savings will be linked to the ACO’s performance

on quality metrics. The ACO physicians must first meet an established performance threshold, called a “quality gate,” based on a composite of quality measures—shared savings are then determined from efficiency metrics. The percentage of potential shared savings linked to quality and efficiency measures has not yet been determined, nor have the target and benchmarks for performance been established. HealthCare Partners is using two years of historical claims data to develop the benchmarks and targets.

HealthCare Partners plans to take on downside risk in future years and phase in a global capitation model over the five years of the ACO contract. Although the budget for the total cost of care is still under development, Anthem has projected a potential 3 percent to 7 percent reduction in the trend in total cost of care in 2012. Anthem has provided two years of historical claims data to HealthCare Partners as one method of determining the potential budget. The budget excludes costly procedures such as organ transplants.

### **Patient Attribution**

The ACO patient population is defined as those who live in or around Los Angeles, are covered by Anthem’s PPO plan, and have historically utilized physicians in HealthCare Partners’ network. Additional patients are added to the pool as a result of patient movement and family member additions. The attribution process will hinge on HealthCare Partners and Anthem’s ability to reach consensus on a data-sharing agreement, which will allow Anthem to share historical claims data used to identify patients’ visit patterns to primary care physicians in the ACO.

Anthem and HealthCare Partners are working to identify a valid and reliable patient attribution methodology. The ACO patient population will include Anthem’s commercial PPO patients in 2011 and 2012. For purposes of attributing patients in the first year and calculating shared savings, Anthem will employ the Episode Treatment Group (ETG) attribution model. The ETG model creates episodes of care by collecting all inpatient, outpatient, pharmacy, and ancillary services for a patient into clinically homogeneous,

mutually exclusive, and exhaustive categories. It also assigns patients based on the plurality of allowed charges to either a primary care provider or specialist. To have continuity across the Brookings–Dartmouth pilot sites, Anthem and HealthCare Partners also will use the Brookings–Dartmouth attribution model in year one of the pilot. Unlike the ETG model, the Brookings–Dartmouth methodology assigns patients prospectively based on historical care patterns, specifically the plurality of outpatient evaluation and management visits.<sup>2</sup> Based on a March 2011 application of the ETG method, there were 50,000 patients attributed to the ACO. At that time, the number of patients attributed using the Brookings–Dartmouth method was not reported. Anthem anticipates providing comparisons in the third quarter between the ETG and Brookings–Dartmouth attributed populations.

### **Benefit Design**

In 2012, Anthem plans to introduce an ACO/PPO product that will eliminate the need for patient attribution. Employers and patients will be given the opportunity to purchase the ACO health plan. While the details are still under development, the rationale is that patients who select the ACO product (as opposed to the PPO or HMO plans) can select their primary care physicians. HealthCare Partners feels it is important to preserve patients’ choice among providers.

### **Patient Engagement and Notification**

Patients will be notified of their participation in the ACO and given an opportunity to opt out. Anthem and HealthCare Partners will inform patients through a cobranded letter sent to patients along with a new ACO ID card. This letter will be followed by a letter from the patient’s physician explaining the enhanced care coordination services the ACO will offer. As discussed above, it is expected that the ACO/PPO product will eliminate the need for patient attribution since patients

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<sup>2</sup> J. P. W. Bynum, E. Bernal-Delgado, D. Gottlieb et al., “Assigning Ambulatory Patients and Their Physicians to Hospitals: A Method for Obtaining Population-Based Provider Performance Measurements,” *Health Services Research*, Feb. 2007 42(1 Pt. 1):45–62.

will self-select a primary care physician when they sign up for the ACO benefit plan.

### Physician Engagement

Members of the internal ACO steering committee are developing a strategy to engage frontline physicians in the ACO. HealthCare Partners notified physicians about the ACO in the third quarter of 2011, although many were already aware of it to some degree. The employed group model physicians who were aware of the ACO were generally positive about it and felt that the care delivery model aligned with HealthCare Partners' current structure. To engage physicians in the ACO, it is important that they do not view it as a disruption of their workflow. It will be especially important to engage those physicians who contract with different payers and may participate in more than one IPA, as they may be less inclined to adopt ACO interventions if they do not see the benefit to their practice. HealthCare Partners will introduce training workshops for physicians in areas such as generic prescribing, patient outcomes, clinical guidelines, and greater use of freestanding ambulatory surgery centers.

