

# Jumping into the accountable care organisation model

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**Abstract** The US healthcare system is continuing to face many challenges, including rising healthcare costs, and issues related to quality and safety – driving healthcare reform. To address these challenges healthcare providers are looking to provide higher levels of care while controlling the cost of care. The approach that is rapidly being adopted is to establish Accountable Care Organizations (ACOs) or Clinically Integrated Networks (CINs). The number of ACOs across the US has grown significantly over the past several years. To effectively support an ACO or CIN model the organisation needs to address key focus areas that are different from traditional hospital or community practice group functions or capabilities. Establishing an ACO/CIN requires very different operations, financial, and technologies from traditional fee-for-service healthcare payment models. Many ACOs are challenged with becoming financially self-sufficient due to the significant upfront investments in provider performance programmes, technologies and infrastructure which may not be the best initial investments to drive the return of investment of a population health management programme. New ACOs/CINs and financially struggling ACOs/CINs can benefit by understanding the key areas to focus as they expand services. Knowledge gained from the paper provides ACO executives areas to focus to develop successful ACO operations.

**KEYWORDS:** Population Health Management (PHM), Accountable Care Organization (ACO), Clinical Integration Network (CIN), PHM strategy, healthcare technologies for value-based contracts

## INTRODUCTION

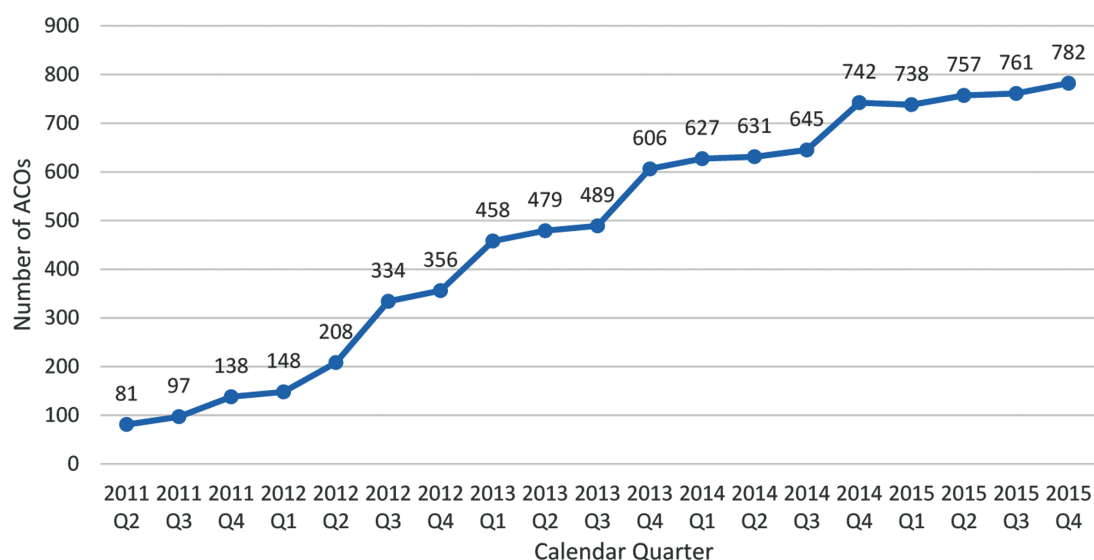
The US healthcare system is continuing to face many challenges, including rising healthcare costs, and issues related to quality and safety — driving healthcare reform. To address these challenges healthcare providers are looking to provide higher levels of care while controlling the cost of care. The approach that is rapidly being adopted is to establish Accountable Care Organizations (ACOs) or Clinically Integrated Networks (CINs). The number of ACOs across the US has grown significantly over the past several years (Figure 1).

Clinical integration is a medical practice model that brings together hospitals with providers from different practices and specialties to coordinate care. As a result patient care is safer, more effective, and more efficient. When providers work together to care for patients in a clinically integrated environment, provider organisations are able to deliver higher-quality care more efficiently and with greater value to patients, which is unattainable compared to the same providers working independently within their practices.

In establishing a CIN, it is required that an aligned team of caregivers is established, a large enough number of members are identified to be managed by the CIN and a financial incentive model is established to support the change in care activities and to align goals of the person and goals of providers. In this paper, I am addressing the establishment of operations and technologies to support the CIN to bring together multiple practice groups and numerous participating providers located in a geographic area that provides high level of quality care services and together negotiate risk-based payer contracts for an attributed patient population.

## ESTABLISHING AN ACO OR CIN MODEL FOR POPULATION HEALTH MANAGEMENT

Clinical integration is an economic model, whereby integrated providers share the costs of their efforts, making care more affordable for all. It is a legal model through which members of a clinically integrated entity



**Figure 1:** Number of ACOs established each quarter

Source: Muhlestein, D., Gardner, P., Caughey, W. and de Lisle, K. (2015) 'Projected growth of accountable care organizations', LP Corp Projected Growth of Accountable Care Organizations Comments, available at: <http://leavittpartners.com/2015/12/projected-growth-of-accountable-care-organizations> (accessed 4th January, 2016).

present themselves to the marketplace as a single entity, not as individual practices. As a single entity the integrated practices can participate in joint venture activity, such as payer contracting, if it is ancillary to and supportive of their efforts to deliver greater value to consumers.

