Creating the right culture for ACOs

By James Furbush | December 16, 2016

As healthcare organizations grapple with risk, more are turning to the ACO model. But how do you shift physicians' behavior and approach to build an ACO from scratch and make it a success? drkondle_headshot

Venu Kondle, M.D., founded the accountable care organizations Golden Life Healthcare ACO, Medical Benefits Administration ACO, and California ACO.

He sat down with athenaInsight to explain how a culture of "sharing hearts and willing minds" — supported by a strong, data-driven operational structure — can result in better care and significant cost savings.

Q Why did you decide to jump into the ACO market?

A Almost one-fifth of the national budget goes into delivering healthcare, but the outcomes are not satisfactory. There are millions of lives that are not being really cared for because we are more interested in treating the incidences and treating the emergencies — and treating conditions that result from neglecting underlying preventative medicine for years and years. ACOs will allow us to understand that the population has a social element, a behavioral element, and a financial element.

Q How are your ACOs structured to track population health and use this data to make medical decisions?

A The vision is population health, and the strategy was to use ACOs as the vehicles. There needs to be a team of five people: one who understands medicine, care, and care delivery; a second one who understands operation; a third one, a nurse who can delegate and oversee the care coordination; a fourth one who understands statistics and applies statistics in medicine — that's really important. And the last one is the IT and computer complement. The computer complement is becoming fairly important because of the predictive analytics. If you take 32 criteria, on every single patient the computer should be able to tell — with a 20 to 30 percent certainty — this patient is at high risk to emerging risk to have a heart attack in the next 24 months. You focus on that patient, so that patient shouldn't have that heart attack.

Q **Can you tell us about your vision of "sharing hearts and willing minds" and how this is embedded in the culture of your ACOs?**

A When we were forming the first ACO, the question came: How many doctors can share their success with the other core doctors who are in the same boat? If we have 20 doctors for collectively 5,000 patients, 16 or 17 doctors are breaking even, but 4 doctors are saving $4 million. If somebody has no sharing heart, they really can't hop on this boat — because they will be miserable that there will be underperformers in the boat. But then there is the second question: Do you have a determined will and determined mind? If you have a sharing heart but you don't have a determined mind, then you really can't hop on the boat either, because the challenges are going to be tremendously high. When you talk about an ACO, first you have to change your own behavior. Then you have to change your team's behavior. Then you have to change your patients' behavior. It is extremely challenging.

Q **Given how important it is to have the right people in the boat, how do you hire physicians?**

A We ask the specific question. My staff and I have to feel they mean it when they say they are on board with this approach, and we don't judge if you aren't — individuals are different. But those who understand what it means to share and agree, those are the only ones allowed to hop on the boat. It doesn't work for everyone. There are four or five physicians, in a group of 300 to 400, who said, "Well, we have a determined mind, but we can't share." So we created a different platform. They're in our group, but not in the ACO.

Q **Can you talk about how that culture actually supports the success of the ACO?**

A With all of our 54 physicians, we give a red card, yellow card, and green card every month. If you're a green card, that means you are doing good; yellow card, you're borderline; and the red card means you are spending a lot of money. That will be the first step to understand that you are costing the ACO and need to change your behavior and work hard to understand where the costs are and to control them. Month after month, we worked extremely hard, and we have almost decreased the spending to the tune of $40-plus million for Medicare in just a matter of three years.

Q **What does this model look like in practice?**

A There is a huge chart. We have ACO designees in every single office. ACO designees report to the care coordinators. Care coordinators report to the care managers. Care managers report to the CMO. The CMO engages to the doctor and the doctor engages to the ACO designee. The ACO designee manages patients. If they have any questions, if they have any doubt — if they have to go to the ER, urgent care, missed appointment, anything happens — the ACO designee gets the call right away by email or by phone. And the ACO designee resolves the issue right there, and if she can't, it goes to the care coordinator. If she can't, it goes to the care manager. If she can't, it goes to the medical director. But if the medical director can't, the medical director calls the doctor and says, "You have to see this patient today." The patient can't go to the emergency room. If that patient was to go to the emergency room, it's going to cost $5,000; if you saw the patient then you saved, that day, five grand. That's huge. In one day, one doctor's office, we literally calculated we had saved $64,000.

James Furbush is managing editor for athenaInsight.

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