### MONITORING PROGRESS TOWARD ACCOUNTABLE CARE

From HealthCare Partners' vantage point, the ACO will be a success if it seamlessly integrates the fee-for-service PPO population into the existing HealthCare Partners' delivery model. The metrics HealthCare Partners will use to define success will differ year to year, depending on how much risk is taken. Overall, HealthCare Partners hopes the ACO will improve quality and population health while reducing costs. In the first year, success will be evaluated according to whether HealthCare Partners: 1) managed the PPO population diligently, 2) facilitated hospital participation in the ACO, 3) developed and rolled out a communication strategy for notifying patients and providers, 4) improved quality metrics, 5) decreased the trend in the total costs of care by 3 percent to 7 percent, and 6) raised patient satisfaction. After the first year, HealthCare Partners will measure success based on how easily it is able to take on higher levels of downside risk. Additionally, the ACO's success will be judged on whether shared savings were generated. Achieving shared savings through both quality improvements and cost reductions creates a value proposition for both Anthem and HealthCare Partners to continue to pursue ACO implementation.

**Exhibit 8. Brookings–Dartmouth ACO Pilot Site Starter-Set Measures**

Priority area	Starter set measures	NQF #
Overuse	Low back pain: use of imaging studies	52
	Appropriate testing for children with pharyngitis	2
	Avoidance of antibiotic treatment in adults with acute bronchitis	52
	Appropriate treatment for children with upper respiratory infection (URI)	69
Population health	Breast cancer screening	31
	Cervical cancer screening	32
	Diabetes: HbA1c management (testing)	57
	Diabetes: cholesterol management (testing)	63
	Cholesterol management for patients with cardiovascular conditions (testing)	n/a
	Use of appropriate medications for people with asthma	36
	Persistence of beta-blocker treatment after a heart attack	71
Safety	Annual monitoring for patients on persistent medications	21

Source: Measures are drawn from the National Quality Forum (NQF) list of endorsed performance measures (Available at: [http://www.qualityforum.org/Measures\\_List.aspx](http://www.qualityforum.org/Measures_List.aspx)).

## Performance Measurement

HealthCare Partners and Anthem are still finalizing which performance measures to use for the ACO; however, they will likely adopt measures that will be factored into a quality gate and efficiency scorecard. As described above, the quality gate is the minimum performance threshold that must be upheld in order to receive a shared savings bonus. It is established to ensure that the quality of care is not jeopardized for the sake of cost savings. These measures are derived from a set of IHA measures of physician and hospital quality, and align with the measures selected by the Brookings–Dartmouth ACO Performance Measurement Technical Workgroup.

Through participation in the workgroup, HealthCare Partners and Anthem have provided input on the feasibility of collecting proposed measures and vetted them on their usefulness and relevance to the quality of care. The workgroup has identified measures and specifications in three categories: a claims-based starter set (including all-cause readmission rates and utilization measures), clinically enriched measures (which rely on data extracted from clinical data systems, as well as administrative claims data), and patient-reported measures (including patients' experiences of care and patient-reported outcomes) (Exhibits

8 and 9).

These measures were derived from the National Quality Forum's list of endorsed measures. HealthCare Partners is fully capable of capturing and reporting on these measures. Through its IT infrastructure, the organization already collects and analyzes administrative measures, clinically enriched measures, and patient experience measures, as well as efficiency and cost measures.

## Performance Reporting

The organization's commitment to comprehensive quality measurement and reporting has earned it top recognition among its peers. The IHA releases annual composite scores across eight California regions in four performance measurement domains: clinical quality, patient experience, information technology–enabled “system-ness,” and coordinated diabetes care. HealthCare Partners was recognized by IHA in 2010 as one of the top-performing medical groups in California for the seventh year in a row. Also in 2010, HealthCare Partners ranked highly in the annual California's Office of the Patient Advocate Quality Report, especially in the area of patient satisfaction. The organization also participates in the Pacific Business Group on Health (PGBH) annual quality performance reporting. PGBH

**Exhibit 9. Brookings–Dartmouth ACO Pilot Site Clinically Enriched Performance Measures**

Priority area	Clinically enriched measures	NQF #
Coronary artery disease	Cholesterol management for patients with cardiovascular conditions	n/a
	ACE inhibitor or ARB therapy*	66
Diabetes	Low-density lipoprotein (LDL-C) control in diabetes mellitus	64
	Hemoglobin A1c poor control in diabetes mellitus	59
	HbA1c control (<8.0%)	575
	High blood pressure control in diabetes mellitus	61
	Kidney disease screen	62
Hypertension	Blood pressure control	18
Pediatrics	Childhood immunization status	38
	Immunization for adolescents	n/a
Preventive care	Colorectal cancer screening	34

\* This measure was drawn from the Physician Consortium for Performance Improvement metrics. All other measures in this table are from the Healthcare Effectiveness Data and Information Set (HEDIS).

helps purchasers improve the quality of health care and moderate health care cost increases. HealthCare Partners' willingness to engage in public reporting of its performance is a testament to its commitment to transparency. The organization plans to continue publicly reporting its performance data while implementing the ACO.