Clinical integration allows medical communities the opportunity to coordinate care, improve the value of medical services, promote that improved value, attract greater market share and conduct joint venture activities as a single entity for various projects such as payer contracting. Maintaining clinical integration provides continuous improvement in every aspect of the practice group and provider organisation.

To effectively support an ACO or CIN model the organisation needs to address three key focus areas which are different from traditional hospital or community practice group functions:

- I. Care model
- II. Operations
- III. Technologies

In a successful CIN, the care models significant changes from a model of multiple independent acute or episodic interactions between healthcare providers and the patient, to a longer-term horizon view of care for the person with identification, management and coordination among healthcare and social providers, addressing multiple aspects of a person's health and social situation.<sup>1</sup> The successful CIN care model requires close coordination and communications among all participants involved in the overall quality of life of the person. The interactions change from event or episodic activities between each of the separate healthcare entities providing individual services to the patient to continuous interactions where the person has trusted advocates who support the person in multiple aspects of their needs, not just specific medical or clinical needs.

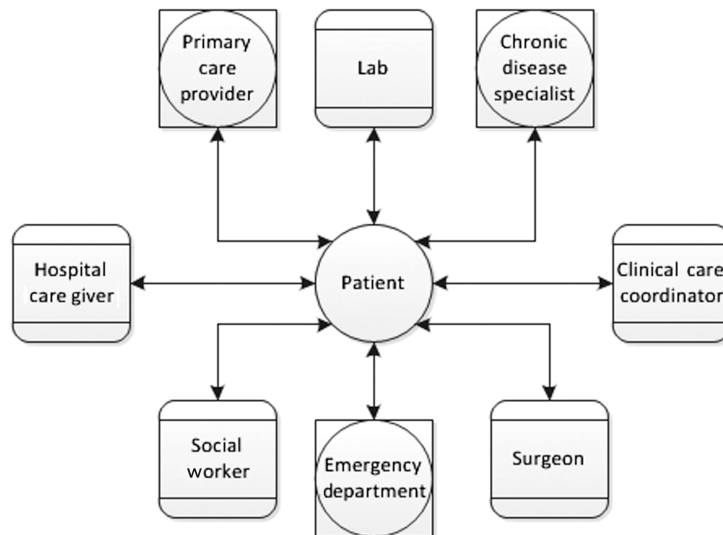
## THE CARE MODEL

CIN's enhanced care model changes the objectives of each of the entities (providers) that have interactions with the patient, from simple goals of addressing the single event interaction that the healthcare provider has with the patient, to establishing higher-level objectives that are aligned with the person's goals of improved living. To support the new holistic objectives requires ability for the entire care team to understand the person's goals and work together to satisfy and support the person obtaining those goals. This new care model in a clinically integrated environment requires a robust communication and coordination of activities and sharing of information across the ecosystem of providers that touches the person (Figures 2 and 3).

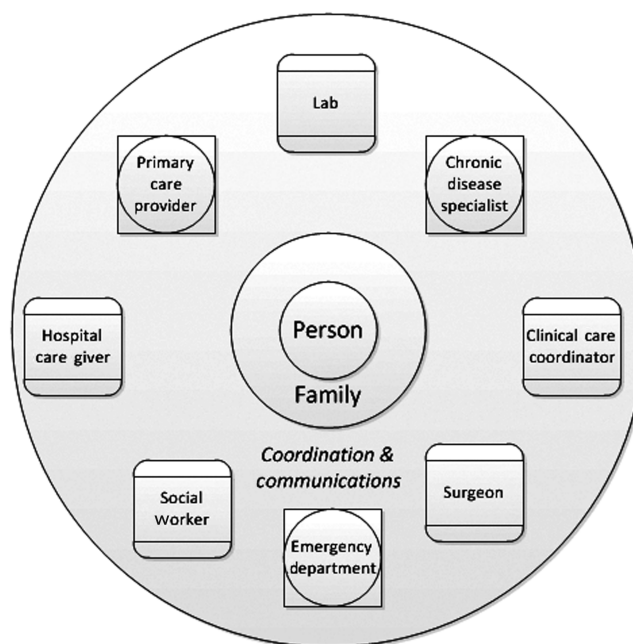
Successful population health management (PHM) requires revamping the healthcare systems' delivery models. To be fully engaged in the interests of the patient and simultaneously managing healthcare costs, the CIN needs to address individual patient engagement and include how social determinants impact patient health. Some of the known correlations between social determinants and overall quality of a person's healthcare and daily activities are as follows:

1. Obesity issues lead to diabetes mellitus and coronary artery disease (Figure 4).
2. Smoking is known to be a factor leading to cancer issues (Figure 5).
3. Poor housing conditions for children increase rates of asthma (Figure 6).
4. Stress levels impact the rate of hypertension.
5. Lack of transportation results in emergency room utilisation versus primary care provider office visits.
6. People choose to pay rent or food bills over medication costs.

Healthcare needs to address these issues and work with our community leaders to positively impact each person's health.



