Are ACOs Really Engaging Patients?

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CHOIR Center for Healthcare Organizational and Innovation Research

Berkeley School of Public Health

Data Sources

- National Survey of ACOs (N=101)
- Follow up phone interviews with 11 ACOs
- Site visits to four additional ACOs involving approximately 20 clinical practices and 100 respondents

Funders

- Gordon & Betty Moore Foundation
- The Commonwealth Fund
- Patient Centered Outcomes Research Institute (PCORI)

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The Challenge

- To meet quality and expenditure targets, ACOs need to change how care is delivered to reduce preventable hospitalizations, readmissions, ED visits, and unnecessary tests.

- To do this, ACOs need to increase engagement with patients

Survey Highlights

Question	% Yes
% PCPs working with patients/families to set treatment plan goals	62%
% PCPs receiving training in PAE	48%
% PCPs receiving training in shared decision making practices	58%
% of ACOs high-risk chronic illness patients that participate in a care transition program	60.7%
% of ACOs high-risk chronic illness patients that participate in peer support groups or group visits	18.5%

Survey Highlights Cont'd

Question	% Yes
ACO provides patients access to their medical records AND to clinical notes	23.8%
ACO recruits patients/families to participate in quality improvement activities	50.5%
ACO leadership believes PAE is critical to ACO success	7.35 (1-9 scale)

Source: Shortell SM, NJ Sehgal, S Bibi, PP Ramsay, L Neuhauser, CH Colla, and VA Lewis, **"An Early Assessment of ACOs Efforts to Engage Patients and Their Families,"** Medical Care Research and Review, Online June 2015.

Major Challenges

- Competing priorities
- Lack of time
- Workflow disruption
- Resource constraints

Major Challenges- Examples

- “This has been a difficult process to implement, and the lack of education of the physicians has been a barrier.”
- “It is a struggle but worth it in the end”
- “Our clinicians have…so much on their plates. It’s really hard for them to think about the whole package that’s available for their patients…there’s competing priorities.”

What's Working?

- Freeing up the PCP by off-loading tasks to the care team (RNs, LPNs, MAs, Dieticians, Nurse Educators, and others). A really engaged team
- Communications training
- Targeting "difficult to change" patients—multiple methods
- Embedding behavioral health

What's Working- Examples

- "We provide a full interdisciplinary team to each patient identified at risk and develop a very individualized plan of care to include medicine, behavioral, and social issues."

- "We have health coaches who have been trained in motivational interviewing and self-management support who work with our patients after they have seen their PCP to establish self-management goals"

What's Working- Examples Cont'd

- "RN care coordinators work one-on-one with patients and their family members to understand patient limitations."

- "When we first started putting care coordinators in the offices we got pushback from the doctors that we were taking some of the things that they do. But after they got familiar with it and realized that you don't really need a medical degree for these things …they were ok with it."

Further Information

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