## **LESSONS LEARNED**

Although HealthCare Partners has made significant strides in implementing the ACO, it has encountered a range of challenges. Its experience in overcoming these challenges and building on its early successes offers lessons for other health care organizations considering development of an ACO.

### **Challenges**

#### **Patient Attribution**

Finalizing the ACO patient assignment methodology presented significant challenges. Anthem currently provides two years of claims history data to HealthCare Partners. Instead of this retrospective data, HealthCare Partners would like to have real-time information about the attributed population. The organization needs timely patient assignment data to get a better sense of patients' care patterns, including those receiving most of their care outside of the delivery network. Members of the ACO steering committee believe it will be difficult to coordinate care for patients seeking high volumes of health services outside of HealthCare Partners' network.

Two potential solutions have been identified. Anthem could send an automated claims data feed, on a daily basis if feasible, to HealthCare Partners. Alternately, Anthem could refresh the ACO patient assignment at least every month and provide an updated list of patients to HealthCare Partners. Anthem wants to formalize its approach to packaging and transmitting patient-level information before releasing it to HealthCare Partners. Resolving the patient assignment challenge will require some level of compromise. Nevertheless, the two parties are committed to adopting an attribution plan that meets both organizations' needs.

HealthCare Partners is particularly enthusiastic about the proposed Anthem ACO/PPO product since it does not involve patient assignment. The ACO steering committee believes this approach will support patients' choice of providers, while allowing HealthCare Partners to identify high-risk and high-cost patients for care management interventions.

#### **Developing Trust and Support Among IPA Physicians**

Physicians in the medical group model have expressed support for the ACO, while IPA physicians are more skeptical and hesitant. IPA physicians see the ACO as a threat to their financial viability and believe it will stimulate acquisitions and mergers in their regional market. To enlist IPA physicians' participation in the ACO, Tyler Jung, M.D., director of inpatient services and high-risk programs, said that HealthCare Partners seeks to share its culture through consistent communication of its mission and values. IPA physicians are also exposed to HealthCare Partners' culture through their interaction with the organization's hospitalists, skilled nursing clinicians, and high-risk programs.

The organization is developing an incentive plan for IPA physicians as a way of garnering their support and demonstrating the value that HealthCare Partners places on care management. HealthCare Partners has also sought to incorporate IPA physicians into practice redesign pilots. Additionally, the organization depends on the Regional Accountability Teams to educate IPA physicians about the ACO and help strengthen the relationship between HealthCare Partners Corporate and IPA physicians.

#### **Persuading PPO Patients to Join the Anthem ACO/PPO Plan**

Incorporating PPO patients into HealthCare Partners' delivery model depends in part on PPO patients' willingness to participate in the ACO. The ACO steering committee believes it has to adapt HealthCare Partners' managed care model to fit the PPO patients. However, it is unclear whether PPO patients will feel like this will lead to an infringement of their freedom to choose their providers. The steering committee believes there

is a need to strike a balance between unlimited provider choice and guidance for PPO patients. The committee also believes PPO patients welcome advice and coordination of their care, but will need to adjust to having a care team. It is working on a communication strategy to convey to potential PPO patients that the ACO will still allow patients to choose different providers while allowing for greater coordination of care.

### **Success Factors in Early Stages of ACO Development**

Several factors contributed to HealthCare Partners success in developing the capacity to provide accountable care and creating a formal payment model to incentivize the delivery of such care. These factors include:

- stable leadership structure,
- strong primary care base,
- emphasis on health prevention and health promotion,
- integrated IT infrastructure,
- effective care coordination,
- linking performance measurement and reporting to accountability, and
- ability to take on risk.

#### **Stable Leadership**

The ACO at HealthCare Partners was developed under strong and stable leadership. HealthCare Partners believes its leaders have cultivated a culture that promotes openness and accountability, and encourages individuals, departments, and regional business units to identify innovative solutions to problems. The longevity of the senior leadership team has helped sustain this culture at all levels of the organization.