**Figure 2:** Standard care model of acute interactions between patient and providers

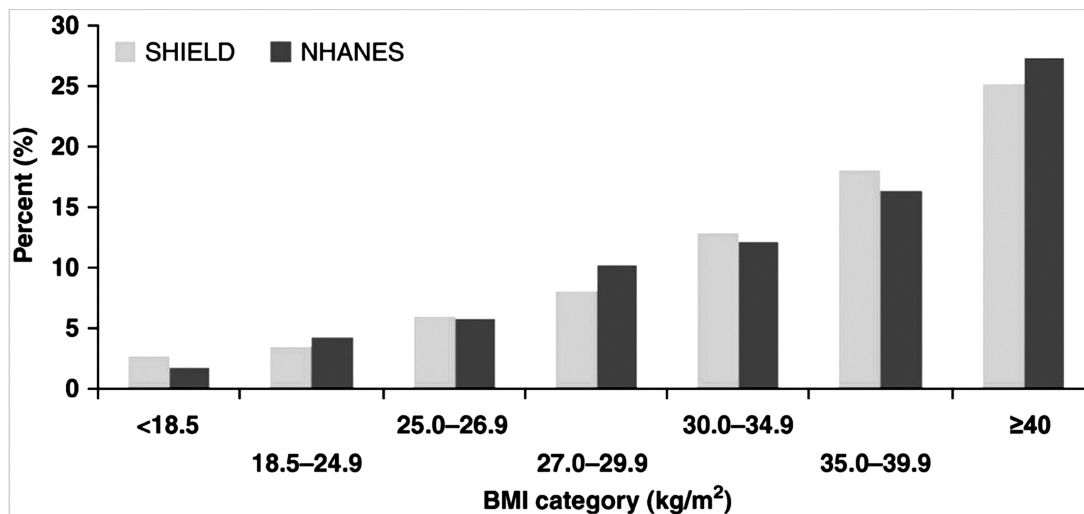


**Figure 3:** CIN interactions with person (patient)

### OPERATIONS NEEDS TO SUPPORT PHM CIN ORGANISATIONS

There is a significant difference in the operations that are required to support a PHM model of a CIN and standard fee-for-service (FFS) payment models for healthcare.

The PHM incentive models that are initially being adopted by provider groups and payers have been focused on shared savings models. The communities of providers generally are hesitant of adopting full financial risk models, since they have no history or clear

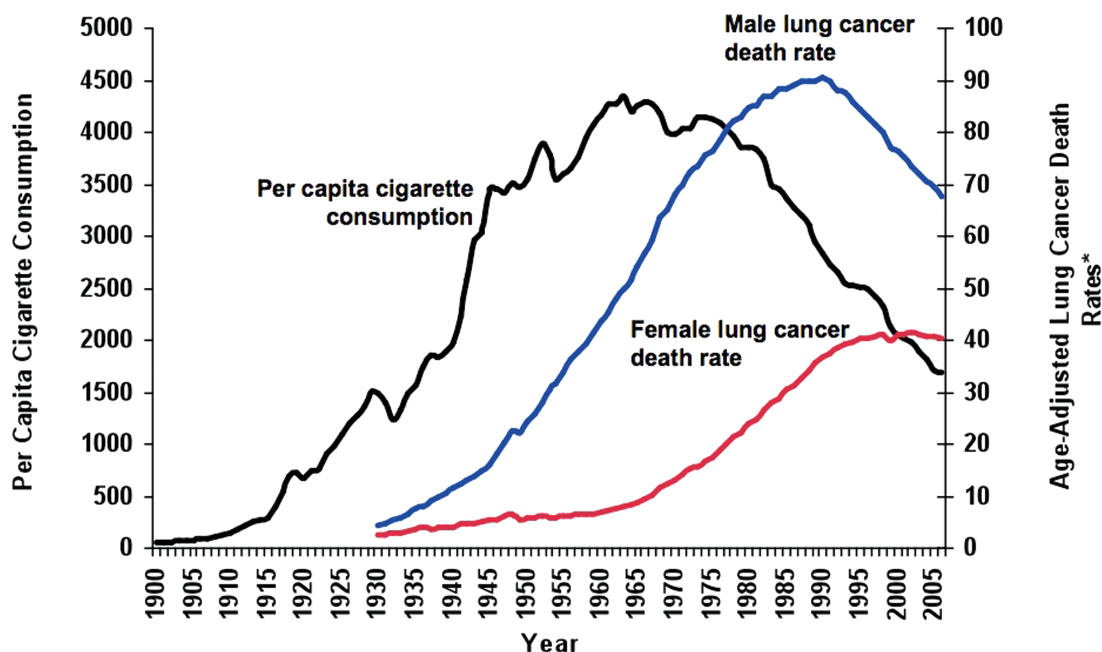


**Figure 4:** Correlation of obesity to diabetes mellitus

Note: Prevalence of diabetes mellitus (types 1 and 2) by body mass index (BMI) level.  $p < 0.001$  in tests of linear trend across BMI groups within each study [Study to Help Improve Early evaluation and management of risk factors Leading to Diabetes (SHIELD) and National Health and Nutrition Examination Surveys (NHANES)];  $p < 0.001$  in tests comparing SHIELD with NHANES estimates (for each BMI category).

Source: Bays, H. E., Chapman, R. H., Grandy, S.; SHIELD Investigators' Group (2007) 'The relationship of body mass index to diabetes mellitus, hypertension and dyslipidaemia: Comparison of data from two national surveys', available at: <http://onlinelibrary.wiley.com/doi/10.1111/j.1742-1241.2007.01336.x/full> (accessed 4th January 2016).

