

## How ACOs Are Caring for People with Complex Needs

Emerging models of healthcare payment and delivery, including accountable care organizations (ACOs), present an opportunity to improve quality outcomes and lower costs for individuals with complex health and social needs. Understanding how ACOs manage care for this population can help build the evidence base for which strategies should be spread more broadly and where more research is still needed.

Since 2012, the National Survey of ACOs (NSACO) has examined factors that influence the formation, implementation, and performance of ACOs and provides comprehensive data on ACO characteristics, capabilities, and strategies. With support from the [Six Foundations Collaborative](#) [1], researchers at the Dartmouth Institute for Health Policy & Clinical Practice used a cross-sectional descriptive analysis of its most recent NSACO, fielded in 2017–18, to better understand which evidence-based approaches ACOs use to manage care for people with complex needs.

As highlighted in the [report](#) [2], the survey results showed that many ACOs integrate the following evidence-based strategies into care delivery for high-need individuals:

- Identifying people who are at high risk for adverse clinical events (often referred to as risk stratification)
- Separating high-risk patients into subgroups with common needs (segmentation)
- Improving care transitions across settings
- Engaging individuals and their families in care decisions
- Using programs that help patients address chronic illness

However, the analysis also found that the number of evidence-based strategies implemented varies widely across ACOs. Even among ACOs that report having comprehensive care management programs, relatively few have multiple evidence-based strategies in place. Additionally, strategies thought to be especially effective for high-need patients (e.g., integration of behavioral health services) are not widespread.

## Conclusion

The majority of NSACO responders report that they offer comprehensive chronic care management programs for people with complex needs. However, there are several evidence-based strategies in which ACOs are not investing, which suggests opportunities for improvement. It will be important for the field to build the evidence base for which interventions have the greatest impact on quality outcomes and costs of care for high-need patients, and identify ways to accelerate their adoption on a broader scale.

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[2]

### ‘Eyes in the Home’: ACOs Use Home Visits to Improve Care Management, Identify Needs, and Reduce Hospital Use

A new study published in *Health Affairs* finds that 80 percent of ACO leaders use home visits to manage the overall health of people with complex needs.

[3]

# Association Between Care Management and Outcomes Among Patients with Complex Needs in Medicare ACOs

A new study published in *JAMA* finds that ACO-reported care management and coordination activities are not associated with improved outcomes among people with complex needs.

[4]

# How Do Accountable Care Organizations Deliver Preventive Care Services? A Mixed-Methods Study

A new study published in the *Journal of General Internal Medicine* identifies how some Medicare ACOs are addressing the preventive care needs of their patient population.

[5]



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## Links

[1] <https://petersonhealthcare.org/six-foundations-combine-forces-transform-care-delivery-high-need-patients>

[2] [https://petersonhealthcare.org/sites/default/files/Peck\\_ACO\\_Care\\_Complex\\_Needs\\_6F\\_final\\_v2.pdf](https://petersonhealthcare.org/sites/default/files/Peck_ACO_Care_Complex_Needs_6F_final_v2.pdf)

[3] <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00003>

[4] <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2737898>

[5] <https://link.springer.com/article/10.1007/s11606-019-05271-5>