ACOs: What Every Care Coordinator Needs in Their Tool Box

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A few years ago, Gene Lindsey, president of Atrius Health, told the *Wall Street Journal*, "An ACO is like a unicorn; everyone thinks they know what one is, but no one has ever seen one." Although the definition of an accountable care organization (ACO) can vary, and some healthcare systems probably use the term quite liberally, it appears we now have vast herds of unicorns roaming the country. Meanwhile, we have seen a surge in tech startups and new business lines from traditional health vendors offering care coordination tools to help ACOs deliver better care. Given the swell of ACOs and the surge in new technologies designed to support them, we should pause to ask ourselves: What are the features we truly need in care coordination tools to deliver on the promise of the Triple Aim? In this article, we will start with a quick overview of this growing market segment and then look at 5 essential features that care coordination tools must have to be helpful to care coordinators and their patients.

First, it is important to briefly share background on the authors, as we are approaching this topic based on our own experience and to settle on a working definition of an ACO. We have collectively served as a registered nurse with oversight of the clinical components of an ACO-like arrangement (the Intensive Outpatient Care Program started by Boeing in St. Louis to better manage the care of their chronically ill employees), an overseer of both a patient-centered medical home with UnitedHealthcare in Arizona and ACO implementations across the state of California with Blue Shield of California, and a former health plan executive with strategy and implementation oversight for the information and technology enablement of ACOs across California.

For the purposes of this article, we will define an ACO as a "care coordination model designed to improve quality of care, increase patient satisfaction, and lower the cost of care by leveraging and connecting the relationships of hospitals, medical groups, and health plans to work together to decrease fragmented care." Interestingly, for a care system focused on patient experience, patients are rarely aware that they are part of an ACO and the connectivity between the 3 entities is often invisible to them.

Care Coordination Is Key for Many Reasons

From our combined experience, we both know how critically important it is to have good care coordination in any healthcare system or arrangement, including ACOs. Care coordination helps providers to form a complete picture of a patient's overall heath and it also allows them to be able to better communicate with the patient, their family, and with each other. Care coordination also requires constant prioritization and re-prioritization of patients for effective panel management; it means applying art and science to split attention between patients with immediate needs and those ripe for preventive measures or patients we regard as healthy working adults. In these arrangements, it is essential to have a lead care coordinator. An MD can play this role, but given our own experience and backgrounds, this article will focus on what nurses need from care coordination tools.

The Market for Care Coordination Tools Is Exploding

The marketplace for care coordination tools is growing at an exponential rate: in 2014, venture funding for digital health companies surpassed $4.1 billion—nearly the total of all 3 prior years combined.[1] A recent online poll from KPMG indicates that a growing number of healthcare leaders think investment in population health management tools will pay off in a big way.[2] Additionally, the health plans are investing big and earning dividends too—Optum Health recently saw its revenue jump 33%, compared with the prior year's second quarter.[3] The wearables market is growing exponentially as well, with sales of mobile wearable devices, including health and fitness devices and smart glasses, expected to reach almost 70 million items by 2017.[4] Wearables, from fitness trackers to medical-grade

devices, are helping to give patients and providers feedback and are thereby playing a growing role in improving care coordination.

Interestingly enough, with all this growth and investment, we also believe we are seeing a sort of "bifurcation" in the market. Some vendors are being very intentional about developing highly specialized tools or services for niche populations, such as an app for teens with diabetes, while others are pursuing a big picture approach, offering comprehensive out-of-the-box tools for complete care coordination.

What Do Care Coordinators Need From the Tools?

With this surge in investment in care coordination tools, what do nurses need in their care coordination toolbox to ensure they can accomplish real care coordination? We suggest focusing on 5 features:

1. Care coordination tools should be tailored to your patient population.
With so many new tools on the market, it is critical to choose ones that match your patient population. Patients' preferences for how they receive messages about their health (and the content of those messages) is greatly impacted by their lifestyle, age, and socioeconomic status. There is no 1-size-fits-all solution. For example, tools that offer e-mail reminders may be less effective with a Medicaid population compared with those that communicate via text.[5] Tools need to provide the right mode of delivery (eg, e-mail, phone call, text), as well as the right message, tailored to the audience at the right time. In our experience, because some chronically ill patients in the commercial population don't necessarily like to think of themselves as "sick" or singled out for intervention, finding tools that encourage use and participation in a more social, "fun" manner may increase buy-in and utilization. Conversely, the more senior population may generally be more receptive to acknowledging their conditions and prefer to focus on communications customized to their specific needs.