## Tobacco Use in the US, 1900-2006

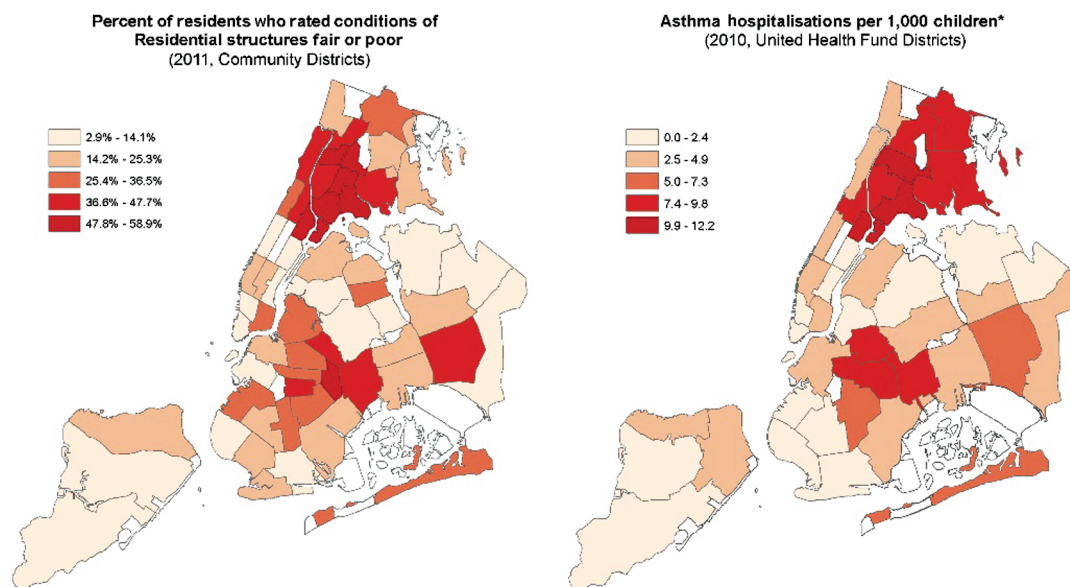


**Figure 5:** Correlation of smoking to cancer

\*Age-adjusted to 2000 US standard population.

Source: Death rates: US Mortality Data, 1960–2006, US Mortality Volumes, 1930–1959, National Center for Health Statistics, Centers for Disease Control and Prevention, 2009. Cigarette consumption: US Department of Agriculture, 1900–2007.

Source: 'Cancer Statistics 2010', Cancer Facts & Figures 2010, available at: <http://www.cancer.org/research/cancerfactsstatistics/cancerfactsfigures2010/acs/groups/content/@nho/documents/document/acspc-026316.ppt>. pp. 27 (accessed 4th January, 2016).



**Figure 6:** Correlation of poor housing to children asthma hospitalisations

Source: Keeping Track of New York City's Children. Keeping Track Online, Citizens' Committee for Children of New York, Inc. (2010) 'Asthma hospitalizations', available at: <http://data.cccnewyork.org/data/map/7/asthma-hospitalizations#7/a/4/11/8/a> (accessed 28th December, 2015).

predictors on how they would perform. The shared savings payer contractual models that are becoming initially attractive to CINs with commercial payers are modelled after the Centers for Medicare & Medicare Services (CMS) Medicare Shared Savings Programs (MSSP). These contract models tend to have limited downsides but provide an upside financial potential for the providers participating in the CIN. These contractual models allow each practice group to bill for services for care provided, but they have the opportunity to gain additional financial incentives at the end of a period by sharing in the payer savings. The payers generally use a model of overall decreased average cost of care for the member population for the time period (annual), and the amount of shared savings that is received from the decreased costs is based on measurement of specific quality measures that have been established at the beginning of the period. These quality measures are generally defined from either the CMS Physician Quality Reporting System (PQRS) or the National Quality

Forum (NQF) measures, where the CIN provider performance is either compared to a previous period established benchmark or a national reported benchmark. The Federal Trade Commission (FTC) has established advisory opinions that allow groups of participating providers that would normally compete in a geographic area to come together to establish a CIN. The general opinion to be considered a CIN by the FTC is that the main purpose of establishing the CIN is to provide a higher level of quality of care to patients. The FTC needs to be reassured that providers are not coming together to collude on rates. The accepted approach of validating that the participating providers are involved in the CIN is that the providers are "actively" involved in the CIN, are monitored, and are provided feedback to improve their performance measure with clinical quality metrics. The need to increase collaboration and communications among the multiple caregivers is critical towards the success of the enhanced care model.

Many CINs initially focus and invest in the operations activities to market and enlist providers, and to establish an ability to collect data to report on practice group and provider performance. Initially, there is a strong need for marketing activities to engage and enlist community providers into the network and gain their confidence by the provider community in the model so they are willing to participate and incur the additional work activities that are involved. The ability to demonstrate the active involvement by the providers, and the measurement, reporting and improving the provider performance are important activities for the CIN, but these activities are only indirectly translated into improved care for the patients. The CIN also needs to manage financial aspects of operational and reporting activities that are not required to support standard healthcare provider services. These new activities are required to support financial management and incentive sharing. A CIN's operational capabilities to support these additional activities include:

- Website and marketing presence targeted at community providers;
- data collection approaches to be able to report clinical quality measures;
- reporting and monitoring provider performance;
- leveraging quality metrics to monitor overall healthcare's care costs for the CIN;
- development of operational solutions to potentially allocate realised shared revenue savings to participating providers; and
- investments in establishment of the physician-led committees to support the CIN (eg, Board of Managers, Finance Committee, Quality Board, Issue and resolution committee)

There is only a loose indirect relationship of provider clinical or operational quality

performance measures to an individual's quality of care. The relationship of provider performance to healthcare cost reduction appears to have even a less direct relationship. Established CINs/ACOs have reported that the most successful approaches towards improving the care of the managed population and reducing the cost of care to realise shared savings is through strong communications among the care providers and providing very high touch personal care coordination activities for the population with the highest healthcare risks.