#### **Strong Primary Care Base**

HealthCare Partners prides itself on its strong foundation of primary care. Primary care providers are responsible for coordinating the care of each patient in their panel, and have been given greater levels of accountability for their patients over time. Primary

*Culture changes [have] to take place. And without good leadership and vision, it'll die.*

Bill Chin, M.D., executive medical director  
HealthCare Partners

care providers have become more involved in efforts to improve efficiency, promote wellness and prevention, enhance patient-centeredness, coordinate care, and manage the global costs of their patients. HealthCare Partners also encourages its primary care providers to take the lead in suggesting and piloting quality improvement initiatives. Having such a strong primary care focus will be an important element of HealthCare Partners' ACO.

#### **Emphasis on Prevention and Health Promotion**

HealthCare Partners' approach to health care delivery involves patient outreach, prevention, and health promotion. For example, when the Provider Information Portal was launched, physicians were eager to test out the program's functionalities—particularly the pursuit list, which allowed physicians to identify patients in need of screening or testing. Physicians' engagement in health prevention and promotion is an asset HealthCare Partners can leverage for the success of the ACO.

#### **Integrated Information Technology Infrastructure**

Building a sophisticated data warehouse and integrated IT infrastructure gives HealthCare Partners a significant head start in implementing the ACO and will be a key factor in its ability to succeed as an ACO. The organization relies on technology, data exchange, and clinical data to support its care coordination strategies. The information generated from the data warehouse forms the basis for the development of population health management programs and offerings, which have enabled HealthCare Partners to achieve financial savings from reducing unnecessary hospitalizations and achieving improvements in quality.

#### **Effective Care Coordination**

Continuous investments in care coordination, particularly for high-cost, high-risk, and chronically ill patients, have resulted in sustainable improvements in patient health. For example, over the course of two

years, the chronic obstructive pulmonary disease management program resulted in a 30 percent reduction in total admissions, a 39 percent reduction in total bed days, a 23 percent reduction in total emergency department visits, a 34 percent reduction in the cost of care (based on a per-member per-month payment), a 30 percent increase in primary care visits, and a 3 percent reduction in drug costs. The organization's proven ability to coordinate patients' care puts it in a good position to improve the health of ACO patients.

### **Linking Performance Measurement and Reporting to Accountability**

Performance measurement and reporting are fixed components of HealthCare Partners' care delivery model. Physicians, in particular, take performance measurement seriously, in part because incentives and bonus payments are tied to their performance on quality, care coordination, efficiency, and preventive measures. The use of a real-time data loop via the Provider Information Portal enables providers to keep abreast of their patients' care and their performance on specified measures. It also allows them to compare their performance with their peers, which drives improvement. According to physicians at Montebello Clinic, physicians take ownership of their panels since HealthCare Partners endorses a collaborative approach to improving patient care.

The organization prioritizes transparency through an emphasis on internal and external reporting of performance data. Performance results, including patient experiences, are shared publicly via the California Office of the Patient Advocate, HealthCare Partners' Web site, and IHA. HealthCare Partners particularly prides itself on sharing results of patient satisfaction surveys. It believes a commitment to consistent measurement, reporting, and internal feedback is indispensable to being an ACO.

### **Internal Ability to Take on Risk**

Members of the internal ACO steering committee emphasized that ACOs need to take on downside risk

*[An ACO] has to reach out to see who is truly at risk and then build wellness programs around them, and you can only do this if you collect data on your population.*

Robert Margolis, M.D., CEO,  
HealthCare Partners

to drive change, and that their financial model must create strong alignment between financial and quality incentives. HealthCare Partners is equipped to handle full financial and global risk. It has been able to leverage the tension between the incentives created by the financial risk model and the desire for strong clinical outcomes. In doing so, HealthCare Partners has created a culture of accountability aimed at driving health care quality improvements and reducing costs. It hopes to strike the same balance with the ACO.

### **CONCLUSION**

Prior to establishing an ACO, HealthCare Partners built the infrastructure to take on global financial risk and cultivated an organizational culture committed to delivering accountable care. The ACO will enable HealthCare Partners to expand its services to a PPO population. As the ACO evolves, HealthCare Partners will need to address existing and potential challenges, such as: developing payer and provider data-sharing agreements that support effective patient attribution, garnering IPA support for the model, and designing a plan to communicate the benefits of the ACO to PPO patients. It has built the readiness for ACO implementation through its strong institutional leadership; care coordination capabilities; sophisticated health information systems; and experience promoting performance measurement, preventive health, and continuity of care. Leveraging its strengths and mitigating existing challenges will enable HealthCare Partners to advance toward achieving the triple aim of providing better care for individuals, improving the health of populations, and reducing per capita costs.

For a complete list of case studies in this series, along with an introduction and description of methods, see <http://www.commonwealthfund.org/Publications/Case-Studies/2012/Jan/Four-Health-Care-Organizations.aspx>.



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