2. Care coordination tools should have a single place the care coordinator can visit to get the full picture at the panel and patient levels.
Across the country, we have seen some great examples of integrated delivery networks successfully using health information exchange technology to pull together complete records of a patient's care. The giant organizations like Kaiser and the Veterans Health Administration have figured out these systems quite well. Several states and regional entities are attempting to do the same, but broad adoption is yet to be seen. For the care coordinator in a disjointed system, this can pose a problem. Consider the example of a patient in a preferred provider organization with a chronic heart problem who sees a cardiologist in a different system than his or her primary care physician; it may be very difficult for the care coordinator to get a complete medical history. Although ACOs can start to bridge that gap, the technology and health information exchange needs to keep up. Ensuring the data is easy to locate and does not require multiple log-ons to access will be a critical component of any system seeking to aggregate data. It remains a real challenge—one that care coordination tools should start to address.

3. Care coordination tools must allow for convenient use of clinical pathways and be flexible for the care coordinator.
Several care coordination tools offer clinical decision support in the form of "decision trees" for providers and care coordinators. As an example, the proposed tool will recommend a set series of steps for the patient diagnosed with diabetes. However, we have also seen tools that are, in some ways, too rigid, where for example, the care coordinator does not have enough flexibility to decide which path to choose first among patients with multiple chronic conditions and related psychosocial issues. In our experience, when the nurse and patient can work together to set mutual goals, health behaviors can be changed; ultimately, the nurse needs to be able to use his or her judgment and work with the patient to negotiate a care path that the patient will adhere to. If these clinical pathway tools force the care coordinator to choose a single, very specific path, there may be patient attrition, as some patients might just give up. For some patients, a recommended 30 minutes a day of exercise is just too daunting, for example. This is the part of healthcare that is both an art and a science: care coordinators need flexibility—that artistic license—to negotiate care paths that will be doable for the patient. The tool can help by giving some general scientific guidance.

4. Care coordination tools need to have strong communication features among providers to facilitate care hand-offs and to involve family/caregivers when appropriate.
Within an ACO, a patient may have interaction with a care coordinator, a primary care doctor, a specialist, a case manager, a pharmacist, a dietician, a social worker, a hospitalist, and a behavioral health clinician. That can mean a lot of hand-offs and a lot of potential for medical errors if the right information is not relayed. Good care coordination tools will help the care team to focus on key events, such as the results of lab tests or a hospital discharge; moreover, they won't overburden the care coordinator with too many flags or "alerts," as this can lead to "alert fatigue." A good tool will also show when a hand-off has been successfully completed so the communication loop can be closed. Family/caregivers need to be included in communication activity upon transitions and hand-offs, particularly in the post discharge scenario, and/or with patients who are challenged in complying with their care plan.

5. Care coordination tools should integrate with other systems—or at least be straightforward about their ability to do so.

So many times in our careers we have had the same conversation with vendors: we ask if the care coordination tool integrates with [fill-in-the-blank]. Often, the short answer is "yes," but usually there is a much longer conversation needed. In an ideal world, all technology would seamlessly integrate: for example, that care coordination app that delivers mobile health reminders would seamlessly integrate with the electronic medical record (EMR) system. When a tool vendor promises integration, we have learned there are 3 important follow-up questions to ask: first, "Have you done this integration before?" then "With whom?" and "How?" It is also important to assess if the other system (eg, the EMR company in our example) wants integration. It is easy to say you will attempt integration with another system that you know will never integrate with you.

CONCLUSIONS

Across the board, we are pleased with the growing national movement toward greater care coordination, as more health systems realize there are better ways to deliver care. New and traditional technology vendors are riding this wave and there are many exciting new tools to choose from. We hope we have provided some basic guidance to care coordinators based on our own experience, though we know there is much still to learn.

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