CINs should focus on biggest value proposition for their PHM approaches, which require investment in establishing a strong care coordination organisation, implementing the appropriate technology tools to be able to identify and stratify high-risk attributed members and establishing healthcare protocols for chronic disease management, care coordination workflow processes, and communications across the care teams.

## **TECHNOLOGIES SUPPORT TO CIN**

Technologies to support a CIN can be identified into four key "pillars" that support the enhanced care model.<sup>2</sup> These are as follows:

- Engagement with the person and person's advocates and/or family;
- integration and coordination among care team providers;
- quality evidence-based management of care to population across the care team (includes evidence-based management, individualised protocols, evaluation and analysis of provider conformance to quality measures); and
- analytics and administration of quality of care, identification of person needs and cost management

Use of technology is critical to support the enhanced care model. Many technologies

may already be in place to support the individual providers to automate and manage their care activities and operations, such as electronic medical records (EMR) with advanced instrumentation, documentation and safety protocol checking. The CIN-enhanced model expands the need for different types of technologies focused on documentation, data collection, communications, coordination, analysis and analytics. It becomes critical to no longer just have technology that supports and improves the individual interaction between a patient and the provider but have technologies that provide sharing of information across the entire care team.<sup>3</sup>

CIN establishes new operational requirements that are non-existent in the current acute-based interactions that occur between a patient and each care provider. There is a greater importance to be able to identify the person, the primary, secondary and tertiary care providers and person's advocates who are part of the ecosystem of managing the daily care and social support activities. As healthcare organisations strive to reduce costs and improve care effectively using PHM technology will involve more than selecting and implementing systems.<sup>4</sup> Operations of a CIN require identification, risk stratification and management of the population or people who are being managed by the CIN; identification and management of all the care providers who interact with the person; monitoring of the quality of services being provided and education to the care providers to continuously improve their quality of services; and financial management activities to share incentives and cost savings. Some health organisations that have established as a health maintenance organisation (HMO) or aligned large independent practice association (IPA) with a closed network of providers and members have implemented operation models that are similar to what is required for a CIN, but generally do not fully support all the needs of future PHM models.

## TECHNOLOGY STRATEGY AND APPROACH TO SUPPORT CIN

The five key technical capabilities that support the PHM care management goals of successful CIN are as follows:

1. Ability to extract/collect, store, manage, stratify, risk assess and exchange information specific to individual health information
2. Ability of providers, patients and other members of the patient's health team to communicate among themselves to effectively provide healthcare delivery and social community benefits support
3. Ability to collect, store, measure, monitor and report on processes, patient goals, outcomes, provider performance and quality of care
4. Ability of providers and their practices to engage in decision support for evidence-based treatments and follow proven care protocols which are updated and adjusted based on feedback from patient outcomes
5. Ability of consumers and patients to be informed and literate about their health and medical conditions and appropriately self-manage with monitoring and coaching from provider team and a person's health advocate, which may be family, a social worker, a care coordinator, or a provider

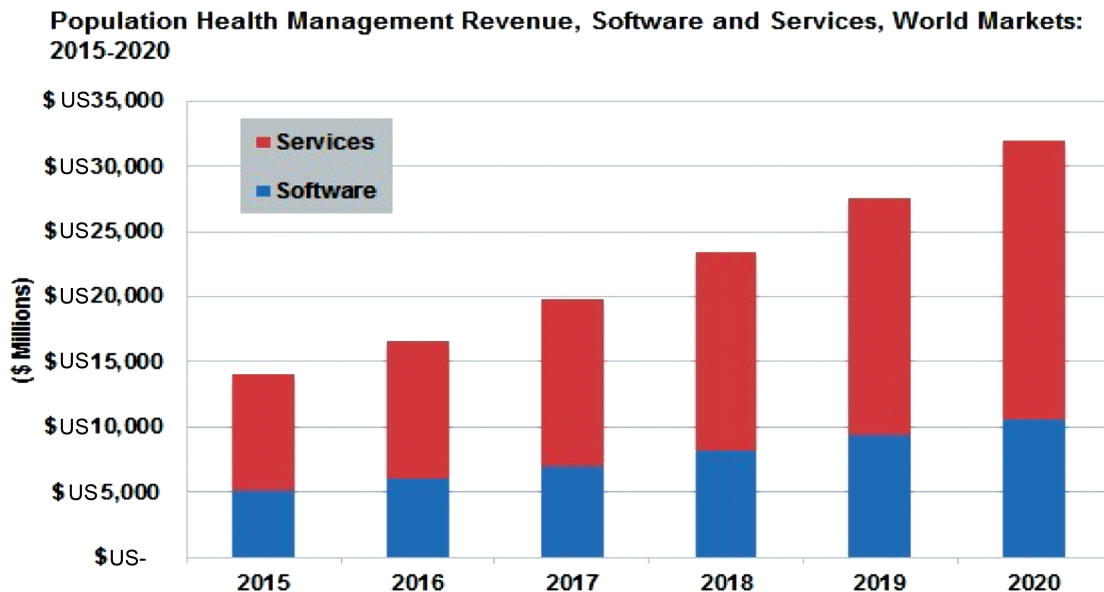
Notice that the difference in the above five key technologies from the early set of technology needs to be identified for the CIN. These later identified technology needs are focused directly on providing higher levels of care for the population. By implementing technologies to support these five key areas, the CIN will have the ability to monitor and manage providers and provider performance as natural output.

Healthcare organisations are actively establishing ACOs and/or CIN to support populations in specific demographic service areas. Technology is identified as critical to successful PHM programmes.<sup>5,6</sup> The question

is what technologies and how should they be implemented. To successfully establish a CIN programme with the appropriate technology solutions, healthcare organisations are partnering with commercial vendors to support them with services, software, hardware, technologies and capabilities required to successfully implement clinical integration programmes. Recent forecasts indicate that the global market for PHM software and services will more than double in size during the next five years, increasing from US\$14.0bn in 2015 to US\$31.9bn by 2020 (Figure 7).

Many CINs when first established immediately focus on technologies to report and monitor the provider performance but attempting to collect and report on clinical quality measures using PQRS or NQF definitions. The challenge that they are experiencing with an approach focused initially on provider quality measures is that the required data to support the measures is not available in standard structured data formats, nor is it easily retrieved from

EMRs. Depending on the composition of participating providers in the CIN, the required patient health data may be scattered across potentially hundreds of separate EMRs. There are numerous challenges with quality reporting using the standard industry specifications. Clinical quality calculation and reporting issues occur because the required data is not readily available from EMRs in a standard structured format. As an example of this challenge, the 2015 PQRS Measure #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up not only requires a patient's BMI to be calculated and reported, but it also requires that the care provider has established and communicated a follow-up plan with the patient. The calculation of a person's BMI is relatively easy using formulas on height and weight, which are generally structured data in the EMR; but the establishment and communication of a follow-up care plan with the patient is not generally in a structured data field and instead is captured in free-text notes. This simple example



**Figure 7:** PHM software and services market growth

Source: Vyas, C. (2015) 'Population health management market to double in size to \$31.9 billion by 2020', available at: <https://www.tractica.com/newsroom/press-releases/population-health-management-market-to-double-in-size-to-31-9-billion-by-2020> (accessed 10th December, 2015).

is just one of the many challenges that are encountered in calculation of simple clinical PQRS metrics. Yes, it is important to establish clinically relevant quality measures to measure provider performance, but if the measure cannot be confidently reported with minimum manual activities, the measure becomes irrelevant, since the accuracy of the measure is in question.

In determining the most effective source of truth for data analytics, the CIN needs to review: what is the best source of data that can be regularly reporting and have confidence on the accuracy. The data needs to come from an electronic system that stores and validates the required data required to calculate the quality measure. The data needs to be standard well-defined structured data field. The most robust and well-defined data source on a person's healthcare procedures available to CINs is the payer's adjudicated claims. Adjudicated claims do not contain a full clinical data set, but they meet three of the four key items for data (data availability, data accessibility, data quality and data velocity), required to support business/clinical intelligence requirements.

Adjudicated claims data is readily available either from the payer or patients under risk-based contracts, and pre-adjudicated claims data is available for all patients receiving care directly from the provider billing systems. The format of the billing claims data is standardised using the Health Insurance Portability and Accountability Act (HIPAA) transactions 837 P and 837 I XML format, so data is easily accessible for Current Procedural Terminology 4 (CPT 4), International Statistical Classification of Diseases and Related Health Problems ninth or tenth Revision (ICD-9/ICD-10) and Healthcare Common Procedure Coding System (HCPCS) coding of professional services data. Although there exist Current Procedural Terminology II (CPT II) codes that are an attempt to deliver clinical value ranges for specific lab test in a claims file, CPT II codes are not supported by many

practice management systems and many payer systems cannot accept claim files containing CPT II codes with zero charge amounts as claim line items. The data quality is high since the providers need to submit clean data for payment and the payers reject claims that do not meet minimum payer required data fields. The question many clinician raise with leveraging billing data for quality metrics is that the claims do not provide a complete clinical picture of the patient. Considering all aspects of claims data quality, accessibility and availability, they provide a higher level of confidence for quality reporting on provider performance than attempting to extract data from multiple EMR systems that do not store all required clinical quality data elements in standard structured formats. Other issues experienced with using adjudicated claims for quality metric reporting include the latency of the data and the issue that payers can only provide data for their members that the CIN is under a financially at-risk contract. The availability of adjudicated claims can be more than 120 days delayed from the time of the patient encounter. The payer only provides adjudicated claims for a portion of the population. The adjudicated claims data provided by the payer only provides a partial view of the provider's performance limited to only patients covered under specific payer financial at-risk contracts. A demonstrated successful approach to calculate some provider performance metrics addressing adjudicated claims latency and limit population data issues is to collect and parse the pre-adjudicated billing claims that the providers submit in the standard HIPAA 837 XML format. The approach of using pre-adjudicated claims eliminates the data latency issue but creates other challenges. The two significant challenges with pre-adjudicated claims for reporting are reporting on non-finalised information, and potential issues with duplication of information since the same claim can be submitted multiple times to address rejected responses from the

payer. If the calculation of quality measures is based on pre-adjudicated claims, the system must be able to manage and update correctly the reporting database each time the same claim is resubmitted. Vendors do not provide commercial off-the-shelf solutions to parse claims for the purpose of reporting metrics, so custom development is required.

Mature CINs have realised that the true value of the CIN is not reporting on provider performance and trying to standardise provider processes but rather to support the overall continuum of care of the person.

### **HOW TO GET STARTED AND DEVELOP A BETTER TECHNOLOGY STRATEGY FOR THE CIN**

CINs desperately need unique technologies that are generally not used at acute or clinic settings. There are no commercially available vendor solutions that provide all the technology needs of the CIN. This is because the CIN's business and care delivery model is new and rapidly transforming as the healthcare is moving towards value-based healthcare reimbursement from quantity-based reimbursement. The payers and the providers are both experimenting with new approaches and financial incentive models to develop appropriate incentives for the providers to enhance the level and quality of care while simultaneously working to decrease the average cost of care for the covered population. This is truly new territory that PHM organisations are venturing in providing longitudinal continuum of care for individuals. The value-based models are designed to reduce the number of in-patient high-cost episodes and move towards lower overall cost models of maintaining a person's overall quality of life.

Newly established CINs and struggling networks need to stop and re-evaluate the focus of the PHM programme and review their planned and current processes and operations. They need to determine if

the operations and technologies that are being implemented support the true PHM objectives. The CINs should evaluate if the operations activities are directly focused on enhancing their attributed person's care or have them been led down the unfortunate trap of focusing on provider profiling and provider performance through quality metric measurement and reporting. The CIN should develop an operations strategy on how to transform the organisation and increase the level of investment on social, community benefits and care coordination. Develop a validated approach of identification of high medically at-risk and high utiliser persons of the network resources. Establish operational care models on how to identify and communicate among the care team that touches and cares for a person. Develop an approach on sharing each attributed person's social and medical situation with the entire care team. Focus on a strong operations model before determining required technologies.<sup>7</sup> Remember many vendors are now offering PHM solutions, but most do not really know what is critical and valuable from a CIN and PHM perspective. Yes, there is a need for data analytics and predictive analysis, but first determine the operations investment and strategy. Develop processes on how to align personal health and social care teams around individuals. Develop financial operations models that support the required increase in non-billable care coordination, care management and social community support activities. Understand that initially a larger portion of the financial shared savings with payer contracts will need to support the infrastructure development and increased non-direct billable care coordination activities.

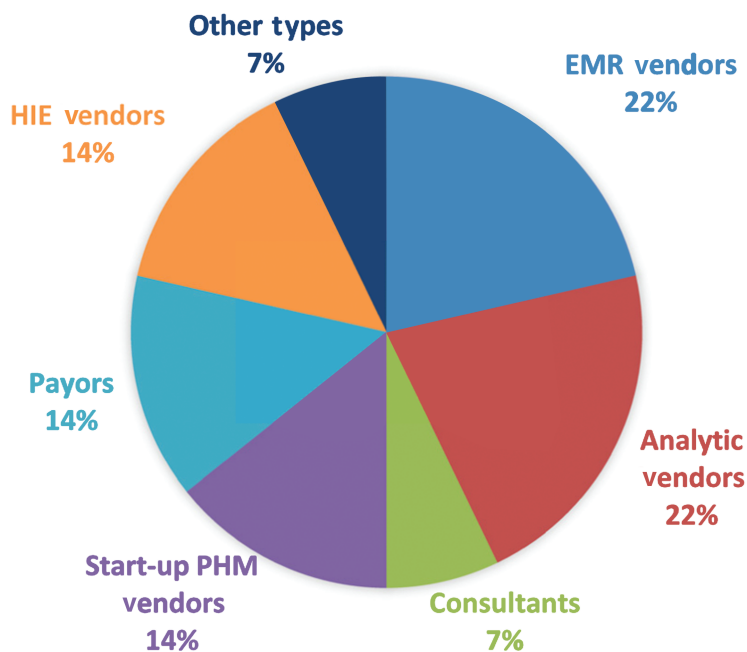
Once an operations strategy is formulated and can be easily communicated to the internal and external stakeholders, then focus on the required technology solutions. Do not allow the technology vendors to incorrectly drive the PHM requirements.

### CATCHING UP THE TECHNOLOGY

The CIN operations strategy does not have to be finalised before starting the development of the technology strategy for the CIN, but core portions on staffing, planned key activities and processes need to be identified by the business before starting to research potential PHM technology vendor solutions. The technology vendors are anxious to be involved in the early development activities and looking for client CIN references that have agreed to purchase their solutions, so the vendor can use the CIN for marketing and sales purposes. Many vendors have entered the market with PHM solutions that are no more than PowerPoint slideware depicting all the benefits of integrated networks and performing data analytics to improve the quality of care. Vendors with different initial focuses have entered the market offering PHM solutions. The Health Information Exchange (HIE) vendors present the value proposition of sharing clinical data to multiple provider groups located at disparate locations.<sup>8</sup> The EMR vendors approach selling solutions

as a centralised information warehouse, where quality measures, reports and analytics are delivered and providers can all access and share patient information in the single EMR solution. The sophisticated analytics vendors tout their ability to drive deep historical and predictive analytics and reporting. Many vendors have only been in the process of developing solutions for the past couple of years; these solutions are generally developed with a beta client and tend to be tailored specifically for requirements that the specific client requested and not necessarily transferrable to other PHM clients. Vendors are in process of developing care coordination and patient management solutions. Unfortunately, many of these systems are only deployed in pilot or proof of concept clients, and the vendor software development teams are unable to deliver required capabilities quick enough that were promised by the sales team to the clients (Figure 8).

In developing the technology strategy and roadmap, the CIN needs to understand that the business is still experimenting with the financial and operations models and therefore



**Figure 8:** PHM vendor backgrounds (based on 28 vendors known for PHM solutions)

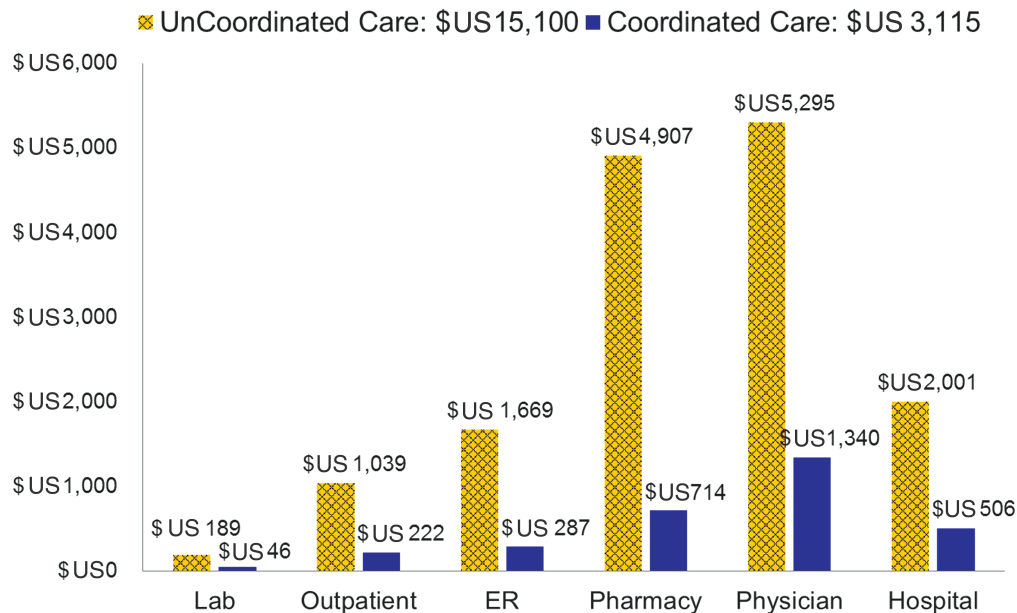
does not have a clear vision of the full business functionality or technical requirements. The CIN needs to develop its technology strategy knowing that many items are only concepts and will rapidly change over the next couple of years. Determine what activities can be supported with processes and in-place technologies before committing to large investments with PHM solution vendors. Use the operations strategy and address the five key technologies identified to support the PHM care management goals of successful CIN to develop a process and technology strategy and roadmap implementation plan. Determine the trade-offs of trying to procure and implement new technology solutions to establishing highly defined workflow processes that will support these CIN capabilities.

Leverage consultants as needed to drive and identify technologies and process solutions. Do not be shy to change direction on technical requirements to support the rapidly changing business and operations

models. Develop the strategy and technology roadmap that the business stakeholders can understand and can articulate the value proposition of each technology component.

## CONCLUDING COMMENTS

Establishing or re-engineering a CIN is not a simple activity. It requires strong executive support and will require new types of skilled resources who previously may not have been essential for care provider organisations. These new skilled resources include community nursing and community benefit resources, performing activities such as patient navigators and care coordinators. Business or clinical intelligence experts, and data management, and data scientists are required resources for a successful CIN to be able to effectively analyse and develop required data reports. Focus on establishing a strong care coordination programme to significantly decrease healthcare costs (Figure 9).



**Figure 9:** Comparison of costs of uncoordinated care to coordinated care

Source: Kay-Owens, M. (2009) 'Identifying and quantifying the cost of uncoordinated care: opportunities for savings and improved outcomes', available at: [http://www.sec-rx.com/~fhslc5/sec-rx.com/images/stories/documents/Summary\\_of\\_SEC\\_Analyses\\_on\\_Cost\\_of\\_Uncoordinated\\_Care\\_2010.pdf](http://www.sec-rx.com/~fhslc5/sec-rx.com/images/stories/documents/Summary_of_SEC_Analyses_on_Cost_of_Uncoordinated_Care_2010.pdf) (accessed 2nd January, 2016).

Building a core team with the required skills is challenging. The recommended approach is to identify the key leadership resources and the team by identifying well-qualified resources while supporting these new required skilled positions with consultant resources that are familiar with CIN organisations and PHM requirements. Hire or develop relationships with consultant experts that have deep understanding of healthcare technologies, business intelligence solutions and new healthcare operation models for CINs or ACOs. Remember these are brand new business models that can provide potentially rewarding outcomes, but are still in their infancy of maturity. There will be many unexpected challenges and there are no 'silver bullet' vendor solutions that can solve them.

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